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CYSHCN LHJ Summaries 2021-2022

LHJs selected local strategies and body of work summaries are listed below.

MCHBG Combined LHJ Summaries 2021-22

This Combined Focus of Work covers all MCH domains except Children and Youth with Special Health Care Needs. The shaded sections below list the state-level priorities and strategies. LHJs selected local strategies and body of work summaries are listed below.

CYSHCN LHJ Summaries 2021-2022

Declaration of Purpose - WAC 246-710

The purpose of the Children and Youth with Special Health Care Needs (CYSHCN) program is to assure comprehensive, coordinated, integrated, family-centered, and culturally competent systems of care. The CYSHCN program focuses on developing, extending, and improving services and service systems for identifying, diagnosing, and treating infants, children, and youth up to eighteen years of age who have or are at risk of developing chronic physical, developmental, behavioral, or emotional conditions, or any combination thereof, and require health and related services of a type beyond what is required by children generally. The program works to ensure CYSHCN are able to achieve the healthiest lives possible and develop to their fullest potential by building the capacity of communities to support CYSHCN and their families while developing and enhancing the capacity of statewide systems of care that are comprehensive, coordinated, integrated, family-centered, community-based, and culturally appropriate with the purpose of supporting and promoting health equity.

Vision

All CYSHCN and their families **belong, participate,** and **thrive** in **communities** with **integrated, accessible** systems that **equitably support** their social, health, developmental, and emotional **well-being.**

Goals

We will promote:

- a **system of care** that is family-centered, integrated, collaborative, coordinated, and equitably accessible to all CYSHCN and their families.
- equitable **funding** strategies that improve access and flexibility for underserved families and their providers and align with best practice interventions for CYSHCN.
- **equitable access** to high-quality care and related services to optimize support, health, and well-being for underserved CYSHCN populations, especially those facing disadvantages due to systemic racism and other systemic factors.
- **concrete supports** that CYSHCN and their families need for **well-being** and quality of life including:
    - Social-emotional support & connectedness to other families
    - A sense of belonging and inclusion in their community
    - Access to mental health and behavioral supports that are developmentally appropriate
- **family navigation**, and other family-centered **care coordination** models, to meet the complex needs of CYSHCN and their families, including health, socioeconomic, and psychosocial needs.

Required Activities

All LHJs are required as part of CYSHCN work outlined in the MCHBG Statement of Work to complete the following:

- **Complete intake and renewal process into Child Health Intake Form (CHIF)** database on all infants and children receiving assistance and accessing services through the local CYSHCN Program, as well as children residing in the jurisdiction who are receiving services from maxillofacial review boards, and who are accessing Diagnostic and Treatment Funds. Submit data by the 15th of the month after the end of the quarter. CHIF data reporting deadlines are documented in your contract deliverables. Required fields include ProviderOne number (if a child is participating in Apple Health / Medicaid), county, client name, zip code, date of birth, gender, race, ethnicity, economic level, third-party payment sources, ICD 10 diagnosis code, and additional involvement.
- **Work with partners to share updated local CYSHCN resources with Within Reach / Help Me Grow (HMG).** Review resources for your local area on ParentHelp123.org annually for accuracy and submit any updates to Within Reach.
- **Administer Diagnostic and Treatment Funds** for infants and children as needed, and track and report status of obligations periodically, as requested. Complete a Health Services Authorization (HSA) form for purchased CYSHCN services as needed.
- **Dedicate at least 30% of your total MCHBG budget to CYSHCN**. This requirement will inform the completion of your 2021-22 MCHBG Budget Workbook.

- ***Select at least one Local Strategy to address CYSHCN (see below)***. Examples of optional activities are listed after each Local Strategy. LHJs were allowed to design alternative strategies and activities after consultation and approval.

Local Strategies

Strategy 1: System of Care

Increase the percentage of CYSHCN who receive family-centered, integrated, collaborative, coordinated, and equitably accessible care.

Related MCHBG Priority Need: Identify and reduce barriers to needed services and supports for children and youth with special health care needs and their families.

Example Activities

- Promote networking and partnerships and provide targeted consultation to local health care, education, and social service providers on areas of expertise such as children and youth with clinical and behavioral complexity, Universal Developmental Screening (UDS) and referral, navigating systems, care coordination, family navigation, community referral systems, school-based services, and clinical linkages.

Asotin

- Activity: Become fluent with statewide resources, their benefits, and how to teach others to navigate the systems.
- Activity: Educate policy makers, community, school administration, staff, students, families and daycares about the unique needs of CYSHCN and teach them to link CYSHCN to services provided by other entities while informing them of the benefits and resources available through the program, to link CYSHCN to needed resources to affect positive outcomes. This will be done though community forums, school collaboration, peer education, daycare staff training, social media and other venues.
- Activity: Promote networking and partnerships with local pediatric hospital and clinics to build better systems between partners who serve CYSHCN.

Benton-Franklin

- Activity: Maintain Regional Roadmap to assure appropriate referrals to assure collaborative, coordinated and equitably accessible care for B-3. Review contacts quarterly and update roadmap.
- Activity: Maintain Regional Roadmap to assure appropriate referrals to assure collaborative, coordinated and equitably accessible care for B-3. Post to web and share with partners/providers.

Chelan-Douglas

- Activity: We will do this by convening members of managed care case management, case managers from Confluence Health and CVCH, and education service providers to identify duplication of services, share available services being offered and determine who can best meet the needs of clients and include this in plans of care.
- Activity: We will share information about and encourage use of the Strong Start data system among health care providers and parents.

- Activity: We will work with our local DDA case managers to increase the number of referrals to CYSHCN and help families understand how to request paid services from DDA.
- Activity: We will assess current blood lead screening activity among our providers and share information about risk factors, targeted screening, retesting and appropriate assessments/referrals with medical providers and families.

Clallam

- Activity: We will attend coalition meetings including Readiness To Learn with the Quilayute Valley School District, the Quileute Tribe and Hoh Tribe; and Birth to Three, which connects DDA and family resource coordinators for this vulnerable age group. Attend pre-approved workshops and trainings that will build knowledge about need and resources available to CSHCN clients and share information about best practices learned with partners at the coalition meetings listed.

Clark

- Activity: MCHBG CYSHCN staff will facilitate Clark County Interagency Coordinating Council meetings and attend SW Regional Care Coordination Networking meetings, outreach to local family birth centers/NICUs; pediatric providers; PEACE/Parent2Parent, PAVE, DDA, school districts, and ESD 112/ESIT, Hispanic Disability Support SWWA (Pasitos Gigantes) and pediatric providers to increase awareness of CYSHCN program and community resources that benefit CYSHCN.
- Activity: The CYSHCN nurse will explain their current role supporting CYSHCN families, provide available resource materials, and prioritize regular messaging to community partners in advance of CYSHCN public health's transitioning role to population-level health strategy work effective September 30, 2022.

Cowlitz

- Activity: We will do this by partnering with local parent support groups/organizations (such as Parent to Parent Programs, the local Arc, Young Child Wellness Council, Cowlitz Community Network, Youth & Family Link, etc.) to connect CYSHCN families within the community.

Grant

- Activity: Reengage with the healthcare system for focused collaboration on CYSHCN
- Activity: Active participation with local and regional workgroups such as CICC (Coordinated Interagency Council and Autism Collaborative
- Activity: Team meetings with either healthcare or school districts

Island

- Activity: Promote networking and partnerships and provide targeted consultation to local health care, education, and social service providers on areas of expertise.

Klickitat

- Activity: Identify partners in the community who serve CYSHCN. We will do this by networking with the medical groups and school districts in our community.

- Activity: Identify the resources/access to services in the community that exist currently and identify gaps/system improvements needed to ensure services. We will attend Interagency Meetings and research the resources in our community to gain understanding.
- Activity: Identify community training needs, through a gap analysis of collected data. We will develop a survey, implement the survey to community partners, analyze the data, and identify gaps in understanding.

Lincoln

- Activity: We will do this by meeting with local providers at their medical team meetings, will email or do phone consultation with counseling center and schools through special ed directors so they know about UDS through Child Find.
- Activity: We will use staff time to develop a brochure for families and a reference sheet for providers to promote the new Washington State UDS system Strong Start and local services such as CYSHCN, local school districts, and local healthcare and mental health providers to facilitate the knowledge base of available services and the coordination amongst providers in Lincoln County to benefit families

Mason

- Activity: Participate in the Mason County Early Learning Coalition.
- Activity: Participate in the Pediatric Provider Case Management Meetings that are also attended by education providers, school therapy staff (OT, PT, and SLP), pediatricians, B-3 Early Intervention staff, hospital pediatric therapy staff (Therapy manager, PT, OT and SLP), and developmental preschool staff.

Okanogan

- Activity: OCPH will attend local and county meetings related to CYSCHCN such as perinatal mental health task force, early childhood advisory groups (HSAC) and coalitions (Oroville/Okanogan) that promote a system of change, policy development and increasing equitable access to service.
- Activity: OCPH will review pertinent health data from local hospitals/DOH and share that information with local advisory groups and appropriate community health meetings to identify and reduce barriers.
- Activity: OCPH will participate in local/regional needs assessments and health care transformation efforts through to elevate the needs of CYSHCN and their families in this work.

Pacific

- Activity: We will serve as Chief Health Strategist in local birth to eight coalitions, Developmental Disability Advisory Committee and Pacific County Immigrant Support to identify needs of the community and ensure that there is representation of our English as a second language communities.
- Activity: We will assign staff who are culturally appropriate, and equity minded to represent the Health Department in these meetings
- Activity: We will keep group accountable to including English as a second language in an equitable way while planning community events and trainings.

- Activity: We will develop strategies to recruit to the various groups, individuals who represent the communities we serve, particularly in the Hispanic population.

San Juan

- Activity: We will serve on the Health Care Provider Outreach team as part of the Help Me Grow WA and disseminate information to Community partners via email, in person, and group meetings. Continue to work with local healthcare providers to promote and provide training for UDS implementation in the clinical setting. Ensure local resources are updated annually to ParentHelp123.org. Facilitate Child Find activities and ensure families and children are connected to services and supports.

Sea-King

- Activity: We will do this by outreach to local schools with IEP teams, local pediatricians, and other locals service agencies to provide services to pregnant individuals and infants.
- Activity: Build foundational public health systems that promote an environment that is suitable for community agencies and other service providers to expand CYSCHN services in King County.

Skagit

- Activity: Lead Help Me Grow-Skagit Health Care Provider Engagement action team in developing and carrying out work plan.
- Activity: Coordinate with state Help Me Grow Health Care Provider Engagement team efforts.
- Activity: Coordinate with DOH UDS program to encourage local provider participation. When Strong Start is launched, this could include sharing information about the new data system and encouraging healthcare providers and parents/legal guardians to enter and access screening information into the system.

Spokane

- Activity: We will Make connections with Spokane County partners, Early Intervention Network, and case managers with MCO's to enhance referral processes to local services.

Thurston

- Activity: We will attend Early Childhood Coalition, Mother-Baby Coalition. Will also outreach local providers (peds, family practice) to the promote/advocate special needs of CYSHCN via one-on-one contact and email outreach.

Wahkiakum

- Activity: As an LHJ we will coordinate quarterly networking meetings to allow for agency resource sharing and care coordination.

Yakima

- Activity: Child and Family Staffing- Host monthly meeting with Children's Village and community providers; begin tracking ethnicity of children staffed to support and inform continued health equity.

- Activity: Care Coordinator meetings- Host monthly meeting with local care coordinators to promote networking and information sharing**.** Identify and engage Care Coordinators from new areas, including the Yakama Nation. Secure various disability related speakers/trainers for these meetings.
- Activity: Yakima County Interagency Transition (to adulthood) Network- Co-host ITN- identify/recruit multicultural members and representation from agencies not active with disability networks, that serve primarily multicultural families.

Enhance medical homes in your local community through consultation to local primary care and other providers on medical home and the Standards for Systems of Care for Children with Special Health Care Needs.

Adams

- Activity: We will communicate with local pediatricians and family physicians within our county and coordinate a quarterly meeting, either in-person or virtually to ensure that current Systems of Care for CYSHCN clients are being met.
- Develop formal and informal agreements on roles and data sharing between health systems, Medicaid Managed Care Plans, and various agencies serving CYSHCN throughout the county.

Cowlitz

- Activity: We will do this by working with community providers such as Progress Center, Cowlitz Tribal Health, ARC, etc., to develop MOUs or informal agreements to share information.

Tacoma-Pierce

- Activity: We will collaborate with MCO care management teams to educate about the CYSHCN population and provide consultation on appropriate and available services to meet child and family needs.
- Activity: We will regularly be in contact with our MCHBG contract leads as we identify gaps in MCO coverage and support for CSYCHN families
- Partner with the Medical Home Partnerships Project in autism systems development through participation in School Medical Autism Review Teams (SMART) Teams and other local coalitions working on autism screening, diagnosis, and treatment. Assist in recruiting primary care and other local providers to participate in Autism Centers of Excellence and ECHO training opportunities.

Chelan-Douglas

- Activity: We will do this by attending our local SMART Team meetings, attending the SMART Team Networking Meetings hosted by the Medical Home Partnerships Project and sending emails to local pediatricians about COE and ECHO training opportunities.

Gray's Harbor

- Activity: We will be coordinating the SMART Team for our county and partnering with Pacific County. We will coordinate referrals and facilitate monthly SMART Team meetings for review and follow-up with families that will also be given the opportunity to enroll in the CYSHCN program for continued support connecting with and navigating resources.

- Activity: The department CYSCHN coordinator will be participating in monthly statewide SMART Team networking calls and ECHO training through the UW Medical Home Partnership Program.
- Activity: As part of other MCHBG system work, we will be conducting outreach and education to local medical providers. With this work we also hope to recruit at least 1 more provider to attend COE training in 2022.

Jefferson

- Activity: Attend SMART Team Network calls to gain knowledge for effective SMART team development.
- Activity: Complete AAP "Identifying and caring for Children with Autism Spectrum Disorder" course and COE training.
- Activity: Identify partners in the community who serve children who need autism assessment.
- Activity: Recruit interested providers for UW Center of Excellence training.
- Activity: Identify partners within the school districts, Early Intervention services, and community for development of SMART Team and recruit SMART Team members.
- Activity: Identify community and regional resources that exist currently and identify gaps for support and treatment of ASD related needs.
- Activity: Convene SMART teams.
- Activity: Other activities as identified in the process of developing a local SMART team. Communicate with partners about staffing transition and JCPH commitment to convening SMART team in Jefferson County.

Mason

- Activity: Participate in the Mason County School Medical Autism Review Team (SMART)

San Juan

- Activity: We will coordinate and meet monthly as part of the San Juan County Autism Collaborative (SJCAC) – SMART. Participate in Statewide SMART networking and ECHO calls. Develop a robust resource list to connect families and children with Autism to services and supports. Conduct outreach to healthcare providers and community partners to ensure families and children are connected to SJCAC if needing a diagnosis or resource navigation.

Skagit

- Activity: Attend local and statewide SMART network meetings, as available.
- Activity: Incorporate this into our Help Me Grow health care provider engagement work.

Snohomish

- Activity: We will participate in School Medical Autism review team (SMART) monthly video conference calls

- Activity: We will assist in recruiting local primary care physicians to participate in the Autism Centers of Excellence and ECHO training opportunities. Our goal will be to outreach support to at least 2 providers as soon as a UW training becomes available.

Partner with the state CYSHCN Nutrition Network, local providers, and feeding teams to increase the availability of referral options for children who need nutrition-related services

Benton-Franklin

- Activity: Participate in CYSHCN Nutrition Network trainings and share resources with partners

Jefferson

- Activity: Activities limited to: identify Registered Dietitians (RD) within the community and potentially those eligible via remote service options and connect these RDs with the Nutrition Network.
- Activity: Explore WA Academy of Nutrition and Dietetics WSAND – "Find a Nutrition Expert" website and assess RDs availability through the local healthcare system to locate contact information for local RDs who would potentially want to join the Nutrition Network.
- Connect identified eligible RDs with Nutrition Network contractors at the Center on Human Development and Disability University of Washington.

San Juan

- Activity: We will attend Nutrition Network meetings and trainings. Work with Toddler Learning Center to set up a new Feeding team to serve children in Island and San Juan Counties. Set up a referral system for families needing feeding support. Conduct outreach activities to share Feeding Team information and resources to Community stakeholders. Convene regular Feeding Team meetings to serve children and families.

Walla Walla

- Activity: We will determine if there is a need for a feeding team in Walla Walla County by collecting data from providers, CHYSCN families, referral agencies, and neighboring county Benton-Franklin's feeding team.
- Activity: We will partner with WIC to explore improved methods of estimating CYSHCN participation in the WIC program.
- Activity: We will identify any key agencies and professionals within the community to determine the need, educate those key agencies on client benefits and cost effectiveness of a feeding team, and if needed, identify and recruit team members for a feeding team.
- Activity: We will coordinate and support training needs as required to establish feeding team.

Engage youth with special health care needs and families of CYSHCN in systems planning, development, and improvement efforts. Provide opportunities to connect youth and family voices with community providers and existing planning efforts.

Adams

- Activity: We will conduct a survey of CYSHCN and their families on experiences with services provided by local providers to share feedback/input on services/access). We will develop a simple survey in both English and Spanish and mail the survey to CYSHCN families.

Walla Walla

- Activity: We will follow-up with families already established with the CYSHCN program to collect qualitative data on unmet community needs.
- Activity: We will provide surveys in English and Spanish to families enrolled in CYSHCN program aimed at collecting data on what community resources are utilized and what resources in the community families need or would like to see.
- Activity: We will communicate data obtained from family surveys to community providers via FST and CICC meetings.

Develop methods to establish baseline data on CYSHCN in your local community, monitor systems, identify training needs, detect gaps, and determine system improvements needed to ensure CYSHCN and their families have access to community-based services.

Adams

- Activity: We will work with healthcare providers, schools, and other entities offering developmental and medical services in our area to identify areas of need within our community and work to address those areas by collaborating with other members of Medical Home Team.

Clark

- Activity: We will engage our Information Services Coordinator and our Health Assessment and Evaluation team to analyze CHIF data and information from focus group discussions conducted under CDC Essentials for Childhood grant.
- Activity: We will assess data for strengths and gaps in services and evaluate increased demand for services currently provided in the community. This process will inform allocation and distribution of available funds and inform strategic application for future available grant opportunities.
- Activity: We will distribute aggregated draft report to our key community partners (E.I., School Districts, Behavioral Health Providers, Specialty Care Providers, etc.).

San Juan

- Activity: We will complete intake and renewals to update the CHIF database. Work with Toddler Learning Center to ensure seamless transition of children to CYSHCN after their third birthday if needing CYSHCN support. Partner with our School Districts, Early Learning Programs and Health Care Providers to provide timely referrals and CYSHCN resources. Participate in a Community Asset Mapping project to identify assets and gaps/ needs for community-based services.

Spokane

- Activity: We will run a report in January, make any edits/updates and share with local and state stakeholders to emphasize the needs in our county.

Whitman

- Activity: Identify CYSHCN services locally. Have they survived COVID?
- Activity: Survey active CYSCHN services to find out what their utilization rates have been like in the past 2 years and any issues that made it difficult to help the families they serve due to COVID.

Explore ways to enhance the comprehensiveness of CHIF data through data share agreements.

Klickitat

- Activity: We will do this by gaining understanding of the CHIF data and identifying the gaps in data sharing agreements. We will meet with Sarah Burdette, Process Improvement Specialist for CYSHCN in order to help with this work.

Participate in local and regional needs assessments and health care transformation efforts and elevate the needs of CYSHCN and their families in this work.

Adams

- Activity: We will increase CYSHCN program awareness and education through involvement in the assessments and transformation efforts.

Clallam

- Activity: We will provide input based on observations and data developed through CYSHCN services to Clallam County Health and Human Services for 2022 Community Health Assessment.

Gray's Harbor

- Activity: Partnering with local agencies (The Arc, Birth to Three/ESIT) to develop and distribute a parent survey with the purpose of better understanding the needs around support and gaps in services. Including an emphasis on connecting with the Hispanic/Latino community.

San Juan

- Activity: We will work on a Community Asset Mapping project with SJCAC, Early Learning, Health Care Partners, Parents of children with special health care needs and other Community stakeholders.

Snohomish

- Activity: We will participate in the Children's Commission and the Accountable Communities of Health in the MCH-specific committees.

Spokane

- Activity: We will attend local Equipment Sharing Network monthly meetings to facilitate sharing of needed equipment from local therapy centers to families of CYSHCN.

Walla Walla

- Activity: We will create and distribute surveys in English and Spanish to local providers, social workers, and families of CYSCHN to evaluate their needs and whether those needs are being met or not.

Whitman

- Activity: Identify our current list of CYSCHN families. Ensure that they are included in our community health needs assessment efforts, including focus groups.
- Activity: Utilize the CHNA to gather data points on infant health outcomes based on race and ethnicity (BIPOC)

Strategy 2: Financing

Increase the amount of local financing options available to families and providers that improve equitable access, flexibility, and alignment with best practice interventions for CYSHCN

Example Activities

- Identify gaps and barriers in adequate health care financing and communicate to DOH.
- Convene local funders and stakeholders to raise awareness of the needs of local CYSHCN and their families and develop funding and other strategies to meet those needs.
- Provide information and work with DOH staff to identify gaps in coverage of some items, services and supports for CYSHCN.
- Support local efforts to coordinate and assist families to enroll in health care coverage (including Medicaid as a secondary insurance) by providing technical assistance and consultation on options for coverage for CYSHCN and the importance of adequate insurance for this population. (Enabling services to enroll CYSHCN can be found under Strategy 5).

Okanogan

- Activity: OCPH will ensure that data collected during intake of CYSHCN and provide health navigation resources for those that are not enrolled.

Thurston

- Activity: We will do this by referring families to patient navigators at Providence, Choice Regional Health Network, and directly to Apple Health for enrollment assistance.

Strategy 3: Equity

Reduce and eliminate disparities in equitable access to high-quality health and related services for all CYSHCN populations.

Example Activities

- Improve overall awareness of the complex needs of CYSHCN and the inequities they face in access to communities and systems of care due to systemic ableism and other factors.

Grant

- Activity: Sharing resources with local home visiting programs on CYSHCN resources
- Activity: Connecting families with translation resources for both medical and developmental appointments for their child. We will provide our community partners with updated information as well as updating our local Community Resource Forum group.
- Activity: Share the best-practice with community providers about the importance of providing services within the migrant family schedules.

Jefferson

- Activity: We will attend local meetings to advocate for families with CYSHCN, engage families of CYSHCN who in local systems work.

San Juan

- Activity: We will attend regional equity work group meetings and share resources and materials to local community stakeholders. Work with Toddler Learning Center, School Districts SPED, Parent 2 Parent partners, and SJCAC SMART to connect with CYSHCN and families to address barriers and challenges in access to care.

Utilize CHIF data and other local data to identify inequities that affect health of CYSHCN and develop strategies to eliminate those disparities.

Sea-King

- Activity: We will work closely with our epidemiology team to analyze data from a variety of local sources, in particular, the Best Starts for Kids annual survey. This analysis will help us identify which communities we are missing. Once we know who we are missing, we can target outreach efforts to those communities.

Whitman

- Activity: Analyze local CHIF data for new trends or gaps in services as part of the CHNA. Looking specifically to answer questions about access to care and insurance coverage.

Engage families of CYSHCN that are Black, Indigenous, or People of Color (BIPOC) in systems planning, development, and improvement efforts.

Increase representation of youth with disabilities in system planning as a complex disparate group with a high intersectionality between other known populations vulnerable to risk factors.

Through partnerships, understand and mitigate the disparate impacts of provider shortages for children and youth with special health care needs (CYSHCN) in terms of location, type of insurance accepted, provider capacity, or if the provider is taking new patients.

San Juan

- Activity: We will partner with community providers to address the barriers CYSHCN and families face with access to care and the gaps in resources and supports in our rural community and work on identifying and implementing strategies to better support CYSHCN and their families.

Whitman

- Activity: Survey local clinics for ability to care for CYSHCN patients based on insurance and capacity.

Strategy 4: Well-being

*Increase the percentage of CYSHCN and their families that have the **concrete supports** they need for **well-being** and quality of life.*

MCHBG Priority Need: Promote mental wellness and resilience through increased access to behavioral health and other support services.

Example Activities

- Identify and promote local resources that provide social-emotional support for families of CYSHCN and connectedness to other families.

Adams

- Activity: Initiate contact with providers in our county and assess social-emotional support resources and how our CYSHCN families can easily access the resources. Incorporate this into the welcome packet that is sent to families that are new referrals.

Chelan-Douglas

- Activity: We will do this by collaborating with the Brave Warrior Project and other service providers to increase access to family support services and improve the lives of CYSHCN in our area. We will share resources and opportunities for support and connectedness with the families we serve.

Garfield

- Activity: We will: share quality Behavioral Health Wise program with school counselors, with parents who have child on IEP, and through social media update.

Island

- Activity: Access a directory of local providers specializing in perinatal mental health through PSI-WA.
- Activity: Partner with Island County Human Services (ICHS) to explore local counseling practitioners.
- Activity: Work with the Parent to Parent (P2P) coordinator from Island County Human Services (ICHS) to provide information to her to share with children/families through her newsletter, Facebook page, etc.
- Activity: Connect with local groups (Mother Mentors, Birth – Three programs, local healthcare practitioners) to collect information about their services and primary focus.

Kitsap

- Activity: We Will: Work with Kitsap Connecting for Kids Coalition (a Help Me Grow sub affiliate group Family and Community Outreach team) and Northwest Family Medicine Residency Behavioral Health Coordinator along with other coalitions and community partners to identify and share new or existing local resources that can support CYSHCN families.

Kittitas

- Activity: Attend local coalitions and workgroups including Kittitas County Early Learning Coalition, Kittitas County Health Network Childcare Workgroup, Kittitas County Parent to Parent, Kittitas County Resilience and ACEs Workgroup/Task Force, Kittitas County Family of Resources Coalition, Kittitas County Health Network Behavioral Health Workgroup.
- Activity: Conduct outreach with and stay up to date on services of local primary care and behavioral health providers, Developmental Disabilities program, school district special education programs/developmental preschools/counseling staff, Yakima Children's Village (Early Support for Infants and Toddlers program provider), WIC, and Head Start and Early Head Start programs.
- Activity: KCPHD has begun to talk about how we will transition out of the sub-contract that KCPHD has with Community Health of Central Washington and how we will bring that work back into the Kittitas County Public Health Department.
- Activity: Work with 211 to keep resource lists of local services up to date and accessible in the community.

NE Tri

- Activity: Staff will attend monthly Ferry County Coalition meetings, Stevens County Round table meetings that occur once a quarter, and Pend Oreille County Health Coalition quarterly; in addition to the county coalition meetings staff will attend meetings when available by other community partners to collaborate on social-emotional needs of families with CYSHCN and promote available services.

Okanogan

- Activity: OCPH will work to connect CYSHCN and their families to mental wellness services through involvement with local community entities such as ESIT and school based mental health services such as WISE.

Skamania

- Activity: We will work with local Pathways Program providers to promote infant and perinatal mental health, elevating the needs of CYSHCN and their families.

Spokane

- Activity: We will send resources to CYSHCN families via email group and will promote and be involved with planning for newly formed Parents Empowering Parents support group

Yakima

- Activity: Coordinate with Parent to Parent to ensure supportive resources are shared with families attending parent groups, and through the newsletter (English/Spanish).
- Activity: Identify opportunities to share information about the value of parent support and the Parent-to-Parent program with Yakama Nation families.
- Activity: Coordinate with Parent to Parent to provide outreach to Yakama Nation families raising children with special needs.

Work with local recreation, education, and other community providers on developing inclusive and accessible programs that increase the sense of belonging in their community for CYSHCN and their families.

Kitsap

- Activity: We will attend Kitsap HEAL (Healthy Eating and Active Living) Coalition quarterly meetings and Early Childhood Education Workgroup to develop relationships with partners working to support healthy eating and movement activities. Discuss ways to address CYSHCN specific concerns and the feasibility of forming a group to address these needs.
- Activity: We will collaborate with KPHD Chronic Disease Prevention Team to collaborate on the Kitsap Moves campaign. Partner to write a newsletter to families regarding the Kitsap Moves campaign and pledge form to increase movement in the classroom and in the home in addition to exploring the possibility of “free day” at the YMCA to CYSHCN families or other engagement, healthy eating, and movement opportunities for CYSHCN families.

Kittitas

- Activity: Work with coalitions, workgroups, and partners identified above, in addition to municipal parks departments, Central Washington University, Kittitas County Chamber of Commerce, and local elected officials.

Raise awareness of disparities in ACES for CYSHCN, support work on Strengthening Families for CYSHCN, and identify opportunities to infuse trauma informed care into working with CYSHCN.

Adams

- Activity: We will arrange meetings and/or presentations for local providers to spread awareness and offer knowledge and resources on trauma informed care and how to incorporate it into practice and policies.

NE Tri

- Activity: Staff will attend trainings to strengthen knowledge and skills in TI care as well. This will increase awareness to respond to the needs of CYSHCN who experience trauma.

Okanogan

- Activity: We will achieve the above through active involvement in coalitions and attendance at local/regional meetings.

Participate in anti-bullying and suicide prevention efforts in your local community, elevating the unique needs of CYSHCN. Support interventions to address suicide ideation among CYSHCN.

Garfield

- Activity: We will: share latest information related to CYSHCN and bullying/suicide rates with school counselors, with parents who have child on IEP, and through social media update.

Island

- Activity: Work with ICHS staff for inclusion of strategies addressing needs of CYSHCN.
- Activity: Utilize resources from www.StopBullying.gov if appropriate.
- Activity: Establish potential relationships with the local school districts beginning with elementary schools to discuss anti-bullying strategies they currently use.
- Activity: Discuss with Fleet and Family Support staff their efforts to combat this in childcare.

NE Tri

- Activity: Staff will attend meetings and work with HFCC to promote the unique needs of CYSHCN.
- Activity: HFCC has several community partners, one of the community partners has received funding for increased mental health support to focus on suicide prevention and opioid addiction, CYSHCN coordinator will work to partner with this group to promote needs of CYSHCN.

Participate in local efforts to promote infant and perinatal mental health, elevating the unique needs of CYSHCN and their families.

Island

- Activity: Discuss with local obstetric and pediatric providers the needs women who may be experiencing a perinatal mood disorder and advocate for them screen and refer to local support groups.
- Activity: Discuss with obstetric, pediatric, and family practice providers in Island and Skagit counties the possibility of hosting a Perinatal Mood and Anxiety Disorders training and what that would look like. Chief Health Strategist role of bringing partners together and emphasize unique needs of CYSHCN families.

Okanogan

- Activity: We will connect families with local resources such as early childhood groups and perinatal support groups linked through local health providers and/or early childhood programs like OCCDA, Dad's Move, and other local/regional coalitions/supports such as local parenting education support groups.

Snohomish

- Activity: Will continue to host, provide backbone services and steer the NEAR Collaborative meetings in 2022 of which perinatal mental health is the main priority.
- Activity: We will attend at least one WA State Perinatal Collaborative meeting to learn more about the work and to build a relationship with them. Once we have learned more and built a relationship with the collaborative, we will be able to define our level of engagement as well as the goals and activities of the engagement.

Spokane

- Activity: We will co-facilitate Birth Outcomes Task Force in Spokane

Strategy 5: Family Navigation & Care Coordination

Increase the percentage of CYSHCN and their families that have access to family navigation or other family-centered care coordination, to meet their complex health, socioeconomic, and psychosocial needs.

Example Activities

- Provide consultation and technical assistance to community organizations on care coordination for CYSHCN to build capacity in the community to transition enabling services to community providers. You may also provide enabling services to CYSHCN and their families where other services are not available. **Note**: Enabling services are non-clinical services that enable individuals to access health care and improve health outcomes. Enabling services include, but are not limited to care coordination, referrals, translation/interpretation, transportation, eligibility assistance, connecting to a medical home, health education for individuals or families, health literacy, and outreach. We recognize that counties have differential access to resources

and that communities will tailor these services to the needs of their community. **Therefore, provision of enabling services can continue indefinitely**, with the intent that communities with pertinent resources will strategically leverage such resources to support health systems activities.

Benton-Franklin

- Activity: Coordinate monthly Feeding Team meetings to allow for agency resource sharing and care coordination among service and therapy providers in our community.
- Activity: Participate in regularly scheduled Neonatal Intensive Care Unit (NICU) discharge planning meetings with local Early Support for Infants and Toddlers (ESIT), The Women, Infants, and Children Nutrition Program (WIC), and local hospitals.
- Activity: Will provide care coordination for NICU families.

Chelan-Douglas

- Activity: We will do this by meeting with clients currently on our caseload to help access enabling services.
- Activity: We will develop transition plans for current clients to ensure their complex needs will be met by other systems in the community.
- Activity: We will meet with stakeholders to identify gaps/needs that exist in our communities that lead to barriers in care.

Clallam

- Activity: We will support families in working towards equitable access to health care services through initial assistance navigating and ultimately familiarizing them with transportation systems including Paratransit and remote care services such as telehealth.

Clark

- Activity: Our 1.0FTE CYSHCN Nurse will spend 28hrs/week (0.7FTE) providing care coordination services for currently enrolled families. The last day for new referrals into this existing/historical system of care is scheduled for July 15, 2022. Effective July 18, 2022, all referrals will use the new care coordination system (currently under development with community partners). The existing/historical system of care coordination will formally sunset (all remaining clients will be transitioned/closed) by September 30, 2022.

Columbia

- Activity: CYSHCN nurse will spend 3 hours a week providing care coordination services.
- Activity: We will conduct a community asset mapping exercise to identify accessible services that are available to the entire age range of CYSHCN.

Cowlitz

- Activity: We will do this by providing enabling services to family members of CYSHCN by increasing care coordination/navigation services for CYSHCN with other community agencies in service area.

- Activity: We will do this by providing care coordination services for CYSCHN families that includes but isn't limited to consulting with healthcare team.

Gray's Harbor

- Activity: LHJ staff will support CYSHCN families to access resources that may include medical service providers, transportation, case management and coordination with the purpose of helping empower families to advocate for their children.

Jefferson

- Activity: Provide care coordination for 38 CYSHCN.
- Activity: Promote Successful transition from our enabling services (care coordination) to other agencies/services that can meet family needs. Conduct community asset mapping to determine resources and agencies/ services that can meet family's needs

Kitsap

- Activity: Our CYSHCN Nurse will provide care coordination services for families to connect them to community resources. Additionally, we will show steps in our transition plan of these services in our updates.

NE Tri

- Activity: We will provide 1.0 FTE to provide care coordination.
- Activity: We will conduct a community asset mapping exercise to identify accessible services that are available to the entire age range of CYSHCN.

Pacific

- Activity: We will refer children from our WIC clinic to one of our partners: start with N. County ELC Intervention (Specialist 0-5 group) and then they would refer if appropriate to higher level of care including one of 3 autism assessors.
- Activity: We will stay active with prevention coalitions to have a voice in community trainings and promote information within our own groups (e.g. parenting classes, behavioral intervention specialists and other family support trainings.)

Sea-King

- Activity: We will do this by working directly with the families of our CSHCN clients, linking them with tools, resources, and training so they can best support their child with special health care needs.

Snohomish

- Activity: We will conduct a community asset mapping exercise to identify accessible services that are available to the entire age range of CYSHCN.
- Activity: Create and implement a communication plan for our community partners and residents who have come to depend on the CYSHCN enabling services we have provided for decades to

make them aware of the change. This will be done gradually throughout the transition process and will feed into the new population-level services of use of the CYSHCN repository we will be creating and maintaining. Eventually, as the community becomes more aware of the change and lack of enabling services from us, entities that refer clients will be contacted and directed to the resource repository. Residents who self-refer will also be directed to the resource repository and those without internet access or language barriers will be sent a resource packet by support staff. We will translate most frequently used resources into the top used non-English languages in the county to prepare for the new way of serving clients.

- Activity: We will define the different acuity levels in our CYSHCN enabling services with a goal of creating a protocol to manage transition of cases based on acuity. The new protocol will guide the transitioning of services to the community based on acuity level. Lower acuity clients will be transitioned out quicker.
- Activity: We will conduct outreach with Snohomish County FQHCs to learn about any care coordination activities that they may be doing for CYSHCN as part of our community asset planning activity. We will develop a relationship with them so as to create a platform for us to provide consultations and technical assistance on care coordination as needed. Once this foundation is in place, we will conduct monthly outreach to them.

Tacoma-Pierce

- Activity: Our 1.0FTE CYSHCN Nurse will spend 28hrs/week (0.7FTE) providing care coordination services for currently enrolled families. The last day for new referrals into this existing/historical system of care is scheduled for July 15, 2022. Effective July 18, 2022, all referrals will use the new care coordination system (currently under development with community partners). The existing/historical system of care coordination will formally sunset (all remaining clients will be transitioned/closed) by September 30, 2022.
- Activity: We will begin to gauge interest of a stakeholder group to identify gaps and community-based strategies to address the care coordination needs of the CYSCHN population as we transition out of the care coordination role in the next grant cycle. This can include partners from our hospital systems, HMG, PAVE, MCOs, schools, Family Support Centers, and DCYF.
- Activity: We will request consultation from DOH as we move toward the Chief Health Strategist role to ensure families are not left without support and care coordination.

Thurston

- Activity: Our CYSHCN Nurse will work with families to connect them to resources such as transportation, housing, medical homes, medical plans and other resources to help meet their psychosocial, physical health and socioeconomic needs.

Walla Walla

- Activity: Our 1.0FTE CYSHCN Nurse will spend 28hrs/week (0.7FTE) providing care coordination services for currently enrolled families.

Whitman

- Activity: Continue to provide care coordination to clients currently on our caseload

- Activity: Promote successful transition from our enabling services (care coordination) to other agencies/services that can meet family needs.

Work with Help Me Grow (HMG), health systems, family led organizations, and other providers to improve access to care coordination and family navigation.

Benton-Franklin

- Activity: Provide technical assistance and resources to system partners as requested or opportunities arise.

Cowlitz

- Activity: We will do this by partnering with local parent support groups/organizations (such as Parent to Parent Programs, the local Arc, Young Child Wellness Council Cowlitz Community Network, Youth and Family Link, etc.) to help improve access to care coordination services.

Grant

- Activity: We will make sure they are aware of the resources available in Grant County since they are referring families to various resources.
- Activity: We will continually update our resource list and make sure Help Me Grow has the most updated information.
- Activity: We will work with other organizations (MSS, the FRCs, school nurses/counselors) to make sure families are aware of the Help Me Grow resource or have access to it.
- Activity: New group forming in Moses Lake who will be working on assisting families with family navigation in schools. We will ask to be a part of this team

Gray's Harbor

- Activity: Participation in local and regional HMG action teams, as well as early learning coalitions to build support and referral systems for families and providers.

Jefferson

- Activity: We will serve as the Regional Family Voice (formerly Family and Community Outreach) co-lead for the Washington Communities for Children - Help Me Grow WA.
- Activity: Work with families to improve access to Transportation, Translation, Outreach, Respite Care, Health Education, Family Support Services, Purchase of Health Insurance, Case Management, and Coordination with Medicaid, WIC, and Education.
- Activity: Develop a transition plan to meet with community partners to pull to gather partners to determine identify to serving families Jan to September 2022.

Kitsap

- Activity: We will provide consultation and technical assistance to HMG PECC local affiliate for Family and Community Outreach, Family Resource Coordinators, Community Health Workers, patient navigators, care coordinators, case managers, family navigators, and other providers on

care coordination standards for CYSHCN. Share CYSHCN specific needs, concerns, and resources with these providers.

NE Tri

- Activity: Attend meetings and gatherings with local partners, promote CYSHCN care needs while enforcing their complex health, socioeconomic, and psychosocial needs.
- Activity: Do a media campaign through social media and website.

San Juan

- Activity: We will partner with providers to ensure access to care coordination for CYSHCN and parents/caregivers as well as transportation, interpretation, housing, durable medical equipment, and other basic needs.

Sea-King

- Activity: We will continue to participate as an active voice throughout HMG development and beyond

Skagit

- Activity: Coordinate with Help Me Grow-Skagit Physician Champion to develop and share referral processes and pathways.
- Activity: Work closely with Help Me Grow-Skagit Family Resource Navigator and other local resource navigators to function as a system.

Tacoma-Pierce

- Activity: We will participate in monthly Pierce County Interagency Coordinating Council (PCICC) meetings to build partnerships and linkages with community agencies that serve CYSHCN.
- Activity: We will participate in the local HMG activities (ex. HMG Health Provider Outreach Team monthly meetings) to ensure the needs of the CYSHCN population are being addressed.

Walla Walla

- Activity: We will facilitate monthly Family Support Team (FST) meetings for professionals working with CYSHCN enrolled in the early intervention program to provide a time for interagency coordination and referrals. Also, allowing a time for care coordination/resource connection for children age three-eighteen years old whom professionals are working with.
- Activity: We will chair County Interagency Coordination Council (CICC) meetings for the local Early Supports for Infants and Toddlers (ESIT) – Birth to Three Early Intervention Program.
- Activity: We will facilitate the Developmental Disabilities Administration (DDA) Birth to Three & Autism Support Services focus groups formed form the CICC and others as needed.
- Activity: We will partner with the Walla Walla Valley Early learning Collation (ELC) to facilitate joint ELC and CICC meeting as appropriate to assist with implementing a community process for resource and service coordination

Whatcom

- Activity: Support Whatcom Taking Action Leadership team to promote CYSHCN priorities into planning efforts and increase alignment.
- Activity: Support the Help Me Grow planning efforts to prioritize CYSHCN in expansion efforts.
- Activity: Support the Family Tools team to increase parent involvement and develop outreach efforts

Provide consultation and technical assistance to Family Resource Coordinators, HMG Navigators, Community Health Workers, patient navigators, care coordinators, case managers, family navigators, and other providers on care coordination standards for CYSHCN.

Grant

- Activity: This will be a part of the collaboration we conduct at our Interagency Coordinating Council. We will staff complex cases and working with our local team who serve CYSHCN

Lewis

- Activity: We will facilitate meetings with local service providers to promote networking and partnerships that will improve access to community-based services for CYSHCN and their families.
- Activity: We will work closely with Lewis County Special Education Cooperative to ensure students and families are aware of and able to access family centered and culturally competent care in our community.
- Activity: We will build relationships with community service providers who serve the Latinx community.
- Activity: Materials that are shared with providers, schools, and the community will be translated to make information more accessible.
- Activity: We will increase opportunities/access for Latinx families to participate and provide feedback in community coalitions and workgroups.
- Activity: We will share resources, educational opportunities, and tools that promote health equity related to service coordination for the CYSHCN population.

Mason

- Activity: Participate in the Mason County SMART Team and Pediatric Care Coordination Meetings.
- Activity: Work with Help Me Grow (HMG), health systems, family led organizations, and other providers to improve access to care coordination and family navigation.
- Activity: Work to build more resources and systems planning for CSHCN

San Juan

- Activity: We will attend Statewide CYSHCN meetings and trainings. Convene regular meetings with local care coordinating entities such as Toddler Learning Center, School Districts, Resource

Centers, Community Health Workers, etc. to share resources and materials. Collaborate with partners to host, organize, and promote trainings.

Sea-King

- Activity: We will do this through frequent outreach and regular meetings. Our existing consultation and technical assistance networks cover most of King County. As we identify underserved communities, we will outreach to agencies who serve those communities and develop consultation networks specific to those communities.

Spokane

- Activity: We will provide consultation to family resource coordinators and LHJ ESIT program staff as needed on appropriate resources, best practices, and health information.

Walla Walla

- Activity: We will provide a resource, detailing care coordination standards for CYSHCN, on Walla Walla County website.

Train, engage, and support families and youth with special health care needs to be involved as advocates at all levels of program planning and implementation of services for CYSHCN.

Spokane

- Activity: We will send information regarding available services to CYSHCN families via local CYSHCN email group.
- Activity: We will attend County Inter-agency Coordination Council meetings and executive council meetings.
- Activity: We will work with local "Silos and Gaps" workgroup comprised of community partners and parents of children with complex medical conditions to detect gaps in services for CYSHCN and discuss improvements to ensure CYSHCN and their families have access to needed community services.

Promote and facilitate successful transitions, including transitions from early intervention to school and community-based services, and from pediatric services to a meaningful adult life.

Adams

- Activity: We will communicate with CYSHCN families with children that are advancing into school age and with children that are readying to age out of the CYSHCN system and mail out newsletters and information on transitioning into adult life and what that may look like for them. We will send this information to all CYSHCN families we are currently serving so that we can also create awareness for those that may need it in the future.
- Activity: We will discuss these different transition periods with healthcare providers and partners that offer other supportive services to develop goals and plans to assist our CYSHCN clients with the transition.

Clallam

- Activity: We will work with schools to improve care coordination services by offering technical guidance and support to schools and outside agencies providing support to school age kids. Provide navigation services directly to families by advocating alongside them for development of care plans that support their complex needs, including IEPs and transition plans beyond the school setting.

Columbia

- Activity: Reach out to clinic partners to explore how this will fit into the planning process.

Garfield

- Activity: We will reach out to school partners to investigate how this role with fit in to the planning process.
- Activity: We will work with school counselors and special education leaders to help with transition plans.

Grant

- Activity: We will have group meetings with our FRC coordinators/B-3 teacher on the transition plan as kids graduate out of the B-3 program.

Lewis

- Activity: We will partner with local family Resource Coordinators to enhance connections to DDA waiver services for 3 year olds who are transitioning from Early Intervention to school-based services. We will share and/or develop materials that will increase provider and family knowledge and of resources and supports that are available during various transition points. These materials will be provided in both English and Spanish.
- Activity: We will provide technical assistance to Northwest Pediatric Center social worker, Parent to Parent and The Equity Institute to enhance resource coordination for youth and families who are navigating the transition from pediatric services to adult services, including medical care, social services, housing, and recreation.

Okanogan

- Activity: OCPH will participate in local early intervention/school based 504 plans/local DDA meetings to promote and facilitate successful transitions, including transitions from early intervention to school and community-based services and from pediatric services to a meaningful adult life including sharing online resources such as *Informing Families**.***
- Activity: OCPH will attend monthly community coalitions, health service advisory meetings, early intervention (ICC) meetings to identify new resources and share data resource information with Help Me Grow/Within Reach and other systems that support CYSHCN, families and providers.

Sea-King

- Activity: We will do this through warm handoffs, interacting directly with the schools and community-based services so that the family and child feel supported and welcomed post-transition.

Spokane

- Activity: We will engage with LHJ ESIT program staff and Early Intervention Network regarding transition processes to ensure all children transitioning from ESIT services transition successfully to community-based and school-based services.

Develop resource materials for your local area that can be utilized across systems to support CYSHCN, their families, and providers. This includes adapting state or regional resource materials for your local area. Share local resources with Within Reach / HMG for their database.

Adams

- Activity: We will work with our CYSHCN partners within our county to update our comprehensive resource list to include the most updated services and contact information.

Benton-Franklin

- Activity: Update the BFHD website monthly with resources for CYSHCN families
- Activity: Share resources via social media
- Activity: Assure CYSHCN metrics are included in community assessment efforts

Clallam

- Activity: We will maintain existing resource lists used internally by assuring that all contact information and services provided are up to date. Work with community to find ways to publish and disseminate resource lists.

Clark

- Activity: We will develop resource materials that will benefit both CYSHCN, their families, health care providers, ECE, school district staff, and allied support services partners to better identify the range of supports available in Clark County.
- Activity: We will use information and feedback collected from our focus group sessions with service providers (funded through the CDC Essentials for Childhood grant award, completed by our Health Assessment and Evaluation Team and Chronic Disease Prevention Team) to inform resource mapping/material development.
- Activity: We will collect feedback from a parent survey (currently in development in partnership with HMG and community partners) that will be distributed to CYSHCN families receiving care coordination services and broader sampling of families with children ages birth-five currently living in Clark County to inform the development and maintenance of resource materials.
- Activity: We will work with our Help Me Grow partners to populate their database in alignment with their closed-loop referral system development as the workplan goals and objectives are shaped in parallel to MCHBG CYSHCN resource material development.

Cowlitz

- Activity: We will do this by partnering with local parent support groups/organizations (such as Parent to Parent Programs, the local Arc, Young Child Wellness Council, Cowlitz Community Network, Youth & Family Link, etc.) to connect CYSHCN families within the community, share information via social media platforms, and with Within Reach/HMG for their database.
- Activity: We will do this by attending meetings with community partners that have a focus on addressing homelessness and food security.

Grant

- Activity: This will be part of our new client onboarding to include providing a resource list as well as care binders for families to track care of their child. We will ensure all families have the resources they need.

NE Tri

- Activity: Share local resources with Within Reach / HMG for their database. This may include adapting state or regional resource materials that can be shared through electronic format with other organizations, NETCD website and social media. If unable to adapt materials through research, will search out a funding source to purchase needed materials to promote access to family navigation.

Okanogan

- Activity: OCPH will work with local Help Me Grow (HMG) and local health systems, family led organizations such as Early Intervention, local early childhood groups, Dad's Move, Family Health Centers and Room 1 and other providers to improve access to care coordination and family navigation.
- Activity: OCPH will attend local and county meetings related to CYSCHCN families and share data around the barriers/difficulty of families accessing care and strategies to meet their needs.

Skamania

- Activity: We will develop resource materials for our local area that can be easily reached by families with limited access.
- Activity: We will provide printed materials to all local health providers, essential businesses and service providers in our community. We will update social media pages and County websites to also include information about these resources.

Snohomish

- Activity: We will adapt materials provided by Within Reach and other organizations to meet the local needs of Snohomish County families.
- Activity: We will create new materials as needed to assist Snohomish County families with connecting to care.

Walla Walla

- Activity: We will update County CYSHCN resource list in English and Spanish at least every 6 months and distribute via website and to partners and local health care networks, as well as families and members within the community. Share his local resource list with Within Reach/HMG for their databases.

MCHBG Combined LHJ Summaries 2021-22

This Combined Focus of Work covers all MCH domains except Children and Youth with Special Health Care Needs. The shaded sections below list the state-level priorities and strategies for your information. LHJs selected local strategies from those listed below.

Women-Maternal Health

State Priorities	Optimize the health and well-being of adolescent girls and adult women, using holistic approaches that empower self-advocacy and engagement with health systems.	Promote mental wellness and resilience through increased access to behavioral health and other support services.
State Strategies include	Behavioral health, Substance use, Trauma-informed services, Maternal mortality, Preventive medical visits	

Local Strategies:

1. Increase resources and coordination of services to improve the quality of well women visits. This could include prenatal nutrition, sexual and reproductive health, cultural competency, etc.

None Selected.

2. Collaborate with local community Maternal Child Health coalitions, hospitals, managed care organizations, and provider groups serving pregnant/postpartum women and infants to increase referrals and ensure eligible women have access to breastfeeding information, mental and behavioral health, and necessary counseling and referrals.

Benton-Franklin

Activity: Identify partners in the community who serve pregnant and postpartum people; gather interest in birth outcomes/perinatal workgroup development.

Activity: Participate in local, regional & State workgroups or meetings that promote the importance of perinatal and postpartum support services

Activity: Work with BFHD Performance Management Team to develop/utilize assessment tools, compile and analyze data, and share out with community partners

Activity: Identify the resources in the community that exist currently and identify gaps

Activity: Work with Performance Management & CYSHCN coordinator to identify the impacts and referral sources for postpartum people & infants diagnosed with Neonatal Abstinence Syndrome or Substance Exposed Newborns, unspecified.

Klickitat

Activity: We will attend local MCH coalitions to share the data related to the mental health needs of pregnant/postpartum women.

Okanogan

Activity: OCPH will attend and participate in Perinatal Task force meetings and work within that group to support maternal/infant health including access to mental and behavioral health counseling and referrals.

Activity: OCPH will attend and participate in local Health Services Advisory groups that include supporting breastfeeding information including local WIC.

Skagit

Activity: Participate in Skagit Breastfeeding Coalition.

Activity: Participate in Breastfeeding Coalition of Washington (BCW).

Activity: Support local perinatal health capacity-building efforts including breastfeeding equity efforts with local organizations and non-traditional partnerships.

Activity: Connect all of this to Help Me Grow-Skagit system

Tacoma-Pierce

We will staff and support the efforts of the Perinatal Collaborative of Pierce County (PCPC;501c3). The PCPC supports professional practice improvement and improvements in systems of perinatal health care. Services addressed include prenatal education, breastfeeding support, nutrition, safety, and behavioral health.

Activity: In collaboration with the PCPC Board of Directors, we will convene quarterly meetings of the PCPC to promote interagency communication and cooperation.

Activity: We will convene and facilitate Board of Directors meetings during which quarterly membership training is planned and the work of various collaborative partners and subcommittees is monitored and supported.

Activity: We will support the work of the PCPC through attendance at quarterly meetings and educational offerings by the PCPC, and through participation on subcommittees.

Whatcom

Build connection and coordination among the local, regional, and statewide partners supporting perinatal and infant mental health.

Activity: Develop a local community standard of care around perinatal and infant mental health.

Activity: Increase community awareness of perinatal mood and anxiety disorders and normalize seeking support and skill building during the transition to parenthood.

Activity: Expand and facilitate access to culturally responsive peer support for parents prenatal to five years postpartum.

Activity: Increase community capacity to therapeutically identify, refer, and treat families experiencing perinatal mood and anxiety disorders by providing training and consultation opportunities for a variety of providers, including for health care, mental health, early learning and home visiting providers.

Yakima

Activity: Identify resources in the community that exist currently and identify gaps in services and resources.

Activity: Work with partners in the community who serve pregnant and postpartum people and promote community resources and education.

Activity: Participate in local workgroup/meetings that promote the importance of perinatal and postpartum support services.

Activity: Develop a pathway for breastfeeding that assist the transition from hospital/home that assures all women can receive breastfeeding assistance if needed.

Activity: Participate in local monthly Yakima Breastfeeding Coalition Meetings and Quarterly Washington State Breastfeeding Coalition Meetings. Identify ways to support coalition and use their resources to create local resources so that breastfeeding assistance/education are equitable for all mothers.

Activity: Identify behavioral/mental health services available for all perinatal people and create a perinatal resource and referral handout.

Activity: Identify who and when providers are screening for PMADs and what tools are used.

3. Participate in local, regional and statewide coalitions and task forces to promote the importance of maternal and child health. (e.g., Develop/use success stories, data and other tools to promote the importance of maternal and child health).

None selected.

4. Monitor emerging needs and prepare for future public health emergencies. Increase emergency preparedness capacity of families including those that have children with special health care needs.

None selected

5. Identify strategies to improve access to affordable, quality health care, regardless of location, language spoken, gender identity, race, sexual orientation or insurance. (e.g., Increase knowledge and visibility of and access to resources and services available locally. Promote linkages to services that meet unique client or subpopulation gaps in care).

Mason

Activity: Connect with community providers to identify gaps and plan for serving the family planning and nutrition needs in our community after our loss of WIC and Planned Parenthood.

Activity: Identify and promote supports for Spanish and indigenous language (Mam and Q'anjob'al) speakers in this population.

Activity: Provide information and partner with DOH Staff to raise awareness and develop strategies to meet these needs (i.e. WIC and family planning, etc.).

6. Increase connection to support services for parents. Implement and promote fatherhood inclusion opportunities and support resources. Promote inclusion of additional people taking parenting roles, such as foster parents, grandparents, kinship care.

Cowlitz

Activity: We will do this by gathering information about community resources for fathers, attend Cowlitz Café Fatherhood Council Meeting and share info about importance of providing info to fathers.

Snohomish

Activity: We will promote fatherhood inclusion opportunities with community partners

Activity: We will explore groups in the county that are already working with people in parenting roles (such as foster parents, grandparents) to identify ways we can partner with them on CYSHCNs issues.

Spokane

Activity: We will collaborate with Community Minded Enterprises (Help Me Grow lead) on an assessment of existing referral practices of medical providers into community-based programming. Identify strengths, challenges, and opportunities to develop an integrated health and social services system to meet the needs of parents/caregivers of young children (0-5). Disseminate findings and recommendations among community partners.

Activity: Promote the use of home visiting services and creating social connections to other parents and trusted adults by utilizing existing peer support groups and community cafes. Promote linkages to services that meet unique client or subpopulation gaps in care to address the impact of 'pair of ACEs' on equitable health outcomes. Implement and promote fatherhood inclusion opportunities and support resources.

Activity: Develop and provide information on community-based parenting enrichment activities to cross-sector health and social services providers to increase connectivity of parents/caregivers to services.

Promote inclusion of additional people taking parenting roles, such as foster parents, grandparents, kinship care.

Activity: Identify and engage representatives from local home visiting programs to assess and compile information about referral criteria to participate in each home visiting program. Develop an intra-agency referral process, centering the client's needs and utilizing a strengths-based approach to match them with the most appropriate program offerings.

Perinatal-Infant Health

State Priorities	Enhance and maintain health systems to increase timely access to preventive care, early screening, referral, and treatment to improve population health across the life course.	Improve infant and perinatal health outcomes and reduce inequities that result in infant morbidity and mortality.
State Strategies include	Bi-directional referral, Preventive care, early screening, referral, Breastfeeding, Home visiting, Trauma-informed services, Substance use, Access to services	

Local Strategies:

1. Provide Nurse Family Partnership services. (7 counties selected).

Clark

Activity: We will support a 1.01 FTE of a nurse to enroll into NFP first time pregnant (primiparous) clients, and those who have had previous pregnancies (multiparous) who experience low-income. The program prioritizes serving teen parents, Black, Brown, Indigenous, and persons of color as well as families with English as a second language and cultural identities outside of white dominant or Christian belief systems.

Kitsap

Activity: We will fund .5 FTE NFP staff

Lewis

Activity: We will subcontract with Thurston County to fund .5 FTE to provide evidence-based home visiting services for qualifying pregnant women through Nurse Family Partnership (NFP) program. The NFP subcontract will include language that will require use of data to address disparities and increase outreach to target populations.

Skagit

Activity: Funding will support up to 0.1 FTE administrator time and up to 0.15 FTE promotora time to work as a "cultural interpreter" to support NFP nurses with serving Mixteco and other immigrant families who enroll in NFP.

Tacoma-Pierce

Activity: We will support 1.5 FTE of an NFP nurse home visitor using MCHBG

Thurston

Activity: We will fund a .9FTE Nurse Home Visitor

Yakima

Activity: Maternal Health Services receives referrals from all community agencies that request home visiting for a nurse and or a counselor for the Maternal Child Population. As the centralized referral site, a referral is triaged, with other community sites that provide services for Perinatal women, infants, or children, decreasing duplication of services. If Parents or families are not eligible for other services provided for in the community, Maternal Health services provide home visiting to identify at risk families, using the evidenced based Strengthening Families (SF) Framework to promote and build protective factors. We will fund 1.4 RN, .4 Support staff & .4 BHS

2. Promote practices and policies that support breastfeeding in worksites, schools, institutions, and health care settings. (7 counties selected)

Grant

Activity: Active participation with our local Moses Lake Breastfeeding Coalition of WA.

Activity: Provide data to the coalition on breastfeeding rates for our community i.e., initiation rates, continuation rates using WIC data as well as key informant interviews and focus groups

Activity: Provide sample workplace breastfeeding policies to agencies to incorporate into their companies.

Activity: Work with the coalition to conduct a community needs assessment as staffing permits

> Success/Barriers: We are re-establishing our breastfeeding coalition which stopped meeting in 2020 due to the pandemic. A barrier we face is a lack of provider support at our local birthing hospital to support breastfeeding.

Kitsap

Activity: We will attend Kitsap Breastfeeding Coalition and Washington State Breastfeeding Coalition meetings to promote networking and partnerships and identify gaps and training needs to ensure eligible families have access to chest feeding/ breastfeeding information and necessary counseling and referrals.

Kittitas

Activity: Facilitate the Kittitas County Breastfeeding Coalition (KCBC), serve as the Chief Health Strategist for the KCBC and work with KCPHD Assessment Coordinator and Quality Improvement Coordinator to make available data and resources from Public Health (data sources include vital records, WIC, local hospital data from Kittitas Valley Healthcare, local community health assessment), support KCBC identified priority activities as time allows.

Activity: Attend quarterly Breastfeeding Coalition of Washington meetings to identify resources.

Activity: Work with the Washington State Department of Health's breastfeeding content experts (i.e., Milo Nicholas).

Sea-King

Activity: Update and create new breastfeeding policies to support early learning providers who have children in care taking bottles with breastmilk.

Activity: Create best practice policy to provide a welcoming space for mothers to breastfeed at the childcare programs.

Activity: Disseminate information on the benefits of breastfeeding.

Activity: We will participate in the Mahogany Moms Coalition

Activity: We will continue our work promoting equity and antiracism work in King County by publicizing antiracism trainings and events with childcare workers and lactations consultants in King County

Skagit

Activity: We will work with the Breastfeeding Coalition and community partners to reach out/provide consultation to worksites and other community settings to promote baby-friendly spaces and policies, using strategies such as those outlined by the CDC https://www.cdc.gov/breastfeeding/pdf/strategy5-support-breastfeeding_workplace.pdf

Activity: Along with promoting breastfeeding, we will work with employers, business-related organizations and the Skagit-Islands Human Resource Management Association to help them connect employees to health, development, social and early learning services so that children have safe, stable, nurturing relationships and environments and parents can focus on work without worrying about their children.

Snohomish

Activity: We will provide educational materials to community groups, employers and schools from Breastfeeding Coalition of Washington and the Breastfeeding Coalition of Snohomish County

Activity: We will continue to be a participating member of the Breastfeeding Coalition of Snohomish County

Activity: We will continue to work on establishing a breastfeeding-friendly childcare program. Work currently includes DOH as DOH would like the program we establish to be a pilot for a state-wide program. We will partner with childcare providers in Snohomish County. As with all MCHBG programs, targeted intensive outreach will be conducted in MCH priority areas for equity purposes (see 'Health Equity Lens' section).

Tacoma-Pierce

Activity: We will collaborate with hospitals, managed care organizations, and provider groups serving pregnant and post-partum women and infants to increase capacity for, and access to, community lactation support.

Activity: We will support hospitals and clinics to pursue and obtain the highest level possible of Lactation and Infant Feeding-Friendly Environments (LIFE) hospital and clinic designation. through the Washington State Department of Health.

Activity: We will work with community groups to develop and sustain culturally competent Peer Breastfeeding Counselor (PBC) training and support, focusing on populations with lower breastfeeding rates to eliminate disparities.

Activity: We will continue partnering with Help Me Grow Family Connects Pierce County in conjunction with Pierce County Early Childhood Network in their creation of Baby Lounges throughout the county. Through our IBCLCs we will provide expertise in the development of BF focused Baby Lounges. Our IBCLCS will also help promote connecting clients to these Baby Lounges through outreach to perinatal medical and service providers in Pierce County. Additionally, we will provide expertise/tech assistance on developing culturally relevant leadership/facilitation of the Baby Lounges.

Activity: We will continue supporting the Pierce County Breastfeeding Alliance. The Alliance membership includes black birth workers, doulas, health equity advocates, and providers. The Alliance coordinates educational offerings to promote breastfeeding support and enabling practices and policies.

3. Take action to identify and address BIPOC infant health and health disparities (e.g. gather data, raise awareness with decision makers, develop, recommend, implement and/or evaluate community efforts).

None selected

4. Facilitate access to free or affordable and accessible prenatal care across the state, ensuring culturally competent care such as doula care.

None selected

5. Participate in local, regional and statewide coalitions and task forces to promote the importance of maternal and child health. (e.g., Develop/use success stories, data and other tools to promote the importance of maternal and child health).

Okanogan

Activity: We will attend community coalition meetings such as Oroville Cares, Okanogan Community Coalition, Health Services Advisory group, and Okanogan Community Health Improvement (CHI) meetings.

Skagit

Activity: Participate in local and regional early learning coalitions (Children's Council and Northwest Early Learning), including serving as regional rep to First5Fundamentals

Activity: Participate in local, regional and state Help Me Grow action teams and coordination efforts.

Activity: Participate in Population Health Trust (community health advisory board) to ensure that maternal and child health is well-represented in community health improvement plan.

Activity: Convene local Prenatal to Three Network on a quarterly or so basis.

Activity: Partner with North Sound ACH to elevate MCH efforts in our region.

Activity: Coordinate with neighboring LHJs whenever possible to create synergy and expand capacity to support MCH in our region.

Activity: Build new partnerships with business community/employers and others to support MCH.

6. Monitor emerging needs and prepare for future public health emergencies. Increase emergency preparedness capacity of families including those that have children with special health care needs.

None Selected

Child Health

State Priorities	Enhance and maintain health systems to increase timely access to preventive care, early screening, referral, and treatment to improve population health across the life course	Promote mental wellness and resilience through increased access to behavioral health and other support services.	Optimize the health and well-being of children and adolescents, using holistic approaches
State Strategies include	Well child visits; Universal Developmental Screening; ACEs prevention; Assessment of Parent/caregiver and child health capacity, access and service effectiveness; family support, protective social norms		

Local Strategies:

1. Universal Developmental Screening: Support statewide roll-out of developmental screening data system (Strong Start).

Chelan-Douglas

Approach: Gather information about current activities related to UDS screening tools, available resources and service gaps, referral mechanisms, and sources for referral.

Activity: We will do this by meeting with the area managers of pediatric/family practice offices and childcare directors and/or surveying medical and childcare staff to assess current UDS activities, screening tools utilized, referral mechanisms etc.

Activity: We will share information about and encourage use of Strong Start as it is rolled out statewide.

Columbia

Approach: Increase the number of early learning and healthcare providers trained on developmental screening tools and a community referral system.

Activity: We will do this by promoting use Within Reach Parent Help 123 and Strong Start, Coordinating with Region Birth-Three Resources, Distributing latest version of ASQ questionnaire to daycares and community

Garfield

Activity: We will participate in the training for the system and providing information about it to families and the local medical clinic.

Grant

Activity: Reengage with the healthcare system for focused collaboration on CYSHCN

Jefferson

Activity: This is a placeholder. Could include sharing information with your local healthcare providers and parent networks.

Lincoln

Activity: We will do this by meeting with local providers at their medical team meetings, will email or do phone consultation with counseling center and schools through special ed directors so they know about UDS through Child Find.

Activity: We will use staff time to develop a brochure for families and a reference sheet for providers to promote the new Washington State UDS system Strong Start and local services such as CYSHCN, local school districts, and local healthcare and mental health providers to facilitate the knowledge base of available services and the coordination amongst providers in Lincoln County to benefit families

Mason

Activity: Share information and provide support about UDS and Strong Start to local health care providers, local early childhood partners, and parents/legal guardians.

Sea-King

Activity: The CCHP (Child Care Health Program) staff will, upon discerning UDS concerns from childcare providers, connect childcare providers with the UDS systems and supports being rolled out in King County.

Activity: Support the statewide rollout of the Strong Start data system by following. When ready, we will follow direction from DOH and contribute to educating community agencies about the Strong Start system.

Activity: The CCHP will design or distribute tools and methods for enhanced understanding of UDS resource materials that parents, guardians, and providers can easily access (such as https://www.cdc.gov/ncbddd/actearly/milestones-app.html), allowing adults the means to access UDS materials to facilitate positive outcomes from the UDS process.

Activity: Promote ParentHelp123 (https://www.parenthelp123.org/) use and other resources that facilitate UDS and follow-up after screening. Refer to the WithinReach Family Health Hotline (https://withinreachwa.org/) and Parent Trust (https://www.parenttrust.org/for-families/developmental-screenings/), which can provide assistance with resources.

Activity: Provide education and technical assistance to providers to help them understand follow-up processes and how to communicate with families and access available community resources to ensure appropriate services and supports.

Skagit

Activity: Coordinate with DOH UDS program to encourage local provider participation. When Strong Start is launched, this could include sharing information about the new data system and encouraging healthcare providers and parents/legal guardians to enter and access screening information into the system.

Whatcom

Activity: Elevate family voice and experiences in accessing preventive care and the impacts on their children and families

Activity: Inform families about the safety and importance of preventive care and motivate them to make an appointment

Activity: Work with community groups and stakeholders to address systemic racism and inequitable access to preventative care services

Activity: Promote preventive care screening and behavioral and physical wellness visits

Activity: Share information about the Strong Start data system to track developmental screenings over time.

2. Complete an inventory of current local strategies by collecting community data to capture evidence-based, emerging, and innovative policies, processes/procedures, and programs being implemented locally to strengthen family resiliency and promote healthy child development. The focus is on strategies that benefit pregnancy, infancy, young childhood, middle childhood, and caregiving/parenting. The intent is to share a completed inventory with Angie Funaiole in the Child Health Unit (formerly the Essentials for Childhood Landscape Asset Inventory Pilot Project). If you select this strategy, Angie will provide you a template to report your findings due by the end of the contract year.

None Selected.

3. Support healthy nutrition and physical activity best practices in schools, before-and after-school programs (including Safe Routes to School), early learning programs, youth community centers, and community settings accessed by children.

Garfield

Activity: We will attend school wellness council/committee with the school district. We will find out what they (and families) are interested in changing; and bring expertise on best practices to the table. We will use the models from CDC. Comprehensive School Physical Activity Programs: A Guide for Schools (cdc.gov) and Comprehensive Framework for Addressing the School Nutrition Environment and Services (cdc.gov)

Sea-King

Activity: Review childcare and early learning program menus.

Activity: Disseminate best-practice information on healthy meals for children including those resources available on the Nourished and Active in Early Learning :: Washington State Department of Health website

Activity: Disseminate best-practice information on physical activity.

Spokane

Activity: We will support early learning programs to utilize National CACFP (Child and Adult Care Food Program) Sponsors Association tools and recipes, along with WA DOH resources: Nourish and Active in Early Learning; Child and Toddler Physical Activity and Active Environments resources.

Activity: Train Early Achiever's coaches in nutrition and physical activity best practices.

Wahkiakum

Activity: Meet quarterly with school and ECEAP staff to discuss approaches to ensure adequate healthy nutrition is able to be accessed by families in the communities that may be hindered by food insecurity.

Activity: Discuss options with local food banks/pantries to ensure that families with food insecurity can access healthy, nutrient dense foods as needed. Public Health will reach out to the local food banks to set up a meeting to discuss policy and potential policy, environmental and system changes that could assist in meeting goals.

Activity: Encourage and assist outreach with community/school gardens to help provide season appropriate fresh fruits and vegetables. Also discuss with school district their policy on ensuring healthy, nutrient dense foods are available to students as well as summer and weekend food programs. Discuss policy and potential policy, environmental and system changes that could assist in meeting goals to include setting up a system for potential plans of regularly providing food to families in need to include contacting local entities (store, food banks and restaurants to name a few) to provide excess healthy foods to be placed in food boxes for families to bridge the gap.

4. Support establishing new and/or enhancing existing Safe Kids Coalitions by serving as Chief Health Strategist on coalition. Potential approaches might include strategies to reduce preventable injuries, poison prevention, and/or substance use.

None selected

5. Trauma-informed services/Adverse Childhood Experiences: Serve as Chief Health Strategist to share education about the 10 Kaiser ACEs and other adverse experiences with community partners (e.g. schools, youth serving community coalitions, juvenile justice, providers) and encourage them to provide staff training and adopt TI practices/policies. Work with own LHJ to become a trauma-informed agency by providing education to staff and developing policy to become a TI Agency.

Adams

Approach: Work closely with providers locally and in surrounding areas to increase education on ACES program and policies and ways to implement them. Encourage providers and other healthcare staff members to increase awareness and education in an effort to recognize the need for ACES practices within our community.

Activity: We will discuss ways to incorporate ACES program and policies into daily practice with local providers.

Approach: Increase the education for employees in our own agency on Trauma-Informed practice, program, and policies. Encourage communication between staff members on methods to educate providers within community.

Activity: We will continue to attend regular educational classes to increase competency in Trauma-Informed practice.

Asotin

Activity: Learn current information and resources and share with community partners serving youth.

Benton-Franklin

Activity: Implement an internal Trauma-Informed agency policy

Activity: Educate staff on integrating TI approaches into existing work

Activity: Collaborate with schools and community partners to assess needs for staff and/or community trainings around ACEs/Resilience/Trauma-Informed Approaches

Activity: Plan and implement local resilience trainings for school staff and other adult influencers, in partnership with local partners

Columbia

Approach: Assessment: Develop and implement an assessment of existing programs, organizations and coalition in the larger community that aim to prevent ACEs and promote resilience.

Activity: We will develop an assessment tool with our Public Health staff, we will administer the assessment to at least 5 community organizations.

Approach: Education: Increase the number of opportunities for LHJ staff, community services providers, and/or community members to learn about ACEs, complex trauma, brain science and resilience.

Activity: We will share knowledge of available trainings on ACEs and resilience with community partners attending Southeast Washington Alliance for Health, Coalition for Youth and Families, as well as other organizations, and we will email training opportunities to local partners.

Approach: Partner Engagement: Increase resources and coordination of services and aim to prevent ACEs and promote resilience. This may include engaging new partners and/or sectors. Efforts may include sharing information about interventions, programs, and/or coalitions.

Activity: We will invite 4 new partners and will attend our Southeast Washington Alliance for Health, Coalition for Youth and Families coalition which addresses resiliency, quarterly.

Approach: Increase resources and coordination of services that aim to prevent ACEs, promote resilience, and increase staff awareness about the 10 Kaiser ACEs.

Cowlitz

Activity: We will do this by sharing information with partners about interventions, programs and/or sharing information about ACEs at coalition meetings. Will also work to engage new partners and/or sectors with TI work.

Grays Harbor

Activity: Activity: We will continue the work of our department Trauma Informed Committee and the 3-year action plan the committee implemented. One of the goals of the committee is to identify policy, knowledge and environment changes within our department each year to promote progress toward a

Trauma-Informed approach to service delivery. This plan also includes continued training opportunities offered to staff in team meetings or as part of their individual professional growth and development plan.

Activity: Partner with other internal department programs and/or local coalitions/boards to bring training opportunities to the community about ACEs and Trauma Informed Care.

Kittitas

Activity: Working externally with the Resilience and ACEs Task Force/workgroup though the Kittitas County Health Network by attending at least 10 monthly workgroup meetings and 8 monthly Kittitas County Health Network Leadership Council meetings. Provide access to relevant data, best practices, resources, and trainings.

Approach: Work with own LHJ to become a trauma-informed agency by providing education to staff and developing policy to become a TI Agency**.**

Activity: Work with our internal KCPHD Health Equity Committee to provide technical assistance and data around health equity and trauma-informed care and ensure internal application of these principles (data/best practice sources include state-wide Community of Practice, ACEInterface, Community Resilience Initiative, Kitsap Strong)

NE Tri

Activity: Through partnership with DCYF and Strengthening Families Locally (SFL) funding was received to provide TI trainings. NETCHD will assist with coordination, organization, and providing information on trauma informed trainings for child serving agencies and community partners for development of creating “Caring Communities”. This may include local caregivers, community partners and child serving agencies, community partners. To increase resource sharing between agencies and provide a way to identify additional needed resources for our communities.

Sea-King

Activity: Conduct “grand rounds” style meetings during which community providers (health care workers, childcare providers) come together to share, build community, and collaboratively problem-solve about ACEs and trauma and to connect providers with the growing body of resources for resilience associated with the traumas of the COVID-19 pandemic, which have amplified other ACEs’ factors.

Activity: The CCHP will engage in education and planning to become a more trauma-informed program that increases its skills in attending to the intersection of inequity and trauma as that plays out in human behavior-- internal to the team’s health-services functioning as we work toward becoming a trauma informed system.

Activity: Through dialogue, interaction, and support, the CCHP will help child care providers and families to understand the importance of how ACEs and complex trauma affect children.

Activity: The CCHP will also meet regularly with providers, who in turn support families, to understand the community’s resources that can help them build resilience, coping, and capacity to deter ACEs’ harms and prevent ACEs as well.

Activity: Through established meetings and collaboration, the CCHP will engage in planning, education, and systems change to become a more trauma-informed program that increases its skills in attending to the *intersection* of inequity and trauma as that plays out in human behavior.

Snohomish

Activity: We will conduct outreach to 10 community partners to engage them in exploring becoming trauma-informed or helping them understand ACES

Activity: We will continue to offer train Snohomish Health District staff and community partners through the ACES Quarterly trainings

Spokane

Activity: We will convene SRHD Beginnings Matter program to operate as Chief Health Strategist to provide data, information, and education about how addressing the "Pair of ACEs" and using HOPE (Healthy Outcomes from Positive Experiences) science can decrease the impact of ACEs, improve resilience and pursue health equity in Spokane County.

Activity: Provide education about "pair of ACEs" and HOPE science via presentations, targeted trainings, and listserv information sharing to cross-sector community partners working with pregnant people and families with young children (0-5).

Activity: Gather information about all current local collaboratives, alliances, and task forces with a main focus on ACEs prevention and family resilience development to determine areas of emphasis, populations of focus, areas of alignment and their needs. Determine gaps, barriers, and assets for greater collaboration on prevention of ACEs.

Activity: Assess interest and readiness of organizations that focus on women and children (0-5) to engage in a county-wide effort to examine and change current policies and practices to implement HOPE science in organizations.

Activity: Identify and engage key community partners across different systems who work with pregnant people and families with young children (0-5) in a county-wide collaborative work group to evaluate current policies and practices that promote HOPE and develop resilience in families with young children (0-5). Prioritize the inclusion of partners who are not represented in other current community collaboratives and task forces focused on ACEs prevention and development of resilience in families with young children (0-5).

Activity: Promote the mitigation and prevention of ACEs by providing education on HOPE and sharing resources from "Project Pinwheel", a webpage created in conjunction with the Our kids: Our business child abuse and neglect prevention coalition. The main messaging includes information about how the community can support parents, so children grow, play and learn in safe and nurturing environments. The promotion of this upstream approach to preventing ACEs and developing resilience in families with young children (0-5) will include providing education, information about available training and opportunities to implement HOPE framework in existing work. The team will provide technical assistance in implementing HOPE in the work of the local, regional, and statewide groups we are part of.

Activity: HOPE science and Project Pinwheel will be promoted during our participation in local, regional, and statewide coalitions, tasks forces and collaboratives such as: DCYF- Strengthening Families Locally,

Better Health Together Collaborative work team meetings, The Spokane Regional Domestic Violence Coalition, the Our kids: Our business coalition meetings, Spokane Regional Birth Outcomes Task Force, and Statewide Essentials for Childhood Steering Committee.

Activity: Continue to be a bridge between Our Kids: Our Business coalition and DV Prevention Coalition and maintain the focus on the needs of mothers and children, and how the 'pair of ACEs' are creating inequities in Spokane County communities.

Activity: Work with DCYF and early learning stakeholders to identify how self-regulation and social emotional well-being can meet the new Early Achievers quality rating criteria and support systems change.

Activity: Provide support and expertise to assist Child Care Aware of Eastern Washington (CCAEW) to identify ways to integrate social emotional well-being into early learning training and coaching to support the 2022 Early Achievers Quality Improvement program.

Activity: Assess interest and common priorities in developing resilience in families with young children (0-5) within SRHD programs that focus on women and children (e.g. WIC, NFP, CYSHCN, and Opioid Treatment Program) and provide information about infusing programmatic activities with HOPE science, using health equity lens.

Activity: Review and revise the SRHD 1-2-3 Care: A Trauma-Sensitive Toolkit for Caregivers of Children with updated research findings to include HOPE science, 'Pair of ACEs", and information about healthy nutrition and physical activity' roles in building resilience in families with young children (0-5).

6. Participate in local, regional and statewide coalitions and task forces to promote the importance of maternal and child health. (e.g., Develop/use success stories, data and other tools to promote the importance of maternal and child health).

Grays Harbor

Activity: CYSHCN Coordinator and program Manager will continue participation and attendance at monthly and quarterly early learning coalition meetings (local, regional and statewide.) Participation and engagement with these groups will continue to help inform services and need for resources for local MCH programs and work.

Activity: We will also use information and resources received when providing presentations about the state of MCH to local Board of County Commissioners (at least 2x per year) and other community partners (at least 2x per year.)

Skagit

Activity: Participate in local and regional early learning coalitions (Children's Council and Northwest Early Learning), including serving as regional rep to First5Fundamentals

Activity: Participate in local, regional and state Help Me Grow action teams and coordination efforts.

Activity: Participate in Population Health Trust (community health advisory board) to ensure that maternal and child health is well-represented in community health improvement plan.

Activity: Convene local Prenatal to Three Network on a quarterly or so basis.

Activity: Partner with North Sound ACH to elevate MCH efforts in our region.

Activity: Coordinate with neighboring LHJs whenever possible to create synergy and expand capacity to support MCH in our region.

Activity: Build new partnerships with business community/employers and others to support MCH.

Spokane

Activity: We will explore interest in "Lunch and Learns" regarding child development, domestic violence prevention (including child abuse and neglect) with additional area employers - including male dominated fields. Tailor messages as appropriate.

Activity: We will continue to be involved with Our kids: Our business, our local child abuse prevention coalition. We will assist with project planning and implementation to promote the importance of maternal child health

Wahkiakum

Activity: We will participate in quarterly ACH meetings as a health department quarterly

7. Monitor emerging needs and prepare for future public health emergencies. Increase emergency preparedness capacity of families including those that have children with special health care needs.

Cowlitz

Activity: We will do this by acting as surge capacity during public health emergencies; sharing resources with CYSHCN families that include planning for emergencies.

Okanogan

Activity: We will attend local/regional North Central Accountable Communities of Health (NCACH) meetings quarterly.

Activity: We will ensure families of children with special health care needs have information regarding emergency preparedness including having a physical address on file for EMS purposes.

Whitman

Activity: Use the CHNA to look specifically for COVID related gaps in service or barriers to care in the MCH and CYSHCN community.

Adolescent Health

State Priorities	Identify and reduce barriers to quality health care	Promote mental wellness and resilience through increased access to behavioral health and other support services.	Improve the safety, health, and supportiveness of communities
State Strategies include	Well child visits, ACEs prevention, Behavioral health, Substance use, Family support, Reduce barriers to access		

Local Strategies:

1. Use evidence-based strategies to support healthy nutrition and physical activity best practices in schools, before-and after-school programs, youth community centers, and community settings accessed by adolescents and teens.

None Selected

2. Support community efforts to increase holistic health among adolescents and young adults through direct support and/or referrals to community resources.

None Selected

3. Promote use of the Bright Futures guidelines for adolescents among providers.

None Selected

4. Support and enhance efforts to increase health literacy among adolescents and young adults.

Garfield

Activity: We will provide references and resources for general health and well-being information to the school counselors, library and local clinic for use by adolescents and young adults to help increase their understanding of navigating health systems.

Kittitas

Activity: Work with Assessment Coordinator to conduct a literature review of best practices and evidence-based strategies for supporting/increasing youth and adolescent health literacy

Activity: Connect with other education, healthcare, and community-based organizations that work with youth to share findings on health literacy interventions, collect information on current practices/interventions in place and develop regular communication plan as part of work plan (below)

Activity: Create a work plan to implement selection intervention/practice and review with DOH, work with Health Equity Committee during development

5. Promote preventive care screening and behavioral and physical wellness visits for adolescents and young adults.

None Selected

6. Support local school-based health center work.

Island

Activity: Explore potential community partners for School Based Health Clinic (SBHC) establishment.

Activity: Develop an SBHC advisory group composed of parents, Human Services, DOH, WhidbeyHealth, SeaMar, school district staff, nonprofit groups, and other stakeholders.

Activity: Review feasibility of different models, such as Rural Health Clinic (RHC) designation and Federally Qualified Health Centers (FQHC).

Activity: Review alignment of SBHC with addressing needs outlined in CHIP 2020 and ongoing needs assessment conducted by Assessment & Health Communities.

Activity: Develop a sustainable SBHC framework document in partnership with community stakeholders, working with guidance from the Washington School Based Health Care Alliance.

7. Participate in local, regional and statewide coalitions and task forces to promote the importance of maternal and child health. (e.g., Develop/use success stories, data and other tools to promote the importance of maternal and child health).

Garfield

Activity: We will attend the Pomeroy Partners meetings, and the Accountable Communities of Health Coalition.

8. Monitor emerging needs and prepare for future public health emergencies. Increase emergency preparedness capacity of families including those that have children with special health care needs.

None Selected