Appendix B – MCHBG Local Work

Overview

During 2021, nearly all local health jurisdiction (LHJ) work continued to focus on COVID-19 response. For many, COVID-19 duties continued into 2022. Many of the LHJ leads for MCHBG work are nurses or trained in emergency response, and they have been serving vital roles related to the pandemic. They became involved in incident management, contact tracing, isolation and quarantine, as well as care coordination. Once the vaccines were rolled out, these same partners jumped into the planning and implementation of vaccine clinics. Many of our LHJs experienced turnover in staff assigned to the Block grant. In order to minimize disruptions to our partners, we decided to extend their 2020-21 work plans through the end of 2021. While the Block grant is structured to report on activities Oct 2020 to Sept 2021, in order to be responsive to Block grant reviewer comments, we opted to report on the timeframe that reflects the changes the reviewers requested. Starting in January 2022 we aligned the LHJ work and reporting with the state work plan (by domain). The LHJs are reporting quarterly and the information from their first reports, Jan-March, is reflected in this year's Block grant submission.

Grant Activity Reporting

For the strategies that fall under the Women/Maternal Health, Perinatal/Infant Health, Child Health, Adolescent Health, and Children with Special Health Care Needs population domains, we have included a description of the local health jurisdiction work in the annual reports for each domain. For local work in the area of emergency planning and preparedness, we have included local work in that section of the narrative. Several local health jurisdictions are also doing work that spans across multiple population domains, or work to strengthen the public health systems, and that work is described below.

Local Health Jurisdictions' Cross-Cutting and Systems Building Work

While most of the work selected by the LHJs can be found at the end of each of the Domain sections of this report, there were some strategies that didn't fit clearly within a particular Domain and are considered Cross-Cutting. Included below as part of this Appendix is work related to Adverse Childhood Experiences (ACEs), representation as the maternal-child chief health strategist on state coalitions and/or task forces, work to improve access to care and fatherhood-specific work.

Following this narrative section, which includes each LHJ's report within the above identified areas for the period Jan-March 2022, there are several charts showing which LHJs have chosen which strategies (CYSHCN by County/Domain, CYSHCN by Domain/Approach, Combined Strategies by County/Domain, Combined Strategies by Domain/Approach, and Health Equity by

county). You will also find the Focus of Work (FOW) document for CYSHCN and one for the Combined Strategies. All LHJs were required to select at least one Approach from the CYSHCN FOW. LHJs selected additional work based on their allocated funding award.

The Health Equity work shown here is new in this report. We began a pilot project in 2019 to add language to their contracts requiring LHJs to use a Health Equity lens to determine which work they would select. Due to the COVID-19 Pandemic, much of this work was put on the back burner as staff was reassigned to response work. In their work plan templates starting with their January-March 2022 reporting, LHJs show what they intend to do and the work they did during this period. Some still encountered barriers to moving this work forward, but many LHJs were able to begin.

ACEs: 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, Asotin, Benton-Franklin, Columbia, Cowlitz, Grays Harbor, Kittitas, NETCHD, Sea-King, Snohomish, Spokane (11)

Adams: No activity. Unfilled Public Health Nursing positions

Asotin: Attended four webinars to help educate myself on ACE's and Resiliency within the LC Valley, learned what information is available and connected with other community partners. Also, met with a representative from Vroom to get more information on their app and got handouts for our LHJ parents. I was able to give them contact information for other community partners that could benefit from their app and information. Success is that there seems to be a lot of information within our community about ACE's, however, the information stays within the same population of people and isn't reaching those within our Valley who could really benefit from the education.

Benton-Franklin: Twice monthly meetings with Resilient Benton Franklin Collaborative and leadership committee which includes CPWI and school district partners to plan resilience summit. Currently assessing interest in what the two tracts should be and outlining speakers for various speakers. Attended Webinars/Conferences: 2/3 2022 WSU Elson S. Floyd College of Medicine Inclusive Excellence Scholar in Resident Health Justice and Belonging Conference, 2/4: Building the Movement with Child Welfare and Justice Systems, 2/8 Adverse Childhood Experiences (ACES) and Resiliency, 2/10 Trauma, Compassion Fatigue and Secondary Traumatic

Stress Training, 2/18: Building the Movement through Transformative Justice and Faith-Based Communities, 2/22 COVID-19 Recovery and Resilience Speaker Series

Columbia: ACEs Podcast shared with internal staff (WIC, Medicaid, Program Coordinators and YWCA Advocate). Shared information on ACEs and Resilience trainings and continued collaboration with YWCA Advocate for prevention of domestic violence

Cowlitz: No activity. We were in the hiring/recruiting/training period for our MCH PHN position, so we were unable to actively tackle this local strategy while we brought the new MCH PHN up to speed with her role.

Grays Harbor: Led the Trauma Informed Committee - a department Environmental Change Committee was created with the purpose of staff providing input and feedback to department leadership. Suggestions put into action so far include new art purchased for clinic room walls with the hope of creating a more comfortable and calming atmosphere, ADA accessible picnic tables were purchased for building grounds to be used during staff lunch/breaks, community members can also enjoy.

Kittitas: KCPHD staff attend the monthly Resilience and ACEs Task Force/workgroup meetings. MacKenzie Carter (KCPHD) has also became the Task Force chair. The Task Force has been able to provide trainings to the Ellensburg Police Department and are reaching out to other organizations to provide ACEs trainings. She has already done several ACEs presentations including KCPHD All Staff meeting and planning a more in depth All Staff Retreat presentation. This quarter MacKenzie has been able to get more familiar with Trauma-informed services and ACEs and has attended the following webinars: Trauma-Informed Incident Response & Interviewing seminar, Adverse Childhood Experiences (ACEs)-A two-part series through Aurora Behavioral Health System, Rural-Urban Differences in Adverse and Positive Childhood Experiences. MacKenzie read numerous articles. The Health Equity Committee is still in the process of updating Kittitas County Public Health Department Communications policy. This process has been taking longer than anticipated as there has been quite a bit of position transitions among KCPHD staff. Audi, the committee chair transitioned into the Health Promotion Supervisor role and that has taken a lot of her time in the last few months. KCPHD leadership will continue to support health equity as a department priority.

NETCHD: Coordinated Course 1 Trauma informed training for other professions through CRI, self-directed course. Coordinated Courses 2 and 3 CRI training for other community partners. Developed media campaign for Positive Parenting Program: Local newspapers, social media, Website. Coordinated distribution of learning materials for Positive Parenting Program to local families registered for the course. Program for trauma informed training began at the start of a large COVID-19 surge and staff had to scramble to change course 1 to self-directed learning opportunity. During this time, staff were also working to train a new staff.

Sea-King: The CCHP staff has been consulting with individual childcare providers to help them understand ACEs when they bring up issues of children and staff members' responses to the pandemic, childcare business, children and families and other stresses in light of historic ACEs and traumas that exacerbate reactions during such difficult times. These consultations are often one-on-one (the CCHP recorded 65 trauma-informed consultations during the first quarter), but in additional the CCHP has met with small groups of providers 2-3 times each month to talk about building resilience and other capacities in the face of ACEs and to help them gain access to resources (grants, PPE, food, connections with other services, and more) that can bolster providers' trauma-informed system change for them to be able to adopt and provide trauma informed care to selves and the children in their care. The CCHP staff conducted 65 trauma-informed consultations during this quarter with childcare providers to address issues of complex trauma, inequitable access to resources that engenders that trauma, and what can be done to give better access to resources and supports to build resilience. The CCHP has increased the body of accessible content around well-being, trauma, and human behavior on its website. Providers are notified of changes to the documents twice a month through childcare sector emails sent to them about childcare related health information.

Snohomish: Conducted outreach to 5 organizations that are relevant to MCH: ChildStrive, DSHS, Sherwood, The ARC of Snohomish County, Snohomish County Human Services. Provided access to an introductory TI practices relevant training. Conducted a series of trainings on trauma and resilience for the COVID-19 response team per request from upper management. The series covered the following topics based on a needs assessment conducted: 3 sessions on Compassion. 3 sessions on Trauma-Informed Care Sessions (Learning About Trauma & Practicing Trauma-Informed Care). 1 session on Transitioning to What's Next & Listening Circle Session to support them as many lost their term-limited jobs on 03/31/2022. 2 sessions on Conflict, Escalation, & De-Escalation Training Sessions. 9 sessions on Mindfulness. Received a lot of positive feedback which was included in final report to upper management. Explored with the SHD Healthy Communities Team on how to make their services more trauma informed.

Spokane: Completed the "Pair of ACEs" infographics with local data to be used during presentations and conversations with community partners. Program staff attended multiple workshops and trainings on trauma-informed systems, HOPE framework and building community resilience, some of which are 2022 Workshop Series: Building a National Movement to Prevent Trauma and Foster Resilience; the Second HOPE Symposium; IECMHC Centering equity from the start. Staff connected with the PACEs Connection social network and began the process to establish a Spokane County community site, where our program can share with the community members information about ACEs prevention, Positive Childhood Experiences (PCEs), HOPE science and community resilience, and all members can share relevant information, services, trainings. Beginnings Matter program staff met with Building Community Resilience and NACCHO representatives to discuss the steps of becoming a Resilience Catalyst when the next cohort

recruitment starts. We also met with other participating LHJs such as Tacoma-Pierce County and learned about their experiences of implementing the BCR model to pursue racial equity in their community. Connected with Clark County LHJ to discuss their future plans for involving families with young children in community assessment and gathering information about their experiences with getting support and information about child development and parenting. In January: - we presented HOPE science and building community resilience to respond to the ongoing COVID-19 pandemic during the SRHD Facebook Live. CHAS pediatric providers – presentation about using HOPE framework in working with families and connecting them to community-based services as a protective factor. In February - presented to SRHD Board of Health about ACEs prevention and the use of HOPE framework to provide strength-based services to families with young children and build resilience in the community. - presented findings of the DOH EFC Inventory of What Works assessment to the community-based organizations which participated in the assessment. Organized findings within the Building Blocks of HOPE to introduce the framework and discussed how collaborative work can address the 'Pair of ACEs' in our community and build resilience for families. After the presentation of the inventory of what works to community partners on February 9th, staff followed up with the attendees and other organizations which were not able to attend the meeting to inquire about their interest and readiness to engage with a county wide collaborative with a focus on implementing HOPE science in organizations providing services to families with young children. Three organizations replied with willingness to be part of future collaborative efforts. Staff created a shared folder where information about current training opportunities and learning can be shared with the interested community partners. The PACEs connections community site will be used for a shared space where all participants in the collaborative will be able to share content, announcements, program information with each other and the community. In March – presented to Birth Outcomes Task Force. Reached attendees who are healthcare, social services and education providers during the perinatal period. - presented findings from the DOH EFC Inventory of What Works assessment completed in summer 2021 to the MCHBG Peer-to-Peer meeting. Discussed the main themes of the assessment and how findings will be used in our future programmatic activities. Staff has started a list of local collaboratives, alliances, and task forces with a focus on ACEs prevention and development of family resilience to examine how their work overlaps and what challenges exist for a greater collaboration. Staff met with DCYF Strengthening Families Locally community facilitator, Health and Justice Recovery Alliance, to discuss possibilities to collaborate on ACEs prevention and resilience development for families with young children. The SFL initiative has been convening community organizations and community members for over a year and has entered the phase of creating a community prevention plan. Met with local providers who work with culturally and linguistically diverse populations and discussed how HOPE science can provide guidance in their efforts to provide trauma-informed supports/services to employees, especially those with young children. Presented on HOPE and building community resilience to staff from Kindering Cherish program, whose services for children 0 – 3 are provided by Early Intervention agencies with CHERISH programs serving families in King, Pierce, and Snohomish counties and were looking to connect with providers from Spokane County. To celebrate April as CAN prevention month, staff assisted Our kids: Our business with the creation of pinwheel bouquets that are available for community

agencies and members to pick up along with yard signs promoting Project Pinwheel. Planning for next year, we have discussed "planting HOPE" as a tagline for next year's pinwheel promotion. With the aim of spreading information about HOPE, Project Pinwheel and how to build resilience in the community. Staff attended and Early Learning Collaboration meeting convened by Spokane Public Schools to assist with the strategizing and troubleshooting issues as the school district plans to increase Pre-K availability within SPS. Discussion ensued about a referral system. SRHD staff is making the case to go more upstream and develop a system of community- based parent enrichment activities that could then serve as a "pipeline" into pre-K programs. Doing so would assist parents making social connections and children being prepared for school. Project Pinwheel information was shared at the local Strengthening Families meeting, the Better Health Collaborative and included in the Spokane County prevent child abuse and neglect proclamation for April. The proclamation will be read at the County Commissioner meeting, Spokane City Council and the Our kids: Our business April CAN awareness event. Continuing to attend monthly SRDVC meetings and advocate for the interests of children impacted by DV. Staff is learning more about the justice system to understand how therapeutic courts such as DV court, Drug court and Baby court interface and collaborate with each other. Baby Court representatives presented at the March SRDVC meeting. Met with CCAEW coach supervisor to discuss EA coach training in social emotional self-regulation. CCAEW received funding through a tribal scholarship to help send early learning coaches to the Conscious Discipline summer institute in Oregon. This aligns with the new specialized coaching tract. Discussed with CME coach supervisor the need to support EA coaches in the Conscious Discipline's Social Emotional Learning series to prepare for the summer institute and their specialized SEL coaching tract. Scheduled HOPE presentation and discussion with SRHD WIC RDs. Staff met with CYSHCN and ESIT staff to discuss how HOPE framework and building community resilience approach fits in their work and offered information about the approaches. Staff has arranged to present about HOPE science to Family Resource Coordinators at their monthly meeting organized by ESIT. Reviewed toolkit and outlined content to be updated and add resources on family resilience, building blocks of HOPE, nutrition and physical activities. COVID-19 pandemic fatigue creates a barrier for engagement with partners who may be overworked, under-resourced and burned out due to the continuous crisis engagement.

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, Grays Harbor, Okanogan, Skagit, Spokane, Wahkiakum (8)

Garfield: Attended Pomeroy Partners meetings, and the Accountable Communities of Health Coalition to represent the public health aspect of prevention and health care for this population.

Grays Harbor: Program Manager attends monthly: Grays Harbor Early Learning coalition meetings and is the Vice Chair, Visions for Early Learning regional coalition meetings, Washington Communities for Children Health Provider Voice action team meetings (regional lead). Grays Harbor Early Learning Coalition - Community presentation about MCH/Early Learning – local resources and Strengthening Families Protective Factors, through Summit Pacific Medical Center Community Education series.

Okanogan: Attended HSAC meeting on 1/12/22 – inclusion of maternal/child health and perinatal mental health topic of discussion. Requested to join task force for project which is sponsored by Help me Grow – next meeting scheduled in April 2022 for Perinatal MH project. ESIT meeting is scheduled for next quarter. At HSAC meeting – conversation about referrals from NICU and hospitals have declined. New Parent to Parent provider – plan to make contact. ESIT staff member of SMART team to identify autism – that is just starting up and taking referrals. Oroville CARES coalition meeting attended 1/20/22 via phone – 2/15/22 – discussion of data. School district opted not to do HYS - using SAMSHA survey – discussion about the health questions missing - reason for opting out was because of sexual health questions. 3/14/22 – Coalition – attended and participated meeting/event that included presentations by Poison Control and Hidden in Plain Sight. Attended CHI meeting – where several presenters from NACH presented. Attended NCACH meeting on COVID and Behavioral Health – provided insight on crisis and COVID and effects on youth, adults and communities.

Skagit: Participated in monthly Children's Council meetings, various HMG action teams and monthly Children's Council Board meetings. Participated in regional early learning coalition meetings and regional Help Me Grow implementation team meetings. Participated in monthly First5Fundamentals board meetings (though missed January meeting due to COVID demands). On Help Me Grow local and regional implementation/leadership teams. Participated in several state HMG team meetings, including Health Care Provider, Coordinated Access Point and Family/Community Voice teams. Regional HMG leadership had meeting with Washington Communities for Children (WCFC) leadership to discuss some challenging dynamics that seem to have emerged in the statewide build-out of Help Me Grow. We had questions and concerns that we wanted to explore as we proceed with our local and regional Help Me Grow work. Participated in monthly Population Health Trust (PHT) membership and steering committee meetings. We have finalized our community health improvement plan, which was adopted by the Board of Health in March and is published as our **Skagit County COVID Recovery Plan**. Deep review of the plan/strategies and sharing out with community partners as an organizing framework for our community collective impact work. This is guiding our new childcare strategies team that is an added component to our local Help Me Grow work. Convened local Prenatal to Three Network on March 31 with about 20 participants. Met with Marco Morales to discuss a new language equity project, and how this might connect to our HMG health care provider efforts. Connected our new DEI person and Skagit Pediatrics team to Marco about this project. Represented our department in practice transformation cohort to assure that MCH population is considered in ACH strategies. Convened regional partners on January 7 with

plan to do this on a quarterly or so basis. Several new people in MCH related roles, mostly compared notes on programs and needs, explored opportunities for partnership and support. Also met with Island County MCH nurse to exchange ideas, discuss potential partnerships.

Spokane: SRHD staff explored opportunities for providing community-based education for parents which coincides with existing youth activities. Staff met with ESD 101 Drug Free Communities' staff members to discuss opportunities for spreading HOPE information in conjunction with ESD's planned activities. Staff is provided ongoing training and facilitated discussions to a local non-profit organization about HOPE and using the strengths-based approach in trauma-informed services with refugee and immigrant families and children. Assisted OKOB with planning April child abuse and neglect awareness events including a community education event featuring an author who was formerly a foster youth. Staff assisted with materials development to promote the month. Distribution of materials will be taking place at Vanessa Behan, our local crisis nursery during the month of April. Staff provided OKOB leadership input and narrative framing suggestions, obtained from the Frameworks Initiative, to inform content creation for the new OKOB website. Staff are a welcomed partner and participant in various local, regional, and statewide coalitions and collaboratives. Staff have opportunities to share information about programmatic activities, new MCH research, policies, etc.

Wahkiakum: HHS Director is attending ACH meetings as available.

Access to Affordable Care: 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, Whitman (2)

Mason: Information provided to Manager to present to community meeting to strategize replacing WIC and Planned Parenthood. Working with DOH WIC for May 18th community meeting for input about community needs. One or two agencies may be interested but having the requirement of all bilingual staff will be a challenge. Reviewed local activities and resources and found several posters for events and supports for Spanish speakers. Sent them via text to CSHCN families and information was also given to our Spanish speaking staff, who uploaded information to Facebook. We are working to create social media and webpage in Spanish through other funding but will benefit MCH/CSHCN work. Staff will be meeting with CIELO in April to review current services in newly opening office in Shelton. Met with Manager to discuss strategies and data for her to be able to connect with Jean O'Leary regarding options for restarting a WIC clinic under a different agency. Worked with DOH WIC for May 18th community meeting for input about community needs and provided agency and contact information for the state to invite to this meeting. Spoke with several WIC

providers and previous providers to get input on what our community needs are and what are our barriers in our area. I reviewed this information with management and connected them for further needs.
Whitman: We scheduled Community Listening Sessions for April 21-23. We are inviting 20-25 MCH and CYSHCN families to participate in Listening Sessions on Access to Resources such as housing, food, health care.

Fatherhood: 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, Snohomish, Spokane (3)

Cowlitz: PHN attended training provided by Washington Fatherhood Council/Dad Allies to learn and provided information to the team on inclusion of queer dads. PHN & OW attended Perinatal Mental Health Screening & Referrals for Moms & Dads in Cowlitz County training. Training provided an opportunity to learn skills to make effective referrals for both mothers and fathers who might be experiencing perinatal mood and/or anxiety disorders. Training was very inclusive of fathers and highlighted their unique needs and resources available that can be incorporated into future work with fathers. PHN attended Fathers Matter Community Conversation with Cowlitz County Dads to share applicable information with fathers and bring feedback from local fathers back to the team to discuss future opportunities for inclusion of fathers in MCH work. Networking opportunity to connect with other service providers who serve fathers. Barriers prior to the Fathers Matter Community Conversation included a lack of understanding on the specific needs of local fathers. The local conversation with fathers provided an opportunity for us to learn about the needs of fathers directly from the target population and help build a platform for future inclusion opportunities for fathers in Cowlitz County that target their specific needs.

Snohomish: No activity.

Spokane: Staff convened meetings, approximately 2-3x a month, with the Spokane Fatherhood Initiative (SpoFi) lead to build a relationship, learn more about their ongoing projects and identify collaboration possibilities. After learning about Spokane Fatherhood initiative's plans to focus on building capacity within the faith community to strengthen families, staff shared a "HOPE for Faith Communities Toolkit". Future plans include discussing the applicability of the toolkit together and determine if it coincides with current project plans. If elements of the toolkit are a good fit, staff will help SpoFi incorporate HOPE strategies into SpoFi's project planning. Staff attended the "Queer Dads Myths and Realities" webinar. Staff convened representatives from Community Minded Enterprises and CSHCN to create a plan for the provider/referral assessment. We reached out to Pierce County to learn about the process they used while creating their "Provider Voice" Action Team. Planning discussions are ongoing. Currently, we are

identifying medical and dental providers that interact with families and children 0-5. Once identified we will learn who within the practice is responsible for making referrals. We plan to reach out to the refer-er with a survey and information regarding HOPE science and the importance of creating community support for families with young children. Contacting providers is tentatively scheduled for mid-April. We have reached out to the 211 regional lead to learn more about the resources they provide, how resources get added to 211 and the process used to ensure resources are still available at the time they make a referral. SRHD staff are also discussing the possibility of seeking a GIS skilled, Masters level intern to assist with asset mapping within Spokane County. The information gathered will be shared with 211. Planning continues to occur as we await the reopening of public places now that COVID-19 is waning in our community. Staff is currently working with Community Minded Enterprises on identifying and compiling a list of medical providers that engage with pregnant women and families with children 0-5. We are awaiting the results of parent focus groups to learn where parents usually obtain information regarding universal development and finding services for their children. This information will guide future outreach efforts. Staff has spent at least 10 hours researching activities open in the community and identifying practitioners to engage. Future work includes developing an information sheet combining information on HOPE sciences and where parents can go to develop networks of support in the community. There is a lot of interest and discussion around how best to create community supports for parents as we emerge from the pandemic. Partners have been receptive to conversations regarding HOPE science and are interested in learning more.

2022 Local Health Jurisdictions by Domain

All Local Health Jurisdictions were required to select at least one strategy from the Children and Youth with Special Health Care Needs (CYSHCN) domain (see additional chart). This chart shows strategies selected by Local Health Jurisdictions within each domain.

Women-Maternal Health	Perinatal-Infant Health	Child Health	Adolescent Health	Cross-Cutting
Access and referral to breastfeeding, mental/behavioral health information/services: Benton-Franklin, Klickitat, Okanogan, Skagit, Tacoma-Pierce, Whatcom, Yakima (7)	**Breastfeeding:** Grant, Kitsap, Kittitas, Sea-King, Skagit, Snohomish, Tacoma-Pierce, Yakima (8)	**Collect data to assess local family and child health practices, programs, policies, and systems that are believed to increase family resiliency and healthy child development. Share findings with DOH and other partners:** Benton-Franklin, Whitman (2)	**Health Literacy:** Garfield, Kittitas (2)	**ACEs**: Adams, Asotin, Benton-Franklin, Columbia, Cowlitz, Grays Harbor, Kittitas, NETCHD, Sea-King, Snohomish, Spokane (11)
	Nurse-Family Partnership: Clark, Kitsap, Lewis, Skagit, Tacoma-Pierce, Thurston, Yakima (other HV program)(7)	**UDS:** Chelan-Douglas, Columbia, Garfield, Jefferson, Mason, Sea-King, Whatcom (7)	**School-based Health Centers:** Island (1)	**Emergency Preparedness**: Cowlitz, Okanogan, Whitman (3)

Women-Maternal Health	Perinatal-Infant Health	Child Health	Adolescent Health	Cross-Cutting
		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, Sea-King, Spokane, Wahkiakum (4)		**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, Grays Harbor, Okanogan, Skagit, Spokane, Wahkiakum (6)
				Fatherhood: Cowlitz, Snohomish, Spokane (3)
				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, Whitman (2)

2022 Local Health Jurisdiction Health Equity by County

In development of their 2022 work plans, all Local Health Jurisdictions were asked to consider how health equity and anti-racism figured into their approaches and how their selected strategies would address health disparities and promote equity. They were asked to share how they identified the populations served. The chart below shows their planned approaches and 1st quarter(Jan-March) updates.

COUNTY	Cross-Cutting
Adams	**Approach:** For the next year, our plan is to focus on the Mixteco population within our county by initiating communication and creating awareness with our local providers. The Mixteco population has a barrier to resources in our county because of the communication gap and lack of a written form of the language. The goal is to work with our local service providers and healthcare facilities, including our medical home team to be able to make the resources increasingly accessible. **Update:** No activity. Position unstaffed.

COUNTY	Cross-Cutting
Asotin	**Approach:** One of the largest barriers to service for our participants is the disconnect between services in Washington State and having all of our pediatricians and our only hospital the serves children and delivers babies in Idaho. This leads to a disparity in referrals versus services especially for those children and youth with special health care needs. By first focusing on creating a relationship with those who serve our participants, we can then help educate and promote resources available. **Update:** Using the resource Research Shows How We Can Reduce Bias in Ourselves and Our Organizations - Mindful, read through and worked through article. Looking into Breaking Through Implicit Bias in Healthcare training.

COUNTY	Cross-Cutting
Benton-Franklin	**Approach:** Due to the MCHBG staff's heavy involvement in our COVID-19 response, minimal modifications were made to the new action plan. Our Health Equity Committee has been on hold, though we are still operating a bi-weekly equity taskforce to gather input from community-based organizations during the response. As staff return to typical duties, the Health Equity Committee, Trauma Informed Approaches Team, and Diversity and Inclusion Team will resume and continue efforts to implement the Health and Equity Impact Assessment Tool. The pandemic continues to highlight disparities in our community as well as throughout the nation. **Update:** bi-weekly taskforce for COVID outreach continues. CHW covid outreach toolkit was developed by BFHD and is now being used to train CHW's region-wide. MCH funds are not being used for this work but data and existing MCH partnerships are informing it. There is a continued focus on diversifying and supporting the public health workforce and providing equity-based and trauma-informed training to supervisory and management staff. Assigned staff to participate/review the MCHwork Fast & Focused Learning Focus on Health Equity Series. Reviewed the Public Health & Equity Resource Navigator: PHERN | Public Health and Equity Resource Navigator (communitycommons.org) Attended webinars: • Addressing Health Equity and Impact of Racism on Child and Adolescent Health: What Can Be Done? • An update on Racial Disparities in the course of illness, treatment and recovery for Substance Use Disorder • Racism, Racist Inequities and the Child Welfare System: Implications for Prevention • Introducing the Intentional Equity Framework: How to Design Equitable Health Communications Following HB 5228- Directing DOH to make rules for health professionals to take health equity continuing education

COUNTY	Cross-Cutting
Chelan-Douglas	**Approach:** We considered county level data for Chelan and Douglas Counties (Source- 2020 Census Data) Chelan Co.- 67.6% Caucasian, 28.2 % Hispanic, 12.2% living in poverty Douglas Co.- 63.4% Caucasian, 32.3% Hispanic, 10.9% living in poverty *Our CYSHCN Program FY2021*- 90.54% Hispanic; 58% of families monolingual Spanish; 92% had Title XIX coverage. Our CYSHCN Program can help address identified needs from our Community Health Needs Assessment (access to care, behavior/mental health, housing, literacy) and reduce health disparities for children with special health care needs. There are 199 children in Chelan County and 116 children in Douglas County (under 18 years) eligible for DDA programs and services. This provides an opportunity to work with DDA case managers on referrals to CYSHCN Our focus on Child Health will address early screenings (promotion of developmental and lead screenings and referral to appropriate services). Many of our communities are in areas with high risk to lead exposure based on age of housing per the Lead Exposure Risk Mapping Tool. Some local providers are unaware of the exposure risk in our counties and unaware of the screening guidelines. We recognize that racial minorities experience greater health disparities. We also recognize that people living in poverty experience greater health disparities because of the social determinants of health. Poverty limits access to medical care, healthy foods and safe neighborhoods, increases risk of lead exposure etc. Our focus will be on these populations. **Update**: • Attended webinar Cultural Humility- Autism and the BIPOC Community • Reached out to DDA case manager to share our CYSHCN referral form and parent flyer • Our agency hired a bicultural, bilingual outreach team to work in our communities to share information about our programs at community outreach events and to help improve access to care for our minority population.

COUNTY	Cross-Cutting
Clallam	**Approach:** Our Maternal Child Health Case Manager serves the whole county but is based out of the West End of our county. This region has the lowest median income in the county and highest population of Latinx and Native American residents. By housing our case manager in this region, we improve access to populations commonly underserved by health care and social services. Our case manager continuously develops and strengthens partnerships with local service providers, by having a presence in the community she has her finger on the pulse of the community's needs and has the ability to pivot programming to meet those needs. **Update:** Regular communication with Derechos Humanos and local Tribal schools/clinics/social service providers to assure all are up to date on CYSHCN programming.

COUNTY	Cross-Cutting
Clark	**Approach:** While health/racial equity did not inform *which* strategies we selected to implement for the 2022 MCHBG cycle, racial equity *does* inform how we approach our collective work, regardless of the approach or population served. We operate with the understanding that racism is the root-cause of broader health inequities and social determinants of health. At present, we are working with our leadership and management teams to train staff on how to think using an anti-racist framework *and* make our efforts actionable to dismantle institutional and structural racism. Our internal equity committee is currently viewing the American Public Health Association Advancing Racial Equity webinar series. The first webinar begins to unpack systems drivers which operate to sustain racism as the ultimate underlying condition. The second webinar focuses on reproductive justice for pregnant and parenting families. We will view, discuss, and use strategies identified in these webinars to guide our continuing education and equip staff with the knowledge and tools to dismantle racism using the foundational frame offered in the first webinar – *How is racism operating here?* Our organization is also researching the feasibility of joining the Government Alliance on Race and Equity to inform the future of our values, practices, policies, and procedures as it relates to the service of our Maternal Child Health populations. **Update:** We recently completed a department-wide Racial Equity staff survey with a 98% completion rate. The survey included an inventory of questions dedicated to understanding our staff's experiences and competencies discussing and advancing racial equity strategies tied to programmatic and administrative public health efforts. The survey also collected feedback on staff assessments of historically available training and interest in participating as part of our Equity, Diversity, and Inclusion Group (EDIG). We are working on finalizing the executive summary of the survey's findings, at which point they will be distributed to All Staff for discussion and next steps for implementing our APHA webinar series viewing by department (beginning with Leadership Team, Management Team, and existing EDIG members). We have also reached out to our county Human Resources Department to advocate for a county-level membership to the Government Alliance on Race and Equity to better systematize our efforts locally. We are still waiting for a response related to our request.

COUNTY	Cross-Cutting
Columbia	**Approach:** Health equity in Columbia County is focused on actively identifying, evaluating and engaging community members affected by disparities. By providing information, education and contact with needed resources to individuals and families with potential needs for promotion of health in a holistic manner. Looking to also identify important health disparities and inequities in opportunities and resources due to work conditions, income, financial/housing issues, education and social exclusion. Collaborating with WIC and Medicaid/Medicare Coordinator to reach these community members. **Update:** We gave individuals information and guidance to health or wellness resources available in the community, also sources for immediate needs such as food bank, emergency care, behavioral health and WIC. This information is available via social media, websites, in person or over the phone. We prioritize the financially challenged because many are seeking programs for which they are eligible. Providing ECEAP staff with resource information for low income families
Cowlitz	**Approach:** We did not use a standardized tool when drafting this action plan. According to the CDC's Social Vulnerability Index, Cowlitz County has a high level of vulnerability with a score of 0.7885 (as of 2018), with 0 indicating lowest vulnerability, and 1 indicating the highest. With that in mind, the populations we identified for focus in Cowlitz County include CYSHCN and their families, fathers, and community partners that serve these populations. **Update**: PHN attended training provided by Washington Fatherhood Council/Dad Allies to learn and provide information to the team on inclusion of queer dads. PHN & OW attended Perinatal Mental Health Screening & Referrals for Moms & Dads in Cowlitz County training. Training provided an opportunity to learn skills to make effective referrals for both mothers and fathers who might be experiencing perinatal mood and/or anxiety disorders. Training was very inclusive of fathers and highlighted their unique needs and resources available that can be incorporated into future work with fathers. PHN attended Fathers Matter Community Conversation with Cowlitz County Dads to share applicable information with fathers and bring feedback from local fathers back to the team to discuss future opportunities for inclusion of fathers in MCH work. Networking opportunity to connect with other service providers who serve fathers.

COUNTY	Cross-Cutting
Garfield	**Approach:** Health equity in this county is focused on those with financial challenges and/or those with a Hispanic origin, as the populace is mostly Caucasian. The strategies to help promote equity are to have resource information available to all. Also, to utilize other programs, which may bring these populations in, e.g. WIC, to also provide any needed resources for other health needs. We look at the promotion of health in a holistic manner and try to assess and capture any potential needs individuals or families have and help provide information, education and contact with needed resources. We can provide many informational resources in the Spanish language also. **Update:** This is ongoing. We can provide information to help guide people to any health or wellness resources available in the county as well as sources for immediate needs such as food bank, WIC program, emergency care, behavioral health. We can provide information to connect families to BOOST, the Birth to Three program contracted with the county and /or refer them to the school for assessment of children over aged three. This information can be given over the phone, posted around town and via social media and websites or in person. The financially challenged are prioritized because many are seeking those programs for which they are eligible and may see the program information posted around town or on the social media and websites. We have made information available through the persons in charge of the local homeless shelter and those seeking to sign up for Medicaid and SNAP benefits. The WIC program has information printed in Spanish and we can utilize an interpreter service.
Grant	**Approach:** Our identified populations include monolingual Spanish speaking families, as well as families with limited literacy. Providing translation and interpretation resources is fundamental for engaging limited and non-English speaking communities. Resources include translation of written materials as well as a cultural bilingual dedicated staff to work with families. Selecting times that work best for our families who often work long hours is essential to the success of a case management partnership. Resources are adapted for families with limited literacy to a grade appropriate understanding. **Update:** Currently working with two deaf families and addressing barriers to family health. Working with our community health worker for case management of our Spanish speaking families. Updated our family resource brochures in English and Spanish to serve our Spanish speaking families. Partnering with the regional library to get information and literature out to Spanish speaking families.

COUNTY	Cross-Cutting
Grays Harbor	**Approach:** Our department has collected and discussed qualitative and quantitative data about gaps in service related to early childhood, CYSHCN, and maternal health. Many of the gaps and barriers identified center around people's access and/or language. The strategies and activities that we have chosen for our action plan target those barriers and gaps. Our department uses a tool called Health in All Policies (similar to a tool used at Pierce County HD) when considering program and policy implementation and/or change. Our department has included health equity as a focus in our current strategic plan which includes considering healthy equity principles in program planning and evaluation and creating a plan to incorporate community voice in all programs by the end of 2022. **Update:** The program supervisor has been attending a five-part virtual series of conversation about language accessibility in IDD services. The Language Access Forum Series is offered and facilitated by Wise in collaboration with Open Doors for Multicultural Families. The series is offered once per month for five months starting February 23rd. https://www.gowise.org/languageaccess/ Our department Trauma Informed Committee led activities at our February and March All-Staff meeting. Reviewed Health in All Policies tool; in breakout groups went over scenarios that staff and programs may work through using the tool. Did a breakout room to review and discuss the current Health Equity resource list; staff provided thoughts and feedback about how the resource list can be used and applied to work, updated and improved.

COUNTY	Cross-Cutting
Island	**Approach:** The population in Island County is fairly homogenous with very small percentages overall of the following ethnicities: African-American, Latinx, Asian-Pacific Islander. Island County is also home to members of the LGBTQ+ community. The Naval Air Station plays a significant role in bringing people from many areas of the United States and some foreign nationals to our county. This military population is constantly changing thereby affecting our demographic; there are services for military members only, but many also access services and programs through county services. Moving forward, an equity lens will be employed when creating materials for distribution and any assessment tools. Additionally, information will be sought from local groups cross-culturally, if possible, encouraging input for programs moving forward. **Update:** To promote the work of Local Strategy 4 Well-Being, a sampling of pictures representing several ethnicities were utilized in updating brochures for other Maternal Child brochures. Specifically, pictures of Caucasian, African-American, Asian, and Hispanic mothers with infants/children were used. During this reporting period there was no interaction specifically with local cross-cultural groups; this activity will be targeted for the next quarter.

Jefferson	**Approach:** We have identified health equity challenges through a disparity lens. Health inequities disproportionately affect the Jefferson County population, compared to state averages, due to its rural and isolated location. Additionally, Jefferson Co. residents experience lower per capita income, median household income and average earnings per job than WA residents; and 1 in 3 Jefferson Co. residents live below 200% of the poverty level. Jefferson County, WA is a rural county located hours from specialty medical services. Jefferson County populations face barriers such as cost, transportation, limited provider capacity, lack of specialty services. According to the 2019 Jefferson County Community Health Assessment Report, key informants and community members broadly identified access to health care as the main driver of health concerns in Jefferson County. There are no diagnostic services for Autism in Jefferson County. Families face wait times of up to 2 years to access needed specialty diagnostic services in Seattle and Tacoma. Nutrition Network and Center on Human Development and Disability, University of Washington has identified Jefferson County as an area with limited access to nutrition related services. There are only 3 identified Nutrition Network RDs in this area and it's uncertain how many will be active resources in the 2022 and beyond in our rural area. JCPH will work with community partners to participate in and enact change needed to enhance service delivery models, advocate for families and CYSHCN, and evolve staff awareness of institutional/structural racism and ways to reduce and eliminate disparities in equitable access to high-quality health and related services. **Update:** Jefferson Co. Public Health CYSHCN staff continues to work with Kate Orville, University of Washington to recruit Jefferson Co. medical providers for Centers of Excellence training and exploration of community support and capacity for forming a SMART Team in Jefferson County. COVID prevention, treatment and care continues to place a heavy burden on the healthcare system and healthcare workers. This is certainly a reality as we work to engage Jefferson Healthcare administration and providers in Autism diagnosis systems at the local level. We have gained the support of the Chief Medical Officer of Jefferson Healthcare to develop systems within Jefferson Healthcare to support their staff participation in SMART teams. This healthcare system change strategy will require a local practitioner completing the UW- COE training. JCPH succeeded in encouraging 3 local providers to enroll in the January 2022 Centers of Excellence training for ASD Diagnosis through SMART teams. Unfortunately, due to a number of circumstances including COVID, only one provider (Non-Jefferson Healthcare) was able to complete this training and the 2 others postponed attendance to the next training in September 2022. There are other steps that we are taking to prepare for a local SMART team, as we wait for the next Centers of Excellence training in September 2022. We are currently participating in regional and states SMART networking to learn about how the

COUNTY	Cross-Cutting
	SMART teams function as well as embarking on a community Asset Mapping project to identify Jefferson County resources related to neurodevelopmental diagnosis and referral services.
Kitsap	**Approach:** Kitsap County, like many counties in our state, shows disparities in health outcomes based on income levels. Our low-income families have inequities in their ability to access services. We use our health equity lens on strategies to address these inequities in this plan. Kitsap families may be unaware of many services available to them due to language, technology, transportation, or other barriers. Systems to assist families in need of services may not be up to date, not inclusive of new services, or not available in the language spoken. Working to resolve these barriers will help to make services in Kitsap more equitable. Along with frequent updating to the Within Reach system, working to improve Kitsap's local referral systems will improve access for more families. We plan to improve access through identifying and promoting services that can assist CYSHCN families to find behavioral health and other supports, all families to find home visiting and childhood services, new parents to find home visiting services that best meet their needs, and chest feeding/ breastfeeding families to find assistance when needed whether they live in the north or south end of the county. **Update:** 3/17/22 HVSA Anti-Bias Practice Toward Families Who Have Experienced Trauma 3/22/22 LGBQT and Diversity Webinar Gathered local resources supporting African American/ Black families for future connection and support for black infant health.

COUNTY	Cross-Cutting
Kittitas	**Approach:** Kittitas County Public Health Department has created an internal Health Equity Committee to work with department leadership and program staff to incorporate health equity review into ongoing processes. We do not use a standardized tool to conduct a health equity review, however the Committee is still working toward the goal of developing an in-house tool similar to the Tacoma-Pierce County Health Department's Health Lens Analysis Tool. We are working to adapt that tool to be used at major decision points and periodic reviews of strategy progress; it has been significantly delayed due to COVID-19. Rather than select a specific local strategy to address ACEs and childhood trauma, our plan is to include that as an aspect of all our local strategy work. Kittitas County Public Health Department has also been awarded the COVID-19 Rural Health Equity grant through DOH. We will be forming a coalition of community partners and community members, who will guide what strategies are best to address COVID-19 health disparities and health inequities in our county. We hope to align that work with our department wide health equity work. **Update:** The Health Equity Committee continues to meet and working towards the incorporation of health equity review practices within the department. They are currently working on the Kittitas County Public Health Department Communications policy, where they are looking at how communication plays a big piece within our community. The committee is also looking at various health equity review tools, and plan to create one that fits the needs of our organization. Once this health equity tool is put in place, it will be used as a guide to ensure that all programs and decisions within the department are as equitable as possible. The Health Equity Committee will be presenting on what health equity is and presenting a training module for everyone to do in the department. We are also working on the creation on the first webpage dedicated to health equity in the health department, in that webpage we plan to include health equity facts along with health equity coalition (grant received recently) updates for the community to view.

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Klickitat	**Approach:** Currently we sit on a committee that one of our healthcare partners Klickitat Valley Health (KVH) started in 2020 - present. KVH received a grant for this work. Our work with KVH continues to identify a county Health Equity Lens definition, identification of unconscious bias work/understanding, and educating staff. Our population focus is Healthcare Employees that work with the maternal child health population. We do not have a standardized tool for this work. **Update:** • Attended three community meetings regarding Health Equity Work • Attended six Diversity, Equity, and Inclusion (DEI) workshops hosted by UW Psychiatry, Sound Physicians & Parker Smith & Feek. • Created a committee within the Health Department to look at the work and gain understanding of the topic.

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Lewis	**Approach:** When choosing our strategies and planned activities, a Health Equity Lens was used to identify areas of need for enhancing outreach to specific populations and increasing knowledge and capacity to address inequity in our Maternal Child Health programs. Although a standardized tool was not used, review of county data identified the Latinx community as a population that was not proportionally represented in our CYSHCN program or family support programs (Lewis County Autism Coalition, Parent to Parent, InTot Developmental Center, Summit Center for Child Development). The following examples are ways that we will use a Health Equity Lens in our CYSHCN activities to address this gap: • Build new or better relationships with community service providers who serve the Latinx community • Materials shared with providers, schools, and community will be in both English and Spanish whenever possible • Increase opportunities/access for Latinx families to participate and provide feedback in community coalitions and workgroups To further address health equity in MCH, we have identified the need for increased internal and community awareness and capacity. In order to support this, our MCH strategies will include sharing resources, educational opportunities, and tools that promote health equity. In addition, our Nurse-Family Partnership subcontract will include use of data to address disparities and increase outreach to target populations. **Update:** We continue to build partnerships and capacity to serve community members who do not speak English as their first language. We have worked with The Equity Institute and local services providers to increase availability of Spanish interpreters and translation services to better serve families who speak Spanish. I have been attending a monthly statewide Language Access Forum that is being facilitated by Open Doors for Multicultural Families with a focus on access to services for individuals with developmental disabilities and their families.

COUNTY	Cross-Cutting
Lincoln	**Approach:** The population of focus is low income residents making less than $25,000 per year. The Lincoln County Health Department plans to contract with a Health Equity Coordinator to work on behalf of and support the health collaborative partners of our county to address health equity with a focus on reducing the number of poor mental health days experienced by individuals making less than $25,000 annually (currently on hold due to COVID). This will not be funded using MCHBG. This plan was the result of reviewing the Lincoln County Demographics and Social Characteristics 2018 and Indicators Summary 2018 produced by the Data Center at Spokane Regional Health District. These reports as well as the subsequent community forums to review them were facilitated and compiled by Steve Smith, Research Scientist with the Spokane Regional Health District utilizing Foundational Public Health Funds earmarked for these endeavors. The community health forums were held to present the findings of the Lincoln County health indicators report (Indicators Summary), to ask community members if they felt that the indicators accurately reflected the quality of life in Lincoln County, and to ask for their input on the community health improvement plan to be developed based on the health indicators. MCH issues discussed at the meetings included immunization rates, maternal smoking rates, and resources for Children and Youth with Special Health Care Needs (CYSHCN). We had 8-10 community members at each forum who gave valuable input that will be used going forward in the development of the community health improvement plan. **Update:** Conducted interviews March 2022 and hired a new staff member who begins work April 2022. Her name is Liz Richardson and her work will include community health education, data assessment interpretation, community facilitation and collaborative work on community identified priorities. Her job will be to move forward the work left off in 2018 of using the information gathered at the community forums to address the health priorities identified, and all of this work will be conducted using the health equity lens. The plan is still to contract with a Health Equity Coordinator on behalf of the community partners, but I wanted to note that work done by Liz here at and specific to the health department will be conducted using a health equity lens.

COUNTY	Cross-Cutting
Mason	**Approach:** Native American family focus: Continue to respond and participate in the tribal maternal child health work that can provide more insight into tribal views and needs in our community Hispanic family focus: We have utilized a well-known community interpreter to help link us to the needs of Spanish speaking and Spanish as a second language families. She is seen as a trusted matriarch so that families will feel comfortable to share their needs. Working with her and Spanish-speaking families, I have seen the difficulties that families face when trying to help their child get their needs met. We have also been able to hire an additional full-time bilingual staff person to assist with outreach, interpretation, and translation. Community specific needs: Participating in the monthly Pediatric Provider Case Management Meeting brings all agencies together for case management and tries to create solutions to the barriers families face (such as low-income constraints on transportation and lack of knowledge about Medicaid transportation, ability to access food, assistance with specialty appointments in other counties, literacy, language and other services). Mason County Early Learning Coalition as a group has identified support needed for young age groups (2-5) and Hispanic families. This group also brings all the agencies together that provide support to Maternal Child Health in our county. **Update**: Our full-time interpreter and translator has been such a wonderful resource to have in the office every day. He assists me in calling referrals to help with resources and needs and is working on social media and web site information and updating forms for Spanish Speaking families.
NETCHD	**Approach:** With the use of information by location (IBL) mapping tool for health disparities and county health rankings map; Ferry, Stevens, and Pend Oreille counties rank high in overcrowded housing and population living in poverty. When determining strategies for MCH action plan for 2022, focus was on ways to work towards coordinated services and outreach to better serve our population. With a focus on ways to increase community partners' knowledge on trauma informed care. **Update :** Staff continue to set-up opportunities for local community partners to increase knowledge on Trauma-informed care. Staff have been networking to find ways to increase awareness of available services in our area, given the lack of internet availability any many locations.

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Okanogan	**Approach:** OCPH uses the health equity lens and specifically the basis of the social determinants of health as one of the health equity tools in determining gaps in services and where other structural and environmental factors create barriers to care. **Update:** Met with Advance, a non-profit entity that utilizes CHW's. We are strategizing to assess barriers and gaps in services for families that are underserved or marginalized in an effort to bridge gaps and identify resources.
Pacific	**Approach:** With our workplan we will continue to work on engaging, recruiting, and supporting a more diverse group of parents and community members on our Advisory Boards, our SMART team and other groups that work on improving the health of the community as a whole. Our county is primarily Caucasian. Per the Demographics from 2019 our county makeup was 96% Caucasian; 1% Black; 3% Native American; 2% Asian/Pacific Islander; and 10% Hispanic. Our current CYSHCN caseload does not reflect this, so in 2022 we plan to continue efforts at reaching this population by strengthening our relationship with the Pacific County Immigrant Support Group (PCIS) to more actively engage with Hispanic families throughout the county. Our hope is to continue breaking down barriers to their ability to obtain services. Our WIC certifier will be assigned to MCHBG moving forward. WIC is a program heavily utilized by our Hispanic community and she is Spanish speaking. We hope to see an increase in referrals through this process and gain knowledge on where our other gaps are by increasing our reach into this community **Update:** Our WIC certifier has been able to refer Spanish speaking WIC clients to the CYSHCN program. Lettie and Kim have worked well in this process. Princess and Lettie have attended the PCIS (Pacific County Immigration Services) meetings to represent the CYSHCN's program and Lettie is able to advocate in Spanish at these meetings. Meetings have been virtual and we are looking forward to in person meetings soon.

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San Juan	**Approach:** In San Juan County, children under 18 are 13% of the population. Approximately 10% of the population lives below the Federal Poverty Level (FPL). The Hispanic population is ~7%. According to the County Health rankings, 13% of children live in poverty and 24% of children under 5 live in poverty in San Juan County. According to the 2019 Region 3 Data Profile, 24% of residents in San Juan County are SNAP Eligible and 8% of households use SNAP benefits. In Spanish speaking households, 24% live at or below 100% of FPL. According to Office of Superintendent for Public Instruction, San Juan County School Districts have 39-50% of Elementary and Middle School children on Free and Reduced School Meals. The 2018 ALICE (Asset Limit Income Constrained Employed) report found ~40% in San Juan County find it difficult to afford basic cost of living and in Friday Harbor the only incorporated town, that number was 48%. In San Juan County the relatively high cost of housing, transportation, and affordable childcare make it difficult for working families to meet basic needs. The Washington State Healthy Youth Survey 2016 shows that 82% of San Juan County youth experience insufficient physical activity. The 2017 Washington Department of Health Chronic Disease Profile found 28% of the population experiences food insecurity. There are currently no Medicaid Dental providers in San Juan County for children over the age of 5 and the only ABCD provider is on San Juan Island, creating transportation barriers for children on other islands to access oral health care. **Update**: San Juan County HCS staff have joined a LatinX advisory group on San Juan Island to ensure LatinX voices are key contributors to addressing health equity and systemic issues and barriers and identify needs and solutions. We have participated in two meetings thus far with a focus on health screenings, access to well child visits, and improving bilingual communication between the school and parents. We continue to ensure that our mobile dental van information and application, upcoming Smile Mobile dental van serving children, and food access program information and applications are all translated into Spanish. Use interpreters when needing to schedule or assist Spanish speaking clients to access services or make appointments.

COUNTY	Cross-Cutting
Sea King	**Approach**: Racism has been declared a public health crisis in King County. All our public health programs are required to actively work to break down racist systems and barriers that perpetuate the health effects of racism on families across our county. Our CSHCN program is aggressively working to identify and change racist structures affecting our CSHCN families. One way we are working toward this goal is by working directly with our Help Me Grow program, who are experts at identifying services that match the cultural needs of our clients, then creating personalized referral processes, ensuring all our families receive competent and respectful care. The CCHP listens to child care providers from culturally and linguistically diverse communities, in part, to choose practice strategies that better meet children's and providers' needs. The CCHP, in its efforts to elevate equity and inclusion, has heard providers are seeking greater access to the CCHP's health, behavioral health, nutrition, and like information to improve child well-being in early learning settings. To that end, the CCHP has hired a Language Access Coordinator who will collaborate with providers, Community Based Organizations that support them, and King County and Seattle partners to create a system that manifests translations and interpretations of CCHP materials, guidance, and support. The CCHP received from Child Care Aware a list of the top languages, other than English, for this purpose. This initiative is intended to enhance provider access to the CCHP's website and its other critical child health and safety communications and materials for children's well-being and development. Planned Approach: • The CCHP will work on building a system that engages child care providers and partners, from their community-informed perspectives and needs, around language and cultural access to information for healthy and safe child development. • The CCHP will strive to disseminate translated and tailored materials to care providers additionally on topics related to nutrition; ACEs, trauma, and resilience; and the developmental screening, referral, and follow-up considerations noted herein. **Update:** The CCHP, during this quarter, has built upon its language and cultural access initiatives by asking child care provider communities, through surveys and focus groups, what and how they need child health and safety information communicated. It is using that community-informed guidance to alter, update, or otherwise infuse health information accessibility and literacy principles into the CCHP's COVID and other communications, inclusive of its website documentation for providers. Additionally, the CCHP is involved in larger Public Health and KC language access initiatives to broaden the scope of its abilities to communicate and receive feedback about health information that can provide a continuous loop resulting in provider access to the most helpful, supportive child health and development methods and resources.

Skagit	**Approach:** Skagit County's Population Health Trust (PHT) is a county-wide leadership group that is responsible for our community health assessment and planning. The PHT launched a Maternal-Child Health ("First 1,000 Days") workgroup in 2018, which resulted in a collective action plan for improving children's health and well-being over the life course starting from before birth. This plan with four primary goals was written with equity threaded throughout the plan and called out specifically. One thing that emerged loud and clear in these planning efforts was the absence of an easily navigable system for families in this stage of life. As one parent put it, "tracking down resources was like an underground network". This challenge is amplified for families who experience systemic racism, who experience cultural or language barriers, or who have a variety of special needs. Our MCHBG work has been rooted in that plan, in coordination with our PHT and the Children's Council of Skagit County, our local early learning coalition. The biggest body of that work is creating a system where ALL families can find the supports they need, when they need them in the ways that they need them. The opportunity to connect to our newly expanding Help Me Grow Washington system came along, and our strategies in our proposed action plan all connect to our emerging Help Me Grow Skagit system. Help Me Grow WA is working to lead with equity rather than retrofit the system after the fact. Both the PHT and the Children's Council have been growing in our equity journey. We decided to fill a vacancy in the Child & Family Health Division late last year by creating a new promotora position with a preference for someone from our Indigenous Mexican population who could speak Mixteco or Triqui. Our still relatively new promotora is from the Mixtec community and has been able to build trust in the community and help our Division and our Department, overall, provide better services to the Mixteco community. This is one of our primary areas of focus, along with a strong focus on our Spanish-speaking, Latinx community. We did not use a standardized tool, just our demographic data and listening sessions with our community. **Update:** • Promotora received breastfeeding peer counseling training with new WIC peer counselors to strengthen her knowledge about lactation/infant feeding and to help us address inequities in infant nutrition. Also to strengthen partnerships with WIC staff. • Met with ACH staff about a new language equity project which will provide an opportunity for high school youth and adults to obtain high school/college credit and certification as interpreters. Working with team to pave the way for internship opportunities with community health partners and to help recruit participants. • Promotora resigned as of March 1 to take a position with a local legal aid organization, which fits with her long-term career goals. Position was posted and we successfully recruited a new promotora who also is from the Mixteco culture and who speaks English/Spanish/Mixteco. This was a key quality that we were recruiting for, as our Mixteco and other Indigenous Mexican populations have significant needs that we hope to address in accordance to their cultural and language needs.

COUNTY	Cross-Cutting
	• New Diversity, Equity and Inclusion planner joined our Public Health team at the end of last quarter. We have been in regular communication to share equity tools and ideas and to ensure that our promotora team is working synergistically across our department. • Equity is an essential focus of our Help Me Grow system development work, and we have been engaged in the HMG equity team efforts to the degree possible. We are also looking at equity measures with our HMG work, overall.
Skamania	**Approach:** We chose this local strategy to target low-income families who have limited access to resources and services. There is not a lot of "racial diversity" in Skamania County so we believe focusing on low-income families would best serve our community and promote health equity for those families with limited access. **Update:** Community Health operations are as per usual, working provide services to all families looking for supports. More social media outreach as an agency to reach more families as we have found that to be most successful, but this is agency wide and not MCH specific.
Snohomish	**Approach:** In 2019, Snohomish Health District conducted an MCH needs assessment and compiled a report that identified our priority populations to guide our services for 5 years. Here is how this will be reflected in our programs: - For enabling services, we will be prioritizing populations that are vulnerable to poor MCH outcomes i.e. people living in poverty e.g. Medicaid recipients, homeless shelters; Black, Indigenous, and People of Color. - For population-level services, we will be prioritizing partners who are located in priority areas or serve priority populations as identified by the 2019 Snohomish County MCH Needs Assessment e.g. FQHCs, organizations/providers along I-5 & Highway 99 corridor, etc. **Update:** No reporting activities for quarter 2

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Spokane	**Approach:** We used a Health Equity Lens when identifying the process we adopted for the development and implementation of our action plan. The team has decided to use the Building Community Resilience (BCR) process as a framework which acknowledges the impact of environmental adversity on community health and focuses on system changes to address existing inequities. Including the 'Pair of ACEs' education in our work internally and with community partners will allow us to take a system approach to creating healthy environments for thriving communities in Spokane County. The focus of the policy, systems and environmental (PSE) change work will be on systems that impact children 0-5 years old and their families. The equity lens for the PSE work will have a significant focus on the CYSHCN population. The PSE staff and the CYSHCN nurse will work closely on Combined Strategies, particularly Local Strategy 6. **Update**: Beginnings Matter team have engaged with local Black activist and early childhood educator who is championing for expanding services for Black mom's mental health and perinatal support and in the process of organizing a Black doula association, has several social media sites to provide support to Black women (Melanin Moms Facebook group and podcast, "Girl Get a Doula"). Our team provided guidance and assistance to her in applying for Strengthening Families Locally funding to establish a perinatal mental health task force in Spokane County. - Participated in the development of community prevention plan centering equity with community partners and supported by the Strengthening Families Locally community facilitator (Health and Justice Recovery Alliance). The goal of the plan is to develop strategies to strengthen and support families, with the outcomes of reduced child maltreatment and foster care entry, eliminated racial disproportionality in child welfare cases, and increase family and community resilience. -Beginnings Matter staff connected with the Health Equity Circle Spokane and will take participation of their work on Child Health Equity. The group consists of medical, public health and allied medical students from local universities such as WSU, UW, Gonzaga, Whitworth and EWU

COUNTY	Cross-Cutting
Tacoma-Pierce	**Approach:** When we participated in our recent county assessment, we spoke with multiple agencies and communities to gauge where disparities were present and what interventions might be effective in addressing these disparities. We found disparate outcomes for maternal health in the African American community. We work closely with our Black Infant Health program not only to learn the needs of the community, but to have recommendations coming out of the community itself. • We have a Nurse Family Partnership collaboration with the Puyallup Tribal Health Authority to serve the Native American population who also experience higher rates of maternal and infant mortality. • There is a lower rate of breastfeeding in the African American population, and we target our breastfeeding work to facilitate peer support, social norming and enabling workplace policies. • At a national level, the African American CYSCHN population has more unmet needs and are less likely than other populations to connect with a medical home. We have also observed fewer referrals for this group. Our Community Health Worker is being trained to work with the CYSHCN population, particularly to be a trusted messenger for the African American CYSHCN population. She also serves in the Black Infant Health program and will be able to serve as a liaison between the two programs and encourage CYSHCN families who need support to engage in the program. • We continue to explore cross divisional work internally, so we can have more representation of the communities we are working with. **Update:** Our staff are making future plans to host trainings for new cohorts of community members interested in becoming Peer Breastfeeding Counselors (PBC). This work seeks to provide supports from within the African American community in particular. For our previous PBC cohorts, we continue sharing opportunities for training and development opportunities so they may expand their knowledge base and work within their representative communities. Much of this work is based on maintaining relationships within the communities. Our CHW in our CYSHCN and Black Infant Health program has started carrying a caseload of CYSHCN clients in Q1 and doing outreach to families. As her knowledge of the systems of care and resources for this population grows, she will continue to be able to promote this work and support to connections through the Black Infant Health program and serve as a trusted messenger for CYSHCN families in the African American community. Our staff are working with the Family Connects team through Help Me Grow to discuss ongoing collaboration as well as share more culturally responsive resources to the families Family Connects serve. Our health equity work strategy comes from building relationships and trust with community partners, which is slow but deep work, so moving the needle can take time.

COUNTY	Cross-Cutting
Thurston	**Approach:** Our programs are dedicated to providing services to underserved populations because they are at the greatest risk of health disparities. We continue to strive to have a diverse workforce, many of whom are bilingual to include Spanish and Mandarin. With this, our programs can serve a high number of Hispanic families. Additionally, we are focusing on serving families with physical and cognitive disabilities as well as well as mental health concerns. **Update:** CYSHCN program uses a bilingual health dept. employee for interpreting. Our whole MCH team received 6 hours of training on Anti Bias Practices towards Families and children who have experienced trauma. We have hired two bilingual nurses in the last month. This brings us to a total of 5 team members that are bilingual Spanish. This was important to our program as we want to ensure services to underserved populations. We also provide written materials in Spanish.

COUNTY	Cross-Cutting
Wahkiakum	**Approach**: Wahkiakum County is a rural, community of approximately 4,000 people. The racial make-up of the county, according to the 2010 census, is 94% white (with 2.7% being of Hispanic or Latino origin), 1.3% American Indian, 0.6% Asian, 0.3% black or African American, 0.2% Pacific islander, 0.7% other races. Of 1,737 households, 21.9% had children under the age of 18, 57.2% were married couples that are living together, 6.2% had a female householder with no husband present, 31.7% were non-families, and 26.8% of all households were made up of individuals. The household median income was $40,372 and the median income for a family was $47,266. The per capita income for the county was $23,115. About 7.1% of families and 12.2% of the population were below the poverty line including 14.5% of those under age 18 and 10.7% of those age 65 or over. We utilized conversations with WIC clients, community partners and community members who serve those below the poverty line on a regular basis such as the school, local health clinic and human services as well as going over the most recent community survey to help identify which strategy would be most beneficial to focus on in Wahkiakum County. After these discussions and research, we determined that ACEs effect most of our community in one way or another and education for the community is very important as well as ensuring providers and local partners have the tools to utilize. To achieve this, we will provide information to local partners to share with families and clients, provide opportunities for in person (as allowed)/online training to partners and offer information as contact is made with people who want and welcome the information. Being a rural community and having a population of 14% below the federal poverty level, care coordination is important to ensure that CYSHCN are getting the appropriate services. This was determined when speaking to clients and local clinics about services provided and ability to access these services based on socioeconomic factors. We will be doing outreach to the schools, St James Family Center (which includes daycare, after school care and DV shelter) and local health partners to provide information to hand out about available services. **Update**: Coordination with school, clinic and St James to reach out to known to individuals/families that could utilize services that we provide such as Public health, WIC, Mental health and SUD services. Information about how each of these services could assist reiterated. Inquired about level of ACE's training received and what kind of training they could potentially be interested in to better serve our community equitability.

COUNTY	Cross-Cutting
Walla Walla	**Approach:** In Walla Walla County some of our priority populations include our Latinx residents, our agricultural workforce, our low-income residents, and our un- or under-insured populations. Many within these subgroups experience health disparities stemming from financial restrictions, language/cultural barriers, fear of government agencies, lack of health insurance, or they are simply unaware of available resources. Our goals are to increase utilization of community resources, ensuring that those utilizing the resources reflect the diverse population we serve, and to limit the health disparities of those within our community. To achieve this, we plan on engaging these priority populations to understand their unique needs, histories, cultures, and capacities through needs assessments and establishing regular meetings with community leaders to ensure inclusivity. This will allow us to implement strategies that will increase the equity of our community resources. Additionally, by networking and creating partnerships between providers, educators, and social service providers, we can ensure that more children in need are connected to community resources. Lastly, to ensure that we are providing equitable care we will interpret CHIF data, as well as other shared data from agencies serving CYSHCN throughout the county, to ensure that we are serving all populations in need. **Update:** We have established a relationship with our LatinX residents through our regular visits to our agricultural employers. We continue to offer our services and resources for needs that arise with their employees and their families. We plan to share information regarding our CYSHCN program and involve them in the referral process. We have distributed information for our Ad Valorem Family Assistance Program to Walla Walla Center for Children and Families (WWCCF) in English and Spanish to reach our CYSHCN families who may have financial needs when it comes to the care of their child. We have been reaching out monthly through site visits to our local domestic violence shelter (YWCA) and family rescue mission (Christian Aid Center) during COVID by offering COVID & flu vaccine and COVID prevention education. Now that COVID numbers are down, we are taking a more thoughtful approach. We have an established relationship with them and plan to focus on preventative health and behavioral health. We plan to create a reference resource for their staff to involve them in the CYSHCN referral process to those children that qualify. We plan to keep them up to date about the CYSHCN resources available in the community.

COUNTY	Cross-Cutting
Whatcom	**Approach:** Our Health Department is striving to have racial equity be an overarching goal and be embedded in all of our specific work plans. The strategies selected below represent work we are continuing to move forward and all are based on community priorities that have been raised through our Community Health Improvement Plan and dovetail with priorities of multiple stakeholder groups. Our assessment and planning processes have become grounded in racial equity; so, by using strategies identified by the community, we are taking a healthy equity lens. During our most recent Community Health Improvement Planning process, there was a commitment to make space for BIPOC community member's voice and leadership. Through BIPOC leadership, we are building in approaches to our work that call out and begin to address racism and ableism in our systems and programs while responding to the declared priorities, such as increasing access to culturally responsive and welcoming services and using peer-based models in our interventions. In addition to having community-driven strategies, we are also responding to the needs of specific populations, most notably the Latinx community. The disparities of health and educational outcomes have long been apparent in the Latinx community in Whatcom County. The pandemic demonstrated that very clearly and also highlighted the lack of access to health care and basic needs many Latinx families experience. We have increased our engagement of and planning with our local Latinx families and this will be reflected in our actions during this work year. **Update:** • Planning family focus groups to better understand the priorities and preferences for connecting to resources, including Spanish-speaking families. Developed materials (in English and Spanish) with the Family Tools Team on Behavioral Health/Mental Health and Community Services for CYSHCN. • Finalized a series of videos that highlight families experiences accessing preventive care in English and Spanish. • Worked with SeaMar Promotoras program to feature services for migrant and seasonal farmworkers on Spanish language videos to encourage families to connect with the SeaMar Promotoras program to access health services to support their family. • Supported in-process development of group peer support for Lummi Nation mothers. Began preliminary discussion about developing group peer support for families experiencing homelessness.

COUNTY	Cross-Cutting
Whitman	**Approach:** Whitman County Public Health serves as a safety net for vulnerable groups in our community like those represented by our MCH and CYSHCN families. The pandemic has highlighted many weaknesses in our public services systems over the past 2 years. We would like to take this opportunity to conduct an in-depth Community Health Needs Assessment (CHNA). Part of the goal of this CHNA will be to better understand how the needs of the MCH/CYSHCN community has changed throughout the pandemic and what we can do to better serve them. **Update**: New staff. No activity.
Yakima	**Approach:** For the first local strategy and planned approaches, consideration of health equity included: 1) Tracking ethnicity of children staffed to ensure equity for multicultural children and families 2) Care Coordinator meetings- Current representation includes Yakima Valley Farmworkers Clinic and local pediatric practices (in addition to Children's Village CYSHCN Coordinators and Community Health Workers). This year we plan to reach out to the Yakama Nation to invite participation to support communication, coordination and relationship building between care coordinators. 3) Current membership of our ITN does not reflect the diversity of our community. We would like to identify and engage agencies and BIPOC communities to ensure a diverse membership. For the second local strategy and planned approaches, we've identified the disproportionately low number of tribal families accessing Parent to Parent support (Parent to Parent data related to individuals served in the program confirms this). **Update:** Updated ethnicity tracking for children staffed: 1 unreported; 4 Hispanic or Latino; 2 White/Not Hispanic or Latino • January 27 Care Coordinators meeting featured Seattle Children's Hospital Care Navigators who serve multicultural families. March 24 meeting featured Yakama Nation Behavioral Health for presentation about services; invited presenter and care coordinator to join our monthly care coordinator meetings; she is now participating. Participants this quarter include care coordinators from: Parent to Parent/Community Health Workers, Yakama Nation Behavioral Health, Yakima Valley Farm Workers Clinic, Yakima Pediatrics, Yakima Neighborhood Health Clinic. • Presented at state-wide Jobs Foundation/Community of Practice about our local ITN. Participated in ITN planning meeting to develop group Charter which will include statements and priorities around equity, diversity, and inclusion.

2022 CYSHCN Local Health Jurisdiction Strategies by Approach

All Local Health Jurisdictions were required to select at least one strategy from the Children and Youth with Special Health Care Needs (CYSHCN) domain.

System of Care	Financing	Equity	Well-being	Family Navigation & Care Coordination
Approach: 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, Benton-Franklin, Chelan-Douglas, Clallam, Clark, Cowlitz, Grant, Klickitat, Lincoln, Mason, Okanogan, Pacific, San Juan, Sea-King, Skagit, Spokane, Thurston, Wahkiakum, Yakima (19)	**Approach:** Support local efforts to coordinate and assist families with CYSHCN to enroll in health care coverage, including Medicaid as a secondary insurance. Okanogan, Thurston (2)	**Approach:** 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, Jefferson, San Juan 3)	**Approach**: Identify and promote local resources that provide social-emotional support for families of CYSHCN and connectedness to other families. Adams, Chelan-Douglas, Garfield, Island, Kitsap, Kittitas, NETCHD, Okanogan, Skamania, Spokane, Yakima (11)	**Approach**: 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, Cowlitz, Grant, Grays-Harbor, Jefferson, Kitsap, NETCHD, San Juan, Sea-King, Skagit, Tacoma-Pierce, Walla Walla, Whatcom (13)

System of Care	Financing	Equity	Well-being	Family Navigation & Care Coordination
Approach: 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 (1)		**Approach:** Utilize CHIF data and other local data to identify inequities that affect health of CYSHCN and develop strategies to eliminate those disparities. Sea-King, Whitman (2)	**Approach:** 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, Kittitas (2)	**Approach:** 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**.** Garfield, Grant, Lewis, Mason, San Juan, Sea-King, Snohomish. Spokane, Walla Walla (9)
Approach: 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, Tacoma-Pierce (2)		**Approach**: 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, Whitman (2)	**Approach**: 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, NETCHD, Okanogan (3)	**Approach**: Provide services to family members of CYSHCN so they can be trained, engaged, supported, and involved at all levels of program planning and implementation of services for CYSHCN. Spokane (1)

System of Care	Financing	Equity	Well-being	Family Navigation & Care Coordination
Approach: Partner with the Medical Home Partnerships Project in autism systems development through participation in our local SMART Team working on autism screening, diagnosis, and treatment. Share Centers of Excellence and ECHO training opportunities with pediatric and other providers. Assist in recruiting primary care and other local providers to participate in Autism Centers of Excellence and ECHO training opportunities. Chelan-Douglas, Grays Harbor, Jefferson, Mason, San Juan, Skagit, Snohomish (7)			**Approach**: Participate in anti-bullying and suicide prevention efforts in your local community, elevating the unique needs of CYSHCN. Garfield, Island, NETCHD (3)	**Approach:** 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, Clallam, Garfield, Grant, Lewis, Okanogan, Sea-King, Spokane (8)
Approach: 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, Jefferson, San Juan, Walla Walla (4)			**Approach**: Participate and initiate local efforts to promote infant and perinatal mental health, elevating the unique needs of CYSHCN and their families. Island, Okanogan, Snohomish, Spokane (4)	**Approach**: 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, Benton-Franklin, Clallam, Clark, Columbia, Cowlitz, Grant, NETCHD, Okanogan, Skamania, Snohomish, Walla Walla (12)

System of Care	Financing	Equity	Well-being	Family Navigation & Care Coordination
Approach: 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, Walla Walla (2)				**Approach:** Provide care coordination services for family members of CYSCHN. Benton-Franklin, Chelan-Douglas, Clallam, Clark, Columbia, Cowlitz, Grays Harbor, Kitsap, NETCHD Pacific, Sea-King, Tacoma-Pierce, Thurston, Walla Walla, Whitman (14)
Approach: 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, Clark, Klickitat, San Juan, Spokane, Whitman (6)				**Approach**: Promote successful transition from our enabling services (care coordination) to other agencies/services that can meet family needs. Chelan-Douglas, Clark, Columbia, Snohomish, Tacoma-Pierce(5),
Approach: Explore ways to enhance the comprehensiveness of CHIF data through data share agreements. Klickitat (1)				

System of Care	Financing	Equity	Well-being	Family Navigation & Care Coordination
Approach: 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, Clallam, Grays Harbor, San Juan, Snohomish, Spokane, Walla Walla, Whitman (8)				