

A. PROCESS

The 2015 Five-Year Needs Assessment (FYNA) process used quantitative and qualitative data and engaged internal and external stakeholders to assess their capacity to conduct work with MCH populations, and solicit their feedback on priorities, activities and future direction for work with the MCH populations.

1. Needs Assessment Goals and Framework

The goal of the FYNA was to assess the needs of the MCH population in Washington and match existing resources and capacity to each of the MCH population domains. The process included assessment of the capacity of the Department of Health (DOH), in particular the Office of Healthy Communities (OHC) and of external partners and collaborators. The assessment was based on guidance provided by HRSA, aligned with DOH strategic plans, and supplemented by existing DOH needs assessments such as reports, data summaries, and surveillance activities.

2. Stakeholder Involvement

Stakeholders were engaged through surveys, key informant interviews, focus groups, and in-person meetings, to identify new ideas and approaches and to evaluate present activities. Stakeholders were consulted from within DOH, other state agencies, local health jurisdictions (LHJs), community members, and MCH professionals.

3. Methods For Assessing Strengths and Needs

The FYNA used current data sources on needs, strengths, trends, and disparities, internal and external input on strengths and capacity, current priorities and strategic planning work by DOH and partners, and recent local health needs assessments.

a) Epidemiology data

The MCH Epidemiology Unit compiled current rates and trends for previous National Performance Measures (NPMs) and State Performance Measures (SPMs), as well as current proposed NPMs, and also assessed trends and disparities for additional measures that affect MCH populations.

b) Internal input

To solicit internal input into the selection of NPMs and SPMs, we used an approach based on the Capacity Assessment for State Title V Programs (CAST-5) tool developed by Association of Maternal & Child Health Programs (AMCHP).

A series of one-on-one interviews with program personnel, who had been identified in the previous year's block grant cycle as content experts, assessed the extent to which current cycle NPMs overlapped with the previous cycle measures. Six focus groups were convened, with two to nine participants each, with composition intended to correspond to MCHBG population health domains and the organization of DOH. These groups each undertook a separate Strengths, Weaknesses, Opportunities and Threats (SWOT) analysis on current cycle NPMs corresponding to their areas of work and expertise. (A summary of the analyses is attached.) The groups were encouraged to propose possible SPMs, and asked to prioritize the measures using the SWOT analyses. All group participants, as one large group, ranked all the NPMs and proposed SPMs. Finally, the results were presented to OHC leadership to confirm the selection of NPMs.

c) External input and priorities

An online survey was sent to key stakeholders, including MCH leads and Children with Special Health Care Needs (CSHCN) coordinators at the LHJ level, other state agencies, coalitions and partnerships working on MCH issues, health care professionals who work with the MCH population, and local non-governmental groups and community groups/members.

Initial questions were based on the Local Partner Input for Chronic Disease Funding survey from 2014, which asked participants to rate their interest in social and emotional wellbeing, community-clinical linkages, active living, healthy weight, healthy eating, and tobacco use prevention. Additional questions were added about gathering and distributing data, giving all babies a planned and healthy start, preventing injury, social determinants of health, health equity, access to care, peer to peer support, health system reform, adverse childhood experiences, developmental screening, patient centered medical homes, and environmental hazards. The final survey included eighteen questions covering eighteen areas of interest. An optional list of questions asked about interest in and capacity to work on the fifteen proposed National Performance Measures.

The survey was administered in English and Spanish. Community members were asked the general questions, but not the questions about the NPMs. Public health professionals were asked all of the questions. The survey was launched in November 2014 and remained open for four weeks, with additional follow-up into January.

OHC shared preliminary findings with the Community Health Advisory Committee, which includes representatives from state agencies, local health and community based organizations. A summary of survey results was shared with local health staff on a video conference hosted by the Washington State Association of Local Public Health Officials. Local health participants were asked to provide comments on the survey results and the internal SWOT analysis results.

d) LHJ specific needs assessment

In 2012, each of the thirty five LHJs contracted with OHC undertook a needs assessment of the local MCH population, and the capacity and the priority of the LHJ and its local partners to address these needs. LHJs noted where they had both capacity and priority and were encouraged decided on which measures to work given these findings. They were also required to choose one of two SPMs identified by OHC as well as NPM 05, reflecting overarching state priorities. After their assessment, LHJs were required to pick their priorities, develop and propose measures to track work on the chosen priorities, and write a brief summary of their process and conclusions.

e) Alignment with State and Office strategic priorities

The needs assessment, including the stakeholder survey, was cross-referenced with the State Plan for Healthy Communities and the DOH Strategic Plan (both discussed in Section II.A.) to ensure strategic alignment.

f) Other external assessments

In March 2015, the American Indian Health Commission passed a resolution on Maternal and Infant Health, which is attached.

As part of the Affordable Care Act, the Washington State Hospital Association analyzed 46 non-profit hospitals' community health needs assessments to determine common themes and strategies. Their report, intended to help identify priorities and possible collaborative efforts around population health goals, is attached.

4. Data and input used to inform needs assessment

a) Data sources

Following the release of the proposed new NPMs and Health Status/Outcome Measures (HS-OM) in 2014/15, the Surveillance and Epidemiology (S&E) section of OHC compiled and shared data relating specifically to these new measures. Many of the measures were new and/or relied on new sources for their data. Where possible, temporal trends or state-to-national comparisons in the data were also supplied.

Data sources consulted included Washington vital statistics data on births, deaths, the linked infant death file (birth data linked to the infant's death file), induced abortions, and fetal death. Hospitalization data was obtained from Comprehensive Hospital Abstract Reporting System. Population data compiled by the Office of Financial Management, from the US Census, were used to create population based rates. The First Steps Data Base at Department Of Social and Health Services provided data from Medicaid on pregnant women and pregnancy outcomes. Surveys utilized included Pregnancy Risk Assessment Monitoring System, Behavioral Risk Factor Surveillance System, National Survey of Children's Health, National Survey of Children with Special Health Care Needs, the Healthy Youth Survey, the Washington Smile Survey, and the American Community Survey.

b) External input results

External input elicited a series of key themes that identified priorities for stakeholders:

- Build resiliency and support at personal, family and community levels. Enhance social and emotional wellbeing.
- Foster community lead engagement, linkages and development.
- Positively affect the social determinants of health.
- Increase access to healthy eating and active living
- Increase equity.

Additionally, respondents who identified themselves as public health professionals were asked to rank their interest and capacity to work on the new NPMs proposed by HRSA. Eight of these NPMs were ranked by 40% or more of public health professionals as being topics they were interested in working on. For each NPM, the capacity to work on the selected topics was judged to be less than the interest, indicating a gap in what these professionals felt should be worked on and what they were able to work on. In descending order of interest, these eight NPMS were:

- NPM 4 (55%/40%),
- NPM 14 (51%/29%)
- NPM 6 (50%/31%)
- NPM 5 (44%/31%)
- NPM13 (44%/25%)
- NPM 11 (43%/23%)
- NPM 7 (43%/17%)
- NPM 15 (41%/16%)

c) Internal input results

Internal results were driven by the SWOT analyses, which identified program needs and capacity. The focus groups for each population domain developed recommendations for which NPMs should be chosen, taking into consideration such factors as available funding, available personnel, perceived priority and availability of surveillance data/activities. The six focus groups were able to identify clear priorities among the NPMs.

d) LHJ needs assessment results and priorities

Based on their judgment of their capacity and priority of each NPM, LHJs identified their priority work. All LHJs also were required to work on NPM05 (percent of CSHCN aged 0-18 whose families report the community-based service systems are organized so they can use them). Twenty LHJs selected SPM 5 (percent of households with children less than 18 years of age with an adult with an ACES score of 3 or more) as a priority area, 21 LHJs selected SPM03 (percent of children who received a standardized developmental screening), and six LHJs selected both. Other topics identified for work were unintended pregnancies, oral health, health equity, medical home, CSHCN transition to adult care, immunizations, teen pregnancy, injury prevention, breastfeeding promotion, childhood obesity, smoking during pregnancy, teen suicide, and adequate insurance.

B. FINDINGS

1. Women/Maternal Health

a) Population

In 2013, there were 1,361,831 women of reproductive age (ages 15-44) in Washington. In 1990, 86% of such women were non-Hispanic* whites; by 2013, this figure was 66%. In 2013, 32% of the adult female population had finished a BA or higher, while 90% had graduated from high school (ACS). In 2012, the state pregnancy rate was 76.8/1,000 and the birth rate was 63.6/1000. Only 5% of live births were to mothers under age 20.

* In this document, "Hispanic" refers to Hispanic/Latino individuals of Latin American origin.

b) Needs

About 52% of pregnant women in Washington were either overweight or obese prior to pregnancy in 2013. This rate has steadily increased since 2003. In 2013, 47% of women gained more weight while pregnant than recommended by Institute of Medicine standards, down from 51% in 2003. (CHS BC data).

The rate of pregnant women with pre-existing diabetes increased almost 3% per year from 2003 to 2013, and rates of gestational diabetes increased at over 4% per year. (CHS BC data)

c) Access to Care

In 2012, 57% of adult women had a preventive visit to their provider during the previous year (BRFSS). That year (before the ACA), about 20% of adult women were uninsured (ACS).

d) Successes

Nulliparous, term, singleton vertex (NTSV) deliveries are considered low risk deliveries. From 2003-2008, the NTSV rate increased over 20%, then moderately decrease, and in 2011 comprised 35% of deliveries.

Pregnancy-related deaths have varied considerably in recent years, including 11.5 per 100,000 births in 2011, and 5.7 per 100,000 in 2012. Washington’s rates have been lower than national rates.

Only 9% of women reporting smoking in their third trimester (PRAMS).

e) Disparities and population-specific strengths and needs

Female headed households with children under 18 had more than twice the rate of poverty than households headed by single men and almost 4.5 times the rate of poverty as households with a married couple. Children in single female headed households were more than twice as likely to have had received public assistance in the previous 12 months than those who lived in households with a married couple (ACS).

After a low of 68% in 2007, rates of women initiating prenatal care in the first trimester increased to 74% by 2013. Among Medicaid eligible women, the rate was 64% in 2013, compared to non-Medicaid eligible women at 83%, though the increase among Medicaid eligible women since 2007 has been greater (FSDB). While overall maternal smoking is low in Washington, 14% of Medicaid women reporting smoking in the 3rd trimester, compared to 3% of non-Medicaid women. Births from unintended pregnancies were higher among women on Medicaid compared to women not on Medicaid, 50% versus 23%.

Black, Hispanic and American Indian mothers were more likely to have not taken vitamins before pregnancy compared to white and Asian mothers. Non-Hispanic Asian women were more likely to be breastfeeding at 2 months post-partum than women of other races/ethnicity. Use of postpartum birth control showed no variance by race. (PRAMS)

f) Identified Priority for Maternal Health

State Priorities and Selected National Performance Measures	
NPM1	Well Woman Visits (Percent of women with a preventive visit in the past year)
State Priority	(8) Quality clinical and preventive treatment services Work also supports: (2) Sexual and reproductive health, (3) Tobacco and substance abuse prevention, (4) Active and safe environments, (5) Healthy eating, (6) Screening, referral and follow-up, (9) Health equity

2. Infants

a) Population

In 2013, there were 86,556 resident births in Washington. About half of all deliveries in Washington were paid for by Medicaid.

b) Needs

In 2013, 382 infants died in Washington, for an infant mortality rate of 4.4/1,000 live births, less than the Healthy People 2020 goal of 6.0/1,000. By subgroup, the perinatal (fetal deaths plus those infants who died within 0-6 days) rate was 8.5/1,000, the neonatal 3.0/1,000, and post neonatal 1.4/1,000.

In 2013, there were 532 fetal deaths, for a fetal death rate of 6.1/1,000 births, exceeding the Healthy People 2020 goal for neonatal deaths of 4.1/1,000 and for post neonatal deaths of 2.0/1,000. (CHS BC data)

The low birth weight (LBW) rate increased from 5.3% in 1990 to 6.4% in 2013, representing 5,545 births. The singleton LBW rate changed from 4.3% to 4.9% in 2013, representing 4,063 births. Washington remains below the national rates.

c) Successes.

In 2013, 9.6% of all births in Washington were preterm (<37 weeks gestation), continuing a decreasing trend started in 2006. Washington ranked 6th lowest among states. In 2013, 8.2% of all singleton births were preterm, below the HP2020 objective of 11.4% (CHS BC data).

Washington has a well-developed system of perinatal regionalization to address high-risk deliveries. Since 2011, over 89% of infants weighing less than 1,500 grams were delivered at an institution with a neonatal intensive care unit and appropriately trained staff (CHS BC data).

Washington has excellent rates of initiation of breastfeeding. According to PRAMS (2011), 96% of women reported ever having breastfed their infant.

In 2011, 82% of women reported most often laying their baby down to sleep on his/her back.

d) Disparities and population-specific strengths and needs.

Women who had their deliveries paid for by Medicaid had a higher singleton all infant mortality rate (5.1/1,000) than women who did not (3.7/1,000). Singleton LBW rates were 5.3% of Medicaid deliveries and 3.9% of non-Medicaid. Also, 9.5% of Medicaid deliveries were preterm and 6.9% of non-Medicaid(FSDB, 2012 Birth Cohort data).

Initiation of breastfeeding is not significantly different by Medicaid/non-Medicaid delivery. However, by two months post-partum, the drop-off among Medicaid women is particularly steep, down to 67%, compared to 80% among non-Medicaid women.

Women with Medicaid paid for deliveries were less likely to report putting their infant on her/his back to sleep (77%) than other women (86%).

Between 2008 and 2010, of the 38 states for which the National Center for Health Statistics (NCHS) reported an African American IMR, Washington's IMR among African Americans was the lowest in the nation, 8.8/1,000 live births. Among Hispanics, Washington ranked 16th of 42 states. However, both groups regularly have higher IMRs than the state's other racial/ethnic groups (CHS BC data).

For 2009-2011, non-Hispanic Asian women had the highest breastfeeding rates at 2 months (82%) while non-Hispanic American Indian and non-Hispanic Pacific Islander moms had the lowest rates (62% and 57%). (PRAMS) Non-Hispanic Black and non-Hispanic Pacific Islander women were less likely to place their infants on their backs to sleep than were mothers of other races and ethnicities (PRAMS).

e) Identified Priority for Infant Health

State Priorities and Selected National Performance Measures	
NPM4	Breastfeeding (Percent of infants who ever breastfed;% of infants breastfed exclusively through 6 months)
NPM5	Safe Sleep (Percent of infants placed to sleep on their back)
State Priority	(1) Healthy Starts <i>Work also supports (4) active and safe environments. (5) healthy eating, (7)social and emotional wellbeing,</i>

3. CSHCN

a) Population

In 2009/10, 15% of children 0-17 years of age in Washington were CHSCN, an estimated 235,920 individuals. In Washington, 4% of all children reported having a disability, one factor that predisposes children to be a CSHCN. Among those 5-17 years of age, 4.2% (approximately 48,600) children had a cognitive difficulty, the most common disability reported (ACS). Children aged 6-11 years were more likely to have a special health care need than younger children.

In Washington about 25% of families reported having to take time off or quit their job completely due to their child's condition (NS-CSHCN).

b) Needs

In 2007, 65% of parents of CSHCN in Washington reported their child's health to be "Excellent or Very Good," 24% "Good," and 11% "Fair or Poor," similar to national rates. About half of CSHCN had care that met the criteria for being in a Medical Home, while for non-CSHCN children 60% had care that met the criteria (NSCH 2011/12).

c) Successes

Since 2010, Washington has had universal developmental screening system development as one of its State Performance Block Grant measures. Washington also has a nurse home visiting program which ensures more children will be evaluated by a health professional at an early stage in their lives. As of 2010/11, Washington was doing slightly better at getting CSHCN children into a medical home than was the nation as a whole, 45% to 43%. (NSCH)

In 2014, the state Early Hearing-loss Detection, Diagnosis and Intervention Program screened 97% of children before they were discharged from the hospital.

d) Disparities and population-specific strengths and needs

Hispanic children were slightly less likely to have a special health care need (16%) than non-Hispanic white children (11%) or non-Hispanic Black children (14%).

While there are some interpreter services available to parents/family of CSHCN in Washington, language and cultural barriers can make it more difficult for non-English speakers to access services, information and/or resources for their CSHCN, especially among immigrant and refugee populations.

Children 0-5 were less likely to have a special health care need (5%) than children 6-11 (18%) or adolescents 12-17 (20%). Boys were more likely than girls to have a special health care need (17% to 13%). Household income did not have an effect. (NS-CSHCN)

e) Identified Priority for CSHCN

State Selected National Performance Measures and Priorities	
NPM11	Medical Home (Percent of children with and without special health care needs having a medical home)
State Priority	(8) Quality clinical and preventive treatment services <i>Work also supports (1) healthy starts, (6) screening referral and follow-up, (9) health equity</i>

4. Child Health

1. Population

In 1990, 82% of children 1-11 years old were non-Hispanic white; in 2013 that number was 57%. In 2013, 20% reported being Hispanic of any race, 7% Asian, 4% Black/African American, 2% Native American/Alaska Native and 0.8% Native Hawaiian/Other Pacific Islander. 9% reported two or more races.

2. Needs

Compared to other populations, children 1-11 have a scarcity of data collected on them. In many cases, they are combined with younger or older age groups.

In Washington, 82% of children 6-11 reported excellent or very good health, and 80% had a preventive care visit in the previous year, similar to the national rates. 30% of children 10 months to 5 years had received a developmental screen in the previous year. (NSCH)

3. Successes

Children 6-11 in Washington had a much lower rate of asthma (5%), than the nation as a whole (10%), though the rate was higher among children 12-17 years old (8%) (NSCH).

Hospitalization rates due to injury among 1-11 year olds in Washington have declined since 1990 from 245.4/100,000 to a record low of 107.2/100,000 in 2013. The most common causes of injuries resulting in non-fatal hospitalizations were falls, poisonings, and motor vehicle collisions (Washington CHARs).

4. Disparities and population-specific strengths and needs

In 2010, 58% of 3rd graders either had or have a history of dental caries on primary or permanent teeth. Lower income and minority children, especially Hispanics, were at higher risk for caries (Washington Smile Survey).

Hispanic children in Washington were less likely to report having excellent/very good health (71%) than their non-Hispanic white peers (88%).

5. Identified Priorities for Child Health

State Selected National Performance Measures and Priorities

NPM6	Developmental Screening (Percent of children, ages 9-71 months, receiving a developmental screening using a parent completed screening tool)
NPM7	Child Safety (Rate of injury-related hospital admissions per population ages 0-19 years)
State Priorities	(1) Health Starts <i>Work also relates to (4) Active and safe environment (7) social and emotional wellness, (9) Health Equity</i>

6. Adolescent Health

a) Population

In 1990, 88% of adolescents 12-17 were non-Hispanic white; in 2013 it was 63%. In 2013, 20% reported being Hispanic of any race, 7% Asian, 4% Black/African American, 1% Native American/ Alaska Native and 0.8% NHOPI. 9% reported being two or more races.

b) Needs

In Washington, 20% of adolescents 12-17 (an estimated 102,424 individuals) have a special health care need (NS-CSHCN).

In 2014, 83% of 10th and 8th grade students reported having had a dental visit in the prior 12 months. 7% of 6th grade students reported having missed at least one day of school due to dental pain, a decrease from 9% in 2010 (HYS).

In 2012, 27% of students in grades 6, 8, 10 and 12 reported bullying. In 2014, 35% of 10th graders reported depressive feelings in the prior year, with 21% having considered suicide, and 10% having attempted suicide (HYS).

In 2012, 26% of adolescents 10-17 were obese (NCHS). 36% of children 6-11 and 20% of adolescents 12-17 reported being physically active for at least 20 minutes per day. 58% of 6th graders, 56% of 8th graders, 51% of 10th graders, and 47% of 12 graders reported being physically active 5 or more days in a week (HYS).

Among 10th grade students in Washington, 8% reported having smoked cigarettes, 18% reported having used e-cigarettes, 21% reported having consumed alcohol, and 18% reported having smoked marijuana in the prior 30 days,

c) Strengths

Hospitalization rates due to injury among 12-19 year olds in Washington have declined since 1990 from 627.4/100,000 to 161.9/100,000 in 2013 (Washington CHARs).

Since 1990, the birth rate among Washington teens has dropped significantly, with the most rapid decreases since 2008. In 2013, the rate hit a historic low of 8.9 births/1,000. Births among teen Hispanics and teen American Indian/Alaska Natives were considerably higher among teens of other races and ethnicities (15.8 and 13.7/1,000) (CHS BC data).

Teen pregnancy rates have similarly declined, from 28.8/1,000 among teens 15-17 in 2008 to 14.6/1000 in 2013. (CHS BC data).

d) Disparities and population-specific strengths and needs

Among 10th grade students, non-Hispanic Asians were much less likely to have smoked cigarettes, used e-cigarettes, used marijuana or consumed alcohol in the previous 30 days than their peers of other races/ethnicities. Both non-Hispanic Blacks and non-Hispanic American Indian/Alaska Native 10th graders were more likely to have smoked marijuana in the previous 30 days than non-Hispanic whites (HYS).

e) Identified Priorities for Adolescent Health

State Selected National Performance Measures and Priorities	
NPM7	Child Safety (Rate of injury-related hospital admissions per population ages 0-19 years)
NPM10	Adolescent Well Visits (Percent of adolescents with a preventative service visit in the last year)
State Priority	(8) Quality Clinical and Preventive Treatment Services <i>Work also relates to (2) Sexual and Reproductive Health, (4) Active and Safe Environments, (6) Screening, Referral and Follow-Up</i>

7. Cross Cutting or Life Course

a) Health Status and disparities

Despite the ACA, health insurance in Washington has not yet arrived at universal coverage. (See Section 2A: Overview). Washington chose NPM 15 because 100% of children in Washington can and should be covered by adequate health insurance.

b) Identified Priorities for Cross-cutting or Life course

State Selected National Performance Measures and Priorities	
NPM15	Adequate Insurance (Percent of children 0-17 years who are adequately insured)
State Priority	(8) Quality Clinical and Preventive Treatment Services <i>Work also relates to (1) Healthy Starts, (2) Sexual and Reproductive Health, (6) Screening, Referral and Follow-up, (9) Health Equity</i>

MATERNAL AND INFANT HEALTH (MIH) WORK GROUP MATERNAL AND CHILD HEALTH (MCH) BLOCK GRANT RECOMMENDATIONS

WHAT IS THE MCH BLOCK GRANT: Enacted in 1935 as a part of the Social Security Act, the Title V Maternal and Child Health Program is the Nation's oldest Federal-State partnership. For over 75 years, the Federal Title V Maternal and Child Health program has provided a foundation for ensuring the health of the Nation's mothers, women, children and youth, including children and youth with special health care needs, and their families. Title V converted to a Block Grant Program in 1981.

Specifically, the Title V Maternal and Child Health program seeks to:

1. **Assure access to quality care**, especially for those with low-incomes or limited availability of care;
2. **Reduce infant mortality**;
3. **Provide and ensure access to comprehensive prenatal and postnatal care** to women (especially low-income and at risk pregnant women);
4. Increase the number of children receiving health assessments and follow-up diagnostic and treatment services;
5. Provide and ensure access to preventive and child care services as well as rehabilitative services for certain children;
6. Implement family-centered, community-based, systems of coordinated care for children with special healthcare needs; and
7. Provide toll-free hotlines and assistance in applying for services to pregnant women with infants and children who are eligible for Title XIX (Medicaid).

State Maternal and Child Health agencies (which are usually located within a State health department) apply for and receive a formula grant each year. In addition to the submission of a yearly application and annual report, State Title V programs are also **required to conduct a State-wide, comprehensive Needs Assessment every five years**. States and jurisdictions use their Title V funds to design and implement a wide range of Maternal and Child Health and Children with Special Health Care Need activities that address National and State needs. (HRSA web site) (Note: This is the year for their five year comprehensive needs assessment.)

BACKGROUND: We have an opportunity to provide input regarding our priorities for the upcoming MCH Block Grant for WA DOH. A survey was recently sent out to our delegates and our MIH Work Group to request their opinions regarding their MCH priorities. The MIH Work Group met this past Monday, December 8th to discuss this opportunity and to develop a set of recommendations to be submitted for your approval. There is a very short turn around for input-the deadline is December 19th, so time is of the essence.

WORK GROUP RECOMMENDATIONS: The group agreed that the recommendations are an important opportunity to address our mutual goals of reducing infant mortality and improving care. The recommendations are in line with current plans, grants, programs, and projects the Tribes and the State are already engaged in and support them. They are also in line with lessons learned at the Tribal and State Leaders Health Summit and the briefing papers presented there.

The following are presented to you as the Work Group's recommendations for discussion and hopefully for your approval. This is a draft of suggestions and a work in progress. The final form that this takes depends on your input and approval. Pending your approval of the recommendations they will be developed into a white paper to be submitted to the State. It is important that you be heard.....

- AIHC MIH Strategic Plan: We are now 5 years into the plan (published in 2010) and we need to review all of the data points in the Plan to see where we are improving and where we need to refocus efforts. Measurable standards need to be developed. These standards should correlate with the GPRA measures, and Healthy People 2020.
- Data: Establish a plan for measuring the changes in outcomes (disparities) that were listed in the strategic plan. Improved data sharing is part of this plan. That way, we will know if the work we are doing is having a measurable impact. Hire a part-time epidemiologist to develop a plan. A plan would include the data sources and the time frame for collecting data.
- There needs to be a connection between PRAMS and State Medicaid data and it needs to be easily accessible to Tribes and UIHO's for making program decisions and grant proposals to address MIH disparities.
- There is a disconnect between federal funding and state priorities and IHS. The Feds, State, and IHS need to work together to establish priorities, goals, and strategies with appropriately linked quality measurements.
- Behavioral Health: Services need to be improved and easily accessible for our pregnant women. Currently women get screened for depression or domestic violence-then there is no place to get appropriate treatment for those problems. Access to behavioral health services is an issue. This can have lifelong impact for moms and babies.
- Domestic Violence, suicide, and sexual abuse impacts everyone, pregnant women, babies, children families, elders. We are looking at the total lifespan of impact and of care. (This is reflected in ACES.) We need to bring it out into the open, into the light, talk about it and find effective ways to prevent this
- Teen Pregnancy: Collaboration with State PREP program, NPAlHB, and AIHC for Teen Pregnancy curriculum in Tribal schools and/or modified for Tribal after school programs. This should include support for parenting teens, with one goal being high school completion. Making healthy choices needs to start and be taught at a very young age, to prevent lifelong consequences of unhealthy choices that can adversely affect generations to come.
- Involve Youth: It is clear that youth have a voice that needs to be heard. And we all heard at the Summit-there was hardly a dry eye in the room. They have questions and they have answers. They are our future. We need to include them in a meaningful way in decision making. Now. It is not optional it is imperative. The State should fund a half time youth coordinator to begin a youth panel to help guide our work, and be a key part of our consultant team.

Questions-discussion?

Please signify your approval by a show of hands.

MCHBG Cross Walk with State Plan for Healthy Communities, SHIP, and DOH Strategic Plan

MCHBG Population Domains key: 

Women/Maternal Health 

Perinatal/Infant Health 

Child Health 

Adolescent Health 

Children w/ Special Health Care Needs (CSHCN)

Performance Measure	Domain 2 Environmental Approaches	Domain 3 Health Systems	Domain 4 Community & Clinical Preventative Services	DOH Strategic Plan/ State Health Improvement Plan (SHIP)	Results Washington
1. Well Woman Visits Percent of women with a past year preventative visit  	Strategy 6 - Support sexual and reproductive health	Strategy 1 - Increase timely access to preventative care Strategy 7 - Increase awareness of screening and follow up	Strategy 2 - Support linkage of prevention efforts	Strategic Plan - Goal 2/Objective 1: Give all babies a planned, healthy start SHIP Near Term Impact - Access to care	Goal 4/1.1.d: Decrease the rate of teen pregnancy for 15-17 year olds. Goal 4/1.2.A.d: Increase percentage of adults with healthy weight. Goal 4/1.2.A.e.1: Decrease percentage of pregnant women who smoke.
4. Breastfeeding A) percent of infants who are ever breastfed and B) Percent of infants breastfed exclusively through 6 months 	Strategy 4 - Increase access to healthy foods and beverages (including breastfeeding) Strategy 7 - Increase social connectedness, healthy relationships, violence-free environments and community engagement	Strategy 2 - Promote availability of health care, education, resources and services Strategy 4 - Improve knowledge and ability of health professionals to deliver comprehensive evidence-based services	Strategy 4 - Disseminate health education that is scientifically accurate, age-appropriate and culturally/linguistically suitable	Strategic Plan - Goal 2/Objective 1: Give all babies a planned, healthy start Strategic Plan - Goal2/Objective 3: Support healthy weight in children and adults SHIP Long Term Shift - Invest in the health and well-being of our youngest children and families	Goal 4/1.2.Y.d: Increase the percentage of 10th graders with healthy weight.
5. Safe Sleep Percent of infants placed to sleep on their backs 	Strategy 3 - Protect from second-hand smoke	Strategy 4 - Improve knowledge and ability of health professionals to deliver comprehensive evidence-based services	Strategy 2 - Support linkage of clinical and community prevention efforts Strategy 4 - Disseminate health education that is scientifically accurate, age-appropriate and culturally/linguistically suitable	Strategic Plan - Goal 2/Objective 1: Give all babies a planned, healthy start SHIP Long Term - Invest in the health and well-being of our youngest children and families	Goal 4/1.1: Decrease the infant mortality rate for children under 1 year old. Goal 4/1.1.b: Decrease the percentage of infants born with low birth weight among Blacks and American Indian/Alaska Native populations.
6. Developmental Screening Percent of children, ages 9-71 months, receiving a developmental screening using a parent completed screening tool 	Strategy 7 - Increase social connectedness, healthy relationships, violence-free environments and community engagement Strategy 8 - Develop community informed interventions, organizational structures and supports to address health inequities	Strategy 1 - Increase timely access to preventative care Strategy 2 - Promote availability of health care, education, resources and services Strategy 4 - Improve delivery of comprehensive evidence-based services Strategy 5 - Promote early identification of behavioral health issues and access to quality behavior health services Strategy 7 - Increase awareness of importance of screening and follow up	Strategy 1 - Enhance capacity, infrastructure, and leadership of community-based orgs that serve socially disadvantaged populations Strategy 2 - Support linkage of clinical and community prevention efforts	Strategic Plan - Goal 2/Objective 1: Give all babies a planned, healthy start Strategic Plan - Goal2/Objective 5: Prevent or reduce impact of ACEs Strategic Plan - Goal2/Objective 7: Raise awareness and implement strategies to promote mental health SHIP Long Term - Invest in the health and well-being of our youngest children and families	

<p>10. Adolescent Well Visits Percent of adolescents with a preventative service visit in the last year</p> 		<p>Strategy 1 - Increase timely access to preventative care Strategy 2 - Promote availability of health care, education, resources & services Strategy 5 - Promote early identification of behavioral health issues and access to quality behavior health services Strategy 6 - Promote culturally and linguistically appropriate health care services Strategy 7 - Increase awareness of screening and follow up</p>	<p>Strategy 2 - Support linkage of clinical and community prevention efforts Strategy 4 - Disseminate health education that is scientifically accurate, age-appropriate and culturally/linguistically suitable</p>	<p>Strategic Plan-Goal 2/Objective 2: Increase immunization rates for all age groups Strategic Plan-Goal 2/Objective 6: Protect people from violence, injuries and illness Strategic Plan-Goal 3/All: Improve access to quality, affordable and integrated healthcare for everyone SHIP Near Term - Access to care</p>	<p>Goal 4/1.2.Y.d: Increase the percentage of 10th graders with healthy weight. Goal 4/1.2.Y.d: Decrease percentage of 10th graders who report smoking cigarettes.</p>
<p>11. Medical Home Percent of children with and without special health care needs having a medical home</p> 	<p>Strategy 7 - Increase social connectedness, healthy relationships, violence-free environments and community engagement</p>	<p>Strategy 1 - Increase timely access to preventative care Strategy 2 - Promote availability of health care, education, resources & services Strategy 4 - Improve ability to deliver comprehensive evidence-based services Strategy 5 - Promote early identification of behavioral health issues and access to quality behavior health services Strategy 6 - Promote culturally & linguistically appropriate health care services Strategy 7 - Increase awareness of screening and follow up</p>	<p>Strategy 1 - Enhance capacity, infrastructure, and leadership of community-based orgs that serve socially disadvantaged populations Strategy 2 - Support linkage of clinical and community prevention efforts Strategy 4 - Disseminate health education that is scientifically accurate, age-appropriate and culturally/linguistically suitable</p>	<p>Strategic Plan-Goal 3/All: Improve access to quality, affordable and integrated healthcare for everyone Strategic Plan-Goal 3/Objective 3: Incorporate public health and prevention practices in the reforming healthcare system SHIP Near Term - Access to care SHIP Long Term - Support development of healthy neighborhoods and communities</p>	
<p>7. Child Safety Rate of injury-related hospital admissions per population ages 0-19 years</p> 	<p>Strategy 1 - Increase access to physical activity Strategy 7 - Increase social connectedness, healthy relationships, violence-free environments and community engagement Strategy 8 - Develop interventions & supports to address health inequities</p>		<p>Strategy 2 - Support linkage of clinical and community prevention efforts Strategy 4 - Disseminate health education that is scientifically accurate, age-appropriate and culturally/linguistically suitable</p>	<p>Strategic Plan-Goal 2/Objective 6: Protect people from violence, injuries and illness SHIP Long Term - Support development of healthy neighborhoods and communities</p>	
<p>15. Adequate Insurance Percent of children 0-17 years who are adequately insured</p> 		<p>Strategy 1 - Increase timely access to preventative care Strategy 2 - Promote availability of health care, education, resources and services Strategy 3 - Establish mechanism for reimbursement of tobacco cessation and substance abuse/mental health</p>	<p>Strategy 2 - Support linkage of clinical and community prevention efforts Strategy 3 - Support payment reform</p>	<p>Strategic Plan-Goal 3/All: Improve access to quality, affordable and integrated health care Strategic Plan-Goal 2/Objective 2: Increase immunization rates for all age groups SHIP Near Term - Access to care SHIP Long Term - Support development of healthy neighborhoods and communities</p>	<p>Goal 4/1.2.Y.a: Increase the percent of children (19-35 months) receiving all recommended vaccinations.</p>

WSHA Analysis of Hospital Community Health Needs Assessments (CHNAs)

As our state builds a “Healthier Washington,” hospitals’ community health needs assessments (CHNAs) serve as an important tool in helping hospitals and communities plan for the future. All 501(c)(3) hospitals are required under the Affordable Care Act to perform an assessment every three years; a number of other hospitals voluntarily undertake this effort as well. WSHA analyzed 46 non-profit hospitals’ CHNAs to determine common themes and strategies. This information helps identify priorities and possible collaborative efforts around population health goals.

Analysis of CHNAs

The CHNAs varied greatly. Most hospitals created a CHNA and implementation strategy specific to their hospital and community. Some hospitals, however, produced documents jointly with other local hospitals or those within their health system. For example, all non-profit and public hospitals in King County collaborated on one assessment along with Public Health- Seattle & King County. One hospital system created CHNAs specific to each hospital, but an implementation strategy that applied to all.

- Nearly all hospitals worked with public health departments and used broad community involvement to determine needs, often through public interviews and surveys.
- Assessment geographic areas ranged from single cities to multiple counties.
- The majority of the data used for the assessments came from state and national sources including the Washington Behavioral Risk Factor Surveillance System (BRFSS), US Census, CDC and others.

Top Priorities Addressed in Implementation Strategy	Frequency Out of 46 CHNAs
Access to Care	32
Obesity	25
Mental Health	24
Chronic Conditions (not specific to Obesity, Diabetes, or Tobacco use)	15
Diabetes	11
Food/Nutrition	10
Social Determinants	10
Women/Infants/Maternal	8
Tobacco	7
Cancer	6
Care Coordination*	3
Other**	24

* While Care Coordination was low on the list, it was frequently listed as a strategy for addressing priorities higher on the list, such as access to care and mental health.

** Other priorities included preventive care, culturally appropriate care, youth and at-risk children, military populations, motor vehicle accidents, unintentional hospitalizations, health literacy, assault and violence, HIV/AIDS, seniors, and dental care.

Analysis of Implementation Strategies

Access to Care - Strategies focused on insurance coverage and enrollment. They included helping uninsured people enroll in Medicaid and the Exchange, training hospital staff to assist in this process, recruiting and retaining providers, especially in primary care, continuing to offer charity care, and improving care coordination, which often involved enhancing the role and services within primary care.

Obesity - Most frequent strategies were community education classes and corporate wellness programs. Other strategies included nutrition initiatives in schools, media campaigns, partnerships with farmers' markets, developing recreational facilities to promote physical activity, offering healthier hospital food and advocating for better insurance coverage for obesity-related services.

Mental Health - The most common initiative was to increase mental health education and awareness for health care providers in order to increase mental health screenings and treatment. Other frequently-referenced strategies involved improved care coordination and awareness of common mental health occurrences for children and adolescents.

Diabetes, Other Chronic Conditions, and Food and Nutrition - Two common strategies that emerged were partnering with various community resources, and offering classes and educational opportunities to the public. Additional strategies focused on promoting healthier food within the walls of the hospital and/or promoting access to healthy food through venues such as farmers' markets.

Other Common Themes - While relatively few hospitals specifically addressed cancer, there was a recurring strategy of offering free and easily accessible cancer screenings. Within the category of women/infants/maternal care, the strategies were primarily targeted at healthy babies and high-risk pregnancies. Several strategies in the "Other" category specifically targeted children, although the goals and needs were very broad. When mentioned, social determinants primarily focused on addressing various needs for the poor and underserved.

Next Steps

An important opportunity to enhance CHNAs is through measuring their outcomes. The majority of the strategies in first year were binary; the hospital committed to engaging in an action or partnership. Metrics to measure progress and intended outcomes would improve the process, with many hospitals expressing a need for better data, analytic capabilities and common measures.

WSHA continues to assess opportunities to provide assistance and work with key partners to improve CHNAs, their implementation and the health of the state.