

SPMs	Group	Description	MF Score
<i>Proposed SPM1 - Previous Cycle NPM 05</i>	<i>CSHCN</i>	<i>Percent of children with special health care needs age 0-18 whose families report community-based service systems are organized so they can use them easily</i>	<i>5</i>
<i>Proposed SPM 2</i>	<i>Screening, Referral</i>	<i>Percent of children 9-11 who have their lipids screened</i>	<i>5</i>
<i>Proposed- SPM 3- Previous Cycle SPM 1</i>	<i>Sexual & Adolescent Health</i>	<i>Percent of Pregnancies that are unintended</i>	<i>5</i>
<i>Proposed SPM 6- Previous Cycle NPM 09</i>	<i>Maternal-Infant-CBP</i>	<i>Percent of third grade children with a protective dental sealant on a permanent tooth</i>	<i>5</i>
<i>Proposed SPM 7</i>	<i>Maternal-Infant-CBP</i>	<i>Percent of infants who are breastfed at two months</i>	<i>Na</i>

<i>Proposed SPM 10</i>	<i>Maternal-Infant-CBP</i>	<i>Percent of 10th graders that eat 5 or more fruits and veggies per day</i>	<i>5</i>
<i>Proposed SPM 11- Previous cycle SPM 6</i>	<i>Health Equity</i>	<i>Identify health disparities, develop and implement interventions to address disparities and evaluate the effectiveness of interventions in achieving health equity</i>	<i>5</i>
<i>S&PM Priority</i>	<i>Health Equity</i>	<i>Include for every prioritized state and national performance measure, one structural and process measure related to equity or disparate population</i>	<i>5</i>
<i>Proposed SPM 8- Previous Cycle SPM 5</i>	<i>Maternal-Infant-CBP</i>	<i>Percent of households with children 0-18 years in which the reporting adult has an ACE score of 3 or more</i>	<i>4.7</i>

<p><i>Proposed SPM 4</i></p>	<p><i>Sexual & Adolescent Health</i></p>	<p><i>Percent of adolescents receiving comprehensive sexual health education at a school</i></p>	<p><i>4.5</i></p>
<p><i>Proposed SPM 12- A.) Previous cycle SPM 7, B.) new</i></p>	<p><i>Health Equity</i></p>	<p><i>A.) The rate of infant mortality among the Native American Population</i></p>	<p><i>4.5</i></p>
<p><i>Proposed SPM 12- A.) Previous cycle SPM 7, B.) new</i></p>	<p><i>Health Equity</i></p>	<p><i>B.) The rate of infant mortality among the API/HN population</i></p>	<p><i>4.5</i></p>
<p><i>Proposed SPM 5- Previous Cycle SPM 4</i></p>	<p><i>Screening, Referral</i></p>	<p><i>The degree to which the state has assisted in planning and implementing comprehensive, coordinated care, in order to develop an integrated system of care for children birth to eight</i></p>	<p><i>4</i></p>

<i>Proposed SPM 9</i>	<i>Maternal- Infant-CBP</i>	<i>Percent of women who have recently given birth who report having used marijuana during their pregnancy</i>	<i>2.5</i>

SWOT Justification

This measure is cross-cutting with the Great LINCS grant and selected LHJ performance measures, tying in with care coordination and medical home work. Prioritizing this could help to increase the sustainability of the work related to the Great LINCS grant after the grant expires. We currently do not provide our contractors enough funding to move the needle on outcomes, moving the needle on the work of DSHS, HUD, and other partners is somewhat limiting to what we can actually accomplish on this measure.

This measure is intended to address obesity, diabetes and cardiovascular disease and is line with the American Academy of Pediatrics proposal, the governor has expressed support and staff are highly interested in moving forward. Many health systems are not currently doing this work. Some Health systems have expressed interest though uptake remains slow. Funds devoted to reimbursing time for engaging pediatricians with accurate information will likely help move this forward. We do not currently have a data source for this measure, though we may be able to get this reported through Health System Partners.

Interventions have multiple funding sources, additionally work with domestic violence and sexual assault prevention, cross-cutting with other NPMs and Results WA. Weaknesses include a lack of widespread recognition of this as a public health issue, and suspect timing of PRAMS data and questionable translation into Spanish. Leveraging additional funds to support this measure can improve data collection and interventions, including a key question for providers and additional provider training. Currently vulnerable to general fund state cuts.

Strengths: Dental sealants are an effective evidence-based public health practice (CDC); DOH has high quality data from the Smile Survey, including historic and trend data; there are many mobile school based and private providers in the state providing this work; key program staff has background in public health and clinical practice work. Largest weakness is the extent to which the Oral Health program is understaffed, formerly 3 FTE, currently 0.8. Also, it is not known if the Smile Survey will be funded for 2020, and providers are not currently required to report on this measure. Many opportunities exist if resources are increased, including increased analysis, for example, utilizing HCA Medicaid claims data; and improving statewide coordination among the increasing number of mobile dental sealant providers to facilitate reach and reporting. This work is 100% MCHBG and cannot afford any more cuts.

Please review the SWOT analysis on NPM 10 for more details. "Two months" was selected as a cutoff point because data are more reliable for this distinction. Staff feel this measure is far more representative of their work than NPM 10.

Healthy eating is tied with many chronic conditions, including obesity, heart disease and diabetes. Nationally and in the state, momentum is increasing for improving food in places accessed by children and teens, such as schools, YMCAs, and homes. Most of DOH funding for healthy eating comes from CDC and focuses only on policy systems and environmental changes, with very little funding for education. Funds for healthy eating have decreased over the last few years.

Strengths include partnerships with multiple organizations, staff training resources, a health equity impact review guide, and consistent support from leadership for moving beyond trainings to the policy level. DOH prioritization of this work supports partners with resources, and with external validity of their work on equity. Weaknesses include systemic problems with DOH's ability to work with disenfranchised groups, including limited staff capacity, and limitations in the RFP process. Critically, the RFP process is slanted in favor of organizations with more resources; historically disenfranchised organizations are less likely to have the resources needed to appear competitive. Opportunities include creating a more intentional RFP process, that could help to support organizations that currently appear less competitive. Similarly requiring pass through investments to NPOs or LHJs to target community organizations or disenfranchised groups. Finally, the MCHBG as non-competitive funding source provides a unique opportunity to focus on PSE changes. Threats to this measure include recreating historic power dynamics that occur if the state does not remain in a supportive role, as well as the constant need to call out equity in our work, as historically this will otherwise not be addressed.

Including a S&PM for every measure that address a disparate population related to the measure, or else an equity component of the work, will help us succeed in agency goals of incorporating equity into all features of our work. For example, if current cycle NPM 15 were prioritized, having to do with pregnant women and household smoking, an S&PM requirement could be prevalence of smoking among low income women.

Many LHJs have been working on this measure, and staff want to see that continued. There is growing state-wide interest in this work. This is one of the only truly life course measures given in this cycle, aligning well with agency and office goals. We are not likely to see a change in this measure over the next five years, in part by design of the measure, and in part because there is currently no BRFSS with ACEs model. Although we do not need yearly data for measurement, it is unclear when the next BRFSS with ACEs model will occur. Because many LHJs have prioritized this measure, there will be political ramifications for not choosing this measure. Preliminary results from our external survey show this is large priority of community partners, with multiple entities proposing their own ACEs measure, or otherwise expressing support for it.

Current evidence suggests there is a growing shift in favor of comprehensive sexual health education, but currently comprehensive sexual sex ed is not mandated, is under local control, and suffers from a lack of skilled providers, lack of quality control among providers, and lack of understanding of the current context of sexual health ed by providers. Specifically targeting funds to this will help staff to strengthen existing, early relationships with higher education, as well as work with OSPI to develop a certification program, and reconfigure messaging in order to mobilize new partners. Currently vulnerable to general fund state cuts.

A.) Strengths include an existing campaign for safe sleep targeting tribes, as well as partnerships with DEL, WIC, and AIHC. Weaknesses include limitations in both internal and external staff capacity, systemic limitations on DOH's approach to the 29 distinct tribal protocols, including the weaknesses with the RFP process articulated in previous cycle SPM 6. Opportunities may develop as AIHC continues to increasingly utilize program staff. The current Government to Government training, offered by DES and the Governor's Office of Indian Affairs, is under utilized. Similarly, the health equity workgroup could improve the ability of staff to work with tribes, and assist with developing opportunities to work with Urban Indian populations. Threats include the sometimes inconsistent emphasis on equity as management turnover occurs. Not picking this measure may create barriers for future DOH MCH consultation with tribes.

B.) Strengths include that ASC staff are starting to pursue this work, and for data purposes, DOH has treated API/HN a distinct population since 2003. Weakness in data are that API/HN population have a small n, that even with a climbing birth rate, has a sporadic morality rate. There are many opportunities to pursue this work, including partnerships with the Governor appointed Commission on Asian Pacific Affairs, and the Asian Pacific Islander Coalition against tobacco, as well as the revisions to the RFP process articulated in previous cycle SPM 7. Because work on this measure is in it's early phases, the largest threat is that not selecting this measure may hinder work currently being pursued by staff.

Staff are currently providing TA for quality guidance to medical and EL providers about developmental screening, while work is being restructured to meet the collective impact approach. Much of the work is similar to NPM 5, as the work this measure more descriptively captures is requisite to moving the needle on NPM 5.

May have an opportunity to leverage state funds to support this work. Adding the needed PRAMS question is being pursued. Local partners have expressed a need for capacity building in this area. Anecdotally, reports exist of people changing their using habits toward marijuana post legalization. Relatively speaking, we have a stronger evidence base for adverse effects of marijuana during pregnancy, then other adverse effects of marijuana. Staff want to articulate this could be addressed outside of MCHBG, but it is critical this happens, just not essential that it be a five year goal, or come through the MCHBG.

Notes	Data Needed
<p><i>It may possible that this measure serves as an S&PM one of the selected NPMs above.</i></p>	<p><i>National Survey of Children's Health (NSCH) IF AND ONLY IF, pending changes to the NSCH will not change the question(s) historically used to calculate this measure.</i></p>
<p><i>Depends on the wording of the measure, options that may be easier for data collection are given in the comments field to the right.</i></p>	<p><i>OR- Percent of health plans using their data to monitor percent of children 9-11 who have had their lipids screened. OR- Percent of providers or insurers who provide or cover lipids testing in 9-11 year olds.</i></p>
<p><i>Staff suggested using a key question for providers, both as an intervention and as a data source, specifically asking <u>any</u> provider seeing a client 12 years or older to ask if they plan to become pregnant this year, if no, ask them what type of contraception they're using, and recommend PRN. Current research suggests this is absolutely not happening.</i></p>	<p><i>PRAMS data, and or survey responses to capture results of the additional key question</i></p>
<p><i>This is the only measure in this cycle which addresses the middle childhood population. Staff feel future MCH work should include a more intentional approach to this population. This measure is an excellent partnership for oral health and middle childhood program staff.</i></p>	<p><i>Smile Survey</i></p>
<p><i>This measure was proposed prior to the revision and addition of part b.) to NPM 4. Staff now feel it is unnecessary</i></p>	<p><i>PRAMS</i></p>

	<p>HYS</p>
	<p>Staff reported to S&E</p>
<p><i>Note that although this is a high priority strategy, it is still distinct from the suggested SPMs as, SPM 6 measures change at a systems level, and there is no current NPM that will cover SPM 7, though there is a health outcome measure for the general population</i></p>	<p>Varies</p>
<p><i>While staff believe this not a perfect measure, they believe it is critical for keeping a foot in the door for continuing to pursue ACEs work. One suggestion reported during the external survey was to consider a measure that looks at "percent of families receiving ACEs education" a measure worded this way may be preferable for analysis, though staff will need to evaluate this.</i></p>	<p><i>BRFSS with the ACE model included, unclear when the next cycle will occur.</i></p>

<p><i>Though this work is contentious and decision makers have historically feared pushback, research suggests this pushback is the voice of a vocal minority, and not a representation of Washington. If truly comprehensive sex ed is offered, it will also provide a means to reach far more at risk students, including foster care, and students who drop out before the 9th grade.</i></p>	<p><i>Number of schools offering comprehensive sexual health education, estimated drop out rates for these schools prior to the placement of comprehensive sexual health ed in the curricula.</i></p>
<p><i>Note that this measure builds on the previous cycle's by additionally including the API/HN population</i></p>	<p><i>PRAMS</i></p>
	<p><i>PRAMS</i></p>
<p><i>This measure could potentially serve as a S&PM to support guidance NPM 6, OR vice versa</i></p>	<p><i>Staff report program evaluation to S&E</i></p>

Range of scores as 4, 4, 3, 2, 1, 1, more contentious than other measures. One proposal from our external survey is to look at "percent of women using drugs pregnancy" which may make for a more effective measure, though staff will need to confirm this.

PRAMS, with a question pending that will measure this

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