Spotlight on Idaho .................................................. 375
Community Social and Economic Context .......................... 375
Life Expectancy and Leading Causes of Death and Hospitalization 385
Overview of Children and Youth with Special Healthcare Needs/Chronic Conditions .............................................................. 387
Healthcare Access and Preventative Care .................................. 388
Mental and Behavioral Health .................................................. 390
Maternal and Child Health ..................................................... 404
Weight Related Health and Behavior ..................................... 405
Suicide and Injury Prevention ................................................. 411
Community Input ............................................................... 412
Spotlight on Communities in Idaho .......................................... 413
Boise/Ada County ............................................................. 413
Nampa/Canyon County ......................................................... 416
Pocatello/Bannock County ..................................................... 420
Sandpoint/Bonner County ....................................................... 422
Spotlight on Montana .......................................................... 423
Community Social and Economic Context .......................... 423
Life Expectancy and Leading Causes of Death and Hospitalization 438
Children and Youth with Special Healthcare Needs and Chronic Conditions .............................................................. 440
Healthcare Access and Preventative Care .................................. 441
Mental and Behavioral Health .................................................. 444
Maternal and Child Health ..................................................... 453
Weight Related Health and Behavior ..................................... 454
Suicide and Injury Prevention ................................................. 459
Community Input ............................................................... 459
Spotlight on Communities in Montana .......................................... 464
Bozeman/Gallatin County .......................................................... 464
Appendix A: Methods ........................................................................................................475
Identification of Health Needs and Selection of Indicators .........................................................475
Limitations ................................................................................................................................477
Description of the Data .............................................................................................................477
Community Input Limitations ....................................................................................................480
Review of Existing Reports ........................................................................................................480
Evidence-based and Evidence Informed Practices ....................................................................482
Appendix B: Report Structure ..................................................................................................482
Report Definitions and Structure ..............................................................................................482
Appendix C: Evaluation of Our Community Benefit
   Implementation Strategies 2016-19 ..................................................................................486
Background ..............................................................................................................................486
Summary ..................................................................................................................................486
Results ......................................................................................................................................489
   1. Coordinated Care for Children with Chronic Conditions .................................................489
   2. Suicide and Violence Prevention .......................................................................................492
   3. Healthy Eating, Active Living, Food Security .................................................................493
   4. Mental and Behavioral Health ..........................................................................................498
Looking Forward ......................................................................................................................502
Endnotes ....................................................................................................................................503
Introduction
At Seattle Children’s, we are committed to helping every child live the healthiest and most fulfilling life possible. We deliver quality patient care, advance new discoveries and treatments through pediatric research, and serve as the pediatric and adolescent academic medical center for Washington, Alaska, Montana and Idaho (WAMI) – the largest region of any children’s hospital in the country. We also identify the needs and assets of the communities we serve and reach beyond our hospital and clinics to provide programs and services aimed at improving the health and safety of children and their families where they live.

Every three years, non-profit hospitals are required by the Patient Protection and Affordable Care Act (ACA) to conduct a Community Health Needs Assessment (CHNA). The objective of the assessment is to identify both the most significant needs impacting the health of the community and ways to address those needs. In 2018, and continuing in 2019, Seattle Children’s joined Public Health – Seattle & King County, the Washington State Hospital Association and 10 other hospitals and health systems in King County, Washington, on a collaborative initiative called “King County Hospitals for a Healthier Community” (KCHHC), publishing our second comprehensive and jointly authored 2018/2019 CHNA Report.1

In this, our own independently authored 2019 Pediatric Community Health Assessment (CHA), we focus more heavily not only on pediatric and adolescent populations but also share community input and data about the WAMI region, when available. At Seattle Children’s, we do not include the word “needs” in our report because we believe that the communities we serve offer more than a list of needs or challenges. They also have their own unique set of assets and are places that actively develop and harness their own capabilities and strengths.

Our CHA pulls data from various sources to provide insights into several factors impacting the health and well-being of the communities we serve in the WAMI region. Such factors include the diversity of the population, health status, health behaviors, access to healthcare and preventive services, environments, and social and economic forces. Our assessment also describes some of the assets and resources already available in the WAMI region to address the health of the community; many of these assets were highlighted and expressly named by community members themselves.

In our CHA, we aim to create an inclusive document that highlights trends in our region and gives a snapshot of the assets and opportunities in the communities we serve. This assessment guides our hospital’s community benefit priorities and subsequent implementation and evaluation plans for 2020 through 2023.

We hope this CHA will provide useful information for hospitals, public agencies and local organizations interested in improving the health and safety of our communities. We also hope it leads to enriching conversations across the WAMI region.

In the ensuing pages, our 2019 CHA provides qualitative and quantitative information, including:

- **A Description of Our Community**: Although the majority (51%) of our patients live in King County, Washington, and an additional 45% of our patients are from other locations
in Washington state, we will explore the pediatric health status of communities throughout the WAMI region.

- **Life Expectancy and Leading Causes of Death and Hospitalization:** Life expectancy rates across the WAMI region vary by state and local communities. Life expectancy in King County neighborhoods, for example, can vary by up to 10 years. Suicide and injuries are a leading cause of death among children, teens and young adults throughout the WAMI region. Thus, mental and behavioral health weighs on the minds of parents and guardians, and this region increasingly relies on us here at Seattle Children’s and other community providers to care for mental and behavioral health conditions.

- **Additional identified health needs:**
  - Access to healthy lifestyles: affordable healthy, nutrient-rich food; safe places to play and be active; and food security
  - Health impacts caused by more upstream determinants such as poverty, economic security, and lack of affordable housing
  - Children and youth with special healthcare needs (CSHCN) and chronic conditions seeking care closer to home and care coordination for children and youth without a specialty care provider close by
  - Access to care, adolescent health, as well as family education and resources including health insurance coverage, health literacy and navigating healthcare services.

The profile of each specific health need includes key indicators of relevant health outcomes, which describe the population health status of a community and the factors that could influence health outcomes. This includes access to quality healthcare, health behaviors, social factors and the physical environment. Such an assessment embraces a broad concept of health that includes social determinants so that, working collaboratively both within and outside the health system, Seattle Children’s can help build on expertise and resources to address critical health needs and address the “triple aim” of health care: enhancing the patient care experience, improving the health of populations and reducing the per capita cost of healthcare.

Social factors and the physical environment are especially important because they represent the conditions in which people are born, work and play. Neighborhoods with affordable and healthy food, safe and accessible housing, and quality employment opportunities facilitate healthy lifestyles. The World Health Organization calls the living conditions that can affect a person’s health and quality of life the “social determinants of health.” ² Our CHA highlights the importance of addressing the social determinants of health by including data about these determinants and crafting strategies and tactics to address the needs related to the social and physical environment.

**Figure 1: General Socioeconomic, Cultural and Environmental Conditions Impacting Health**¹

---

Only 20% of overall health outcomes are affected by quality of healthcare and access to care. The vast majority of health outcomes are influenced by social determinants of health. This includes basic needs, such as income, housing, safety, education and nutrition.

**Figure 2: Impact of Social Determinants of Health on Pediatric Health Outcomes**

---

2 Adapted from University of Wisconsin Public Health Institute. (2010). *County health rankings model*. Retrieved from https://sph.uth.edu/dotAsset/d30b9171-5f3a-4b9e-826f-b000a82c8914.jpg.
Health inequities cause health disparities—defined as health differences that are closely linked to social, economic or environmental disadvantages.\(^{4}\) When available, this CHA report provides data for neighborhoods, cities, counties and regions, and by other important demographic breakdowns, such as race/ethnicity, age, income/poverty, gender and sexual orientation. Comparisons are also made to the national Healthy People 2020 objectives, when possible.

The report also features both qualitative and quantitative data. Each identified health need has a corresponding section and each section is organized by epidemiological data, followed by sections with community input, asset and opportunities. An executive summary of this report is available by visiting: http://www.seattlechildrens.org/about/community-benefit/community-health-assessment.

**About Seattle Children’s**

Founded in 1907, Seattle Children’s is primarily a specialty hospital serving children ages birth to 21. For more than 100 years, Seattle Children’s Hospital has specialized in meeting the unique physical, emotional and developmental needs of children from infancy through young adulthood.
The hospital has 407 licensed beds (361 beds currently in operation), more than 7,800 total employees and an active medical staff of 1,650. We have 1,665 Washington State Nursing Association member nurses. We also had 960 total physicians in training and 758 medical students in training during the 2018 to 2019 academic year.

For the past 25 years, *U.S. News and World Report* has ranked Seattle Children’s as one of the top children’s hospitals in the country and the top children’s hospital in the Pacific Northwest. Seattle Children’s is also the primary teaching, clinical and research site for the Department of Pediatrics at the University of Washington School of Medicine.

At the forefront of pediatric medical research, Seattle Children’s Research Institute is working to cure childhood disease in partnership with our hospital and foundation. The research institute consists of nine major centers, and is internationally recognized for its work in cancer, genetics, immunology, pathology, infectious disease, injury prevention and bioethics.

Through the collaboration of physicians in nearly 60 pediatric subspecialties, we provide inpatient, outpatient, diagnostic, surgical, rehabilitative, behavioral, emergency and outreach services – regardless of a family’s ability to pay. We also provide programs and services outside our hospital and clinics to improve the health and safety of children, teens and families where they live based on identified community needs.

**Opportunities for Better Health**

In Washington, Alaska, Montana and Idaho – as in communities across the nation – neighborhood conditions, race, income, language and education are highly correlated with disease burden and life expectancy. Community health data consistently show that these social determinants of health—shaped by local distributions of money, power and resources—cannot be ignored if we hope to improve individual healthcare and health outcomes.

The relationship between lack of opportunities and poor health is clear. In King County, Washington, for example, neighborhoods with the lowest educational attainment and highest levels of poverty are also the areas with the greatest concentrations of obesity, diabetes and many other adverse health outcomes. (See Figure 4 and 5 below.)
Figure 4: King County Poverty, Education and Obesity Map by Area

Figure 5: King County Population Measures by Area

U.S. Census Bureau. BRFSS, CHARS, data, map produced by Public Health — Seattle & King County.

U.S. Census Bureau. BRFSS, CHARS, data, map produced by Public Health — Seattle & King County.
Since access to healthcare services accounts for only about 20% of overall health, nonclinical and clinical approaches by hospitals, health systems and partners are necessary in order to meet a community’s health needs.\(^5\) Having equitable access to opportunities, resources and basic needs, such as education, housing and jobs, is necessary to improve health outcomes and quality of life across all communities.

**Working Together Toward Healthier Communities**

Healthcare reform and, more recently, Washington state’s 1115 Medicaid Transformation Waiver from the federal government, have led to an increase in collaboration among hospitals and health systems, public health, social services, housing, community development and other sectors that address the underlying determinants of health for residents. In order to achieve the “Triple Aim,” these groups recognize the need for more collaboration.\(^6\) The aforementioned 1115 waiver refers to section 1115 of the Social Security Act whereby the U.S. Secretary of Health and Human Services and allow states to use federal Medicaid dollars in ways that are not otherwise allowed; Washington state was issued such a waiver in 2017; an agreement that will be in place through 2021.

Seattle Children’s is involved in a number of initiatives that help accelerate the goals of local and state health transformation plans. Community partnerships that address the upstream, non-medical drivers of health are a key part of ultimately achieving the “Triple Aim.” The Healthier Washington initiative recognizes that health happens at the local level and that communities are at the core of bringing about the changes that will improve the health of their residents. Also, in Washington state, nine regional Accountable Communities of Health (ACH) provide incentives for providers who are committed to changing how they deliver care. Through the ACH, each region can pursue projects aimed at transforming the Medicaid delivery system to serve the whole person and use resources more wisely. These transformation projects aim to:

- Build the capacity of health systems by addressing regional workforce needs, enhancing technology and tools, and assisting providers to adopt value-based strategies.

- Redesign care delivery to:
  - provide integrated physical and behavioral health services;
  - strategically focus care for specific populations;
  - coordinate care and case management to serve the whole person; and
  - support outreach, engagement and recovery.

- Promote prevention by targeting specific activities to specific populations and regions

As a foundational piece of health assessment work that can be built upon in the years ahead, Seattle Children’s CHA helps lay the groundwork for future community partnerships and well-aligned strategies that will succeed in responding to the identified community needs.

**Methods**

**Design**
Some of the data referenced in this CHA were collected as part of the comprehensive King County 2018/2019 CHNA, which was created by a collaborative of 11 hospitals and Public Health – Seattle & King County. These Hospitals for a Healthier Community members defined health broadly using a population-based community health framework to identify health needs and establish criteria for selecting key indicators within each health topic. To identify community concerns and assets for both the King County CHNA and Seattle Children’s 2019 CHA, we interviewed stakeholders, consulted recent community-based reports and pulled information from the region’s previous CHNAs. Both assessments use a data collection approach that includes primary data, such as key informant interviews, community listening sessions and a community assets assessment. Secondary data gathering includes analyzing epidemiological data on health outcomes, as well as demographic, behavioral and environmental data. Data for Alaska, Montana and Idaho were compiled using publicly available data sources. Additional analyses for Washington state localities were based on Washington State Department of Health data as well as Healthy Youth Survey data and/or Youth Risk Behavior Surveys.

Recognizing that the jointly authored King County 2018/2019 CHNA and Seattle Children’s 2019 pediatric CHA could not provide comprehensive data for each health topic, indicators of relevant health outcomes were selected according to the following criteria:

1. Ability to address health equity, particularly by age, gender, sexual orientation, race/ethnicity, geography and socioeconomic status, although not all demographic breakdowns may be available for all indicators.
2. Availability of high-quality data that are population-based (where possible), measurable, accurate, reliable and regularly updated. Data should focus on rates rather than counts.
3. Ability to make valid comparisons to a baseline or benchmark.
4. Prevention orientation with clear sense of direction for action by hospitals for individual, community, system, health service or policy interventions that will lead to community health improvement.
5. Ability to measure progress of a condition or process that can be improved by intervention, policy or system change, and whether there is a capacity to affect change.
6. Alignment with local and national healthcare reform efforts, including the “Triple Aim.”

When appropriate, indicators that satisfied these criteria were statistically analyzed by Public Health – Seattle & King County for both reports. Hundreds of health indicators were analyzed and then interpreted by a dedicated team of Master of Public Health (MPH) students and updated every summer over a three year time period, from 2016 through 2019. These epidemiology and community-oriented public health practice students were integral to this work. They extracted, examined and spent countless hours analyzing and interpreting epidemiological data sets that are presented in this report. For the most part, data on Alaska, Montana and Idaho were not statistically analyzed for this report, but cited as published in reports from local and/or state health departments.

Input was also gathered between 2016 and 2019 from people representing the broad interests of the communities we serve through different methods. This included interviews with stakeholder coalitions and community leaders; listening groups with youth, parents, caregivers and experts on specific topics; and a review of recent reports on local health needs. To identify community concerns and assets, Seattle Children’s worked with pediatricians in their second year of
resident who, as a part of their training, take a month-long rotation in the Community Health and Benefit division of the External Affairs and Guest Services Department at Seattle Children’s. These residents interviewed stakeholders, consulted recent community-based reports and pulled information from previous hospital CHNAs.

Between 2016 and 2019, these pediatricians and the community health and benefit team members at Seattle Children’s who trained them conducted 26 listening sessions across the WAMI region with parents or caregivers of children ages 0 to 21. We conducted all of our listening sessions in English, and provided Spanish translation at three events, Somali translation at five events, Amharic translation at five events, Oromo translation at one event and Vietnamese translation at one event. Additionally, the residents visited eight communities that were urban, suburban or rural, including villages, to learn about community health challenges. They also interviewed 172 key informants in the WAMI region. The geographic spotlights in this report are based on their learnings and findings from these geographic areas.

**Figure 6: Map of Listening Session Locations 2016-2019**

Many, if not all, of the following interview questions were used for key informant interviews and/or listening sessions with community participants:

- Help us understand a little more about you all. What are some things you like to do as a family?
- When you think about your kids, what keeps you up at night or what worries might you have?
- When you think about your kids, what do you hope for?
- Do you feel it is easy to find information about:
  - raising kids?
  - health and safety information?
  - mental or behavioral health, such as depression, anxiety or ADHD?
  - healthy eating or physical activity for kids and families?
    - If it isn’t “easy” per se, what resources are you looking for that you haven’t been able to find?
- Think about the last time you went to the doctor, to the hospital or the emergency room. Think about things like courtesy and kindness as well as cultural respect. Tell me about the specific things that the care providers did to demonstrate kindness, courtesy and respect to you? Tell me about the things people said or did that made you feel your culture was honored or tell me how you felt you were treated unkindly or were not respected by the people taking care of your child.
- One area of focus for Seattle Children’s is mental and behavioral health. In fact, out of all our clinics, the one that serves the largest amount of kids each year is our psychiatry clinic and our behavioral medicine unit. So, we’d like to learn about mental and behavioral health in your community. What are the most significant needs or gaps? Are there any health care providers or community organizations here that address this well?
- What about substance abuse and drug use? What are the most significant needs or gaps? Are there any health care providers or community organizations here that address this well?
- Think about the child(ren) in your life. First, let’s talk about resilience. Being resilient means the ability to become strong, healthy or successful after something bad happens. It is that quality that allows some people to be knocked down by life and still stand up again. When I think of children in my life I see that sometimes they have trouble dealing with and then navigating disappointment (Billy didn’t get his way and is falling apart as a result). Other times I see them recognizing the feelings of others and responding appropriately (Sally knocked down a friend’s tower accidentally, apologized and offered to help rebuild it). Who wants to share a story about their child first? We have time for a couple.
- Now please think about the joy and challenge of parenting. Is there someone that you can turn to for day-to-day emotional support with parenting or raising children? What was the impact? Can a few of you share examples of the support you have had?
- Do you feel like you have a place in your community where children can be physically active? If not, what prevents families from being physically active? How does your community address these challenges?
- Where are places that families can easily get healthy foods, such as fresh fruit and vegetables that are affordable? What barriers exist? How does your community address these challenges?
- What local resources are available to families that are hungry?
- What would you like to see Seattle Children’s do or provide here related to the health and well-being of kids?
- Do you have anything else you’d like to share with us?
Data Sources
Quantitative data were compiled from local, state and national sources, such as the U.S. Census Bureau, U.S. Centers for Disease Control and Prevention, health departments in Washington, Alaska, Montana and Idaho and Public Health – Seattle & King County. A sampling of some data sources used for this report include:

- **American Community Survey**: U.S. Census Bureau


- **Healthy Youth Survey**: Washington State Department of Health

- **Immunization Rates/National Immunization Survey**: Centers for Disease Control and Prevention and/or the Washington State Immunization Information System (formerly Child Profile Health Promotion and Immunization Registry System).


- **Washington State Cancer Registry**: Washington State Department of Health, State Cancer Profiles from the National Cancer Institute and the Centers for Disease Control and Prevention for state level data.

- **Student demographic characteristics**: Washington State Office of Superintendent of Public Instruction, Alaska Department of Education and Early Development, Growth and Enhancement of Montana Students as part of the Montana Office of Public Instruction, and Idaho State Department of Education.


Limitations
Key limitations of this report include incomplete or inadequate quantitative data on some topics of interest and our inability to summarize every asset and opportunity in the communities we serve. Although we report data on fruit/vegetable consumption, for example, comprehensive population-based data on healthy eating are simply not available. Additionally, for some data sources, the most recently available data comes from 2015 and not more recent years.

Racial/ethnic comparisons are made using broad race categories, many of which are limited by what is asked in a survey or in a medical record. This means comparisons are made using broad race categories based on a narrow range of options for self-identification in surveys. It is important to report by race/ethnicity where possible, in order to track progress towards achieving health equity, but we are not able to distinguish between the diverse ethnic groups or nationalities that comprise our broader categories. Our ability to report data by the many ethnic groups and nationalities living in the WAMI region is limited by insufficient sample sizes and how various surveys collect self-reported racial/ethnic data.

Data was collected from numerous agencies using varying data sets. A particular challenge was inconsistent age groupings in epidemiological and outcome data, particularly where we had to use published reports not raw data. Data sources were also inconsistent in defining life-stage categories, such as when a child is considered an adult. Also, inconsistencies in terminology and definitions made it difficult to make side-by-side comparisons. For example, the definition of “Hispanic” varies from one community to another. Occasionally, some data reports would define leading causes slightly differently from another report. The definition of “community” also varies by individual. A community can be a geographic area, a racial/ethnic group, a school or a religious affiliation. This poses problems when analyzing interview and survey results. When we ask a question, for example: “what are resources in your Walla Walla community that help families stay healthy and active?” respondents interpreted Walla Walla as the city, the county and others neighborhood.

While we gathered a great deal of community input from a wide range of stakeholders, limited resources made it impossible to reach all of the areas that constitute the WAMI region. We were able to conduct listening groups with multiple communities and interview several community members, these qualitative results should be interpreted as the perspective of the people who participated.

In addition, space and resource limitations prevented us from mentioning all the valuable organizations and assets in our communities. We look forward to continuing to learn more about community strengths and resources. A continuously updated statewide database of health and human service information and referrals for Washington state can be found at https://win211.org/about/2-1-1-in-washington/.

Unfortunately, these limitations may inadvertently reinforce health inequalities. Seattle Children’s sought to mitigate limitations by including representatives of diverse and under-resourced populations throughout the qualitative components. For example, listening sessions were conducted in multiple languages in multiple locations. More details about the CHA methodology are included in Appendix A.
**Definition of Community**

Seattle Children’s serves the states of Washington, Alaska, Montana and Idaho (WAMI). For the purposes of this CHA, we defined our community as the children and youth in the WAMI region, with a deeper focus on Seattle, King County and Washington state.

The definition of our community is due, in part, to our patients’ origins in fiscal year 2018: 18% from Seattle; 33% from other places in King County; 45% from other locations in Washington state; 3% from Alaska, Montana and Idaho; and 1% from outside the WAMI region. Since more than half of our patients and families reside in Seattle and King County and an additional 45% call Washington state home, this CHA will focus more deeply on the status of pediatric health in those communities, but we will also cover the pediatric health status of children, youth and young adults living in Alaska, Montana and Idaho.

**Figure 7: Community Health Assessment Focus Area**
What We Heard From the Community – Key Findings

This section reports on common themes and issues identified through our conversations with community coalitions, community organizations, families, youth and subject matter experts. As noted in the methods section above, our Seattle Children’s team has spent the better part of three years conducting data analysis and gathering community input in service to this 2019 CHA. After integrating and analyzing all the qualitative and quantitative data and feedback we gathered since 2016, our community benefit priority areas are: Mental and behavioral health, followed by healthy lifestyles, suicide and injury prevention, and economic security. Our sustaining programs and services are: access and care coordination, adolescent health, programs and services for children with special needs, and family education and resources.

Figure 8: 2020-2023 Seattle Children’s Community Health & Benefit Priority Areas

These priority areas were approved by our Board of Trustees in May 2019. Because our mission at Seattle Children’s is to “provide hope, care and cures to help every child live the healthiest and most fulfilling life possible,” our CHA processes have dictated that we not only analyze what is hurting, harming and hospitalizing children in our region, but where we are uniquely positioned as a pediatric specialty care hospital to impact and hopefully mitigate those harms alongside the communities we serve. Our community health and benefit priority areas are essential to our mission. In the section below, we will provide a summary of our key findings that have led us to name these priority areas.
**Mental and Behavioral Health**

**Washington State**
A common concern voiced by communities outside of King County was the difficulty in accessing subspecialty care, especially mental health and developmental services. In communities outside of Seattle, this was the top theme identified. The most discussed needs were access to neurodevelopmental and behavioral health services.

In Yakima, Tri-Cities and Seattle, participants in listening sessions discussed the importance of recognizing and supporting children and families who have adverse childhood experiences (ACEs) and providing trauma-informed care.

At some of the town halls in Seattle, participants highlighted the importance of offering accessible and sensitive behavioral health resources for youth. Families felt that behavioral health and services for drug abuse and addiction were overlooked, and that support was difficult to find.

**Alaska**
Most key informants in Anchorage discussed problems related to substance abuse and mental health. According to one participant, the biggest barriers are access to treatment services and local providers’ capability to treat mental and behavioral health issues. One stakeholder voiced worries about substance abuse among parents and how that impacts their children.

**Montana**
Mental health was identified by families and providers in both rural and urban communities as Montana’s biggest challenge. The stigma of depression and anxiety was described as a barrier to accessing services, as was the impression that many families do not know what mental health resources are available. Schools and primary care offices were seen as generally supportive environments for children with mental health needs.

Healthcare providers noted that, while they screen frequently for mental health problems, there are not enough services to provide therapy for the children who screen positive. Waitlists for formal evaluations are prohibitively long, and it takes many hours to drive from smaller communities for appointments.

Several pediatric primary care providers voiced their desire to have access to the Partnership Access Line (PAL) to support their management of children’s mental health needs. PAL is a Washington state-funded program operated by Seattle Children’s that provides mental health consultation to primary care doctors for mental health related questions, such as diagnostic clarification, medication adjustments or treatment planning.

Families discussed how children often “fall through the cracks” in a system that cannot offer adequate services, but that parents often have unmet mental health needs as well. They also talked about the relationship between substance abuse and mental health, and the concern over firearm access and teen suicide. Community members were concerned about the lack of adequate suicide crisis services, and the upstream services to prevent such crises.
**Idaho**
In Boise and Nampa, several parents mentioned the lack of available inpatient psychiatric beds in Idaho. One parent described her experience waiting for a psychiatric bed for several days for her child, saying that she was told there was a nine-person waitlist for six available beds. Her child was admitted to a general pediatric hospital bed while waiting for the psychiatric bed, but no psychiatric therapies were available.

According to a pediatric emergency room doctor, patients admitted to the general pediatrics team often wait several weeks before transferring to an inpatient psychiatric bed. A local parent support group leader mentioned that parents will often drive out of state for residential treatment or inpatient psychiatric care when in crisis, which is not always covered by their Idaho insurance.

Parents were also frustrated by the lack of an intensive outpatient program or a partial hospitalization program.

**Healthy Lifestyle Opportunities and Challenges**

**Washington State**
Food insecurity is defined as an uncertainty of having or an inability to acquire enough food for all household members because of insufficient money or other resources. Families in King County and Yakima discussed food insecurity and cited the high cost of healthy foods and the lack of education about healthy eating as the biggest barriers to accessing nutritious meals.

In Seattle, families asked for more education related to healthy lifestyles. For example, they suggested a Somali channel that highlights healthy cooking, exercise and other lifestyle examples.

In Yakima, the discussion also centered on safe and convenient ways to participate in recreational activities. They voiced concerns about how urban spaces are not pedestrian-friendly or bike-friendly, and how access to safe outdoor spaces is limited.

**Alaska**
In Anchorage, some of the key informants mentioned the challenges of staying active and eating healthy foods, especially when living in areas that lack access to fruits, vegetables and whole grains.

Another key informant said it is easier when it is cold for families to stay inside, make something quick to eat and turn on the television, especially in rural areas. This leads to a more sedentary lifestyle.

Positive steps are being taken in schools and at the state level. The state has the “Play Every Day” program that encourages children to exercise, while also competing with classmates and earning prizes. At the school level, one stakeholder discussed free workout classes offered to students after school. Breakfast and lunch are free to qualifying students year round. Community
gardens are also becoming more popular, with diverse populations and cultures emphasizing healthy eating in their neighborhoods.

**Montana**

Access to healthy and affordable foods was a challenge for many families. Parents in the Montana sessions described helpful programs, such as the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), food stamps, the Missoula Food Bank and programs to send food home in kids’ backpacks. In some communities, these backpack programs are covered by the school district or through other grant funding.

One parent described how the cost of medical care created food insecurity for her family. After co-pays and deductibles that were beyond what she budgeted, her family had to choose between paying bills on time and buying enough food to eat.

**Idaho**

Parents described how healthy lifestyle support and resources through online groups provide a sense of inclusion and wealth of information such as events. However, these communities are primarily in English, and non-English speakers can often feel excluded. Additionally, Idaho residents have access to a wealth of protected land available for hiking and other outdoor activities.

**Suicide and Injury Prevention**

**Washington State**

In Washington state, an average of 720 children die each year.\(^8\) Suicide and unintentional injuries were the leading causes of death among children ages 0 to 19 between 2015 and 2017. Youth suicide by firearm increased 2% in a single year from 2016 to 2017, and youth death by suicide is up 65% since 2007. Families we spoke to stated that they needed education and resources specific to their needs, as well as healthcare services that included trauma-informed approaches to help address the impact of trauma on families, especially young children. Families felt they were under-equipped to support their children through these situations and would like age-appropriate materials to promote safety, mental health and stress reduction.

**Alaska**

Almost all key informants in Anchorage brought up concerns about the rates of child abuse and maltreatment across the state. It is one of the top needs identified by multiple organizations throughout Alaska.

While we hosted many listening sessions in Alaska since 2016, there were no exclusive listening sessions with families identifying as only Alaska Native/American Indian. The Southcentral Foundation conducted their own listening sessions and identified several priorities. These included domestic violence, child abuse, child neglect, behavioral health issues, and alcohol and drug addiction.

**Montana**
In Montana, the people interviewed were acutely aware of their children’s risks for serious outcomes from injuries and were keen on starting or improving injury prevention programs to keep their kids safe.

Families in Missoula praised the local fire department’s car seat fitting program. Some community members wished that bicycle helmet use was mandatory. Parents of a child with autism spectrum disorder expressed concerns about supervision needs, and other parents of children with special healthcare needs shared similar worries. Parents of adolescents worried about risk-taking behaviors, especially when teens are driving. Caregivers also identified drowning and water safety as significant concerns.

Access to and the use of firearms were also a frequent safety topic. Many households in Montana have a firearm, either for hunting or personal protection. Many parents worried about firearms being around children and expressed a desire for better access to lockboxes and firearm safety education. They wished for parents to be more comfortable talking about whether guns are secured at the homes of their child’s friends and for medical providers to be more comfortable talking about this topic and offering resources.

Idaho

Suicide is a central issue for the residents of Idaho, exacerbated by a lack of access to mental healthcare services. Parents reported having to become advocates for their children’s mental healthcare, even going as far as to become nurses to care for their own children.

Access to mental healthcare was reportedly only available after an adverse incident, so prevention was rarely accessible. Crisis care was also difficult to access in certain parts of Idaho, making suicide prevention difficult to prioritize. Children often have to wait as much as a year between diagnosis and care.

Economic Security

One in three U.S. children spend one year or more living in a household that is below the poverty line before their 18th birthday.9 Children experiencing poverty are more likely to enter school behind their peers, score lower on achievement tests, work less and earn less as adults, and have worse health outcomes.10 This pattern is especially clear for the poorest and youngest children and those who remain in poverty a long time during childhood.11 There is strong evidence linking income and health that suggests that policies promoting economic equity may have broad health effects. Income is strongly associated with morbidity and mortality across the income distribution, and income-related health disparities appear to be growing over time.12

Our conclusions include:13

- Income influences health and longevity through various clinical, behavioral, social and environmental mechanisms. Isolating the unique contribution of income to health can be difficult because this relationship intersects with many other social risk factors.
• Poor health also contributes to reduced income, creating a negative feedback loop, sometimes referred to as the “health-poverty trap.” This impacts families most.
• Income inequality has grown substantially in recent decades, which may perpetuate or exacerbate health disparities.
• Policy initiatives that supplement income and improve educational opportunities, housing prospects, and social mobility (what we call economic security) – particularly in childhood – can reduce poverty and lead to downstream health effects not only for low-income people but also for those in the middle class.

**Washington State**
Health is more than just health care. By addressing upstream determinants of health through our clinical and community practices, we can have a greater impact on community health. In Washington state, the issues that stakeholders mentioned most frequently included safety, affordable housing, transportation, access to care (especially mental and behavioral health), living wages, and opportunities to be physically active and afford healthy foods.

In several communities, families wanted better access to safe after-school activities for teenagers whose working parents cannot supervise them.

In Seattle, immigrant communities voiced frustration over navigating the education system in terms of obtaining support with Individualized Education Programs, interpretation and/or translation of important materials for parents, communication with teachers, and outreach by parent-teacher associations to under-represented communities.

**Alaska**
All of the key informant interviews in Anchorage emphasized a lack of resources within the community. This included language services, transportation, housing, social services and healthcare.

Informants spoke of the decline in public transportation and low walkability of Anchorage. According to participants in the interviews, streets are poorly planned and often remain unplowed in the winter months. This can leave children isolated at home. As the population of Anchorage grows, housing availability and affordability declines. Key informants raised concerns about the number of families in homeless shelters.

**Montana**
In Montana, the basic needs most frequently mentioned included affordable housing, transportation, access to healthy and affordable foods, affordable childcare, access to safe and healthy places for children, and parenting resources.

Affordable housing is increasingly scarce as cost of living rises in places like Missoula. Families in several communities in Montana described rising housing costs affecting their families’ ability to afford other basic needs.

In rural communities, inadequate transportation affects families’ ability to access healthcare and other services. Missoula residents were glad to have a free bus system in town, though the
limited hours and stops do not make it sustainable for families to go without a car. Families felt like they were living on an island if they did not have reliable access to a vehicle.

**Idaho**
Stakeholders and key informants, particularly those with children who have special health care needs, have mentioned the cost of care, only some of which is covered by private insurance or Medicaid. These high costs negatively impact quality of life and access to basic needs. Areas where grocery stores are scarce, food insecurity, and transportation were also mentioned by community members and are considered as big issues in parts of Idaho.

**Accessing Care**

**Washington State**
Across Washington state, access to care was identified as an important issue. Discussions centered around barriers to navigating the healthcare system and insurance coverage, long wait times, a lack of care coordination and the challenges of travelling to Seattle for certain services.

Families in King County requested that clinics co-locate and coordinate services, such as offering services like primary care, dental care, behavioral health, nutrition, urgent care, educational services for families, and Women, Infants and Children (WIC) programs in one location to help reinforce the connection between health, education and wellness.

Families and stakeholders across different locations also described an interest in improved integration of care and collaboration between services, such as pediatricians communicating directly with behavioral health specialists and schools.

Creating medical homes or neighborhoods were discussed as a key goal by stakeholders in most locations. Primary care doctors at locations outside of Seattle described the challenges of accessing subspecialty records. In Yakima, families were frustrated that although some subspecialties were available, the full team of providers available in Seattle was not available locally.

For families of children with special healthcare needs and at-risk teenagers, parents worried about how their children will navigate the healthcare system on their own in the future since they (parents) struggle to navigate the system. Families facing language and/or cultural barriers or literacy challenges discussed the need for support systems and patient navigators.

**Alaska**

Care coordination was mentioned most often in Alaska related to children with special healthcare needs who require care at Seattle Children’s. Since Alaska’s population is spread out over vast distances with many villages only accessible by plane, care coordination is uniquely challenging.

A number of pitfalls can occur when trying to coordinate care between providers in Seattle and families living in isolated villages in Alaska. Specific examples mentioned included:
• Information about appointments not making it to the local village health aide and, instead, being sent to a provider at a regional referral center.
• A lack of understanding among providers about the limited availability of certain resources.
• A lack of advanced notice needed to arrange transport for appointments.
• Poor communication between local providers and providers in Seattle.

Many families may also require assistance coordinating transportation to Seattle and with taking care of basic needs while in Seattle.

To improve care coordination, they suggested better coordination of transportation to get children back to Alaska more quickly; doing everything possible in one trip when a family has to travel to Seattle; and using telehealth to augment the hospital’s care coordination services.

**Montana**

Almost every individual, whether during a listening group or an individual interview, commented on access to care as a significant concern, especially access to pediatric subspecialists and the long waitlist for services.

Many families currently drive long distances (sometimes longer than five hours) or travel to Seattle for a subspecialty appointment. The idea of taking medical transport to Seattle for every illness was a major financial and logistical challenge. Multiple families described sending their child by medical airlift to Seattle for life-saving care only to be saddled with an impossibly large transport bill. Many desired a medical home where they could go for reliable advice and evaluation closer to home, especially for children with special healthcare needs.

Multiple caregivers of children with special healthcare needs also expressed worry about the transition of adolescents to adult medical services, especially if there are long waitlists.

**Idaho**

In Idaho, parents reported long wait times to get a diagnosis and for therapy or other prescribed services. Among the Spanish-speaking population, families shared how the challenges with access to care are even greater despite the availability of some translator services in the area.

In Boise and Nampa, families discussed how children have to “fail” before they are able to access the care they need. For example, they reported school meetings where they were told they could not access resources because their child was not failing academically. They also discussed the “drug court,” which is one of the few ways that children can get substance use rehabilitation, but it is only for children who have been arrested related to drug use. Similarly, kids with behavior problems essentially need to get arrested and put into the juvenile detention system in order to gain access to some of the bigger residential facilities or group homes.

**Cultural Humility**

**Washington State**
The issue of cultural competency – understanding a patient’s belief system in order to sensitively provide care - was discussed at all listening sessions across Washington state. Here at Seattle Children’s we call this “cultural humility” since we believe that you can never fully be “competent” in a culture if you don’t originally come from that culture, but you can approach the culture with humility. Families voiced the importance of educating families and healthcare workers.

In Seattle, families asked for visual learning tools and for teaching that addressed some misconceptions and mistrust of the medical community in a sensitive way. They also asked for culturally sensitive education about medications and immunizations.

Families and stakeholders in Bremerton, Seattle and Yakima also discussed the importance of expanding healthcare education, healthcare resources and other social resources for non-English speakers for a variety of literacy levels, with sensitivity to different cultural perceptions on health and disease.

In the Tri-Cities, families discussed how the Hispanic/Latinx community does not talk about certain topics, such as teen pregnancy and drug use, and how sometimes there are missed opportunities to discuss prevention and provide education on these topics.

There were also several discussions across the different locations about the lack of cultural humility among providers and a lack of providers who represent the communities they serve. Families felt that a lack of cultural competency led to poor communication and worse care. They sought a more diverse healthcare workforce and called for improved education around cultural competency.

**Alaska**

Families in Alaska desire care that is respectful, kind and culturally sensitive. Cultural humility was specifically discussed in regard to families who identify as Alaska Native/American Indian and travel to Seattle Children’s to receive care. These families may have negative experiences if their medical team does not have an awareness of cultural differences that exist. People who are Alaska Native, for example, may be quiet and may not initially ask many questions, which may be incorrectly interpreted as a lack of interest in their child’s care.

Additionally, extreme differences in daily life between Seattle and a rural Alaskan village can lead to misunderstandings. In some places, families may rely on ATVs and other modes of transportation other than cars. In these cases, families would benefit from conversations on the use of seatbelts and car seats when in Seattle. One stakeholder suggested cultural-competency training for staff members to specifically address these issues.

**Montana**

Parents and key informants mentioned challenges surrounding the stigma and cultural norms of mental health and receiving care.

While the majority of Montana’s residents are white, Montana is also home to several American Indian tribal areas. These communities live separately from their non-native counterparts in large
parts of Montana. Also, the largest health inequities are experienced by American Indians in Montana when compared to other racial or ethnic groups.

**Idaho**
Some families in Idaho reported having a difficult time accessing mental health care because of language barriers. Cultural background of families also played a part in how parents sought and children received care. Parents reported having support from each another as they advocated for their children.

**Community Input and Inclusiveness**

**Washington State**
Families across Washington state asked for more community engagement and empowerment, and for communities to be involved in defining the support they need and receive. All families described how educational and useful it was to hear stories of resiliency and struggle from their peers.

In communities with increasing diversity, families discussed the value of having in-person and online support groups, and they wondered how to make these more accessible across different languages, cultures and literacy levels.

In Seattle, families asked for inclusive community meetings incorporating various cultures and for community-based mentorship and help navigating the healthcare system. Families asked that healthcare professionals come to community-based meetings at sites where they feel safe and supported, to offer education and assistance and to hear feedback. Families also asked for more healthcare services, group meetings, active community health boards and outreach efforts to provide education regarding existing resources. Families identified community centers as the best location for these resources and outreach activities.

**Alaska**
Community members emphasized fostering a sense of community through mentorship programs, particularly for the native population. Homes are often multi-generational, which helps build community and a sense of self. Parents describe culture as the backbone of many Alaskan communities, providing a shared moral framework and important community values. Language and traditional foods also nurture feelings of inclusiveness.

Some have mentioned that cities consider their communities strong and isolated but also cohesive and reliable. This is shown through the private support of public programs that had been cut. Certain communities are tackling large issues like hunger.

An important community value mentioned was addressing inactivity in youth. Giving youth activities is considered a way to address or prevent some behavioral and mental health issues. Many stakeholders, however, mentioned a need for more of these activities, particularly free, transportation-accessible, drop-in options.
Montana

Parents and caregivers described finding community in many places. Many individuals discussed turning to their relatives and friends for support. Several discussed the benefits of living in small, tight-knit communities.

In rural areas, families often look to older generations for support and health information. Schools and churches are an important source of community. In particular, families of children with mental or behavioral health issues described schools as important partners and support structures.

Parents of children with special healthcare needs frequently described Facebook and other social media communities as places to connect and share information with parents facing similar challenges. Several community members described a feeling of isolation related to their geographic location in Montana and/or their status as the caregiver of a medically complex child, especially because they have no time for anything other than work and caring for their child’s needs.

Idaho

Parents in Boise and Nampa discussed the importance of support groups as a way to connect to other families whose children are going through similar medical or behavioral health issues. They mentioned several local in-person and online parent groups that were helpful in providing support and friendship. Parents found out about resources and activities and had a place to go when they had questions. There was some concern that this support does not extend to parents who do not speak English.

Community Assets and Resources

Although never all-inclusive, identification of community assets and resources is essential to the community health improvement process and strategy development. We invited stakeholders to tell us about the people, places, policies and programs that help their community thrive. Community strengths relevant to identified health needs are highlighted in each of the subsequent sections, so here we present just a few of the frequently mentioned assets.

- **Partnerships, coalitions and collaborations**: Across the board, whether the focus was mental and behavioral health, suicide and injury prevention, healthy eating and active living, or access to care closer to home, existing partnerships and coalitions were identified as key assets that are essential for success in improving the health and well-being of communities. At the same time, many listening session participants believed coordination among community-based organizations could be improved. They stressed the need for increased collaboration between community-based organizations, governmental agencies, advocacy organizations, hospitals and health systems, and the private sector.
- **Faith-based institutions and committees** were recognized for their tireless efforts to address homelessness, food insecurity and other basic needs.
- **Community health centers**, particularly clinics that specialize in providing culturally sensitive and appropriate care, were respected for their outreach to and care for hard-to-reach, under-resourced and marginalized communities.
Food banks and other food-related programs, such as Fresh Bucks, were recognized as valued resources for families struggling with food insecurity, which is a key health concern.

Key Findings Summary
Our team has spent the past three years studying the epidemiological factors impacting pediatric health in our WAMI region. Likewise, we spent an equal amount of time traveling to different parts of the region, working alongside the pediatric practitioners and caregivers, seeking to understand what factors are challenging to families and highlighting all the resiliency factors that each community has within it to mitigate these harms. We analyzed countless indicators of the status of pediatric health in our region and hosted 19 listening sessions in as many communities in the WAMI region with parents or caregivers of children ages 0-21 years of age, visited 8 communities that were urban, suburban or rural, including villages to learn community health challenges therein and interviewed 172 key informants in the WAMI region. In addition, we co-hosted upwards of 15 community cafes, which are local gatherings in the Seattle/King County region to gather input and feedback from parents, caregivers and youth themselves. After all this, the path for the next three years is clear for us. We will be focusing on strategies and tactics to impact community health indicators in four major areas - primarily Mental & Behavioral Health, followed by economic security, healthy lifestyles and suicide and injury prevention. The following chapters of this CHA illustrate more as to how and why we landed on these four areas of focus.

Spotlight on Washington State
Community Social and Economic Context
The health of children, teens and young adults is influenced by a variety of environmental and social factors. Social risk factors, such as poverty, a lack of affordable housing, racial/ethnic bias and racism, create inequities in health and are all associated with poorer health outcomes for youth. In this section, we present quantitative data on several sociodemographic and environmental characteristics that are considered social determinants of health. (See Figure 1 and Figure 2 to view the various social determinants of health.)

Overview of Washington State
In 2018, about 25% of the more than 7.4 million residents in Washington state were under age 20. The age distribution of individuals in this group was approximately even, with the largest population growth since 2008 occurring among children ages 5 to 9.

Table 9: Population Change by Age Group Between 2008 and 2018, Washington State

More than half of youth ages 0 to 19 in Washington state were non-Hispanic white, and approximately one in five youth are Hispanic/Latinx (see Figure 10). Additionally, 8.7% of youth were non-Hispanic and two or more races, 7.7% were non-Hispanic Asian and 4.2% were non-Hispanic Black. Youth identifying as non-Hispanic Native Hawaiian/ Pacific Islander and American Indian/Alaska Native were among the smallest racial/ethnic groups in Washington state in 2018. The state’s census data also shows that nearly 16% of the population is foreign born, with about 19% speaking a language other than English at home. This is important to note since Washington state is experiencing unprecedented growth in language diversity. The foreign born population in our state grew by 54 percent in the years 2000 to 2014. It is estimated that 46.7 percent of Washington’s total foreign born population is limited in English proficiency (LEP) Individuals who primarily speak a language other than English are less likely to have health insurance, see a health provider regularly, or follow instructions for medical care and are more likely frequent emergency departments or other safety net options.

Figure 10: Youth (Ages 0 to 19) Population by Race/Ethnicity, Washington State, 2018

<table>
<thead>
<tr>
<th>Ages</th>
<th>2008</th>
<th>2018</th>
<th>Percent change (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-4</td>
<td>431,649</td>
<td>455,075</td>
<td>5.4%</td>
</tr>
<tr>
<td>5-9</td>
<td>429,558</td>
<td>470,073</td>
<td>9.4%</td>
</tr>
<tr>
<td>10-14</td>
<td>435,733</td>
<td>469,139</td>
<td>7.7%</td>
</tr>
<tr>
<td>15-19</td>
<td>468,209</td>
<td>459,979</td>
<td>-1.8%</td>
</tr>
<tr>
<td>All ages</td>
<td>6,608,245</td>
<td>7,427,570</td>
<td>12.4%</td>
</tr>
</tbody>
</table>

Health Inequities and Resulting Disparities

Healthy People 2020 defines “health equity” as the “attainment of the highest level of health for all people. Achieving health equity requires valuing everyone equally and will require focused and ongoing efforts to address avoidable inequalities, and historical and contemporary injustices to end health and healthcare disparities.”

Equity does not mean equal treatment since some populations may need more or different services to achieve health equity.

The Healthy People 2020 initiative defines a “health disparity” as “a particular type of health difference that is closely linked with social, economic and/or environmental disadvantage. Health disparities adversely affect groups of people who have systematically experienced greater obstacles to health based on their racial or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion.”

Health disparities are evident in Washington state based on data. Though Washington state generally fares well with respect to health indicators compared to other U.S. states, these better health outcomes are not consistent for all communities across the state. Disparities are present for health outcomes, such as higher infant mortality among the Black/African American population and health behaviors, such as lower physical activity levels among individuals with lower income. In addition, disparities extend to access to care. Although 91% of adults (ages 18 to 64) in Washington state had health insurance coverage in 2011 through 2015, this percentage was substantially lower among the Hispanic/Latinx population with approximately 60% of adults estimated to have health insurance coverage.

A root cause of racial and ethnic disparities is structural racism, often defined as the normalization and legitimization of historical, cultural, institutional and interpersonal dynamics that work to the detriment of communities of color. Unlike individual racism, structural racism encompasses larger systems that work to create and maintain dominant white culture to the detriment of people of color. Poverty and economic insecurity are underlying issues that are closely linked to embedded racial inequities. People of color are disproportionately poor as a result of oppression, historical disadvantages and discriminatory practices that have been institutionalized. This creates and/or perpetuates barriers to services, resources and opportunities, and impedes the ability to meet critical needs, including but not limited to food, housing, education and employment; hence the resulting disparity rooted in the inequity. All these factors are cross-sectional and lead to health disparities that our communities are grappling with daily.

For health inequities and resulting disparities that impact the health of our youth, one such example is within prenatal care access. Maternal and infant health are fundamental indicators of social and emotional well-being in the early years of life. Mothers that access consistent and early prenatal care reduce the risk of adverse health outcomes in childhood and beyond. Infant health problems, such as developmental delays, malnourishment, and other more severe medical conditions are a strong predictor of lower pre-school cognitive abilities. Utilization of medical services is often lower for populations of color due to various socio-economic
barriers, including: lack of health care coverage, language and cultural differences between the provider and potential users, mistrust of government systems or institutional providers, and lack of knowledge about available services and supports. The consequences of these and other embedded inequities increase the likelihood of poor infant health outcomes such as preterm birth and low birth weight, both of which show similar disparities by race/ethnicity, putting these children at risk for developmental delays and poor school readiness.

**Rural Washington**

About 10% of the population in Washington state lives in rural areas. On average, residents in rural communities face greater disparities than their urban counterparts across numerous social determinants of health. The unemployment rate in rural Washington state in 2018 was 5.9% compared to 4.4% in urban Washington state. From 2013 to 2017, an average of 11.9% of rural Washington state residents ages 25 and older did not complete high school, compared to 8.9% in urban Washington state. During that same time period, 24.2% of residents from rural communities completed college, compared to 35.6% of residents living in urban areas. Of note, there is wide variation in income levels and health status within urban areas like Seattle, so it is not always the case that urban residents fare better than rural residents.

Across the United States, many people who live in rural areas have dense social networks, shared life experiences, and a high quality of life, but they may also lack streetlights and facilities to stay physically active. This contributes to a more sedentary lifestyle than people from urban areas. They may also have less access to healthy foods. Across the United States, food insecurity – limited or uncertain access to adequate food – is often higher in rural areas than in urban areas.

The scarcity of primary care physicians in rural areas coupled with the long distances needed to travel to receive healthcare services also pose additional challenges for families living in rural communities. In 2016, urban counties in Washington state had an estimated 87.3 primary care physicians providing direct patient care per 100,000 people, while rural counties had an estimated 57.1 primary care physicians providing direct patient care per 100,000 people. There is also often a lack of adequate transportation in rural areas, which limits the accessibility of obstetric, mental health, dental health and substance abuse services.

**Figure 11: Rural and Urban Counties in Washington, 2017**

---

Poverty Among Youth

The U.S. Department of Health and Human Services creates a measure of income for individuals and families to determine their eligibility for federal programs, subsidies and benefits, called the Federal Poverty Level (FPL). This is used as a national guideline to determine if families and individuals are considered impoverished. The 2017 Federal Poverty Level (FPL) for a family of four was $24,600 (100% FPL).

Washington state had one of the lowest poverty rates among children in the country, ranking 17th among all states in 2017. In the same year, about 14% of children under the age of 18 in Washington state lived in poverty, compared to 18% in the United States. Nearly 7% of children under age 18 in Washington state lived in extreme poverty in 2017, which translates to 50% of the FPL (about $12,500 for a family of four).

An estimated 25% of children in Washington state lived in households that received public assistance in 2017, including Supplemental Security Income, cash public assistance income, or food stamps/Supplemental Nutrition Assistance Program (SNAP) benefits. The percentage of individuals living in poverty in 2017 was higher in rural Washington (15.9%) than in urban Washington (10.5%).
Growing up in poverty is one of the greatest threats to a child’s health and development. Being from a low-income household can impact the ability of parents or guardians to provide their children with a safe and reliable place to live, nutritious food to eat and quality education. Children who live in households who do not own a vehicle may have limited access to healthcare services, especially in rural settings.

Exceptionally stressful events experienced during childhood, often referred to as adverse childhood experiences (ACEs), including economic hardship, are linked to poorer health later in life, such as depression, obesity and alcoholism. Stress experienced by parents living in poverty can also negatively impact engagement and bonding with their children, which affects children’s healthy growth and development. Children who experience economic instability at home face greater difficulties concentrating at school and age-appropriate cognitive, social and emotional development may be hindered by such difficulties. Creating environments for kids to thrive requires policies that improve the economic well-being of parents and children.

**Figure 12: Percentage of Children Under 18 Whose Families Had Income Below FPL in 2017**

---

Table 13: Poverty Rates in Children by Age Group, Washington State and United States, 2017

<table>
<thead>
<tr>
<th>Age Group</th>
<th>WA (%)</th>
<th>U.S. (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total population in poverty</td>
<td>11%</td>
<td>13%</td>
</tr>
<tr>
<td>Total children under 18 in poverty</td>
<td>14%</td>
<td>18%</td>
</tr>
<tr>
<td>Children ages 0-5 in poverty</td>
<td>14%</td>
<td>20%</td>
</tr>
<tr>
<td>Children ages 6-17 in poverty</td>
<td>14%</td>
<td>18%</td>
</tr>
</tbody>
</table>

Poverty levels in Washington state have been decreasing over the past few years. Between 2008 and 2013, the percentage of children living in poverty across the state increased steadily, from about 14% to nearly 19%.53 In 2014, the rate of children living in poverty began to decrease,54 declining to 16% in 2015, and 14% in 2016 and 2017.55

---

Another indicator of poverty is student eligibility for the free or reduced-price meal program in schools. This program provides free or low-cost nutritious meals to students who might not otherwise be able to afford them. According to data from the Washington State Office of Superintendent of Public Instruction, 43.4% of public school students were enrolled in free or reduced-price meal plans in Washington state as of Oct. 31, 2018.56

Figure 15: Percentage of Children Under 18 Living in Poverty11 and Eligible for Free or Reduced-rice Meals12 in Washington State and by Selected County

Housing Affordability and Availability

When analyzing housing affordability, experts rely on the rule of thumb that renters should spend no more than 30% of their before-tax income on rent and utilities. Spending more than 30% of income on housing can make it more difficult for people to afford transportation, food, medical care and other basic needs. People may be at risk for developing chronic medical conditions if they do not seek proper medical care in a timely manner and if they do not have access to healthy foods or an ability to participate in healthy activities.

As the population has increased across Washington state, so have housing costs and the rates of homelessness. A lack of affordable housing is one of the factors influencing the rate of homelessness in communities; homelessness rates have been increasing across Washington state since 2013.

In 2017, nearly one-third of children in Washington state lived in households that spent more than 30% of their income on housing and housing-related expenses.

People who rent and people of color experienced a higher-than-average housing cost burden. Among renters in Washington state, 46% spent more than 30% of their income on housing. In 2016, about 46% of people identifying as Black/African American and 36% of people identifying as Hispanic/Latinx spent more than 30% of their income on housing, compared to about 27% of people identifying as white and 28% of people identifying as Asian.
Figure 16: Percentage of Households With Children With High Housing Cost Burden in Washington State, 2008-2017

Among children in Washington state living in low-income households (families with an income less than 200% of the federal poverty level) in 2017, nearly two-thirds (64%) had a high housing cost burden.

Figure 17: Percentage of Children in Low-income Households With High Housing Cost Burden in Washington State, 2008-2017

---


In 2017, 13% of children in Washington state lived in crowded households. A crowded household is one where there is more than one person per room.

**Youth Experiencing Homelessness**
There is no safe level of homelessness for children. Children’s HealthWatch, a research group composed of pediatricians, public health researchers and policy experts, investigates social and economic impacts on child health. For children under age 4, they found that children of mothers who experienced homelessness during pregnancy or after birth had an increased risk of being hospitalized, having fair or poor health, and experiencing developmental delays compared to children who were never homeless (either prenatally or postnatally).

Unaccompanied youth and young adults experiencing homelessness are at higher risk for everything from sexually transmitted infections (STIs) to life-threatening asthma exacerbations, yet they are some of the least likely to seek medical care. Young people who are homeless have fewer primary care visits, are more likely to present in an emergency room setting and are more likely to be admitted to the hospital. They are also less likely to have completed all of their immunizations, putting them at risk for diseases like measles, pertussis and meningitis. There are many barriers to seeing a doctor, including distrust of authority figures who have historically failed them, low priority of health concerns given competing basic needs, lack of transportation, and limited healthcare coverage.

According to some reports, as many as one-quarter of teens and young adults have traded sex for food or shelter, and youth who are homeless represent a disproportionate percentage of sex trafficking victims. Homeless youth have sex at earlier ages and with more partners than youth who do not experience homelessness. As a result, there is significantly increased risk of contracting sexually transmitted infections as well as teen pregnancy. Studies have found
high rates of hepatitis B and hepatitis C (17% and 12% respectively)\textsuperscript{77} and suggest increased risk of contracting HIV/AIDS infection among youth who are homeless.\textsuperscript{78}

Unstable housing increases risk for food insecurity, which may result in skipped meals and consumption of foods with low nutritional quality.\textsuperscript{79} Malnutrition increases risk for stunting their growth and obesity. Dental health also suffers with rates of poor dental development and dental caries (cavities) that are 10 times higher than the general population, according to the National Health Care for the Homeless Council.\textsuperscript{80}

Among homeless youth, psychiatric and mental health conditions are common.\textsuperscript{81} Compared to their high school peers, adolescents who are homeless are more likely to be depressed (rates as high as 61%). Substance abuse (drugs and alcohol) is also prevalent among homeless youth.

Some youth and young adults experience homelessness outside of the context of families, meaning no parents or guardians are present and the youth/young adults are not parents living with their children.\textsuperscript{82} Others experience family homelessness, which is distinct from episodic homelessness often experienced by unaccompanied youth or adults fleeing abuse or neglect, and from chronic homeless, which tends to be among adults with significant mental illness, substance abuse or other chronic medical conditions. Family homelessness is often transitional; families become homeless due to unaffordable housing, the burden of health care costs resulting in debt, or a financial crisis. This economic impact may be exaggerated by caregiver mental health issues, extended unemployment, domestic violence or addiction.

The Voices of Youth Count report of youth homelessness in the United States found that one in every 30 adolescents ages 13 to 17, and one in every 10 young adults ages 18 to 25 endured some form of homelessness over the course of a year, which may include things like “couch surfing” or sleeping in cars, shelters or on the streets.\textsuperscript{83} The highest rates of homelessness are among teenagers identifying as lesbian, gay, bisexual, transgender or questioning (LGBTQ).\textsuperscript{84} Particular subpopulations are at higher risk for homelessness, including LGBT youth, youth with less than a high school diploma or GED, or unmarried parenting youth.\textsuperscript{85}

Hospitals cannot ignore the impact of housing instability and homelessness on their communities. Housing instability disproportionately affects the health of many of Seattle Children’s patients. Medical professionals can play a role in improving the health of children and youth experiencing homelessness. Specifically, the American Academy of Pediatrics makes the following recommendations to pediatricians:\textsuperscript{86}

- Facilitate the enrollment of eligible children in Medicaid
- Become familiar with the management of chronic diseases in homeless populations
- Optimize health visits to provide comprehensive, preventive care
- Connect families to community resources
- Identify the underlying causes of homelessness
- Assist in the development of shelter-based care

A 2017 article urges hospitals to develop new types of partnerships within the community and to direct a percentage of their investment portfolios toward affordable housing initiatives.\textsuperscript{87} Furthermore, hospital systems could coordinate wraparound services or partner with the existing
Housing Choice Voucher program. Nationally, there are hospital systems that are using housing vouchers to reduce health care costs and endowment funds to build affordable housing units and fund community improvement initiatives.

**Homelessness in Washington State**

In Washington state, the Homeless Housing and Assistance Act requires that each county in the state conduct an annual point-in-time count that shows the number of sheltered and unsheltered homeless people living in the state on that particular day. This is conducted in accordance with the requirements of the U.S. Department of Housing and Urban Development (HUD). Of note, there are limitations to point-in-time counts due to changes in methods, self-reported data and the cross-sectional or “snapshot” nature of the measure rather than providing a count of people who experienced homelessness at any time during the year. Interpretations of point-in-time counts should carefully consider these limitations. In addition, publicly available data from the Washington state point-in-time count does not include county-specific counts of youth experiencing homelessness.

Washington state had the sixth highest rate of homelessness among families with children in the nation in 2017. An estimated 11.2 out of every 10,000 families were homeless on any given night in Washington state compared to about 7.4 out of every 10,000 families who were homeless in the United States in 2017. According to the 2018 Washington state point-in-time total, 3,777 children were estimated to be experiencing homelessness, of whom 558 were unsheltered.

**Figure 18: Number of Families Homeless for Every 10,000 Families in General Population, 2017**

---

In spite of the high rates of homelessness among families in some states, this rate nationwide decreased by about 5% from 2016 to 2017. In Washington state, the number of people in families experiencing homelessness has decreased by about 42% from 2007 to 2018. From 2017 to 2018, the number of people in families experiencing homelessness in Washington state decreased by about 7%.

**Figure 19: Number of People Experiencing Homelessness in Washington State, 2007 - 2018**

---

However, the number of homeless students in Washington state increased by nearly 20,000 (a 94.2% increase) over the last decade, and is particularly high among children of color. Of note, some of this increase may reflect improved data quality and reporting. During the 2017 to 2018 school year, there were 40,365 homeless students in Washington state – about 3.4% of the overall student population. Among those, about 61% were youth of color.

Figure 20: Number of Homeless Children in Public Schools, Washington State, 2008 to 2018

---

Students who experience homelessness are more likely to drop out of school, be suspended or expelled from school, and have higher rates of absenteeism and truancy compared to their peers who have stable housing. During the 2017 to 2018 school year in Washington state, the graduation rate of students who were homeless was 55.5% and the dropout rate was 28.3%. This is compared to an 80.9% statewide graduation rate and an 11.2% dropout rate for all students in the state. The same report shows that 9.8% of students who were homeless during the 2017 to 2018 school year in Washington state were suspended or expelled, compared to 3.8% of the overall student population.

Students who were homeless during that same school year in Washington state were also substantially more likely to be absent from school. In fact, 36.2% of students who were homeless were chronically absent and 25.6% were truant. Comparatively, 15.4% of all students were chronically absent and 7.7% were truant. Chronic absenteeism means a student had 18 or more full-day absences (excused or unexcused). Truancy means students had either five or more full-day unexcused absences in any continuous 30-calendar-day period or students had 10 or more full-day unexcused absences during the school year.

---

Figure 21: Percentage of Student Population Who Are Homeless by Race and Ethnicity, Washington State, 2017-18 School Year

Students who experience homelessness are more likely to drop out of school, be suspended or expelled from school, and have higher rates of absenteeism and truancy compared to their peers who have stable housing. During the 2017 to 2018 school year in Washington state, the graduation rate of students who were homeless was 55.5% and the dropout rate was 28.3%. This is compared to an 80.9% statewide graduation rate and an 11.2% dropout rate for all students in the state. The same report shows that 9.8% of students who were homeless during the 2017 to 2018 school year in Washington state were suspended or expelled, compared to 3.8% of the overall student population.

Students who were homeless during that same school year in Washington state were also substantially more likely to be absent from school. In fact, 36.2% of students who were homeless were chronically absent and 25.6% were truant. Comparatively, 15.4% of all students were chronically absent and 7.7% were truant. Chronic absenteeism means a student had 18 or more full-day absences (excused or unexcused). Truancy means students had either five or more full-day unexcused absences in any continuous 30-calendar-day period or students had 10 or more full-day unexcused absences during the school year.

---

Schools are often the most stable, supportive and safest place for students experiencing homelessness. The Washington State Legislature passed the Homeless Student Stability and Opportunity Gap Act in 2016 to amend laws in an effort to improve the educational outcomes for students who are homeless by increasing housing stability, in-school supports and identification services.112

**Employment and Income**

In June 2019, the seasonally adjusted unemployment rate in Washington state was 4.6%.113 The rate of unemployment in June 2018 was very similar at 4.4%.114

**Figure 22: Unemployment Rates, June 2015-June 2019**19

![Unemployment Rates, June 2015-June 2019](image)

**Figure 23: Unemployment Rates by County in Washington State, June 2019**20

---


In June 2019, Ferry County had the highest not seasonally adjusted unemployment rate (10.5%), while King County had the lowest not seasonally adjusted unemployment rate (2.9%).

According to data from 2016, 3% in children in Washington state (46,000) lived in low-income households with no working adults.

Figure 24: Percentage of Washington State Children Living in Low-Income Households Without a Working Adult, 2008-2016

---

King and Snohomish counties reported having the highest median household income, with a 2018 projected income of $89,881 and $85,758, respectively.\textsuperscript{117} Pend Oreille and Grays Harbor counties had the lowest incomes in the state, with a 2018 projected median household income of $42,161 and $43,540, respectively.\textsuperscript{118} The projected median household income in Washington state in 2018 was $73,294\textsuperscript{119} and the U.S. median household income in 2017 was $60,336.\textsuperscript{120}

**Early Childhood Education**

Early education is important for the social, physical and cognitive growth of young children in their first three to five years of life. High-quality early education, such as preschool or pre-kindergarten for children ages 3 and 4, can help with school preparedness. The Head Start program began in the 1990s and promotes school readiness for children under age 5 who come from low-income families.\textsuperscript{121} Even with these programs available, there are still many young children who do not access early education. Only 40% of 3-year-old children were enrolled in a preprimary program in 2017.\textsuperscript{122}

In Washington state, Head Start served 13,436 children in 2018.\textsuperscript{123} On average from 2015 to 2017, 57% of children ages 3 and 4 were not enrolled in school in Washington state.\textsuperscript{124} According to 2018 to 2019 estimates from the Washington State Department of Children, Youth, and Families, 41,143 children were eligible for the Early Childhood Education and Assistance Program (ECEAP),\textsuperscript{125} but only 34% were served by ECEAP and another 22% were served by Head Start.\textsuperscript{126}
Table 25: Children Ages 3 and 4 Not in School in Washington State, 2012-2017

<table>
<thead>
<tr>
<th>Year</th>
<th>Number of children (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012-2014</td>
<td>112,000 (60%)</td>
</tr>
<tr>
<td>2013-2015</td>
<td>110,000 (60%)</td>
</tr>
<tr>
<td>2014-2016</td>
<td>107,000 (58%)</td>
</tr>
<tr>
<td>2015-2017</td>
<td>107,000 (57%)</td>
</tr>
</tbody>
</table>

According to a report from December 2018, Seattle Public Schools, located in King County, had 1,537 slots for Head Start and ECEAP programming and 1,450 eligible children. Spokane Public Schools, located in Spokane County, had 993 slots and 1,687 eligible children. The Tacoma Public Schools, located in Pierce County, had 1,018 slots and 1,499 eligible children.

**Educational Attainment**

Education is a key indicator of future income, access to resources and overall health. Evidence shows that individuals who graduate high school usually have higher earnings than individuals who do not graduate high school. Communities with more educated citizens also tend to benefit from better health outcomes and a stronger economy than communities with residents with lower rates of higher education.

High school graduation (or equivalency) is a necessary step in the transition to college. Washington state had one of the lowest high school graduation rates in the nation during the 2016 to 2017 school year, with an on-time high school graduation rate of 79%, compared to the national rate of 85%. Washington state data indicate that 80.9% of the class of 2018 graduated high school in four years. Additionally, Washington state ranked 46th in the number of high school graduates attending college directly from high school, with 50% of high school graduates (from either public or private high schools) heading to college directly from high school.

Table 26: Washington State Class of 2018 Graduation Demographics

---


Washington state graduation rates for the class of 2018 were lower for students who were homeless (55.5%), students who were English language learners (64.1%), students with disabilities (61.7%) and low-income students (72.1%). Since 2005, graduation rates have increased across all ethnicities in Washington state, yet students identifying as American Indian/Alaskan Native, Pacific Islander, Black/African American and Hispanic/Latinx still have lower graduation rates than students identifying as Asian and white.

Foster Care
Foster placement services are provided when children need short-term or temporary protection because they are abused, neglected or involved in family conflict. The Washington State Department of Social and Health Services reports that 9,528 youth ages 0 to 17 were served by Foster Care Placement Services in 2017. About 3% (47,000 children) were being raised by their grandparents in 2017. In 2018, the state had 5,060 licensed foster homes and 1,341 adoptions were finalized.

Lesbian, Gay, Bisexual, Transgender and Questioning (LGBTQ)Youth

Methodology and Terminology
The pediatric lesbian, gay, bisexual, transgender and questioning (LGBTQ) community has a unique perspective and set of challenges in daily life and when accessing healthcare services. Just as language constantly evolves, the words we use to describe this community and other facets of identity are also changing.
In this chapter, terminology will be based on resources from the American Psychological Association, NLGJA: The Association of LGBTQ Journalists, the National Center for Transgender Equality and our own Seattle Children’s Gender Clinic. We will use the acronym LGBTQ. Note that the “Q” can stand for “questioning,” as in still exploring one’s sexuality, or it can stand for “queer,” or sometimes both. The term “queer” was once considered a demeaning slur for being gay, but is being reclaimed by some as a self-affirming umbrella term, especially among those who consider other labels restrictive. Since some still believe it is a homophobic slur, we feel it is always best to ask or to wait for the person who you are speaking with to use it. For the purposes of this chapter, LGBTQ means “lesbian, gay, bisexual, transgender and questioning.”

This chapter pulls relevant data from the King County Community Health Needs Assessment 2018/2019 LGBTQ Community Spotlight, which was written in collaboration with the King County Hospitals for a Healthier Community, of which Seattle Children's is a member. Additional information and qualitative analyses are included in the full report.

In this section of our report, we examine the health inequities affecting the pediatric LGBTQ population primarily in King County, Washington, in particular for teens and young adults. We also provide information about community health needs. We present findings from a series of eight listening sessions with 72 LGBTQ youth (ages 13 to 17) and young adults (ages 18 to 24) living in King County, and from seven key informant interviews with advocates who work with LGBTQ youth.

To complement these qualitative findings, we present relevant survey data from:
- The Behavioral Risk Factor Surveillance System (BRFSS) for adults;
- The Healthy Youth Survey (HYS) for youth in Washington state and King County; and
- The Count Us In survey of King County’s sheltered and unsheltered homeless population (youth and adults).

The Count Us In survey collected data on LGBTQ populations, whereas the BRFSS and HYS surveys did not offer response options beyond heterosexual, lesbian, gay or bisexual; hence, “LGB” will be used when referencing responses from lesbian, gay or bisexual respondents.

Throughout the report, we use terms and acronyms that are used in LGBTQ communities, some of which are defined in the endnotes. A more comprehensive list of terms and definitions can be found in the Glossary of LGBT Terms for Health Care Teams published by the National LGBT Health Education Center (a program of the Fenway Institute).

What We Know

National data show LGBTQ individuals are more likely to experience mood disorders, to be victims of hate crimes and to have difficulties developing relationships with healthcare providers than people who identify as heterosexual.

LGBTQ youth also often deal with institutions that do not know how to meet their needs. For example, electronic health records can perpetuate the use of incorrect names and pronouns through the use of fixed categories. Individuals identifying as LGBTQ in King County reported
facing provider stigma and often confronted barriers in accessing healthcare services, which can lead to worse health outcomes when care is inadequate or delayed. While we realize that some of our pediatric community identifies as LGBTQ, we do not yet have data on our LGBTQ patients that is as complete as we would like at Seattle Children’s. One of the most important things we can do to support our patients is to consistently and respectfully use a patient’s preferred/affirmed name and pronoun.

In July 2018, Seattle Children’s upgraded its electronic health record system and registration records to ask every patient their preferred name and/or pronouns. We also now ask patients about their legal sex and birth sex, and our inpatient armbands and labels now display our patient’s preferred name alongside their legal name. In May 2017, we adopted new guidance for all our providers about communicating with transgender patients and their families, which included caregiver tips for transgender and family interactions, as well as policies and procedures originally recommended for hospitals by the Human Rights Campaign. We plan to include more focused analyses and information in our 2023 Community Health Assessment on the LGBTQ population.

**Health Risk Profile**

In 2015, nearly 28,000 transgender/gender nonconforming people across the United States participated in the largest survey of transgender people.

Key findings included:

- Transgender youth are one of the most vulnerable populations.
- One-third of survey respondents had a negative experience with a healthcare provider because of their gender identity.
- The rate of serious psychological distress was eight times higher among respondents than in the general U.S. population (49% compared to 5%).
- Suicide attempts among respondents was nine times the national rate (40% compared to 4.6%).
- Survey respondents ages 18 to 25 had the highest rate of suicide attempts in the previous year.

While there may be higher rates of negative health outcomes in LGBTQ populations, qualitative data from key informants indicates that these “… are not inherent to their sexual orientation or gender identity, but due to the systemic barriers and oppressions that they face because of their identity.” When asked about barriers to health and wellness, youth identified similar systemic and interpersonal barriers – not problems stemming from their sexual orientation or gender.

Despite inclusive and progressive laws and policies, people identifying as LGBTQ in Washington state and King County face challenges. In Seattle, hate crimes targeting the LGBTQ community have tripled since 2014. LGBTQ adults still encounter barriers to care and health insurance coverage, often because of cost. About 28% of respondents to the 2015 U.S. Transgender Survey from Washington state reported living below the poverty line, compared to 13.3% of Washington state residents who do not identify as transgender.
Research also indicates that individuals who identify as belonging to sexual minority groups experience higher rates of adverse childhood experiences (ACEs).\textsuperscript{149} For more information on ACEs and trauma-informed care, please see the Adverse Childhood Experiences and Trauma-Informed Care chapter in addition.

In Washington state, 29\% of transgender residents reported having problems with health insurance coverage because of their status as transgender in 2015.\textsuperscript{150} Nearly two out of five (38\%) of transgender residents reported at least one negative experience related to gender identity with their healthcare provider.\textsuperscript{151}

In 2018, 10\% of eighth graders, 12\% of 10th graders and 13\% of 12th graders in Washington state identified as LGB, and between 3\% to 5\% of eighth, 10th and 12th graders reported being unsure of their sexual orientation.\textsuperscript{152}

In King County, eighth, 10th, and 12th graders identifying as LGB reported significantly higher rates of feeling unsafe and experiencing bullying. One in five (21\%) youth identifying as LGB reported feeling unsafe at school, compared to 12\% of youth who identified as heterosexual.\textsuperscript{153} Youth identifying as LGB were nearly three times as likely to feel unsafe or threatened while on dates than youth identifying as heterosexual (17\% compared to 6\%) in 2016.\textsuperscript{154} In King County, 30\% of eighth, 10th and 12th grade students identifying as LGB reported that they were bullied at school in 2016 – nearly twice the rate as students identifying as heterosexual.\textsuperscript{155}

Figure 27: King County Students Who Reported Feeling Unsafe on Dates and Students Who Were Bullied at School by Sexual Orientation and Race/Ethnicity\textsuperscript{24}
Behavioral risk factors are also more prevalent in the LGB population. Youth in eighth, 10th and 12th grades who identified as LGB were more than three times as likely to smoke cigarettes, 1.7 times more likely to binge drink and twice as likely to use marijuana in the past month than youth identifying as heterosexual in King County in 2016. Binge drinking means having five or more alcoholic drinks in a row in the past two weeks. Rates of obesity among youth identifying as LGB were almost double the rate of youth identifying as heterosexual (14% compared to 8%).

Figure 28: King County Student Rates of Binge Drinking and Cigarette Smoking by Sexual Orientation and Race/Ethnicity

---

25
In King County, more than half (57%) of students who identified as LGB reported having depressive feelings, compared to 25% of students identifying as heterosexual in 2016. \(^{158}\) Additionally, they were nearly three times more likely to experience a mental health condition, such as depression or generalized anxiety disorder, than students identifying as heterosexual. Since many of these risk factors can lead to poorer educational outcomes, an increased risk of injury, and can heighten their risk of developing chronic diseases later in life, it is important to monitor and work toward eliminating disparities in the LGBTQ population.

**Figure 29: King County Student Rates of Depression by Sexual Orientation and Race/Ethnicity**\(^ {26}\)
**Intersecting Identities**

Many of the quantitative indicators show a strong relationship between individuals identifying as LGB and exposure to potentially traumatizing experiences. Qualitative data emphasized that youth with multiple marginalized identities are experiencing the added effects of intersecting oppressions on many of the health disparities experienced by LGBTQ youth and young adults.

Inequities associated with race, place, income, language and homelessness visible in the general population are magnified in the LGBTQ population. For example, LBG youth were more likely to report feeling unsafe at school than their heterosexual counterparts. Black/African American youth or those who identified their race as “other” who also identified as LGB reported even lower rates of feeling safe at school compared to other racial/ethnic groups and heterosexual youth. LGB youth identifying as Asian, Black/African American, Hispanic and “other,” and those in the South Region of King County were less likely to have an adult to talk to than youth identifying as heterosexual or LGB youth from other racial/ethnic groups. Among subgroups, South Region LGB youth were more likely to be at risk for obesity, Black/African American and Hispanic LGB youth were more likely to binge drink, and Black/African American LGB youth were more likely to use marijuana.

Estimates from the Count Us In survey on homelessness in King County indicated that 33% of unaccompanied youth and young adults who were homeless identified as LGBTQ in 2018 – double the rate of respondents who were homeless who identified as heterosexual. Additionally, regarding their first experience of homelessness, 71% of LGBTQ respondents who were homeless during the survey reported experiencing homelessness during childhood or young
adulthood, compared to 42% among heterosexual respondents who were homeless during the survey.\textsuperscript{162}

**Community Input**
Seattle Children’s, the King County Hospitals for a Healthier Community, Public Health – Seattle & King County, and other community partners conducted listening sessions with members of the LGBTQ community and key stakeholders to learn about their concerns. Key informants and youth participants in King County who identified as LGBTQ were asked to reflect on access to healthcare and experiences with healthcare providers. Participants described a set of interpersonal barriers, structural barriers and societal stressors that make it difficult to get the supportive healthcare they need. They described the lack of control that LGBTQ youth feel over their own health. Comments were usually set in the context of relationships with family, other supportive adults and healthcare providers.

**Control Over Personal Health**
LGBTQ youth, particularly those who have not disclosed their sexual orientation to their friends and family, may feel an internal stigma as well as stigma from their community and healthcare providers. They want to be involved in making decisions about their own care, but often feel excluded because of their age. Parents and providers discuss their health without asking for their input. However, this may be because of their age rather than their identification as LGBTQ.

LGBTQ youth want to know how to navigate the healthcare system and want clear information about their rights – particularly those regarding privacy and confidentiality – and what services they can access without parental consent. These services may include contraception, therapy and gender-affirming care.

Youth had difficulty feeling heard and understood by caregivers and felt that providers created obstacles in accessing contraception, puberty blockers, and other types of mental and sexual health services. Among transgender youth, unmet medical needs (such as hormone therapy or puberty blockers, which are available with parental consent) may have unintended consequences, including untreated gender dysphoria and mental health concerns that are associated with increased suicide attempts, sexual violence and negative school outcomes.

**Support Systems**
LGBTQ youth who did not have a support system of friends and accepting adults had much more difficulty getting their medical needs met. A lack of a support system affected self-esteem, mental health and the ability to navigate the healthcare system. Pediatric care providers for youth identifying as LGBTQ should note that family rejection may have serious consequences for physical and mental health.\textsuperscript{163} Research indicates that parental rejection of LGBTQ individuals is associated with health risk behaviors and poor health outcomes among, such as higher rates of suicide attempts, depression, illegal drug use and unprotected sex.\textsuperscript{164} Youth expressed a desire for more opportunities to speak with providers privately and for their providers to initiate these discussions.\textsuperscript{165} Key informants mentioned offering more support and acceptance to prevent negative outcomes, such as alcoholism, drug abuse and destructive sexual activity.
For more information about LGBTQ youth and suicidal ideation, please visit the Mental and Behavioral Health section.

**Visibility and Acknowledgement**

There are social cues that create a safe and supportive environment for LGBTQ youth. These include use of inclusive language and acknowledgement that patients may be gender nonconforming, non-binary or transgender. Inclusive language “acknowledges diversity, conveys respect to all people, is sensitive to differences and promotes equal opportunities.”\(^{166}\) When presenting a generalization, for example, use plural noun forms like “people,” “individuals” or “students,” or the plural pronoun “they” rather than a masculine pronoun “he.” Instead of terms like “mankind” and “Congressman,” use gender-neutral terms like “humanity” or “Member of Congress.”\(^{167}\)

**Relationships With Mental and Physical Health Providers**

Stakeholders wanted to develop safe and trusting relationships with providers before they felt comfortable talking about physical, mental and emotional health needs, in addition to sexual health. Previous negative experiences discouraged youth from opening up to providers and even discouraged them from seeking healthcare services in the future. Many LGBTQ youth mentioned that they feared that providers would disclose their status to their families or would tell them that what they were feeling or doing was wrong. Another barrier was the limited time during visits. Short visits created difficulty in establishing a patient-provider relationship.

Being able to identify with an LGBTQ provider gave LGBTQ youth a sense of ease and acceptance. Some youth imagine that having a LGBTQ provider would add to a feeling of understanding and comradery. Additionally, youth wouldn’t be faced with the task of educating their providers on how to care for them. When youth felt comfortable and not “bothered” during their first encounter with a provider, they were more likely to engage in an open and trusting dialog.

**Navigating Healthcare**

Patients who have health insurance were prevented from accessing care if they didn’t have up-to-date legal documents with their name and gender that matched the information from their health insurance.\(^{168}\) This is particularly relevant for youth who are transitioning. Electronic health records often have limited options for gender and only use a patient’s legal name.\(^{169}\) This may cause providers to make mistakes when addressing transgender patients by appropriate pronouns and names, possibly causing a sense of harm.

Additionally, conversations about sexual health assume relationships are heterosexual and this assumption prevents youth from feeling comfortable speaking openly about sexual health. This creates additional stigma around relationships.

Informants also mentioned that a lack of relevant and accurate health information is provided to youth in school. School-based sex education courses, for example, do not prepare them for the types of relationships they are actually having.
Key informants voiced a need for more training for medical and mental health providers, particularly in pediatrics, family practice and primary care. One physician noted a need for training about ways to positively discuss sexuality. Other informants discussed a need for anti-stigma education for providers.

**Transgender Individuals Face Unique Barriers to Healthcare**

It is important to call out the issues LGBTQ adults experience in order to provide support and services to dismantle the systemic conditions that are contributing to the physical and mental health inequities that exist in the LGBTQ population. Despite improvements in policies for coverage of transgender health needs, 29% of transgender people in Washington state reported problems with their health insurance coverage due to their transgender status in 2015. More than one-third (38%) of transgender people in Washington state who saw a healthcare provider in the previous year reported at least one negative experience related to their gender identity.

A lack of providers with training, knowledge and experience relevant to caring for transgender patients creates additional challenges. While locally maintained databases of trans-competent providers exist in the Seattle area, many, if not most, of the practices are full. There are also lower numbers of trans-competent providers in the more rural areas of the state. Many insurers require letters from mental health providers before transition-related medical care can be accessed. If someone does not have coverage for behavioral health services, they cannot access these additional health services. These challenges may contribute to the unmet healthcare needs among LGBTQ populations and the persistent disparities in health outcomes.

**Stressors and Safety Concerns**

As stated previously, disparities that persist in the general population by race/ethnicity, income, language and rates of homelessness are magnified in the LGBTQ youth community. LGBTQ youth experiencing homelessness is considered a severely burdened and vulnerable population. The rate of homelessness among LGBTQ youth are similar in urban and rural areas however.

Compared to youth identifying as heterosexual, youth identifying as LGB in King County are more likely to be bullied, physically abused by adults, feel unsafe or threatened by someone they were dating, and feel a lack of support from adults. They are also more likely to carry a weapon to school, which may reflect feelings of vulnerability. They may believe that carrying a weapon to school will help protect them from aggressors and bullies. People identifying as LGBTQ in King County were disproportionately represented among the homeless community; more than half of the homeless LGBTQ people who were surveyed reported a history of domestic violence or partner abuse. Seven out of 10 respondents to the “Count Us In” survey experienced homelessness before age 25.

**Assets and Resources**

- **Seattle Children’s Hospital Gender Clinic**: A multidisciplinary clinic that cares for transgender and gender nonconforming youth under age 21.
- **Gender Odyssey**: An international conference concentrating on the needs of transgender and gender diverse children, their families and communities, and the professionals who
serve them. The conference discusses social support, emotional health and medical transitions.

- **Family Acceptance Project:** Using research-based and culturally grounded approaches, the Family Acceptance project works to prevent health and mental health risks for LGBTQ children and youth in the context of their families, cultures and faith communities.
- **Lambert House:** A safe space in Seattle for LGBTQ youth age 22 and under. They offer support groups, meals, a computer lab and planned activities.
- **NW Network:** This network in Seattle provides advocacy and a safe space for LGBTQ youth who have experienced victimization or harm, or those who are at risk. They offer classes on healthy relationships and facilitate LGBTQ groups in schools and community settings.
- **Planned Parenthood:** A provider of comprehensive sexual and reproductive healthcare services regardless of insurance coverage. The organization also provides health education. Some locations in Washington state offer hormone services to transgender patients.
- **2017 King County Trans Resource & Referral Guide:** In addition to cataloging resources for members of the transgender and gender-diverse community, this guide also includes numerous resources for providers seeking additional training and support on working with these communities.
- **Ingersoll Gender Center:** An organization by and for transgender and gender nonconforming people that offers support groups to network, consult and share resources.

**Opportunities**

Youth participants and key informants identified a complex set of systemic and interpersonal barriers and oppressions that affect the health outcomes of LGBTQ populations and contribute to inequities that impact these communities in King County.

Quantitative analyses supported what we heard in listening sessions and interviews, and can be used to raise awareness among the parents, teachers, healthcare providers and other trusted adults whose support is important to LGBTQ youth as they navigate this vulnerable period of development. Additional data collection is needed across different systems and services to be inclusive of the LGBTQ population.

Based on its policies and anti-discrimination laws, Washington state is one of the top-ranked states for LGBTQ equality. Sexual orientation and gender expression or identity are protected classes under state anti-discrimination laws. Washington was an early state to pass marriage equality legislation and prohibits discrimination or harassment based on gender identity and sexual orientation in schools, housing and employment. The Washington Law Against Discrimination (WLAD) protects LGBTQ individuals from violence and bullying in schools, and from discrimination in public accommodations, housing, employment, credit transactions and insurance transactions. In terms of healthcare, private health insurers in Washington state are legally prohibited from denying coverage to transgender policyholders for services provided to policyholders who identified with their sex assigned at birth, and Washington Apple Health covers gender-related care in many circumstances. During the 2018 legislative session, the
Washington State Legislature passed a bill banning conversion therapy for minors (clinical practices that attempt to change someone’s sexual orientation or gender identity).\textsuperscript{183}

Societal bigotry toward any sociodemographic category has compounding negative effects when an individual is subject to multiple interlocking prejudices based on their identity. These challenges, together, create a dense web of barriers where individuals must selectively disclose parts of their identity based on their interaction with healthcare providers. Given the information learned, there are opportunities for education and improvement within the healthcare sector.

One reason it is important to call out some of the large disparities we are seeing in the LGBTQ population is because patterns established during the early years – as teens and young adults – can continue later in life, potentially leading to earlier onset of serious illnesses, both physical and mental. Some of the health-related behaviors more common among LGB youth and young adults are also potentially addictive and can be difficult to change in adulthood. They also place youth at greater risk for injury and illness. Excessive alcohol consumption, for example, increases the risk of unintentional injuries, violence, risky sexual behaviors and the development of chronic diseases.\textsuperscript{184 185} In addition to being addictive, marijuana use can affect brain development – from the prenatal period through early adulthood (about age 25).\textsuperscript{186 187} Similar disparities by sexual orientation reported for youth were mirrored in adult data for binge drinking, cigarette smoking, and marijuana use, as well as mental health indicators.\textsuperscript{188} Mental distress and substance use disorders often co-occur in an unhealthy symbiosis.\textsuperscript{189}

However, some indicators, such as obesity, inadequate physical activity and a lack of social support, showed significant differences between LGB and heterosexual youth, but no corresponding differences among adults.\textsuperscript{190} It is unknown whether some of these observed disparities by sexual orientation narrow in adulthood because King County LGB youth achieve better health as they get older, or if rates of heterosexual adults becoming obese, sedentary and socially isolated are increasing with age.

For some adult indicators – mental distress, binge drinking and marijuana use – some of the highest rates were seen in LGB adults younger than 25.\textsuperscript{191} Our knowledge is far from complete, but evidence shows that improving the experience of LGB youth by better integrating physical and mental healthcare services, as well as creating better support systems and educating parents, teachers and healthcare providers, may reduce risky behaviors and improve educational and health outcomes.\textsuperscript{192 193}

\textit{Life Expectancy and Leading Causes of Death and Hospitalization}

Local, state and federal public health agencies often use life expectancy rates and leading causes of death and hospitalization as broad foundational health measures to monitor progress in promoting well-being, preventing disease and disability, and reducing health disparities. Longer life expectancy rates indicate better health.

\textit{Life Expectancy}
Average life expectancy refers to the number of years a newborn can expect to live. In Washington state, the average life expectancy was about 80 years in 2015. The rate varies by county and by race/ethnicity. The average life expectancy of people who identified as Asian in Washington state at 85 years is about 12 years longer than people identifying as American Indian/Alaska Native and Native Hawaiian/Pacific Islander at 73 years. Across Washington state’s counties, the range of life expectancy is 76 to 86 years.

**Leading Causes of Death**

Across the United States, injuries were the leading causes of death among youth ages 1 to 19 years of age in 2016. Car crashes and firearm uses were the leading causes of those injuries, accounting for 20% and 15% of deaths, respectively. The findings indicated that the United States had higher rates of death due to car crashes and firearms among youth than many other developed countries.

In 2017, accidents were among the top three leading causes of death in Washington state for youth ages 1 to 24. For youth ages 10 to 24, intentional self-harm was among the top three leading causes of death.

**Figure 30: Leading Causes of Death in Washington State by Age, 2017 (Rate Per 100,000)**

<table>
<thead>
<tr>
<th>Age Group (Years)</th>
<th>Rank 1 (Rate)</th>
<th>Rank 2 (Rate)</th>
<th>Rank 3 (Rate)</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; 1</td>
<td>Certain conditions originating in the perinatal period (166.5)</td>
<td>Congenital malformations, deformations and chromosomal abnormalities (81.0)</td>
<td>Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified (63.3)</td>
</tr>
<tr>
<td>1 – 4</td>
<td>Accidents (5.2)</td>
<td>Malignant neoplasms (Suppressed)</td>
<td>Signs, symptoms and abnormal clinical and laboratory findings, not elsewhere classified (Suppressed)</td>
</tr>
<tr>
<td>5 – 9</td>
<td>Accidents (Suppressed)</td>
<td>Assault (homicide) (Suppressed)</td>
<td>Malignant neoplasms (Suppressed)</td>
</tr>
<tr>
<td>10 – 14</td>
<td>Accidents (Suppressed)</td>
<td>Intentional self-harm (suicide) (Suppressed)</td>
<td>Malignant neoplasms (Suppressed)</td>
</tr>
<tr>
<td>15 – 17</td>
<td>Intentional self-harm (suicide) (15.0)</td>
<td>Accidents (9.5)</td>
<td>Assault (homicide) (5.1)</td>
</tr>
</tbody>
</table>

---

### Leading Causes of Hospitalization

In 2017, respiratory disease was the main reason for pediatric hospitalizations for children ages 1 to 9. Among youth ages 10 to 17, the most frequent reason for hospitalization was mental illness. For individuals ages 18 to 24, hospitalizations related to pregnancy and childbirth were the most common.

Injury and poisoning are two of the top causes of hospitalization across all age ranges – from infants to age 24. The number of mental illness-related hospitalizations increases as children and young adults get older. Mental illness is the leading cause of hospitalization for individuals ages 10 to 17 and the second leading cause of hospitalization for individuals ages 15 to 24.202

---

#### Figure 31: Leading Causes of Hospitalization (Fatal and Non-fatal) in Washington State by Age, 2017 (Rate Per 100,000)28

<table>
<thead>
<tr>
<th>Age Group (Years)</th>
<th>Rank 1 (Rate)</th>
<th>Rank 2 (Rate)</th>
<th>Rank 3 (Rate)</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; 1</td>
<td>Certain conditions originating in the perinatal period (3,041.9)</td>
<td>Diseases of the respiratory system (1,505.4)</td>
<td>Congenital anomalies (874.8)</td>
</tr>
<tr>
<td>1 – 4</td>
<td>Diseases of the respiratory system (474.1)</td>
<td>Injury and poisoning (135.7)</td>
<td>Diseases of the digestive system (112.1)</td>
</tr>
<tr>
<td>5 – 9</td>
<td>Diseases of the respiratory system (143.0)</td>
<td>Diseases of the digestive system (99.2)</td>
<td>Injury and poisoning (85.9)</td>
</tr>
<tr>
<td>10 – 14</td>
<td>Mental illness (298.4)</td>
<td>Diseases of the digestive system (134.1)</td>
<td>Injury and poisoning (101.5)</td>
</tr>
<tr>
<td>15 – 17</td>
<td>Mental illness (746.3)</td>
<td>Complications of pregnancy; childbirth; and the puerperium (294.9)</td>
<td>Injury and poisoning (194.4)</td>
</tr>
</tbody>
</table>

---

Complications of pregnancy; childbirth; and the puerperium
Mental illness
Injury and poisoning

18 – 19

1,359.6
(615.9)
(245.4)

20 - 24

2,907.0
(679.3)
(261.5)

Note: For children < 1 year of age, hospitalizations due to live birth were excluded from this analysis, as most infants in Washington state are born in hospitals.

Overview of Children and Youth with Special Healthcare Needs/Chronic Conditions

Children with special healthcare needs are infants, children and youth up to age 18 years who are defined as having or are at risk for chronic physical, developmental, behavioral or emotional conditions. They require health and related services of a type or amount beyond what is generally needed by the rest of the pediatric population. Chronic conditions, like asthma, diabetes, cancer, and heart disease, are among the leading causes of death, in King County, Washington, and across the United States. They are generally characterized by multiple risk factors, a long period of development, prolonged course of illness and increased incidence with age. We use two phrases interchangeably to describe children with complex chronic conditions: children and youth with chronic conditions and children with special healthcare needs (CSHCN).

In the United States and Washington state, about 19% of children have special healthcare needs. In Washington state, 27.6% of these children have health conditions that greatly affect their daily activities, and 6.3% experienced a period of time without health insurance at some point during the past year. Among CSHCN families in Washington state, 25.5% pay $1,000 or more in medical expenses per year, and 24.5% report one or more unmet needs for specific healthcare services. Additionally, 9.4% of caregivers spend 11 or more hours per week providing and/or coordinating healthcare services for their child.

Care Coordination

Care coordination, also known as care or case management, “is the set of activities which occurs in the space between visits, providers, and hospital stays.” It has been identified as a key issue and high priority for Medicaid and the pediatric and adolescent population. Care coordination within healthcare systems involves deliberately organizing patient care activities and sharing information among all participants concerned with a patient's care to achieve safer and more effective care.

For CSHCN and their families, care coordination can be critical for linking them to necessary medical and non-medical services, and for providing logistical assistance and emotional support. These children, their families and their providers face numerous challenges including, coverage of specialty items or services, access to pediatric specialists, and navigating the various health and non-health system. As a result, CSHCN may receive fragmented or duplicative services and...
typically have many more unmet medical needs than other children.\textsuperscript{212} Research has demonstrated that care coordination decreases unmet specialty care needs among CSHCN and that the impact of care coordination is significant regardless of household income.\textsuperscript{213}

For parents of CSHCN, it is often overwhelming to manage their children’s entire universe of care, from traveling to appointments with multiple providers, to administering treatments and medicine, to managing educational needs and making sense of insurance coverage.

This is even more challenging among non-English speaking families. Therefore, care coordination is essential to ensuring children and families get the right care, at the right time, in the right setting, which is the basis for achieving the Triple Aim.\textsuperscript{214} At its best, care coordination should be a covered service that addresses the interrelated medical, social, developmental, behavioral, educational and financial needs of children and their families.

There remains confusion over who is responsible for providing care coordination services, who should pay and how to get reimbursed for services. In Washington state, local health departments have programs to link children with special health care needs to necessary services and programs. CSHCN coordinators serve each county in Washington state.\textsuperscript{215} In Washington state, there is a Medicaid investment in care coordination. The Children with Special Health Care Needs Program at the Washington State Department of Health has implemented a “CSHCN flag system” in the state’s Medicaid database of enrollees that is used by contracted managed care organizations. The flag system is a recognition of the need for enhanced care coordination in this population.

Other state efforts specifically focused on the special needs population include:

- The Medicaid and Early Childhood Home Visiting Collaboration to support health and early learning in children\textsuperscript{216}, and
- The Medically Intensive Children’s Program through the Developmental Disabilities Administration, which provides skilled nursing services to children 17 and younger.\textsuperscript{217}

Nevertheless, in Washington state, only 64.8\% of CSHCN reported that they received effective care coordination compared to 70\% of non-CSHCN children.\textsuperscript{218}

Moreover, care coordination is often fragmented and limited, with minimal connections across systems (e.g., social services and the medical home; home and community case management and hospitals). For families, the vast majority of care coordination is provided by phone with no connection to a trusted person in the community or from the health care setting.

Largely provided by the local health jurisdictions (LHJs) or other local organizations, locally based CSHCN coordinators ensure that the needs and preferences of a child and their family are known ahead of time and communicated at the right time to the right people, and that this information is used to provide safe, appropriate, and effective care.\textsuperscript{219, 220} Although these individuals are not placed in a practitioner’s office, they are uniquely qualified to provide care coordination. With budget cuts and changes in the public health delivery system, access to a CSHCN coordinator is limited.
Adolescent Transition

Medicaid and Children’s Health Insurance Program (CHIP) in Washington state serve a disproportionately large and ever-increasing number of CSHCN who will likely remain publicly insured when they become young adults. These CSHCN, along with their healthier peers, will need to transition from pediatric to adult healthcare settings. Among youth ages 12 to 17 in the United States, a 2018 study showed a low level of transition planning (17% for youth with special healthcare needs (YSHCN) and 14% for non-YSHCN). The findings were better in some of the other transition measures. For example, more than half of youth, especially those with special needs, actively work with their healthcare provider to gain self-care skills or understand changes in healthcare at age 18. But, youth remain ill prepared for health care transitions overall. The 2016 National Survey of Children’s Health reveals that 83% of youth with special healthcare needs and 86% of youth without special needs do not meet the standard to easily transition from your provider to adult provider (called the national composite Health Care Transition performance measure).

In 2013, Medicaid and CHIP covered 7.8 million adolescents ages 12 to 17, and 38.4% (about 3 million) of these have a special healthcare need. Over time, the proportion of CSHCN who are publicly insured has increased dramatically – from 25.8% in 2005/2006 to 38.4% in 2011/2012 to 46% in 2018. Medicaid covers an additional 4.8 million young adults ages 18 to 25. Certain youth and young adults covered by Medicaid are particularly vulnerable during the transition period from early adolescence into young adulthood, including the 1.2 million Supplemental Security Income recipients under age 18.

Without adequate support, CSHCN transitioning to adult healthcare services are at increased risk for poor health outcomes, dissatisfaction with care and higher costs. The literature shows that youth and young adults are often unable to name their health condition, relevant medical history, prescriptions and insurance. Their adherence to care is lower, medical complications are increased, and emergency room and hospital use is higher. Further, many young adults and families are dissatisfied with their lack of preparation, information about adult care, vetted adult providers, communication between pediatric and adult providers, and sharing of medical information. Many report having difficulty finding an adult provider willing and interested in accepting them as a new patient, particularly those with developmental disabilities, mental health conditions and complex medical conditions. Therefore, the need for adolescent transition support is highly important.

Many of the benefits of adolescent transition are documented on the Got Transition/Center for Health Care Transition Improvement website funded through the U.S. Maternal and Child Health Bureau and The National Alliance to Advance Adolescent Health. Furthermore, adolescent transition is highlighted in the national “Standards for Systems of Care for Children and Youth with Special Health Care Needs.” Since the release in 2014 of the new transition model - the Six Core Elements of Health Care Transition (Version 2.0) - states are refining and updating their transition objectives and strategies. A total of 36 states and jurisdictions selected transition as one of at least five National Performance Measures for programmatic focus. Additionally, 21 states and jurisdictions selected transition as one of the seven to ten priorities for focused programmatic efforts over the coming five-year reporting cycle.
Up until Sept. 30, 2018, the Washington State Department of Health offered information and resources for families through the “Adolescent Transition” section of the cshcn.org website. The websites provides materials to keep track of medical information, age-specific transition booklets, advocacy tips and resources to help teens plan for the future. However, following a loss of state funding, there is no longer staff to update the cshcn.org website on a regular basis. \(^{29}\)

Transition planning between youth, families, and providers has been associated with improvements in satisfaction, continuity of care and greater adherence to care. \(^{239}\) Yet, most pediatric providers have no organized clinical process for transition, which should include the following: \(^{240}\)

- Description of the practice transition policy and recommended age for transfer
- Method for assessing youth’s transition readiness or self-care skills
- Plan of care that incorporates the youth’s transition goals
- Current medical summary and emergency care plan
- List of vetted adult providers
- Plan to communicate with adult providers and share up-to-date medical information
- Mechanism to confirm transfer and consumer feedback.

Similarly, most adult providers have no organized clinical process for identifying clinicians in their practice interested in caring for young adults, overseeing transfer information and communication with past pediatric providers, welcoming new young adults, tracking young adults in their patient population, assessing their self-care skills and providing consumer feedback.

Research indicates that disengagement from medical services among young adults with special healthcare needs is common. \(^{241}\) Some common barriers for the transition from pediatric to adult care include ending long relationships with previous pediatric care providers, accessing qualified care providers, issues with insurance, and beliefs and expectations about adult care. \(^{242}\) Furthermore, evidence suggests that the transition from pediatric to adult care can be associated with poorer health among individuals. \(^{243}\) A 2011 review suggests that transition programs incorporating patient education and transition clinics with both pediatric and adult care or specific young adult care may be successful strategies for improving health care transitions for CSHCN. \(^{244}\)

As stated earlier, in Washington, 19% of children aged 0-17 years have special health care needs. Historically, many children would die due to complex conditions like cystic fibrosis, blood cancers, congenital heart disease and premature birth. Many more CSHCN now survive into adulthood because of new technologies and treatments. At Seattle Children’s, 70% of our patients are CSHCN, two-thirds of whom are considered complex CSHCN.

---

\(^{29}\) Note: Due to a loss of state funding, the Center for Children with Special Needs closed its doors effective Sept. 30, 2018. Many resources on cshcn.org will become available on seattlechildrens.org.
**Assets and Opportunities**

In 2002, 2011, and, most recently, in 2018, the American Academy of Pediatrics (AAP), American Academy of Family Physicians (AAFP) and the American College of Physicians (ACP) published joint clinical reports and consensus statements regarding transition for YSHCN and CSHCN, calling for sweeping but simple improvements to a well-recognized issue.\(^{245}\) In its Healthy People 2020 objectives, the U.S. Department of Health and Human Services specifically identified improvements in transition for YSHCN as a public health goal.\(^{246}\) Directing resources toward pediatric-to-adult transition is particularly important for special populations as they are the most vulnerable to poor outcomes and higher care costs.\(^{247}\) A 2018 study demonstrated that social complexity by itself or with chronic medical conditions is the source of many disparities in healthcare for ethnic and racial minorities, immigrant and refugee populations, LGBTQ youth, and youth impacted by poverty, homelessness or foster care.\(^{248}\) Therefore, improving transition represents not only a medical and public health priority, but also one of equity.

Fortunately, national organizations have begun addressing this problem. One notable organization is Got Transition™, a collaboration of the non-profit National Alliance to Advance Adolescent Health and the U.S. Department of Health and Human Services’ Maternal and Child Health Bureau in the Health Resources and Services Administration.\(^{249}\)

Got Transition™ outlines its Six Core Elements of transition, which provide a national standard for the framework of adolescent transition care:\(^{250}\)

1. **Transition policy:** Develop policy statements, educate staff, share with youth and families
2. **Transition tracking and monitoring:** Identify youth, track progress, and incorporate into electronic medical record
3. **Transition readiness:** Regular readiness assessments, develop shared goals/actions
4. **Transition planning:** Develop provider transfer package, develop youth transfer plans, counsel on “care at 18,” provide connections
5. **Transfer of care:** Confirm providers, complete transfer packages, first full adult appointment
6. **Transfer completion:** Confirm and elicit feedback, build collaboration.

**Childhood Asthma**

**Figure 32:** Current Asthma Among High School Students, Washington State, 2014-2016\(^{30}\)
Respiratory diseases are the leading cause of hospitalization for children ages 1 to 9 in Washington State. According to the Washington State Department of Health, an average of about 4,800 people are hospitalized due to asthma each year. Disparities in asthma prevalence exist among racial and ethnic groups in Washington State. Low income and people of color asthma patients experience greater severity due to a variety of factors including environment and access to health care. At Seattle Children’s, asthma was the fifth highest reason for hospital admission in 2018.

Disparities in asthma prevalence exist among racial and ethnic groups in Washington State. Low income and people of color asthma patients experience greater severity due to a variety of factors including environment and access to health care.

In 2016, 6% of children from birth to age 17 had asthma in King County, compared to 7.3% of children in Washington state and 8.3% of children throughout the United States. As indicated by a 2016 report, only one third of Washington youth with asthma reported having a written asthma plan to help them control their medications and exposures.

**Childhood Diabetes**

Nationally there is increased frequency of both type 1 and type 2 diabetes in young people. The relative increase of type 2 diabetes is increasing at a faster rate than type 1. Unlike type 1 diabetes which has seen the highest rate of new pediatric cases in non-Hispanic whites, the
highest rates of newly diagnosed pediatric type 2 diabetes are of those who are members of racial or ethnic minority groups.\textsuperscript{262}

In Washington State, 1 in 400 youth younger than age 20 have diagnosed diabetes, or about 4,500 youth.\textsuperscript{262} It is important to note that this does not include the number of individuals with undiagnosed diabetes nor does it include those with pre-diabetes.\textsuperscript{264} In 2014, 3\% of King County students in eighth, 10th and 12th grades had doctor-diagnosed diabetes, which includes type 1 and type 2 diabetes.\textsuperscript{265}

\textbf{Cancer}

Cancer incidence in children from birth to age 20 in Washington state (2012 to 2016) was 19.9 per 100,000, slightly higher than the U.S. incidence of 18.9 per 100,000.\textsuperscript{266} On average, there are 335 cases of childhood cancer per year in the state.\textsuperscript{267} Stevens and Cowlitz counties had the highest cancer incidence rates at 28.9 per 100,000 and 24.6 per 100,000, respectively.\textsuperscript{268}

\begin{table}[h]
\centering
\begin{tabular}{|c|c|c|}
\hline
Age Group (Years) & Incidence Rate (per 100,000) & Mortality Rate (per 100,000) \\
\hline
0 – 4 & 25.4 & 2.3 \\
5 – 9 & 15.1 & 2.4 \\
10 – 14 & 17.0 & 2.0 \\
14 – 19 & 26.2 & 2.9 \\
20 – 24 & 39.9 & 4.2 \\
\hline
\end{tabular}
\caption{Washington State Youth Cancer Incidence Rate and Mortality Rate, 2014-2016\textsuperscript{51}}
\end{table}

There are more than 100 types of cancer.\textsuperscript{269} The most common types of childhood and adolescent cancers are:

\begin{table}[h]
\centering
\begin{tabular}{|l|c|}
\hline
Type & Incidence Rate (per 100,000) \\
\hline
Leukemia & 4.8 \\
Lymphoid leukemia & 3.4 \\
Brain and other nervous system & 3.2 \\
Hodgkin lymphoma & 1.2 \\
Non-Hodgkin lymphoma & 1.2 \\
\hline
\end{tabular}
\caption{Incidence Rates of Most Common Childhood and Adolescent Cancers\textsuperscript{32}}
\end{table}

\textbf{Transplants}

More than 124,000 people in the nation are waiting for a life-saving organ transplant.\textsuperscript{270} An average of 20 people, both children and adults, die each day from the lack of available transplant

Potential recipients who are waiting for a deceased-donor organ are listed with the United Network for Organ Sharing (UNOS).

As of July 28, 2019, 81 youth under 18 years of age in Washington state were in need of a life-saving organ transplant. All patients waiting for a deceased-donor transplant in the United States have equal access to donated organs. UNOS however does have special allowances for children under certain circumstances. For example, pediatric liver transplant candidates need smaller organs so they will receive priority if the donor is younger than 18. The same is true for pediatric lung transplant candidates, as the best opportunity for a successful transplant is from a donor of similar age and size.

Table 35. Children and Youth on Waitlist for Organ Transplant in Washington State as of 07/28/2019

<table>
<thead>
<tr>
<th>Organ Combinations</th>
<th>Under 1 year</th>
<th>1-5 years</th>
<th>6-10 years</th>
<th>11-17 years</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Organs</td>
<td>3</td>
<td>24</td>
<td>19</td>
<td>35</td>
</tr>
<tr>
<td>Kidney</td>
<td>0</td>
<td>12</td>
<td>9</td>
<td>24</td>
</tr>
<tr>
<td>Liver</td>
<td>0</td>
<td>7</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>Pancreas</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Kidney/Pancreas</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Heart</td>
<td>3</td>
<td>3</td>
<td>1</td>
<td>6</td>
</tr>
<tr>
<td>Lung</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Heart/Lung</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Intestine</td>
<td>0</td>
<td>2</td>
<td>5</td>
<td>3</td>
</tr>
</tbody>
</table>

*Totals may be less than the sums due to patients included in multiple categories.

Heart Disease

Congenital heart defects (CHDs) are the most common birth defect in the United States. There are different types of congenital heart defects. Some do not require any treatment, about 25% are more critical congenital heart defects that require surgery during the first year of life, and some people with congenital heart defects may need ongoing treatment, including surgery, throughout their life. Regardless of the type of defect, all people with congenital heart defects should receive ongoing monitoring by a cardiologist. People with CHD can face issues such as developmental delays, heart rhythm problems, issues with growth and eating, and even heart failure, sudden cardiac arrest and stroke. The majority of children born with a congenital heart defect survive into adulthood, yet many require specialized and ongoing medical treatment. The cause of most congenital heart defects is still unknown and can be genetic, but some congenital heart defects can be prevented. Being obese, having diabetes, and smoking during pregnancy increase the chances of having a baby born with a heart defect. In the United States, about 40,000 infants are born with a heart defect each year.

While Washington State does not have a comprehensive birth defects registry, thus making it difficult to find specific birth defect rate information, the Collaborative on Health and the Environment – Washington (CHE-WA) “estimates that about 800 babies are born with heart defects or congenital heart disease every year in Washington State.” Between July 2015 and June 2017, 230 Washington state infants were diagnosed with critical CHD, meaning a CHD requiring surgery within the first year of life.
Community Assets and Resources

Care Coordination

- Seattle Children’s Pediatric Partners in Care (PPIC) program has recently sunset, after having improved outcomes and reduced the total cost of care for children with special health care needs. Launched with a federal grant, PPIC kept children out of the hospital, reduced the use of emergency services for non-emergent care, and prevented unplanned inpatient returns.

Adolescent Transition

- Seattle Children’s multidisciplinary Adolescent Health Transition Committee and Family Task Force formed in 2016 to develop an infrastructure for adolescent health transition at the hospital. Ten clinics, centers and departments have offerings in place to support families with adolescent health transition. We have updated our patient and family education resources and have made them more accessible to both families and healthcare providers.
- The Transition Care Program at the University of Washington Medical Center works with young adult patients who are between 18 and 24 years old and have complex medical needs as they transition from to adult healthcare.

Chronic Conditions

- The Stanley Stamm Camp provides a medically supported one-week overnight camp experience in an outdoor wilderness setting for children ages 6 to 14 with terminal or chronic medical illnesses. The camp is free to all who attend.

Cancer

- The Seattle Cancer Care Alliance (SCCA) brings together Seattle’s top cancer research organizations: Fred Hutchinson Cancer Research Center, University of Washington Medicine and Seattle Children’s. Through the SCCA partnership, Seattle Children’s cares for hundreds of new pediatric cancer patients each year. Research has found that teenagers with cancer do better if they are given treatment plans designed for children. Through the SCCA, teenagers can continue to be treated on pediatric protocols as they enter adulthood.
- The Fred Hutchinson Cancer Research Center conducts research to improve prevention and treatment of cancer and related diseases. The center pioneered bone marrow transplantation procedures.
- The Adolescent and Young Adults With Cancer (AYA) Program at Seattle Children’s provides expert medical care and support for teens and young adults with most forms of cancer into their late 20s. The program offers a weekly “Teen Hangout” staffed by a hematology/oncology social worker where young people with cancer can meet peers and address their psychosocial needs. The AYA is open to anyone in the community. The group partners with other community organizations that provide support for young adult patients and survivors.
- Seattle Children’s Cancer Survivor Program is a follow-up program for childhood cancer survivors, whether they were treated at Seattle Children’s or elsewhere. It aims to keep survivors healthy throughout their lives by providing care and education about their health risks. The Cancer Survivor Program was designed to meet the unique needs of survivors treated during childhood. The program serves survivors who are still children, as well as adults who were treated for cancer during childhood. It also gives survivors the...
chance to take part in research studies so we can learn more about the best ways to keep survivors well.

- Seattle Children’s is a regional and national leader in fertility preservation services and education. Children who have had cancer may experience decreased fertility as a result of their treatment. We lack resources, treatment guidelines and systems for treating pediatric cancer patients’ reproductive issues. Data shows that fertility preservation improves hope and resilience among cancer therapy patients. In response to patient/family requests and community needs, Seattle Children’s Cancer Center developed the fertility preservation program, providing fertility counseling and reproductive services for cancer patients. Seattle Children’s offers a variety of fertility preservation services including sperm banking and storing eggs.

- Through Seattle Children's Cancer and Blood Disorders Center, the multidisciplinary team of pediatric cancer experts treats about 250 children newly diagnosed with cancer every year — more than any other institution in the region — and provides follow-up care to more than 12,700 children and adolescents. In outpatient clinics and in the 48-bed inpatient unit, children receive advanced diagnoses and treatments, participate in state-of-the-art research studies and get specialized care.

- Seattle Children’s is specifically:
  - Implementing health awareness efforts targeting secondary cancer prevention (testicular, breast and skin cancers).
  - Working to increase awareness and health promotion for the Gardasil vaccine (for boys and girls).
  - Promoting community education regarding the Gardasil vaccine and skin cancer.
  - Addressing myths associated with sperm banking.
  - Providing web-based education to any cancer patient with materials such as “Having a Life With Cancer” and “Fertility and Cancer,” which is a fertility preservation informational video for girls.
  - Using social media for patient education and support.

- Seattle Children’s providers:
  - Share practice guidelines, resources and systems with other healthcare institutions regarding fertility preservation and reproductive services for cancer patients.
  - Provide consultation and share expertise, resources and guidelines through Continuing Medical Education to community practitioners about adolescent and young adult oncology, fertility preservation and other topics.

**Transplant**

- Seattle Children’s Transplant Center is the largest and only pediatric transplant center serving UNOS Region 6 (Washington, Alaska, Idaho, Montana, Oregon and Hawaii). Seattle Children’s delivers world-class care to patients with end-stage diseases of the kidneys, heart, liver and intestine, and has been transplanting organs for more than 25 years. The center focuses on patient care, provider education, community partnerships and advocacy.

**Heart Disease**

- The American Heart Association’s mission is to build healthier lives free of cardiovascular diseases and stroke through advocacy, research and educational resources for healthcare providers, patients, families and the community. In Washington state, the
American Heart Association’s branches in Seattle, Tacoma and Spokane organize awareness events and campaigns, offer online resources and fund state-specific research.

- **Seattle Children’s Heart Center** is working on goals to improve heart health in the community.
- The **Sudden Cardiac Arrest (SCA) Awareness Act** went into effect in 2015 to make youth athletes, their families and coaches aware of sudden cardiac arrest.

**Community Input and Opportunities**

Via community input and listening sessions, many strategies for addressing the needs of CSHCN were brainstormed. These include promoting adequate reimbursement, working with families to assure insurance coverage, training local providers in how to care for patients with special needs and encouraging medical homes. One theme we heard consistently from families is “care closer to home” is imperative for their quality of life, summarized below:

**CSHCN Overall**

Overall, children with special health care needs have concerns above and beyond the healthy population. CSHCN are more likely to have difficulty obtaining needed referrals or meeting the criteria for care in a medical home compared to children without special needs. They are also less likely to have adequate insurance to meet their healthcare needs. Opportunities to address these issues include:

- Improving data systems used to identify clients needing care coordination;
- Supporting comprehensive systems of care with fiscally sustainable reimbursement;
- Ensuring that there is a viable system of CSHCN Coordinators to serve children with special health care needs and that managed care organizations reimburse appropriately for care coordination;
- Addressing the safety net for undocumented children with special health care needs. Currently, children who are “undocumented” remain in fee-for-service Medicaid, and children in foster care have the option of either fee-for-service or managed care;
- Identifying opportunities to incorporate the nationally developed Standards of Care for Children and Youth with Special Health Care Needs into systems development and improvements.

**Cancer**

In “A National Action Plan for Cancer Survivorship: Advancing Public Health Strategies”, several public health strategies have been recommended by the Centers for Disease Control and Prevention (CDC) to improve cancer survivorship.286 Elements of these strategies were commented on in listening sessions with patient families from 2016-2019:

- Ensure all cancer survivors have adequate access to high-quality treatment and other post-treatment services.
- Establish or maintain training for healthcare professionals to improve delivery of services and increase awareness of issues faced by cancer survivors.
- Identify appropriate mechanisms and resources for ongoing surveillance of people living with, through and beyond cancer.
- Increase awareness among the general public, policymakers, survivors, providers and others of cancer survivorship and its impact.
More recently, the Centers for Disease Control and Prevention proposed the Public Health Action Model for Cancer Survivorship, with foundational principles of behavioral change, dissemination and implementation, and evaluation.\textsuperscript{287} The model suggests that the physical, social, emotional, and financial well-being of cancer survivors. In addition, the model suggests that public health actions must occur on multiple levels, including the individual level (cancer survivors), interpersonal, organizational, community, and policy levels.

**Figure 36: The Public Health Action Model for Cancer Survivorship\textsuperscript{34}**

**Transplant**
- Continue to raise awareness about organ donation and encourage people to become donors because the recipient need is larger than the number of available organs.
- Seattle Children’s must continue to act as a regional expert and partner resource for pediatric transplants.

**Heart Disease\textsuperscript{288}**
- Increase cardiovascular screening in athletes.\textsuperscript{289} The goal of performing cardiovascular screening of young athletes is to reduce sudden cardiac death through early detection and appropriate medical interventions, activity modification or withdrawal from athletic participation.
- In early adolescence, CHD survivors needing lifelong congenital heart care should begin to transition to appropriate adult congenital heart disease care.\textsuperscript{290} A successful transition will include coordinated comprehensive care with adequate financing, education of providers about management of adult patients with CHD, and continual communication.

**Healthcare Access and Preventative Care**

Accessing healthcare services can lead to the prevention and early detection of many medical conditions. Health insurance reduces the out-of-pocket costs of healthcare and has been shown to be the single most important predictor of healthcare utilization. Without health insurance coverage, many people find healthcare services unaffordable and may forgo care. This often leads to disparities in health and quality of life between individuals with health insurance and those without health insurance.

Over the past few years, access to health insurance has improved with the expansion of Medicaid eligibility and the implementation of health insurance marketplaces for Qualified Health Plans. However, there are still children across Washington state without health insurance. In part due to inadequate insurance coverage, too many adults and children do not receive recommended clinical preventive services or regular oral healthcare services.

Access to Care
While the Affordable Care Act (ACA) was primarily designed to address uninsured adults, its implementation, the expansion of Medicaid and the transition of Medicaid clients into managed care have also benefitted children, teens and young adults.

For children who are U.S. citizens and meet financial eligibility standards (including those in foster care and adoption support), the ACA implementation means they are part of the Medicaid managed care plan instead of a fee-for-service plan. Children who are in an undocumented status are in a fee-for-service plan. Tribal members can choose to participate in either a fee-for-service or managed care plan.

The implementation of the ACA also required families to apply for or renew their Medicaid coverage through the Washington Healthplanfinder. This process has been challenging for many, including those with limited English skills and families who have the additional responsibilities of caring for a child with special healthcare needs.

Many families live in areas with limited Internet access and have long wait times when contacting a call center, which may use up their cellphone minutes. Additional supports, such as health navigators, have an additional set of challenges because they must work with multiple different Medicaid managed care plans that each have different sets of rules, processes and reimbursement rates.

States administer their Medicaid managed care programs within general federal rules. States must identify individuals with special healthcare needs to managed care organizations (MCOs), to identify any ongoing conditions that require treatment or monitoring.

Local health jurisdictions have brought in care coordinators working with children with special healthcare needs to assist this vulnerable population. These providers have knowledge of and connections with community resources. However, care coordinators also face challenges due to budget cuts and changes to the local public health delivery system.

In 2017, 2.7% (or about 45,000) children ages 0 to 18 in Washington state had no health insurance coverage — a rate that has held steady since 2015 but marks a substantial reduction.
from years prior to 2015. This compares to 5% of children in the United States with no health insurance coverage in 2017.

Figure 37: Percentage of Children Ages 0 to 18 Without Health Insurance Coverage in Washington State, 2008-2017

About five in 10 children (51%) in Washington were covered by employer-based insurance, and about four in 10 children (38%) were covered by Medicaid in 2017. An additional 5% and 3% of Washington children were covered by non-group insurance and other public insurance such as military, Veterans Administration, and nonelderly Medicare coverage, respectively.

Immunization Rates
Diseases that were once common in the United States, such as polio, measles and pertussis (whooping cough), can be prevented through vaccinations. Although newborns are born immune to certain diseases due to the immunity of their mother, this immunity will slowly wear off through their first year of life, making early vaccinations essential. Immunizing children also helps protect others by preventing the transmission of disease within the community, especially for those who cannot be vaccinated.

Barriers to accessing clinical preventive services and family choices to not have children vaccinated are some of the reasons why children and teens do not receive the recommended vaccinations.

Immunizations for Ages 19 to 35 Months\textsuperscript{298}

In Washington state, estimates of immunization compliance with the immunization schedule developed by the Centers for Disease Control and Prevention (CDC) are derived from vaccination records submitted by healthcare providers to the Washington State Immunization Information System (WSIIS). The 4:3:1:3:1:4 immunization series, recommended to be completed by 19 months, includes at least 4 doses of DTaP (diphtheria, tetanus, and acellular pertussis) vaccine, at least three doses of polio vaccine, at least one dose of MMR (measles, mumps, and rubella) vaccine, at least three doses of hepatitis B vaccine, at least three doses of Haemophilus influenza type B vaccine, at least one dose of varicella (chickenpox) vaccine, and at least four doses of PCV (pneumococcal conjugate) vaccine.

According to the most recent data on immunization compliance in 2018, between 25\% to 75\% of children ages 19 to 35 months had completed the recommended of 4:3:1:3:1:4 immunization series, with a state average of 59\%. Asotin, Garfield, and Klickitat counties in Washington state had the lowest rates of immunization coverage for this age group. Adams, Grant, and Douglas counties had the highest rates of immunization coverage for this age group.

Figure 38: Immunization Series 4:3:1:3:1:4 Coverage for Youth Ages 19 to 35 Months by County, Washington State, 2018\textsuperscript{36}


Percent of 19 to 35 Month Olds Completing 4:3:1:3:1:4 Immunization Series

- Adams: 72%
- Asotin: 19%
- Garfield: 29%
- Klickitat: 33%
- Island: 35%
- Pacific: 37%
- Stevens: 40%
- Pend Oreille: 40%
- Skamania: 46%
- Ferry: 47%
- Pierce: 49%
- Clark: 49%
- Kitsap: 48%
- Columbia: 49%
- San Juan: 51%
- Jefferson: 51%
- Okanogan: 52%
- Chelan: 54%
- Douglas: 56%
- Spokane: 56%
- Mason: 57%
- Grays Harbor: 56%
- Thurston: 57%
- Cowlitz: 57%
- Wahkiakum: 59%
- Statewide: 59%
- Skagit: 59%
- Whitman: 62%
- Whatcom: 62%
- Snohomish: 64%
- Lewis: 64%
- Franklin: 64%
- Chelan: 64%
- King: 65%
- Benton: 65%
- Walla Walla: 67%
- Lincoln: 67%
- Kittitas: 67%
- Yakima: 68%
- Douglas: 70%
- Grant: 71%
- Adams: 72%
**Immunizations for Ages 4 to 6**

The CDC recommends the 5:4:3:2:2:2:2:4 immunization series for children be completed by age 4. This includes at least five doses of DtaP (diphtheria, tetanus, and acellular pertussis), at least four doses of Haemophilus influenzae type B, at least four doses of polio, more than three doses of hepatitis B, at least two doses of MMR (measles, mumps, and rubella), at least two doses of varicella (chickenpox), at least two doses of HepA (hepatitis A), and at least four doses of PCV (pneumococcal conjugate) vaccines.

In 2018, 44% of children ages 4 to 6 in Washington state had received the recommended immunization series. Klickitat, Pend Oreille and Asotin counties had the lowest rates of immunization coverage in the state among children ages 4 to 6. Douglas, Adams and Chelan counties had the highest rates of immunization coverage in the state among the same age group.

**Figure 39: Immunization Series 5:4:3:2:2:2:4 Coverage for Children Ages 4 to 6 by County, Washington State, 2018**

---

**Immunizations for Ages 11 to 12**

For children ages 11 and 12, the CDC recommends the initiation of the 1:1:1 immunization series. The 1:1:1 series includes at least one dose of Tdap (tetanus, diphtheria, and acellular pertussis), at least one dose of MCV (meningococcal conjugate), and at least one dose of HPV (human papillomavirus) vaccines.
In 2018, 38% of children ages 11 and 12 in Washington state received these recommended immunizations. Asotin, Pend Orielle and Klickitat counties had the lowest rates of immunization coverage among children ages 11 and 12 in 2018. Yakima, Douglas and Grant counties had the highest rates of immunization coverage among this age group in the state.

**Figure 40: Immunization Series 1:1:1 Coverage for Children Ages 11 and 12 by County, Washington State, 2018**

---

**Immunizations for Ages 13 to 17**

By age 13, the CDC recommends the completion of the 1:1:UTD immunization series. The 1:1:UTD series includes at least one dose of Tdap (tetanus, diphtheria, and acellular pertussis), at least one dose of MCV (meningococcal conjugate), and up-to-date UTD) for HPV (human papillomavirus) vaccines, reflecting the age at initiation of HPV vaccine.

In 2018, 51% of children ages 13 to 17 in Washington state received these recommended immunizations. Klickitat, Pend Oreille and Asotin counties had the lowest rates of immunization coverage among children ages 13 to 17 in 2018. Yakima, Douglas, and Adams counties had the highest rates of immunization coverage among this age group in the state.

**Figure 41: Immunization Series 1:1:UTD Coverage for Youth Ages 13 to 17 by County, Washington State, 2018**

---

Oral Healthcare
Tooth decay in children (including dental caries/cavities), is a preventable condition that can cause infections and chronic pain if untreated. This may lead to problems with swallowing, chewing, speaking and sleeping; difficulty learning; loss of self-esteem; behavior problems; and missed days of school. When children who have untreated tooth decay become adults, they have higher rates of oral diseases and chronic medical conditions.

Healthy People 2020 set a goal for at least 49% of children, adolescents and adults use the oral healthcare system each year. According to data from the Washington State Department of Health, in 2016, about 56% of Medicaid eligible youth under age 21 accessed dental care. Data from the 2018 Healthy Youth Survey indicate that 87% of eighth graders, 83% of 10th graders and 79% of 12th graders had a dental visit in the past year.

In general, Washington State youth in grades 8, 10 and 12, are reporting high levels of seeing a dentist in the last year, but there are disparities that remain. Findings from the 2015-2016 Smile Survey in Washington state, which is conducted every five years, show that children in kindergarten, second grade, and third grade who are low-income, speak a language other than English at home, or are from some racial/ethnic minority groups had the highest levels of tooth decay. While toothaches are a preventable condition, rates of youth who miss school due to a toothache vary across counties. In addition to the pain, potential infection and missed school that can be associated with tooth decay, children with poor dental health are more likely to have oral health issues into adulthood.

Community Input
Access to Care and Insurance Coverage
For those with health insurance coverage, accessing specialty care, adult dental care and behavioral health services, and the high costs of health insurance premiums, deductibles and co-pays continue to pose challenges. These high costs may deter a person from seeking care if choosing between paying for basic needs, like food and housing, or paying for healthcare services.

Losing health insurance coverage means a loss of services, which may include case management, integrated mental health, nutrition counseling and other non-clinical services. This can present another challenge to maintaining good health. There are also financial barriers; there are substantial potential financial impacts associated with losing health insurance coverage and about one-third of bankruptcies declared in the United States are tied to health care debt.

Healthcare Workforce Capacity
Community health centers report severe shortages of primary care providers. Community members stress the importance of a workforce that reflects our communities’ diversity. In listening sessions with community health center providers, they explain that their primary care providers are considered safety net providers because they deliver healthcare to uninsured patients and Medicaid patients. Safety net providers work in community health centers, federally qualified health centers, public hospitals, school-based clinics, and community and teaching hospitals. Without these safety net providers, many communities would have little or no contact with the healthcare system.
Program funding, financing mechanisms and incentives, and implementing infrastructure changes are all needed to ensure that clinicians are attracted to primary care, faculty are available to educate healthcare professionals, and healthcare delivery is efficient and effective. Ameliorating the problems presently impeding primary care delivery involves more than just training additional doctors to become primary care physicians. In their article on the “primary care crisis”, Sherman, Moscou, and Dang-Vu explain that at the core of the debate are several issues: (1) how to address the financial reimbursement inequities seen in primary care and specialty care; (2) how healthcare will be delivered; (3) which professionals will provide primary care, oral health care, and behavioral healthcare; and (4) how emerging technologies will be used.312

Incomplete Immunization
In key informant interviews and listening sessions, parents expressed concerns about the rates of incomplete immunization. Washington state and King County do not meet the Healthy People 2020 objective of complete vaccination coverage for 80% for children ages 19 to 35 months.

Community Assets and Resources
Access to Care
- Project Access Northwest manages the Premium Assistance program, which partners with several hospitals and helps make insurance more affordable. Eligible individuals include those who are Washington residents, living at or below 300% of the Federal Poverty Level and not eligible for Medicaid or Medicare.
- The Washington State Department of Health has a program to work with children with special healthcare needs within the Healthy Starts and Transitions unit in the Office of Healthy Communities. The program is primarily funded through the federal Maternal and Child Health Block Grant (Title V). The CSHCN program promotes an integrated system of services for infants, children and youth up to age 18 years who are defined as having or are at risk for developing chronic physical, developmental, behavioral or emotional conditions that require services of a type or amount beyond what is generally needed by the general youth population. The Washington State Department of Health works closely with Apple Health to identify children with special healthcare needs through a data-sharing process and provide coordination and liaison activities for this population. This relationship has been beneficial to children and families as this population migrates into managed care.
- Historically, CSHCN coordinators have assisted with accessing eligibility for the CSHCN program, but are currently experiencing issues with timely enrollment of hospitalized newborns with complex medical needs. In order to better support these families, Apple Care has hired staff at the local level to assist families.
- The Health Coalition for Children and Youth (HCCY) is a coalition of organizations in Washington state that works to meet the full spectrum of health needs of children, including medical, dental and mental health. Currently, it is chaired by the Director of Federal and State Government Relations at Seattle Children’s.
- Community health centers continue to serve all residents, regardless of their ability to pay. Public health centers, tribal clinics and school-based health centers also serve the health needs of the community.
Seattle Children’s is committed to providing charity care to low-income individuals and enrolling residents in health insurance. In fiscal 2018, Seattle Children’s provided more than $146 million in uncompensated care.

- **Project Access Northwest** connects low-income and uninsured patients with specialty care and provides health literacy education.
- The **Pacific Hospital Preservation and Development Authority** provides funding for programs that address issues related to access to care.
- The **First Friday Forum** is a coalition of community health centers, social service organizations, government agencies and hospitals that share information related to publicly sponsored healthcare program eligibility, enrollment and best practices.
- **WithinReach** connects families to whatever resources they may need online, in person and through a telephone hotline. These services may include access to food and other basic needs, and enrollment in health insurance.
- The **Medical Legal Partnership for Children (MLPC)** is a collaboration of pediatric clinicians, social workers and attorneys who address the unmet legal needs of patients and families. While this program model has been used in more than 46 states and 333 healthcare organizations, MLPC was the first partnership of its kind in the Pacific Northwest. The program, which began in 2008, serves children and families from Seattle Children’s Odessa Brown Children’s Clinic (OBCC) and the Harborview Children and Teens’ Clinic. The organization addresses unmet legal needs by training healthcare workers and other stakeholders to handle advocacy issues affecting vulnerable families; enabling constituents to identify potential legal issues and offer referrals; provide case consultation to providers and direct legal services to pediatric patient families (up to and including full-court representation, when indicated); and participate in systemic advocacy efforts that promote child health and well-being.

- **OBCC**, a Seattle Children’s community clinic located in Seattle’s Central District, was established in 1970 and had 23,582 patient visits in fiscal 2018. Serving an urban, predominantly African-American population insured primarily by Apple Health for Kids, OBCC’s staff members are strong advocates for multicultural families.
- **Seattle Children’s** provides school-based care at Garfield, Madrona and Beacon Hill schools. The school-based and school-linked health center model is nationally recognized as one of the best ways to provide effective, efficient and appropriate healthcare services to adolescents. School-based and school-linked health centers are comprehensive primary care clinics that provide medical and mental health screening and treatment for young people on or near school grounds. The center targets adolescents who are uninsured and underinsured and serves youth with health insurance who desire confidential care and advice.

**Workforce Capacity**

- Seattle Jobs Initiative’s Healthcare Career Pathway program trains diverse, low-income residents in healthcare careers.
- As part of its healthcare workforce strategic plan, Seattle Central Community College expanded its nursing and allied health programs by opening the Seattle Central **Health Education Center** at the Pacific Tower in January 2016. The new satellite location offers additional training opportunities and programs for students pursuing careers in
healthcare. A consortium of local colleges is also creating a program for community healthcare workers/patient care navigators.

- The University of Washington School of Medicine is investing in the next generation of physicians by offering the only pediatric residency program in the Washington, Alaska, Montana and Idaho (WAMI) region. Resident programs include:
  - **WAMI rotation:** Pediatric residents spend two months of their training in a rural primary care setting.
  - **Pathway program:** Eight residents per year participate in the Community Health and Global Health pathways, which provide public health, clinical and research experience so residents can understand and influence the determinants of child health and health disparities at the community level.
  - **Alaska track:** Four residents per year focused on primary care spend one-third of their training in Alaska.

- During the 2017-18 academic year, 758 medical students and 960 total physicians trained at Seattle Children’s. Seattle Children’s offers fellowships in more than 30 specialty areas. More than half of all Seattle Children’s-affiliated graduates practice in the Pacific Northwest after completing their training.

**Incomplete Immunizations**

- The VAX Northwest Immunity Community program trains parents to be immunization advocates in child care settings, preschools and elementary schools, and aims to ensure that everyone can find accurate information about the value of vaccines.
- Pediatric providers are enrolled in the Vaccines for Children Program, a federal program that provides vaccines at no cost to children who otherwise may not be vaccinated. Caregivers can view participating pediatric providers on map through the Washington state Department of Health.
- Each year, Public Health – Seattle & King County’s Immunization Program and the Washington State Department of Health visit about half of the clinics enrolled in the Vaccines for Children Program. They assess clinics for best immunization practices and provide education and recommendations to healthcare providers. Additionally, about 25% of these clinics receive a site visit from the CDC’s Assessment, Feedback, Incentives and eXchanges (AFIX) quality improvement program to increase immunization coverage.
- WithinReach promotes immunization coverage through a variety of programs, including the Immunization Action Coalition of Washington, which raises public awareness and provides education to various groups, including healthcare providers and parents/guardians.
- The Washington State Department of Health’s Child Profile Health Promotion System helps ensure that kids in Washington state receive preventive healthcare services they need, provides free educational resources to families, and tracks individual and population-level immunization coverage. The system sends child health and safety information to all families with young children in Washington State by mail and e-mail. Each mailing has age-specific reminders about well-child check-ups and immunizations, and provides up-to-date information on growth and development, nutrition, safety and many other health topics.
**Oral Healthcare**

- Seattle Children’s provides dental services at OBCC for children ages 1 to 15, and The Dental Clinic at Seattle Children’s Hospital sees patients on the main hospital campus by referral.
- The Seattle and King County Access to Baby and Child Dentistry program connects low-income children from birth through age 5 with private dentists. The Seattle-King County Dental Society provides donated dental services for low-income residents who do not qualify for Medicaid.
- SmileMobile is a mobile dental office offering oral health services to low-income children who have limited access to a dentist. Services range from examinations and preventive care to fillings and minor oral surgery. Seattle Children’s is a partner in operating the SmileMobile. Since 1995, the mobile clinic has treated more than 44,000 children throughout Washington state — that’s an average of 70 children per week.

**Opportunities**

**Access to Care**

- For several years, Seattle Children’s worked with the Children’s Hospital Association on federal legislation called the Advancing Care for Exceptional (ACE) Kids Act, which passed in spring 2019. The legislation creates networks to better manage the care for medically complex children insured by Medicaid in all states. The network provides appropriate care close to a child’s home, thus decreasing the need for emergency room visits and hospital stays.
- Families with CSHCN may not have adequate private or public insurance coverage for necessary medical services. What is not widely known is that families with a private insurance plan can also apply for Medicaid as a secondary insurance for their children. This is a crucial piece of information for families who may incur high additional medical expenditures (co-pays, deductibles, benefits and limits to services not present in Medicaid). Having Medicaid as a secondary insurance may mitigate the additional expenditures for this special population. There is an opportunity to include this information in navigator or in-person assistor training.

**Incomplete Vaccinations**

- Because patients trust their healthcare providers, recommendations from their providers can shape a caregiver’s decision to vaccinate a child.
- Improving vaccination coverage data would help public health practitioners identify patient populations in particular need.
- Working with alternative and allopathic healthcare providers to improve vaccination coverage is also important and may help improve data on vaccination coverage.

**Oral Healthcare**

- Increasing reimbursement rates could provide incentive for dentists to accept patients with Medicaid.
Mental and Behavioral Health
This section includes information on child and adolescent mental and behavioral health as well as developmental disorders. There are nuanced and emerging definitions of the terms “mental health” as opposed to “behavioral health.” Mental health is generally defined as one’s emotional, psychological, and social well-being. The American Psychiatric Association states that mental health involves effective functioning in daily activities resulting in productive activities, healthy relationships, and ability to adapt to change and cope with adversity whereas mental illness refers collectively to all diagnosable mental health conditions or disorders. Behavioral health looks more at habits and behaviors, which can involve examining emotions and behaviors that affect both physical and mental health. The terms are not interchangeable, although there is substantial overlap, so this chapter will use the term “mental and behavioral health” to encompass the wide range of contributions to mental wellness as well as mental illness.

Mental and behavioral health challenges for children and adolescents include a range of conditions, such as depression, anxiety, lack of social support, bullying and suicidal behavior. Poor mental or behavioral health can impact a child’s ability to learn while at school, can limit productivity at home, and can contribute to or exacerbate poor physical health. The rate of youth with emotional disturbances dropping out of school is double the rate for youth with other disabilities. Adolescents and young adults who have untreated mental or behavioral health disorders are at high risk of unsafe behaviors, including alcohol or drug use, self-harm and suicide. The long-term effects of untreated mental health or behavioral health conditions may include the development of chronic diseases, and psychosocial and economic costs impacting not only the individual, but also their families and communities. Mental health disorders are one of the most common causes of disability.

It is critical to develop early mental health interventions and support mechanisms for our youth, especially because symptoms of mental illness can be obscured by the behavioral changes typical of puberty and adolescence. One in five youth aged 13 to 18 are estimated to have a mental health condition, and half of all chronic mental health conditions begin before the age of 14. Half of children with a mental health disorder do not receive needed treatment from a mental health professional.

According to Mental Health America’s “The State of Mental Health in America 2019” report, Washington state ranked 31st in the country (out of 50 states and the District of Columbia) for the prevalence of mental illness and access to care for youth. This ranking means Washington state’s youth have higher than average prevalence of mental illness and lower than average rates of access to mental healthcare services.

Adverse Childhood Experiences and Trauma-Informed Care
Adverse childhood experiences (ACEs) are experiences in childhood that are potentially traumatic. Examples of ACEs include physical and emotional abuse, neglect, and household dysfunction which could include parental substance abuse, living with a parent who has a mental illness, divorce, incarceration, and violence between parents. Among adults, experience with one or more ACEs is associated with a wide range of conditions, such as myocardial infarction,
frequent mental distress, and diabetes.\textsuperscript{321} ACEs are known to increase the risk of adverse mental and physical health conditions in both childhood and adulthood.\textsuperscript{322}

ACEs are unfortunately common; the CDC-Kaiser ACE study, conducted from 1995 to 1997, found that nearly two-thirds of study participants reported at least one ACE.\textsuperscript{323} Additionally, the study demonstrated a dose response relationship between the number of ACEs and adverse health outcomes, such that higher number of ACEs experienced increased risk for adverse health outcomes. This is often best understood when looking at one poor health outcome. For example, people who experienced one ACE are 1.8 times more likely to attempt suicide than people with an ACE score of zero; people who had experienced 3 ACEs were 6.6 times more likely to attempt suicide than people with zero. People with an ACE score of 4 or more were 12.2 times more likely to attempt suicide. \textsuperscript{324} In Washington in 2011, 26\% of adults reported having experienced three or more ACEs.\textsuperscript{325}

Analysis of 2016 National Survey of Children’s Health indicates that 33.7\% of Washington State children ages 0 to 5 have experienced at least one ACE.\textsuperscript{326} This figure rises to 42.5\% among children ages 0 to 17. Among children who have experienced at least one ACE in Washington state, less than half (48.3\%) are considered to be “engaged” in school, measured by parent report of school performance and completion of required homework. While the prevalence of ACEs among Washington state youth is slightly lower than national levels, with 46.3\% of children ages 0 to 17 experiencing at least one ACE nationwide, ACEs remain an important issue in Washington state. Efforts should be dedicated to preventing ACEs and developing and providing necessary interventions for children and youth who have experienced ACEs.

While ACEs are unfortunately common nationally and in Washington state, opportunities to prevent ACEs exist. Key factors for prevention include economic support for families, social norms that supporting parents and positive parenting strategies, early life childcare and education that engages families, interventions to improve parenting skills such as home visitation in early childhood, and interventions to reduce existing harms and to prevent future risk.\textsuperscript{327} In addition, promoting emotional resilience and encouraging positive relationships between families and healthcare providers and teachers may mitigate the risks of adverse health impacts associated with ACEs.\textsuperscript{328}

ACEs are a form of trauma, which “results from an event, series of events, or set of circumstances experienced by an individual as physically or emotionally harmful or life-threatening with lasting adverse effects on the individual’s functioning and mental, physical, social, emotional, or spiritual well-being.”\textsuperscript{329} In order to best address for patients’ physical, mental, and emotional health needs, it is imperative to consider the role of trauma in a patients’ health. Trauma-informed care emphasizes the role of “what happened to you”, rather than “what is wrong with you,” in the clinical care.

Trauma-informed care is guided by six principles: safety, trustworthiness and transparency, peer support, collaboration and mutuality, empowerment voice and choice and cultural, historical, and gender issues.\textsuperscript{330} In addition, trauma-informed care systems function with the following four principles, often referred to as the “Four R’s”:\textsuperscript{331}

- **Realize** the high prevalence and impact of traumatic events
- **Recognize** signs and symptoms of trauma
- **Respond** by creating trauma-informed polices, procedures, and practices
- Actively seek to **Resist Re-traumatization**

A defining experience of trauma is feeling unsafe. At Seattle Children’s we have placed welcome signs at all hospital entrances that explicitly state the value we place on the diversity of our patients, families and employees. This intervention is trauma informed in that it offers an open welcome to all who walk through the doors of the hospital. Other “safety” interventions include a universal trauma screen in the emergency department. During the intake processes, nurses routinely ask patients if they feel safe at home. At a local Seattle-based listening session, families suffering from domestic violence voiced that they “live in fear every day” and that their “biggest goal is to reduce stress from trauma.”

Trustig, personal relationships are a critical element of trauma healing and should begin at the initiation of contact with healthcare. An example of the impact of positive communication is seen in a study of medical assistants’ interactions with Latinx families in pediatric care; parents who had better perceptions of interactions with medical assistants were more willing to discuss their child’s mental and emotional health. Healing happens within the contexts of relationships, emphasizing the importance of both the patient-provider relationship and provider-provider relationships. At Seattle Children’s, we have several systems in place that help facilitate connection with staff. There is a psychiatric nurse that goes around to the medical floors twice daily to offer personal support and help with self-care skills. Many departments have weekly case conferences aimed at group processing. There is also a staff support team available to help debrief difficult cases.

One major impact of trauma is the dysregulation of emotions and impulses. Naturally following, a goal of trauma informed care should be to help manage these emotional impulses. Part of best addressing the emotional needs of others is first recognizing and addressing our own emotions. Additionally, labeling feelings can be beneficial. The process of consciously labeling troublesome emotions has a direct, calming effect on those emotions. Furthermore, techniques such as relaxation, visualization and deep breathing can be useful in emotionally dysregulated situations. At Seattle Children’s we have Code Purple to indicate a response is needed for behavior that may pose a threat to self, others or property. While this is a useful and necessary procedure to have in place, Code Purple has potential to be redesigned with a trauma informed lens.

Critical to understanding trauma and creating a trauma informed system is awareness of disparities. Research indicates that ACEs are more common among individuals who are Black, Latinx, multiracial, LGBTQ, or low-income. This highlights the need for equity, and focus on disparity when working on mental health and trauma informed interventions.

**Anxiety**

Anxiety is a mental disorder that is characterized by high levels of fear and worry that interfere with day-to-day activities. For youth, this means they may be unable to control their worry, and the anxiety may cause distress or impairment in their functioning. Notably, symptoms of anxiety in children can also include angry or irritable moods, difficulty concentrating, and
fatigue or sleep disturbance. These symptoms could impact academic performance or school engagement.

According to findings from the 2016 National Survey of Children’s Health, 7.1% of children and youth ages 3 to 17 in the United States are estimated to be currently diagnosed with anxiety. Depression commonly co-occurs with anxiety. Among the estimated 7.1% of children and youth with anxiety, 32.3% are estimated to also have a current depression diagnosis. Around 40% of youth with anxiety are not receiving mental health treatment.

By self-report, anxiety is a mental health challenge faced by around half or more of Washington state high school students. State-wide in 2018, between 55% and 68% of eighth, 10th, and 12th graders reported feeling nervous, anxious or “over the edge” in the past two weeks. In addition, between 45 and 59% of eighth, 10th, and 12th graders in Washington state reported being unable to stop or control worrying in the past two weeks. More high school youth report symptoms of anxiety than symptoms of depression. This self-report data also indicates that older students experience higher rates of anxiety than younger students. The percentage of youth reporting symptoms of anxiety increases from 8th grade to 10th grade to 12th grade, with 12th graders reporting the highest rates of anxiety symptoms.

The prevalence of anxiety among Washington youth, and the substantial percentage of youth not receiving treatment, suggest that this is an area where improvement is needed.

Figure 42: Washington State Youth Who Experienced Anxious Feelings by Grade, 2018

---

There are some regional differences in rates of anxiety. Youth in the western part of Washington state (Kitsap and Clallam counties) report higher rates than the state average. A contributing factor may be the presence of military bases in these counties, given that parental deployment is associated with higher rates of anxiety in children and adolescents. On the other hand, youth in Pierce County, where there is a joint military base, report rates of anxiety consistent with the statewide average. Youth in the eastern part of the state (Grant, Benton, Franklin, Walla Walla, Chelan, and Yakima counties) report rates of anxiety comparable with the state average. Youth in King County, the most urban, report slightly higher rates than statewide average.

**Autism Spectrum Disorder**

Developmental disabilities are a group of disorders that consist of difficulties in learning, behavior, and/or self-care. According to findings from the National Health Interview Survey, about 7% of children ages 3 to 17 were estimated to have been diagnosed with a developmental disability in the United States. As of July 1, 2018, 47,527 clients were enrolled with the Washington State Department of Social and Health Services Developmental Disabilities Administration. Of these clients, 20% were ages 0 to 3, 27% were ages 3 to 18, and 5% were ages 18 to 21.

**Figure 43: Number of Clients of the Washington State Department of Social and Health Services Developmental Disabilities Administration, By County, as of July 1, 2018**

---

One of the most common neurodevelopmental delays, Autism Spectrum Disorder (ASD), is a developmental disability that can cause communication, behavioral and social challenges. ASD is the diagnosis of a spectrum disorder that included the former diagnoses of Asperger syndrome, pervasive developmental disorder not otherwise specified, and autistic disorder. According to the Centers for Disease Control and Prevention, one in 59 children in the United States has ASD, and ASD occurs four times more frequently in boys than girls. The Washington State Department of Health estimates that between 8,000 to 12,000 youth in the state have some form of ASD.

The implications of ASD extend beyond the associated communication, behavioral and social challenges. According to Autism Speaks, adolescents with ASD receive healthcare transition services half as frequently as adolescents with other special healthcare needs. In addition, mothers of children with ASD earn about one-third less than mothers of children with other disorders or disabilities and about half as much as mothers of children with no health limitations.

Services for youth with ASD are also typically specialized services, which inevitably make them harder to access initially and sustainably. For more information on challenges with accessing mental health services for youth with ASD and developmental disabilities, see the Community Input section of this chapter.
Bullying
Bullying is a type of violence that involves repeated, intentional, negative behavior from an aggressor toward a target in a perceived power imbalance. When technology is used for bullying, it is called cyberbullying. Cyberbullying occurs through email, texts, instant messages, different social media platforms and/or other digital applications, which can make cyberbullying hard to detect.

It is important to consider the impact and prevalence of bullying on youth mental health. Students who report being harassed or bullied are more likely to have lower grades in school, drop out of school, and may experience depression, anxiety, low self-esteem and have suicidal thoughts. Several studies have found an association between bullying and depression. Notably, youth who report bullying or cyber-bullying were at a higher risk for reporting suicidal ideation and attempts. In addition, students who bully others are more likely to have academic problems, substance abuse problems, and to experience violence later in life.

At a minimum, all schools in Washington state are required to implement policies and procedures that prohibit intimidation, harassment and bullying. Despite efforts to deter bullying, students still report that it is happening in schools.

According to the 2018 Healthy Youth Survey of sixth, eighth, 10th and 12th graders, between 17% and 31% of Washington state students reported that they were bullied at school in the past month, with the prevalence of bullying decreasing as grade increased. In the survey, bullying was defined as when “one or more students threaten, spread rumors about, hit, shove, or otherwise hurt another student over and over again. It is not bullying when two students of about the same strength or power argue or fight or tease each other in a friendly way.”

According to the 2018 Healthy Youth Survey:

- Nearly one in five middle school and high school students in Washington state reported that they did not feel safe at school.
- About one in 10 eighth, 10th and 12th grade students reported missing school because they did not feel safe.
- Around 6% of 10th and 12th graders reported carrying a weapon on school property in the past month.

Figure 44: Percentage of Students Who Reported Being Bullied in the Past Month in Washington State, 2018

---

Furthermore, between 7% to 16% of students also reported being cyberbullied or harassed due to their race or perceived sexual orientation within the past month.\(^\text{361}\)

**Figure 45: Percentage of Students Who Reported Being Harassed Due to Their Perceived Sexual Orientation or Race, or Bullied By Cell Phone or Computer in the Past Month in Washington State, 2018\(^\text{43}\)**
In King County in 2018, between 13% and 27% of students reported being bullied within the past month — rates that were slightly lower than the state average. Highest rates of bullying (27%) were reported among sixth graders.

- Between 13% and 19% of students reported that they did not feel safe at school.
- About one in 10 students in eighth, 10th and 12th grades reported missing school because they did not feel safe.
- 4% of 10th and 12th graders reported carrying a weapon on school property in the past month.

**Figure 46: Percentage of Students Who Reported Being Bullied in the Past Month in King County, 2018**

About one in 10 students in King County also reported being cyberbullied or harassed at school due to their race or perceived sexual orientation within the past month, with highest rates among sixth graders.\(^{364}\)

**Figure 47**: Percentage of Students Who Reported Being Harassed Due to Their Perceived Sexual Orientation or Race, or Bullied By Cell Phone or Computer in the Past Month in King County, 2018\(^{45}\)

---

In 2016, nearly one-third (30%) of King County youth in eighth, 10th and 12th grades who identified as lesbian, gay or bisexual reported that they were bullied at school, compared to 16% of youth who identified as heterosexual.\textsuperscript{365}

**Figure 48:** Percentage of Students Who Reported Being Bullied by Sexual Orientation, Grade & Race/Ethnicity, King County, 2016\textsuperscript{46}
Depression

Depression is a serious mental health condition that is typically characterized by feelings of sadness or hopelessness and may involve a loss of interest or pleasure in activities that were previously enjoyable. Rates of adolescent depression, defined as experiencing a major depressive episode within the last year, increased by 52% between 2005 and 2017. Depression may go undetected and untreated, leading to adverse consequences for that individual and those around them. Early signs of depression can include long durations of sadness or hopelessness that can impact a person’s day-to-day activities.

According to a 2019 report from Mental Health America, 12.6% of youth ages 12 to 17 in the United States experienced a major depressive episode, defined as a depressed mood or loss of interest or pleasure in daily activities for at least two weeks. Of youth diagnosed with...
depression, 19% received no follow up care in the 3 months after their diagnosis. Additionally, almost half of youth prescribed an anti-depressant did not have a visit to their provider in the 3 months following the prescription. These statistics raise concerns that many adolescents with depression receive an unacceptable level of care.

In Washington state, 13.2% of youth experienced a major depressive episode. Depressive Disorders were the top reason for inpatient admission to Seattle Children’s in 2018.

According to the 2018 Healthy Youth Survey:

- 32% of eighth graders in Washington state felt so sad or hopeless for two weeks or more that they stopped doing their usual activities — up from 24% in 2008.
- 40% of 10th graders in Washington state felt so sad or hopeless for two weeks or more that they stopped doing their usual activities — up from 30% in 2008.
- 41% of 12th graders in Washington state felt so sad or hopeless for two weeks or more that they stopped doing their usual activities — up from 29% in 2008.

Notably, this data shows a significant increase in self-report of depressive symptoms over the last decade. On average, about 4 in 10 middle and high school students experience depressive symptoms – in Washington state, that is over 150,000 youth.

Washington state high school youth self-report much higher rates of depressive symptoms than the national rates of diagnosed depression. This could suggest that depression in adolescents may be underreported [to providers] and/or under-diagnosed; it may also suggest that many youth experience depressive symptoms but do not all meet criteria for a diagnosis.

Based on self-report data, older students report higher rates of depression than younger students. Female youth generally report higher rates of depression than male youth. Youth who identify as lesbian, gay, or bisexual (LGB) report depressive symptoms at almost double the rate of heterosexual youth. One of the strongest protective factors for LGB youth is family acceptance; youth who report low levels of family acceptance reported significantly more depression, substance abuse, and suicidal ideation and attempts.

Figure 49: Washington State Youth Who Experienced Depressive Feelings by Grade, 2018

---

Although there is some variation by region, it is minimal. Youth in the western and southwestern part of the state (Kitsap, Clallam, Thurson, Mason, and Lewis counties) report slightly higher than state average rates of depression. Youth in the northern part of the state (Snohomish, Skagit, and Whatcom counties) report slightly lower than state average rates of depression. Youth in the eastern part of the state (Spokane, Chelan, Benton, and Grant counties) report rates of depression consistent with the state average.

**Suicide**

Suicide is a serious public health problem that has increased in the United States over the last several years. Among youth ages 1 to 19, suicide was the second leading cause of death in Washington state in 2017. Since 2015, the rate of suicide among youth, of all age groups and genders, has been increasing, but the suicide rate for female youth ages 10-14 has tripled.

There are some populations of youth more at risk for suicidal ideation and attempts. Lesbian, gay, and bisexual (LGB) youth are at higher risk of suicidal behavior. The suicide rate for transgender adults is nearly nine times the attempted suicide rate in the U.S. population; this suggests that transgender youth are also an at-risk population. Youth who experienced bullying or cyberbullying were at higher risk for suicidal ideation and suicide attempts. Additionally, youth who report bullying others were also at higher risk for suicide-related behavior.

The Healthy Youth Survey, given to 8th, 10th, and 12th graders in Washington, asks questions about depression and suicidal ideation; suicidal ideation refers to thoughts of engaging in behavior intended to end one’s life. In 2018 one out of five 10th and 12th graders reported considered attempting suicide. Around 10% of all three grades reported attempting suicide in the past year.
There are some regional differences noted. Youth in the western and southwestern part of Washington state report higher rates of considering and attempting suicide than the state average. Youth in the eastern part of the state rates comparable with the state average. Youth in King County, where the city of Seattle is located, as well as Snohomish County, which is directly above King County, report slightly lower rates than statewide average. These differences may be explained by differences in access to care – many areas of the state that are more rural lack pediatric mental health outpatient and inpatient resources. Some regional differences are noted below.

The dramatically increasing rates of suicide and the staggeringly high number of high school youth self-reporting suicidal ideation and suicide attempts should cause grave concern. In a high school of 1,400 students, about 140 will have attempted suicide. This should be seen as an area where improvement is necessary.

The CDC also notes additional risk factors for suicide: barriers to accessing mental health treatment and unwillingness to seek help because of the stigma attached to mental health. This indicates that increasing access to care and decreasing the stigma associated with mental health is of paramount importance as we look to reduce youth suicide.

---

In addition to Mental and Behavioral Health, Suicide and Injury Prevention is a top community health and benefit priority for Seattle Children’s. For more information about the work being done to prevent suicide deaths and other injuries, please see the Suicide and Injury Prevention section of this report.

**Alcohol, Drug and Tobacco Use**

Brain development continues until a person is in their mid-20s, and research shows that the developing brain is especially vulnerable to the effects of alcohol and drug use. Alcohol and drug use can also contribute to unintentional injuries, which are leading causes of hospitalization and death in Washington state youth.

**Alcohol Use**

Underage drinking is not only against the law, it is also harmful to the health and safety of adolescents and young adults. Consuming alcohol can lower a person’s self-awareness and cause them to be in dangerous situations. It can also damage their vital organs while they are still developing. Youth who drink alcohol are more likely to have problems in school, including poor grades and social issues, and are at a higher risk of physical injuries, such as burns, falls and motor vehicle collisions.

According to the 2018 Healthy Youth Survey, 2% of sixth graders, 8% of eighth graders, 18% of 10th graders and 28% of 12th graders in Washington state reported drinking at least once in the past month.

**Figure 51: Washington State Youth Who Reported Drinking at Least Once in the Past Month or Heavy Drinking, 2018**

Problem or heavy drinking, which is defined as drinking three or more days in the past month and/or one or more binge drinking episodes (drinking five or more drinks in a row in the past two weeks), is also a concern for youth in Washington state. In Washington state, 2% of sixth graders, 5% of eighth graders, 11% of 10th graders and 18% of 12th graders reported problem or heavy drinking.

Across all grades, alcohol was most commonly obtained through friends. Parties, giving money to someone to purchase alcohol and taking alcohol from home with or without permission were other common ways that students obtained alcohol.

Figure 52: Where Youth in Washington State Get Alcohol by Grade, 2018

The percentages in this chart are based on all students who reported getting alcohol in the past 30 days, regardless whether they reported drinking in the past 30 days. Students could select multiple sources.

---

Youth are less likely to drink if they believe that their parents or their communities think it is wrong. In 2018, 50% of 10th graders who drank alcohol believed their parents would not think it was wrong to drink alcohol, compared to 14% who drank even though they believed their parents thought it was wrong.

**Figure 53: Perceptions of Alcohol Consumption Norms in Washington State, Grade 10, 2018**

![Perceptions of Alcohol Consumption Norms in Washington State, Grade 10, 2018](https://example.com/image)

**Cigarette Use**

Youth smoking holds both short-term and long-term health consequences. Long-term consequences include damaged respiratory function, which may be irreversible, heart disease, and stroke. For young people, smoking can drastically lower their endurance and physical fitness. Compared to non-smokers, teens who use tobacco are 22 times more likely to use cocaine, eight times more likely to use marijuana and three times more likely to use alcohol. Smoking tobacco and other substances is associated with other risky behaviors, including violent behaviors.

In Washington state in 2018, 5% of 10th graders and 8% of 12th graders had smoked cigarettes in the past 30 days. It is estimated that 104,000 youth in Washington State who are alive now will die early because of smoking. Smoking is also highly associated with low academic performance.

Older students are more likely to smoke than younger students in Washington state. About 8% of 12th graders reported having smoked a cigarette in the past month, compared to 1% of sixth graders, 3% of eighth graders, and 5% of 10th graders. Across the state, more students who smoked cigarettes reported having lower grades in school (Cs, Ds or Fs) compared to non-smokers.

---

Like cigarette smoking, the use of electronic cigarettes and vapor products containing nicotine may cause harm to cognitive development during childhood/adolescence and into adulthood. Nicotine use at a young age also increases the likelihood of tobacco use and addiction to other drugs. Although the rates of tobacco use across Washington state have declined in recent years among youth, the use of vapor products and electronic cigarettes has increased substantially over the last few years. Rates of vapor product and electronic cigarette use also increases by grade.

In 2018, 3% of sixth graders, 10% of eighth graders, 21% of 10th graders and 30% of 12th graders in Washington state reported using vapor products within the 30 days prior to the survey. According to the 2018 Healthy Youth Survey, 62% of 12th graders who used vapor products said the product contained nicotine, 24% said the product contained marijuana, 26% said the product included flavor only and 8% did not know what substance was in the vapor product.

---

Electronic Vapor Product Use

---

The percentage of 12th grade students in Washington state who smoked cigarettes decreased by 60% from 2008 to 2018. Meanwhile, the percentage of 12th graders in the state using vapor products has increased substantially in the between 2014 and 2018. In 2018, nearly four times as many 12th graders used vapor products compared to cigarettes.

**Figure 56: Current (Past 30-day) Use Trends in Washington State, Grade 12, 2018**

---


Rates of vapor product use in Washington state varies by race/ethnicity. In 2018, the highest rate of vapor product use in the state was among students identifying as American Indian/Alaska Native (38% of 12th graders). The lowest rates were among youth identifying as Asian (14% of 12th graders) and students identifying as Black/African American (21% of 12th graders).

Figure 57: Current Vapor Product Use in Washington State by Race/Ethnicity, Grade 12, 2018

Note: N/S indicates that the question was not surveyed in that year.

---

In 2016, Washington state passed a vapor product law to establish a statewide licensing system and protections to reduce youth access to vapor products, whether or not they contain nicotine. Although the minimum age to purchase tobacco and vapor products is currently 18, youth are able to obtain these products from older friends and classmates. Beginning January 1, 2020, the sale or sharing of tobacco and vapor products to individuals under age 21 will no longer be legal.

**Marijuana Use**

Marijuana can be addictive and is the most commonly reported drug used among youth who enter drug treatment programs. Although some teens may use marijuana to cope with anxiety, depression or other mental health concerns, research has shown that anxiety and depression can worsen with the use of marijuana. Marijuana use may also lead to a decreased attention span, memory and learning function. Teens who use marijuana are also more likely to fail in school.

In some states, including Washington, marijuana has been legalized for recreational use among adults. However, Washington state law prohibits selling or giving marijuana to minors under age 21.

According to the 2018 Healthy Youth Survey, about 43% of youth in Washington state had tried marijuana at least once. Students in high school (10th and 12th grades) reported using marijuana at higher rates than students in sixth and eighth grades. The report also revealed that 5% of 10th graders and 9% of 12th graders reported heavy marijuana use, defined as using marijuana on 10 or more days in the past month.

**Figure 58: Current Marijuana Use and Heavy Marijuana Use Among Youth in Washington State, 2018**

---

**Note:**

The prevalence of marijuana use across Washington state in 2018 was similar to the Healthy Youth Survey results since 2010, even though marijuana was legalized for recreational use among adults in November 2012. More than half of eighth, 10th and 12th graders in Washington state reported getting marijuana from friends. Giving money for someone else to buy it and getting it from an older sibling are other prevalent ways youth in the state got marijuana. About half of 10th and 12th graders in Washington state perceived that marijuana was easy or very easy to get.

Figure 59: Where Youth in Washington State Get Marijuana, 2018

---

In Washington state, 10th graders are less likely to use marijuana if they believe their parents and/or their community believes it is wrong. This emphasizes the importance of parental discussions about marijuana use, yet only 64% of eighth grade students in Washington state reported having had discussions with their parents about not using marijuana. By 12th grade, only about half of students in Washington state said they had discussions with their parents about not using marijuana.

**Figure 60: Relationship Between Marijuana Use and Perceived Parental and Community Norms, Grade 10, Washington State, 2018**

Living with a marijuana user is a risk factor for youth marijuana use. Tenth graders in Washington state who live with a marijuana user are more than four times as likely to be a regular marijuana user than those who do not live with a marijuana user.

---

Prescription Medication Use

Prescription drug abuse is when an individual uses a medication that was not prescribed to them or takes their prescription medication for a reason other than why it was prescribed. This may include using stimulants, such as Ritalin, to stay awake or get high. Prescription drugs also include opioid painkillers, stimulants and depressants that cause dependence and addiction.

Often, teens who abuse prescription medications get them from friends or relatives with or without the knowledge of the original user of the medications. Prescription drug abuse is a growing issue across the United States as well as in Washington state. In 2014, there were more deaths due to overdose than motor vehicle crashes in the U.S.

In 2018, 2% of eighth graders and 4% of 10th and 12th graders in Washington state reported using painkillers in the last 30 days to get high. These painkillers included prescription drugs, such as Vicodin, OxyContin and Percocet.

Figure 61: Students Who Reported Using Painkillers to Get High at Least Once in Last 30 Days and Using Prescription Drugs Not Prescribed to Them in Past Month, Washington State, 2018

![Graph showing the percentage of students who reported using painkillers and prescription drugs not prescribed to them.]

In 2018, 6% of eighth graders and 7% of 10th and 12th graders in the state reported using prescription drugs not prescribed to them within the past month. The majority of students surveyed reported that they believed their parents and friends would think it was wrong to use prescription drugs not prescribed to them.

Opioid Use

Death due to opioid overdose is a growing public health problem in the United States, with rates growing substantially in the last decade.

Estimates indicate that an average of 130 Americans die from an opioid overdose per day.

The Centers for Disease Control and Prevention describe opioid overdose deaths in 3 waves:

1. Wave 1 beginning in 1999, characterized by increased prescribing of opioids.

---

2. Wave 2 beginning in 2010, characterized by fast increases in overdose deaths due to heroin.
3. Wave 3 beginning in 2013, characterized by overdose deaths due to synthetic opioids, including those including fentanyl.

Analysis of 2017 National Vital Statistics System drug overdose death rates suggests that the rate of drug overdose deaths is higher in rural counties than urban counties for natural and semisynthetic opioids, but higher in urban counties than rural counties for heroin and synthetic opioids other than methadone.⁴³¹

Between 2013 and 2017, there were 16 deaths due to overdose involving any opioid in Washington state among adolescents ages 13 to 17.⁴³² In the same time period, 89 youth ages 13 to 17 were hospitalized for overdoses involving any opioid.⁴³³ Due to small numbers, there are no hospitalization data available for some counties in Washington state.

Figure 62: Washington State Any Opioid Overdose Death Rate Among All Ages, 2013 – 2017

Any Opioid Overdose Death Rate (2013-2017)

 Integrated Mental and Behavioral Health Care

⁴³¹ As provided upon request from the Washington State Department of Health.

118 | P a g e
Advances in medicine over the past several decades have contributed to the increased survival of children with previously fatal diseases. In the United States, nearly one-quarter of children now grow up with a chronic medical condition. The associated demands of physical illness, including doctor appointments, medications, pain and fatigue can complicate the lives of these young people. Children with chronic physical illnesses are four times more likely to suffer from mental illness than their healthy counterparts. The repercussions of untreated mood disorders within this population are well studied. For example:

- Pediatric liver transplant patients with depression are less likely to be adherent.
- Patients with sickle cell disease and depression are more likely to visit the emergency department.
- Teenagers with type 1 diabetes and depression are more likely to be admitted to the hospital.

The recognition that caring for a person’s mental health status is an integral part of their well-being is becoming more widespread in the medical community. Primary care practices nationwide are integrating behavioral health care into their standard services. Children with chronic medical conditions certainly benefit from adequate behavioral health care, but reaching these patients in a primary care setting can be difficult since so much of their healthcare is managed through specialty care.

Currently, Seattle Children’s has the support of social workers in all subspecialty departments. Though social workers will often perform a psychosocial assessment on complex patients, they are unable to offer therapeutic treatment to those with concerning screenings. Social workers also lack the time to fully coordinate and follow up on mental health referrals. Patients who require outpatient mental and behavioral health services face insurance barriers, long wait lists and difficulty scheduling appointments.

Several clinics at Seattle Children’s are working to better integrate mental health directly into their services, especially at Odessa Brown Children’s Clinic. As a result of recommendations by their national foundations, both the Cystic Fibrosis Program and the Endocrine and Diabetes Clinic formally screen teenagers for depression annually. Several other departments at Seattle Children’s have mental health providers available to provide therapy to patients. These departments include the Cancer and Blood Disorders Center; Gastroenterology and Hepatology; the Heart Transplant Program; and Rehabilitation Medicine.

In 2014, the Washington State Legislature passed a bill that requires the full integration of physical and behavioral health services for Medicaid beneficiaries by 2020.

**Community Input**

Interviews with members of the WAMI community identified four key issues related to behavioral health: (1) access to mental and behavioral health care, resources, and services; (2) providers’ lack of understanding of mental health; (3) the mental health care system is complicated and detached from the physical health care system; and (4) mental health stigma is prevalent.
In an effort to gain a more thorough understanding of mental and behavioral health, Seattle Children’s conducted interviews with internal stakeholders. Interviews with those stakeholders identified similar key issues; the relevant themes from their responses are included in the themes listed below.

**Access to Mental and Behavioral Health Care, Resources, and Services**

One of the first things mentioned in each listening session or community stakeholder interview was the community’s felt lack of resources. Participants referenced long waitlists, lack of providers, and lack of providers who treated pediatric patients or specific diagnoses. Parents and caregivers described feeling like there were no mental health services available because every provider had a waitlist.

Participants articulated multiple challenges with insurance coverage and expensive out of pocket treatments. The concept of mental health system as only a crisis system or only a reactive system was discussed in multiple sessions; participants shared examples of struggling to get care for their child because their child was not acute enough or was not in crisis; some also shared that services went away when their child was out of crisis.

When discussing challenges in mental health care, internal stakeholders consistently identified access as a primary concern. Stakeholders discussed challenges in accessing Seattle Children’s mental and behavioral health resources as well as the lack of resources in the community. There are waitlists for almost every service in Seattle Children’s Psychiatry and Behavioral Medicine department; demand far outweighs capacity for outpatient care, inpatient care, and care for children with Autism Spectrum Disorder.

Stakeholders also articulated a concern about the lack of community resources as a challenge for accessing mental and behavioral health care. Consistently identified as lacking were intensive outpatient options including Intensive Outpatient Programs (IOPs) and Partial Hospitalization Programs (PHPs). Additionally, participants identified geographical disparities in access to care, noting that care was harder to access in more rural areas and in counties without mobile crisis response teams. Lastly, stakeholders noted that specialty care was especially challenging to access; participants cited care for ASD, programs for youth with suicidal ideation such as Dialectical Behavioral Therapy (DBT), and services for youth with behavioral challenges.

**Access for Youth with Autism Spectrum Disorder and/or Developmental Disabilities**

In discussing the challenges of accessing mental health care and resources, in almost every listening session, participants would highlight the additional challenge of finding services for their child who had a developmental disability or an Autism Spectrum Disorder (ASD). Parents discussed the challenge of needing a diagnosis prior to being eligible for services, only to discover that the waitlist for a diagnosis was months or a year. This theme emerges as a distinct subset of the challenges articulated related to access to care. Participants in almost every session or every site described waitlists for diagnoses of Autism, need for services for their child with a developmental disability, lack of developmental pediatricians or resources, and a lack of understanding of Autism and Developmental Disabilities among local providers.
Shortage of Mental Health Workforce
Related to discussions of inadequate access to care, internal stakeholders consistently expressed concerns about shortage of providers in the mental health workforce at all levels. The dearth of child and adolescent psychiatrists is a nationally recognized problem. Additionally, there are not enough therapists and psychologists in the community who treat pediatric clients.

Providers’ Lack of Mental Health Understanding.
Participants shared that providers in multiple disciplines did not have enough mental health understanding to provide high quality, effective, and empathetic care for their children. Examples ranged from pediatricians, doctors in hospitals, emergency department medical staff, teachers, school staff, and law enforcement. Participants discussed care being provided to their child that lacked an understanding of their diagnosis, such as ASD. Parents discussed how inappropriate it felt to have un-trained law enforcement involved in mental health crises or escalations because the mental health system lacked the capacity. Schools needing trauma-informed practice was also discussed by participants. Ultimately, caregivers articulated that many of the places children are receiving care or interacting with their community do not have pediatric trained personnel nor do those personnel have mental health training.

Internal stakeholders also identified the challenge of mental health competency in medical providers both internally and externally. While some medical providers report that they are comfortable managing mental health care for their patients, others report that it is out of scope for their practice. Stakeholders identified that this contributes to the challenge of access – narrowing the quantity of providers who can support families in navigating the mental health care system.

The Mental Health Care System is Complicated and Detached from the Physical Health Care System
Participants frequently discussed how challenging the mental health care system is. Often this was due to two primary factors: (1) the process of navigating the system to find resources or care is complicated and, in many cases, overwhelming or impossible for parents; and (2) the mental health care system is not integrated with the physical health or primary care system.

Regarding the challenge of finding resources or care, parents discussed how challenging it is that there is no single point of care for mental health resources. Many shared stories of having to navigate the system on their own, which was time-consuming, only marginally effective, and incredibly frustrating. Parents described navigating the mental health system as a “self-guided tour” and stated “it’s like stumbling around in the dark.” One parent described an experience of spending hours filling out paperwork and “jumping through hoops” that ultimately went nowhere. Even when parents sought resource recommendations from professional care providers, they were often provided with misinformation or outdated information about services that were ultimately no longer available.

Secondly, there is minimal integration with the physical healthcare system, making coordinating care for children with co-morbid physical and mental health diagnoses challenging. Some parents shared that their primary care provider did not know about mental health resources and
could not provide adequate mental and behavioral health treatment. Parent noted that there were many barriers to accessing care for their children, some of which were “hidden barriers.”

In a few sessions, participants discussed the challenge of managing transitions to and from inpatient psychiatric care, highlighting another complicated part of the mental health care system.

**Mental Health Stigma is Prevalent**
Participants articulated stigma as a problem when discussing or treating mental health. Parents described being abandoned or ostracized by their community after mental health issues with their children. Parents also mentioned that stigma was a huge challenge nationally.

Stigma also came up as parents discussed their experiences with feeling judged, dismissed, or outright ignored by their providers. Consistently, parents described not being taken seriously when raising concerns about their child’s mental health.

Internal stakeholders also expressed this was a concern and a challenge. Stakeholders articulated that stigma in the community at large was a concern and likely was a barrier to patients and families seeking and accessing mental or behavioral health care. Additionally, stakeholders frequently discussed the presence of stigma against mental health care by physical health care providers.

**Community Assets and Resources**
- In 2015, Seattle Children’s grew its inpatient mental health services by expanding its Psychiatric and Behavioral Medicine Unit from 20 beds to 41 beds. The unit works to diagnose, treat and prevent problems with emotions and behavior in patients ages 3 to 18 through a hospital stay, which averages about five to seven days. The PBMU also works closely with each child’s community providers to support the return home.
- The Seattle Children’s outpatient Psychiatry and Behavioral Medicine department provides short-term evidence-based treatment for children and adolescents through specialty clinics.
- Seattle Children’s Emergency Department (ED) has a Mental Health Team that works with patients who present to the ED for a mental health concern. The team includes a Mental Health Evaluator (MHE) who evaluates the patient to determine the level of service necessary, a Pediatric Mental Health Specialist II (PMHS II) who acts as a Mental Health Navigator for families throughout their ED visit, and a Patient Watch Officer who supervises the patient for safety, typically a member of our Security team.
- Seattle Children’s Odessa Brown Children’s Clinic (OBCC) offers family-focused, evidence-based programs, such as the Promoting First Relationships program, which focuses on parents of children up to age 3, and Parent-Child Interactive Therapy for children who have difficulties with emotional regulation from ages 3 to 8. Seattle Children’s has experts who are involved in mental health-related prevention efforts, including violence prevention in collaboration with schools and community organizations.
OBCC provides mental health services, along with primary care and care coordination in multiple public elementary, middle and high schools, and Wellspring, which serves homeless children.

OBCC provides pediatric mental healthcare in the same facility as primary care services and trains pediatricians on how to integrate mental healthcare into primary care visits.

OBCC is partnering with Nowland Premier Soccer Academy Foundation to provide soccer training at the Rainier Vista Boys & Girls Club. The program is an example of using sports to help teach social and emotional skills. It is a high-level, year-round, free soccer training that aims to prepare teams in Rainier Valley to compete in Seattle leagues.

Seattle Children’s Autism Center provides assessment, diagnosis, treatment and support for autism spectrum disorders. Its clinicians provide medical, psychiatric, behavioral and speech services for babies, children and young adults.

Seattle Children’s Alyssa Burnett Adult Life Center offers classes and activities for adults with ASD and other developmental disabilities as they transition out of the education system and into adulthood. The Alyssa Burnett Adult Life Center hosts year-round classes and activities for adults ages 18 and older that promote lifelong learning and independence, enhance quality of life and provide meaningful ways to take part in the community.

Seattle Children’s publishes the Autism Blog and Teenology 101, which are blogs that frequently address mental health in teens.

Seattle Children’s offers meal support classes for parents of children or teens with eating disorders, and support groups for deaf and hard-of-hearing teens and preteens who have mental illness.

The Partnership Access Line (PAL) is a state-funded, telephone-based child mental health consultation service in Washington state that is administered by child psychiatrists at Seattle Children’s.

The Washington Mental Health Referral Service for Children and Teens connects families with mental health providers who are accepting new clients and who meet the child’s needs. The Mental Health Referral Service is funded by Washington state and operated by Seattle Children’s. Referral specialists connect families with evidence-support outpatient mental health services in their community. The service is free and the child does not have to be a patient of Seattle Children’s.

Telemental Health through Seattle Children’s allows children with mental healthcare needs in certain under-resourced communities in Washington and Alaska to receive mental health services from a psychiatric provider, psychologist, or therapist through videoconferencing. The provider must be licensed in the state in which the patient resides in order to provide care through Telemental Health. During the service delivery, patients and families are typically located at a clinic or community behavioral health agency and the provider is typically located at the main campus of Seattle Children’s Hospital or the Seattle Children’s Autism Center. In the past year, the Telemental Health service has expanded to allow Telemental Health services to patients and families located at their home, through the Telehealth Direct to Consumer program, based on changes in Washington State law.

The Crisis Consultation Clinic is a pilot program that started at Seattle Children’s in Spring 2019. Patients in crisis who are in need of intensive resource can be referred to the
Crisis Consultation Clinic for stabilization of suicidality on an outpatient basis, in many cases preventing an inpatient admission.

- **Children’s Crisis Outreach Response System (CCORS)** provides mobile crisis outreach and crisis stabilization services for children and youth up to age 18 in King County.
- The Middle School Support Project (MSSP) is a partnership with Nesholm Family Foundation and Sound Mental Health. The program assigns four care coordinators, who are master’s level child mental health professionals, to one Seattle middle school each. Students who have mental health needs, are involved in multiple systems, and are having academic problems can be referred for support from MSSP.
- School-based integrated health centers provide behavioral and physical healthcare.
- Culturally specific providers provide care to diverse communities, often with the ability to provide services in patients and families’ native language. Some of these culturally specific providers include the Seattle Indian Health Board, the Snoqualmie Nation Clinic, Sea Mar, Consejo, Seattle Counseling Service, and the Asian Counseling and Referral Service.
- King County’s Mental Illness and Drug Dependency (MIDD) Behavioral Health Sales Tax Fund provides additional services for individuals who do not qualify for Medicaid. The program helps stabilize youth and adults suffering from chemical dependency and mental illness so they can receive the mental healthcare services they need to avoid an emergency room visit or jail stay.  
- King County’s Best Starts for Kids initiative and the MIDD will expand their Screening, Brief Intervention, and Referral to Services (SBIRT) school-based tool to promote mental health and prevent substance use for middle school students.
- Specialty courts, such as domestic violence court, drug court, mental health court and family treatment court, also address mental health.
- The Washington Council for Behavioral Health advocates for community behavioral health agencies so they can improve the lives of individuals in Washington state who have mental illness or a substance use disorder.
- The **Washington Autism Alliance and Advocacy** is a personal and legislative advocate for children and adults with Autism Spectrum Disorder (ASD) and other developmental disabilities.
- The New Journeys program is focused on providing comprehensive to youth and young adults who are experiencing their first episode of psychosis. This service is provided by Valley Cities Behavioral Health Care.
- In many listening sessions, community members identified that local community collaboratives and resilience initiatives were assets in their community.

**Opportunities**

- Our current mental health system does not have the capacity to handle the volume of patients who need care. To address this, the state’s Managed Care Organizations should be held accountable for providing timely access to mental health care, and we need to invest in increased hospital capacity for inpatient and outpatient care. Creative use of telemedicine, like Seattle Children’s Partnership Access Line, can help bridge gaps where there are too few providers in a region to care for all the children, teens and young adults who need mental health services.
Currently Washington state Medicaid does not pay for intensive outpatient options such as Intensive Outpatient Programs (IOPs) or Partial Hospitalization Programs (PHPs), limiting program development in the community and creating gaps in the continuum of care youth should have access to. Medicaid reimbursement for services such as IOP and PHP can help create more access to care and prevent inpatient psychiatric hospitalizations.

Additional outreach services through partnerships with community centers, schools and organizations in places where vulnerable children and families live could support earlier intervention and prevention efforts.

Seattle Children’s and OBCC have expertise in pediatric mental healthcare with psychologists, psychiatrists and counselors who see patients and do groundbreaking research to improve care. These experts could potentially engage in efforts to build capacity among primary care providers to provide mental health screenings and manage treatment for some mental health conditions.

OBCC will be opening an additional clinic in South Seattle to increase access to healthcare closer to home. As in the current model of care at OBCC, the new clinic will provide integrated physical and mental health services.

Offering support and educational opportunities to parents/guardians will reinforce their parenting skills and help them learn new skills and knowledge about child health and development.

Public health messaging about mental health could inform and educate children and families.

Creating an integrated care coordination system/process that facilitates the notification of behavioral and physical healthcare providers with information about both physical and mental health care could create efficiencies and reduce unnecessary emergency department use.

Clinicians in primary care settings and emergency departments can use the Screening, Brief Intervention, and Referral to Treatment (SBIRT) process to identify individuals at risk for substance abuse disorders.

Continued advocacy for improved coordination between mental and physical health services can highlight the importance of this issue.

Applying trauma-informed care principles within healthcare facilities and schools can reduce unnecessary trauma for youth living with a mental health disorder or trauma impacts.

Continued advocacy for strategies to reduce the stigma associated with mental illness and mental health care. This could be in the form of prevention efforts, awareness campaigns, and/or integrated physical and behavioral health care.

Maternal and Child Health
Having healthy mothers, infants, and children is an important goal that can help improve health outcomes across generations. Mental, physical, emotional and socioeconomic well-being — before, during and after pregnancy — can affect a child’s outcomes during infancy, childhood and adulthood. Moreover, maternal and child health outcomes are markers of a community’s overall health. This section focuses primarily on access to health care although other
environmental and social factors such as early intervention, educational/employment/economic opportunities, and social support influence infant, child, and maternal health outcomes.

**Early and Adequate Prenatal Care**
Prenatal care is an opportunity to educate expectant mothers on ways to have a healthy pregnancy by avoiding potentially harmful exposures, following an exercise plan, choosing a healthy diet and controlling existing medical conditions, like diabetes and high blood pressure. Prenatal care is also important because it can help prevent complications during pregnancy and delivery, and thus impacts the health of the infant.

Beginning prenatal care early in the pregnancy and having regular visits with a provider improves the likelihood of a healthy pregnancy. In Washington state among women in 2016 with known timing of initiation of prenatal care, 80.5% of pregnant women received early prenatal care in their first trimester. This is higher than the Healthy People 2020 goal of 77.9% of expectant mothers receiving early prenatal care, although not all counties met this goal.

**Figure 63: Rates of First Trimester Prenatal Care by County, 2014-2016 Average**

---

Lower rates of early prenatal care were reported among women under age 25, women identifying as Native Hawaiian/Pacific Islander, women on Medicaid and women who had a high school education or less.446
We wish to note about Figure 64 that while this table illustrates many important elements of birth statistics for women giving birth in Washington and their access to or lack thereof of prenatal care, we realize that the subgroup terminology specific to Native Hawaiian and Other Pacific Islander (NHOPI) and Undocumented aren’t the titles we’d prefer to use when describing these individuals.

---

Infant Mortality
The infant mortality rate refers to the number of babies per 1,000 live births who die before their first birthday. Leading causes of infant mortality include birth defects, preterm birth, low birth weight, and maternal pregnancy complications. The infant mortality rate is an indicator of the overall health of a population because many of these deaths are preventable, which is one reason that early and adequate prenatal care is an important measure of healthcare.

The Healthy People 2020 goal for infant mortality is less than 6.0 deaths per 1,000 live births. In 2017, the infant mortality rate in Washington state was 3.9 deaths per 1,000 live births, which was less than the national infant mortality rate of 5.8 deaths per 1,000 live births. The infant mortality rate in Washington state was down from previous years — 4.3 per 1,000 live births in 2016, 4.9 per 1,000 live births in 2015 and 4.5 per 1,000 live births in 2014.

However, there are some continued disparities in infant mortality in Washington state. For 2013 to 2015, infant mortality rates were higher among infants of mothers who were less than 20 years old, Black/African American, American Indian/Alaska Native, recipients of Temporary Assistance for Needy Families, or had an education level of high school or less.

Low Birth Weight
Infants born weighing less than 2,500 grams (about 5.5 pounds) are considered low birth weight. Low birth weight in infants is caused by premature birth or fetal growth restriction. Low birth weight increases risk of respiratory issues, jaundice, and infections in infancy. Low birth weight has long term health implications as well, as it increases the risk of cardiovascular disease, diabetes, and intellectual and developmental disabilities. Of note, both the health conditions common at birth and the long term health implications of low birth weight may require extensive medical needs, resulting in high cost of medical care. The Institute of Medicine reported in 2007 that the costs related to premature birth in the United States were an estimated $26.2 billion each year. Some causes of premature birth and fetal growth restriction can be monitored and addressed in prenatal care, re-emphasizing its importance for infant health.

In 2016, 6.4% of infants in Washington state were low birth weight. This meets the Healthy People 2020 goal of 7.8% or fewer infants born at low birth weight.

Community Assets and Resources
- The Global Alliance to Prevent Prematurity and Stillbirth (GAPPS) is dedicated to improving understanding of the causes of prematurity and stillbirth as a foundation for developing successful prevention and treatment strategies. GAPPS is home to a large repository of specimens collected from a large and diverse group of pregnant women. These specimens are available to investigators worldwide who aim to understand the biological mechanisms of prematurity and stillbirth. GAPPS stewards the Preventing Preterm Birth initiative, a Grand Challenge in Global Health from the Bill & Melinda Gates Foundation designed to unite the scientific community to combat and prevent prematurity. The Perinatal Interventions Program (PIP) aims to improve survival and reduce disability of newborns and mothers by standardizing the care of preterm infants.
and improving maternal conditions that lead to preterm birth, stillbirth and other life-threatening and disabling conditions.

- The Equal Start Community Coalition seeks to reduce infant mortality by bringing together leaders of nearly 30 organizations to promote healthy mothers, families and communities.
- The Native American Women’s Dialogue on Infant Mortality is a native-led collective whose members are concerned about high rates of infant mortality in their communities.
- Governor Jay Inslee’s statewide “Results Washington” framework calls for reducing birth outcome disparities.
- Nurse Family Partnership and other home-visiting and prenatal-support programs, including MOMs Plus, offer support for high-risk pregnant women and mothers. However, providers remain concerned that there is not sufficient capacity within these programs.
- Seattle Children’s Protection Program promotes the Period of PURPLE Crying Approach to Shaken Baby Prevention and hosts a statewide taskforce to disseminate this information through state hospitals, clinics and agencies that have contact with pregnant women and their partners, as well as to parents and caregivers of newborns.

Opportunities

- The Baby-Friendly Hospital Initiative encourages and recognizes hospitals and birthing centers that offer an optimal level of care for infant feeding and mother/baby bonding. In Washington state, 10 hospitals are currently designated as Baby-Friendly.
- Adverse Childhood Experiences (ACEs) are common and increasingly recognized as significant risk factors for poor child and adult health outcomes. Because of the impact that trauma has on physical, mental, and emotional health, trauma-informed care addresses past traumatic experiences and aims to prevent future traumatic experiences by incorporating safety, connection, and managing emotional impulses into healthcare. The ACEs Collaborative, an informal work group of providers through Public Health-Seattle & King County, is developing a common framework of trauma-informed care and the life-course model (a strengths-based framework grounded in understanding and responding to the impact of trauma throughout a person’s life). The group’s goals are to offer technical guidance and support, and to promote existing and emerging data and research on the life-course model.
- Prenatal care can offer an opportunity to address lifelong health issues with women.
- Many community-based organizations offer home visits, provide other support to pregnant women and mothers, and are strong partners to healthcare systems.
- The Public Health Improvement Partnership — convened by the Washington State Department of Health — aims to prevent or reduce the impact of adverse childhood experiences, such as abuse and neglect.

Weight Related Health and Behavior

Children who are overweight or obese often have worse health, limited ability to move and be active, lower self-esteem and increased risk for developing type 2 diabetes compared to children who are a healthy weight. People who are overweight or obese during their youth have a higher risk of being obese as adults.
Poor diet and physical activity are risk factors for becoming overweight or obese. Youth who have fewer opportunities for physical activity have increased time spent on sedentary activities, including using computers or watching television. Eating fewer meals at home, increased availability and affordability of unhealthy food, and increased food portion sizes can all contribute to poor diet among youth.

Children and adolescents who are obese are at high risk of developing chronic health conditions later in life, and are more likely to be bullied and to suffer from social isolation, depression and lower self-esteem.\(^{466}\) As with many leading causes of disability and death, there are disparities by race/ethnicity, economic status, geographic location and sexual orientation.

**Obesity and Overweight Prevalence**

Children, teens and young adults are considered overweight if their body mass index (BMI) is in the top 15% for their age and gender\(^ {467}\) and obese if their BMI is in the top 5%.\(^ {468}\)

In Washington state from 2016 to 2017, 10.1% of children ages 10 to 17 were considered obese.\(^ {469}\) This rate is based on data from the National Survey of Children’s Health, which collects information on the health of children in the United States by asking parents or caregivers to report their child’s height and weight. Washington state has the third lowest rate of obesity for children ages 10 to 17 in the United States, according to the survey. The national obesity rate among the same age group was 15.8%.\(^ {470}\)

**Figure 65: State-by-State Comparison of Youth Obesity Rates, Ages 10 to 17, 2016-2017\(^ {63}\)**

---

According to the 2018 Healthy Youth Survey of students in Washington state, 14% of students in eighth grade, 15% of students in 10th grade and 15% of students in 12th grade were overweight by self-report of height and weight. Additionally, 12% of eighth graders, 14% of 10th graders and 17% of 12th graders were considered obese.

**Food Insecurity**

Food insecurity is defined as an uncertainty or limited availability of or ability to acquire safe and nutritionally adequate foods. While hunger affects people on an individual level, food insecurity occurs at the household level. Food insecurity is divided into the categories of “low food insecurity” and “very low food insecurity.” Low food security is defined as “reports of reduced quality, variety or desirability of diet with little or no indication of reduced food intake.” Very low food insecurity is defined as “reports of multiple indications of disrupted eating patterns and reduced food intake.”

Children who experience hunger are more likely to be hospitalized and experience medical conditions, including asthma and anemia. They are also more likely to have behavioral and social problems, repeat a grade in elementary school, and experience impairments related to motor skills and language development.

Nationally, about one in six children (17% or about 12.5 million) lived in food-insecure households in 2017. Across the United States, about 84% of counties with high food insecurity were in rural communities.

In Washington state in 2017, the rate of food insecurity among children was just above the national average (17.3% compared to 17.0%). According to the 2018 Healthy Youth Survey, Washington state eighth, 10th and 12th graders who reported experiencing food insecurity also reported lower grades in school compared to their peers.

Federal and state assistance programs have been shown to reduce child food insecurity rates and lessen the health impacts of food insecurity among children. These programs include the Supplemental Nutrition Assistance Program (SNAP), national school meal programs and the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC).

More than half (57%) of children who were food insecure in Washington state were eligible for federal nutrition programs based on income level in 2017. In 2018, more than 517,000 children in Washington state participated in the National School Lunch Program, and nearly 200,000 children participated in the National School Breakfast Program. Also in March 2019, nearly 481,000 households (about 826,000 people) in Washington state participated in SNAP, and about 131,000 people participated in WIC.

Figure 66: Percentage of Children Who Were Food Insecure in Washington State, 2017

---

Fruit and Vegetable Consumption

Nutritional recommendations for children and youth depend on age, sex, and physical activity level, though ample consumption of fruits and vegetables are recommended for all ages. Eating fruits and vegetables lowers the risk of developing many chronic diseases and can support weight management.

In 2018, 19% of eighth graders and 17% of 10th and 12th graders in Washington state reported eating five or more servings of fruits and vegetables per day over the past seven days. Rates of fruit and vegetable consumption varied between 14% and 24% among students in the Washington counties highlighted in this report.

Figure 67: Percentage of Youth Who Ate Five or More Fruit/Vegetable Servings Daily by Grade, 2018

---

Youth Consumption of Sugar-Sweetened Beverages
Sugar-sweetened beverages are beverages that are sweetened with added sugars, such as high-fructose corn syrup, glucose, raw sugar, and honey. The consumption of sugar-sweetened beverages is associated with obesity, diabetes, and diseases of the heart, kidneys and liver. Furthermore, consumption of sugar-sweetened beverages is associated with increased prevalence of dental caries in children, even after accounting for differences in sociodemographic and maternal oral health.

There is considerable variation in patterns of consumption of sugar-sweetened beverages by demographic characteristics. In children and youth, rates of consumption of sugar sweetened beverages are higher among males, individuals who are adolescents, youth who are non-Hispanic Black/African American, and youth who are living in a low-income family.

In Washington state in 2018, 3% of eighth and 10th graders, and 5% of 12th graders reported drinking sweetened drinks daily at school. These rates have decreased substantially over the past decade. Among 10th graders, the rates declined by 84% - from 19% in 2008 to 3% in 2018.

Figure 68: Percentage of 10th Grade Students in Washington State Who Drank Sweetened Drinks at School, 2018

---

Though rates of consumption of sugar-sweetened beverages daily at school have decreased, past-week consumption of sugar-sweetened beverages remains high. In Washington state, about three-quarters of students in eighth, 10th and 12th grades reported drinking sugar-sweetened drinks in the past week.\textsuperscript{498}

Figure 69: Percentage of Youth Who Drank Sugar-sweetened Drinks in Past Week by County and Grade, 2018\textsuperscript{67}

\textsuperscript{67} Healthy Youth Survey. (2018). \textit{HYS fact sheets}. Retrieved from \url{http://www.askhys.net/FactSheets}. 
Physical Activity

Regular physical activity during childhood and into adolescence is crucial for promoting lifelong health and preventing the development of certain chronic conditions. The benefits of physical activity include improving physical fitness, maintaining strong bones and healthy muscles, helping with weight control, decreasing depressive feelings and improving cognition. It is recommended that children and adolescents ages 6 to 17 participate in at least 60 minutes of physical activity every day. However, many youth do not meet these physical activity recommendations. In 2016, only 24% of U.S. youth met the recommendation.

In Washington state, fewer than 25% of school-age children meet the recommendation of participating in at least 60 minutes of physical activity seven days a week. According to the 2018 Healthy Youth Survey, 73% of sixth graders, 72% of eighth graders, 78% of 10th graders and 79% of 12th graders in Washington state did not meet this physical activity recommendation.

Community Input

Physical activity

- Many low-income families and listening group participants report difficulty being physically active because of public safety issues, lack of exercise-related information in their own language, body image stigma, cost and lack of time.
- Listening group participants report other barriers, such as transportation issues, winter weather conditions and a lack of opportunities for physical activity in rural locations.
Participants also share challenges engaging in physical activity if the parents have more than one job, which limits their time and results in children spending unsupervised time indoors, usually watching television or playing video games. Listening session participants also mentioned that indoor activities for children in inclement weather are cost-prohibitive and outdoor activities aren’t adjacent to where they can afford to live.

**Nutrition**

Recent community-based surveys of low-income women and women of color reported on the difficulty of purchasing healthy food with limited food assistance and/or limited income. In addition, low-income families often depend on public transportation when purchasing food, which can make grocery shopping a lengthy and difficult endeavor. Recent Metro bus service reductions may exacerbate this problem. There are fewer transportation options in suburban cities.

Listening group participants shared concerns about the quality of school food (including breakfast and lunch) and appropriateness for their culture.

Teen and adult participants have some knowledge about nutrition, such as the importance of eating fruits and vegetables and limiting soda consumption, but adults mention challenges finding time to prepare healthy meals, particularly if they have more than one job.

Participants say they are not always sure if their child is a healthy weight. In some immigrant communities, this may be partly because of cultural perceptions that heavier weight in children is desirable or the perception that heavier weight shows success and prosperity.

**Community Assets and Resources**

**Nutrition**

As of 2019, organizations in Washington have grouped together to propose a fruit and vegetable prescription program supported by the Food Insecurity Nutrition Incentive (FINI) Program. The idea is for healthcare providers and supportive housing sites to screen individuals for food insecurity, provide the food insecure with Fruit and Vegetable Prescriptions to use at participating retailers for fresh produce, and track their health outcomes. Such a program, mirrored after the Wholesome Wave’s Fruit and Vegetable Prescription Program (FVRx), would bring greater food security to food insecure households, reduce healthcare costs, support the local economy and help prevent diet-related chronic diseases.

Community gardens and farmers’ markets provide the opportunity to learn about and access fruits and vegetables.

The Fresh Bucks program enables shoppers who receive basic food assistance to increase up to double their money at farmers’ markets.

The Women, Infants and Children Special Supplemental Nutrition program helps pregnant women, new mothers and young children eat well, learn about nutrition and stay healthy.

Food banks and other feeding programs sponsored by faith-based organizations are working to provide healthier options to customers.
Seattle Children’s participates in several nutrition initiatives that benefit the community:
- The nutrition team offers healthier options on menus and provides nutrition education to employees, patients and visitors.
- Seattle Children’s contributes to local and regional initiatives to improve access to fruits and vegetables, such as Fresh Bucks, grocery store vouchers for produce, and free or low-cost food bags.
- Seattle Children’s has organic gardens and offers classes to patients and families about gardening and nutrition.

Healthy Eating and Active Living
- Local parks, community centers and pools offer public places for physical activities; some offer programs, such as single-gender swim times and scholarships for children. Some participants commented on affordability of these activities and how it can cause disparate access to these programs.
- The Healthy King County Coalition aims to reduce health inequities by improving nutrition, increasing physical activity, and decreasing smoking rates and other tobacco use.
- OBCC promotes healthy lifestyles during well-child visits and offers follow-up visits for children who are overweight or obese. Families can learn about healthy eating and attend nutrition and cooking classes.
- Childhood Obesity Prevention Coalition, a coalition of 52 organizations, engages in legislative advocacy.

Opportunities

At Seattle Children’s
- Seattle Children’s has adopted the “Healthy Food in Healthcare” pledge and enrolled in the Healthier Hospitals Initiative Healthy Beverages Challenge, which calls on institutions to increase healthy beverage purchases by 20%. In 2012, Seattle Children’s removed all sugar-sweetened beverages from cafeterias, vending machines and gift shops. More than 57% of beverages purchased for the cafeteria, patient menus and vending machines are now healthy.
- Seattle Children’s is also working to increase the purchase of local and sustainable food by 15% each year.
- In fall 2016, Seattle Children’s opened a larger, better-equipped kitchen that has enabled staff to prepare made-to-order meals using fresh ingredients for hospitalized patients. The kitchen was designed with the goal of creating tasty, healthy, fresh whole foods, including locally sourced foods from the Pacific Northwest, more gluten-free and organic products, and antibiotic-free meats. Kitchen staff will also prepare food for the cafeteria and catering requests.

In Communities
- Evidence based opportunities include ideas that communities should offer free or low-cost education on cooking and grocery shopping for adults and children through fun, interactive activities that the whole family can enjoy together in settings that are convenient for community members. Educational opportunities and information should
also be available online or through social media for families who are not able to attend in person. Opportunities should be culturally relevant and accessible to families who speak different languages. Immigrant families have different needs compared to U.S.-born families because they are exposed to and interested in both U.S. foods and familiar foods from their countries of origin.

- Increase access to affordable and healthy foods and beverages in low-income communities, including at retailers and farmers’ markets.
- Work with schools and childcare centers to increase consumption of healthier foods and improve physical activity offerings, including outdoor activities.
- Provide training and capacity-building around healthy eating and active living to teachers, administrators, school nurses, primary care providers and others who work with children.
- Improve access to physical activity in collaboration with employers, coalitions, agencies and communities. These groups are creating walking trails, building new exercise facilities, providing access to existing nearby facilities, reducing the cost of opportunities for physical activity and providing activities for the whole family. It is important to provide opportunities for physical activity that are inclusive and non-competitive.
- Provide culturally relevant education about positive parenting and incorporate content related to healthy eating and active living. Participants in listening groups representing different cultures and communities expressed their commitment to their children’s health, and several mentioned an interest in parenting education and support. For recent immigrants, this could include parenting in a new country and balancing U.S. culture with the preservation of original culture and traditions, potentially incorporating information related to eating and nutrition using both traditional and U.S. foods.
- Work with communities to improve community safety, increase active commuting to school and ensure access to safe places for physical activity and recreation. Communities with high rates of obesity and overweight frequently also have high rates of crime, and many listening group participants mentioned concerns that their neighborhood was not a safe place for children to play outside.
- Promote safe transportation options, including walking and bicycling.
- Advocate for policies to support food security, healthy eating and active living at the local, state and federal levels.
- Help residents increase their earning capacity (and their ability to buy healthy food) by supporting job training programs, community economic development and living wage ordinances.

**Suicide and Injury Prevention**

Unintentional injuries are injuries due to accidental or unintentional causes that result in harm. Intentional injuries are those that are either self-inflicted or inflicted by another person with the intent to cause harm, such as suicide attempts, child maltreatment or assault. Deaths that result from intentional injuries are categorized as homicide or suicide.

In this chapter, we explore qualitative and quantitative data related to suicide and injury prevention primarily in Washington state. See the spotlight chapters on Alaska, Montana and Idaho for data specific to those states.
In Washington state, an average of 720 children die each year.⁵⁰⁹ Suicide and unintentional injuries were the leading causes of death among children ages 0 to 19 in Washington state between 2015 and 2017.⁵¹⁰ In 2016, there were 127 deaths due to unintentional injuries among Washington state residents ages 0 to 19. In the same year, there were 97 intentional injury deaths, comprised of 65 suicides and 32 homicides. In 2015, there were 2,187 nonfatal unintentional injury hospitalizations and 802 nonfatal intentional injury hospitalizations.⁵¹¹ Most of these deaths and injuries are preventable.⁵¹²

The Healthy People 2020 initiative, funded by the U.S. Department of Health and Human Services, set a goal to reduce the unintentional injury mortality rate to no more than 36.0 deaths per 100,000 population for all ages. In 2016, the unintentional injury mortality rate in Washington state was 43.6 per 100,000 for all ages.

The Healthy People 2020 initiative also aims to reduce suicides to no more than 10.2 per 100,000 population and homicides to no more than 5.5 per 100,000 for all ages. In 2016, the Washington state suicide mortality rate was 14.9 per 100,000 and the homicide mortality rate was 3.0 per 100,000 for all ages. Washington state has met the Healthy People 2020 homicide target but not the suicide target.⁵¹³

Although some injuries among children in Washington state have declined since the 1990s, youth suicide – especially by firearm – and poisoning deaths are increasing.⁵¹⁴ Based on our analysis of Community Health Assessment Tool (CHAT) data provided by the Washington State Department of Health, youth suicide by firearm increased by 12% between 2016 and 2017 and is up by 65% since 2007. It should be noted that poisoning deaths and child maltreatment figures have also risen since our last community health assessment published in 2016.⁵¹⁵

Some types of injuries and motor vehicle collision death rates have remained steady since the 1990s. Even though rates are not increasing, they are still a major cause of harm and death to children and young adults in Washington state.

**Leading Causes of Death and Injuries**

From 2013 to 2017, the leading causes of death in children and youth ages 0 to 24 in Washington state in order of frequency were suicide, motor vehicle collisions, unintentional poisoning, assault and unintentional drowning.⁵¹⁶

**Figure 70: Leading Causes of Injury-related Death, Washington State 2013-2017⁶⁸**

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Rank 1&lt;sup&gt;st&lt;/sup&gt;</th>
<th>Rank 2&lt;sup&gt;nd&lt;/sup&gt;</th>
<th>Rank 3&lt;sup&gt;rd&lt;/sup&gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; 1</td>
<td>Unintentional Suffocation 68</td>
<td>Assault Unspecified 13 (2.96)</td>
<td>Unintentional Motor Vehicle Traffic 8</td>
</tr>
</tbody>
</table>

---

Data from the Washington State Department of Health indicate that there is substantial variation in leading causes of injury-related deaths by age group. In considering priorities for improving the health and safety of children and youth in the state, this variation in causes of injury-related deaths demonstrates that it is imperative to consider the developmental contexts and relevant risks within each age group when designing and implementing prevention and intervention strategies.

Among Washington state infants less than 1 year old, unintentional injury was the third leading cause of death and homicide was the fifth leading cause of death from 2015 to 2017. Specifically concerning injury-related death from 2013 to 2017, unintentional suffocation, assault (unspecified) and unintentional motor vehicle traffic collisions were the three leading causes of death among this age group. In injury-related deaths, unintentional suffocation was by far the leading cause of death, occurring at a rate of approximately 15.5 deaths per 100,000 infants, potentially suggesting a need for education around safe sleep practices in Washington state.

From 2015 to 2017, unintentional injury was the leading cause of death in Washington state, occurring at a rate of 5.4 deaths per 100,000 children for children ages 1 to 4. Homicide was the fourth leading cause of death. The leading causes of injury-related death were assault (unspecified), unintentional motor vehicle traffic, unintentional fire/burn, and unintentional pedestrian accidents, each of which occurred at a rate of approximately 1 death per 100,000
children. The data indicates a need for more resources regarding safe car seat installation and child proofing.

The leading cause of death for children ages 5 to 9 in Washington state was unintentional injury from 2015 to 2017, which occurred at a rate of 2.8 deaths per 100,000 children. Additionally, the second, third and fourth leading causes of death were malignant neoplasms, congenital anomalies, and homicide, respectively. Among injury-related deaths for this age group, the leading cause was unintentional motor vehicle traffic collisions, which occurred at a rate of 1.1 deaths per 100,000 children from 2013 to 2017. Unintentional drowning and unintentional fire/burn were the second and third leading causes of death, respectively. Data suggests a need for more resources about safe booster car seat installation practices and safe water practices.

Among youth ages 10 to 14 in Washington state, the leading cause of death was suicide, which occurred at a rate of 2.4 deaths per 100,000 youth from 2015 to 2017. Unintentional injury closely followed as the second leading cause of death, occurring at a rate of 2.3 deaths per 100,000 youth. Concerning deaths due to injury specifically, suicide by suffocation, which occurred at a rate of 1.35 deaths per 100,000 youth, was the leading cause of injury-related death from 2013 to 2017. This was followed by unintentional motor vehicle traffic collisions and suicide by firearm, respectively. Because suicide is the highest ranked cause of death in this age group, Washington state youth may benefit from increased support for mental health and suicide prevention activities, including safe gun storage.

For adolescents and adults ages 15 to 24 in Washington state, unintentional injury was the leading cause of death, with 23.6 deaths occurring per 100,000 people from 2015 to 2017. Suicide and homicide were the second and third leading causes of death, occurring at rates of 17.7 and 5.9 deaths per 100,000 people, respectively. Specifically examining injury-related deaths in 2013 to 2017, unintentional motor vehicle traffic deaths occurred at a rate of 11.9 deaths per 100,000 youth in this age group, which was the leading cause of injury-related death. Unintentional poisoning and suicide by firearm were the second and third leading causes of injury-related death, each occurring at a rate of approximately 7 deaths per 100,000 people. The high rate of deaths due to motor vehicle crashes and suicide suggest a strong need to focus on suicide prevention and safe-driving initiatives, such as anti-texting and driving campaigns.

**Disparities and Inequities**

Injuries and deaths disparately affect some communities more than others. Nonfatal injury hospitalization rates differed by county (see Figure 71 below: rates not presented for counties with five or fewer hospitalizations or residual standard error greater than or equal to 30%. A bar with a blue background indicates a rate significantly different than the state average.)

**Figure 71: Nonfatal Unintentional Injury Hospitalizations in Washington State by County, Ages 0 to 19, 2012-2015**

---

Injury deaths, hospitalizations and emergency department visits also vary by race, ethnicity, gender, geography, living in a rural or urban area, socioeconomic status, environmental factors, health literacy and disability. These inequities result from historical and contemporary public policies, institutional practices and social norms that have adversely affected some populations for generations.\textsuperscript{534} Disparate access to resources including housing, education, employment, earnings, benefits, credit, healthcare, safe neighborhoods, criminal justice and media perpetuate these inequities and the discriminatory views that reinforce them. At a family level, inequitable access and implicit biases can impede easy and inexpensive availability of safety resources like car seats, services like access to swimming lessons, and resources like healthcare and housing.

Addressing social factors or determinants of health disparities is possible, and numerous strategies show promise toward increasing health equity.\textsuperscript{535, 536} Achieving equity is likely to lower the rate of intentional and unintentional deaths and injuries among children and youth, particularly in under-resourced communities.
Intentional and unintentional injuries often lead to hospitalization and death. Not all injuries result in hospitalization, however, and nationwide changes occurred to hospital injury codes in 2015. Thus, currently available data from hospitalizations likely underestimate the true impact of injuries and it should be noted that data are suppressed if the occurrence is smaller than 10.

**Intentional Deaths**

**Suicide**

Suicide was the leading cause of death among youth ages 10 to 14 and youth ages 15 to 24 in Washington state from 2013 through 2017, similar to the U.S. rate. A total of 529 youth died from suicide in Washington state between 2015 and 2017:

- 32 deaths among children ages 10 to 14 (a rate of 2.4 per 100,000 population), and
- 497 deaths among teenagers and young adults ages 15 to 24 (a rate of 17.7 per 100,000 population).

Consistent with national trends, more males than females died from suicide, though females made more attempts. American Indian/Alaska Native youth had the highest rate of suicide per 100,000 (12.8 compared to 7.3 overall), followed by white youth. The lowest rates of suicide were among youth classified as Asian and Hispanic. Although King County experienced the highest number of suicides, Spokane and Yakima counties had the highest rate of suicide per 100,000 youth ages 0 to 24 at rates of 10.3 and 10.1, respectively.

Firearms were the most common mechanism of suicide deaths in Washington state for both the general population and youth ages 10 to 24 from 2013 to 2017. Roughly three-fourths of the suicide deaths in this age group resulted from firearms. In the majority of suicide deaths by

---

firearms among youth in King County, the weapon was stored unlocked and/or was loaded. Evidence suggests that firearm availability in the home increases the risk of suicide by 90% to 460%. Preventing access to a firearm decreases the likelihood of firearm-related suicide.

**Figure 73: Washington State Firearm Suicide Deaths, Ages 15-24, 2009-2016**

A 2018 survey of Washington state youth showed that roughly 10% of eighth, 10th and 12th graders attempted suicide in the past year. Reducing the number of suicides is a national priority. Healthy People set a 2020 goal to reduce the percentage of youth in ninth through 12th grades who attempt suicide to 1.7%.

Suicide rates in Washington state have been climbing for more than 20 years. Preventing suicide will require a multi-faceted approach that includes:

- increasing child and young adult access to psychiatric care and crisis intervention services;
- screening for depression and suicidal ideation; and
- increasing use of lethal means safety, including safe firearm storage practices and medication-locking devices.

Prevention efforts should be comprehensive for communities with higher-than-average rates of suicide. Child death review teams recommend increasing parental education and supervision of teens and pre-teens, and increasing funding to provide mental health services at schools.

---

For more information on suicide and youth, see the suicide section of the Mental and Behavioral Health chapter.

**Homicide Deaths**
There were 212 homicide deaths among youth ages 0 to 24 in Washington state between 2015 and 2017 – an average of about 71 per year. Nearly 79% of homicide deaths were among youth ages 15 to 24.

**Table 74: Homicide Deaths Among Children and Young Adults, 2015 to 2017**

<table>
<thead>
<tr>
<th>Age</th>
<th>Washington state</th>
<th>King County</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td># of homicide</td>
<td>Rate per</td>
</tr>
<tr>
<td></td>
<td>deaths (average</td>
<td>100,000</td>
</tr>
<tr>
<td></td>
<td>per year)</td>
<td>population</td>
</tr>
<tr>
<td>0-4 years</td>
<td>29 (10)</td>
<td>2.2</td>
</tr>
<tr>
<td>5-14 years</td>
<td>Suppressed</td>
<td>n/a</td>
</tr>
<tr>
<td>15-24 years</td>
<td>167 (56)</td>
<td>5.9</td>
</tr>
</tbody>
</table>

Males were more likely than females to die from an assault (4.7 deaths compared to 1.2 deaths per 100,000, respectively). The rate of homicide deaths among Black/African American youth is more than twice the overall rate. Roughly one-third of homicide deaths in the state occurred in King County, and most were concentrated in the areas that comprise South Seattle. Due to population size, King County had the highest number of child and youth homicide deaths overall in Washington state, but Grant and Yakima counties had the highest homicide death rate per 100,000 children and youth.

**Figure 75: Homicide Rate Per 100,000 Among Washington State Youth Ages 0 to 24, 2010 to 2017**

---


Investing in and ensuring safe, protective and healthy family environments to support child development, as well as early child education and positive relationships between youth and caring adults helps prevent violence.\textsuperscript{561} Community, family and individual-level risk factors increase the likelihood of violence, and community, family and individual-level approaches can be effective at reducing youth violence.\textsuperscript{562}

**Nonfatal Assault-related Hospitalizations**

Washington state hospitalizations included 4,084 poisoning and injury incidents and 339 assault incidents during 2016 and 2017.\textsuperscript{563} Assaults that do not result in hospitalization are excluded, thus the prevalence of nonfatal assaults on children and youth is underestimated. Roughly one-third of the assaults occurred in King County\textsuperscript{564} and victims were more likely to be male than female (a rate of 11.4 and 2.4 per 100,000, respectively) and the majority were between ages 20 to 24. The most common injuries were from intentional strikes (hitting) and firearms, followed by cuts and burns.\textsuperscript{565}

**Table 76: Nonfatal Assault-related Hospitalizations Among Children and Young Adults, 2016 to 2017\textsuperscript{75}**

<table>
<thead>
<tr>
<th>Age</th>
<th>Washington state</th>
<th>King County</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total number</td>
<td>Rate per 100,000 population</td>
</tr>
<tr>
<td></td>
<td>(average per year)</td>
<td></td>
</tr>
<tr>
<td>0-1 years</td>
<td>Suppressed</td>
<td>n/a</td>
</tr>
<tr>
<td>1-14 years</td>
<td>20 (10)</td>
<td>0.8</td>
</tr>
<tr>
<td>15-24 years</td>
<td>313 (156)</td>
<td>16.6</td>
</tr>
</tbody>
</table>

\textsuperscript{75} Table crafted by Seattle Children’s based on CHARS data
As mentioned previously, community, family and individual-level prevention and intervention efforts can reduce the likelihood of violence. A public health approach to preventing violence with strong community involvement that addresses environmental conditions and involves collaboration across community sectors has the best chance of successful violence prevention.566

**Child Maltreatment**

While legal definitions of child maltreatment vary by state, four types are generally recognized: physical abuse, sexual abuse, neglect (including educational neglect, medical neglect and other forms), and emotional maltreatment.

Child abuse and neglect is detrimental to child mental health and development567 and increases the likelihood of experiencing other forms of violence later in life.568 It is associated with an increased risk of delinquency, under-age pregnancy, suicide, depression, anxiety disorders, PTSD, eating disorders and high-risk behaviors like drug use in adulthood.569 The U.S. Centers for Disease Control and Prevention’s (CDC) strategic plan focuses on addressing the social determinants of child maltreatment and family risk factors as keys to preventing further abuse and neglect.570

In the national statistical system that tracks child maltreatment, children are counted as victims if an investigation by a state child welfare agency classifies their case as either “substantiated” or “indicated” child maltreatment. *Substantiated cases* are those in which an allegation of maltreatment or risk of maltreatment was supported or founded according to state law or policy. *Indicated cases* are those in which an allegation of maltreatment or risk of maltreatment could not be substantiated, but there was reason to suspect maltreatment or the risk of maltreatment.571

In 2017, Washington state received 95,603 reports of child abuse and/or neglect and investigated 41,299 children for possible maltreatment572 573—an increase over recent years.574 Neglect is defined as “a failure to provide the basic needs required to sustain and promote a child’s health, safety and well-being”575 and accounts for 70% of validated child maltreatment cases in the state. Children ages 0 to 5 are at greatest risk for child abuse and neglect, with rates slightly higher for girls than for boys.576 Eastern Washington and Western Washington had the highest rates of child maltreatment investigation (79 and 88 per 100,000 respectively) and foster care placement (4 and 5 per 100,000, respectively), King County and Central Washington had the lowest rates of child maltreatment investigation (44 per 100,000) and foster care placement (2 per 100,000).577

Data suggest that American Indian/Alaska Native children experience the highest rates of abuse and child maltreatment.578 Furthermore, not only are American Indian/Alaska Native youth more likely to experience trauma, but their families and communities have been subjected to substantial trauma throughout history.579 Examples of historical traumatic events include devastation of American Indian/Alaska Native populations due to infectious disease, forced relocation to reservations and urban areas in the 19th Century, and loss of identity and disruption of family structures among multiple generations of youth who were forced to assimilate to white culture through boarding schools beginning in the 1870s. These experiences have historically resulted in unresolved grief, the impacts of which can extend across generations and may play a role in high rates of child abuse and neglect and other health inequities among American Indian/Alaska Native communities.580
Understanding the intersection of these adverse childhood experiences (such as child maltreatment) and historical trauma within the context of grief and trauma for American Indian/Alaska Native populations is critical. According to public health science practices, “understanding how historical trauma influences the current health status of racial/ethnic populations in the United States may provide new directions and insights for eliminating health disparities.”

Taking historical trauma into account, it is to be expected that current American Indian/Alaska Native populations are reconciling the grief inherited from generations before them. In other words, there has been a greater understanding of epigenetics – functional changes in DNA that result in different expressions of genetic material – in recent years. Through epigenetic changes, the genetic-level impacts of trauma may be carried through generations. In examining any mental, physical or emotional health data among American Indian/Alaska Native children, considering the historical context of their communities is imperative for equitable and effective interpretation, prevention and intervention efforts.

Published rates of abuse and neglect among American Indian/Alaska Native children are higher than those for other racial and ethnic groups. However, data used to calculate these rates are incomplete. A recent study found that data on the abuse and neglect of American Indian/Alaska Native children from published reports and from different national sources differ substantially. The National Child Abuse and Neglect Data System (NCANDS) is often used to compare incidents of abuse to U.S. Census Bureau data. However, the NCANDS does not include all of the data on child abuse and neglect among American Indian/Alaska Native children. This was confirmed by data from the Bureau of Indian Affairs (BIA) and Indian Health Service (IHS) that are not routinely reported to the NCANDS. Given these facts, true rates of child abuse and neglect may be even higher than the widely quoted high rates of abuse and neglect among American Indian/Alaska Native children.

**Figure 77: Trends in Rate of Occurrence for Screened-in Intake by Race, Washington State, 2018**

---

At Seattle Children’s, we wish to note that a system designed and controlled by American Indian tribes/nations and Alaska Native people may provide the best way to address problems in the existing and underreported data, as opposed to existing systems – some of which are operated by groups that have historically enforced oppressive measures against American Indian/Alaska Native communities. An initial step in the design of such a system would be to give American Indian/Alaska Native people an opportunity to develop a culturally appropriate definition of abuse and neglect and to have a larger say in when and how a designation of neglect is made for American Indian/Alaska Native children.585

According to child death review teams in Washington state, prevention recommendations include substance abuse interventions, access to training and resources to help parents cope with crying infants or periods of intense crying, and home visits by public health nurses.586 In an intervention developed by and for Alaska Native communities, there is an understanding that each community is unique and support for healing must acknowledge historical context, cultural strengths, individual and community vision, and support from allies. Strengths-based solutions built on truth, honesty, compassion and shared responsibility for healing and protecting today's children have shown success.587

**Commercial Sexual Exploitation of Children**

*A note on inclusion*

We include this section within the *Suicide and Injury Prevention* chapter of our Community
Health Assessment because we believe that commercial sexual exploitation of children (CSEC) is directly correlative to injuries of these children. By presenting qualitative and quantitative data within our Pediatric Community Health Assessment, we not only list it as something that is hurting and harming our pediatric population, it allows us to examine the issue more carefully and explore cause, effect and harm as a result.

**What we've learned**

Commercial sexual exploitation of children is the exploitation of a child by an adult accompanied by a payment in money or in kind to the child or adolescent (male or female) or to one or more third parties. This includes but is not limited to prostitution, human trafficking, and the production, promotion, and distribution of child pornography. According to the National Center for Missing and Exploited Children, 100,000-293,000 children are in danger of becoming sexual commodities. Though this may seem like a global problem and not a local one, in 2017, there was a 13% increase in human trafficking cases identified through the National Human Trafficking Hotline in the United States. Of the 10,615 survivors in 2017, 2,762 were minors. Identified cases represent only a fraction of the total number of people being trafficked and sexually exploited. The median age for entry into sex trafficking in the U.S. is 13 to 14.

In 2018, Washington state ranked 12th among states for the highest number of National Human Trafficking Hotline phone, email, and website form submissions from human trafficking victims. Various factors influence the vulnerability of trafficking victims or those at risk. LGBT youth are at a particularly high risk for human trafficking, in addition to other risk factors including homelessness, substance abuse, other victimization, and living in poverty. Sex traffickers prey on vulnerable members of the community and specifically target people of color. Commercial sexual exploitation of children can occur through sex trafficking and pimp-led prostitution on the streets and on the internet. Additionally, homeless youth may engage in “survival sex,” the selling of sex to meet subsistence needs such as food, shelter, drugs, or money.

**Current Legal Definitions**

The legal system has a major role in shaping how various organizations seek to reduce the incidence and prevalence of CSEC. Federally, the Trafficking Victims Protections Act (TVPA) established that human trafficking is a federal crime and has laid the groundwork for combatting the different forms of trafficking. Federal legislation specific to sex trafficking of children makes it illegal to “recruit, entice, obtain, provide, solicit, patronize, move or harbor a person, or to benefit from such activities” for people under the age of 18.

At the state level, Washington law states that a person is guilty of commercial sexual abuse of a minor if he or she provides anything of value to a minor as compensation for engaging in sexual conduct with the minor as well as if they solicit, request, or offer sex in return for anything of value. Consent by the minor to sexual activity does not constitute a defense. Legislation is also in place to charge a person with promoting commercial sexual abuse of a minor if he or she knowingly advances commercial sexual abuse or profits from such conduct. Again, consent by the minor does not constitute a defense. Lastly, there is a ‘safe harbor law’ in place wherein a young person accused or convicted of prostitution may have their offense “diverted” if there are
programs to provide safe housing, case management, mental health and chemical dependency services, education and employment training, and referrals to specialized services in the county where they were arrested. Though the safe harbor law allows for better protections for youth who are survivors of CSEC, the latter part of the law is currently an unfunded mandate and cannot consistently be enforced.

**At Risk Youth**

In 2008, King County law enforcement estimated that between 300-500 girls under the age of 18 are involved in prostitution in the Seattle area. However, this range is likely an underestimate. Data on arrests among juveniles for prostitution in Washington state indicate 50 arrests were made in 2006; African American youth were over-represented with respect to the state population at 28% of the total arrests.

Sexual exploitation through the internet is increasing. Service providers reported an increases in gang-affiliated prostitution, prostitution-related violence and trafficking of youth across state lines. These experiences can affect youth for years to come; arrest records show that youth become involved in prostitution and often stay involved for decades. Youth are often misclassified as criminals as opposed to the victims of child abuse and sexual exploitation. It should be noted that research on male victims is particularly scarce.

There are several risk factors that make youth more susceptible to exploitation. Research indicates that youth identifying as lesbian, gay, bisexual, transgender, or queer (LGBTQ), American Indian/Alaska Native females and youth who have experienced abuse and/or neglect, lived in a group foster home, have experience with Child Protective Services or experienced homelessness represent a large proportion of CSEC. When considering these identities, we should also consider the intersectionality that may occur with these identities, and how this may increase risk of CSEC. For example, the 2018 Count Us In survey indicated that there were strong ties between identifying as LGBTQ; 71% of all respondents identifying as LGBTQ reported first experiencing homelessness as a youth or young adult. There are no reliable statistics for King County but a study in 2001 that surveyed homeless and/or runaway youth in 5 cities, including Seattle, found that 3.4% of males reported that they had “prostituted for money” (compared to 2.5% of females) and 3.8% reported that they had ever traded sex for money or drugs (compared to 4.7% of females). In addition, King County appears to be the area of Washington state with the highest number of CSEC – in 2006, 49 out of 50 juveniles arrested in Washington state for prostitution were from King County.

**Health Risk Profile**

There are a number of adverse health outcomes associated with youth sex and labor trafficking, including traumatic injury from sexual and physical assault or work-related injury, STIs, other infections, chronic untreated medical conditions, pregnancy and related complications, chronic pain, substance abuse and malnutrition. Mental health outcomes are similarly numerous and include depression, PTSD suicidal attempts, self harm, anger control issues, dissociative disorders, and their comorbidities. Mental health issues often may precede human trafficking and/or develop as a consequence of trauma. It is important to note this as traffickers will often use underlying mental health issues or cause others to perceive trafficked youth as less credible reporters of their own health.
Given the wide range of adverse health outcomes that occur when youth are trafficked, it is imperative that CSEC be redefined as a major public health issue in King County. We must take a system-based approach and consider underlying structural factors, such as poverty and homelessness, when implementing solutions. It is also important to ensure that all solutions are rigorously tested, evidence-based, and grounded in trauma informed care in order to best serve those who are most vulnerable.  

**Unintentional Injuries**

Unintentional injuries are one of the leading causes of death and hospitalizations for children and youth in Washington state. The most common causes of unintentional injury deaths from 2016 to 2017 was from motor vehicle collisions, followed by poisoning. Similarly, transportation-related injury was a leading cause of unintentional death among youth, especially among males ages 15 to 19.  

**Unintentional Injury Deaths**

Between 2013 and 2017, 1,413 Washington state youth ages 0 to 24 died from unintentional injuries, resulting in an average of 283 deaths per year.  

Motor vehicle deaths are particularly common and are among the top three causes of unintentional injury death for youth ages 0 to 24, with most occurring among youth ages 15 to 24. The rate was higher among males than females in Washington state.  

Unintentional injury deaths are more likely among American Indian/Alaska Native and Black/African American youth than youth of other races. Yakima County’s rate of unintentional injury deaths per 100,000 was highest among all counties in Washington state (23.8 deaths per 100,000 compared to an overall statewide rate of 11 deaths per 100,000) in 2016 and 2017. The rate in King County was similar to the state rate (8.7 per 100,000). There were 289 unintentional injury deaths among children and youth in King County – an average of 58 per year.  

**Table 78: Leading Causes of Unintentional Injury Deaths by Age Group in Washington State, 2013-2017**

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Rank</th>
<th>1st</th>
<th>2nd</th>
<th>3rd</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; 1</td>
<td></td>
<td>Unintentional Suffocation 68 (15.49)</td>
<td>Unintentional Motor Vehicle Traffic 8 (Rate Suppressed)</td>
<td>Unintentional Drowning 4 (Rate Suppressed)</td>
</tr>
<tr>
<td>1 – 4</td>
<td>***</td>
<td>Unintentional Motor Vehicle Traffic; Unintentional Fire/Burn;</td>
<td>Unintentional Drowning 15 (0.84)</td>
<td>Unintentional Suffocation 10 (Rate Suppressed)</td>
</tr>
</tbody>
</table>

---

Unintentional Other Pedestrian
18
(1.01)

5 – 9 Unintentional Motor Vehicle Traffic
25
(1.1)
Unintentional Drowning
10
(Rate Suppressed)
Unintentional Fire/Burn
6
(Rate Suppressed)

10 – 14 Unintentional Motor Vehicle Traffic
22
(0.99)
Unintentional Drowning
11
(Rate Suppressed)
Unintentional Other Transportation
7
(Rate Suppressed)

15 – 24 Unintentional Motor Vehicle Traffic
556
(11.94)
Unintentional Poisoning
339
(7.28)
Unintentional Drowning
83
(1.78)

(Note: The number of deaths presented, followed by rate of deaths per 100,000 in parentheses. Rate suppression is presented because the relative standard error is greater than 30%. *** Among children ages 1 to 4, unintentional motor vehicle traffic, unintentional fire/burn, and unintentional other pedestrian each occurred at a rate of 1.01 deaths per 100,000 youth, with 18 deaths in each category.)

Unintentional Injury Hospitalizations
Unintentional injury-related nonfatal hospitalizations are more frequent than suicides or assaults in Washington state. As with intentional injuries, not all injuries result in hospitalization in the state. There were nationwide changes to injury codes in 2015, which means Washington state hospitalization rates likely underestimate the prevalence of unintentional injuries.

In 2016 and 2017, Washington state hospitals reported 4,020 unintentional injury hospitalizations, most from motor vehicle collisions and falls. These unintentional injuries were more common among males than females, and youth ages 15 and older. Patterns were similar in King County, which had 1,127 unintentional injury hospitalizations over the same time period.625

Figure 79: Nonfatal Injury Hospitalization Rate Per 100,000 for Washington State Youth Ages 0 to 24 years, 2016-201778

Motor Vehicle Deaths
Motor vehicle deaths result from motor vehicle collisions (MVC) and include deaths of vehicle occupants, motorcyclists, bicyclists and pedestrians. A total of 629 unintentional motor vehicle collision deaths among children and youth occurred from 2013 to 2017 in Washington state – an average of 126 per year. Most occurred among youth ages 18 to 24. Males were more likely to die in a motor vehicle collision than females, and American Indian/Alaska Native youth had the highest motor vehicle death rate compared to other racial/ethnic groups. During this same period, 115 children and young adults died in motor vehicle collisions in King County.

Table 80: Motor Vehicle Deaths Among Children and Young Adults in Washington State and King County, 2013 to 2017

<table>
<thead>
<tr>
<th>Age</th>
<th>Washington state</th>
<th></th>
<th>King County</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total number</td>
<td>Average per year</td>
<td>Total number</td>
<td>Average per year</td>
</tr>
<tr>
<td>0-4 years</td>
<td>36</td>
<td>7</td>
<td>Suppressed</td>
<td>n/a</td>
</tr>
<tr>
<td>5-9 years</td>
<td>25</td>
<td>5</td>
<td>Suppressed</td>
<td>n/a</td>
</tr>
<tr>
<td>10-14 years</td>
<td>22</td>
<td>4</td>
<td>Suppressed</td>
<td>n/a</td>
</tr>
<tr>
<td>15-17 years</td>
<td>85</td>
<td>17</td>
<td>12</td>
<td>2</td>
</tr>
<tr>
<td>18-19 years</td>
<td>124</td>
<td>25</td>
<td>21</td>
<td>4</td>
</tr>
<tr>
<td>20-24 years</td>
<td>347</td>
<td>70</td>
<td>69</td>
<td>14</td>
</tr>
</tbody>
</table>

Motor Vehicle Injury Hospitalizations
Washington state had approximately 1,368 nonfatal hospitalizations from motor vehicle collisions in 2016 and 2017. The average per year was lower than prior estimates for all age groups.
groups, except among adults ages 20 to 24. The same is true for King County, which saw around 349 hospitalizations for nonfatal motor vehicle collisions.

Table 81: Nonfatal Motor Vehicle Injury Hospitalizations Among Children and Young Adults in Washington State and King County, 2016 and 2017

<table>
<thead>
<tr>
<th>Age</th>
<th>Washington state</th>
<th></th>
<th>King County</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total number</td>
<td>Average per year</td>
<td>Total number</td>
<td>Average per year</td>
</tr>
<tr>
<td>0-1 year</td>
<td>Suppressed</td>
<td>n/a</td>
<td>Suppressed</td>
<td>n/a</td>
</tr>
<tr>
<td>1-4 years</td>
<td>55</td>
<td>28</td>
<td>14</td>
<td>7</td>
</tr>
<tr>
<td>5-9 years</td>
<td>89</td>
<td>45</td>
<td>19</td>
<td>10</td>
</tr>
<tr>
<td>10-14 years</td>
<td>117</td>
<td>59</td>
<td>35</td>
<td>18</td>
</tr>
<tr>
<td>15-17 years</td>
<td>219</td>
<td>110</td>
<td>48</td>
<td>24</td>
</tr>
<tr>
<td>18-19 years</td>
<td>224</td>
<td>112</td>
<td>61</td>
<td>31</td>
</tr>
<tr>
<td>20-24 years</td>
<td>664</td>
<td>332</td>
<td>172</td>
<td>86</td>
</tr>
</tbody>
</table>

The rate of nonfatal hospitalizations due to motor vehicle collisions increased markedly, however, for children older than age 14 and are highest among youth ages 18 to 24. In 2016 and 2017, for example, the rate of motor vehicle hospitalizations ranged from 40 per 100,000 for youth ages 11 to 17, to more than 60 per 100,000 for those ages 18 to 24 (this is compared to between 7.6 and 12 per 100,000 among children 14 and younger).

According to child death review teams, modifiable risk factors for motor vehicle deaths included alcohol and/or drug-impaired driving, distracted driving, and improper use of car seats and seat belts.

In 2016, about 6% of sixth graders, 15% of eighth graders and 17% of 10th and 12th graders reported riding in a vehicle driven by someone who had been drinking alcohol in the past 30 days. In 2016, 5% of 10th graders and 9% of 12th graders reported driving after drinking alcohol in the past 30 days.

Child Passenger Safety

Preventing harm to children and young adults caused by motor vehicle collisions involves increasing the use of safe restraints, like seat belts and safety seats, and preventing collisions and impaired driving.

Nationally, 43% of children ages 4 to 7 are restrained in booster seats. Child safety seats reduce the risk of death in passenger cars by 71% for infants and by 54% for children ages 1 to 4. For children ages 4 to 7, booster seats reduce injury risk by 59% compared to seatbelts alone. Child-restraint systems are often used incorrectly. One study found that 72% of nearly 3,500 observed car and booster seats were misused in a way that could increase a child’s risk of injury during a crash.

---

Driving under the influence of drugs and alcohol increases the risk for and severity of motor vehicle crashes. In motor vehicle crashes resulting in death, 20% of drivers were legally drunk and 61% of the children weren’t properly restrained.

The Healthy People 2020 initiative aims to:
- reduce crash-related deaths and injuries; and
- increase the percentage of children restrained with age-appropriate methods.

Education and enforcement methods can increase the use of car safety restraints for children, and deeper education around height and weight guidelines and laws for car seats and booster seats may impact child passenger safety.

**Poisoning**

In 2017, the Washington Poison Center responded to 62,987 calls, 18% of which involved children under age 6. Nationally, the highest frequency of poisoning cases occurs among children ages 1 to 2, but severity of injury is higher in teenagers. During 2013 to 2017, nine children under the age of 9 and 339 youth ages 15 to 24 died from unintentional poisoning in Washington state. American Indian/Alaska Native youth had a higher rate of death due to poisoning than children from other racial/ethnic groups (10 deaths per 100,000, compared to between 2.3 and 3.4 deaths per 100,000). From 2013 to 2017, King County had 94 fatal cases of unintentional poisoning in children and youth ages 0 to 24, most commonly among youth ages 15 to 24.

Poisoning deaths are on the rise and refer to unintentional or intentional fatal intoxication resulting from an improper use of pharmaceutical drugs (either prescribed or over-the-counter medications) or illicit drugs. In the United States, an estimated 8.6 million adolescents and young adults reported current illicit drug use, including prescription psychotherapeutics, marijuana, crack/cocaine, heroin, hallucinogens, inhalants or methamphetamine. Given data trends, this report cannot conclude why poisoning deaths are on the rise in Washington state, but according to a 2019 study published in the *Journal of Studies on Alcohol and Drugs* that analyses such trends in poisoning deaths among adolescents and young adults, Washington state’s legalization of marijuana and the current opioid crisis may play a role.

In the United States between 2006 and 2015, 36,422 adolescents and young adults (8.4 per 100,000 population) died of drug poisoning. Poisoning due to opioid use was the primary contributing cause of death for nearly half (47%) of these deaths. The majority of drug poisoning deaths were unintentional (84.7%). Washington state’s rates of adolescent and young adult drug poisoning death rates are slightly lower than the national average for opioid-related deaths, but slightly higher than the national average for pharmaceutical drug and illicit drug-related deaths (excluding opioids).

For more information on opioid use among Washington state youth, see the opioid section of the Mental and Behavioral Health chapter.

Preventing poisoning deaths involves restricting access to poisons – including medications – and education about prevention and response. Interventions include distribution and use of
medication-locking devices, programs promoting the safe disposal of prescription drugs, and education and resources on childproofing. Preventing drug-related deaths also requires increased access to rehabilitation programs and mental and behavioral health services.

**Drowning**

Unintentional drowning is one of the top five leading causes of injury-related death for children and youth in Washington state, ranking second after motor vehicle traffic deaths for children ages 5 to 14 and third for youth ages 15 to 24.\(^{651}\)

Between 2013 and 2017, 123 children and youth ages 0 to 24 drowned, an average of 25 deaths a year.\(^{652}\) Youth identifying as American Indian/Alaska Native had a higher rate of drowning compared to youth from other racial/ethnic groups, and males had a higher rate of drowning than did females.\(^{653}\)

A Washington state study child deaths from 2012 to 2016 showed that 65% of drowning deaths occurred in open water.\(^{654}\) Risk factors varied by age and location, with most open-water drowning deaths attributed to not wearing a life jacket, not knowing how to swim/lacking water competency, or the water was too cold.\(^{655}\) In 2016, 43% of eighth graders, 34% of 10th graders, and 32% of 12th graders reported always wearing a life vest when boating.\(^{656}\) Most of the swimming pool deaths occurred among small children who were out of sight of a parent or caregiver for less than five minutes.\(^{657}\) Deaths in spas, tubs and pools resulted primarily from a lack of supervision.\(^{658}\)

The U.S. Centers for Disease Control and Prevention (CDC) recommends the use of personal flotation devices (life jackets) and close supervision of all children and youth, regardless of swimming ability, to prevent drowning.\(^{659}\) Four-sided fencing around pools, swimming skills and learning CPR are also evidence-based strategies to prevent drowning. Public awareness campaigns and life jacket loaner programs have shown some success in increasing use of flotation devices.\(^{660}\) The highest use occurs when they are mandated such as laws that require young children in boats or people on personal watercraft to wear life jackets. Continued education, including CPR classes, and ensuring public swimming areas have lifeguards are also likely to reduce the number of drowning deaths. Child death review teams also recommended increasing awareness of the risk of cold water and using a life jacket when swimming in open water.\(^{661}\)

**Bicycle and Pedestrian Injuries**

Bicycling is a common means of transportation and an increasingly popular source of recreation, exercise and sport. With more than 100 million bicycle owners, the popularity of bicycling has reached an all-time high in the United States and Washington state. Along with increased use of bicycles comes the risk of significant injuries. According to national statistics, more than 1.8 billion bicycle outings occur each year, resulting in nearly 494,000 visits to emergency departments.\(^{662}\) Bicycle injuries range from common abrasions and cuts (soft tissue injuries) to more serious musculoskeletal injuries. Head injuries resulting from a bicycle accident could lead to lifelong health issues or death.\(^{663}\) In Washington state, 177 children and young adults were hospitalized for bicycle-related injuries in 2016 and 2017, one-third (67%) of which involved a motor vehicle.\(^{664}\)
A properly fitting helmet can reduce the risk of head injury by nearly 85% although many children do not reliably wear a properly fitting helmet while riding bicycles.\textsuperscript{665} Evidence suggests that nearly 20\% of children never wear a helmet while riding a bicycle.\textsuperscript{666} The most recent data available from 2012 shows that among youth who ride bicycles, 52\% of sixth graders reported always or often wearing a helmet, as did 31\% of eighth graders, 27\% of 10th graders and 26\% of 12th graders.\textsuperscript{667} Though there are laws in King County and Seattle that require children to wear bicycle helmets, many do not wear them. In one study, children were asked what they would change about helmets to wear them more often and more than 50\% of respondents would change the look.\textsuperscript{668}

Pedestrian injuries resulted in 235 nonfatal hospitalizations and six deaths during 2016 and 2017 in Washington state among children and youth ages 0 to 24.\textsuperscript{669} In 2016, nationally, one in every five children under the age of 15 who were killed in traffic crashes were pedestrians.\textsuperscript{670} In each of the past five years, there has been an increase in the number of pedestrians killed on the roads in Washington state, more than doubling since 2013.\textsuperscript{671} According to Washington’s Target Zero Plan, vehicle-traveling speed is a critical factor and one of the key first steps to addressing deaths and serious injuries among pedestrians and bicyclists.\textsuperscript{672} Even though Washington state compares favorably to many other states in terms of pedestrian safety, collisions do happen and we must continue to make improvements.

Figure 82: Washington State Crash Data Summary Involving Pedestrians and/or Bicyclists, 2009 to September 1, 2019\textsuperscript{81}

\begin{center}
\begin{tabular}{|c|c|c|c|c|c|}
\hline
Year & Total Crashes & Fatal & Suspected Serious Injury & Suspected Minor Injury & Possible Injury & No Apparent Injury \\
\hline
2009 & 3,171 & 71 & 409 & 1,445 & 1,137 & 109 \\
2010 & 3,343 & 70 & 414 & 1,587 & 1,161 & 111 \\
2011 & 3,200 & 81 & 409 & 1,495 & 1,112 & 103 \\
2012 & 3,341 & 90 & 447 & 1,503 & 1,187 & 114 \\
2013 & 3,118 & 63 & 341 & 1,368 & 1,213 & 133 \\
2014 & 3,469 & 86 & 411 & 1,468 & 1,354 & 150 \\
2015 & 3,624 & 103 & 404 & 1,480 & 1,520 & 117 \\
2016 & 3,679 & 114 & 486 & 1,417 & 1,530 & 132 \\
2017 & 3,431 & 123 & 452 & 1,296 & 1,435 & 125 \\
2018 & 3,717 & 122 & 528 & 1,328 & 1,599 & 140 \\
2019 & 1,709 & 59 & 288 & 573 & 728 & 61 \\
\hline
\end{tabular}
\end{center}

\textit{Sports Injuries}

\textsuperscript{81}Washington State Department of Transportation. (2019). \textit{Washington State Ten Years + Current Year, Crash Data Summary Involving Pedestrians and/or Bicyclists}. Retrieved from https://remoteapps.wsdot.wa.gov/HighwaySafety/Collision/Data/Portal/Public/PublicReport/TenYearPedSummary
Nationally, sports injuries are the second leading cause of emergency room visits for children and adolescents and the second leading cause of school injuries.\(^{673}\) Nearly 38 million children and adolescents participate in sports, and one in three of those children sustain an injury serious enough that they miss games or practices.\(^{674}\) Half of the injuries sustained by youth while playing sports are likely preventable.\(^{675}\) The most common injuries include bone sprains, muscle sprains, bone injuries, repetitive motion injuries and heat-related injuries.\(^{676}\)

Most recently, traumatic brain injuries (TBIs) have garnered national attention. More than 62,000 children are taken to hospitals annually for TBIs.\(^{677}\) Awareness is a powerful source of risk-reduction and can help with the timely identification and treatment for reducing the severity of injury, as well as the long-term effects.\(^{578}\) Children and youth who have suffered these types of injuries are at greater risk for repeated brain injuries and can take longer to recover.\(^{679}\) Adults involved in leading and coaching child and youth athletics, as well as parents, often do not have the training or the knowledge for adequate prevention.

**Falls**

Falls are the leading cause of non-fatal injury-related hospitalizations among children in Washington state and nationwide.\(^{680}\) In 2016 and 2017, there were 24 suicide-related falls and 1,514 unintentional or undetermined falls in Washington state; the rate of falls was just slightly higher than the rate of motor vehicle injuries (32.4 falls per 100,000 compared to 28.5 motor vehicle injuries per 100,000, respectively).\(^{681}\) Between 2013 and 2017, 73 Washington state children and youth died from falls – about 88% were ages 15 to 24 and just over half of these falls were suicide rather than unintentional.\(^{682}\) The majority of fall-related deaths in Washington state among children in Washington state are associated with falls from heights, most from three stories or higher.\(^{683}\)

**Community Input**

Community members during listening sessions and stakeholder interviews throughout the Pacific Northwest expressed the need for increased regional coordination and standard implementation of best practices in suicide and injury prevention.

**Intentional Injuries**

Strong community support was expressed for training all community providers – including social workers, medical providers and mental health providers – in suicide assessment and treatment interventions.

In regional listening sessions, caregivers expressed concern about the fact that when their child was suicidal, they were told to call law enforcement and these same caregivers expressed concern about the level of mental health training these law enforcement officers have.

Many caregivers discussed concerns about the high suicide rate in their communities, almost always coupled with a concern about the lack of resources for helping youth with suicidality or mental health concerns. As one caregiver described it as “abyssmal,” and “completely lacking,” noting that their community has “the highest suicide rate and some of the lowest access to mental care.” Another mother shared a story about her son who was threatening to kill himself but they still experienced a two-month wait time to access
services. Community input regarding challenges in accessing mental healthcare is discussed more extensively in the Mental and Behavioral Health Chapter of this assessment.

In one listening session specifically, all caregivers expressed concern about the youth in the community and their access to firearms. One parent stated that they were concerned about suicidal teens having access to guns, but other parents were just concerned about the prevalence of access to firearms in their community.

Unintentional Injuries

- Community members said they were increasingly concerned about texting, talking and other uses of mobile devices while driving.
- Law enforcement officials expressed concern about a possible rise in impaired driving related to the legalization of marijuana. They also said that quickly testing the blood of drivers arrested for suspicion of driving under the influence is critical to accurately assessing the level of impairment.
- Individuals that self report that they have few economic resources or little formal education also report that they are less likely to use safety devices due to lack of money. They are more likely to lack transportation to a store where they could purchase safety devices, to lack control over housing conditions, and less likely to believe that injuries are preventable.

Community Assets and Resources

Suicide

- **Forefront**, a research organization based at the University of Washington, is training health professionals, firearm retailers, schools and others to develop and sharpen their skills in the assessment, management and treatment of suicide risk.
- Legislation passed over the last several years in Washington state require school staff, behavioral health providers and other healthcare providers to participate in suicide prevention training as part of their licensure.
- **Children's Crisis Outreach Response System** provides mobile crisis outreach and crisis stabilization services for children and youth up to age 18 in King County.
- Harborview Injury Prevention and Research Center and Seattle Children's researchers are studying and identifying interventions to reduce the risk of suicide.
- The **Zero Suicide Initiative** is being implemented at Seattle Children's. All patients 10 years and older are screened for suicide risk.
- Washington state has a Mental Health Promotion/Suicide Prevention Workgroup that implements prioritized goals and recommendations from the state’s suicide prevention plan. The group’s goal is to strengthen suicide prevention efforts statewide by pooling perspectives, knowledge, experiences and resources.
- **Youth Mental Health First Aid** is offered by Seattle Children's and other organizations across Washington state and the nation.
- Seattle Children's **Partnership Access Line** (PAL) program connects community providers in Washington state to psychiatrists for consultation.
Child Maltreatment

- Strengthening Families Program in Washington state (formerly Council for Children and Families), an initiative of the Washington State Department of Early Learning, focuses on helping strengthen family bonds, understand child development and develop positive parenting skills.
- Parent Trust for Washington Children promotes health and safety in families and communities by offering free or low-cost classes, workshops, educational campaigns and coaching for families.
- Childhaven, a therapeutic nursery school serving children who have experienced abuse and neglect.
- Seattle Children’s promotes and trains new parents in the Period of PURPLE Crying approach to shaken baby prevention.

Commercialization of Sexually Exploited Children

- YouthCare connects homeless youth who have experienced sex trafficking to resources such as case management, education or employment help, housing, mental health support and substance use counseling.
- The Center for Children and Youth Justice (CCYJ) and YouthCare developed and implemented a model protocol for responding to cases of CSEC and established a multidisciplinary team for helping youth who have been trafficked.
- The King County CSEC Task Force has done an exemplary job of offering frequent trainings to people who come into contact with sexually exploited children and adolescents and holds quarterly multidisciplinary task force meetings to meet with other partners. They are currently seeking to help streamline communication between the various groups that work to reduce the incidence and prevalence of CSEC in King County so as to better concentrate efforts where they are most needed.
- Seattle Children’s Hospital has taken a lead in bringing awareness to and more consistently addressing CSEC: thanks to the efforts of Dr. Shaquita Bell, a Trafficking Workgroup was formed and a Guideline for Human Trafficking Evaluation was subsequently developed in order to better guide the clinical decision making of healthcare providers and offers a comprehensive list of risk factors, appropriate screening tools, and resources to contact in order to best support patients who are at risk for or are being trafficked.
- The Sexual Assault and Traumatic Stress Center at Harborview Medical Center provide care for victims of sexual assault, as well as access to medical forensic consultation and psychosocial services.
- The S.H.E. Clinic at Aurora Commons, which was founded in partnership with Harborview Medical Center, was founded in 2018 and provides a number of non-judgmental health and social services for female identified sex workers and fills a substantial need for the local community.
- Seattle Against Slavery provides education to prevent labor and sex trafficking and advocacy for issues related to trafficking.
- The Organization for Prostitution Survivors (OPS) provides survivor services to adult women, community education, and a men’s accountability program.
- Real Escape from the Sex Trade offers a variety of services to victims of sexual
exploitation including advocacy, an emergency receiving center for women ages 18 and older, and drop in services.

**Firearm Safety**

- **Lock It Up**, a program of Public Health – Seattle & King County, promotes the safety of communities through increasing safe storage of firearms.
- Seattle Children’s, in partnership with local hospitals, Safe Kids, public health and Lock It Up, has distributed more than 5,000 safe firearm lock boxes, along with demonstrations and practice, to firearm owners across Washington state.
- Seattle Children’s co-leads the Firearm Tragedy Prevention Network in partnership with Washington Chapter of the American Academy of Pediatrics, Public Health – Seattle & King County, and Harborview Injury Prevention and Research Center.
- Seattle Children’s Odessa Brown Children's Clinic, Seattle Children's ambulatory clinics and the inpatient Psychiatry and Behavioral Medicine Unit provide safe firearm storage devices for patient families.
- **Safer Homes, Suicide Aware** is a public health campaign focused on saving lives lost to suicide. The Safer Homes Coalition, led by Forefront Suicide Prevention (through the University of Washington) and the Second Amendment Foundation, is comprised of firearms retailers, second amendment rights groups, healthcare providers, and suicide prevention experts who came together around the single goal of saving lives.

**Motor Vehicle and Child Passenger Safety**

- In Washington state, several laws support child passenger safety, including the child passenger restraint law and the seat belt law.
- **Safe Kids Washington**, Safe Kids Seattle South King County, and other coalitions across the state implement programs, such as car seat checks and safety workshops, to help prevent motor vehicle-related injuries.
- To address impaired driving, law enforcement conducts high-visibility patrols and uses the Mobile Impaired Driving Unit (MIDU), a self-contained mobile DUI processing center and incident command post.
- The **Target Zero Task Force** focuses on reducing traffic crashes and traffic-related injuries to zero by the year 2030.
- The **Safety Restraint Coalition** collaborates with families, law enforcement, healthcare providers, and government agencies to advocates for seat belt and car seat use.
- **Boosterseat.org** is a website maintained by Harborview Injury Prevention and Research Center and created by the Washington State Booster Seat Coalition.
- **Washington Traffic Safety Commission** coordinates Washington state’s traffic safety efforts by working with communities to identify and help resolve traffic safety issues, analyzing data, distributing state and federal traffic safety funds, and conducting education campaigns.
- Seattle Children’s provides free car seat and booster seat checks to the public to review individual seats for proper installation and to educate parents. The Family Resource Center provides car seats and booster seats, including demonstration and education, to patient families for free or at very reduced cost.
• Seattle Children’s Odessa Brown Children's Clinic provides car seats, including demonstration and education, to patient families.

Poison Prevention
• The Washington Poison Center (WAPC) provides immediate, free and expert treatment, advice and telephone assistance in cases of exposure to poisonous, hazardous or toxic substances. Poison prevention education resources and outreach activities occur in local communities.
• Prevention Works in Seattle (Prevention WINS) is a community coalition formed in 2006 to put comprehensive programs and strategies into place that, when consistently implemented, are proven to reduce drug and alcohol use rates.
• King County Secure Medicine Return promotes drop boxes at pharmacies and law enforcement offices.

Drowning Prevention
• Public parks departments, YMCAs and other organizations provide swimming lessons, single-gender swims and lifeguarded pools and beaches.
• Washington State Parks Boating Program helps coordinate and set up boating safety and life jacket loaner programs.
• Public Health – Seattle & King County tracks drowning deaths and has water safety information on their website.
• Safe Kids Coalitions coordinate life jacket loaner programs across the state.
• The U.S. Coast Guard develops and maintains national and international lifesaving standards for commercial ships and recreational boats and tracks boating incidents nationwide.
• The Washington State Department of Health provides information and education related to water safety.
• The Washington State Drowning Prevention Network provides a forum for organizations to work together on drowning prevention. It is led by Seattle Children's, Washington State Parks Boating, Public Health – Seattle & King County, the Washington State Department of Health/Safe Kids Coalitions in Washington state, Washington Recreation Parks Association’s Aquatics Section and Seattle Parks and Recreation Aquatics.
• Seattle Children’s is recognized locally, nationally and internationally for its work on drowning risk and prevention, with a particular focus on open water. Seattle Children’s work is considered a national model for bringing diverse groups together. Ongoing activities include low-cost life jacket sales with Seattle Parks, promoting life jacket loaner programs, making information available for diverse communities, policy and system change advocacy, hosting a drowning prevention and water safety website and serving as a state and national resource.

Bike Helmets and Bike Safety
• Safe Kids is a nationwide network working to prevent unintentional childhood injury by educating the community, providing safety devices to families and advocating for laws to keep children safe. Safe Kids has a coalition in Washington state and 12 county coalitions in the state, including Safe Kids Washington and Safe Kids Seattle South King.
• **Cascade Bicycle Club** provides education, advocacy and opportunities for children in diverse communities to learn how to ride bicycles in Seattle and King County, with the goal of creating a better community through bicycling.

• Since 1994, King County has required all bicyclists to wear a helmet. In 2003, the law was expanded to include Seattle, where bicyclists may be cited and fined for not wearing helmets.

• **Harborview Injury Prevention & Research Center** (HIPRC) led a statewide community campaign to promote the importance of wearing bicycle helmets. They are currently partnering with Seattle Children's to evaluate the Kohl's Cares for Kids Bike Helmet Initiative. The Kohl’s Cares for Kids program supports kids’ health and education initiatives in communities nationwide. Kohl's helps fund Seattle Children's bike helmet giveaways and education through the Kohl’s Helmet Safety Program at Seattle Children’s that has helped spearhead a statewide community education effort promoting the importance of wearing bicycle helmets. We have reached out to under-resourced communities across the state where Seattle Children’s staff and volunteers conduct helmet-fitting giveaways. Seattle Children’s is also a sponsor of Bike to Work Day.

• The **Washington Bike Alliance** advocates for bicyclists and a bike-friendly Washington state through legislation, research, education and the built environment.

• Seattle Children’s Odessa Brown Children’s Clinic Bike Helmet Program educates the community on the importance of wearing bike helmets and distributes and fits children with bike helmets.

• **Bike Works** strives to make biking more accessible and affordable by offering youth bike education, leadership and bike giveaway programs to families in southeast Seattle.

**Pedestrian Safety**

• **Feet First** advocates for safe walking in neighborhoods and cities and raises concerns of pedestrians in conversations with government agencies and community groups.

• **Transportation Choices Coalition** believes the current transportation system is environmentally, economically and socially unsustainable and encourages Washingtonians to make alternate transportation choices, like taking a bus or train, riding a bike or walking.

• Seattle Children’s current efforts related to pedestrian safety are part of the hospital’s comprehensive transportation plan, which includes capital projects that support biking and walking in northeast Seattle. Strategies include linking the hospital and surrounding community to larger walking and biking networks.

• Seattle Children’s researchers are conducting studies on the epidemiology and prevention of pedestrian injuries, environmental influences on physical activity and eating behaviors, and on the psychosocial factors that influence individual choice for weight-related behaviors. This work includes examining how the neighborhood environment affects weight, physical activity and dietary behaviors across the lifespan and the effectiveness of Walking School Buses – groups of children who walk to school together with one or more adults.

**Sports Injuries and Concussions**

• **Brain Injury Association of Washington** (BIAWA) works to prevent brain injury and
increase awareness, support and hope for those affected by brain injury through education, assistance and advocacy.

- **Safe Kids** aims to prevent unintentional childhood injuries, including brain injuries.
- Seattle Children’s’s assets include the Orthopedics and Sports Medicine Department, which has developed an advocacy and outreach model for sending athletic trainers to work with young athletes in Seattle-area high schools. Seattle Children’s has also helped develop concussion care and treatment guidelines to determine if the patient is able to return to play. The Seattle Pediatric Concussion Research Collaborative is pursuing research to help reduce the incidence and consequences of concussion among children and adolescents. The collaborative includes experts from Seattle Children’s, the University of Washington, Harborview Medical Center, the Harborview Injury Prevention & Research Center, the Seattle Sports Concussion Program and other top institutions.

**Window Falls**
Harborview Injury Prevention & Research Center, Public Health – Seattle & King County, Safe Kids Coalitions and Seattle Children's provide education on window fall prevention, including the use of window guards.

**Opportunities**
- Provide coordination between emergency department staff and law enforcement/first responders, including meetings to discuss challenges and opportunities of working with people who are homeless and/or have serious mental illnesses.
- Share emergency department data with the Washington State Department of Health to provide a more complete understanding of the impact of violence and injuries on youth.
- Utilize existing suicide prevention tools and strategies, and offer low-barrier mental health and substance abuse screenings at health fairs to help identify more people at risk for suicide.

**Intentional Injuries**
- Increasing universal screening for suicide and integrating mental and behavioral health within physical healthcare settings.
- Continue research efforts, like the Collaborative Adolescent Research on Emotion and Suicide (CARES) study by the University of Washington and Seattle Children’s, which evaluates the effectiveness of dialectical behavior therapy among suicidal adolescents.
- Opportunities to tackle child maltreatment include increasing public education about what abuse is, how to recognize and report it, and culturally informed and community-driven education for parents on positive, safe and nurturing strategies to raise children.

**Commercially Sexually Exploited Children**
- CSEC-related training for healthcare providers, given that more than 87% of people who are commercially sexually exploited report that they had some contact with healthcare workers while being trafficked. If done in a trauma informed manner, an intervention from the healthcare perspective has the potential to allow for more youth to receive proper interventions, as well as to provide a more realistic sense of the burden of CSEC.
in communities.

- Implement targeted screening for CSEC in emergency departments, along with training in trauma informed care for providers.

**Unintentional Injuries**

- To improve motor vehicle safety, it is important to offer prevention-focused primary care screenings, including intake assessments that ask questions about the use of cell phones and devices while driving, seatbelt use and driving while impaired.
- To promote child passenger safety, it is important to increase the availability of car seats by offering low-cost car seats or booster seats, and to promote car seat education by offering car seat checks to families in multiple languages.
- Increasing the use of life jackets through policy, life jacket loaner programs and offering free or low-cost life jackets for all ages may address drowning. Additionally, it is important to increase access to swim lessons for low-income and culturally diverse children, develop a culturally informed water competence campaign and increase the number of lifeguarded swim beaches.
- To improve pedestrian safety, improvements can be made in the community infrastructure to create safer walking environments, such as more pedestrian bridges, streetlights, playgrounds, sidewalks, paths and trails.
- To improve bicycle safety, community organizations should increase the accessibility of bicycle helmets – especially to low-income families – boost education about bike safety and offer additional helmet fittings in the community.
- To address sports injuries, players, parents and coaches need to learn the signs and symptoms of traumatic brain injuries (including concussions), and take appropriate action when they suspect such an injury.

A comprehensive effort to ensure child and youth safety integrates a public health approach to achieve health equity in communities that is done in partnership with communities. Gender, race and place are all related to the likelihood of child injury, whether from suicide, assault or unintentional injury. There is a need for action to reduce and eliminate these disparities. The evidence is growing that effective and promising programs will help to reduce injuries among children and adolescents.

**Spotlight on Communities in Washington**

Part of our methodology in this CHA was to visit and spend time in and alongside the communities we feature for spotlighting. We partnered with community based organizations and pediatricians and other youth care providers, including parents and caregivers, in each community to gain a better understanding of these communities. Our learnings are below and are in alphabetical order.

**Bremerton/Kitsap County**

**Population**

Kitsap County is located in the Central Puget Sound region of Washington state. The county is comprised of four incorporated cities - Bremerton, Bainbridge Island, Port Orchard and Poulsbo.
- which make up about one-third of the total population. The county is home to multiple American Indian Tribes and several Navy base installations. Bremerton — the largest city in the county — had an estimated population of about 41,500 in 2018.

Although it is one of the smallest counties by geographical size, it is the third most densely populated county in the state, with an estimated population of 267,120 in 2018.\textsuperscript{689} Youth under age 18 comprise nearly 21\% of the county’s population.\textsuperscript{690}

### Table 83: Population Change by Age Group Between 2008 and 2018, Kitsap County\textsuperscript{82}

<table>
<thead>
<tr>
<th>Ages</th>
<th>2008</th>
<th>2018</th>
<th>Percent change (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-4</td>
<td>15,032</td>
<td>16,147</td>
<td>7.4%</td>
</tr>
<tr>
<td>5-9</td>
<td>15,652</td>
<td>15,759</td>
<td>0.7%</td>
</tr>
<tr>
<td>10-14</td>
<td>16,394</td>
<td>15,387</td>
<td>-6.1%</td>
</tr>
<tr>
<td>15-19</td>
<td>17,772</td>
<td>14,114</td>
<td>-20.6%</td>
</tr>
</tbody>
</table>

Although 64\% of the population under age 18 was white (non-Hispanic/Latinx) in 2018, the county has become more racially/ethnically diverse over the last few years. Among youth under age 18 in 2018, youth identifying as multiracial comprised 13\% of the population, and youth identifying as Hispanic/Latinx comprised 18\% of the population — a rate that has nearly doubled since 2000.\textsuperscript{691} Kitsap County estimates from 2017 indicate that approximately 7\% of the population speak a language other than English.\textsuperscript{692}

### Figure 84: Youth (Ages 0 to 19) Population by Race/Ethnicity, Kitsap County, 2018\textsuperscript{83}


Poverty Among Youth
In Kitsap County, about 12% of youth under age 18 lived in poverty in 2017 — a rate that has declined since 2014. In October 2018, 32.2% of students in Kitsap County public schools were enrolled in free or reduced-price meals. The eligibility rates for the program varied from 6.1% in the Bainbridge Island School District to 60.6% in the Bremerton School District. Nearly three out of every 10 students in the North Kitsap and Central Kitsap school districts were enrolled in free or reduced-price meals.

Youth Experiencing Homelessness
According to the 2019 Point-in-Time Count conducted in Kitsap County, 480 people were homeless (307 sheltered and 173 unsheltered). Among those who were homeless, 114 were from households with at least one adult and with children under age 18, and less than 10 individuals were in a household with only minors (no adults present).

Employment and Income
In June 2019, Kitsap County had one of the lowest unemployment rates in Washington state at 5.2% (not seasonally adjusted). The projected median household income in Kitsap County in 2018 was $74,729, one of the top in the state, exceeding the state 2018 projected median household income and national 2017 median income.

Educational Attainment
During the 2016 to 2017 school year, the high school graduation rate in Kitsap County was 82.2%, which was higher than the state rate of 79%. On-time graduation rates were lower than the county average for several groups, including English language learners, students who were low-income, students in special education, male students and students in all racial/ethnic groups other than Asian or white. The dropout rates among these groups were also higher than the county dropout rate of 8.9%.

**Foster Care**

In Kitsap County, 405 children ages 0 to 17 were served by Foster Care Placement Services in 2017.

**Lesbian, Gay, Bisexual, Transgender and Questioning Youth**

In Kitsap County, 12% of eighth graders, 16% of 10th graders and 17% of 12th graders identified as lesbian, gay or bisexual in 2018. About 5% of eighth and 10th graders, and 3% of 12th graders in Kitsap County indicated that they were questioning/not sure when it came to their sexual orientation. When asked about gender identity, 6% of eighth graders, 5% of 10th graders and 6% of 12th graders identified as transgender, questioning/not sure, “something else fits better”, or selected multiple gender identity responses.

**Oral Healthcare**

In 2018, according to the findings of the Healthy Youth Survey, 85% of eighth graders, 87% of 10th graders and 80% of 12th graders had seen a dentist in the last year in Kitsap County. Between 5% to 7% of students reported missing school due to a toothache within the last year.

**Figure 85: Percentage of Youth Who Missed School Due to Toothache, Kitsap County (“Local”) and Washington State, 2018**

---

Suicide

In 2018, about one-quarter of students in eighth, 10th and 12th grades in Kitsap County considered attempting suicide and about one in 10 students actually attempted suicide in the past year.

Figure 86: Kitsap County Youth Who Reported Suicidal Feelings and Actions by Grade, 2018

---

According to the 2018 Healthy Youth Survey, nearly one-third of 12th graders in Kitsap County reported drinking at least once in the past month — a rate that is higher than the state average among 12th graders. About 18% of 12th graders reported problem or heavy drinking.

**Figure 87: Kitsap County Youth Who Reported Drinking at Least Once in the Past Month or Heavy Drinking, 2018**

---

Cigarette Use\textsuperscript{706}
In Kitsap County, 7\% of 10\textsuperscript{th} graders and 9\% of 12th graders reported smoking cigarettes in the past 30 days. Smoking rates in eighth, 10th and 12th grades were higher in Kitsap County than the Washington state averages.

Electronic Vapor Product Use\textsuperscript{707}
Nearly one-quarter of 10th grade students and about one-third of 12th grade students in Kitsap County reported using vapor products within the 30 days prior to the Healthy Youth Survey in 2018 — rates that were higher than the state averages.

Figure 88: Current Vapor Product Use in Washington State Compared to Kitsap County (“Local”), 2018\textsuperscript{87}
Rates of vapor product use are on the rise across the county — increasing by about 39% since 2016. Nearly four times as many 12th graders used vapor products compared to cigarettes in 2018. Overall, cigarette smoking rates have decreased by 64% over the last decade among 12th graders in Kitsap County.

**Figure 89: Current Use Trends in Kitsap County, Grade 12, 2018**

---

Marijuana Use

In Kitsap County, about 28% of 12th graders reported that they had used marijuana at least once in the last month and 10% reported heavy marijuana use. These rates have stayed about the same since 2010, despite the legalization of marijuana for recreational use among adults.

Note: N/S indicates that the question was not surveyed in that year.
Figure 90: Current Marijuana Use and Heavy Marijuana Use Among Youth in Kitsap County, 2018

![Current Marijuana Use and Heavy Marijuana Use Among Youth in Kitsap County, 2018](image)

Prescription Medication Use

In 2018, 3% of eighth and 10th graders, and 4% of 12th graders used painkillers in the last 30 days to get high in Kitsap County.

Figure 91: Students Who Reported Using Painkillers to Get High at Least Once in Last 30 Days and Using Prescription Drugs Not Prescribed to Them in Past Month, Kitsap County, Kitsap County, 2018

---


90 Students Who Reported Using Painkillers to Get High at Least Once in Last 30 Days and Using Prescription Drugs Not Prescribed to Them in Past Month, Kitsap County, Kitsap County, 2018
Between 6% to 7% of students in Kitsap County reported using prescription drugs not prescribed to them within the past month.

**Opioid Use**

In 2013 to 2017, there was one death due to opioid overdose among adolescents ages 13 to 17 in Kitsap County.

**Early and Adequate Prenatal Care**

In 2016, 81.8% of pregnant women began prenatal care in the first trimester of pregnancy in Kitsap County.

**Infant Mortality**

In 2015, Kitsap County’s infant mortality rate was 5.9 deaths per 1,000 live births — a rate higher than the state average and slightly under the Healthy People 2020 goal.

**Figure 92: Students Who Reported Smoking in the Past 30 Days, 2018**

---

Low Birth Weight\textsuperscript{713}

In 2016, about 6.3% of babies who were residents of Kitsap County were low birth weight.

Obesity and Overweight Prevalence\textsuperscript{714}

In 2018, more than one-quarter of eighth, 10th and 12th graders were obese or overweight in Kitsap County. These rates have increased over the last decade among 10th and 12th graders. In 2018, 12% of eighth grade students, 13% of 10\textsuperscript{th} grade students, and 14% of 12\textsuperscript{th} grade students were considered to be obese.

Figure 93: Kitsap County (“Local”) Youth Obese or Overweight Rates Compared to Washington State, 2018\textsuperscript{92}

Food Insecurity

At 17.4%, the rate of food insecurity among children in Kitsap County in 2017 was similar to the state and national rates. About half of children who were food insecure were eligible for federal nutrition programs based on income level.

Figure 94: Percentage of Children Who Were Food Insecure in Kitsap County, 2017

---

Note: N/A indicates question was not asked of that grade.


---

Fruit and Vegetable Consumption
In Kitsap County, 20% of eighth graders, 19% of 10th graders and 18% of 12th graders ate five or more servings of fruits and vegetables per day over the past seven days in 2018.

Youth Consumption of Sugar-Sweetened Beverages
In 2018, 76% of eighth graders, 74% of 10th graders and 75% of 12th graders in Kitsap County reported drinking sugar-sweetened drinks in the past week. About 2% of 10th graders in the county reported drinking sugar-sweetened drinks daily at school in 2018 — a 87% decline since 2008 (from 15% to 2%).

Physical Activity
In 2018, 73% of sixth and eighth grade students, 82% of 10th grade students and 80% of 12th grade students in Kitsap County did not meet the daily 60-minute physical activity recommendation. Rates were slightly higher than the state averages for students in eighth, 10th and 12th grades.

Figure 95: Kitsap County (“Local”) Rates of Youth Who Did Not Meet Recommendations for Physical Activity Compared to Washington State, 2018

Community Input

---

In 2018, we engaged with Bremerton community members, including members of the healthcare workforce and parents of children with special needs though interviews with key informants and a listening session with community members.

The standardized key informant interviews included a Navy pediatrician, an employee at a Kitsap County mental health provider, a public health nurse and children with special health care needs coordinator and a Kitsap community health worker. Each key informant interview revealed several themes including various strengths and gaps seen in the community.

A total of 7 participants attended the family listening session: 5 were parents to children with special needs and 2 were community liaisons including a behavioral analyst and public health nurse (who also was a stakeholder). All family listening session attendees were female.

Access to care and long wait times for services were referenced by both stakeholders and parents:

- Prominent gaps and prolonged wait times are still evident, even when access to care is available. Children with multiple mental or behavioral health specialties are not co-managed very well.
- As reported by parents and stakeholders, families are experiencing such long wait times for services, and initiatives need to be taken to develop resources for families who are waiting for a diagnosis or waiting for treatment services. Some parents described waiting years for a diagnosis or services and limited hospital resources if inpatient stay was warranted.
- In addition, with the evolving demographics of Bremerton, such resources being generated and provided should be thoughtful and available in appropriate languages to be culturally sensitive.
- A significant limitation heard across stakeholder interviews was the role of the school and how they can be a barrier to therapies. The need for a medical home was stressed. Families take on the role of care coordinator, which adds additional stress to parenting.
- Parents felt there was limited support or respite care services for families.

Stakeholders and parents both shared some information about the Bremerton community:

- Children and families of the U.S. armed forces are unique, because they are, in their words, constantly being uprooted and tend to have more behavioral health needs. For that reason, the Navy works closely with therapists in the area who take their specific insurance, and families are able to self-refer which can expedite the process. The Bremerton Naval base is also unique because it has an internal child psychiatrist.
- All of the stakeholders mentioned that, looking outside of mental and behavioral health, there are other important issues plaguing the Bremerton community (homelessness, poverty, etc.), and until families have their basic needs met, the issue of mental and behavioral health will continue be inadequately addressed.
- Another identified theme was the feeling of defeat among families when examining how the community is addressing issues. One parent described a scenario where she had the opportunity to move to another state that might better serve her family, and another parent encouraged her to leave.
Two other problems expressed included:

- Funding streams are challenging as each funding source is very isolated, which makes collaboration across programs and services very difficult.
- Unfortunately, a lack of compassionate care by providers to families with special needs children was expressed. Disheartening stories were shared by families describing how providers treated them with very little respect during visits.

Lastly, parents shared the spirit of resilience that exists in the Bremerton community: families, despite various hardships, still had an overwhelming passion to help their community and other families in similar situations.

**Moses Lake/Grant County**

**Population**

Grant County is located in eastern Washington state. It is the fourth largest county in the state, larger than King county by over 400 square miles. The northernmost city of Grand Coulee and the southernmost city of Mattawa are two hours apart by car. There are significant differences between the north and south portions of the county in terms of age, race/ethnicity, educational attainment and poverty status.

The county is comprised of 10 cities and five towns, with about 55% of the county’s population living in incorporated cities. The estimated population of Grant County in 2018 was about 97,000. The largest city in Grant County is Moses Lake, with a population around 22,000. Youth under age 20 made up about 30% of the county’s population.

<table>
<thead>
<tr>
<th>Ages</th>
<th>2008</th>
<th>2018</th>
<th>Percent change (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-4</td>
<td>7,714</td>
<td>7,761</td>
<td>0.6%</td>
</tr>
<tr>
<td>5-9</td>
<td>7,191</td>
<td>8,142</td>
<td>13.2%</td>
</tr>
<tr>
<td>10-14</td>
<td>7,121</td>
<td>8,145</td>
<td>14.4%</td>
</tr>
<tr>
<td>15-19</td>
<td>7,193</td>
<td>7,185</td>
<td>-0.1%</td>
</tr>
</tbody>
</table>

In 2018 in Grant County, 61% of the population under age 18 were Hispanic/Latinx, and 37% of the population were white. Grant County has a higher percentage of Hispanic/Latinx residents than Washington state overall. 2017 estimates indicate that about 37% of people living in Grant County speak another language.

**Figure 97: Youth (Under 18) Population by Race/Ethnicity, Grant County, 2018**

---


Agriculture and manufacturing are the major industries in Grant County, although large Seattle-area companies like Microsoft and Boeing have a presence in the region. Grant County has four hospitals, located in Ephrata, Grand Coulee, Moses Lake, and Quincy. Six cities have no health care offices, and Royal City does not have any medical providers or local first responders.

**Poverty among Youth**
In 2017, about 21% of youth under age 18 in Grant County lived in poverty — a rate that has been declining since 2013.725

In October 2018, 67.9% of students in Grant County public schools were enrolled in the free or reduced-price meal program.726 The eligibility rates varied across the county’s different school districts, from 36% in the Coulee-Hartline School District to 94.3% in the Warden School District.727 In the Moses Lake School District — the largest school district in the county — 60.4% of students were enrolled in the free or reduced-price meal program.728

**Youth Experiencing Homelessness**729
In Grant County, 148 people were homeless, according to the 2019 Point in Time Count (66 sheltered and 82 unsheltered). Among those who were homeless, 71 were from households with at least one adult and with children under age 18, and there were no households with no adults present.

**Employment and Income**
The unemployment rate in Grant County in June 2019 was 5.8% (not seasonally adjusted).730
The projected median household income in Grant County in 2018 was $68,731, which was under the 2018 predicted state median but exceeded the 2017 national median.  

**Educational Attainment**

The high school graduation rate during the 2016 to 2017 school year in Grant County was 73.9% — the fourth lowest rate in the state. The dropout rate in the county for the same time period was 15.7%. Male students, students who were low-income, students in special education, students who were English language learners, and students who identified as American Indian/Alaskan Native or Hispanic or Latinx had graduation rates that were lower than the county average. About one-quarter of English language learners and students in special education, for example, dropped out of high school.

**Foster Care**

There were 136 children ages 0 to 17 served by Foster Care Placement Services in Grant County in 2017.

**Lesbian, Gay, Bisexual, Transgender and Questioning Youth**

In 2018, 9% of eighth graders, 12% of 10th graders and 10% of 12th graders in Grant County identified as lesbian, gay or bisexual. About 4% of eighth graders, 3% of 10th graders and 2% of 12th graders indicated that they were questioning/not sure when it came to their sexual orientation. When asked about gender identity, 5% of eighth graders, 6% of 10th graders and 4% of 12th graders identified as transgender, questioning/not sure, “something else fits better”, or selected multiple gender identity responses.

**Oral Healthcare**

In Grant County, 80% of eighth graders, 77% of 10th graders and 80% of 12th graders had seen a dentist in the last year. Between 6% to 12% of students reported missing school due to a toothache within the last year.

Figure 98: Percentage of Youth Who Missed School Due to Toothache, Grant County (“Local”) and Washington State, 2018

---

Suicide

In 2018, one-fifth of students in in eighth, 10th and 12th grades in Grant County said they considered attempting suicide, and between 9% to 13% of students reported that they attempted suicide in the past year.

Figure 99: Grant County Youth Who Reported Suicidal Feelings and Actions by Grade, 2018

---

**Suicide**

In 2018, one-fifth of students in in eighth, 10th and 12th grades in Grant County said they considered attempting suicide, and between 9% to 13% of students reported that they attempted suicide in the past year.

**Figure 99: Grant County Youth Who Reported Suicidal Feelings and Actions by Grade, 2018**

---

Alcohol Use

Students in sixth, eighth and 10th grades in Grant County reported drinking at least once in the past month at rates higher than the state average (4%, 12% and 22%, respectively). The rates of heavy drinking in Grant County were also at or above the state average for all grade levels.

Figure 100: Grant County Youth Who Reported Drinking at Least Once in the Past Month or Heavy Drinking, 2018

---

Cigarette Use\textsuperscript{738}

Cigarette smoking rates among students in Grant County were similar to the rates of Kitsap County and higher than state average, with 7% of 10th graders and 9% of 12th graders reporting that they smoked cigarettes in the 30 days before the survey in 2018.

\textbf{Figure 101: Youth Cigarette Smoking Rates in Grant County, 2018\textsuperscript{100}}

\begin{center}
\includegraphics[width=0.7\textwidth]{cigarette_use.png}
\end{center}

Electronic Vapor Product Use\textsuperscript{739}

In Grant County in 2018, students in sixth, eighth and 10th grades reported using vapor products at similar rates than the state average. Students in 12th grade, however, reported using vapor products at a lower rate than the state average.

\textbf{Figure 102: Current Vapor Product Use in Washington State Compared to Grant County (“Local”), 2018\textsuperscript{101}}

\begin{center}
\begin{tabular}{|c|c|c|c|c|}
\hline
\textbf{Grade} & \textbf{Local} & \textbf{State} & \textbf{Local} & \textbf{State} \\
\hline
6th & 1\% ±1 & 3\% ±1 & 7\% ±2\textsuperscript{*} & 9\% ±2 \\
8th & 3\% ±1 & 3\% ±1 & 5\% ±1 & 8\% ±1 \\
10th & & & & \\
12th & & & & \\
\hline
\end{tabular}
\end{center}


Over the last few years, cigarette smoking rates among 12th graders have decreased, while vapor product use is on the rise. About 2.5 times as many 12th graders in Grant County used vapor products than smoked cigarettes in 2018.

**Figure 103: Current Use Trends in Grant County (“Local”), Grade 12, 2018**

---

Marijuana Use

In 2018, about one out of every five students in 10th and 12th grades in Grant County reported that they had used marijuana at least once in the last month, while nearly one in 10 students in 12th grade reported heavy marijuana use. These rates have decreased slightly since 2010.

Figure 104: Current Marijuana Use and Heavy Marijuana Use Among Youth in Grant County, 2018

Note: N/S indicates that the question was not surveyed in that year.

Prescription Medication Use\textsuperscript{741}

In Grant County in 2018, 10th graders reported using painkillers in the last 30 days to get high at higher rates than eighth or 12th graders (7\% compared to 3\% and 6\%, respectively).

Figure 105: Students Who Reported Using Painkillers to Get High at Least Once in Last 30 Days and Using Prescription Drugs Not Prescribed to Them in Past Month, Grant County, 2018\textsuperscript{404}

Students in 10th grade also reported using prescription drugs not prescribed to them within the past month at rates higher than students in eighth and 12th grades (12\% compared to 5\% and 9\%, respectively).

Opioid Use\textsuperscript{742}

There were no deaths due to opioid overdose among 13 to 17 year olds in Grant County in 2013 to 2017.

Early and Adequate Prenatal Care\textsuperscript{743}

\textsuperscript{104} Healthy Youth Survey. (2018). \textit{HYS fact sheets}. Retrieved from \url{http://www.askhys.net/FactSheets}. 
In Grant County in 2016, the percentage of pregnant women first receiving prenatal care in the first trimester of pregnancy was higher than the Washington state average at 83.2%.

**Infant Mortality**

The infant mortality rate in Grant County in 2015 was 3.3 deaths per 1,000 live births, which is less than the state and national infant mortality rates.

**Low Birth Weight**

In Grant County, about 6.7% of babies born in 2016 were low birth weight.

**Obesity and Overweight Prevalence**

About one-third of eighth, 10th and 12th grade students in Grant County were overweight or obese in 2018. These rates exceed the state averages. In 2018 in Grant County, 18% of eighth graders, 14% of 10th graders and 18% of 12th graders were considered to be obese.

**Figure 106: Grant County (“Local”) Youth Obese or Overweight Rates Compared to Washington State, 2018**

Note: N/A indicates question was not asked of that grade.

**Food Insecurity**

---

In Grant County, 18.7% of children were considered food insecure in 2017 — a rate that was above the state and national averages. About three-quarters (76%) of children who were food insecure were eligible for federal nutrition programs based on income level.

**Figure 107: Percentage of Children Who Were Food Insecure in Grant County, 2017**

**Fruit and Vegetable Consumption**
In 2018, 21% of Grant County eighth graders, 19% of 10th graders and 17% of 12th graders ate five or more servings of fruits and vegetables per day over the past seven days.

**Youth Consumption of Sugar-Sweetened Beverages**
In Grant County in 2018, 84% of eighth graders, 81% of 10th graders and 80% of 12th graders in Kitsap County reported drinking sugar-sweetened drinks in the past week. According to the same survey, about 5% of 10th graders in the county reported drinking sugar-sweetened drinks daily at school — a 78% decline since 2008 (from 23% to 5%).

**Physical Activity**
In Grant County, nearly three-quarters of students in middle school and high school did not meet the daily physical activity recommendation in 2018. The rates were similar to the state averages.

**Figure 108: Grant County (“Local”) Rates of Youth Who Did Not Meet Recommendations for Physical Activity Compared to Washington State, 2018**

---

Community Input
In 2018, we heard from community stakeholders during six key informant interviews. Three community site visits were also conducted to learn more about resources or challenges referenced in key informant interviews. Key informant interviews included representatives from the Grant County Health District, HeadStart, a faith-based homeless outreach program, a Federally Qualified Health Center, the county’s mental health program, and the Moses Lake School District. Each informant shared the unique challenges and strengths of their program.

We also heard from the community members through a listening session. The listening session was attended by six parents and a local pediatrician who assisted with recruitment for the event. Three of the participants work in the healthcare field. The participants represented three different families, with both mother and father in attendance. Their children collectively represented the breadth of pediatrics: from infants to young adults with some healthy children and some children with chronic medical conditions. One family also had a child with a history of mental health challenges.

Mental health was a theme in our discussions:
- Many of the informants referenced news reports of teenage suicides in Moses Lake in the past summer.
- Most informants were concerned about mental health access for adolescents.
- To increase resources, Grant Integrated Services and the Moses Lake School District have a partnership to hire four behavioral health counselors to work full-time in schools. Two of these positions have already been filled.
- Grant Integrated Services reports great connections with the school districts but limited relationships with local medical providers. Even younger children, like those attending HeadStart, also have difficulty accessing age-appropriate mental health services.
The parents echoed the same concerns as community providers about the lack of access to mental health care. One family shared that when their child had mental health issues, they had nowhere to take her except the Emergency Department, who would just fix any medical problem and send them away.

There is also limited support for children with autism in the community. One of the medical providers opened up a program for children 2 to 5, but once they age out, they have to seek behavioral support outside of the county. The pediatrician shared that she hired a behavioral health professional in her clinic, but her clinic is the exception, not the rule.

Access to care was prominently discussed by both stakeholders and parents:

- Parents also described how hard it is to get in to see their child’s primary care provider for an urgent visit. “You have to go to urgent care or the ER”, one parent said. Another parent described never being able to get ahold of their child’s doctor whenever they called with questions.

- Challenges related to accessing care for children with chronic medical conditions was discussed. Grant County does not have pediatric specialty care, so families travel to Wenatchee, Spokane, or Tri-Cities. Some clinics provide outreach to Grant County. They also described difficulty receiving appropriate medical care from the Emergency Department because providers were uncomfortable managing the child’s condition. The local pediatrician mentioned that the community tries to counteract possible misunderstandings through having informational sheets in the local ER for every child with a chronic condition.

- The key informants frequently referenced how transportation limits a family’s access to resources. Within Grant County, Moses Lake is the central office for several programs, such as New Hope Domestic Violence and Sexual Assault services and Grant Integrated Services. Moses Lake is up to an hour away from parts of the county. There are other services, like pediatric specialty care or behavioral/developmental therapy, which are scarce or unavailable in Grant County, requiring families to travel to surrounding cities (Tri-Cities, Spokane, and Wenatchee), up to 90 minutes away. Moses Lake HeadStart noticed they had fewer children enrolled from the southern parts of the city after funding for their transportation program was cut in 2015. Beacon Immigration described the travel and time constraints families overcome to make appointments: to make office hours by 5pm, families take off work and pay for rides, often overpriced, to get to their only office in Moses Lake for a free consultation.

- Limited resources and qualified staff in rural areas were also noted. Many stakeholders commented that professionals often only spend a few years in Grant County for their first job out of school before moving on to more populated cities. This dynamic results in few behavioral or mental health providers in the region. At the time of our discussions, there was only one speech therapist, few dieticians, and many open positions for full-time therapists in Moses Lake schools and New Hope Domestic Violence and Sexual Assault Services. There were no inpatient psychiatry or substance abuse programs, no inpatient neonatal nursery, and no homeless shelters within Grant County. Most families are referred to specialists or transported to resources outside of the county.

Among parents, relating to and supporting adolescents was a key theme:
• One of the families shared various issues they encountered while raising adolescents. They described difficulty relating to their teens regarding medical concerns. For example, marijuana and vaping are popular among teenagers yet parents felt uninformed on how to warn their teens about the risks.
• Parent and guardian participants voiced their desire that they wanted their medical providers to discuss with them how to best support their adolescent once they started attending medical appointments alone.
• Parents also discussed how they learned to individualize their parenting styles to meet their children’s needs and support each one’s success.

Key informants noted that programming for youth is scarce:
• The local Parks and Recreation used to have a drop-in center, but it is no longer open.
• There are no YMCAs or other community centers in Grant County.
• There are also no mentoring programs for at-risk youth to engage with responsible older teenagers or young adults. Existing programs are geared towards youth who have already been in the juvenile justice system.
• Some families do not get the benefits of the Prescription to Play program because of not receiving the information from their medical provider or having difficulty accessing the program due to transportation issues or having siblings who do not qualify.

Through our discussions, Moses Lake community members shared some strengths within their community, especially about promotion of healthy habits:
• Moses Lake is extremely proud of their efforts to promote healthy eating and physical activity for children. The most successful program, Supplemental Nutrition Assistance Program (SNAP) Match, has been in existence for a few years. Families are able to double their electronic benefits transfer (EBT) funds at the farmer’s market through matching, which makes locally grown fruits and vegetables more affordable. Local hospitals donate annually to keep the program running. Grant County is working on expanding the model to other cities.
• Other programs, Prescription to Play and 5210-Go, are encouraging increased physical activity and healthy nutrition. Their incorporation into medical practices and youth development programs have been variable. Some organizations readily incorporated the programs, while others have been slow to adopt them.
• The Food Bank is incredibly successful at serving families experiencing food insecurity. They serve 2,500 unique families per month in addition to 3,300 families in Moses Lake and Warden through the “3 for 3” program, which provides children who qualify for free lunch with 3 meals for 3 days to cover weekend needs.
• Families reported being proud that within Moses Lake, there is a park within a mile of every home. There is also a local water park and a skate park.

Port Angeles/Clallam County

Population
Clallam County, Washington is known for its beauty and as the entrance point to the Olympic national park. It was named for the Klallam people, who still live in the area. In 2018, Clallam
County was home to 75,130 people. Historically, Clallam County was home to a thriving logging industry, as well as fishing and maritime industries, but in the last few decades, the logging industry has significantly diminished, and leisure and tourism have become more prominent.

### Table 109: Population Change by Age Group Between 2008 and 2018, Clallam County

<table>
<thead>
<tr>
<th>Ages</th>
<th>2008</th>
<th>2018</th>
<th>Percent change (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-4</td>
<td>3,371</td>
<td>3,430</td>
<td>1.8%</td>
</tr>
<tr>
<td>5-9</td>
<td>3,476</td>
<td>3,631</td>
<td>4.5%</td>
</tr>
<tr>
<td>10-14</td>
<td>3,922</td>
<td>3,752</td>
<td>-4.3%</td>
</tr>
<tr>
<td>15-19</td>
<td>4,232</td>
<td>3,430</td>
<td>-19.0%</td>
</tr>
</tbody>
</table>

In Clallam County, about three-fourths of youth under age 20 (73%) were non-Hispanic white in 2018, compared to about 16% who were Hispanic. An additional 8% of the population of Clallam County youth identified as non-Hispanic American Indian/Alaska Native and 2% as non-Hispanic Asian.

![Youth Population by Race/Ethnicity, Clallam County, 2018](image)

**Figure 110: Youth (Under 18) Population by Race/Ethnicity, Clallam County, 2018**

---

Poverty Among Youth

---


In Clallam County, approximately 29% of youth under age 18 lived in poverty in 2017, which represents a continued increase over the preceding 5 years.\textsuperscript{752}

In October 2018, 49.8% of Clallam County students were enrolled in the free or reduced-price meal program.\textsuperscript{753} The highest rate of enrollment, at 91%, was in the smallest school district, Quileute Tribal School District, which has 100 students.\textsuperscript{754} The lowest rate of enrollment was among students in the Sequim School District at 43.5% of the district’s 2,829 students.\textsuperscript{755}

**Youth Experiencing Homelessness\textsuperscript{756}**

According to the 2019 Point in Time Count, 196 people were homeless (111 sheltered and 85 unsheltered) in Clallam County. Among those who were homeless, 64 were from households with at least one adult and with children under age 18, and less than 10 were in a household with only minors (no adults present).

**Employment and Income**

In June of 2019, the unemployment rate (not seasonally adjusted) in Clallam county was 7.0%.\textsuperscript{757}

$47,350 was the Clallam County projected median household income for 2018, which was more than $25,000 below the Washington state average.\textsuperscript{758}

**Educational Attainment\textsuperscript{759}**

The Clallam County 2016 to 2017 school year high school graduation rate was the lowest in Washington state at 55.7%. During the same year, the dropout rate was 31.4%. American Indian/Alaskan Native (56.5%), Asian (57.7%), and white (57.9%) students had graduate rates that were higher than the Clallam County average.

**Foster Care\textsuperscript{760}**

In 2017 in Clallam County, Foster Care Placement Services served 137 youth ages 0 to 17.

**Lesbian, Gay, Bisexual, Transgender and Questioning Youth\textsuperscript{761}**

11% of eighth graders, 10% of 10th graders and 11% of 12th graders identified as lesbian, gay or bisexual in Clallam County in 2018. In addition, 5% of eighth graders, 4% of 10th graders and 4% of 12th graders indicated that they were questioning/not sure when asked about their sexual orientation. When asked about gender identity, 7% of eighth graders, 6% of 10th graders and 7% of 12th graders indicated their gender identity as transgender, questioning/not sure, “something else fits better”, or selected multiple gender identity responses.

**Oral Healthcare\textsuperscript{762}**

82% of eighth graders, 85% of 10th graders and 75% of 12th graders in Clallam County reported having a dental visit in the last year in Clallam County. Between 4% to 9% of students in sixth to 12th grades reported missing school due to a toothache over the last year.
Suicide

In 2018, about one-fourth of Clallam County youth reported considering attempting suicide in the past year, about one-fifth of youth reported making a suicide plan in the past year and between 7% and 12% of youth attempted suicide in the past year.

Figure 112: Clallam County Youth Who Reported Suicidal Feelings and Actions by Grade, 2018

---


Alcohol Use

In Clallam County in 2018, about one in five 10th grade students and about one in three 12th grade students reported drinking at least once in the past month. 12% of 10th graders and 23% of 12th graders reported problem or heavy drinking in the past month.

Figure 113: Clallam County Youth Who Reported Drinking at Least Once in the Past Month or Heavy Drinking, 2018

---

Cigarette Use

In 2018, Clallam County students in eighth, 10\textsuperscript{th}, and 12\textsuperscript{th} grades reported current (past 30-day) smoking at rates that were higher than those of Washington state.

Figure 114: Youth Cigarette Smoking Rates in Clallam County, 2018

\footnote{Healthy Youth Survey. (2018). \textit{HYS fact sheets}. Retrieved from \url{http://www.askhys.net/FactSheets}.}
Electronic Vapor Product Use

In 2018, rates of vapor product use in Clallam County were similar to Washington state rates of vapor product use in all reporting grades.

Figure 115: Current Vapor Product Use in Washington State Compared to Clallam County (“Local”), 2018

---

From 2016 to 2018, the percentage of 12th grade students in Clallam County who smoked cigarettes remained virtually unchanged. About four times as many 12th grade students reported vapor product use as compared to cigarette use in 2018.

**Figure 116: Current Use Trends in Clallam County, Grade 12, 2018**

---

Marijuana Use

In 2018, 36% of 12th grade Clallam County students had used marijuana at least once in the last month, and 15% students in 12th grade reported heavy marijuana use.

Figure 117: Current Marijuana Use and Heavy Marijuana Use Among Youth in Clallam County, 2018

Note: S indicates result was suppressed due to insufficient reporting from students of schools.

Prescription Medication Use

In 2018, 3% to 6% of Clallam County student who responded to the Healthy Youth Survey reported using painkillers at least once in the last month to get high.

Figure 118: Students Who Reported Using Painkillers to Get High at Least Once in Last 30 and Days and Using Prescription Drugs Not Prescribed to Them in Past Month, Clallam County, 2018

In addition, between 5% to 8% of eighth, 10th and 12th graders reported using prescription drugs not prescribed to them within the past month.

**Opioid Use**
Between 2013 and 2017, there was one death among Clallam County youth ages 13 to 17 due to overdose involving any opioid.

**Early and Adequate Prenatal Care**
In Clallam County in 2016, of pregnant women for whom information on prenatal care was available, 76.5% received prenatal care beginning in the first trimester.

**Infant Mortality**
In Clallam County in 2015, the infant mortality rate was 13.4 deaths per 1,000 live births, which was higher than the Washington state rate in the same year and does not meet the Healthy People 2020 goal.

**Low Birth Weight**
In 2016 in Clallam County, 5.9% of babies were born with low birth weight.

**Obesity and Overweight Prevalence**
In Clallam County in 2018, between 29% to 34% of students in eighth, 10th and 12th grades were overweight or obese, which was similar to Washington state rates. By grade, 11% of eighth graders, 13% of 10th graders and 19% of 12th graders were considered to be obese.

**Figure 119: Clallam County ("Local") Youth Obese or Overweight Rates Compared to Washington State, 2018**

---

Note: N/A indicates question was not asked of that grade.

**Food Insecurity**

In 2017, approximately one in four children were food insecure in Clallam County. More than three in four of food insecure children in Clallam County were eligible for federal nutrition programs based on income level in the same year.

**Figure 120: Percentage of Children Who Were Food Insecure in Clallam County, 2017**

**Fruit and Vegetable Consumption**

In 2018, 26% of eighth graders, 19% of 10th graders and 16% of 12th graders ate five or more servings of fruits and vegetables per day in the past seven days.

---

Youth Consumption of Sugar-Sweetened Beverages

In Clallam County in 2018, 76% of eighth graders and 10th graders and 78% of 12th graders reported drinking sugar-sweetened drinks in the past week. In the same year, 3% of 10th graders reporting drinking sweetened drinks daily at school – a 80% decline since 2012 (from 15% to 3%).

Physical Activity

Rates of meeting physical activity recommendations in 2018 among sixth, eighth, 10th and 12th grade Clallam County students were similar to Washington state rates.

Figure 121: Clallam County (“Local”) Rates of Youth Who Did Not Meet Recommendations for Physical Activity Compared to Washington State, 2018

Community Input

In 2019, Seattle Children’s heard from Port Angeles community members, through a listening session with 7 mothers and key informant interviews with 6 community stakeholders. Particular attention in stakeholder interviews was given to exploring mental and behavioral health issues, as well as factors impacting healthy eating and active living.

---

Mental and behavioral health was a key theme the respondents discussed:

- Adverse childhood events (ACEs) are not uncommon, with 1 in every 3 children in this community experiencing 3 or more ACEs as reported by a stakeholder. This is an indicator of the burden of stressors affecting children in the community.
- Many parents and providers indicated frustration with the lack of sufficient resources. As an example, one of the stakeholders shared that children with mental health illnesses are chronically undertreated until it reaches the point of significant disruption, at which point they are taken to the juvenile detention center. From there, they can be treated at either an inpatient or intensive outpatient treatment facility but subsequently return to the same environment in their communities.
- There is a mental health clinic in Port Angeles, but participants vocalized that they feel the clinic is understaffed, their impression being there are just a few nurse practitioners who staff the clinic. Parents at this listening session suggested that there are not enough community practitioners specifically trained in providing mental health care for children or adolescents. Their experience has been that local pediatricians are having to step more into the role of psychiatrist to manage children’s complex mental health conditions.
- Behavioral health resources are also limited, with long wait lists for physical, occupational, and speech therapy due to a shortage of local pediatric-specific therapists.
- Navigating the system proves challenging. One story: a child with autism could not be approved for insurance coverage of applied behavioral analysis (ABA) therapy unless the child had received an official diagnosis of autism. Seattle Children’s Hospital is the nearest facility that can officially diagnose with a long wait list (up to a year). After diagnosis, there is an additional wait list for ABA therapy can be 6 months. This can translate to a one and a half year wait for needed therapies.

Support for families with children with special healthcare needs was discussed:

- Some of the main areas of support needed by families with children with special health care needs includes transportation and care coordination for to travel to Seattle for specialty care. The process of travelling to the ferry terminal, taking the ferry to Seattle and navigating unfamiliar city streets is not only stressful, but also expensive and a significant burden on families, especially those with lack of access to private vehicles, strained finances, or tenuous employment situations.
- Parents, as well as case managers, expressed frustration around the difficulty of coordinating multiple appointments with multiple providers. The coordination of appointments and transportation together is a very large challenge for parents, especially those who are working tirelessly to care for children with substantial needs.
- Other topics of discussion included the lack of pediatric specific therapies and long wait lists for the therapies that are available. One parent expressed concern that the delay in initiating such therapy will lead to the loss of valuable time when the child could have most benefitted and made the most progress.

A theme that was present through all of the conversations was the importance of collaboration and sharing resources:

- At the local level, Port Angeles community members have taken this into their own hands, with multiple groups working on creating resource maps to have available for
families. It became apparent during the listening session, that the multiple groups creating resource maps are doing so independently of each other, further highlighting the need for more general awareness of the common initiatives and interests in the community.

- There was also a strong desire for collaboration beyond the boundaries of this city and this county, specifically with Seattle Children’s, in the form of resource sharing. Suggested examples included high quality videos or other public health campaign tools to improve safe sleep and evidence based best practices for suicide prevention.

The strength and resilience of the Clallam County community was evident through these conversation topics:

- This community has already demonstrated the ability to come together to devise a strategy to target the opioid epidemic, which was particularly severe in Clallam County.
- They have also now developed a coalition to tackle the issues surrounding ACEs. This is a collaboration between representatives from multiple groups such as United Way, 4H, First Steps family support services, and the school district.
- Multiple groups and individuals are working on tackling issues such as access to resources, and they all see potential for further organization and action. However, the resources available to address many of the issues being targeted by these groups are limited, and the resources that are available are not widely known.

Seattle/King County

Population

King County is the 13th most populated county in the United States, with an estimated population of 2.2 million people in 2018 — up from about 1.9 million in 2010 (a 15.2% increase). King County is home to nearly 30% of Washington state’s population. Children and teens from birth through age 18 represented about 20% of the county’s population in 2017.

Table 122: Population Change by Age Group Between 2008 and 2018, King County, Washington

<table>
<thead>
<tr>
<th>Ages</th>
<th>2008</th>
<th>2018</th>
<th>Percent change (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-4</td>
<td>116,659</td>
<td>127,785</td>
<td>9.5%</td>
</tr>
<tr>
<td>5-9</td>
<td>112,023</td>
<td>128,712</td>
<td>14.9%</td>
</tr>
<tr>
<td>10-14</td>
<td>109,187</td>
<td>124,190</td>
<td>13.7%</td>
</tr>
<tr>
<td>15-19</td>
<td>117,909</td>
<td>125,343</td>
<td>6.3%</td>
</tr>
</tbody>
</table>

King County includes Seattle and 38 other cities, plus unincorporated and rural areas. The county is home to 20 school districts and 11 hospitals and health systems. In 2016, the South Region of King County had an estimated 741,000 residents, larger than Seattle’s 687,000

---

residents. The East Region had a population of about 549,000, and the North Region was home to about 128,000 people.

**Figure 123: Regions in King County, Washington**

In recent years, poverty rates among children across the county have remained fairly stable. In 2017, about 12% of children lived below the Federal Poverty Level. Highest rates of poverty are seen in King County’s South Region.

Over the past three years, King County has experienced substantial growth in population and diversity. King County’s population increased by about 13% (approximately 259,000 people) from 2010 to 2018, with most of the increase attributable to people of color. People of color now represent 38% of the population in King County, a rate that has nearly tripled in the past 35 years. Growth in the Asian and Hispanic/Latinx populations accounted for a significant portion of the population increase. The number of foreign-born residents, including immigrants and refugees, has also increased significantly over the past 25 years, now accounting for nearly half of King County’s population growth. For the first time, more than half of the children in King County are children of color.

---

About 170 languages are spoken in King County, and one out of every four King County residents speaks a language other than English at home.\textsuperscript{793} In King County, students speak dozens of languages.\textsuperscript{794} Spanish is the most frequently spoken language other than English, and Vietnamese, Chinese, Korean, Tagalog, French and African languages (primarily Somali, Amharic and Tigrinya) are also common.\textsuperscript{795} Language barriers can limit access to healthcare services, employment opportunities and education.\textsuperscript{796}

**Poverty among Youth**

In King County, about 12\% of youth under age 18 lived in poverty in 2017 — a rate that has been in decline since 2014.\textsuperscript{797}

As of October 2018, 32.3\% of students in King County public schools were enrolled in free or reduced-price meals.\textsuperscript{798} The eligibility rates for the program varied widely from 3.5\% in the Mercer Island School District to 67.4\% in the Tukwila School District and 68\% in the Highline School District.\textsuperscript{799} The Skykomish School District, the smallest in King County with 48 students in the 2018-19 year, had the highest eligibility rate at 91.7\%.\textsuperscript{800}

Rates were similar during the 2016-17 school year (see Figure 125 below). Aside from the small Skykomish School District, all districts with 50\% or more students in the free or reduced-price meal programs during the 2016 to 2017 school year were located in South King County.\textsuperscript{801}

Figure 125: Percentage of Students Eligible for Free and Reduced-price Meals in King County, 2016-2017 School Year

Students eligible for free/reduced price meals, King County (school year: 2016-2017)

Housing Affordability and Availability

In King County, on average from 2011 to 2015, nearly half of all renters and more than one-third of owners with a mortgage were paying more than the affordability threshold on housing. Rising housing prices disproportionately impact women, people living in poverty, people of color and adults over age 65. Housing cost burden also affects more than half of King County renters with children.


According to the 2018/19 King County Community Health Needs Assessment:

- About 80% of renters and about 90% of owners with a mortgage who lived at or near the poverty line paid more than 30% of their income on housing costs.
- About 64% of renters and half of all owners with a mortgage who were over the age of 65 exceeded the housing affordability threshold of 30% of their income.
- About 54% of female renters compared to nearly 41% of male renters experienced mortgage-related cost burden (housing costs exceeding 30%).

A large number of people in the Seattle area are choosing to live in apartments. A Seattle Times article from April 2019 detailed how the Seattle area is filling up new apartments at rates that are faster than any other region in the United States — catching up with the city’s construction boom. In 2018, only Los Angeles, Dallas and New York built more apartments than Seattle.

Figure 126: Seattle-area Apartment Construction, 2010-2018

---

Over the past year (ending in March 2019), residents of the Seattle area occupied more than 10,000 apartments — an increase of about 15% over the previous year.\textsuperscript{808} This was the second largest growth since 2000.\textsuperscript{809}

**Figure 127: Seattle-area Apartment Demand Growing, 2000-2019\textsuperscript{126}**

As the demand for apartments has grown, the cost of rent has stayed about the same rate as inflation over the last year and a half.\textsuperscript{810} The average rent across all unit types was $1,940 in Seattle, $1,980 in the East Region and $1,460 in South King County.\textsuperscript{811}

**Youth Experiencing Homelessness**

The trend of increasing homelessness in King County has gained significant traction in the media and in public policy. In June 2019, King County and Seattle leaders announced the End Youth Homelessness Now campaign, which seeks to prevent youth homelessness and to ensure that youth experiencing homelessness are housed within 30 days.\textsuperscript{812}

The 2019 Point in Time Count for King County indicates 11,199 people were homeless (5,971 sheltered and 5,228 unsheltered).\textsuperscript{813} Of the people who were homeless, 2,451 individuals lived in households with at least one adult and children under 18, and 82 individuals lived in households with only minors (no adults present).

According to King County’s 2018 Point in Time Count (a snapshot of how many youth and young adults experienced homelessness on Jan. 25, 2018): 814

- 1,518 unaccompanied youth and young adults through age 24 were homeless or unstably housed. Of these, 172 (about 11%) were under the age of 18, which was 49 fewer people than in 2017. These numbers are likely an underrepresentation and do not include young people under age 25 who are in families or have children.
- Among the group of unaccompanied youth and young adults, 75% were unsheltered, meaning they were living in tents, vehicles, parks, on the street or in places not meant for human habitation.
- Unaccompanied youth and young adults in King County identified as LGBTQ at about twice the rate as survey respondents 25 years and older (33% compared to 16%).
- The majority of unaccompanied young people who were homeless were male (about 63%).
- About one-third (33%) indicated that they had been in foster care in the past.
- Common reasons why youth became homeless included job loss, aging out of foster care, alcohol or drug use, mental health issues and arguments with family members or friends.
- Of unaccompanied youth surveyed, 51% reported psychiatric or emotional conditions.

Figure 128: Unaccompanied Youth and Young Adults Experiencing Homelessness in King County, Total Count by Age, 2018127

In addition to the rates of unaccompanied youth, the 2018 Point in Time Count also showed that 2,624 people in 782 families with children experienced homelessness in King County — 1,583 of these individuals were children under age 18.815 The number of people experiencing homelessness who were in families with children decreased by 7% from 2017 to 2018.

A few additional findings:
- The majority (97%) of families with children who were homeless were sheltered.
- More than three out of five (62%) people in families with children who were homeless were female.

Families with children who experienced homelessness reported rates of domestic violence at more than four times the rate of other survey respondents (21% compared to 5%).

Families with children who were homeless also indicated that they had chronic health problems at higher rates than other survey respondents.

Explaining the epidemic of homelessness in King County involves a network of interwoven causes, ranging from systemic failures in social support to Seattle’s recent unprecedented growth. There is the unfortunate misconception that teenagers experiencing homelessness have done so in pursuit of adventure, reminiscent of the beatnik movement of the 1950’s and 1960’s. Nationally, among youth in Family Youth Service Bureau shelters, close to 90% reported problems with family dynamics as an issue that lead to their experience of homelessness. It must first be clarified that those experiencing homelessness are not running towards romanticized thrills but rather away from trauma that often started long before teenage years.

As noted, 33% of youth under age 24 years living unaccompanied and experiencing homelessness in King County’s 2018 Point in Time count had been in foster care. Upon turning 18, adolescents are expected to transition to becoming independent adults. This means having the life skills and income to support monthly rent. While this is a difficult task for any 18 year old, foster care graduates are at an even further disadvantage given increased risks of previous trauma, behavioral health issues, and developmental delay.

In addition, 33% unaccompanied youth who were experiencing homelessness in King County reported identifying as LGBTQ in 2018. Among adults age 25 and older, this figure is 16%, suggesting that sexual identity may play a role in risk of experiencing homelessness among youth in King County.

While rising costs of living and ballooning rent prices have been a nationwide trend, the effect is particularly potent in Seattle. In 2017, the average Seattle renter paid $21,900 for rent over the course of a year, representing a 63% increase from 2010. Among respondents of all ages to the King County 2018 Count Us In Survey, 80.4% of people indicated that rental assistance/more affordable housing would help in obtaining permanent housing.

**Employment and Income**
Since 2015, unemployment rates in King County have been around 3% or 4% — a rate that has been consistently lower than the Washington state average. The not seasonally adjusted unemployment rate in June 2019 was 2.9% in King County, which was the lowest rate in the state.

**Figure 129: King County Health, Housing and Economic Opportunity Measures**

---

128 King County Equity and Social Justice Annual Report, Retrieved from: [https://www.kingcounty.gov](https://www.kingcounty.gov)
In addition to low unemployment rates, King County had the highest projected 2018 median household income at $89,881 — nearly 23% higher than the median household income in Washington state.  

The median household income on average from 2013 to 2017 varied in King County based on neighborhood and race/ethnicity. Individuals in South King County and people who were Black/African American earned the lowest median income. The cities listed in the table below with the exception of Seattle are all cities located in South King County.

Table 130: Median Household Income in Past 12 Months, King County Cities, 2013-2017

<table>
<thead>
<tr>
<th>City</th>
<th>Median Income in dollars</th>
<th>Margin of error</th>
</tr>
</thead>
<tbody>
<tr>
<td>King County</td>
<td>$83,571</td>
<td>+/- 617</td>
</tr>
<tr>
<td>Seattle</td>
<td>$79,565</td>
<td>+/- 1,076</td>
</tr>
<tr>
<td>Renton</td>
<td>$70,661</td>
<td>+/- 1,920</td>
</tr>
<tr>
<td>Kent</td>
<td>$64,573</td>
<td>+/- 2,507</td>
</tr>
<tr>
<td>Auburn</td>
<td>$64,400</td>
<td>+/- 3,276</td>
</tr>
<tr>
<td>Federal Way</td>
<td>$62,086</td>
<td>+/- 2,648</td>
</tr>
<tr>
<td>Des Moines</td>
<td>$60,814</td>
<td>+/- 3,223</td>
</tr>
<tr>
<td>Burien</td>
<td>$60,732</td>
<td>+/- 3,277</td>
</tr>
<tr>
<td>SeaTac</td>
<td>$51,025</td>
<td>+/- 2,663</td>
</tr>
</tbody>
</table>

---

Early Childhood Education

The city of Seattle (in King County) voters approved the Families and Education Levy first in 1990 and has been revised and renewed three times since then. The 2011 Family and Education Levy (FEL) is designed around three main goals and an established theory of action focused on continuous improvement. Seattle’s Department of Education and Early Learning (DEEL) reports they use a continuous improvement cycle to scale successful programs and improve outcomes. They also partner with schools and service providers to select key performance measures that indicate progress towards larger Levy goals, set performance targets appropriate for the context of each program, and evaluate performance annually. DEEL staff work closely with partners to ensure implementation of co-developed workplans, regularly utilizing data to inform course corrections, revise targets, and close achievement gaps. The investment areas for the levy focus on early learning, elementary, middle and high school strategies and student health. In the early learning category, there are strategies that focus on:

- High-Quality Preschool;
- School Readiness;
- Professional development, coaching/training;
- Resources and materials;
- Parent Child Home Program;
- and Health and Mental Health Screening and Support.

Educational Attainment

In King County, the high school graduation rate during the 2016-17 school year was 80.5% for all students and the dropout rate was 10%. The graduation rates varied by school district, with lowest rates in Renton (74.8%), in the East region of King County, and Tukwila (77% — up from 57.3% during the 2012 to 2013 school year), Auburn (77.6%) and Highline (78.8%), which

---

are all in South King County. Graduation rates in King County were highest in Mercer Island (94.6%), Snoqualmie (92.8%), Issaquah (92.7%) and Bellevue (91.1%).

English language learners, students in special education and students identifying as American Indian/Alaskan Native had the lowest graduation rates in the county with just over half graduating. About 31% of American Indian/Alaskan Native students and 24% of English language learners never finished high school during the 2016-17 school year. It should be noted that these rates are reflective of the historic systemic and institutional racism these communities have faced and the lack of support given to them to achieve educational equity with their counterparts.

**Foster Care**

In King County in 2017, 1,294 0 to 17-year olds were served by Foster Care Placement Services.

**Lesbian, Gay, Bisexual, Transgender and Questioning Youth**

In 2018 in King County, about 12% of eighth graders, 9% of 10th graders and 13% of 12th graders identified as lesbian, gay or bisexual. About 4% of eighth graders, 6% of 10th graders and 5% of 12th graders indicated that they were questioning/not sure when it came to their sexual orientation. In addition, 4% of eighth graders, 5% of 10th graders and 4% of 12th graders when responding to a question about gender identity identified as transgender, questioning/not sure, “something else fits better”, or selected multiple gender identity responses.

To better identify the issues impacting the LGBTQ community, King County released the “LGBTQ Community Spotlight” as part of the 2018/19 King County Community Health Needs Assessment. King County learned about the health needs of the LGBTQ community through listening sessions with youth and young adults identifying as LGBTQ, interviews with advocates working with youth identifying as LGBTQ and surveys. Please see our entire chapter dedicated to LGBTQ youth.

**Life Expectancy**

The average life expectancy at birth for King County residents was 81.9 years in 2015 — up from 79.5 years in 2000. The rate exceeds the 2015 national life expectancy average of 78.8 years.

**Figure 132: King County Average Life Expectancy Rates, 2015**

---

Within King County, life expectancy varies by neighborhood, race/ethnicity and income status. Residents of South Auburn live an average of 10 years less than residents of Northeast Seattle. People identifying as Hispanic or Asian have the highest average life expectancy rates (about 86 years), while people identifying as Native Hawaiian/Pacific Islander have the lowest average life expectancy rate (75 years). Individuals living in low-poverty neighborhoods live an average of five years longer than people in high-poverty areas.

**Figure 133: Life Expectancy at Birth by Health Reporting Areas, King County, 2013-2017**

---

Leading Causes of Death
Among children and youth ages 5 to 24, accidents were among the top three leading causes of death. Among infants less than one year old, conditions related to the perinatal period was the leading cause of death.

Leading Causes of Hospitalization
In King County in 2017, rates of hospitalization were similar to those of the state. Hospitalizations due to injury and poisoning remained highly ranked for 1 to 24 year olds. In the same year, diseases of the respiratory system were the top reason for hospitalization among children ages 1 to 9 and mental illness was the top reason for hospitalization among adolescents ages 10 to 19.

Childhood Diabetes
In 2014, 3% of King County students in eighth, 10th and 12th grades had doctor-diagnosed diabetes, which includes type 1 and type 2 diabetes.\textsuperscript{836}

**Figure 134: Diabetes Prevalence Among Youth in King County, 2010 and 2014 Average\textsuperscript{133}**

Cancer
King County had a cancer incidence of 19.3 per 100,000 in children under age 20 from 2012 to 2016, averaging about 93 cases each year.\textsuperscript{837}

Access to Care
After the statewide expansion of Medicaid and the launch of the WA Healthplanfinder health exchange, the percentage of children without health insurance fell to 1.6% in King County in 2015.\textsuperscript{838} In 2017, 1% of children less than age 6 and 2% of youth ages 6 to 18 were uninsured in King County.\textsuperscript{839}

Among young adults between the ages of 18 and 24, 25% were uninsured in King County in 2009, compared to 9% of young adults between the ages of 19 to 25 in 2017.\textsuperscript{840}

A few additional findings from 2017:\textsuperscript{841}

- A greater percentage of children in low-income households (less than 200% of the federal poverty level) were uninsured compared to children in higher income households.
- Slightly more children ages 6 to 18 (2%) were uninsured than children less than 6 years of age (1%).

**Figure 135: Percentage of Children and Young Adults Without Health Insurance in King County, 2008-2018 Average\textsuperscript{134}**

![Graph showing percentage of children without health insurance in King County from 2008 to 2018.](image)

*Note: Red line corresponds to children less than 6 years of age. Blue line corresponds to children 6 to 17 years of age. Orange line corresponds to children 6 to 18 years of age.*

**Immunization Rates**

In 2018, among children ages 19 to 35 months, King County had better immunization coverage compared to the majority of the counties in Washington state at 65%.\textsuperscript{842} In 2017, Seattle had the highest rate of immunization completion among children ages 19 to 35 months within King

County at 73%.\textsuperscript{843} Vashon Island and parts of Enumclaw and neighboring areas to the east had the lowest rates of immunization compliance in King County.\textsuperscript{844} Although the immunization rates have increased over the last few years in King County from 62\% in 2014\textsuperscript{845} to 65\% in 2018,\textsuperscript{846} there is more work to do to meet the Healthy People 2020 goal of 80\% immunization coverage among this age group.\textsuperscript{847}

**Figure 136: Percentage of Children Ages 19-35 Months With Incomplete Vaccine Series by King County, 2017\textsuperscript{135}**

**Oral Healthcare**

In King County in 2018, 82\% of youth in eighth, 10th and 12th grades had seen a dentist in the previous year.\textsuperscript{848} Among sixth to 12\textsuperscript{th} graders, the percentage of students who had missed school due to a toothache ranged from 4\% to 5\%.\textsuperscript{849}

**Figure #: Percentage of Youth Who Missed School Due to Toothache, King County (“Local”) and Washington State, 2018\textsuperscript{136}**

---


In 2015, about 38% of children in King County who participated in the Smile Survey had treated or untreated cavities. Children eligible for free or reduced-price school meals were significantly more likely than those from higher income families to have untreated dental disease. Untreated dental disease was also more likely among children of color, with highest rates among youth identifying as Native Hawaiian/Pacific Islander.

Figure 137: Percentage of Children With Cavities, King County, 2015

---

Depression
The rates of depression among youth in King County have also climbed over the last decade. According to the 2018 Healthy Youth Survey in King County:\(^{853}\)

- 28% of eighth graders felt so sad or hopeless for two weeks or more that they stopped doing their usual activities — up from 20% in 2008.
- 36% of 10th graders felt so sad or hopeless for two weeks or more that they stopped doing their usual activities — up from 28% in 2008.
- 36% of 12th graders felt so sad or hopeless for two weeks or more that they stopped doing their usual activities — up from 29% in 2008.

Figure 138: King County Youth Who Experienced Depressive Feelings by Grade, 2018\(^{138}\)

---

In King County:\(^{854}\)

- The rates of youth experiencing depressive feelings have increased since 2004, except among youth identifying as Asian.
- Youth in the South Region of King County were more likely to experience depressive feelings than other regions of the county.
- Youth identifying as American Indian/Alaska Native, Hispanic and Native Hawaiian/Pacific Islander experienced the highest rates of depressive feelings among racial/ethnic minority groups.
- Female students were also 1.7 times more likely than male students to experience depressive feelings in King County.

**Figure 139: King County Youth With Depressive Feelings by Subgroup, 2014 and 2016 Average\(^{139}\)**

According to the 2016 Healthy Youth Survey, King County youth in eighth, 10th and 12th grades who identified as lesbian, gay or bisexual also reported having depressive feelings at higher rates than their peers identifying as heterosexual (57% compared to 25%).

Figure 140: King County Depression by Sexual Orientation and Race/Ethnicity, 2016

Suicide
In King County, youth reported similar levels of considering attempting suicide (approximately 20%), creating a suicide plan (approximately 16%) and attempting suicide (approximately 10%).

Figure 141: King County Youth Who Experienced Suicidal Feelings and Actions by Grade, 2018

---

Substance Use

Alcohol Use
The percentage of youth in King County who reported drinking at least once in the past month or problem/heavy drinking were similar to Washington state’s rates.\(^{857}\)

Figure 142: King County Youth Who Reported Drinking at Least Once in the Past Month or Heavy Drinking, 2018\(^{142}\)

Averaging from 2014 and 2016, 11% of King County students in eighth, 10th and 12th grades (combined) engaged in binge drinking.\textsuperscript{858}

- The binge drinking rate for students identifying as American Indian/Alaska Native and Hispanic was nearly three times that of youth identifying as Asian — the group with the lowest rate.
- The binge drinking rate for 12th graders was more than 1.5 times the county average for students of all grades.
- Binge drinking among youth declined for the county overall and for all regions.

**Figure 143: King County Binge Drinking Rates Among School-age Children by Subgroup, 2014 and 2016 Average\textsuperscript{143}**

The rates of binge drinking also varied by sexual orientation. About 17% of King County youth who identified as lesbian, gay or bisexual reported binge drinking in 2016, compared to 10% of youth who identified as heterosexual. These rates were even higher among different racial/ethnic groups. Nearly one in three (30%) of students identifying as Hispanic and about one-quarter (26%) of students identifying as Black/African American who also identified as lesbian, gay or bisexual reported binge drinking.
Figure 144: King County Binge Drinking Rates By Sexual Orientation & Race/Ethnicity, Grades 8, 10, 12, 2016

Tobacco Use

---

In 2018, cigarette smoking rates among eighth, 10th and 12th grade students in King County were lower than the state average, with 4% of 10th graders and 5% of 12th graders reporting that they had smoked cigarettes in the past 30 days.\footnote{Healthy Youth Survey. (2018). HYS fact sheets. Retrieved from http://www.askhys.net/FactSheets.}

**Figure 145: Youth Cigarette Smoking Rates in King County, 2018\footnote{Public Health — Seattle & King County (2018/2019). King County community health needs assessment. Retrieved from https://kingcounty.gov/depts/health/data/community-health-indicators/~media/depts/health/data/documents/2018-2019-Joint-CHNA-Report.ashx.}**

Averaging data from 2014 and 2016, 6% of youth in King County public schools were current cigarette smokers. Youth identifying as American Indian/Alaska Native had the highest rates of smoking — nearly four times the rate of youth identifying as Asian. Overall, cigarette smoking rates have declined among youth in all regions of King County.\footnote{Public Health — Seattle & King County (2018/2019). King County community health needs assessment. Retrieved from https://kingcounty.gov/depts/health/data/community-health-indicators/~media/depts/health/data/documents/2018-2019-Joint-CHNA-Report.ashx.}

**Figure 146: Youth Cigarette Smoking Rates in King County, 2014 and 2016\footnote{Public Health — Seattle & King County (2018/2019). King County community health needs assessment. Retrieved from https://kingcounty.gov/depts/health/data/community-health-indicators/~media/depts/health/data/documents/2018-2019-Joint-CHNA-Report.ashx.}**
In 2016, more than one in 10 (13%) of King County youth who identified as lesbian, gay or bisexual reported smoking cigarettes in the month prior to the survey — a rate that is more than three times the rate of youth who identified as heterosexual.\textsuperscript{863}

\textbf{Figure 147: Youth Cigarette Smoking Rates in King County by Sexual Orientation and Race/Ethnicity, Grades 8, 10 and 12, 2016}\textsuperscript{147}

From 2008 to 2018, the percentage of 12th grade students in King County who smoked cigarettes decreased by 74%. More than four times as many 12th graders used vapor products compared to cigarettes in 2018.

**Figure 148: Current Use Trends in King County, Grade 12, 2018**

---

In King County, 2% of sixth graders, 9% of eighth graders, 16% of 10th graders and 22% of 12th graders reported using vapor products within the 30 days prior to the 2018 Healthy Youth Survey — rates that were lower than the state averages.\textsuperscript{864}

**Figure 149: Current Vapor Product Use in Washington State Compared to King County, Grades 6, 8, 10 and 12, 2018\textsuperscript{149}**

---

**Marijuana Use**

In 2018, the rates of marijuana use among youth in King County were lower than the state average for most grades, with 14% of 10th graders and 19% of 12th graders self-reported using marijuana within the previous 30 days. These rates have declined among eighth, 10th and 12th grade students since 2010.

About 6% of 12th graders reported heavy marijuana use in King County. Overall, about 32% of students in King County reported that they had tried marijuana at least once.

**Figure 150: Current Marijuana Use and Heavy Marijuana Use Among Youth in King County, 2018**

---

In 2016, one-quarter (25%) of King County youth in eighth, 10th and 12th grades who identified as lesbian, gay or bisexual reported using marijuana in the past 30 days, compared to 15% of youth who identified as heterosexual. Rates were especially high among youth identifying as lesbian, gay or bisexual who also identify as Black/African American, Native Hawaiian/Pacific Islander and Hispanic.

Figure 151: Current Marijuana Use Among King County Youth by Sexual Orientation and Race/Ethnicity, Grades 8, 10 and 12, 2016

---

### Prescription Medication Use

In King County, 2% of eighth graders and 3% of 10th and 12th graders in 2018 used painkillers in the last 30 days to get high.

---

**Marijuana use by sexual orientation & race/ethnicity (8th, 10th, 12th grades)**

King County (2016)

<table>
<thead>
<tr>
<th>Category</th>
<th>Heterosexual</th>
<th>LGB</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall</td>
<td>15%</td>
<td></td>
</tr>
<tr>
<td>AIAN</td>
<td>17%</td>
<td></td>
</tr>
<tr>
<td>Asian</td>
<td>7%*</td>
<td></td>
</tr>
<tr>
<td>Black</td>
<td>17%</td>
<td></td>
</tr>
<tr>
<td>Hispanic</td>
<td>18%</td>
<td></td>
</tr>
<tr>
<td>Multiple</td>
<td>18%</td>
<td></td>
</tr>
<tr>
<td>NHPI</td>
<td>19%</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>12%</td>
<td></td>
</tr>
<tr>
<td>White</td>
<td>16%</td>
<td></td>
</tr>
</tbody>
</table>

King County average: 15%

---

Source: Healthy Youth Survey

^ = Data suppressed if too few cases to protect confidentiality and/or report reliable rates

* = Significantly different from King County average
In 2018, 5% of eighth and 12th graders, and 6% of 10th graders reported using prescription drugs not prescribed to them within the past month.

Figure 153: Students Who Reported Using Prescription Drugs Not Prescribed to Them in Past Month, King County, 2018153

---

Among youth ages 13 to 17 in King County, there were 4 deaths and 29 hospitalizations due to overdose involving any opioid between the years of 2013 to 2017.871

**Early and Adequate Prenatal Care**

The percentage of pregnant women beginning prenatal care in the first trimester of pregnancy in King County was also greater than that of Washington State in 2016, at 83.0%.872 Among births to King County residents in 2017, 73% of babies were born to mothers who received prenatal care before the third trimester and at least 80% of the recommended number of prenatal visits.

In King County:873

- About half (55.2%) of teen mothers (under age 18) received early and adequate prenatal care.
- Mothers identifying as American Indian/Alaska Native, Black/African American, Hispanic, Native Hawaiian/Pacific Islander or multiracial were less likely than mothers identifying as Asian or white to receive early and adequate prenatal care.
- Since 2000, the rate of early and adequate prenatal care has increased in Seattle, but has decreased in the East Region of King County. After experiencing a seven-year decline, early and adequate prenatal care has rebounded in the South Region.
- The likelihood that mothers received early and adequate prenatal care was highest in more prosperous neighborhoods and lowest in high-poverty neighborhoods.

**Figure 154: Average rates of early and adequate prenatal care, King County (2013-2017)\textsuperscript{154}**

Infant Mortality
In 2015, the infant mortality rate for the county was 3.6 deaths per 1,000 live births (a rate of 3.3 deaths per 1,000 live births in Seattle).\(^{874}\)

From 2011 to 2015,\(^{875}\)

- Infants born to mothers identifying as American Indian/Alaska Native and Black/African American were more than twice as likely as infants born to mothers identifying as white or Asian to die before their first birthday.
- In King County, infant mortality rates have declined since 2000.

Figure 155: King County Infant Mortality Rates by Subgroup, 2011-2015 Average\(^{155}\)

Low Birth Weight
In 2016, 6.5% of infants who were residents of King County were low birth weight.\(^{876}\)

---

In 2011 to 2015, the highest rates of infants born low birth weight were among those born to Black/African American mothers (9.1 infants per 1,000 births) and American Indians/Alaska Natives (8.3 infants per 1,000 births). The rates of low birth weight have remained constant in King County since 2006. 

**Figure 156: King County Low Birth Weight Rates, 2011-2015 Average**

![Low birth weight rates in King County](image)

**Obesity and Overweight Prevalence**

Compared to Washington state, obesity rates were slightly lower in King County. In 2018, 20% of eighth graders, 23% of 10th graders and 27% of 12th graders were obese or overweight. Of those, 8% of eighth graders, 11% of 10th graders and 13% of 12th graders were obese.

---

In King County in 2014 to 2016:

- Students identifying as Native Hawaiian/Pacific Islander, Hispanic, Black/African American and American Indian/Alaska Native were more likely than students identifying as Asian or white to be obese.
- With an average obesity rate of 26%, students who were Native Hawaiian/Pacific Islander were 3.7 times more likely to be obese than students who were white.
- The South Region had a significantly higher percentage of students who were obese than the King County average.
- Male students were more likely than female students to be obese.
- Students who identified as lesbian, gay or bisexual were significantly more likely to be obese than students who identified as heterosexual.

Figure 158: King County Youth Obesity Rates by Subgroups, 2014 and 2016 Average

---


In 2016, about 14% of King County eighth, 10th and 12th graders who identified as lesbian, gay or bisexual were obese, compared to 8% of youth who identified as heterosexual.\textsuperscript{881} The rates were even higher among youth who were Black/African American or Hispanic and identified as lesbian, gay or bisexual.\textsuperscript{882}

Figure 159: King County Youth Obesity Rates by Sexual Orientation and Race/Ethnicity, Grades 8, 10 and 12, 2016\textsuperscript{159}

Food Insecurity

At 15.5%, the rate of food insecurity among children in King County in 2017 was lower than state and national rates. Half of children who were food insecure were eligible for federal nutrition programs based on income level.

Figure 160: Percentage of Children Who Were Food Insecure in King County, 2017

Fruit and Vegetable Consumption

In King County in 2018, 22% of eighth graders, 19% of 10th graders and 18% of 12th graders ate five or more servings of fruit and vegetables per day over the past seven days.

Youth Consumption of Sugar-Sweetened Beverages

In 2018, 67% of eighth and 12th graders, and 69% of 10th graders in King County reported drinking sugar-sweetened drinks in the past week. Similar to Washington state rates, 3% of eighth graders, 2% of 10th graders and 3% of 12th graders drank sweetened drinks daily at school in 2018 in King County. Among King County 10th graders, the rates declined by 88%, from 16% in 2008 to 2% in 2018.

In King County in 2014-2016:

- Males were 1.7 times more likely than females to drink sodas or sugar-sweetened drinks daily.
- Youth identifying as American Indian/Alaska Native, Black/African American, Native Hawaiian/Pacific Islander or Hispanic were more likely than youth identifying as Asian or white to drink soda or sugar-sweetened beverages daily.
- Youth in the South Region were more likely to consume sugar-sweetened beverages daily than students in the other three regions.

Figure 161: King County Youth Daily Soda or Sugar-sweetened Beverage Consumption Rates by Subgroups, 2014 and 2016

---

884 Fruit and Vegetable Consumption

885 Similar to Washington state rates

886 Among King County 10th graders, the rates declined by 88%, from 16% in 2008 to 2% in 2018.

887 In King County in 2014-2016:

888 Male gender

889 American Indian/Alaska Native, Black/African American, Native Hawaiian/Pacific Islander or Hispanic

890 Asian or white

891 South Region

892 Other three regions

---

Physical Activity
In King County in 2018, there was a greater percentage of students who did not meet the daily physical activity recommendation than the state averages — 82% of 10th graders and 84% of 12th graders.\(^{888}\)

Figure 162: King County (“Local”) Rates of Youth Who Did Not Meet Recommendations for Physical Activity Compared to Washington State, 2018\(^{162}\)

From 2014 to 2016 in King County,\textsuperscript{889}

- As grade level increased, rates of student participation in physical activity.
- Female students were significantly less likely than male students to meet the physical activity recommendation.
- Since 2006, the proportion of students meeting the physical activity recommendation has increased at a slow rate in all regions and among all racial/ethnic groups.

**Figure 163: King County Youth Physical Activity Recommendation Not Met by Subgroup, 2014 and 2016\textsuperscript{483}**
Community Input from Seattle, King County

From 2017 to 2019 Seattle Children’s co-hosted local listening sessions in Seattle and King County, which we called community cafes, with many local community based co-hosts. These co-hosts were community based partners such as the Similow Rainier Vista Boys and Girls Club, the Atlantic Street Center, New Beginnings (a resource center for the survivors of domestic violence and their children), the Somali Health Board, the Eritrean Community in Seattle’s Health Committee, the Ethiopian Community in Seattle’s Health Council, the New Holly Community Center, The Seattle Inidan Health Board, Chief Seattle Club, and the Othello Outreach Clinic at Mercy Housing. Like the listening sessions held in other parts of the WAMI region, we collaborated with local partners to convene a series of these localized listening sessions facilitated by Seattle Children's staff who volunteered for the project. The goals for hosting the Community Conversations are: getting to know the communities we work with; understanding the whole child and family and the communities they live, work and play in; getting to know the important issues impacting communities; learning more about the strengths of communities in Seattle and King County; elicit feedback on community health; and strengthening the existing relationships with our community partners. This effort over the past few years had themes not dissimilar to what we heard from community partners, key informants or parents and caregivers in the WAMI region. To summarize, the major topics of conversation that came up over and over again we’ve grouped into themes from these community cafes. Themes were:

**Neighborhood and Built Environment**
- Personal and neighborhood safety
• Affordable housing (lack of)
• Homelessness
• Affordable and reliable transportation
• Healthy food

Health and Health Care
• Language access – high quality interpreters
• Access to health care
• Families experiences in health care settings
• Mental and behavioral health
• Integrated care
• Health insurance
• Trauma and trauma informed care
• Accessing and navigating healthcare systems with a culturally appropriate lens

Education
• Bullying
• Culturally appropriate classes and support groups
• Culturally responsive teaching
• Racism
• Student Achievement Gap
• Educational opportunities
• School district and other education programs’ policies
• Family experiences
• Access to programs
• Navigating educational systems

Social and Community Context
• Immigration status
• Language access
• Implicit bias
• Racism
• Law enforcement relationships

Economic Stability
• Employment opportunities
• High cost of living in Seattle/Washington State
• Poverty
• Homelessness
• Increasing costs
• Money management
• Affordable/accessible resources – parenting, legal support, nutrition, co-located/coordinated resources
• Desire for self-empowerment but experience traditional systems that are biased

In addition to these co-hosted local sessions, Seattle Children’s held two listening sessions in Southwest King County in 2017 to discuss healthy eating and food insecurity. These groups consisted of high school and college students who were interested in health professions and mothers enrolled in an early childhood development and parenting curriculum. Broadly, participants identified food security as one of the top two concerns facing their households. Food security, housing security, and safety topped most participants’ priorities for their families. Participants cite the public Parks and Recreation Department, partnerships between Electronic Benefits Transfer (EBT) and farmer’s markets, and community gardens as important assets for healthy eating and active living in their communities. Barriers include inaccessibility to fresh and/or organic produce, limited means for home gardening, poor school lunch quality and insufficient public benefit credit provided through WIC and SNAP. Participants suggested that hospitals provide family food preparation areas, food stations that offer raw ingredients rather than prepared and more expensive meals, and more affordable parking.

Opportunities

Specific suggestions and reflections that were explicitly said in these local community cafes:
• Families want help learning how to advocate for themselves and manage their care.
• Would like to see a community center that offers multiple services – mental health, nutrition, food bank, urgent care, parenting skill-building, birth control, Women, Infants, and Children (WIC), mindfulness, help with IEPs, and computer resources to navigate multiple systems – and makes the connection between health care and education.
• Increased education from people within their culture. There is concern about a lack of education that is culture and language specific on health and safety, lifestyle choices, such as cooking, eating, and exercise, as well as medications and the role of immunizations.
• Education about medical insurance and dental care.
• Families feel burdened by the high cost and lack of education about healthy foods. Increased knowledge of healthy food options with respect to culture. Partner with language specific TV stations.
• Educate and connect new and current community members with available resources. Those expressed most frequently were housing, jobs, education, childcare, voting, nutritional information, language support, guidance on green card applications, navigating the legal system and healthcare.
• Need more visual ways of learning and sharing information about asthma.
• Education, compassion, and preventative trauma-informed approaches to help address the impact of trauma for families, especially young children. Parents felt they were under-equipped to support their children through domestic violence situations.
• Inclusive meetings and gatherings with all African cultures in order to increase support and understandings. Host community support meetings in which community members can share their personal experiences to help new community members navigate the healthcare system as well as facilitated meetings where healthcare professionals can help respond to questions.

• **Personal and neighborhood safety:** Concerns about escalating problems with crime were widely discussed, people said problems with teenage boys are growing and they don’t feel comfortable confronting the boys causing problems.

• **Language Access:** Participants want access to high quality interpreters to explain health plans and provider directions. Some families have shared stories about patient safety being impacted due to poor interpretation and that some have gone to other medical centers because of better access to high quality interpreters.

• **Health and Health care**
  o **Access to health care:** families are worried about losing health insurance coverage;
  o **Families experiences in health care settings:** Families feel rushed at medical appointments; participants feel health care providers in Sea-Tac have discriminated against them and are late for appointments; participants felt they need to complain to get results, but not everybody is comfortable to complain; participants shared the worry in their community regarding sterilization without patients’ knowledge and consent;
  o **Mental and Behavioral Health:** families are concerned about their children’s emotional health. Families have left Somalia where their children weren’t diagnosed with conditions like being hyperactive or ADHD or other, but here those are titles and labels now applied to their children. The children are the same, but the location has changed (Somalia vs now in the US)—and even different care providers in the same pediatric clinic practice medicine differently, especially when talking about Mental Health.
    ▪ **Bullying:** Parents are concerned about bullying in school and feel that teachers aren’t adequately responding to this problem. Families suggested having Seattle Children’s partner with schools to support emotional learning in schools.

• **Culturally Appropriate Classes and Support Groups:** parenting, participants stressed the need for this type of class and feel it could help deal with the problems they’re having with teenage boys; Type 1 diabetes, families with children with Type 1 diabetes are concerned their children feel left out or overburdened, families would like more support and groups to help with understanding diabetes, families would like to see nutritional guides/books that reflect the food from their cultures so they have appropriate references

• **Social and Community Context**
  o **Immigration status:** families need help with immigration issues;
  o **Language Access:** families, including children, struggle with language issues;
  o **Social support:** single-parent families are concerned about their children’s well-being; participants are concerned about families and communities being too siloed
and would like to see better efforts to work together, participants feel churches and community centers, as well as law enforcement are helpful.

- **Economic Stability:**
  - **Employment Opportunities:** participants said educated community members can’t get jobs, they shared frustration that college education doesn’t always lead to jobs, they discussed how corporations bring people from overseas for local jobs and specifically called out Microsoft;
  - **High cost of living in Seattle/Washington State:** poverty, food insecurity, housing instability.

- **Specific to the Somali Community in King County, opportunities mentioned were:**
  - Counseling/Social/Emotional support in school setting for children (normalizing not only during crises)
  - Training teachers to be responsive to bullying and to teach with social/emotional learning lens
  - Supportive/inclusive of single-family households (fully integrated health and social care)
  - Supportive of healthy eating and living (FreshBucks/dollars towards healthy food/living)
  - Support groups for children with diabetes and resources/support for parents
  - Create more platforms for the community to be able to discuss health concerns in ways that are most meaningful for them.

- **Specific to the Oromo speaking population we spoke to in King County, opportunities mentioned were:**
  - Partnering with Seattle Children’s on:
    - Finding affordable housing
    - Addressing language access
    - Access to health care
    - Addressing the high cost of living.

---

**Tri-Cities, Benton and Franklin Counties**

**Population**
The Tri-Cities includes Kennewick, Pasco and Richland, which are located in Benton and Franklin counties in Southeast Washington state. The Tri-Cities makes up the largest metropolitan area in the southeastern quadrant of Washington. While these three cities make up the major cities in the metropolitan area, other cities that fall within Benton and Franklin counties include: Benton, Connell, Kahlotus, Patterson, Prosser and West Richland. The Tri-Cities is located where the Columbia, Yakima and Snake rivers meet and is rich with fertile farmland. Hops, grapes, and apples are a few of the many crops that grow bountifully in the region.
Benton County has a population of nearly 200,000, while Franklin County has a population of about 92,000. With a population near 82,000, Kennewick is the most populated of the three largest cities that comprise the Tri-Cities. Pasco has a population of nearly 71,000, and Richland’s population is near 54,000.

| Table 164: Population Change by Age Group Between 2008 and 2018, Benton County |
|-----------------------------------------------|-----|-----|-----|
| Ages | 2008 | 2018 | Percent change (%) |
| 0-4 | 12,465 | 13,636 | 9.4% |
| 5-9 | 12,633 | 14,443 | 14.3% |
| 10-14 | 12,898 | 14,690 | 13.9% |
| 15-19 | 12,860 | 13,186 | 2.5% |

| Table 165: Population Change by Age Group Between 2008 and 2018, Franklin County |
|-----------------------------------------------|-----|-----|-----|
| Ages | 2008 | 2018 | Percent change (%) |
| 0-4 | 7,553 | 8,291 | 9.8% |
| 5-9 | 7,057 | 8,664 | 22.8% |
| 10-14 | 6,319 | 8,537 | 35.1% |
| 15-19 | 5,980 | 7,424 | 24.1% |

The Tri-Cities area is primarily comprised of white and Hispanic/Latinx residents. In Benton County, 56% of youth under age 18 in 2018 were white, and 35% were Hispanic/Latinx. Approximately 10% of Benton County residents are foreign-born. In 2017, an estimated 20% of people living in Benton County speak a language other than English, the majority (76%) of whom speak Spanish.

Figure 166: Youth (Under 18) Population by Race/Ethnicity, Benton County, 2018

---


In Franklin County in 2018, 69% of youth were Hispanic/Latinx, and 27% were white.\textsuperscript{895} The percentage of youth who identified as Hispanic/Latinx exceeded the Washington state average. In Franklin County, approximately 23% of people are foreign-born.\textsuperscript{896} In 2017, an estimated 49% of residents spoke a language other than English, with the majority (92%) speaking Spanish.\textsuperscript{897}

Figure 167: Youth (Under 18) Population by Race/Ethnicity, Franklin County, 2018\textsuperscript{897}

Poverty among Youth
In 2017, about 20% of youth under age 18 in Benton County and 24% of youth under age 18 in Franklin County lived in poverty.\textsuperscript{898} The poverty rate in Benton County has changed very little since 2012. In Franklin County, the poverty rate has decreased each year since 2012.\textsuperscript{899}

In October 2018, 52.1% of students in Benton County and 69.3% of students in Franklin County were enrolled in free or reduced-price meals.\textsuperscript{900} Across both counties, the eligibility rates for the program varied widely from 36.6% in the Richland School District to 69.3% of students in the Pasco School District and 71.1% of students in the Finley School District.\textsuperscript{901}

Youth Experiencing Homelessness\textsuperscript{902}
According to the Point in Time Count conducted in Benton County, 152 individuals were homeless (105 sheltered and 47 unsheltered) in 2019. Of those who were homeless in Benton County, 73 people were from households with at least one adult and with children under age 18, and less than 10 people were from households with only minors (no adults present).

The 2019 Point in Time Count for Franklin County found that 70 people were homeless (all sheltered). Among the people who were homeless, 20 people lived in households with at least one adult and children under 18, and none lived in households with only minors (no adults present).

Employment and Income
The unemployment rates in Benton and Franklin counties in June 2019 were 5.1% and 5.8%, respectively (not seasonally adjusted).\textsuperscript{903}

The projected median household income in Benton County in 2018 was $64,745, while the median projected household income in Franklin County that same year was $68,179, exceeding the average median 2017 household income in the United States.\textsuperscript{904}

Educational Attainment\textsuperscript{905}
During the 2016-17 school year, 76.6% of high school students in Benton County and 74.8% of students in Franklin County graduated high school, while 10.3% of students in Benton County and 12.1% of students in Franklin County dropped out of high school. In both counties, students who were in special education and English language learners had the lowest graduation rates at between 50% and 60%.

Foster Care\textsuperscript{906}
204 Benton County children ages 0 to 17 and 110 Franklin County children ages 0 to 17 were served by Foster Care Placement Services in 2017.

Lesbian, Gay, Bisexual, Transgender and Questioning Youth\textsuperscript{907}
In Benton County, 9% of eighth graders, 10% of 10th graders and 13% of 12th graders identified as lesbian, gay or bisexual in 2018. About 3% of eighth graders, 4% of 10th graders and 3% of
12th graders indicated that they were questioning/not sure when it came to their sexual orientation. When asked about gender identity, 5% of eighth graders and 4% of 10th and 12th graders in Benton County identified as transgender, questioning/not sure, “something else fits better”, or selected multiple gender identity responses. No data were available for Franklin County.

**Oral Healthcare**

In 2018, 87% of eighth graders, 84% of 10th graders and 83% of 12th graders had seen a dentist within the last year in Benton County. Between 5% to 7% of students in Benton County reported missing school due to a toothache in the last year.

Data from the 2018 Healthy Youth Survey were not available for Franklin County.

**Figure 168: Percentage of Youth Who Missed School Due to Toothache, Benton County (“Local”) and Washington State, 2018**

![Graph showing percentage of youth who missed school due to toothache]

**Suicide**

Between 19% and 23% of students in eighth, 10th and 12th grades in Benton County in 2018 considered attempting suicide, and between 7% to 12% attempted suicide in the past year.

Data from the 2018 Healthy Youth Survey was not available for Franklin County.

---

Figure 169: Benton County Youth Who Reported Suicidal Feelings and Actions by Grade, 2018\textsuperscript{169}

\textbf{Suicidal Feelings and Actions...}
Students who report considering suicide, making a suicide plan, and attempting suicide in the past year

\begin{center}
\begin{tabular}{lccc}
\hline
 & 8th & 10th & 12th \\
\hline
Considered attempting suicide in past year & 19\% & 23\% & 23\% \\
Made a suicide plan in past year & 17\% & 19\% & 18\% \\
Attempted suicide in past year & 12\% & 12\% & 7\% \\
\hline
\end{tabular}
\end{center}

\textbf{Substance Use}

\textit{Alcohol Use}\textsuperscript{910}

According to the 2018 Healthy Youth Survey, about one-quarter of 12th graders in Benton County reported drinking at least once in the past month, while 17\% of 12th graders reported problem or heavy drinking. Data from the 2018 Healthy Youth Survey were not available for Franklin County.

\textsuperscript{169} Healthy Youth Survey. (2018). \textit{HYS fact sheets}. Retrieved from \url{http://www.askhys.net/FactSheets}.
Figure 170: Benton County Youth Who Reported Drinking at Least Once in the Past Month or Heavy Drinking, 2018

<table>
<thead>
<tr>
<th>Current Drinking</th>
<th>Problem or Heavy Drinking</th>
</tr>
</thead>
<tbody>
<tr>
<td>Students who report drinking at least once in the past month</td>
<td>Students who report drinking 3 or more days in the past month and/or one or more binge drinking episodes*</td>
</tr>
<tr>
<td>% of Students</td>
<td>% of Students</td>
</tr>
<tr>
<td>6th</td>
<td>8th</td>
</tr>
<tr>
<td>2%</td>
<td>11%</td>
</tr>
</tbody>
</table>

*Tobacco Use
Youth in sixth, eighth, 10th, and 12th grades in Benton County reported similar rates of cigarette smoking as the state average. Data from the 2018 Healthy Youth Survey was not available for Franklin County.

Figure 171: Youth Cigarette Smoking Rates in Benton County, 2018

---

From 2008 to 2018, the percentage of 12th grade students in Benton County who smoked cigarettes decreased by two-thirds. The rates of vapor product use among 12th graders have stayed about the same across the county over the last four years.

**Figure 172: Current Use Trends in Benton County, Grade 12, 2018**

Note: N/S indicates that the question was not surveyed in that year.

In Benton County, nearly one out of every four 10th and 12th grade students in 2018 reported using vapor products over the last 30 days. Data from the 2018 Healthy Youth Survey were not available for Franklin County.

Figure 173: Current Vapor Product Use in Washington State Compared to Benton County (“Local”), 2018

---

Marijuana Use
Students in Benton County reported using marijuana at least once in the past month or heavy marijuana use at rates lower than the state averages. These rates have stayed about the same compared to data from 2010. Data from the 2018 Healthy Youth Survey were not available for Franklin County.

Figure 174: Current Marijuana Use and Heavy Marijuana Use Among Youth in Benton County, 2018

---

Prescription Medication Use\textsuperscript{914}

Between 2\% to 4\% of students in eighth, 10th and 12th grades in Benton County reported using painkillers to get high at least once in the past month in 2018. Data from the 2018 Healthy Youth Survey was not available for Franklin County.

Figure 175: Students Who Reported Using Painkillers to Get High at Least Once in Last 30 Days, Benton County, 2018\textsuperscript{175}

\textsuperscript{914} Healthy Youth Survey. (2018). \textit{HYS fact sheets}. Retrieved from \url{http://www.askhys.net/FactSheets}. 

\textsuperscript{175}
According to the same survey of Benton County students, twice as many 12th graders as eighth graders reported using prescription drugs not prescribed to them within the past month in 2018.

**Figure 176: Students Who Reported Using Prescription Drugs Not Prescribed to Them in Past Month, Benton County, 2018**

For the years 2013 to 2017, no deaths due to overdose involving any opioid occurred among 13 to 17 year olds in Benton County or Franklin County.\(^{915}\)

---

Early and Adequate Prenatal Care\textsuperscript{916}
In 2016, 77.6\% of pregnant women in Benton County began prenatal care within the first trimester of pregnancy. First trimester prenatal care was slightly less frequent among pregnant women in Franklin County in 2016, where 75.3\% of pregnant women began prenatal care early.

Infant Mortality\textsuperscript{917}
The infant mortality rate in Benton County in 2015 was 5.6 deaths per 1,000 live births, which was higher than the infant mortality rate in Franklin County, with 3.0 deaths per 1,000 live births.

Low Birth Weight\textsuperscript{918}
In Benton County, 5.9\% of babies born in 2016 were low birth weight. The rate was similar in Franklin County, with 6.0\% of babies born in 2016 with low birth weight.

Obesity and Overweight Prevalence\textsuperscript{919}
In Benton County, about three out of every 10 students in eighth, 10th and 12th grades were overweight or obese in 2018, similar to state averages. Specifically, 13\% of eighth graders, 14\% of 10th graders and 17\% of 12th graders were considered to be obese. Data from the 2018 Healthy Youth Survey were not available for Franklin County.

Figure 177: Benton County (“Local”) Youth Obese or Overweight Rates Compared to Washington State, 2018\textsuperscript{177}

Note: N/A indicates question was not asked of that grade.

**Food Insecurity**

In 2017, the rates of food insecurity among children in Benton and Franklin counties (18.8% and 18.6%, respectively) were higher than the state and national averages.

**Figure 178: Percentage of Children Who Were Food Insecure in Benton County, 2017**

---

About two-thirds of children in Benton and Franklin counties who were food insecure were eligible for federal nutrition programs based on income level.

**Figure 179: Percentage of Children Who Were Food Insecure in Franklin County, 2017**

Fruit and Vegetable Consumption

In Benton County in 2018, 19% of eighth graders, 14% of 10th graders and 16% of 12th graders in 2018 ate five or more servings of fruits and vegetables per day over the past seven days. Data from the 2018 Healthy Youth Survey were not available for Franklin County.

Youth Consumption of Sugar-Sweetened Beverages

In 2018, 80% of eighth graders, 79% of 10th graders and 78% of 12th graders in Benton County reported drinking sugar-sweetened drinks in the past week. About 4% of 10th graders in the county reported drinking sugar-sweetened drinks daily at school — a 79% decline since 2008 (from 19% to 4%). Data from the 2018 Healthy Youth Survey were not available for Franklin County.

Physical Activity

In 2018, students in Benton County met the daily physical activity recommendation at similar or higher rates than the state averages for students in sixth, eighth, 10th and 12th grades. Data from the 2018 Healthy Youth Survey were not available for Franklin County.

**Figure 180: Benton County (“Local”) Rates of Youth Who Did Not Meet Recommendations for Physical Activity Compared to Washington State, 2018**

---


Community Input from Tri-Cities, Benton and Franklin Counties

In 2017, Seattle Children’s heard from Tri-Cities community members through key informant interviews conducted at the Farm Workers Clinic in Pasco with two parents and two providers. In addition, a listening session drew 29 parents, most of whom had had a child or children with special needs.

Access to care was a major theme:

- Most parents were well connected to a primary care provider.
- Unanimously, parents felt access to specialty care and mental/behavioral health services was limited. Parents reported long lines to see the few specialists in their area and reported wait lists to get in with specialists that ranged from several months to over a year.
- In particular, access to neurodevelopment appointments have been a major challenge for parents. The waiting list is over a year long.
- Driving the 4 or 5 hours from the Tri-Cities to Seattle for care can be impossible if the weather is poor. For some children with special needs, even with good weather, the journey can be too long for them to tolerate.
- Multiple parents reported financial difficulties that resulted from taking time off from work to attend medical appointments.
- In the Hispanic/Latinx communities, there was some concern that children are not receiving the appropriate preventable services, including well child checks and vaccines.

Navigating healthcare systems was noted as a concern:

- Getting insurance to pay for services was challenging, including finding mental/behavioral health services for youth on Medicaid. In the Tri-Cities, many
mental/behavioral health providers only take private insurance. Others spoke about insurance companies denying coverage for crucial medicines.

- Many parents felt getting their children with special needs connected to special educational services within the public school system was a challenge and meant circumventing “dead ends.”

Parents expressed fears related to their child’s transition from child to adult and thus from pediatric to adult care:

- Parents of children that have special needs feared their kids would be increasingly in danger of being misunderstood by police officers or other public figures as they get older and “just get courted off to juvenile hall.”
- Parents expressed that they yearn for their children “to be understood,” so they can become contributing members of society.
- Many worry about youths’ capacity to navigate a health care system that parents themselves struggle to understand.
- Parents worried about finding doctors who cared for adults and could adequately care for patients with disorders traditionally diagnosed in childhood like autism.

Support and resilience were evident among families in the Tri-Cities community:

- Many parents of children with special needs have become increasingly involved in the community, indicating that they have become advocates not only for their own children but for other families as well. One mom used lived experience to become a certified peer counselor. “It created a community for me,” she explained.
- The listening session itself was described as “therapeutic,” by some parents. “Being in this room, I recognize so many people on my team. It feels like I am not alone.”
- Parents shared stories about moments when their children showed resiliency—from stories shared about winning the science fair to making it out to dinner without a behavioral outburst.

**Walla Walla County**

**Population**

Walla Walla County is located in the southeast part of Washington state near the border of Oregon. Agriculture is the dominant economic driver in the county, with a growing wine industry. The county had an estimated population of nearly 62,000 in 2018.924 Walla Walla is the largest city in the county with a population of nearly 33,000.925

**Table 181: Population Change by Age Group Between 2008 and 2018, Walla Walla County**181

---

181 Washington State Office of Financial Management. (2018). Estimates of April 1 population by age, sex, race and
Youth Population by Race/Ethnicity
Walla Walla County, 2018

<table>
<thead>
<tr>
<th>Ages</th>
<th>2008</th>
<th>2018</th>
<th>Percent change (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-4</td>
<td>3,488</td>
<td>3,435</td>
<td>-1.5%</td>
</tr>
<tr>
<td>5-9</td>
<td>3,598</td>
<td>3,736</td>
<td>3.8%</td>
</tr>
<tr>
<td>10-14</td>
<td>3,758</td>
<td>3,922</td>
<td>4.4%</td>
</tr>
<tr>
<td>15-19</td>
<td>4,953</td>
<td>4,893</td>
<td>-1.2%</td>
</tr>
</tbody>
</table>

In 2018, nearly two out of every five youth under 18 in Walla Walla County were Hispanic/Latinx compared to 54% of youth who were white. As of 2017, approximately 19% of the Walla Walla County population was estimated to speak a language other than English.

Figure 182: Youth (Under 18) Population by Race/Ethnicity, Walla Walla County, 2018

Poverty among Youth
In Walla Walla County, 17.5% of youth under age 18 lived in poverty in 2017. This rate has decreased over the past few years from 25.5% in 2012.


Across Walla Walla County, 54.2% of students were enrolled in the free or reduced-price meal program in October 2018. Enrollment rates in the program varied significantly in school districts across the county, from 49.4% in the College Place School District to 89.1% in the Prescott School District. In the Walla Walla School District — the largest district in the county with 6,012 students — 54.3% of students were enrolled in the free or reduced-price meal program.

**Youth Experiencing Homelessness**
In Walla Walla County, the 2019 Point in Time Count revealed that 163 people were homeless (111 sheltered and 52 unsheltered). Among them, less than 10 were from households with at least one adult and with children under age 18, and 12 people lived in households with only minors (no adults present).

**Employment and Income**
In June 2019, the unemployment rate in Walla Walla County was 5.1% (not seasonally adjusted).

The projected median household income in Walla Walla County for 2018 was $53,356, which was substantially lower than the state projected median household income for 2018.

**Educational Attainment**
The on-time graduation rate in Walla Walla County during the 2016-17 school year was 74.4%. The dropout rate that same year was 13%. Graduation rates were lowest among students in special education, English language learners, low-income students and students identifying as Hispanic/Latinx.

**Foster Care**
In 2017, there were 87 children ages 0 to 17 served by Foster Care Placement Services in Walla Walla County.

**Lesbian, Gay, Bisexual, Transgender and Questioning Youth**
In 2018, 12% of eighth graders in Walla Walla County identified as lesbian, gay or bisexual, while about 7% of eighth graders indicated that they were questioning/not sure when it came to their sexual orientation. Furthermore, 5% of Walla Walla County eighth graders identified as transgender, questioning/not sure, “something else fits better”, or selected multiple gender identity responses. No data were available for high school students in Walla Walla County.

**Oral Healthcare**
In Walla Walla County, 84% of eighth graders had seen a dentist within the last year, according to 2018 survey results. Between 7% to 9% of students reported missing school due to a toothache over the last year.

Data from the 2018 Healthy Youth Survey for Walla Walla County were only available for sixth and eighth grade students.
Suicide\textsuperscript{940}

In Walla Walla County, data from the 2018 Healthy Youth Survey was only available for middle school students. In the past year, 21% of eighth graders considered attempting suicide, 16% made a suicide plan and 10% attempted suicide.

Figure 184: Walla Walla County Youth Who Reported Suicidal Feelings and Actions by Grade, 2018\textsuperscript{184}

Substance Use

Alcohol Use

In Walla Walla County, 4% of sixth graders and 11% of eighth graders reported drinking at least once in the past month in 2018, and 3% of sixth graders and 9% of eighth graders reported problem or heavy drinking. Data from the 2018 Healthy Youth Survey for Walla Walla County were not available for high school students.

Figure 185: Walla Walla County Youth Who Reported Drinking at Least Once in the Past Month or Heavy Drinking, 2018

---

Note: “U” indicates that data are unavailable, due to too few surveys, questions not asked, or additional reasons.

---

Note: “U” indicates that data are unavailable, due to too few surveys, questions not asked, or additional reasons.

**Tobacco Use**
In Walla Walla County, data from the 2018 Healthy Youth Survey was only available for sixth and eighth grade students, both of which reported smoking cigarettes at rates that were similar to the state average.

---

**Figure 186: Youth Cigarette Smoking Rates in Walla Walla County, 2018**

---

Data from the 2018 Healthy Youth Survey was only available for students in sixth and eighth grades in Walla Walla County, thus there is no comparison of cigarette to vapor product use trends. Middle school students in the county reported using vapor products at higher rates than statewide averages.\(^{943}\)

**Figure 187: Current Vapor Product Use in Washington State Compared to Walla Walla County (“Local”), 2018\(^ {947}\)**

---

Marijuana Use

In Walla Walla County, 2% of sixth graders and 11% of eighth graders reported using marijuana at least once, while 3% of eighth graders reported heavy marijuana use in the past month. Data from the 2018 Healthy Youth Survey were not available for students in 10th or 12th grades.

Figure 188: Current Marijuana Use and Heavy Marijuana Use Among Youth in Walla Walla County, 2018

Note: “U” indicates results suppressed due to insufficient reporting from students of schools.

unavailable, due to too few surveys, questions not asked, or additional reasons.

**Prescription Medication Use**

In 2018, 3% of eighth graders (only grade for which data was available) in Walla Walla County reported using painkillers to get high at least once in the past month.

Figure 189: Students Who Reported Using Painkillers to Get High at Least Once in Last 30 Days, Walla Walla County, 2018

Note: “U” indicates that data are unavailable, due to too few surveys, questions not asked, or additional reasons.

In 2018, 6% of eighth graders reported using prescription drugs not prescribed to them within the past month.

Figure 190: Students Who Reported Using Prescription Drugs Not Prescribed to Them in Past Month, Walla Walla County, 2018

---


In Walla Walla County, there were no deaths due to opioid overdose among adolescents ages 13 to 17 between 2013 and 2017.\textsuperscript{946}

**Early and Adequate Prenatal Care**\textsuperscript{947}
In Walla Walla County in 2016, 78.0\% of pregnant women began prenatal care in the first trimester of pregnancy in 2016.

**Infant Mortality**\textsuperscript{948}
In 2015, the infant mortality rate in Walla Walla County was 8.9 deaths per 1,000 live births, which exceeded the state and national infant mortality rates and the Healthy People 2020 goal.

**Low Birth Weight**\textsuperscript{949}
About 3.8\% of babies who were residents of Walla Walla County in 2016 were low birth weight.

**Obesity and Overweight Prevalence**\textsuperscript{950}
About 27\% of eighth graders (only grade for which data was available) in Walla Walla County were overweight or obese in 2018 (12\% were considered obese), and 12\% were specifically obese.

**Figure 191: Walla Walla County (“Local”) Youth Obese or Overweight Rates Compared to Washington State, 2018**\textsuperscript{191}

Note: N/A indicates question was not asked of that grade. S indicates result suppressed due to insufficient reporting from students of schools.

**Food Insecurity**

At 17.7%, the rate of food insecurity among children in Walla Walla County in 2017 was slightly higher than the state and national rates. Two-thirds of children who were food insecure were eligible for federal nutrition programs based on income level.

**Figure 192: Percentage of Children Who Were Food Insecure in Walla Walla County, 2017**

Fruit and Vegetable Consumption\textsuperscript{952} 
Data from the 2018 Healthy Youth Survey was only available for sixth and eighth grade students in Walla Walla County. In 2018, 19\% of eighth graders ate five or more servings of fruits and vegetables daily over the past seven days.

Youth Consumption of Sugar-Sweetened Beverages\textsuperscript{953} 
In 2018, 81\% of eighth graders (only grade for which data was available) in Walla Walla County reported drinking sugar-sweetened drinks in the past week. About 3\% of eighth graders in the county reported drinking sugar-sweetened drinks daily at school — a 79\% decline since 2008 (from 14\% to 3\%).

Physical Activity\textsuperscript{954} 
In 2018, about one-third of students in sixth and eighth grades in Walla Walla County met the physical activity recommendations — rates that were higher than the state average.

Figure 193: Walla Walla County (“Local”) Rates of Youth Who Did Not Meet Recommendations for Physical Activity Compared to Washington State, 2018\textsuperscript{193}

Community Input from Walla Walla County

In 2018, Seattle Children’s interviewed eleven stakeholders, including a retired pediatrician, two nurse practitioners, a school-based health center, a child psychologist, a learning specialist and

\textsuperscript{952} Healthy Youth Survey. (2018). \textit{HYS fact sheets}. Retrieved from \url{http://www.askhys.net/FactSheets}. 

\textsuperscript{953} \textsuperscript{193}

\textsuperscript{954}
access and equity coordinator in the public school system, an employee of the Walla Walla County Department of Community Health, an Early Head Start nurse, an employee of Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), an employee at a Walla Walla non-profit for children, and a behavioral health intervention specialist. The Walla Walla family listening session was attended by nine parents, some of whom had children with complex medical issues.

Concerns around youth mental health was a theme in both the Walla Walla County stakeholder interviews and family listening session:

- The significant mental health challenges affecting families and children are seen daily in schools, clinics, and public health programs. Mental and behavioral health issues often consume well child visits.
- Lack of services is an issue given there is just one local child psychologist who screens and refers patient to services in Yakima, where they are scheduling appointments eight or nine months out. There is no child psychiatrist within a 50-mile radius, which means primary care pediatric providers are the main prescribers, and several stakeholders commented that pediatricians feel they are practicing out of their scope. The Masters of Social Work program available at the nearby college does create a supply of counselors, but many do not have specialty training to work with children and may not be licensed mental health counselors, which makes some parents uncomfortable.
- The Seattle Children’s partnership access line is a valuable resource for them and was referenced several times.
- Inpatient psychiatric care is also limited as there are no beds available in Walla Walla. Crisis teams come from other cities (Yakima or Tri-Cities), and patients are not transferred to an inpatient bed if they do not meet very specific criteria. Providers have elected to send families to Seattle or Portland emergency rooms or have even placed children in the juvenile detention center for the night in an effort to ensure patient safety.
- The school-based health centers located at Blue Ridge Elementary, Pioneer Middle School, Walla Walla High School and Lincoln Alternative High School are huge assets, noted by parents as a great resource for both medical care and mental health services. Within the first four months of opening the Walla Walla High School Clinic, they documented 280 mental health visits. The students seen there represent a larger percentage of foster children than the general Walla Walla population, and many are dealing with drug abuse in their families and struggle with it themselves. The Walla Walla High School Clinic offers group and individual counseling referrals, and they also collaborate with The Hub, a facility on one school campus that is able to house homeless youth temporarily.
- Because of the recently created trauma-informed high school at Lincoln Alternative High School (featured in the film “Paper Tigers”) the community is very educated on ACEs and trauma-informed care. Most schools have incorporated a focus on emotional regulation and programs promoting resilience. However, among parents, there was consensus that there were not enough resources to help affected children.
- Walla Walla Public Schools have integration specialists, learning specialist and an Access and Equity coordinator to help families and children who need more resources.
- The Department of Community Health is working to focus efforts on protective factors for behavioral/mental health, as well as improving the process of how those services are
billed in the clinical setting in order to make services, like the Behavioral Health Integration Specialist, more financially sustainable.

Pediatric primary and specialty care was another theme discussed by community members:

- Most of the stakeholders felt that Walla Walla was rich with pediatric primary care providers. They foster great partnerships with the schools.
- There used to be two main hospitals in Walla Walla, but with the closure of Walla Walla General Hospital two years ago, there was a gap of pediatric providers for a few months. While all these providers were eventually absorbed into the Walla Walla Clinic, there was a three month period when patients had decreased access, and families have continued to perceive that they have less health care access with the closure of the hospital.
- A majority of pediatric specialties cannot be found in Walla Walla. Several parents have children with complex medical needs, who always travel out of town for medical appointments, in part because the resources available in Walla Walla have long waiting lists. Parents of children with chronic disease or complex health issues manage multiple appointments between Yakima and Spokane and travel as far as Seattle Children’s Hospital. There is need for case management and care coordination for these appointments.
- In addition, transportation is a large issue for the community. Public transportation is limited, and many people struggle to maintain reliable personal transportation, due to the cost of gas and other travel expenses when venturing out of town for specialty care. There are some pediatric specialists that come for satellite clinics, but the information is not widely publicized, and the care is not consistent.

While there are many resources for parents in Walla Walla, access and perceived stigma can be issues:

- The WIC office provides many resources to families and young children but relying on them comes with a certain stigma.
- Parenting classes are available at the local hospital as well as the Walla Walla Community college, but parenting classes are often seen as “only for bad parents.”
- In addition, there seems to be many parallel projects and resources in Walla Walla, but community stakeholders feel organizations often work in silos. The Department of Health is currently working on an effort to create a hub (potentially digital) where all resources can be located and easily accessible for families.
- Parents noted that there is a lack of daycare services available for those who do not work normal business hours, and while “Birth to Three” services are widely available, there does not seem to be much support for parents after that time.

An important topic of discussion was around healthy eating, physical activity and food insecurity:

- The agriculturally rich area has plentiful fresh fruits and vegetables that are affordable at local markets as well as a large farmers’ market. There are also farmers’ stands further out of town, which enable people to directly purchase produce from farmers.
- SNAP does demonstrations throughout the community about healthy eating.
There are hot meals served every day of the week by multiple faith-based groups as well as food banks at multiple locations. Because of its small size, there are no real food deserts.

Nutrition is a huge priority within the public school system. There are farm-to-table meals provided to students, as well as a garden at each of the elementary schools.

There are many great spaces available for physical activity. In addition, all the public school playgrounds are open to the public at all hours. The YMCA is a well-used resource and offers scholarships for some memberships. Schools offer sports at no cost to families.

The key stakeholders frequently discussed the dichotomy of “Two Walla Wallas,” which refers to the demarcations between the very affluent, predominately white population and the Latinx population that is generally lower income, agriculture farmworkers:

- As the tourist economy flourishes, housing becomes less affordable and poverty continues to increase.
- While services for Latinx communities may already be difficult to access because of language barriers, key stakeholders reported seeing a recent decrease in utilization by those who are undocumented or seeking citizenship in the wake of increased Immigration Control and Enforcement (ICE) presence and proposed changes to public charge.
- There are many great efforts to assist these specific children and families through the work of the Access and Equity Coordinator in Walla Walla Public Schools. In addition, there is the resource of Garrison night school that offers a variety of continuing education classes to agriculture workers during the months of November-February. Also, the public school system will soon introduce its first dual language school in 2019. The SOS Health Services of Walla Walla is an urgent care facility that provides quality walk-in healthcare services to individuals without health insurance (or without adequate health insurance) in the Walla Walla Valley. This clinic was mentioned as another local resource that helps families and children who do not have insurance coverage with free medical care.

Another theme throughout the family listening session was resiliency:

- Parents expressed the Walla Walla community is very resilient and reactive to crises that arise. Parents shared the sentiment that people in the Walla Walla community are working to make a difference.
- When there was a dramatic increase in suicide rates, the community brought in the Suicide Prevention Work Group to work with high school students.

**Wenatchee, Chelan County**

**Population**

Chelan County is located in northcentral Washington state. Wenatchee is the largest city in the county, which is located where the Columbia and Wenatchee rivers meet, directly east of the Cascade Range. Chelan County had a population of about 78,000 in 2018.\(^5\) Wenatchee’s population was nearly 34,000 and East Wenatchee’s population in neighboring Douglas County was almost 14,000.\(^6\) Other cities in Chelan and Douglas counties include: Bridgeport, Cashmere, Chelan, East Wenatchee, Leavenworth and Waterville. Agriculture is a large part of the local economy in Wenatchee — termed the “Apple Capital of the World.”
Youth Population by Race/Ethnicity
Chelan County, 2018

The population of youth under the age of 18 in Chelan County is divided nearly in half, with 50% identifying as Hispanic/Latinx and 45% identifying as white in 2018. 25% of the population is estimated to speak a language other than English.

Figure 195: Youth (Under 18) Population by Race/Ethnicity, Chelan County, 2018
Poverty among Youth
In 2017, approximately 17% of youth under age 18 in Chelan County lived in poverty — a rate that is comparable to the rate five years before at about 18% in 2012.959

In Chelan County, 57.4% of students were enrolled in the free or reduced-price meal program in October 2018.960 Cascade School District had the lowest enrollment rate in the program (37.0%), while Manson School District had the highest (66.0%). In the Wenatchee School District, which is the largest district in Chelan County with 7,642 students, 62.8% of students were enrolled in the free or reduced-price meal program.961

Youth Experiencing Homelessness962
The 2019 Point in Time Count showed that 391 people were homeless (264 sheltered and 127 unsheltered) in Chelan County. Among those who were homeless, 104 were from households with at least one adult and with children under age 18, and less than 10 were in a household with only minors (no adults present).

Employment and Income
The Chelan County unemployment rate (not seasonally adjusted) in June 2019 was 4.2%.963

Chelan County’s projected household median income of $67,058 in 2018 was less than the state median projection but higher than the 2017 median household income nationwide.964

Educational Attainment965
In Chelan County, 75.1% of high school students during the 2016-17 graduated high school on time, and 16.2% dropped out of school. English language learners and students in special education had the lowest rates of on-time graduation among subgroups.

Foster Care966
In Chelan County, 84 children age 0 to 17 years old were served by Foster Care Placement Services in 2017.

Lesbian, Gay, Bisexual, Transgender and Questioning Youth967
In Chelan County, 9% of eighth graders, 10% of 10th graders and 12% of 12th graders identified as lesbian, gay or bisexual in 2018. About 3% of eighth graders, 2% of 10th graders and 3% of 12th graders indicated that they were questioning/not sure when it came to their sexual orientation. In responding to a question about gender identity, 5% of eighth graders, 3% of 10th graders and 4% of 12th graders identified as transgender, questioning/not sure, “something else fits better”, or selected multiple gender identity responses.

Oral Healthcare968
In Chelan County, 90% of eighth graders, 88% of 10th graders and 81% of 12th graders had seen a dentist within the last year in 2018. Between 6% to 9% of students reported missing school due to a toothache over the last year.
Figure 196: Percentage of Youth Who Missed School Due to Toothache, Chelan County (“Local”) and Washington State, 2018

<table>
<thead>
<tr>
<th>Grade</th>
<th>Local</th>
<th>State</th>
</tr>
</thead>
<tbody>
<tr>
<td>6th</td>
<td>9% ±2</td>
<td>7% ±1</td>
</tr>
<tr>
<td>8th</td>
<td>8% ±3</td>
<td>7% ±1</td>
</tr>
<tr>
<td>10th</td>
<td>6% ±3</td>
<td>5% ±1</td>
</tr>
<tr>
<td>12th</td>
<td>8% ±3</td>
<td>6% ±1</td>
</tr>
</tbody>
</table>

Suicide

In Chelan County in 2018, about one-fifth of students considered attempting suicide, and between 8% to 10% of students attempted suicide in the past year.

Figure 197: Chelan County Youth Who Reported Suicidal Feelings and Actions by Grade, 2018

---

Substance Use

Alcohol Use

In Chelan County in 2018, nearly one-third of 12th graders reported drinking at least once in the past month, and one-fifth of 12th graders reported heavy drinking in the past month.

Figure 198: Chelan County Youth Who Reported Drinking at Least Once in the Past Month or Heavy Drinking, 2018

---

**Tobacco Use**

In 2018, students in sixth, eighth and 10th grades in Chelan County reported smoking cigarettes in the past 30 days at rates at or below the state average, while smoking rates among 12th graders were higher than the state average (10% in Chelan County compared to 8% in the state).  

**Figure 199: Youth Cigarette Smoking Rates in Chelan County, 2018**

---

Over the past decade, the percentage of 12th grade students in Chelan County who smoked cigarettes decreased by 44%. At the same time, rates of vapor product use have climbed. From 2016 to 2018, there was a 74% increase in vapor product use among 12th graders in Chelan County.

**Figure 200: Current Use Trends in Chelan County, Grade 12, 2018**

---

The rates of vapor product use among middle school and high school students in Chelan County in 2018 were at or above the state average. About one-third of 12th graders reported using vapor products over the past 30 days.

Figure 201: Current Vapor Product Use in Washington State Compared to Chelan County (“Local”), 2018

Note: N/S indicates that the question was not surveyed in that year.

---

Marijuana Use

In Chelan County in 2018, about 21% of 12th graders reported that they had used marijuana at least once in the last month, and 8% reported heavy marijuana use. Compared to data from 2010, rates of marijuana use among students in sixth, 10th and 12th grades have decreased, whereas rates among eighth graders has stayed the same.

Figure 202: Current Marijuana Use and Heavy Marijuana Use in Youth in Chelan County, 2018

Prescription Medication Use

Students in Chelan County reported using painkillers to get high at least once in the past month at rates similar to the state averages in 2018 - between 2% and 4%.

Figure 203: Students Who Reported Using Painkillers to Get High at Least Once in the Past 30 Days, Chelan County, 2018

---

About 4% of 8th grade students and 6% of 10th and 12th grade students in Chelan County reported using prescription drugs not prescribed to them in the past month.

**Figure 204: Students Who Reported Using Prescription Drugs Not Prescribed to Them in Past Month, Chelan County, 2018**

---

In 2013 to 2017, there were deaths due to overdose involving any opioid among 13 to 17 year olds in Chelan County.  

**Early and Adequate Prenatal Care**

In 2016, 84.0% of pregnant women in Chelan County began prenatal care in the first trimester, which was higher than the Washington state rate.

**Infant Mortality**

Since there were fewer than five infant deaths in Chelan County in 2015, the infant mortality rate could not be calculated.

**Low Birth Weight**

In 2016, 5.7% of babies who were residents of Chelan County were low birth weight.

**Obesity and Overweight Prevalence**

Obesity and overweight rates were higher among students in Chelan County than the state average in 2018, with more than 30% of students in eighth, 10th and 12th grades being overweight or obese. By grade, 12% of eighth graders, 13% of 10th graders and 19% of 12th graders were considered to be obese.

**Figure 205: Chelan County ("Local") Youth Obese or Overweight Rates Compared to Washington State, 2018**

---

Food Insecurity\textsuperscript{980}
In Chelan County, 17.1\% of children were considered food insecure in 2017 — a rate that was about equal to the state and national averages. About two-thirds (65\%) of children who were food insecure were eligible for federal nutrition programs based on income level.

Figure 206: Percentage of Children Who Were Food Insecure in Chelan County, 2017\textsuperscript{206}

Fruit and Vegetable Consumption\textsuperscript{981}
In Chelan County in 2018, 24\% of eighth graders, 21\% of 10th graders and 24\% of 12th graders ate five or more servings of fruits and vegetables per day over the past seven days.

Youth Consumption of Sugar-Sweetened Beverages\textsuperscript{982}
In Chelan County, 83\% of eighth graders, 76\% of 10th graders and 83\% of 12th graders in 2018 reported drinking sugar-sweetened drinks in the past week. About 4\% of 10th graders in the county reported drinking sugar-sweetened drinks daily at school — a 76\% decline since 2008 (from 17\% to 4\%).

Physical Activity\textsuperscript{983}
Nearly three-quarters of middle school and high school students in Chelan County did not meet the daily 60-minute physical activity recommendation in 2018.

Figure 207: Chelan County (“Local”) Rates of Youth Who Did Not Meet Recommendations for Physical Activity Compared to Washington State, 2018\textsuperscript{207}

Community Input from Wenatchee, Chelan County

In April 2017, we heard from parents in Wenatchee through a listening session. A total of 20 people participated. Most were female and the parents of children and youth with special health care needs. All participants were English-speaking. In addition, we obtained stakeholder perspectives through interviews.

Access to care was a common theme:

- Parents and other community members reported challenges in traveling to Seattle for health care. There are times when travel by car is impossible, especially in the winter time, when mountain highway passes are closed. To travel from Wenatchee to Seattle by car, crossing a mountain pass is unavoidable. Once in Seattle, there is difficulty finding affordable places to stay. Because of that, some families drive to Seattle and back (a 150 mile drive each way) in one day. This affects which appointments they are able to take, with one parent saying that early morning appointments are especially challenging. Some families travel to Seattle multiple times per week, which results in missed school and work days for children and parents, respectively. It is a financial burden. Some parents are unable to take off of work to take their children to Seattle. Parents report difficulty for some children in being able to safely travel that distance by car. These barriers affect their ability to attend appointments but also educational opportunities offered by the hospital, such as autism classes. Some families choose to seek care in Spokane instead due to fewer geographic barriers to accessing care.

- There are barriers to medical providers traveling from Seattle to Wenatchee to provide care at the Seattle Children’s Wenatchee Clinic. For similar reasons as previously stated, they may be unable to drive due to weather. Travel by airplane can also be affected by fog and other weather conditions, forcing clinic appointments to be
canceled. In good weather, airplane travel is limited due to only one airline providing services from Seattle to Wenatchee with three flights per day. These limited flight options mean providers may need to stay longer causing decreased productivity.

- Families in the Wenatchee area who are able to utilize the Seattle Children’s Wenatchee Clinic are satisfied with care they receive there. Parents are especially satisfied with the availability of telemedicine. It allows them to access care much closer to home and helps to address barriers to seeking care in Seattle.

- However, several parents mentioned the need and desire for more specialty services than are currently offered, including in-person providers and telemedicine services, mentioning a need for Gastroenterology, Hematology, Oncology, Ophthalmology, Neurodevelopment, Nutrition, Physical Therapy, Occupational Therapy, additional Psychiatry services, and a more comprehensive Diabetes team. Families are interested in modeling care after the Yakima Children’s Village. They would also appreciate opportunities to access educational services offered by Seattle Children’s Hospital, especially through electronic means, such as YouTube videos of classes or live-streaming of classes.

- Families were especially vocal about the lack of access to developmental pediatricians. The only developmental pediatrician in Wenatchee recently retired, and there was no replacement. Wait times at the Autism Center in Seattle can be months to years long. Because of this lag time in diagnosis of autism and ADHD, families are encountering barriers to finding appropriate therapy services and insurance covering the cost of these therapy services.

- Participants also stressed the need for improvement in access to behavioral and mental health services for all children. There are not enough providers in the area to adequately meet this need. In addition, there are waiting lists and turnover of providers. Some families have needed to travel to Seattle for regular mental health services, and they encounter barriers as previously mentioned. Families also struggle with finding counselors and therapists who feel comfortable providing care to children and youth with special health care needs.

Wenatchee community members also expressed thoughts on care coordination:

- Parents mentioned the presence of resources in their community but a lack of centralization and knowledge about all resources. This was true among parents but also among medical providers and other integral community members, such as school staff. Parents are concerned this lack of coordination leads to delays in diagnosis and care of their children but also decreases quality of life for the children and their families. The lack of coordination also can decrease trust in the ability of medical providers to direct families to correct resources.

- Many mentioned the large amount of caring by primary care physicians and other members of the community but lack of cohesiveness in their abilities to consistently and correctly inform parents about resources, services, and educational opportunities.

- One asset identified was the recent addition of pediatric case managers in the Confluence Health System in Wenatchee, which is an attempt at fostering the spirit of a medical home. Community members believe since the start of this program, there have been decreased emergency department visits and hospital admissions. Other community
members hope these case managers can help address education and language barriers that may affect some families.

We also heard about the presence of support in Wenatchee and ways in which the local support network can be improved upon:

- Parents, especially those with children with special healthcare needs, find support among each other. Families find support with other parents going through similar situations and often share resources among each other, meeting in person and/or via online forums on Facebook.
- Over the past several years, several parent advocacy and support groups have been formed and cultivated, including a local chapter of Parent to Parent.
- Parents at the listening session talked at length about their willingness to advocate for their own children and all children in their area.
- There is a concern, however, that the support group composition is not ethnically diverse and non-English speaking families may not find community and support from these groups. They may be isolated. There may be a language and cultural barrier to them knowing about the group and wanting to participate.

**Yakima County**

**Population**

Yakima County is located east of the Cascade Range in Washington state and is home to more than 255,000 people. Yakima is the county seat and the largest city with a population of about 93,000. The county has a strong agricultural industry, producing fruits and vegetables that are exported across the United States, including apples, grapes and hops.

| Table 208: Population Change by Age Group Between 2008 and 2018, Yakima County |
|------------------------|--------------|--------------|------------------|
| Ages       | 2008         | 2018         | Percent change (%) |
| 0-4        | 20,954       | 21,245       | 1.4%             |
| 5-9        | 20,326       | 22,733       | 11.8%            |
| 10-14      | 19,571       | 21,835       | 11.6%            |
| 15-19      | 20,152       | 18,509       | -8.2%            |

In Yakima County, about two-thirds of youth under age 20 (71%) were Hispanic/Latinx in 2018, compared to about one-quarter (24%) who were non-Hispanic white. The percentage of people identifying as Hispanic/Latinx in Yakima County was higher than the Washington state rate. Regarding languages spoken in Yakima County, an estimated 40% of residents speak a language other than English.

---

Poverty among Youth
In Yakima County, nearly 28% of youth under age 18 lived in poverty from in 2017, which was about twice the state average. The poverty rates among youth in Yakima County have decreased in recent years.

In October 2018, 80.7% of students in Yakima County were enrolled in the free or reduced-price meal program — a rate that is 2.5 times greater than King and Kitsap counties. Across Yakima County, enrollment rates varied from 41.8% of students in the West Valley School District to 100% of students in the Granger School District. In the Yakima School District — the largest district in the county with 16,079 students — 93.6% of students were enrolled in the free or reduced-price meal program.

Youth Experiencing Homelessness
In Yakima County, 439 people were homeless (331 sheltered and 108 unsheltered), according to the 2019 Point in Time Count. Among those who were homeless, 140 were from households

---

with at least one adult and with children under age 18, and less than 10 were in a household with only minors (no adults present).

**Employment and Income**
In Yakima County, the unemployment rate (not seasonally adjusted) in June 2019 was one of the higher rates in the state at 6.2%.  

The 2018 projected median household income in Yakima County was the third lowest in the state at $45,683 — nearly half the projected median household income as King County.

**Educational Attainment**
Yakima County had a high school graduation rate of 74.6% during the 2016-17 school year and a 17.2% dropout rate. Students identifying as American Indian/Alaskan Native had the lowest rates of on-time graduation at 49.5% and the highest dropout rate at 38.8%, compared to all other subgroups. Students in special education also had a low on-time graduation rate at 55.1%.

**Foster Care**
Foster Care Placement Services served 510 Yakima County youth ages 0 to 17 in 2017.

**Lesbian, Gay, Bisexual, Transgender and Questioning Youth**
In 2018, 8% of eighth graders, and 11% of 10th and 12th graders identified as lesbian, gay or bisexual in Yakima County. About 3% of eighth and 10th graders, and 2% of 12th graders indicated that they were questioning/not sure when it came to their sexual orientation. When asked about gender identity, 5% of eighth graders, 6% of 10th graders and 4% of 12th graders indicated their gender identity as transgender, questioning/not sure, “something else fits better”, or selected multiple gender identity responses.

**Oral Healthcare**
In 2018, 88% of eighth graders and 84% of 10th and 12th graders had seen a dentist within the last year in Yakima County. Between 8% to 10% of students reported missing school due to a toothache over the last year.

**Figure 210: Percentage of Youth Who Missed School Due to Toothache, Yakima County (“Local”) and Washington State, 2018**

---

Youth in Yakima County reported suicidal feelings and actions at similar rates as other counties in the state. About one-fifth of students in eighth, 10th and 12th grades reported that they considered attempting suicide and about one in 10 students attempted suicide in the past year.

**Figure 211: Yakima County Youth Who Reported Suicidal Feelings and Actions by Grade, 2018**

---

Substance Use

Alcohol Use

According to the 2018 Healthy Youth Survey, one-fifth of 10th graders and more than one-quarter of 12th graders reported drinking at least once in the past month, while 15% of 10th graders and 19% of 12th graders reported problem or heavy drinking.

Figure 212: Yakima County Youth Who Reported Drinking at Least Once in the Past Month or Heavy Drinking, 2018
**Tobacco Use**
In Yakima County, sixth and eighth grade students in 2018 reported smoking cigarettes in the past 30 days at slightly higher rates than the state average. Smoking rates were at or below the state average for students in 10th and 12th grades.

**Figure 213: Youth Cigarette Smoking Rates in Yakima County, 2018**

From 2008 to 2018, the percentage of 12th grade students in Yakima County who smoked cigarettes decreased by 57%. Nearly four times as many 12th graders used vapor products than cigarettes in 2018.

**Figure 214: Current Use Trends in Yakima County, Grade 12, 2018**

---


Rates of vapor product use in Yakima County exceeded statewide averages among sixth and eighth graders but were lower than the state average for 10th and 12th graders in 2018.footnote{1003}

Figure 215: Current Vapor Product Use in Washington State Compared to Yakima County (“Local”), 2018footnote{215}

Note: N/S indicates that the question was not surveyed in that year.


Marijuana Use

One in four 12th grade students in Yakima County in 2018 had used marijuana at least once in the last month, and about one in 10 students in 12th grade reported heavy marijuana use. Compared to 2010 data, rates of marijuana use have stayed about the same.

Figure 216: Current Marijuana Use and Heavy Marijuana Use Among Youth in Yakima County, 2018

---

Prescription Medication Use

About one in every 20 students (4% to 5%) who responded to the 2018 Healthy Youth Survey in Yakima County said they used painkillers in the last 30 days to get high.

Figure 217: Students Who Reported Using Painkillers to Get High at Least Once in Last 30 Days, Yakima County, 2018

---

In 2018, 7% to 8% of eighth, 10th and 12th graders reported using prescription drugs not prescribed to them within the past month.

**Figure 218: Students Who Reported Using Prescription Drugs Not Prescribed to Them in Past Month, Yakima County, 2018**

There was one death among youth ages 13 to 17 due to overdose involving any opioid in 2013 to 2017 in Yakima County.\(^{1006}\)

**Early and Adequate Prenatal Care**\(^{1007}\)
In Yakima County in 2016, 79.7% of pregnant women received prenatal care beginning in the first trimester.

**Infant Mortality**\(^{1008}\)
In Yakima County, the infant mortality rate in 2015 was 4.0 deaths per 1,000 live births.

**Low Birth Weight**\(^{1009}\)
In Yakima County, about 7.4% of babies born in 2016 were low birth weight.

**Obesity and Overweight Prevalence**\(^{1010}\)
Between 35% to 37% of students in eighth, 10th and 12th grades in Yakima County were overweight or obese in 2018 — substantially higher than the statewide averages, especially among eighth and 10th graders. Among Yakima County students, 16% of eighth graders, 20% of 10th graders and 18% of 12th graders were considered to be obese.

---

Figure 219: Yakima County (“Local”) Youth Obese or Overweight Rates Compared to Washington State, 2018

Note: N/A indicates question was not asked of that grade.

**Food Insecurity**

More than one in five children in Yakima County were food insecure in 2017 — a rate that is substantially higher than the state and national averages. Four out of every five children who were food insecure were eligible for federal nutrition programs based on income level.

Figure 220: Percentage of Children Who Were Food Insecure in Yakima County, 2017

---


Fruit and Vegetable Consumption

In 2018, 20% of eighth graders, 18% of 10th graders and 19% of 12th graders ate five or more servings of fruits and vegetables per day over the past seven days in Yakima County.

Youth Consumption of Sugar-Sweetened Beverages

In 2018, 83% of eighth graders, and 81% of 10th and 12th graders in 2018 reported drinking sugar-sweetened drinks in the past week. About 4% of 10th graders in the county reported drinking sugar-sweetened drinks daily at school — an 83% decline since 2008 (from 23% to 4%).

Physical Activity

Similar or higher percentages of students in sixth, eighth and 12th grades in Yakima County reported that they did not meet the daily physical activity recommendation compared to the state averages in 2018, whereas Yakima County 10th grader reported that they did not meet the daily physical activity recommendation at rates higher than the state.

Figure 221: Yakima County (“Local”) Rates of Youth Who Did Not Meet Recommendations for Physical Activity Compared to Washington State, 2018

---

Community Input from Yakima County

In 2017 and 2018, in person stakeholder interviews were conducted throughout the Yakima Valley, with some focused on mental and behavioral health and others including general child and adolescent health topics. A total of 18 stakeholders were interviewed, including general pediatricians, school nurses, clinic managers, behavioral health consultants, directors of community health and maternal and child services, and pediatric subspecialists. Two separate parent listening sessions occurred in English and Spanish.

Mental and behavioral health needs and resources were identified by both the stakeholders and family listening sessions:

- Yakima County has three mental and behavioral health organizations in the community including Comprehensive Health Services (CHC), Behavioral Health Services (BHS), and Catholic Family and Child Services (CFCS). Between these three organizations, there is a wide range of resources made available to the community including child psychiatry, substance use counseling, cognitive behavioral therapy (CBT), applied behavioral analysis (ABA) therapy, etc. They also have partnerships and collaborations between the organizations to emphasize the different strengths each group has. Along with this, every organization has providers that speak Spanish or have in-person interpretation services to ensure that Spanish-speaking patients and families have the same resources that English-speaking families have.

- While there are 3 organizations providing mental health care, the volume of patients is still substantial and contributes to long delays between visits given there are not enough providers to meet the demand.
Recruitment of specialists to rural areas has proved challenging even when there is funding for a position.

The organizations are attempting to addressing lack of providers and long wait times through improved telemedicine access to child psychiatry. They are also providing additional training to existing employees to improve mental and behavioral health expertise in the community.

Spanish-speaking parents expressed waiting even longer for Spanish-speaking providers, and other parents expressed challenges with finding services that accepted their insurance.

Collaboration between the three Yakima County mental and behavioral health organizations is an asset. For example, Children’s Village, a clinic in Yakima city that provides a variety of subspecialty pediatric services to the community, utilizes the classroom services of CFCS for ABA therapy, while also utilizing BHS for in-home visits for ABA therapy. This collaboration allows for more in-depth therapy for families who have children with autism.

There is also integration of mental health services within pediatrics clinics. Both the Yakima Valley Farm Workers Clinic and Yakima Pediatrics Associates have behavioral health consultants that work in the clinic full-time and provide immediate consultation for patients with mental or behavioral health needs.

Even with 3 strong mental/behavioral health organizations, integration between them is challenging. Pediatricians struggle with communication with longer-term mental health providers. The school system is a large source of identifying and addressing youth with mental or behavioral health challenges but lacks good solutions for ensuring prompt follow up between the student and mental health provider. Health records are not easily shared between mental health and medical providers, making it difficult to collaborate on patient treatment goals.

The Yakima Pediatrics Associates is working to develop a clinic within the schools to help provide greater access for youth to meet with a medical or mental health provider to identify and treat mental and behavioral health issues.

For families of children with mental and behavioral health needs, one of the most consistent barriers is work-related time constraints. As Yakima County is a primarily agricultural community, the work schedules of parents are determined by the harvest. It can be difficult for parents to miss time from work during the harvest season to address their children’s mental health needs. There are also challenges with transportation as the county covers a large area, and it can be very difficult for families to travel between clinics and their homes given the lack of reliable public transportation.

Because of the time-related challenges faced by families, organizations have taken action to improve access. The Yakima Valley Farm Workers Clinic has attempted to integrate their services to ensure that patients do not have an overwhelming number of appointments that are unrealistic with the families’ other demands. They also ensure mental and behavioral resources are provided to the parents as well, as their mental health needs play a substantial role in the needs of their children. Other methods include a patient navigator and home health nurse used by Children’s Village which do home visits to help provide further education and help with understanding the diagnosis and management of certain conditions. This is particularly helpful during the prolonged periods of waiting between appointments.
Adolescent health was another theme identified:

- Adverse childhood experiences (ACEs) are common in Yakima County. Stakeholders felt that additional training in trauma-informed care as well as programs around wellness and preventive mental health were needed for adolescents.
- Stakeholders noted that many children are raised in single-parent households or in households with both parents working full-time. As a result, many adolescents are unsupervised or are asked to supervise younger siblings after school.
- Parents and stakeholders both identified significant gaps in afterschool activities for adolescents. Parents felt adolescents lacked opportunities for physical activity, social engagement and self-expression, such as arts activities. Parents felt that gang-involvement and substance use was most connected to a lack of opportunity for other activities and a lack of supervision by working parents. Many also expressed concerns about adolescents’ “addiction” to technology.

Concerns related to healthy lifestyles were also expressed:

- Stakeholders noted that healthy food is more expensive and difficult to access for many families living in poverty. Free breakfast and lunch are provided at schools, but many children go hungry on weekends and school holidays. Parents reported that accessing food banks and other food resources is cumbersome, and that many of the foods provided are very unhealthy.
- Stakeholders and parents also noted that safe outdoor spaces for physical activity are limited, and much of Yakima’s urban spaces are not pedestrian- or bike-friendly. The Yakima Health and Wellbeing Coalition is working to improve this. Yakima Valley Farm Workers in Toppenish has created a lighted path for walking near the clinic, but overall these areas are very limited.

Both challenges and successes were noted regarding health literacy in the diverse Yakima County:

- Stakeholders expressed difficulties in providing health education to the community, including a high proportion of non-English speakers, a wide range of literacy levels among parents, different cultural perceptions of health and disease, and time and resource constraints for working families. Need for childcare, transportation barriers, and inflexible parent work schedules make accessing health education opportunities difficult for families.
- Many schools and health systems provide a range of bilingual classes from topics from nutrition to parenting. Successful programs include Strengthening Families offered in some high schools, which offers sessions in English and Spanish and provides meals and childcare during evening sessions. Resources for these types of programs are limited, making it difficult to scale up and reach a broader audience.

Parents and stakeholders also discussed barriers for Yakima children who require subspecialty care:

- Although a few SCH providers do travel to Yakima, space is limited in these clinics, and services from the full specialty team, such as nurse educators and dieticians, are not available. As a result, families often have to travel long distances to Seattle or Spokane.
• Stakeholders and parents identified significant delays in scheduling appointments, and frustration with delays in rescheduling when appointments were missed due to weather or other transportation barriers.
• For children who require multiple subspecialists, both providers and families expressed difficulties with coordinating the timing of appointments.
• Medical practitioners found challenges with accessing user-friendly patient records and in accessing subspecialty consultation for appropriate care coordination.
• School nurses expressed need for increased education for families dealing with new diagnoses. There is opportunity for collaboration with local health systems and with school nurses in providing more support for these families.
Spotlight on Alaska

Although Alaska is the largest U.S. state by total area — nearly 2.5 times the total area as the second largest state, Texas — it has one of the smallest populations in the nation. In 2018, Alaska had an estimated population of about 738,000, with nearly 28% of the population under the age of 20. The most densely populated areas of Alaska are in the southcentral region.

Figure 222: Mean Population Per Square Mile by County, Alaska, 2013

Community Social and Economic Context

The health of children, teens and young adults is influenced by a variety of environmental and social factors. Social risk factors, such as poverty and a lack of health insurance coverage, as well as racial/ethnic minority status, are all associated with poorer health outcomes among youth. Each year since 1990, the Annie E. Casey Foundation has released a KIDS COUNT Data Book that draws from numerous sources to measure child well-being in four areas: economic well-being, education, family and community, and health. In 2019, Alaska ranked last (50th of 50 states) in health. Alaska ranked highest in substance use rates of any state and highest in child and teen death rates. Alaska has the highest percent of kids with no health insurance (10%) compared to 4% for the U.S. Significant factors impact economic well-being. For example, one in every five children in Alaska live in a household that doesn’t have enough food or energy and 28% of Alaska’s children live in homes with a high housing cost burden.

---

Youth of Alaska

Across Alaska, the population grew across all age groups from 2007 to 2017, but there was minimal growth among children ages 10 to 14, and a substantial decrease in population (nearly 16% decrease) among teenagers ages 15 to 19.  

Table 223: Population Change by Age Group Between 2007 and 2017, Alaska

<table>
<thead>
<tr>
<th>Ages</th>
<th>2007</th>
<th>2017</th>
<th>Percent change (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-4</td>
<td>50,577</td>
<td>52,919</td>
<td>4.6%</td>
</tr>
<tr>
<td>5-9</td>
<td>47,160</td>
<td>54,491</td>
<td>15.5%</td>
</tr>
<tr>
<td>10-14</td>
<td>47,843</td>
<td>48,746</td>
<td>1.9%</td>
</tr>
<tr>
<td>15-19</td>
<td>56,729</td>
<td>47,758</td>
<td>-15.8%</td>
</tr>
</tbody>
</table>

The majority of the population (about 65%) were white (non-Hispanic/Latinx) from 2013 to 2017. People identifying as Alaska Native/American Indian comprised about 14% of the population during the same time period — the second largest group by race/ethnicity in the state.

Figure 224: Population (All Ages) by Race/Ethnicity, Alaska, 2013-2017 Average

U.S. Census Bureau data shows that nearly 8% of the population in Alaska is foreign-born, and 16% of people ages 5 and over speak a language other than English at home. Nearly 3% of children ages 5 to 17 speak a language other than English at home.

Poverty among Youth

In 2017, 14.9% of children and teens under age 18 in Alaska lived in poverty, which is lower than the national average (18%).

Figure 225: Percentage of Children Under 18 Living in Poverty in Alaska, 2008-2017

In Alaska public schools, 52% of students were enrolled in the free or reduced-price meal program during the 2018-19 school year. These rates varied across the state, with 29% of students qualifying for free or reduced-price meals in the Juneau School District, compared to 100% of students in the Dillingham City, Kashunamiut, Lower Yukon, Nome, Saint Mary’s and Yupiit school districts.

Housing Affordability and Availability
According to the U.S. Department of Housing and Urban Development (HUD), households that spend more than 30% of their income on housing expenses — rent/mortgage payments, taxes, insurance and related expenses — are less likely to have enough money for food, clothing, medical care and other needs.

In Alaska in 2017, 31% of households with children had a high housing cost burden, where more than 30% of the monthly income went to housing expenses. This rate has not decreased much since 2008 when the rate was 32%. Alaska renters have a higher housing cost burden than homeowners (46% compared to 23%).

Figure 226: Percentage of Households With Children With High Housing Cost Burden in Alaska, 2008-2017

---


Among children in Alaska living in low-income households (families with an income less than 200% of the federal poverty level), 59% of them had a high housing cost burden in 2015.\textsuperscript{1031}

About one-quarter of children (26%) lived in crowded households, where there is more than one person per room, in Alaska in 2017 — nearly double the national average of 14%.\textsuperscript{1032} According to a statewide assessment released in January 2018, Alaska has made little progress to address overcrowding.\textsuperscript{1033} Over the next decade, the report estimates that the state needs to nearly double the number of housing units built each year to match the demand and reduce overcrowding.\textsuperscript{1034}

The report also found that the highest rates of overcrowding in Alaska were in rural areas where the majority of the population is of Alaska Native/American Indian descent.\textsuperscript{1035} In some areas, nearly half of households were considered crowded households.\textsuperscript{1036} Many of these households take in family members who may otherwise become homeless.\textsuperscript{1037}

Extremely low-income households faced the most significant challenges related to housing affordability and saw shortages of nearly 16,000 units.\textsuperscript{1038} According to the report, low-income households that are cost-burdened spend about 41% less on food and about 74% less on healthcare costs than low-income households living in affordable housing.\textsuperscript{1039}

\textbf{Figure 227: Alaska Housing Needs: Key Facts, 2018}\textsuperscript{227}

Youth Experiencing Homelessness
Alaska had the eighth worst rate of homelessness among families with children in the nation. In 2017, an estimated 10.1 out of every 10,000 families were homeless in Alaska.\textsuperscript{1040}

\textbf{Figure 228: Number of Families Homeless for Every 10,000 Families in General Population, 2017\textsuperscript{228}}

The number of people experiencing homelessness in Alaska has increased since 2009. From 2016 to 2017, the rates of homelessness among all people increased by 9.3% in the state.\footnote{1041}

According to the 2018 Point in Time Count taken in January 2018, 2,016 people experienced homelessness on any given day in Alaska, which includes 193 families with children and 163 unaccompanied young adults ages 18 to 24.\footnote{1042}

During the 2016-17 school year, 4,041 youth enrolled in public schools in Alaska were homeless at some point during the year — a 6.8% increase over the previous school year.\footnote{1043} According to the same report from the National Center for Homeless Education, 872 children/youth enrolled in public schools were considered unaccompanied youth during the 2016-17 school year.\footnote{1044}

**Figure 229: Number of Homeless Children/Youth Enrolled in Public Schools by Year, 2016-2017 School Year**\footnote{229}
The majority (nearly 66%) of the students who were homeless were doubled up, meaning they may be living with another family, and about 10% were unsheltered.\textsuperscript{1045}

**Figure 230: Percentage of Homeless Children/Youth Enrolled in Public Schools by Type of Primary Nighttime Residence, 2016-2017 School Year\textsuperscript{230}**

Employment and Income

In Alaska, the unemployment rate was nearly twice the national rate in April 2019 at 6.4%, compared to 3.3% (not seasonally adjusted). Over the last few years, unemployment rates have declined nationally, but remained fairly steady with minimal declines in Alaska.

Figure 231: Alaska Unemployment Rates Compare to United States, 2012 to 2019

---
Unemployment rates across Alaska vary significantly, from 2.6% in the Aleutians East (the state’s lowest rate) to 20.4% in Kusilvak (the state’s highest rate).\textsuperscript{1047}

Figure 232: April 2019 Unemployment Rate, Not Seasonally Adjusted, Alaska\textsuperscript{232}

On average from 2013 to 2017, the median household income in Alaska was $76,114.\textsuperscript{1048} In households with children under age 18, the median family income was $80,326.\textsuperscript{1049}

**Figure 233: Median Household Income by Race/Ethnicity in Alaska, 2013-2017\textsuperscript{233}**

The median income in Alaska varies by race/ethnicity. On average from 2013 to 2017, individuals who identified as white (non-Hispanic/Latinx) had the highest median income ($84,110), while people identifying as Alaska Native/American Indian had the lowest median income ($47,397).\textsuperscript{1050}

**Early Childhood Education**

High-quality early education, such as preschool or pre-kindergarten for children ages 3 and 4, can help with school preparedness. The Alaska Head Start program provides early childhood education services to more than 3,000 low-income children from birth through age five.\textsuperscript{1051} There are 17 Head Start programs in the state.\textsuperscript{1052}

From 2015 to 2017, 64\% of children ages 3 and 4 were not enrolled in school in Alaska.\textsuperscript{1053}

**Table 234: Children Ages 3 and 4 Not in School in Alaska, 2012-2017\textsuperscript{234}**

<table>
<thead>
<tr>
<th>Year</th>
<th>Number of children (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012-2014</td>
<td>13,000 (61%)</td>
</tr>
<tr>
<td>2013-2015</td>
<td>14,000 (62%)</td>
</tr>
<tr>
<td>2014-2016</td>
<td>14,000 (64%)</td>
</tr>
<tr>
<td>2015-2017</td>
<td>13,000 (64%)</td>
</tr>
</tbody>
</table>


Educational Attainment

High school graduation rates have improved across the state every year over the last 12 years. The on-time graduation rate (number of students who graduate within four years) for the 2016-17 school year was 78.2%.

Figure 235: On-time Graduation Rate in Alaska, 2004-2017

Graduation rates differed by gender, race/ethnicity, income level, and whether or not students had disabilities or were English language learners. Among racial/ethnic groups, students identifying as Alaska Native/American Indian had the lowest graduation rates (68.9%). Just over half of English language learners and students with disabilities graduated high school (57.7% and 58.7%, respectively).

Table 236: 2016-2017 Graduation Rates by Subgroup, Alaska

The dropout rate of students in seventh through 12th grades in Alaska during the 2016-17 school year was 3.5% — a rate that has declined significantly over the last 12 years (from 6% during the 2004 to 2005 school year).1058

Figure 237: Dropout Rate in Alaska, Grades 7-12 Average, 2004-2017237

---

Across Alaska, students identifying as Alaska Native/American Indian descent made up about 22% of the total enrollment in seventh through 12th grades during the 2016-17 school year, but disproportionately accounted for about 38% of the total dropouts. ¹⁰⁵⁹

**Foster Care**
Foster placement services are provided when children need short-term or temporary protection because they are abused, neglected or involved in family conflict. Of the approximately 185,000 children under age 18 who lived in Alaska in 2016, 2,810 children were in foster care — a rate of 15 children in foster care per 1,000 children in the state, which is 2.5 times the U.S. rate of 6 children in foster care per 1,000 children. ¹⁰⁶⁰

In 2016, the rate of children in foster care in Alaska was at its highest rate in about a decade. During that same year, 1,044 children exited foster care in Alaska for various reasons, including adoption (30%) and being reunified with a parent or primary caretaker (53%). ¹⁰⁶¹

**Life Expectancy and Leading Causes of Death and Hospitalization**

Life expectancy rates and leading causes of death and hospitalization are often used as health measures to monitor progress in promoting well-being, preventing disease and disability, and reducing health disparities. Longer life expectancy rates indicate better health.

**Life Expectancy**
Since 1990, the life expectancy rate in Alaska has steadily increased from 72.9 years in 1990 to 76.4 years in 2015. Although lower than the state average, there was an increase of 1.7 years for the Alaska Native/American Indian population, from 68 years in 1990 to 69.7 years in 2015.

**Leading Causes of Death**
Across the United States, injuries were the leading causes of death among youth under age 19 in 2016. In 2017, the leading causes of death in Alaska for youth ages 1 to 14 were unintentional injuries, while suicide was the leading causes of death for teens ages 15 to 19.

Congenital anomalies were the leading cause of death among children under age 1. Motor vehicle crashes, unintentional fires/burns, unintentional drownings and unintentional poisonings were leading causes of unintentional injury deaths for youth ages 1 to 19. For Alaska, over the last ten years there have been 454 drowning deaths, 11% of those drownings were children under the age of 15 and 42% were boating related. The drowning death rate among children aged 0–9 years was 2.6 per 100,000 persons, a decrease of 45% from 4.7 per 100,000 persons in 2000–2006.

**Figure 238: Leading Causes of Death in Alaska by Age and Number of Deaths, 2013-2017**

<table>
<thead>
<tr>
<th>Rank</th>
<th>Age Groups</th>
<th>&lt;1</th>
<th>1-4</th>
<th>5-9</th>
<th>10-14</th>
<th>15-19</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Congenital anomalies</td>
<td>Unintentional injuries</td>
<td>Unintentional injuries</td>
<td>Unintentional injuries</td>
<td>Suicide</td>
<td></td>
</tr>
<tr>
<td></td>
<td>63</td>
<td>26</td>
<td>23</td>
<td>21</td>
<td></td>
<td>18</td>
</tr>
<tr>
<td>2</td>
<td>SIDS</td>
<td>Homicide</td>
<td>Malignant neoplasms</td>
<td>Suicide</td>
<td>Unintentional injuries</td>
<td></td>
</tr>
<tr>
<td></td>
<td>44</td>
<td>10</td>
<td>---</td>
<td>11</td>
<td>14</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Unintentional injuries</td>
<td>Congenital anomalies</td>
<td>Homicide</td>
<td>Homicide</td>
<td>Homicide</td>
<td></td>
</tr>
<tr>
<td></td>
<td>26</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Maternal pregnancy complications</td>
<td>Malignant neoplasms</td>
<td>Congenital anomalies</td>
<td>Malignant neoplasms</td>
<td>Heart disease</td>
<td></td>
</tr>
<tr>
<td></td>
<td>19</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Short gestation</td>
<td>Influenza &amp; pneumonia</td>
<td>Benign neoplasms</td>
<td>Congenital anomalies</td>
<td>Influenza &amp; pneumonia</td>
<td></td>
</tr>
<tr>
<td></td>
<td>19</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Bacterial sepsis</td>
<td>Cerebrovascular</td>
<td>Hernia</td>
<td>Heart disease</td>
<td>Malignant neoplasms</td>
<td></td>
</tr>
<tr>
<td></td>
<td>17</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Circulatory system disease</td>
<td>Benign neoplasms</td>
<td>Meningitis</td>
<td>Benign neoplasms</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>12</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td></td>
</tr>
</tbody>
</table>

Leading Causes of Hospitalization

On average from 2011 to 2015, falls were the leading cause of non-fatal hospitalized injuries for children under age 14.\textsuperscript{1068} The leading causes of non-fatal hospitalized injuries for teens ages 15 to 19 were suicidal actions.\textsuperscript{1069} In 2017, the Alaska Division of Public Health did publish the top fifteen leading causes of hospitalizations in the state, but that data was not striated by age as the table below shows.\textsuperscript{1070}

Figure 239: Leading Causes of Non-fatal Hospitalized Injuries in Alaska by Age and Number of Hospitalizations, 2011-2015\textsuperscript{239}

\begin{table}[h]
\centering
\begin{tabular}{|c|c|c|c|c|c|}
\hline
\textbf{Rank} & \textbf{Age Groups} & \textbf{<1} & \textbf{1-4} & \textbf{5-9} & \textbf{10-14} & \textbf{15-19} \\
\hline
1 & Falls & Falls & Falls & Falls & Suicidal & 232 \\
& & 80 & 134 & 129 & 152 & \\
2 & Assault & Poisoning & Playground & ATV accident & Falls & 117 \\
& & 26 & 84 & 88 & 86 & \\
3 & Suffocation & Foreign object & Bicycle & Suicidal & Motor vehicle accident & 103 \\
& & 11 & 37 & 34 & 63 & \\
4 & Foreign object & Hot substance burn & Accidentally struck & Bicycle & ATV accident & \\
& & 10 & 36 & 31 & 43 & 70 \\
5 & Hot substance burn & Tie: Accidentally struck/dog bite & Tie: ATV accident/motor vehicle accident & Sports & Assault & 82 \\
& & 10 & 18 & 23 & 31 & \\
6 & Poisoning & Playground & Pedestrian & Accidentally struck & Sports & 36 \\
& & 10 & 16 & 14 & 24 & \\
\hline
\end{tabular}
\end{table}

### Children and Youth with Special Healthcare Needs/Chronic Conditions

Children with special health care needs are defined as children under age 18 who have or are at increased risk of a chronic physical, developmental, behavioral, or emotional condition, and who also require health and related services of a type or amount beyond that required by children generally. Because of their complex needs, these families often require services from multiple systems such as education and social services, in addition to health care. As such, the national Maternal and Child Health Block Grant, one of the largest federal block grant programs, outlines specific expectations for states related to meeting the health care needs of the CYSHCN population.

One in every five U.S. families has a child with a special health care need. Nationwide this is over 13 million children. The percent of children in a state who have a special health care need ranges from a low of only 13% (Hawaii) to a high of 24%; about 1 of every 4 children living in Kentucky, Mississippi, and West Virginia has a special health care need. Alaska, at 17%, has a slightly lower percent of children with special needs compared to the nation as a whole (19%).

In 2016, the National Survey of Children’s Health (NSCH) found that, in Alaska, only 19% of CYSHCN ages 0 through 17 receive care in a “well-functioning system.” This data tells us that Alaska is not faring well when it comes to ensuring that CYSHCN have a medical home and access to specialty care. These findings are consistent with what Alaska identified through its participation in the Association of Maternal and Child Health Programs (AMCHP) Action Learning Collaborative on National Standards for CYSHCN.

There is a foundational understanding that system deficiencies impede having a comprehensive and coordinated system of care for CYSHCN families. Care fragmentation is complicated in Alaska due to the vastness of geography compounded by transportation challenges that are unique to the state; 75% of Alaskan communities are not connected to a road system.

---

<table>
<thead>
<tr>
<th>7</th>
<th>---</th>
<th>Suffocation</th>
<th>Dog bite</th>
<th>Motor vehicle accident</th>
<th>Bicycle</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>13</td>
<td>12</td>
<td>23</td>
<td>32</td>
</tr>
<tr>
<td>8</td>
<td>---</td>
<td>Cut</td>
<td>Tie: Cut/poisoning</td>
<td>Snow machine</td>
<td>Tie: Accidentally struck/poisoning</td>
</tr>
<tr>
<td></td>
<td></td>
<td>11</td>
<td>11</td>
<td>18</td>
<td>30</td>
</tr>
<tr>
<td>9</td>
<td>---</td>
<td>Motor vehicle accident</td>
<td>Foreign object</td>
<td>Playground</td>
<td>Snow machine</td>
</tr>
<tr>
<td></td>
<td></td>
<td>10</td>
<td>8</td>
<td>15</td>
<td>23</td>
</tr>
<tr>
<td>10</td>
<td>---</td>
<td>Pedestrian accident</td>
<td>Tie: Other animal injury/sports</td>
<td>Tie: Motor vehicle non-traffic accident/motorcycle/pedestrian</td>
<td>Pedestrian accident</td>
</tr>
<tr>
<td></td>
<td></td>
<td>9</td>
<td>7</td>
<td>8</td>
<td>22</td>
</tr>
</tbody>
</table>

**Note:** counts less than 6 are suppressed as --- to prevent identification of individual cases.

Hospitalized injuries means they are admitted to the hospital for 24 hours or more.

Accidentally struck means they were accidentally struck by a person or object.

---

330 | Page
response to the NSCH data, the AMCHP learning collaborative, and the MCH needs assessment, in January 2016, the Alaska Division of Public Health released a five-year (2016-2021) strategic plan, *Alaska’s State Plan for Children and Youth with Special Health Care Needs*. The plan focuses on six of the *National Standards for CYSHCN* including Screening, Assessment and Referral; Access to Care; Medical Home; Community-Based Services and Supports; Family Professional Partnerships240, and Transition to Adulthood.1077

**Childhood Asthma**

Asthma is one of the most common chronic diseases nationwide affecting nearly one in every 12 children (about 8.1%).1078 On average from 2016 to 2017, 5% of children in Alaska had asthma.1079

**Cancer**

Cancer incidence in children from birth to age 20 in the United States from 2011 to 2015 was an average of 17.9 cases per 100,000 children/young adults.1080 About 70,000 teens and young adults ages 15 to 39 are diagnosed with cancer each year in the United States.1081 This accounts for 5% of cancer diagnoses in the country and is about six times the number of cancers diagnosed in children from birth to age 14.1082 Cancer is the leading cause of disease-related death in the United States among adolescents and young adults.1083

In Alaska, cancer incidence in children from birth to age 20 was an average of 16.1 cases per 100,000 from 2011 to 2015.1084 *In the Anchorage area, between 2011 and 2015, the childhood cancer incidence was 17.9 cases per 100,000 children.*1085 From 2011 to 2015, the childhood cancer incidence in the Fairbanks North Borough area was 14.3 cases per 100,000 children.1086

**Transplants**

More than 113,000 people in the nation are waiting for a life-saving organ transplant.1087 An average of 18 people (children and adults) die each day from a lack of available transplant organs.1088 All patients waiting for a transplant from a deceased donor in the United States have equal access to donated organs and are listed with the United Network for Organ Sharing (UNOS).

In the Northwest (UNOS region 6: Washington, Alaska, Idaho, Montana, Oregon and Hawaii), more than 3,000 people are currently in need of life-saving organ transplants — 85 of those under age 18.1089 UNOS does, however, allow for special allowances for children under certain circumstances. Since pediatric patients need smaller organs, for example, they will receive priority if the donor is younger than 18.1090

---

240 Note: since 2016 when the Division of Public Health, State of Alaska published *Alaska’s State Plan for Children and Youth with Special Needs*, the National Standards for CYSHCN have been updated (i.e., Version 2.0). The ten original domains, which included Family Professional Partnerships as its own domain, have been condensed into eight domains with Family Professional Partnerships as a foundational standard that “should exist in any system that serves CYSHCN, rather than as an individual standard.” Source: [http://www.amchp.org/programsandtopics/CYSHCN/Documents/Standards%20for%20Systems%20of%20Care%20for%20Children%20and%20Youth%20with%20Special%20Health%20Care%20Needs%20Version%202.0.pdf](http://www.amchp.org/programsandtopics/CYSHCN/Documents/Standards%20for%20Systems%20of%20Care%20for%20Children%20and%20Youth%20with%20Special%20Health%20Care%20Needs%20Version%202.0.pdf), page 4, accessed 8.9.19.
Healthcare Access and Preventative Care

Accessing healthcare services can lead to the prevention and early detection of many medical conditions. Health insurance reduces the out-of-pocket costs of healthcare and has been shown to be the single most important predictor of healthcare utilization. Without health insurance coverage, many people find healthcare services unaffordable and may forgo care. This often leads to disparities in health and quality of life between individuals with health insurance and those without health insurance.

Over the past few years, access to health insurance has improved with the expansion of Medicaid eligibility and the implementation of health insurance marketplaces for Qualified Health Plans. However, there are still children across Alaska without health insurance. In part due to inadequate insurance coverage, too many adults and children do not receive recommended clinical preventive services or regular oral healthcare services.

Access to Care
In 2017, 10% of children in Alaska were uninsured — a rate that has declined from 14% in 2008 and 2009. This is twice the U.S. rate of 5% in 2017.

For the report from the Kaiser Family Foundation, the term “uninsured” includes children without health insurance and children who have coverage under the Indian Health Service only. Alaska is tied for the second highest percentage of children ages 0 to 18 who were uninsured in 2017.

Figure 240: Percentage of Children Ages 0 to 18 Without Health Insurance Coverage in Alaska, 2008-2017

---

Immunization Rates
Immunization coverage in Alaska is based on the immunization schedule developed by the Centers for Disease Control and Prevention (CDC). These estimates are collected through the National Immunization Survey, which is a random-digit-dialed telephone survey of parents or guardians of children ages 19 to 35 months followed by a questionnaire mailed to providers to obtain the child’s vaccination history.\textsuperscript{1094}

According to the most recent data from 2017, 69.5\% of children ages 19 to 35 months had completed the recommended of 4:3:1:3:3:1:4 immunization series.\textsuperscript{1095} Immunization rates for children ages 19 to 35 months have increased every year over the last decade.

Figure 241: Immunization Rate in Alaska, Ages 19 to 35 Months, 2008-2017\textsuperscript{242}

**Oral Healthcare**

On average from 2015 to 2016, 76% of children in Alaska had received preventive dental care within the past year, which was just shy of the national average of 80%.\(^{1096}\) About 40% of children had an early dental visit before their second birthday in Alaska in 2017 — twice the rate as 2009.\(^{1097}\)

Nearly one in five 3-year-old children had been diagnosed with early tooth decay or cavities in Alaska in 2017 — up from 13.4% in 2008.\(^{1098}\)

**Figure 242: Early Dental Care in Alaska, 2017\(^{243}\)**

---

Mental and Behavioral Health
Mental and behavioral health encompasses a range of conditions, such as depression, lack of social support, bullying and suicidal behavior.

According to a 2019 report from Mental Health America, Alaska ranked 47th in the country (out of 50 states and the District of Columbia) for the prevalence of mental illness and access to care for youth. This ranking means Alaska has one of the highest rates of mental illness and one of the lowest rates of access to mental healthcare services among youth compared to other states in the country.

Nationwide, 21% of children have one or more emotional, behavioral, or developmental conditions. State distribution ranges from a low of only 15% in Hawaii to 27% of children in Arkansas, Louisiana, Maine, Mississippi, and West Virginia. States in the WAMI region are on par with the national average; 21% of Alaska’s children meet these criteria.

Among children with a special health care need, there is a significant subset comprised of children who have one or more emotional, behavioral, or developmental conditions. Specifically, this is defined as children age 2 to 17 who have autism, developmental delays, depression, anxiety, ADD/ADHD, or behavioral/conduct problems. Some of these children with emotional, behavioral, or developmental conditions also do have a chronic physical condition. Additionally, the National Survey of Children’s Health found that approximately 45% of children in Alaska ages 3 through 17 with a mental or behavioral condition do not receive treatment or counseling.

In 2017, about 56% of Alaska youth in ninth through 12th grades reported that they did not feel alone in their life. About 59% of students felt that their teachers cared about them and supported them, while 52% of students felt like they mattered in their community. The lack of social connection for more than 40% of youth should cause concern and highlight an area of opportunity.
Bullying
Across Alaska, the rates of bullying and bullying through the use of technology (cyberbullying) have increased steadily over the last decade. In 2017, 11.5% of students in grades nine through 12 who completed the Alaska Youth Risk Behavior Survey said they did not go to school because they felt unsafe at school or on their way to or from school on at least one of the past 30 days — this rate has more than doubled from 5.5% in 2007. Nearly 18% of youth in grades nine through 12 in traditional high schools were cyberbullied in the past year — up from 16.4% in 2011. The rates of bullying at school have remained fairly stable over the last few years at between 20% to 22%.

Students in ninth grade reported bullying and cyberbullying at higher rates than students in 10th through 12th grades in Alaska.

Figure 244: Bullying and Cyberbullying in Alaska, Grades 9-12, 2007-2017
It is important to consider the impact and prevalence of bullying in thinking about youth mental health. Students who reported being harassed or bullied were more likely to have lower grades in school, drop out of school, and may experience depression, anxiety, low self-esteem and have suicidal thoughts. Several studies have found an association between bullying and depression. Notably, youth who report bullying or cyber-bullying were at a higher risk for reporting suicidal ideation and attempts. In addition, students who bully others are more likely to have academic problems, substance abuse problems, and to experience violence later in life.

**Depression**
Depression is a mental illness that may go undetected and untreated, leading to adverse consequences for a person and those around them. Early signs of depression can include long durations of sadness or hopelessness that impacts a person’s day-to-day activities.

In 2017, more than one in three students (34.5%) in Alaska’s traditional high schools reported feeling sad or hopeless almost every day for at least two weeks in a row over the past year. This rate has increased by about 17% from 2007 to 2017.

**Figure 245: Percentage of Alaska Youth Who Experienced Depressive Feelings Almost Every Day for More Than Two Weeks Over Past Year, Grades 9-12, 2007-2017**

---

Suicidal Ideation
Like depression, the rates of suicidal ideation among youth in grades nine through 12 in Alaska have also increased over the last decade. In 2017, 21.1% of high school students in traditional high schools had seriously considered suicide, nearly 18% had made a suicide plan and more than 10% of students attempted suicide during the past year.1114

Among the students who had considered, planned or attempted suicide over the past year, nearly 47% had talked to someone about suicide.1115

Alaska has one of the highest suicide rates in the country - consistently being ranked first or second. Some of the risk factors more specific to Alaska are a loss of culture, social disconnection, shame associated with seeking mental health care, historical trauma, and substance use.1116

Another potential factor in the suicide crisis in Alaska is the access to lethal means. For more information on suicide and injury prevention, please reference the Suicide and Injury Prevention section of the Spotlight on Alaska section.

Figure 246: Suicidal Ideation Among Youth in Traditional High Schools in Alaska, Grades 9-12, 2007-2017247

Substance Use
Across Alaska, the rates of youth drinking alcohol and smoking cigarettes have declined over the last decade, while rates of marijuana and heroin use among youth in grades nine through 12 have remained fairly stable.

Alcohol Use
According to the 2017 Alaska Youth Risk Behavior Survey, nearly one-quarter (24.3%) of students in ninth through 12th grades in traditional high schools had at least one drink of alcohol in the past 30 days. Rates have remained fairly stable since 2013 but have decreased by about 38% since 2007.

A few takeaways from the 2017 Alaska Youth Risk Behavior Survey:

- Students in 11th and 12th grades reported higher rates of consuming at least one drink of alcohol in the past 30 days compared to students in ninth and 10th grades.
- Nearly 14% of students in ninth through 12th grades reported binge drinking during the past 30 days. The survey defined binge drinking as four or more drinks in a row for females and five or more drinks in a row for males.
- About 37% of students believed there was great risk of harm if someone drank five or more alcoholic drinks once or twice per week.
- The rate of young people in Alaska riding in a vehicle with a driver who had been drinking alcohol one or more times during the past 30 days also declined, from 23.5% in 2007 to 16.4% in 2017.
Tobacco Use

Over the last decade, there have been declines in daily, frequent and current cigarette smoking rates in Alaska among youth in grades nine through 12. In 2017, 6.7% of youth in traditional high schools in Alaska reported smoking cigarettes at least once in the past 30 days. This is nearly half the rate as 2007 (13.6%).

- In 2017, 1.8% of students in traditional high schools in Alaska were frequent smokers, meaning they smoked 20 or more of the past 30 days.
- 1.3% of students reported smoking cigarettes daily.
- Nearly 28% of students reported that they had tried smoking cigarettes in their lifetime — a decrease from about 48% in 2007.
- Students in 11th and 12th grades reported higher rates of cigarette smoking than students in ninth and 10th grades.
- Male students also smoked cigarettes at higher rates than female students (7.5% compared to 5.9%) in 2017.
- Students identifying as Alaska Native/American Indian reported the highest rates of smoking cigarettes at least once in the past 30 days (12.6%).
In 2017, 16% of youth in Alaska’s traditional high schools reported that they currently used electronic vapor products, a decrease from 19.7% in 2015.\textsuperscript{1119} In 2017, about 38% of students reported that they had tried an electronic vapor product in their lifetime. Students in 11th and 12th grades reported higher rates of electronic vapor product use than students in ninth and 10th grades.

\textit{Marijuana Use}\textsuperscript{1120}

Marijuana use has decreased slightly over the last decade among Alaska’s youth.

- In 2017, 21.5\% of students in ninth through 12th grades in traditional high schools used marijuana one or more times during the past 30 days.
- Nearly 39\% of students had used marijuana at least once in their lifetime.
- One in five students thought there was great risk of harm in using marijuana once or twice a week.
- Students in 11th and 12th grades reported higher rates of marijuana use during the past 30 days compared to students in ninth and 10th grades.

\textbf{Figure 249: Percentage of Alaska Youth in Traditional High Schools Who Used Marijuana at Least Once in Past 30 Days, Grades 9-12, 2007-2017}\textsuperscript{250}

Prescription Drug Use\textsuperscript{1121}

In traditional high schools in Alaska, 7.2\% of students in ninth through 12th grades in 2015 reported taking a prescription medication without a prescription in the past month. Nearly 15\% of students said they had “ever taken a prescription drug without a prescription,” and about 50\% of students think there is great risk of harm in using prescription medications without a prescription or differently than how a doctor told them to use it.

Maternal and Child Health

Healthy pregnancies, healthy babies and healthy mothers are important goals for all communities. Maternal and child health outcomes are markers of a community’s overall health.

Early and Adequate Prenatal Care\textsuperscript{1122}

Beginning prenatal care early in the pregnancy and having regular visits with a provider can improve the chances of a healthy pregnancy. Doctors recommended that women begin prenatal care during the first trimester of the pregnancy (before the fourth month of pregnancy). The national Healthy People 2020 goal for prenatal care in the first trimester is 77.9\%.

Across Alaska, there has been steady improvement in the rate of prenatal care beginning in the first trimester. In 2017, 80.8\% of Alaska women who gave birth received prenatal care in the first trimester, compared to 77.3\% in the United States. In 2016, 64.6\% of Alaska women who gave birth received early and adequate prenatal care, compared to 75.6\% nationally.

The most common reason why women in Alaska did not seek early prenatal care was not knowing that they were pregnant.

Infant Mortality\textsuperscript{1123}
One of the measures of the overall health of a population is the infant mortality rate since many of these deaths are preventable. The infant mortality rate refers to the number of babies per 1,000 live births who die before their first birthday in a given year.

The Healthy People 2020 goal for infant mortality is less than 6.0 deaths per 1,000 live births. In 2016, the infant mortality rate in Alaska was 5.4 deaths per 1,000 live births, while the national infant mortality rate was 5.9 deaths per 1,000 live births. The infant mortality rate in Alaska was down from the previous two years — 6.9 per 1,000 live births in 2015 and 6.6 per 1,000 live births in 2014.

**Low Birth Weight**
Infants born weighing less than 2,500 grams (about 5.5 pounds) are considered low birth weight. This increases their risk of infant mortality as well as developing neurodevelopmental disabilities and respiratory disorders.

An average of 5.8% of infants born from 2012 to 2016 in Alaska were low birth weight. This meets the Healthy People 2020 objective of 7.8% or fewer infants born at low birth weight. This rate has stayed the same for more than a decade.

**Weight-Related Health and Behavior**

**Obesity and Overweight Prevalence**
Children, teens and young adults are considered overweight if their body mass index (BMI) is in the top 15% for their age and gender. They are considered obese if their BMI is in the top 5% for their age and gender.

In Alaska:

- 12.6% of children ages 10 to 17 were considered obese in 2016 and 2017, which is less than the national rate of 15.8%.\(^{1125}\)
- There has been an increase in the rate of overweight and obese teens (grades nine through 12) over the last decade.\(^{1126}\)
- About 16% of students in traditional high schools in Alaska were overweight and nearly 15% were obese in 2017.\(^{1127}\)

**Figure 250: Overweight and Obesity Rates of Alaska Youth, Grades 9-12, 2007-2017**\(^{251}\)

Food Insecurity

Food insecurity is defined as an uncertainty of having or an inability to acquire enough food for all household members because of insufficient money or other resources.\textsuperscript{1128}

In Alaska, the rate of food insecurity among children was above the national average in 2017 — 18.7\% compared to 17\%.

Federal and state assistance programs have been shown to reduce child food insecurity rates and lessen the health impacts of food insecurity among children.\textsuperscript{1129} These programs include the Supplemental Nutrition Assistance Program (SNAP), national school meal programs and the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) program.

More than half (59\%) of children who were food insecure in Alaska were eligible for federal nutrition programs based on income level.\textsuperscript{1130}

As of March 2019, about 52,000 children in Alaska were participating in the National School Lunch Program and nearly 26,000 children were participating in the National School Breakfast Program.\textsuperscript{1131} Also in March 2019, nearly 39,000 households (about 86,000 people) in Alaska participated in SNAP and almost 16,000 people participated in WIC.\textsuperscript{1132}

**Figure 251: Percentage of Children Who Were Food Insecure in Alaska, 2017**\textsuperscript{252}

Fruit and Vegetable Consumption
Eating fruits and vegetables can lower the risk of developing many chronic diseases and supports weight management.

In 2017, about one in 10 students in traditional high schools in Alaska ate fruit two or more times per day and ate vegetables three or more times per day in the past week — a rate that has stayed fairly stable over the past decade.\textsuperscript{1133}

Figure 252: Percentage of Alaska Youth in Traditional High Schools Who Ate Fruits 2+ Times Per Day and Vegetables 3+ Times Per Day in Past Week, Grades 9-12\textsuperscript{253}

Physical Activity

To maintain a healthy lifestyle, children and adolescents should participate in at least 60 minutes of physical activity every day. In Alaska, 18.4% of students in traditional high schools met this recommendation in 2017.\textsuperscript{1134}

Across the nation, youth are participating in sedentary activities at increasing rates. In 2017, 58% of students in traditional high schools in Alaska reported spending three or more hours on an average school day watching TV, playing video games or using a computer for something other than schoolwork.

**Figure 253: Percentage of Alaska Youth Who Were Physically Active for 60 Minutes on Each of the Past Seven Days, Grades 9-12\textsuperscript{254}**

Youth Consumption of Sugar-Sweetened Beverages

In 2017, 46.6% of students in traditional high schools in Alaska reported drinking a soda or sugar-sweetened beverage (including sports drinks) one or more times per day in the past seven days.\textsuperscript{1135} This is about the same as the rate in 2009 but is an increase from 2011 through 2015.

**Figure 254: Percentage of Alaska Youth Who Drank Soda or a Sugar-sweetened Drink One or More Times Per Day in Past Seven Days, Grades 9-12\textsuperscript{255}**


Suicide and Injury Prevention

Alaska ranks 8\textsuperscript{th} in the nation in deaths from unintentional injuries and has the 2\textsuperscript{nd} highest rate of suicide nationwide.\textsuperscript{1136} For every homicide, there are 4 suicides.\textsuperscript{1137} For children and youth age 10-24, suicide is the leading cause of death.\textsuperscript{1138} Suicide rates are higher for males than for females, and rates are disproportionate among racial and ethnic groups.\textsuperscript{1139} Statewide, the mortality rate of suicide varies by tribal region, ranging from 28.3 to 65.5 for every 100,000 people.\textsuperscript{1140} More than half of all deaths by suicide using firearms, followed by strangulation, poisoning, and other methods in Alaska.\textsuperscript{1141} Alaska has the highest rate of gun ownership in the county – 61.7\% of the population owns a gun. Additionally, Alaska also has the highest rate of suicide by firearm in the U.S. at 16.6 deaths for every 100,000 people.\textsuperscript{1142}

Child maltreatment continues to affect the Alaskan population. Currently, 1 in every 3 Alaskan children will likely experience maltreatment in during their childhood.\textsuperscript{1143} Neglect is the most common form of maltreatment. These experiences can increase the likelihood of risky behavior later in life.\textsuperscript{1144}

Transportation deaths and hospitalizations continue to affect Alaskan children and youth. The rate of transportation related injuries for Alaskan children and youth age 15-24 is the second highest rate of any other age group in the state, though it was significantly lower than any other age group for children under 15 years of age.\textsuperscript{1145}

Community Input from Alaska

We visited several cities, regions and villages in Alaska between 2016-2019 including Anchorage, Bethel, Fairbanks, Wasilla (Mat-Su Valley), Haines, Juneau, Metlakatla (Prince of Wales-Hyder) and Sitka. We met with community members and stakeholders to ascertain what they felt were the needs and assets of their communities. In this chapter we start with overall themes and then move to location or geographic specific data.
Community Input Themes Overall

Care Coordination and Access to Resources

- Parents worry about communication and care coordination between and within primary pediatricians and specialists, but only parents with children with chronic conditions voiced this.
- Parents and stakeholders have difficulty finding and assessing information to assist them with treating children, particularly those with special healthcare needs or mental and behavioral health issues. One parent said, “None of my doctors, nurses, or pediatricians have ever discussed signs to help with early diagnosis of a mental and behavioral health issue.”
- One stakeholder said, “I work in the field and it still is hard; hard because I want to read all the things. Even for those of us who are parent-education focused, there is not a singular or one ‘go to’ place for good information. Honestly, the format that would make it easiest to find information is a video-based format like a you-tube channel that I’d be directed to go to by my pediatrician, and I could trust it as having the most up to date brain science, be based on attachment theory. Maybe such a site exists?” And these sentiments are echoed by others.
- Parents and key informants say that good work is being done to combat the homelessness and housing crisis. Organizations including Southcentral Foundation and Catholic Social Services are providing additional shelter for those in need.
- Regarding care coordination directly, parents often mention the lack of a “hand-off” when patients need to travel outside of Alaska for care. However, there are several positive programs that help ease this transition. Specifically, some mentioned that employees from the Port of Seattle help direct and escort families when they arrive at the airport in Seattle. At Seattle Children’s, the Guest Services and Security Services teams often assist families with transportation between the hospital and their local housing. Patient navigators are also available to assist families.

Parent Advocacy and Cultural Sensitivity

- Parents are incredible advocates for their families, but feel they lack choices sometimes (choice of provider, choice of activity).
- Their lack of choice often affects quality of care and can manifest in a lack of cultural sensitivity. For example, one parent mentioned, “This past winter my daughter got lice at school. Our pediatrician was closed so we went to urgent care. We were seen pretty quickly, but we were there a long time. You could tell that they weren’t pediatricians - they spoke to me and not her, and did nothing to mitigate the stigma and shame she was feeling about contracting lice. Also, they prescribed a shampoo, but it just killed the adult bugs, not the eggs. We ended up at the Alaska Lice Clinic at AK Regional and their care was beyond exceptional. The team there got us in quickly, greeted us, spoke about how in some native cultures historically we use Kerosene to kill the lice and instead of making us feel bad about how some in our tribe did that, they explained about the toxicity of some of the older tribal methods (without shame) and helped us.”
- Many community members mentioned trauma-informed care and more culturally competent care to Alaska Native/American Indian families.
Specific to cultural humility, many key informants and/or parents mentioned an example of how a healthcare system is working to harness the strengths of a community is the Nuka System of Care at Southcentral Foundation (Anchorage regional tribal health corporation) and Alaska Native Medical Center. The Nuka system is a relationship-based, customer-owned approach to transforming health care. The healthcare system is owned by Alaska Native/American Indian people and its goals are wellbeing of the entire person, including physical, mental, emotional and spiritual wellness. The focus is on patient (customer)-centered care, cultural-sensitivity and teamwork. Using this framework helps Southcentral Foundation develop initiatives based on community input and using strengths of the community. For example, the Family Wellness Warriors Initiative uses a holistic approach to target domestic violence and child abuse and incorporates aspects of Alaska Native/American Indian culture such as storytelling.

Geography Matters

- Many Alaskans feel isolated (physically and socially); this is heightened in the winter months and can affect healthy lifestyles. One parent said, “In Anchorage in the summer there are plenty of places to get your child outdoors and be active. However, in the winter there is virtually no places to take your kids that are not expensive and/or not available for younger toddlers. This is a hard place to be active year round.”
- Maintaining an active lifestyle is challenging in the settings of rural Alaska and economic inequalities/opportunities of “city” vs. “village” or “rural” life.
- The feelings of isolation and climate impact mental and behavioral health, which is a big concern for the community. This problem is exacerbated by a lack of access to care for mental and behavioral health (MBH) issues.
- Another parent mentioned, “There is actually a years long wait list for kids to be screened for MBH. I think the reason for this is AK Medicaid won’t pay (providers can’t bill them for service) unless it is the supervising psychiatrist that is doing the screening- LISCW and MSWs cannot screen for MBH issues and get paid, so they don’t do it. We need more trauma informed care throughout our state. Same is true preventatively; at-risk kids that are more likely to have MBH issues have to await an actual diagnosis instead of pre-diagnostic intervention merely based on their hi-risk factors. Some providers are afraid to screen for some of the developmental issues out of fear for how long the waitlist is. Anchorage recently lost the only peer-group support services nonprofit recently. It was called Forget-Me-Not because it was no longer financially viable based on their reimbursement mechanism. Funders just don’t see MBH as important here but the need is huge.”
- Not all parents feel this way. One parent said, “My children go to ANMC and they have plenty of resources for mental health and for parents there and we are asked about it in clinic.”
- Alaskans need more access to resources and care with more help coordinating care. Language and geographic barriers present unique challenges to care access and quality, and in some areas, resources are spread thin, particularly for mental and behavioral health and substance use issues.
- Child maltreatment is another area of concern that needs to be addressed.

Community Assets and Challenges
Poverty, employment opportunities, isolation, transportation, and housing are all challenges facing Alaskans.

Strength is, “Supporting Alaska in its ability to support itself.”

“Culturally, Alaska does things differently. Communities think differently because they’ve had to.”

“Alaskans want to build within our own. We want to build up what we have, train our own in helping to support our community.”

Alaska Natives/American Indians have strong family and community values – unique from typical American culture (i.e. more common to live in extended family units instead of nuclear family).

**Anchorage**

**Demographic Overview**

Anchorage is located in the southcentral region of Alaska and is home to more than 40% of the state’s population, making it the most populated city in the state. The total population in Anchorage in 2017 was about 294,000 — nearly 27% under the age of 20. From 2007 to 2017, there was a slight increase in the population of children ages 5 to 9, but a decrease in population of children and teens ages 10 to 19.\(^\text{1146}\)

<table>
<thead>
<tr>
<th>Table 255: Population Change by Age Group Between 2007 and 2017, Anchorage(^\text{256})</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ages</td>
</tr>
<tr>
<td>0-4</td>
</tr>
<tr>
<td>5-9</td>
</tr>
<tr>
<td>10-14</td>
</tr>
<tr>
<td>15-19</td>
</tr>
</tbody>
</table>

Much like the state of Alaska as a whole, the majority of the population in Anchorage (about 64%) were white (non-Hispanic/Latinx), according to U.S. Census Bureau data from 2013 to 2017.\(^\text{1147}\) Nearly 10% of the population were multiracial, about 9% were Asian and about 7% were Alaska Native/American Indian during the same time period.\(^\text{1148}\)

**Figure 256: Population (All Ages) by Race/Ethnicity, Anchorage, 2013-2017 Average\(^\text{257}\)**

---


In Anchorage, 14.3% of children and teens under age 18 lived in poverty — a rate that is slightly lower than the state average.\textsuperscript{1149} During the 2018 to 2019 school year, 51% of students in the Anchorage School District were enrolled in the free and reduced-price meal program.\textsuperscript{1150} In Anchorage, the unemployment rate in April 2019 (not seasonally adjusted) was 5.1% — a rate that was lower than the state average but higher than the national average.\textsuperscript{1151} Rates have remained steady since 2010.\textsuperscript{1152}

**Employment and Income**

On average from 2013 to 2017, the median household income in Anchorage was $82,271.\textsuperscript{1153} In households with children under age 18, the median family income was $83,264.\textsuperscript{1154} People who were identified as white (non-Hispanic/Latinx) had the highest median income ($91,927), while people identifying as Black/African American descent had the lowest median income ($55,747).\textsuperscript{1155}

**Early Education and Educational Attainment**

In Anchorage, the graduation rate during the 2016 to 2017 school year was 81.5%, so higher than the state average.\textsuperscript{1156} For the same school year, the dropout rate of students in seventh through 12th grades was 3.3%, which was lower than the state average.\textsuperscript{1157}

**Food Insecurity**\textsuperscript{1158}

At 16.3%, the rate of food insecurity among children in Anchorage in 2017 was just below the state and national rates. About half of children who were food insecure were eligible for federal nutrition programs based on income level.
Community Input from Anchorage

We visited Anchorage each year between 2016 to 2019 and met with community members and stakeholders to ascertain what they felt were the needs and assets of their communities. Qualitative data was collected through over 30 key informant interviews and one listening session with 12 participants. These interviews included a consistent set of 10 open-ended questions. Questions focused on mental and behavioral health as well as safety, well-being, respect, and resilience. These interviews lasted 30-60 minutes each. Interviews included a pediatrician at Alaska Native Medical Center (ANMC), pediatrician and co-director of AK track for Seattle Children’s Residents, members of the Alaska Injury Prevention Center, Community and Family Health Division of Anchorage DHHS, AK Division of Public Health Section of Women’s, Children’s and Family Health, and Child Welfare Division in AK DHHS. Additionally members of community groups, Stone Soup Group and NeighborWorks, were interviewed as well as an elementary school nurse. There was also a visit to the Southcentral Foundation, the native health corporation for the Anchorage region. In 2018, stakeholder interviews included members of the Adolescent Health Project and Early Care and Education and Obesity Prevention, both at AK DHHS. Members of community groups including AK Food Coalition, AK Children’s Trust and a pediatric hospitalist were also interviewed. Here are the themes:

Community strengths and challenges

Coordination of Care

Coordination of care is vital in Alaska with many rural communities and frequent referrals to care out of state. Key informants spoke highly about the improvements made as well as the constant room for improvement in the coordination of care for patients. The Children with Special Health Care Needs Services Program recently authored an Alaska plan based the Association for Maternal and Child Health Programs national standards. Public health specialists are also working to gather patient feedback and establishing care coordination through distance based learning for the State of Alaska and rural communities. One key informant spoke about STAR, a program ran by Stone Soup Group that supports patients and families when they travel out of state for health care and connects them to other families facing similar circumstances. Another spoke about the coordination of care between Seattle Children’s and the Alaska Native

---

Medical Center (ANMC). Physicians at both hospitals work hard to stabilize patients in Seattle to then have them transferred to ANMC and then eventually home as soon as possible through strong coordination and communication. By streamlining this coordination, patients receive better care and families are less likely to be separated and face additional relocation costs.

**Healthy Eating & Active Living**

Some of the key informants mentioned healthy eating and active living to be difficult for Alaskan residents. One stated that produce isn’t available and another stated there are food deserts present across the state. Alaskans don’t see food growing in their backyard or neighborhoods. Another key informant said it’s easier when it’s cold for families to hibernate, make something quick to eat and turn on the television, with this especially true in more rural Alaskan communities. Good work is being done in the schools and at the state level. The state has a play everyday program children can sign up for through their school. This program allows them to compete with classmates and earn prizes while encouraging them to exercise. At the school level, one stakeholder discussed after school workout classes being offered for free to students. Breakfast and lunch are also free to students in need year round. Community gardens are also starting to be more popular, with diverse populations and cultures emphasizing healthy eating in their neighborhoods.

**Access to Resources**

All of the key informant interviews emphasized a lack of resources within the Anchorage community. Language services, transportation, housing, social services, and healthcare were common concerns. Without language services, families are kept from accessing additional resources. One key informant described Alaska as a very diverse state and brought up Mountainview, a suburb of Anchorage, as being the most diverse neighborhood in the nation with over 190 languages spoken. None of the resources provided by the Department of Health and Human Services (DHHS) are translated and families are constantly wearing out the DHHS language line. Informants spoke of the decline in public transportation and low walkability of Anchorage. Streets are poorly planned and often remain unplowed in the winter months. This can leave children isolated at home. As the population of Anchorage grows, housing availability and affordability goes down. Key informants raised concerns on the number of families being seen in homeless shelters. Good work is being done to combat the homelessness and housing crisis. Organizations including Southcentral Foundation and Catholic Social Services are providing additional shelter for those in need.

Key informants were also concerned about the navigation of the resources that are available. A key informant described them as fragmented and spread thin with not a lot of organizations duplicating services. Navigation is difficult regardless of education level and becomes even more challenging within limited English populations. When families do receive help, it doesn’t seem to be enough.

One key informant also mentioned that although resources are available, it’s a matter of priority to families. When free sources such as car seats are available, 40% of families miss their appointment. When families are trying to navigate systems and survive, a free car seat is not a part of their priority list. This seems to be the same for other resources as well as choosing to buy and consume fresh and healthy food.
Mental Health and Substance Abuse
Most key informants spoke about problems related to substance abuse and mental health. In the state of Alaska, opiates cause more deaths than motor vehicle accidents. One stated the biggest barrier is access to treatment services and provider capabilities. Resources are unavailable when it comes to mental health. When left untreated, drug abuse leads to increases in the foster care system and in WIC participants. One stakeholder voiced their worries about substance abuse in parents. When parents have this issue, they most likely have other issues including low paying jobs, low energy, and high stress. This leaves no time to support their children and provide them with a stable foundation to live and thrive.

Child Abuse & Maltreatment
Almost all key informants brought up concerns about the rates of child abuse and maltreatment across the state. It is seen as one of the top needs identified in multiple organizations throughout Alaska. Child abuse is six times the national average and child maltreatment has increased 107% in Alaska over the past decade. One key informant stated that neglect is about 65% of the cases seen by the Office of Children’s Services (OCS). There are now twice as many kids in OCS’ care, not due to better screening, but to more children being maltreated. Potential reasons behind this include historical trauma, geography, and dark winters impacting mental health and wellbeing. Good work is being done with Anchorage Community Mental Health and their trainings in trauma informed care. The National Strengthening Families Program has also a set list of protective factors for children in crisis and have been able to work with OCS to train employees on vulnerable families and those at highest risk. The 2017 state budget also allowed for 31 new positions at OCS to combat higher case loads.

Telemedicine
Telehealth was spoken highly about as a community strength among many of the key informants. It is being successfully used by tribal health affiliates across the state to bring care to rural communities. One key informant discussed how it keeps patients and their families from being forced to move to Anchorage for care. One key informant discussed how telemedicine is being incorporated into the new neurodevelopment center at ANMC so that patients can access specialists and care from home.

Growing Their Own
Key informants spoke passionately about supporting Alaska in its ability to support itself. This involves supporting and training their own residents to support their community as a whole. Culturally, Alaska does things differently and independently. There is a foundation built that is definitely a resilience factor. One key informant spoke of physicians being able to travel out of state to strengthen skills and stay up to date with conditions not often seen in Alaska. Another spoke highly of the Alaska Track Residency Program by University of Washington and Seattle Children’s. They stated this program demonstrates an outside commitment to the health of Alaskans in a way that Alaskan’s appreciate.

Summary of feedback from Anchorage
Anchorage is the largest city in Alaska, representing 40 percent of the state’s population. Some of the greatest needs that surfaced through the key informant interviews were the need for more
resources for child abuse and maltreatment, mental health services, and language services. Most of the current resources are being spread thin and navigating them can be difficult for most families, especially within limited english speaking populations. While there are many organizations doing good work, families are still feeling overwhelmed and unsure of where to go and even what questions to ask. Where Alaska shows strength is in its coordination of care, telemedicine, and it’s resilience from the desire to support and grow its own community members.

**Bethel**

**Demographic Overview**

Located on the west coast of Alaska, the Bethel Census Area had a population of 17,957 on average between 2013 and 2017, with about 39% under the age of 20.\(^{1159}\) The city of Bethel had a population of about 6,400 on average during the same time period, with about 35% under the age of 20.\(^{1160}\)

In the city of Bethel, the majority of the population (nearly 62%) identified as Alaska Native/American Indian, according to U.S. Census Bureau data from 2013 to 2017. About one-quarter of the population were white (non-Hispanic or Latinx). Across the Bethel Census Area, nearly 83% of the population were Alaska Native/American Indian, while about 11% were white (non-Hispanic or Latinx).

**Figure 258: Population (All Ages) by Race/Ethnicity, Bethel (City), 2013-2017 Average\(^{259}\)**

---

In the city of Bethel, 17.8% of children and teens under age 18 lived in poverty on average from 2013 to 2017.1161 During the 2018 to 2019 school year, about 90% of students in the Lower Kuskokwim School District were enrolled in the free and reduced-price meal program.1162 The Lower Kuskokwim School District serves the city of Bethel and surrounding areas.1163

**Employment and Income**
The unemployment rate in April 2019 (not seasonally adjusted) in Bethel was 13.7% — a rate that was more than twice the state average and more than four times the national average.1164 From 2013 to 2017, the median household income in Bethel was $53,853.1165

**Early Education and Educational Attainment**
In Bethel, the graduation rate for the Lower Kuskokwim School District during the 2016 to 2017 school year was 51.8%, a rate that was significantly lower than the state average.1166 The dropout rate of students in seventh through 12th grades in the Lower Kuskokwim School District during the 2016 to 2017 school year was 7.6% — more than twice the state average.1167

**Food Insecurity**1168
In 2017, 29.5% of children in Bethel were food insecure, a rate that is significantly above the state and national averages. Nearly all children who were food insecure (93%) were eligible for federal nutrition programs based on income level.

**Figure 259: Percentage of Children Who Were Food Insecure in Bethel, 2017**260

-17 school year was 51.8%, a rate that was significantly lower than the state average.1169 The dropout rate of students in seventh through 12th grades in the Lower Kuskokwim School District during the 2016-17 school year was 7.6% — more than twice the state average.1170

**Community Input from Bethel**
We visited Bethel in 2019 and met with community members and stakeholders to ascertain what they felt were the needs and assets of their communities. We met with a nurse practitioner and a physician assistant at Bethel Family Clinic, two outpatient pediatricians, an inpatient pediatrician, a family medicine physician, the director of a women’s shelter, two child advocates

at the women’s shelter, the leader of a teen group, the director and outreach coordinator at a children’s center, and a school board member and former teacher as well as four teenagers at a Teens Acting Against Violence meeting. Here is what was found.

Healthcare System

The structure of the healthcare system, the availability of providers, and the logistics of travel for medical care were common topics of conversation during key stakeholder interviews.

- Health aides are a strength of the healthcare system, serving as valuable first-line providers in the villages. Health aides know the people of the village and know their language and culture.

- The native-run healthcare system is an additional strength of the healthcare system. The healthcare system is rooted in cultural values, so providers are trained in cultural competency, interpreters for native languages are available, and traditional foods are available.

Major needs of the healthcare system identified included:

- More support for developmental therapies in villages including Family Infant Toddler (FIT), Early Head Start, and Head Start. However, there are not enough personnel to staff these programs in every village.

- Early development classes for new parents, since much of the perinatal education focuses on prenatal care.

- Addressing high provider turnover. Many providers are non-native and transient, which limits longitudinal relationships. Potential contributing factors to high provider turnover are high cost of living in Bethel and its remote location.

Barriers to optimal healthcare include:

- Multiple medical home transitions that require communication, the difficulty and expense of travel logistics, and the foreign setting of Anchorage or Seattle for many patients.

- One key stakeholder commented on the importance of clear discharge communication to providers, including a complete medication list and complete procedure list.

- Sometimes these communications will need to occur to multiple providers; for example, for a patient from a village ultimately cared for in Seattle, communication will need to occur to Anchorage, Bethel, and village (health aide) providers to ensure a safe transition of care.

- Bethel is a remote city that can only be accessed consistently by air, so travel logistics are another barrier to care, as many patients do not have the money for plane tickets upfront prior to being reimbursed by insurance.

- The large service area, travel time, and weather limitations of responding to emergencies also contribute to limited access to care. Some children with acute medical needs may not be able to be evacuated immediately, depending on weather and travel time.

Mental and Behavioral Health
During almost every key stakeholder interview, mental and behavioral health were named as areas of need. There have been some recent major improvements over the years, including improved access to social workers in village schools. These social workers are able to get to know the villages and the children that they work with to provide continuity. Some key stakeholders also discussed mental health in a cultural context, naming access to village elders for mentorship and participation in cultural activities as community strengths.

There are still areas of need, including:

- There are few inpatient mental health treatment centers, located only in Anchorage and Juneau.
- There are not many outpatient mental health providers. For example, there are behavioral health therapists in Bethel through YKHC, but they are not specifically trained in treating children; furthermore, there are no behavioral health specialists in the villages, so children need to travel to Bethel for mental health care. Bethel is the only location in the YK Delta region that offers therapy.
- Additionally, there is a lack of native representation among therapists, which can be intimidating for children and their families. Exacerbating mental health issues is the presence of bullying at school, which was named as a major area of need.
- Barriers to optimizing the mental and behavioral health sector include a lack of training in child-specific mental healthcare.

**Community Programs**

There was an understanding among community leaders that giving children something to do was preventative in addressing mental and behavioral health issues and substance abuse. There are already many community programs available in Bethel. These are broad and include youth groups like 4H, Teens Acting Against Violence (TAAV), and church camps, as well as fitness focused activities including Smart Fit Girls, free hours at the community pool, school sports, and community pickup basketball.

Though many options exist already, the community identified a need for more, free, transportation-accessible, drop in programs for youth. Some youth do not have reliable transportation. For some, certain community programs are not an option as they are costly, require transportation to and from the activity, or require supervision during the activity.

**Culture and Identity**

Yup’ik culture was consistently referenced as a backbone of the community.

- For youth, identifying with their culture gives them a sense of identity and role in their society, which adds to their resilience.
- It provides a moral framework for youth to understand community values.
- In Yup’ik culture, there is a tenant to “love one another and love your neighbor,” as well as to respect elders.
Cultural activities were described as bonding and spiritual for youth. For example, the process of berry picking was mentioned by one key stakeholder as being its own form of mental health therapy.

During cultural activities, children are able to learn from their elders and find mentorship. Within the Yup’ik culture, the importance of family is a predominating value, and many family homes are multigenerational, offering children support from multiple family members.

A recent campaign has capitalized on cultural identity by identifying adverse things that are not part of Yup’ik culture. Flyers note, “Tobacco is not my culture,” or, “Alcohol is not my culture.”

While the Yup’ik culture provides the community great strength, the Yup’ik people also suffered the historical trauma of ethnic genocide and forced assimilation.

One stakeholder commented on the loss of some native languages, and the need for younger generations to re-learn traditional practices after a generation of elders were separated from their culture.

Others mentioned how the historical introduction of drugs and alcohol into their community has contributed to high rates of substance use.

Intergenerational trauma contributes to ongoing mental health needs, as a history of forced submission and separation from culture leads to feelings of anxiety and depression.

Fairbanks
Demographic Overview

Fairbanks — part of the Fairbanks North Star Borough — is located in the Alaskan interior in the Central Tanana Valley, about 360 miles from Anchorage. In 2018, the estimated population of Fairbanks was nearly 99,000, with about 27% of the population under the age of 20. There has been a significant increase in the population of children ages 5 to 9 from 2007 to 2017, but significant decreases in the population of children ages 0 to 4 and 10 to 19.

<table>
<thead>
<tr>
<th>Table 260: Population Change by Age Group Between 2007 and 2017, Fairbanks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ages</td>
</tr>
<tr>
<td>0-4</td>
</tr>
<tr>
<td>5-9</td>
</tr>
<tr>
<td>10-14</td>
</tr>
<tr>
<td>15-19</td>
</tr>
</tbody>
</table>

In Fairbanks, on average from 2013 to 2017, more than three-quarters of the population (76%) were white (non-Hispanic/Latinx). About 8% of the population identified as multiracial and 7% were Alaska Native/American Indian during the same time period.

Figure 261: Population (All Ages) by Race/Ethnicity, Fairbanks, 2013-2017 Average

---

In 2017, 4.9% of children and teens under age 18 in Fairbanks lived in poverty — a rate that is significantly lower than the state average. About 35% of students in the Fairbanks North Star Borough School District were enrolled in the free and reduced-price meal program during the 2018 to 2019 school year.

Employment and Income
In April 2019, the unemployment rate in Fairbanks (not seasonally adjusted) was 5.8%. Like the rate in Anchorage, the unemployment rate in Fairbanks was lower than the state average, but higher than the national average. Rates have remained steady with only a slight decline since 2010. The 2013-2017 average median household income in Fairbanks was $76,250.

Early Education and Educational Attainment
The graduation rate during the 2016 to 2017 school year was 77% in Fairbanks — a rate that is lower than the state average. The dropout rate of students in seventh through 12th grades in Fairbanks during the 2016 to 2017 school year was 3.7%.

Food Insecurity
At 16.3%, the rate of food insecurity among children in Fairbanks in 2017 was just below the state and national rates. More than half of children who were food insecure in Fairbanks were eligible for federal nutrition programs based on income level.

Figure 262: Percentage of Children Who Were Food Insecure in Fairbanks, 2017

---

The graduation rate during the 2016-17 school year was 77% in Fairbanks — a rate that is lower than the state average. The dropout rate of students in seventh through 12th grades in Fairbanks during the 2016-17 school year was 3.7%.

Community Input from Fairbanks

We visited Fairbanks in 2019 and met with community members and stakeholders to ascertain what they felt were the needs and assets of their communities. We met with five pediatricians, a director of a homeless shelter, a project coordinator and the directors of a nonprofit serving children with disabilities, a coordinator for Head Start, an intake specialist for an infant learning program, a nurse, a social worker, a child psychiatrist, an occupational therapist, a wellness coordinator, a care coordinator, a public health nurse, a school counselor, and a representative for the intellectual disabilities department for Alaska, in addition to three parents. Here is what we found.

Access to Care

- There are many initiatives that educate the public on resources in the community that emphasize the importance of mentorship and partners with tribal governments and academic organizations to bolster mental health support and education.
- Unfortunately, there are long waits times for counselors and no practicing pediatric psychiatrists in the Fairbanks community.
- The community is home to many families with significant medical and social issues that affect health. If children are in need of inpatient services, they must travel to Anchorage, a 6-hour drive from Fairbanks.
- Some helpful assets include a superintendent of the schools who supports counselors and the Office of Children’s Services that works to ensure that the children have access to resources they need.
- An outpatient psychiatrist travels from Anchorage for one week a month for medication management. The pediatric providers in the community work hard to fill the void of mental healthcare.
- There is legislation being passed through the Alaska House of Representatives, which would allow psychologists and social workers to see patients without psychiatry oversight and would also expand their ability to bill Medicaid for reimbursement.
• Seattle Children’s is also working with Alaska on PAL PAK, a telemedicine-based service where primary care providers can consult psychiatric services to help them manage their patients.
• Additionally, some of those interviewed mentioned that the stigma surrounding mental healthcare has improved over time, yet barriers remain as the closest inpatient care for children is in Anchorage.
• There is a long waiting period between seeking help and actually getting in to see a provider, and reimbursement sometimes limits what services are available to which children.
• Families recounted that the transition to and from mental health facilities outside the community can be difficult given the small number of providers in the community who treat children. Parents, in particular, mentioned how much they appreciate pediatricians in the community stepping in to fill the role of mental healthcare providers.

*Care Coordination and Navigating Resources*

• As resources are always changing for many reasons including recent funding cuts, it is difficult for providers and families to keep track. The families who might need services or resources most are often the families that have the greatest degree of stressors and who are striving to meet their basic needs.
• Additionally, it can be difficult for providers to remember which services or resources are available in each village. Help Me Grow was founded in Alaska and is working to create a centralized database with active care coordination to link families with resources. All Alaska Pediatric Partnership is also working on this issue.
• Access to specialty care and coordination of care are certainly obstacles in Fairbanks secondary to there being a small population of children over a large area. Transportation in Alaska is expensive and difficult to access.
• There can be multi-month waitlists for new, non-critical patients, and if patients do choose to leave the community for care or shorter wait times, they must go to Anchorage. However, care coordinators in the community work tirelessly to schedule appointments and work with parents to encourage them to take an active role in their child’s care.
• The Seattle Children’s provider consult line is valued by providers in Fairbanks. There are outreach clinics, though many stakeholders expressed the desire for more of them.

*Healthy Living*

• Fairbanks is geographically isolated which causes healthy food, like vegetables, to be expensive.
• The climate is a large barrier to keeping kids active and there is a lack of places for younger kids to be active, especially during winter. There are opportunities for older kids to play sports throughout the winter.
• There are some scholarships available for kids; however, sports and other activities can be very expensive.
• Families can use their SNAP benefits at farmer’s markets to receive double the value and the community cited the Children’s Museum and the public library do a wonderful job
organizing activities for kids. Families still need to be encouraged to take advantage of these resources.

**Community Assets and Challenges**
Participants feel that the Fairbanks community is strong and isolated and protective. For example, while some art and sports programs were suffering from budget cuts, the programs were supported by others in the community who consider them valuable. They feel that the community is doing a great job meeting certain needs, such as hunger.

**Haines**

**Demographic Overview**
Haines is located in Haines Borough near Glacier Bay National Park and Preserve in the northern part of the Alaska Panhandle. The total population in Haines Borough was on average 2,500 from 2013 to 2017 — about 22% under the age of 20.1185

<table>
<thead>
<tr>
<th>Ages</th>
<th>2008-2012 Average</th>
<th>2013-2017 Average</th>
<th>Percent change (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-4</td>
<td>130</td>
<td>165</td>
<td>26.9%</td>
</tr>
<tr>
<td>5-9</td>
<td>145</td>
<td>118</td>
<td>-18.6%</td>
</tr>
<tr>
<td>10-14</td>
<td>258</td>
<td>136</td>
<td>-47.3%</td>
</tr>
<tr>
<td>15-19</td>
<td>85</td>
<td>146</td>
<td>71.8%</td>
</tr>
</tbody>
</table>

Much like the state of Alaska as a whole, the majority of the population in Haines Borough (about 80%) was white (non-Hispanic), according to U.S. Census Bureau data from 2013 to 2017.1186 About 8% were Alaska Native/American Indian during the same time period.1187

**Figure 264: Population (All Ages) by Race/Ethnicity, Haines Borough, 2013-2017 Average**265

---

In Haines Borough, 20.5% of children and teens under age 18 lived in poverty — a rate that is slightly lower than the state average. During the 2018-19 school year, 54% of students attending the Haines Borough School District were enrolled in the free and reduced-price meal program.\(^{1188}\)

**Employment and Income**
In Haines, the unemployment rate in April 2019 (not seasonally adjusted) was 8.8%, a rate that was higher than the state and national averages.\(^{1189}\) On average from 2013 to 2017, the median household income in Haines was $70,640.\(^{1190}\)

**Early Education and Educational Attainment**
In Haines, the graduation rate during the 2016 to 2017 school year was 94.1%, a rate that was significantly higher than the state average.\(^{1191}\) The dropout rate of students in seventh through 12th grades during that school year was 1.7%.\(^{1192}\)

**Food Insecurity**\(^{1193}\)
One in five children (21.2%) were food insecure in Haines in 2017 — a significantly higher rate than the state and national averages. Just under half of the children who were food insecure were eligible for federal nutrition programs based on income level.

**Figure 265: Percentage of Children Who Were Food Insecure in Haines, 2017**\(^{266}\)

---

In Haines, the graduation rate during the 2016-17

Community Input from Haines

• Haines youth leave once they can. Opportunities exist for young adults who stay, but many leave.
• Middle school athletics sparsely exist, and the largest complaint is about isolation and lack of ways to fill time after school for youth. If youth are not invested in an activity before entering high school, it’s often too late for them to start.
• There is a public pool alongside the one high school; high school kids have a swim team and a basketball team, but no other athletic (or other youth development) activities exist.
• One summer, a group of Haines middle school age youth initiated a wrestling and cross country running team with one adult ally in the community.

Juneau

Demographic Overview
Juneau is the capital of Alaska and is located along the Gastineau Channel in the Alaska panhandle. The total population in Juneau was an average of 32,434 from 2013 to 2017 — about 24% under the age of 20. The population of children and teens under age 20 has decreased over the last five years.

Table 266: Population Change by Age Group Between 2008 to 2017, Juneau

<table>
<thead>
<tr>
<th>Ages</th>
<th>2008-2012 Average</th>
<th>2013-2017 Average</th>
<th>Percent change (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-4</td>
<td>1,961</td>
<td>1,929</td>
<td>-1.6%</td>
</tr>
<tr>
<td>5-9</td>
<td>2,088</td>
<td>2,038</td>
<td>-2.4%</td>
</tr>
<tr>
<td>10-14</td>
<td>1,993</td>
<td>1,860</td>
<td>-6.7%</td>
</tr>
<tr>
<td>15-19</td>
<td>2,373</td>
<td>2,043</td>
<td>-13.9%</td>
</tr>
</tbody>
</table>

More than two-thirds of the population in Juneau (69%) were white (non-Hispanic), and more than one in 10 people were Alaska Native/American Indian, according to U.S. Census Bureau data from 2013 to 2017.

Figure 267: Population (All Ages) by Race/Ethnicity, Juneau, 2013-2017 Average

---

In Juneau, 12.3% of children and teens under age 18 lived in poverty on average between 2013 and 2017 — a lower rate than the state average. During the 2018-19 school year, 28% of students attending the Juneau Borough School District were enrolled in the free and reduced-price meal program.

**Employment and Income**

The unemployment rate in Juneau in April 2019 (not seasonally adjusted) was 4.6%, a rate that was lower than the state average but higher than the national average of 3.3%. On average from 2013 to 2017, the median household income in Juneau was $90,749.

**Early Education and Educational Attainment**

The graduation rate during the 2016-17 school year was 85.8% in Juneau — a rate that is higher than the state average. The dropout rate of students in seventh through 12th grades during the 2016 to 2017 school year was 3.4%.

**Food Insecurity**

Food insecurity rates among children in Juneau were lower than the state average in 2017 (15.1% compared to 17.5%). Fewer than half of children who were food insecure in Juneau were eligible for federal nutrition programs based on income level.

**Figure 268: Percentage of Children Who Were Food Insecure in Juneau, 2017**

---

Community Input from Juneau

- Substance use disorder is the reality for many high students. This is often attributed to kids who are bored and fill their time with what is available since structured activities are centered around those who are academically or athletically motivated.
- Observations about the transient nature of the Juneau population – State Capitol, legislature, and state agency staff are seasonal. Additionally, summer is high tourist season, but there is not enough gainful employment to stay during the winter; this erodes community building efforts/resiliency.
- Juneau is not a wealthy area. Those who have money can invest it in activities for their kids – those who don’t, can’t. Low-income youth don’t participate in activities because everything is “pay to play” and would rather go home after school then suffer the stigma of not participating due to financial limitations.

Matanuska-Susitna Valley

Demographic Overview

Matanuska-Susitna is part of the Anchorage Metropolitan Statistical Area and had a total population of 106,532 in 2017 — more than 29% under the age of 20. The population of children and teens under age 15 grew significantly over the last decade (from 2007 to 2017), while the population decreased among teens ages 15 to 19 during the same time period.

<table>
<thead>
<tr>
<th>Ages</th>
<th>2007</th>
<th>2017</th>
<th>Percent change (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-4</td>
<td>5,621</td>
<td>7,728</td>
<td>37.5%</td>
</tr>
<tr>
<td>5-9</td>
<td>5,373</td>
<td>7,489</td>
<td>39.4%</td>
</tr>
<tr>
<td>10-14</td>
<td>6,366</td>
<td>9,108</td>
<td>43.1%</td>
</tr>
<tr>
<td>15-19</td>
<td>8,680</td>
<td>7,125</td>
<td>-17.9%</td>
</tr>
</tbody>
</table>

More than three-quarters of the population in Matanuska-Susitna (83%) were white (non-Hispanic), and about 9% of people were multiracial, according to U.S. Census Bureau data from 2013 to 2017.

---

In Matanuska-Susitna, 11.3% of children and teens under age 18 lived in poverty — a rate that is lower than the state average. During the 2018-19 school year, 48% of students attending the Matanuska-Susitna Borough School District were enrolled in the free and reduced-price meal program.

**Employment and Income**
In Matanuska-Susitna, the unemployment rate in April 2019 (not seasonally adjusted) was 7.3%, which was higher than the state and national averages. On average from 2013 to 2017, the median household income in Matanuska-Susitna was $74,887.

**Early Education and Educational Attainment**
In Matanuska-Susitna, the graduation rate during the 2016-17 school year was 81%, a rate that was higher than the state average. The dropout rate of students in seventh through 12th grades during the 2016 to 2017 school year was 1.9%.

**Food Insecurity**
In 2017, nearly one in five children (18.5%) were food insecure in Matanuska-Susitna and about half of those children were eligible for federal nutrition programs based on income level.

---

The childhood cancer incidence was 13.1 cases per 100,000 children in the Matanuska-Susitna Borough from 2011 to 2015.1214

Community Input from Wasilla, Matanuska-Susitna (Mat-Su) Valley

In the summer of 2018 we hosted a listening session in Wasilla for parents or caregivers of children ages 0-21. We had 6 people attend and themes from the evening focused on factors that affect health in their community. Specifically mentioned were:

- Income and economic factors that impact health
- Transportation
- Housing
- Education opportunities
- Family connectedness including social connection and support
- Substance use
- Access to mental and behavioral health
- Safe places to recreate

Prince of Wales-Hyder Demographic Overview

Prince of Wales–Hyder is a census area with an average population of 6,473 from 2013 to 2017 — about 26% under the age of 20.1215 Craig and Metlakatla are the largest communities in the census area.

<table>
<thead>
<tr>
<th>Ages</th>
<th>2008-2012 Average</th>
<th>2013-2017 Average</th>
<th>Percent change (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-4</td>
<td>403</td>
<td>388</td>
<td>-3.7%</td>
</tr>
<tr>
<td>5-9</td>
<td>364</td>
<td>437</td>
<td>20.1%</td>
</tr>
<tr>
<td>10-14</td>
<td>387</td>
<td>453</td>
<td>17.1%</td>
</tr>
</tbody>
</table>

Footnotes:
Nearly half of the population in Prince Wales-Hyder (47%) was white and about 41% identified as Alaska Native/American Indian on average from 2013 to 2017.1216

**Figure 273: Population (All Ages) by Race/Ethnicity, Prince Wales-Hyder, 2013-2017 Average**

![Pie chart showing population by race/ethnicity](image)

In Prince Wales-Hyder, 23.9% of children and teens under age 18 lived in poverty. During the 2018-19 school year, 74% of students attending Craig City School District and 81% of students attending Annette Island School District were enrolled in the free and reduced-price meal program.1217

**Employment and Income**

In April 2019, the unemployment rate in Prince of Wales-Hyder (not seasonally adjusted) was 11.4%.1218 The rate was nearly twice the state average and more than three times the national average. In Prince of Wales-Hyder, the median household income on average from 2013 to 2017 was $52,114.1219

**Early Education and Educational Attainment**

Annette Island School District and Craig City School District serve the Prince of Wales-Hyder area. The graduation rate during the 2016 to 2017 school year for the Annette Island School District was 85.7%, while the graduation rate for the Craig City School District was 62.2%.1220 The dropout rate of students in seventh through 12th grades for the Annette Island School

---

District during the 2016 to 2017 school year was 0.8%, compared to 1.8% for the Craig City School District.1221

**Food Insecurity**1222

About one-quarter of children in Prince of Wales-Hyder were food insecure in 2017—a rate that was significantly higher than the state and national averages. About two-thirds of children who were food insecure were eligible for federal nutrition programs based on income level.

**Figure 274: Percentage of Children Who Were Food Insecure in Prince of Wales-Hyder, 2017**1275

The graduation rate during the 2016-17 school year for the Annette Island School District was 85.7%, while the graduation rate for the Craig City School District was 62.2%.1223 The dropout rate of students in seventh through 12th grades for the Annette Island School District during the 2016-17 school year was 0.8%, compared to 1.8% for the Craig City School District.1224

**Community Input from Metlakatla, Prince of Wales-Hyder**

In 2016, members of the Care Coordination and Guest Services teams from Seattle Children’s took a trip to Alaska to meet with some of our partners to the north and experience firsthand what it is like for families to get to Children’s. The group visited Metlakatla, a village of about 1,400 people located on Annette Island, roughly 16 miles south of Ketchikan. Themes were:

*Getting to and from Seattle can be difficult*

While Annette Island Service Unit Clinic in Metlakatla provides some pediatric care, travel to Seattle or Anchorage may be required to receive certain types of treatment. The difficulty of getting from Metlakatla to basically anywhere else varies greatly with the weather. In good weather, a 15-minute float plane ride or a 45-minute ferry ride gets travelers to Ketchikan. If the weather is bad, the float plane and the ferry may not operate. In an emergency, the Coast Guard can be called on to use their boat to get people from Metlakatla to Ketchikan. From Ketchikan, families can take a direct flight to Seattle. If a family is referred to Anchorage, they may end up on the milk run—a term locals use to describe the five-hour plane ride from Ketchikan to

---

Anchorage, with stops in Juneau and/or Sitka along the way. It is possible that from Anchorage they may need to come to Seattle to be seen at Children’s. This can make for a very long, physically and mentally exhausting journey.

*Resources may not be as readily available at home as they are elsewhere*

While scheduling a blood draw, refilling a prescription or receiving medical supplies may be routine and relatively easy to accomplish in a city, when you live in a remote village these things can be very difficult. Seeing the intricacies of getting care in a place like Metlakatla helped the team realize they have to consider the details when discharging a patient. For example, does the patient need to be sent home with a week’s worth of medication, rather than just a one- or two-day supply (the pharmacy in Metlakatla is not open on the weekends)? Or, do they need specific medical equipment that could be delivered to a patient’s home before they arrive? There is no such thing as “next day air” in many of the small towns and villages in Alaska. If weather is bad, delivery can be impacted even more.

*Being in away from home can be a very different and jaarring experience for some patients and families*

Families coming to Seattle from small towns and villages may have never been on an airplane, in an elevator or seen an escalator. The food and food portions may be very different. Getting food in the cafeteria during a busy time can be intimidating, just as navigating the hospital may be. Metlakata residents shared that understanding the perspective of their families helps other care providers empathize and anticipate how patients and families might feel when they get to an outside hospital.

When the locals in Metlakatla found out the team was visiting, they donated jars of canned salmon and seaweed, local favorites. Many families can't make financial donations but wanted to contribute something to the families currently staying at Children's.

*Advice for non-Metlakatla providers: keep connecting and learning*

Community input focused on how important it is for all of us to take opportunities to learn about our patients and families — where they came from, what their lives are like at home and what we can do to serve them better. Advice like simply looking at a map to see where a family is from, or by asking questions and talking with them about what their life is like at home. Showing genuine interest and helping traveling families acclimate to Seattle can go a long wa.

*Sitka*

**Demographic Overview**

Sitka is located on the outer coast of the Alaska Panhandle. The total population in Sitka was an average of 8,810 from 2013 to 2017 — about 24.8% under the age of 20.1225
Table 275: Population Change by Age Group Between 2008 to 2017, Sitka

<table>
<thead>
<tr>
<th>Ages</th>
<th>2008-2012 Average</th>
<th>2013-2017 Average</th>
<th>Percent change (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-4</td>
<td>588</td>
<td>450</td>
<td>-23.5%</td>
</tr>
<tr>
<td>5-9</td>
<td>472</td>
<td>578</td>
<td>22.5%</td>
</tr>
<tr>
<td>10-14</td>
<td>624</td>
<td>612</td>
<td>-1.9%</td>
</tr>
<tr>
<td>15-19</td>
<td>668</td>
<td>548</td>
<td>-18%</td>
</tr>
</tbody>
</table>

More than half of the population in Sitka (65%) was white and 14% identified as Alaska Native/American Indian on average from 2013 to 2017.1226

Figure 276: Population (All Ages) by Race/Ethnicity, Sitka, 2013-2017 Average

In Sitka, 12.1% of children and teens under age 18 lived in poverty. During the 2018-19 school year, 39% of students attending the Sitka School District were enrolled in the free and reduced-price meal program.1227

Employment and Income
In Sitka, the unemployment rate in April 2019 (not seasonally adjusted) was 4.2% — a rate that was lower than the state average, but higher than the national average.1228 On average from 2013 to 2017, the median household income in Sitka was $70,765.

Early Education and Educational Attainment

---

In Sitka, the four-year adjusted cohort graduation rate during the 2016 to 2017 school year was 78.1%, a rate that was about the same as the state average. The dropout rate of students in seventh through 12th grades during the 2016 to 2017 school year was 2.3%.

**Food Insecurity**
The rate of food insecurity among children in Sitka was 15.9% in 2017. Half of all children who were food insecure were eligible for federal nutrition programs based on income level.

**Figure 277: Percentage of Children Who Were Food Insecure in Sitka, 2017**

In Sitka, the four-year adjusted cohort graduation rate during the 2016-17 school year was 78.1%, a rate that was about the same as the state average. The dropout rate of students in seventh through 12th grades during the 2016-17 school year was 2.3%.

**Community Input from Sitka**

- Sitka, too, is home to a transient population, heavily impacted by summer tourism.
- Recently, the area hosted the “Sitka Health Summit” where community members proposed 33 initial projects in a variety of categories such as physical activity, nutrition, mental health, health equity, etc. and narrowed down to two. The final two were reducing carbon emissions and beginning trauma-informed community conversations.
  - The two chosen projects each will receive $2,000 in seed money, as well as some facilitation services from the Sitka Health Summit advisory team, to help get the projects off the ground.

**Spotlight on Idaho**
Idaho is the 14th largest state in the country by total area, but ranks 39th in the country by total population. In 2018, the population of Idaho was more than 1.7 million, with about 25% under the age of 20. The most densely populated areas of Idaho are in Ada County and Canyon County. This includes the cities of Boise and Nampa.

**Community Social and Economic Context**

---

The health of children, teens and young adults is influenced by a variety of environmental and social factors. Social risk factors, such as poverty and a lack of health insurance coverage, as well as racial/ethnic minority status, are all associated with poorer health outcomes for youth.

**Youth of Idaho**

Across Idaho, the total population has grown by 14.5% from 2007 to 2017 (a 7.6% increase over a five-year period from 2012 to 2017). Among youth under age 20, the population grew by 9.8% over a 10-year period from 2007 to 2017, with greatest population growth among children and teens ages 10 to 19.

<table>
<thead>
<tr>
<th>Ages</th>
<th>2007</th>
<th>2017</th>
<th>Percent change (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-4</td>
<td>116,953</td>
<td>116,226</td>
<td>-0.6%</td>
</tr>
<tr>
<td>5-9</td>
<td>109,456</td>
<td>119,492</td>
<td>9.2%</td>
</tr>
<tr>
<td>10-14</td>
<td>112,455</td>
<td>131,776</td>
<td>17.2%</td>
</tr>
<tr>
<td>15-19</td>
<td>110,956</td>
<td>126,390</td>
<td>13.9%</td>
</tr>
</tbody>
</table>

Idaho has a predominately white, non-Hispanic/Latinx population, with more than 90% of the residents self-reporting as being white alone. There is an increasing Hispanic/Latinx population in the state. On average from 2013 to 2017, about 12% of the population was Hispanic or Latinx.

**Figure 279: Population (All Ages) by Race/Ethnicity, Idaho, 2013-2017 Average**

---

U.S. Census Bureau data for Idaho shows that nearly 5.9% of the population is foreign-born, and 10.7% of people ages 5 and over speak a language other than English at home.\textsuperscript{1238}

**Poverty among Youth**

In 2017, 15% of children and teens under age 18 in Idaho lived in poverty, a decrease from previous years and a rate that is lower than the national average of 18%.\textsuperscript{1239}

**Figure 280: Percentage of Children Under 18 Living in Poverty in Idaho, 2008-2017\textsuperscript{281}**

During the 2017-18 school year, nearly 49% of students received free or reduced-price lunch in Idaho.\textsuperscript{1240} The rate has stayed fairly stable over the past decade. These rates vary across the state, with 21.3% of students receiving free or reduced-price lunch in the Troy School District near the city of Moscow compared to 89.9% of students in the Aberdeen School District.

**Housing Affordability and Availability**

According to the U.S. Department of Housing and Urban Development (HUD), households that spend more than 30% of their income on housing expenses — rent/mortgage payments, taxes, insurance and related expenses — are less likely to have enough money for food, clothing, medical care and other needs.\textsuperscript{1241}

In Idaho in 2017, 24% of households with children had a high housing cost burden, where more than 30% of their monthly income went to housing expenses.\textsuperscript{1242} This is down from a high of 36% of households with children that had a high housing cost burden in 2010.\textsuperscript{1243}

**Figure 290: Percentage of Households With Children With High Housing Cost Burden in Idaho, 2008-2017\textsuperscript{282}**

Among children in Idaho living in low-income households (families with an income less than 200% of the federal poverty level), half of them had a high housing cost burden in 2017.\textsuperscript{1244}

**Figure 291: Percentage of Children in Low-income Households With High Housing Cost Burden in Idaho, 2008-2017\textsuperscript{283}**

About one in 10 children (11%) lived in crowded households in Idaho in 2017. A crowded household is one where there is more than one person per room.\textsuperscript{1245}

**Youth Experiencing Homelessness**

The rate of homelessness in Idaho is below the national average. In 2017, an estimated 5.1 out of every 10,000 families were homeless in Idaho, compared to the national average of 7.4 out of every 10,000 families.\textsuperscript{1246}

According to the 2018 Point in Time Count taken in January 2018, 2,012 people in Idaho experience homelessness on any given day, which includes 209 families with children and 115 unaccompanied young adults ages 18 to 24.\textsuperscript{1247}

During the 2016-17 school year:\textsuperscript{1248}

- 7,143 youth enrolled in public schools in Idaho were homeless at some point during the year — a 5% increase over the previous school year.
- 856 children/youth enrolled in public schools were considered unaccompanied youth during the 2016 to 2017 school year.

**Figure 292: Number of Homeless Children/Youth in Idaho Enrolled in Public Schools by Year, 2016-2017 School Year\textsuperscript{284}**

---

The majority (84%) of the students who were homeless were doubled up, meaning they may live with another family, and 3.9% were unsheltered.1249

**Figure 293: Percentage of Homeless Children/Youth in Idaho Enrolled in Public Schools by Type of Primary Nighttime Residence, 2016-2017 School Year**285
Employment and Income

The Idaho unemployment rate in 2018 and the first four months of 2019 are below the national average. In April 2019, the unemployment rate in Idaho was 2.8% (seasonally adjusted), compared to 3.6% (seasonally adjusted) in the United States. As of April 2019, Idaho had stayed at or below a 3% unemployment rate (seasonally adjusted) for 17 consecutive months.

Figure 294: Idaho Unemployment Rates Compared to United States, 2018 to 2019

---

On average from 2013 to 2017, the median household income in Idaho was $50,985, which is significantly less than the U.S. median household income of $57,652 during the same time period. In households with children under age 18, the median family income in Idaho was $59,673.

**Figure 295: Median Household Income by Race/Ethnicity in Idaho, 2013-2017**

---

The median household income in Idaho varies by race/ethnicity. On average from 2013 to 2017, individuals identifying as Asian (representing about 1% of the population) had the highest median income ($57,434), while people identifying as Black/African American (representing 0.5% of the population) had the lowest median household income ($37,216).  

**Early Education**

The Idaho Head Start program provided early childhood education services to more than 5,000 low-income children from birth through age five during the 2017-18 school year. These services were provided through 13 Head Start programs at 78 sites. 

**Figure 296: Idaho Head Start Program Statistics, Program Year 2017 to 2018**

High-quality early education, such as preschool or pre-kindergarten for children ages 3 and 4, can help with school preparedness. From 2015 to 2017, 65% of children ages 3 and 4 were not enrolled in school in Idaho.  

**Table 297: Children Ages 3 and 4 Not in School in Idaho, 2012-2017**

<table>
<thead>
<tr>
<th>Year</th>
<th>Number of children (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012-2014</td>
<td>33,000 (69%)</td>
</tr>
<tr>
<td>2013-2015</td>
<td>32,000 (69%)</td>
</tr>
<tr>
<td>2014-2016</td>
<td>32,000 (68%)</td>
</tr>
<tr>
<td>2015-2017</td>
<td>31,000 (65%)</td>
</tr>
</tbody>
</table>

**Educational Attainment**

The four-year graduation rate in Idaho for the 2017-18 school year was 80.6%. Graduation rates differed by gender, race/ethnicity, income level, living situation (i.e. foster care, homelessness), and whether or not students had disabilities or were English language learners. Among racial/ethnic groups, students identifying as American Indian/Alaska Native had the lowest graduation rates (60.7%).  

---

Foster Care
Foster placement services are provided when children need short-term or temporary protection because they are abused, neglected or involved in family conflict. Of the nearly 436,000 children under age 18 who lived in Idaho in 2016, 1,516 children were in foster care — a rate of 3 children in foster care per 1,000 children in the state. This is half the U.S. rate of 6 children in foster care per 1,000 children.\textsuperscript{1259} During that same year, 1,076 children exited foster care in Idaho for various reasons, including adoption (16%) and being reunified with a parent or primary caretaker (72%).\textsuperscript{1260}

Life Expectancy and Leading Causes of Death and Hospitalization
Life expectancy rates and leading causes of death and hospitalization are often used as health measures to monitor progress in promoting well-being, preventing disease and disability, and reducing health disparities. Longer life expectancy rates indicate better health.

Life Expectancy
From 2010 to 2015, the life expectancy rate in Idaho was 79.4 years, which is just above the national average of 78.7 years.  

Leading Causes of Death
Across the United States, injuries were the leading causes of death among youth under age 19 in 2016. On average from 2013 to 2017, the leading causes of death in Idaho for youth ages 1 to 14 were unintentional injuries. Suicide was the second leading cause of death for adolescents and teens ages 10 to 19. Congenital anomalies were the leading causes of death among children under age 1. Motor vehicle crashes, unintentional drownings and unintentional poisonings were leading causes of unintentional injury deaths for youth ages 1 to 19.

Figure 299: Leading Causes of Death in Idaho by Age and Number of Deaths, 2013-2017

<table>
<thead>
<tr>
<th>Rank</th>
<th>Age Groups</th>
<th>&lt;1</th>
<th>1-4</th>
<th>5-9</th>
<th>10-14</th>
<th>15-19</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Congenital anomalies</td>
<td>Unintentional injuries</td>
<td>Unintentional injuries</td>
<td>Unintentional injuries</td>
<td>Unintentional injuries</td>
<td></td>
</tr>
<tr>
<td>152</td>
<td>59</td>
<td>33</td>
<td>60</td>
<td>136</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Short gestation</td>
<td>Congenital anomalies</td>
<td>Malignant neoplasms</td>
<td>Suicide</td>
<td>Suicide</td>
<td></td>
</tr>
<tr>
<td>72</td>
<td>15</td>
<td>10</td>
<td>24</td>
<td>106</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>SIDS</td>
<td>Homicide</td>
<td>Congenital anomalies</td>
<td>Malignant neoplasms</td>
<td>Malignant neoplasms</td>
<td></td>
</tr>
<tr>
<td>61</td>
<td>16</td>
<td>16</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Maternal pregnancy complications</td>
<td>Malignant neoplasms</td>
<td>Homicide</td>
<td>Heart disease</td>
<td>Heart disease</td>
<td></td>
</tr>
<tr>
<td>50</td>
<td>50</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Placenta cord membranes</td>
<td>Heart disease</td>
<td>Influenza &amp; pneumonia</td>
<td>Congenital anomalies</td>
<td>Homicide</td>
<td></td>
</tr>
<tr>
<td>27</td>
<td>27</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Unintentional injuries</td>
<td>Anemias</td>
<td>Septicemia</td>
<td>Chronic lower respiratory disease</td>
<td>Congenital anomalies</td>
<td></td>
</tr>
<tr>
<td>23</td>
<td>23</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Hydrops fetalis</td>
<td>Chronic lower respiratory disease</td>
<td>Heart disease</td>
<td>Homicide</td>
<td>Diabetes mellitus</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>Neonatal hemorrhage</td>
<td>Influenza &amp; pneumonia</td>
<td>Suicide</td>
<td>Cerebrovascular</td>
<td>Complicated pregnancy</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>Homicide</td>
<td>Pneumonitis</td>
<td>Complicated pregnancy</td>
<td>Influenza &amp; pneumonia</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>Necrotizing</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Children and Youth with Special Healthcare Needs/Chronic Conditions

Children with special health care needs are defined as children under age 18 who have or are at increased risk of a chronic physical, developmental, behavioral, or emotional condition, and who also require health and related services of a type or amount beyond that required by children generally. Because of their complex needs, these families often require services from multiple systems such as education and social services, in addition to health care. As such, the national Maternal and Child Health Block Grant, one of the largest federal block grant programs, outlines specific expectations for states related to meeting the health care needs of the CYSHCN population.

One in every five U.S. families has a child with a special health care need. Nationwide this is over 13 million children. The percent of children in a state who have a special health care need ranges from a low of only 13% (Hawaii) to a high of 24%; about 1 of every 4 children living in Kentucky, Mississippi, and West Virginia has a special health care need. Idaho, at 18%, has a slightly lower percent of children with special needs compared to the nation (19%).

In 2016 to 2017, more than 77,000 Idaho children had special healthcare needs (based on the federal Maternal and Child Health Bureau’s definition). This represents the number of children under age 18 who are at increased risk of a chronic behavioral, emotional, physical or developmental condition, and who require health services or related services of an amount or type beyond what is required by most children. The 2016 National Survey of Children’s Health found that less than 12% of CYSHCN in Idaho receive care in a “well-functioning system.” This data aligns with what the state learned when it conducted its most recent MCH needs assessment. As part of the MCH Block Grant process, each state conducts a needs assessment every five years. The results of the needs assessment help determine the state maternal and child health priorities. Of the current eight MCH state priorities in Idaho, two relate to CYSHCN - improving access to medical homes and improving access to medical specialists.

Key strategies in Idaho planned to improve access to medical homes include:
- Supporting the medical home demonstration to improve quality of care for CYSHCN in rural areas.
- Supporting the Idaho Children’s Special Health Program to provide financial support to uninsured CYSHCN.
- Developing and disseminating age-specific transition tool kits for youth with special health care needs.
- Partnering with Idaho Parents Unlimited, the state’s Family to Family Resource Center, to increase parent engagement, provide parent education, assist with parent navigation, and provide program consultation.
Key strategies planned to improve access to medical specialists in Idaho include:
- Hosting a statewide learning collaborative for pediatric and family practice clinics related to developmental screening.
- Supporting quality improvement activities to improve depression screening among adolescents.
- Supporting the Idaho Newborn Screening Program to detect disorders and link children to appropriate specialist care.
- Implementing Critical Congenital Heart Defect screening for all newborns.
- Funding pediatric specialty clinics across the state.
Exploring telehealth options with the goal of linking Idaho primary care providers to pediatric specialists to increase specialty care to CYSHCN in areas lacking such care.

**Asthma**
Asthma is one of the most common chronic diseases nationwide affecting nearly one in every 12 children (about 8.1%). On average from 2016 to 2017, 7% of children in Idaho had problems associated with asthma over the past year. According to the 2017 Idaho Youth Risk Behavior Survey, 19.3% of high school students surveyed reported that they had been told by a doctor or nurse that they had asthma during their life.

**Cancer**
Cancer incidence in children from birth to age 20 in the United States was an average of 17.9 cases per 100,000 children/young adults from 2011 to 2015. About 70,000 teens and young adults ages 15 to 39 are diagnosed with cancer each year in the United States. This accounts for 5% of cancer diagnoses in the country and is about six times the number of cancers diagnosed in children from birth to age 14. Cancer is the leading cause of disease-related death in the United States among adolescents and young adults.

In Idaho, cancer incidence in children from birth to age 20 was an average of 17.4 cases per 100,000 from 2011 to 2015.

**Transplants**
More than 113,000 people in the nation are waiting for a life-saving organ transplant. An average of 18 people (children and adults) die each day from a lack of available transplant organs. All patients waiting for a transplant from a deceased donor in the United States have equal access to donated organs and are listed with the United Network for Organ Sharing (UNOS). In the Northwest (UNOS region 6: Washington, Alaska, Idaho, Montana, Oregon and Hawaii), more than 3,000 people are currently in need of life-saving organ transplants — 85 of those under age 18. UNOS does, however, allow for special allowances for children under certain circumstances. Since pediatric patients need smaller organs, for example, they will receive priority if the donor is younger than 18.

**Healthcare Access and Preventative Care**

**Access to Care**
In 2017, 5% of children in Idaho were uninsured — a rate that has declined from 13% in 2008.\textsuperscript{1286} For this report from the Kaiser Family Foundation, the term “uninsured” includes children without health insurance and children who have coverage under the Indian Health Service only.\textsuperscript{1287}

**Figure 300: Percentage of Children Ages 0 to 18 Without Health Insurance Coverage in Idaho, 2008-2017\textsuperscript{292}**

---

**Immunization Rates**

Immunization coverage in Idaho is based on the immunization schedule developed by the Centers for Disease Control and Prevention (CDC). These estimates are collected through the National Immunization Survey.

According to the most recent data from 2017, 69.2% of children ages 19 to 35 months had completed the recommended 4:3:1:3:3:1:4 immunization series.\textsuperscript{1288} Immunization rates for children ages 19 to 35 months have increased every year over the last decade.

**Figure 301: Childhood Immunization Rate in Idaho (4:3:1:3:3:1:4 Series), Ages 19 to 35 Months, 2008-2017\textsuperscript{293}**


Oral Healthcare
In 2016 and 2017, 83% of children under the age of 18 in Idaho had received preventive dental care within the past year — this is compared to 80% of children in the United States over the same time period.\textsuperscript{1289}

Four out of five high school students in Idaho (81.1%) reported that they saw a dentist (for a check-up, exam, teeth cleaning or other dental work) over the past 12 months in 2017.\textsuperscript{1290}

Mental and Behavioral Health
Mental and behavioral health encompasses a range of conditions, such as depression, lack of social support, bullying and suicidal behavior.

According to a 2019 report from Mental Health America, Idaho ranked 50th in the country (which includes 50 states plus the District of Columbia) for the prevalence of mental illness and access to care for youth.\textsuperscript{1291} This ranking means Idaho has one of the highest rates of mental illness and one of the lowest rates of access to mental healthcare services for youth compared to other states in the country.\textsuperscript{1292} Additionally, the National Survey of Children’s Health found that of children ages 3 through 17 in Idaho who have a mental or behavioral condition, almost 40% do not receive treatment or counseling.\textsuperscript{1293}

In 2017, 71.5% of Idaho youth in ninth through 12th grades reported that there was at least one teacher or other adult in their school they could talk to if they had a problem.\textsuperscript{1294}

Figure 302: Rankings of States Based on Prevalence of Mental Illness and Access to Care for Youth, 2019\textsuperscript{294}

---

\textsuperscript{291} Mental Health America. (2019). \textit{Ranking the states}. Retrieved from \url{http://www.mentalhealthamerica.net/issues/ranking-states}.  

\textsuperscript{294} Immunization Rate for Children Ages 19 to 35 Months in Idaho (4:3:1:3:1:4 Series)
Of children with a special health care need, there is a significant subset comprised of children who have one or more emotional, behavioral, or developmental conditions. Specifically, this is defined as children age 2 to 17 who have autism, developmental delays, depression, anxiety, ADD/ADHD, or behavioral/conduct problems. Some of these children with emotional, behavioral, or developmental conditions also do have a chronic physical condition. Nationwide, 21% of children have one or more emotional, behavioral, or developmental conditions. State distribution ranges from a low of only 15% in Hawaii to a whopping 27% of children in Arkansas, Louisiana, Maine, Mississippi, and West Virginia. States in the WAMI region are on par with the national average; 21% of Idaho’s children meet these criteria.

**Bullying**

Across Idaho, the rates of bullying and bullying through the use of technology (cyberbullying) have increased steadily over the last decade. Students who are bullied are more likely than their peers to be lonely, anxious, depressed, have low self-esteem, feel unwell and consider suicide.

In 2017, 25.8% of high school students in Idaho reported that they were bullied on school property one or more times in the past year — this is up from 22.3% in 2009 (the first year when the question was asked).

**Figure 303: Percentage of Idaho Students Who Were Bullied on School Property One or More Times in Past Year, Grades 9-12, 2017**

---

In Idaho, female students and ninth graders reported bullying at higher rates than male students and those in 10th through 12th grades.

**Figure 304: Percentage of Idaho Students Who Were Bullied on School Property One or More Times in Past Year, Grades 9-12, Over Time (2009-2017)**

---

About one in five high school students in Idaho reported that they were cyberbullied in the past year — up from 17% in 2011. This includes bullying through texts, Instagram, Facebook or other social media.

**Figure 305: Percentage of Idaho Students Who Were Electronically Bullied (Cyberbullied) During the Past Year, Grades 9-12, Over Time (2011-2017)**

Other findings from the 2017 Idaho Youth Risk Behavior Study:

- Female students were more likely than male students (38% compared to 28%) to have been called names or teased because of their size, weight or physical appearance over the past year.
- Students identifying as Hispanic were nearly four times more likely than students identifying as white (30% compared to 8%) to report being called names or teased because of their race/ethnicity over the past year.
- About 12% of students reported that they had been called names or teased over the past year because someone thought they were gay, lesbian or bisexual.

It is important to consider the impact and prevalence of bullying in thinking about youth mental health. Students who reported being harassed or bullied were more likely to have lower grades in school, drop out of school, and may experience depression, anxiety, low self-esteem and have suicidal thoughts. Several studies have found an association between bullying and depression. Notably, youth who report bullying or cyber-bullying were at a higher risk for reporting suicidal ideation and attempts. In addition, students who bully others are more

---

likely to have academic problems, substance abuse problems, and to experience violence later in life.\textsuperscript{1301}

**Depression**\textsuperscript{1302}
Depression is a mental illness that may go undetected and untreated, leading to adverse consequences for a person and those around them. Early signs of depression can include long durations of sadness or hopelessness that impacts a person’s day-to-day activities.

In 2017, more than one in three Idaho high school students (35\%) reported feeling sad or hopeless almost every day for at least two weeks in a row over the past year. This rate has increased from 27.4\% in 2007.

**Figure 306: Percentage of Idaho Youth Who Experienced Depressive Feelings Almost Every Day for More Than Two Weeks in a Row Over Past Year, Grades 9-12, 2007-2017\textsuperscript{298}**

![Graph showing percentage of students who felt sad or hopeless almost every day for more than two weeks in a row over past year, Grades 9-12, 2007-2017.](image)

**Suicidal Ideation**\textsuperscript{1303}
Suicide was the second leading cause of death among youth ages 10 to 19 in Idaho in 2015 — accounting for 25 deaths among this age group. Idaho consistently ranks among the 10 states with the highest rate of suicide in the country.\textsuperscript{1304}

Like depression, the rates of suicidal ideation among Idaho youth in high school have also increased over the last decade. In 2017, nearly 22\% of high students had seriously considered suicide — up from 17.1\% in 2007 — and 10\% of students attempted suicide during the past year.

Female students were more than twice as likely as male students in ninth, 10th and 11th grades to consider attempting suicide.

Figure 308: Percentage of Idaho Students Who Seriously Considered Attempting Suicide During the Past Year, Grades 9-12, Over Time (2007-2017)

---


Substance Use
Across Idaho, the rates of alcohol use and cigarette smoking have declined over the last decade among high school youth, while marijuana use has remained fairly stable.

Alcohol Use\textsuperscript{1305}
According to the 2017 Idaho Youth Risk Behavior Survey, more than one-quarter (26.5\%) of high school students had at least one drink of alcohol in the past 30 days. Rates declined by nearly 38\% from 2007 to 2017. Other than a few sips, 15.5\% of students had their first drink of alcohol before the age of 13.

Nearly half (47\%) of students who reported drinking alcohol during the 30 days before the survey said that someone gave them the alcohol they drank.

Figure 309: Percentage of Idaho Youth in High School Who Drank at Least One Drink of Alcohol in Past 30 Days, 2007-2017\textsuperscript{303}

More than 15% of high school students reported binge drinking during the past 30 days in Idaho in 2017. The survey defined binge drinking as four or more drinks in a row for females and five or more drinks in a row for males. The rates of binge drinking were higher among female students than male students.

Figure 310: Percentage of Idaho Youth in High School Who Were Binge Drinking During the 30 Days Before the Survey, 2017

---

Over the last decade, there have been declines in current and frequent cigarette smoking rates among Idaho youth in grades nine through 12. In 2017, 9.1% of high school students in Idaho reported smoking cigarettes at least once in the past 30 days — a decline from 20% in 2007.

Students in 12th grade reported higher rates of cigarette smoking compared to students in ninth, 10th and 11th grades. Male students also smoked cigarettes at higher rates than female students (9.8% compared to 8.3%) in 2017.

**Figure 311: Percentage of Idaho Youth Who Smoked Cigarettes at Least Once in Past 30 Days, Grades 9-12, 2017**

---

Tobacco Use

Over the last decade, there have been declines in current and frequent cigarette smoking rates among Idaho youth in grades nine through 12. In 2017, 9.1% of high school students in Idaho reported smoking cigarettes at least once in the past 30 days — a decline from 20% in 2007.

Students in 12th grade reported higher rates of cigarette smoking compared to students in ninth, 10th and 11th grades. Male students also smoked cigarettes at higher rates than female students (9.8% compared to 8.3%) in 2017.

**Figure 311: Percentage of Idaho Youth Who Smoked Cigarettes at Least Once in Past 30 Days, Grades 9-12, 2017**

---

Also from the 2017 Youth Risk Behavior Survey:
- 2.6% of high school students in Idaho were frequent smokers, meaning they smoked 20 or more of the past 30 days.
- Nearly 28% of students reported that they had tried smoking cigarettes (even one or two puffs) during their lifetime — a decrease from 48% in 2007.
- Nearly one in 10 high school students (8.5%) reported that they had smoked a whole cigarette for the first time before the age or 13.

Figure 312: Percentage of Idaho High School Students Who Smoked Cigarettes at Least Once in Past 30 Days, Grades 9-12, 2007-2017

---

The rate of smokeless tobacco use (chewing tobacco, snuff or dip) among high school students in Idaho declined by 60% — from 11.8% in 2007 to 4.7% in 2017.

**Figure 313: Percentage of Idaho High School Students Who Used Smokeless Tobacco (i.e. Chewing Tobacco, Snuff or Dip) at Least Once in Past 30 Days, Grades 9-12, 2007-2017**

---

Smokeless tobacco use was higher among 12th grade students than younger students, and significantly higher among male students than female students (7.3% compared to 2.1%).

**Figure 314: Percentage of Idaho High School Students Who Used Smokeless Tobacco (i.e. Chewing Tobacco, Snuff or Dip) at Least Once in Past 30 Days, Grades 9-12, 2007-2017**

In 2017, about 14% of high school students in Idaho reported that they used electronic vapor products in the past 30 days, and 41% of high school students had used an electronic vapor product at least once during their lifetime.

Compared to students who were white, students identifying as Hispanic were more likely to report using an electronic vapor product at least once in the previous 30 days (39% compared to 50%).

**Figure 315: Percentage of Idaho High School Students Who Used Electronic Vapor Products at Least Once in Past 30 Days, 2017**

---


Marijuana Use\textsuperscript{309}
Over the last decade, the percentage of students who used marijuana at least once in the past 30 days has not changed significantly.

- In 2017, 16.2\% of students used marijuana at least once in the past month, down from 17.9\% in 2007.
- Nearly one in three high school students (30\%) reported that they had used marijuana at least once in their life, and 6.8\% of students reported using synthetic marijuana at least once.
- About 6\% had used marijuana for the first time before the age of 13.
- Students identifying as Hispanic reported using marijuana during their lifetime at significantly higher rates than students identifying as white (41\% compared to 27\%).

\textit{Figure 316: Percentage of Idaho Youth Who Used Marijuana at Least Once in Past 30 Days, Grades 9-12, 2007-2017}\textsuperscript{308}
Female students, and students in 11th and 12th grades reported the highest rates of using marijuana at least once during the past 30 days. Nearly one in four females in 12th grade (24.4%) reported using marijuana in the last month.

Figure 317: Percentage of Idaho Youth Who Used Marijuana at Least Once in Past 30 Days, Grades 9-12, 2017

Prescription Drug Use

In 2017, 13.9% of high school students in Idaho reported taking a prescription medication without a doctor’s prescription in the past month. The rates were highest among female students and 11th graders.

More students identifying as Hispanic reported using prescription drugs without a doctor’s prescription one or more times during their life than students identifying as white (17% compared to 13%).

Figure 318: Percentage of Idaho Youth Who Took a Prescription Drug Without a Doctor’s Prescription at Least Once in Past 30 Days, Grades 9-12, 2017
Maternal and Child Health

Maternal and child health outcomes are markers of a community’s overall health. Some of these markers include infant mortality, early prenatal care and the birth weight of babies.

Early and Adequate Prenatal Care

Beginning prenatal care early in the pregnancy and having regular visits with a provider can improve the chances of a healthy pregnancy. It is recommended that women begin prenatal care in the first trimester of the pregnancy (before the fourth month of pregnancy). The national Healthy People 2020 goal is for at least 77.9% of pregnant women to receive prenatal care in the first trimester.

In Idaho, there have been steady improvements in the rate of prenatal care beginning in the first trimester of pregnancy. In 2017, 78.3% of women in Idaho who gave birth received prenatal care in the first trimester, compared to 77.3% nationally. In 2016, 77.7% of women from Idaho who gave birth had received early and adequate prenatal care, compared to 75.6% nationally.

Infant Mortality

One of the measures of the overall health of a population is the infant mortality rate because many of these deaths are preventable. The infant mortality rate refers to the number of babies per 1,000 live births who die before their first birthday in a given year.

The Healthy People 2020 goal for infant mortality is less than 6.0 deaths per 1,000 live births. In 2016, the infant mortality rate in Idaho was 6.1 deaths per 1,000 live births, which was more than the national infant mortality rate of 5.9 deaths per 1,000 live births. The infant mortality rate in Idaho was up from the previous eight years. The rate was 4.6 deaths per 1,000 live births in 2015, compared to 5.5 deaths per 1,000 live births in 2014 and 5.6 deaths per 1,000 live births in 2013.
**Low Birth Weight**

Infants born weighing less than 2,500 grams (about 5.5 pounds) are considered low birth weight. This increases their risk of infant mortality and developing neurodevelopmental disabilities and respiratory disorders.

In 2017, 7% of infants born in Idaho were low birth weight, which meets the Healthy People 2020 objective of 7.8% or fewer infants born at low birth weight. This rate has increased slightly each year over the last decade from 6.5% in 2008.

**Weight-Related Health and Behavior**

**Obesity and Overweight Prevalence**

Children, teens and young adults are considered overweight if their body mass index (BMI) is in the top 15% for their age and gender. They are considered obese if their BMI is in the top 5% for their age and gender.

In Idaho from 2016 to 2017, 13.4% of children ages 10 to 17 were considered obese, which is less than the national rate of 15.8%. There has been an increase in the rate of overweight and obese teens in Idaho over the last decade. Nearly 15% of students in Idaho were overweight and about 11% were obese in 2017.

**Figure 319: Percentage of Idaho Youth Who Were Overweight, 2007-2017**

---

Overall, male high school students in Idaho were more likely than female students to be overweight or obese (27.4% compared to 24.8%).

Food Insecurity
Food insecurity is defined as an uncertainty of having or an inability to acquire enough food for all household members because of insufficient money or other resources.\(^{1317}\)

Federal and state assistance programs have been shown to reduce child food insecurity rates and lessen the health impacts of food insecurity among children.\(^{1318}\) These programs include the Supplemental Nutrition Assistance Program (SNAP), national school meal programs and the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC).

In Idaho, the rate of food insecurity among children was under the national average in 2017 (15.8% compared to 17%).\(^{1319}\) About two-thirds of children who were food insecure were eligible for federal nutrition programs based on income level.\(^{1320}\)

As of March 2019, about 147,000 children in Idaho participated in the National School Lunch Program, and more than 71,000 children participated in the National School Breakfast Program.\(^{1321}\) Also in March 2019, about 67,000 households (more than 148,000 people) in Idaho participated in SNAP, and about 31,000 people participated in WIC.\(^{1322}\)

**Figure 322: Percentage of Children Who Were Food Insecure in Idaho, 2017\(^{314}\)**

---

**Fruit and Vegetable Consumption**

Eating fruits and vegetables lowers the risk of developing many chronic diseases and can support weight management.

In 2017, 12.5% of high school students in Idaho reported that they ate vegetables three or more times per day in the past week. This rate has stayed between 11% to 14% over the past decade.

**Figure 323: Percentage of Idaho Youth Who Ate Vegetables 3+ Times Per Day in Past Week, Grades 9-12**

Nearly 15% of high school students in Idaho reported that they ate fruit or drank 100% fruit juice three or more times per day in the past week in 2017. This rate has also stayed about the same over the past decade.

---

Physical Activity

To maintain a healthy lifestyle, children and adolescents should participate in at least 60 minutes of physical activity every day. In 2017, about half (50.4%) of high school students in Idaho reported that they were physically active for at least 60 minutes per day on five or more of the past seven days.

Figure 325: Percentage of Idaho Youth Who Were Physically Active for 60 Minutes on Five or More of the Past Seven Days, 2007-2017

---

Male students were more likely than female students to be physically active for 60 minutes on five or more days within a week (58.5% compared to 42.2%).

Figure 326: Percentage of Idaho Youth Who Were Physically Active for 60 Minutes on Five or More of the Past Seven Days, Grades 9-12, 2017

Youth are participating in sedentary activities at increasing rates. In 2017, about 37% of students in Idaho reported spending three or more hours a day on an average school day playing video or

---

computer games or using a computer for something other than schoolwork. About 17% of students spent three or more hours watching TV on a school day.

**Youth Consumption of Sugar-Sweetened Beverages**

In 2017, about 12% of high school students in Idaho reported that they drank soda or a sugar-sweetened beverage one or more times a day during the past seven days.

**Figure 327: Percentage of Idaho Youth Who Drank Soda or Sugar-sweetened Beverages at Least Once Per Day in the Past Seven Days, Grades 9-12, 2017**

Suicide and Injury Prevention

Idaho ranks among the top 10 states for suicide rates in the United States. Between 2012 and 2016 in Idaho, 105 school-age children died by suicide, 27 of whom were 14 or younger, and in that same span of time, 169 college-age youth (19-24) died by suicide. 60% of suicides were committed by firearm, followed by suffocation, poisoning, and others. Suicide rates for men aged 15-24 were more than 3 times higher than the rates for women of the same age. Idaho has the third highest rate of firearm ownership in the county at 57.9% of the population while also having the 8th highest rate of suicide by firearm at 11.1 for every 100,000 people.

In 2018 there were 56 injury deaths for every 100,000 people ages 15-24. In 2016, accidental deaths were the leading cause of death for children and young adults in every age group except children under 1. Motor vehicle crashes continue to be of concern in Idaho. In 2016, 65 children and youth under the age of 24 died in motor vehicle crashes.

---

under the age of 24 died by drowning during the same year, and 34 children and youth died from poisoning. 1334

Community Input from Idaho

In 2017, we visited Idaho and met with community stakeholders to learn about the needs and strengths of their communities. In 2019, we conducted key informant interviews with Idahoans including the overseer of non-emergent medical transportation in coordination with Medicaid, the pediatric cardiovascular services coordinator, a pediatric resident, a community liaison at a cardiac center, and a deputy health administrator. Here is what we found.

Access to Care and Care Coordination

Coordinating transport to Seattle Children’s from Idaho under Medicaid coverage is a difficult process and coverage is not guaranteed.

- The referral process in cardiac care is necessary because many procedures are not locally available. Patients are referred to a handful of hospitals including Seattle Children’s Hospital. In these cases, care coordination can be challenging, particularly for obtaining transport, housing, meals, and navigating insurance.
- Another stakeholder found that her care coordination efforts have benefited from a streamlined process in which access and control of the schedule as well as contact with the families is seamlessly integrated.
- While there is a statewide care coordination program, qualification requires “no creditable insurance” per the Idaho Department of Health and Welfare.
- For those who do not qualify, care coordination is often an ad-hoc process taken on by a few dedicated individuals. In an anecdotal example, one stakeholder mentioned that there was one person in her clinic dedicated to care coordination as well as two nurses who have taken on the task in addition to their standard responsibilities. These individuals have strong connections with the community and can therefore provide personalized care coordination.
- Additionally, the effectiveness of care coordination efforts all seem to benefit from proactive relationship building.
- However, enhanced mental and behavioral health support is sorely needed and, in this case, an element of clinical separation and community anonymity is desirable yet challenging to achieve.
- Experiences at destination facilities are reportedly overwhelmingly positive. One stakeholder said, “It’s interesting that as stressful as a child getting heart surgery is, the complaints are never about the care or the hospitalization. They are about the uncertainty of everything else.”
- There is tremendous variation in availability and types of services in subspecialty fields and care coordination depending on one’s location within Idaho. Larger, more established centers have a larger coordinated care framework in place while more rural and northern locations like Sand Point continue to need systematic care support.

Community Challenges and Opportunities
The challenges and opportunities of Idaho begin with its wide expanse of land and disproportionately sparse population. Dedicated efforts are being made to ensure the children of Idaho are getting the care they need. But challenges still exist. Key informants cited:

- “There is a need to break out of care silos to better facilitate care for children in Idaho across health care needs. In addition, there is need to relieve the burden on those who may be shouldering care coordination tasks disproportionately and in isolation.”
- “The strengths of the existing cardiology partnership could be the model for a larger, more coordinated effort that encompasses all Idaho patients seen at Seattle Children’s.”

**Boise, Ada County**

**Demographic Overview**

Boise is located in southwest Idaho along the Boise River and is the most populous city in the state. In 2017, the total population of Boise was about 221,000 — nearly 25% under the age of 20. From 2007 to 2017, there was a slight decrease in the population of children under age 5, but an increase among children ages 5 to 19.

<table>
<thead>
<tr>
<th>Ages</th>
<th>2007</th>
<th>2017</th>
<th>Percent change (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-4</td>
<td>12,824</td>
<td>12,574</td>
<td>-1.9%</td>
</tr>
<tr>
<td>5-9</td>
<td>12,620</td>
<td>12,662</td>
<td>0.3%</td>
</tr>
<tr>
<td>10-14</td>
<td>13,434</td>
<td>14,622</td>
<td>8.8%</td>
</tr>
<tr>
<td>15-19</td>
<td>14,655</td>
<td>16,664</td>
<td>13.7%</td>
</tr>
</tbody>
</table>

Much like the state of Idaho, the majority of the population in Boise (nearly 89%) was white (non-Hispanic/Latinx), according to U.S. Census Bureau data from 2013 to 2017.1335

**Figure 329: Population (All Ages) by Race/Ethnicity, Boise, 2013-2017 Average**321

---

In Boise, on average 15.2% of children and teens under age 18 lived in poverty between 2013 and 2017. About 51% of students in the Boise Independent School District received free or reduced-price lunch during the 2017-18 school year.

In Ada County and the city of Boise, the seasonally adjusted unemployment rate was 2.2% in April 2019, compared to 2.5% in April 2018.

On average from 2013 to 2017, the median household income in the city of Boise was $54,547. In households with children under age 18, the median family income was $69,124. People who were Asian (representing 2.5% of the population) had the highest median income ($84,826), while people who were Black/African American (representing about 1% of the population) had the lowest median income ($35,660).

In Ada County, the average median household income from 2013 to 2017 was $60,151. In households with children under age 18, the median family income was $75,721. People who were Asian (representing about 2% of the population) had the highest median income ($74,858), while people who were considered “some other race” (representing about 1% of the population) had the lowest median income ($45,417).

The graduation rate for the 2017-18 school year was 81% for the Boise Independent School District — slightly higher than the state average of 80.6%.

The childhood cancer incidence in Ada County was 18.3 cases per 100,000 children from 2011 to 2015.

The percentage of infants born in Ada County at low birth weight was 6.7% in 2017 — slightly lower than the state average.
The rate of food insecurity among children in Ada County in 2017 was 14.3%, which was under the state and national averages.\textsuperscript{1347} About half of children who were food insecure were eligible for federal nutrition programs based on income level.\textsuperscript{1348}

**Figure 330: Percentage of Children Who Were Food Insecure in Ada County, 2017\textsuperscript{322}**

<table>
<thead>
<tr>
<th>FOOD INSECURITY RATE IN ADA COUNTY (CHILD)</th>
<th>ESTIMATED PROGRAM ELIGIBILITY AMONG FOOD INSECURE CHILDREN IN ADA COUNTY</th>
</tr>
</thead>
<tbody>
<tr>
<td>14.3%</td>
<td></td>
</tr>
</tbody>
</table>

\textbf{Community Input from Boise}

In 2017, we visited Boise and met with community stakeholders to ascertain what they felt were the needs and assets of their communities. We met with the family support coordinator for a local nonprofit who works in mental and behavioral health access, the medical director of pediatrics in an emergency department, and the care coordinator for neurobehavioral health. Additionally, we spoke with 10 parents and one adult sibling.

The most common themes were access to care, particularly in regard to mental health as well as crisis care, parent support, bridging inpatient and outpatient care, and lack of availability of inpatient beds.

**Access to Care**

- Patients admitted to the general pediatrics team to wait for a psychiatric bed often wait for several weeks before being able to transfer. One parent described her experience waiting for a psychiatric bed for several days, saying that she was told there was a 9-person wait list for 6 available beds. While she was admitted to a general pediatric hospital bed and waiting for the psychiatric bed, there was no available psychiatric treatment.
- One key informant mentioned that parents will often drive out of the state for residential treatment or inpatient psychiatric care in crisis, and that this is not always covered by their Idaho insurance.
- Parents were frustrated at the lack of an intensive outpatient program or a partial hospitalization program. They reported that they do not have enough resources to be

supported as outpatients, and then once things have reached a crisis level they have no choice but to call the police to be taken to the emergency room.

- Parents wanted more community-based rehabilitation services.
- Some of these parents had children who have very complex medical and mental or behavioral health needs, which require seeing multiple providers. They feel burdened by care coordination.

One of the issues with this limited access to care is that children had to “fail” before they are able to access the care that they need. This theme reoccurred in multiple settings. Parents reported school meetings where they were told they could not access resources because their child was not failing academically. They discussed the “drug court,” a rare example of substance use rehabilitation, but it is only for children who have been arrested for drug use. There is the same kind of restrictions for kids with behavior problems, as well. Children must be arrested and put into the juvenile detention system before they can get access to some of the bigger residential facilities or group homes.

Community Support and Parent Advocates

- Some parents had trouble getting their school districts to provide accommodations for their children, and some parents felt they had to switch to a different school in order to provide the best experience for their children.
- The parents who attended the listening session were often strong advocates for their children.
- One parent even became a mental health RN because she wanted to be able to take care of her child and was unable to find anybody else to help her.
- Parents reported that when their child has any kind of medical or behavioral health issue, the parents become experts and often end up educating providers. This expertise comes from living day to day with their children, from taking them to all their different specialist appointments, and from the research that is born out of worry.
- Parents report that they have the most successful relationships with their providers who are willing to collaborate with them and have respect for the expertise that parents have.
- Parents seek out and find support from others in similar situations; they mentioned several local parent groups that were helpful in providing support, friendship, and comradery. They met both in person and online. Parents used these groups to find out about resources and activities and voice questions.
- Community members noted that local parent groups sponsor events, such as parenting workshops. There was some concern that some of this community and parent support does not extend to parents who are not English-speaking. Several parents mentioned language as an additional barrier to getting care and finding support in the community.

Nampa, Canyon County
Demographic Overview
Nampa is a city with a population of about 93,000 (as of 2017) and is located about 20 miles west of Boise. In 2017, children and young adults under age 18 comprised nearly 27% of the population. From 2007 to 2017, there was a significant decrease in the population of children under age 9, but an increase among adolescents ages 10 to 19, especially among ages 15 to 19.

Table 331: Population Change by Age Group Between 2007 and 2017, Nampa

<table>
<thead>
<tr>
<th>Ages</th>
<th>2007</th>
<th>2017</th>
<th>Percent change (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-4</td>
<td>8,738</td>
<td>6,696</td>
<td>-23.4%</td>
</tr>
<tr>
<td>5-9</td>
<td>7,656</td>
<td>5,945</td>
<td>-22.3%</td>
</tr>
<tr>
<td>10-14</td>
<td>6,907</td>
<td>7,531</td>
<td>9%</td>
</tr>
<tr>
<td>15-19</td>
<td>5,243</td>
<td>8,129</td>
<td>55%</td>
</tr>
</tbody>
</table>

Much like the state of Idaho, the majority of the population in Boise (nearly 86%) was white (non-Hispanic/Latinx), according to U.S. Census Bureau data from 2013 to 2017.

Figure 332: Population (All Ages) by Race/Ethnicity, Nampa, 2013-2017 Average

In Nampa, 24.2% of children and teens under age 18 lived in poverty — a rate that is significantly higher than the state average. About 64% of students in the Nampa School District received free or reduced-price lunch during the 2017-18 school year.

In Canyon County, the unemployment rate in April 2019 (seasonally adjusted) was 2.9%, compared to 3.1% in April 2018.\textsuperscript{1355} In the city of Nampa, the seasonally adjusted unemployment rate was 2.8% in April 2019, compared to 3.1% in April 2018.\textsuperscript{1356}

On average from 2013 to 2017, the median household income in Nampa was $43,058.\textsuperscript{1357} In households with children under age 18, the median family income was $48,110.\textsuperscript{1358} People who were Asian (representing less than 1% of the population) had the highest median income ($62,716), while people who were American Indian/Alaska Native (representing 1% of the population) had the lowest median income ($28,299).\textsuperscript{1359}

In Canyon County, the average median household income from 2013 to 2017 was $46,426.\textsuperscript{1360} In households with children under age 18, the median family income was $49,638.\textsuperscript{1361} People who were Native Hawaiian/Pacific Islander (representing 0.2% of the population) had the highest median income ($63,403), while people who were American Indian/Alaska Native (representing about 1% of the population) had the lowest median income ($37,375).\textsuperscript{1362}

In the Nampa School District, the graduation rate for the 2017-18 school year was 81.7% — a rate that is higher than the state average.\textsuperscript{1363}

In Canyon County, the cancer rate was 19 cases per 100,000 children from 2011 to 2015.\textsuperscript{1364}

In Canyon County, 7.8% of infants born were low birth weight in 2017 — a rate that was higher than the state average and just met the Healthy People 2020 objective.

In Canyon County, 16.3% of children were food insecure and more than three-quarters of those children (78%) were eligible for federal nutrition programs based on income level in 2017.\textsuperscript{1365}

**Early Education and Educational Attainment**\textsuperscript{1366}

In the Nampa School District, the graduation rate for the 2017-18 school year was 81.7% — a rate that is higher than the state average.

**Low Birth Weight**\textsuperscript{1367}

**Figure 333: Percentage of Children Who Were Food Insecure in Canyon County, 2017**\textsuperscript{325}

Community Input from Nampa

In 2017, we visited Nampa and met with community stakeholders to ascertain what they felt were the needs and assets of their communities. We conducted key informant interviews with a WIC program coordinator and a program manager for a community health center. In addition to key informants, we also hosted listening sessions with eight parents, many of whom have children with special needs. Here is what we found.

Access to Care

- Many participants reported a lack of psychiatric inpatient beds, particularly for children with both medical and mental health issues.
- In addition to the lack of available resources for kids in crisis, there is a lack of support for parents after their children are discharged from the hospital.
- Parents talked about how helpful an intensive outpatient program could be in Idaho, both for kids who have been discharged as well as children who don’t meet criteria for admission but are struggling.
- Parents were also very concerned about long wait times for the few outpatient resources that are available. One parent mentioned waiting 6 months to get in to see a psychiatrist to get a diagnosis, followed by a 6-month wait to get into the recommended therapy.
- One participant, a therapist, mentioned that their practice had increased the number of providers from 9 to 38 in the last several years, and they are still not able to keep up with demand. Their wait times are anywhere from 6-12 months, once children have a diagnosis from a psychiatrist.
- Parents mentioned that they used to have community-based rehabilitation services, and that had been very helpful in the past. However, that resource was recently eliminated.
- Parents were frustrated at the lack of care coordination. Several parents mentioned that they felt overwhelmed juggling all of their different appointments and had trouble following up.
- Access to care is even more difficult for the Spanish-speaking population. There are some translators in the area, but it is difficult to set up appointments and to find a provider who is set up to be able to use translators for delivering care.
- Additionally, some parents talked about the stigma of behavioral health problems within their own ethnic and cultural community that they felt hindered parents from seeking care for their children.

Community Support
Schools are a touch point for mental health assessment and care for children, and some schools are reported to do better than others in terms of response and support. Parents can also rely on support groups for support and information.

- One school counselor who was interviewed mentioned focusing on a child and their behaviors rather than on a formal diagnosis, which seemed to be considered a reasonable approach by other parents.
- Some parents talked about the impact extraordinary teachers had on their children’s school experience as well as their overall life skills abilities.
- However, some parents had trouble getting their school districts to provide accommodations for their children, and some parents felt they had to switch to a different school in order to provide the best experience for their children.
- Parents mentioned how important it was for them to have support groups. It seems invaluable to be able to connect to another parent who has been through what you are going through. These support groups can be found in the local community and online.
- Some parents wanted more formal parent support from the medical professionals who were taking care of her children.

**Pocatello, Bannock County**

**Demographic Overview**

Pocatello — a city in southeast Idaho — is the county seat of Bannock County and had a population of 54,658 on average from 2013 to 2017, with nearly 29% under the age of 20.\(^{1368}\)

The population of children and teens has remained fairly stable over the years.

<table>
<thead>
<tr>
<th>Ages</th>
<th>2008-2012 Average</th>
<th>2013-2017 Average</th>
<th>Percent change (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-4</td>
<td>4,277</td>
<td>4,181</td>
<td>-2.2%</td>
</tr>
<tr>
<td>5-9</td>
<td>3,736</td>
<td>3,804</td>
<td>1.8%</td>
</tr>
<tr>
<td>10-14</td>
<td>3,736</td>
<td>3,786</td>
<td>1.3%</td>
</tr>
<tr>
<td>15-19</td>
<td>4,223</td>
<td>4,051</td>
<td>-4.1%</td>
</tr>
</tbody>
</table>

Much like the state of Idaho, the majority of the population in Pocatello (more than 90%) identified as white (non-Hispanic/Latinx), according to U.S. Census Bureau data from 2013 to 2017.\(^{1369}\)

---

In Pocatello, 23.3% of children and teens under age 18 lived in poverty on average from 2013 to 2017. About 48% of students in the Pocatello/Chubbuck School District received free or reduced-price lunch during the 2017-18 school year.

In Bannock County, the seasonally adjusted unemployment rate was 2.5% in April 2019, compared to 2.8% in April 2018. On average from 2013 to 2017, the median household income was $42,979 in the city of Pocatello and $47,390 in Bannock County.

**Early Education and Educational Attainment**
The graduation rate for the 2017-18 school year was 89.6% for the Pocatello/Chubbuck School District — significantly higher than the state average of 80.6%.

**Cancer**
From 2011 to 2015, the childhood cancer incidence was 18.8 cases per 100,000 children in Bannock County.

**Food Insecurity**
In 2017, the rate of food insecurity among children in Bannock County was 16.7%. This rate is higher than the state average, but lower than the national average. More than two-thirds of children who were food insecure were eligible for federal nutrition programs based on income level.

**Figure 336: Percentage of Children Who Were Food Insecure in Bannock County, 2017**

---

Sandpoint, Bonner County

Demographic Overview
Sandpoint is the county seat of Bonner County, is surrounded by three major mountain ranges and is located along the shores of Lake Pend Oreille, the largest lake in Idaho. On average from 2013 to 2017, the population of Sandpoint was 7,918 — 23% under the age of 20.1380

Table 337: Population Change by Age Group Between 2008 and 2017, Sandpoint529

<table>
<thead>
<tr>
<th>Ages</th>
<th>2008-2012 Average</th>
<th>2013-2017 Average</th>
<th>Percent change (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-4</td>
<td>592</td>
<td>397</td>
<td>-33%</td>
</tr>
<tr>
<td>5-9</td>
<td>636</td>
<td>503</td>
<td>-20.9%</td>
</tr>
<tr>
<td>10-14</td>
<td>451</td>
<td>473</td>
<td>4.9%</td>
</tr>
<tr>
<td>15-19</td>
<td>459</td>
<td>466</td>
<td>1.5%</td>
</tr>
</tbody>
</table>

Much like the state of Idaho, the majority of the population in Sandpoint (nearly 95%) identified as white (non-Hispanic/Latinx), according to U.S. Census Bureau data from 2013 to 2017.1381 Over the last five years, there have been sharp declines in the population of children ages 0 to 9.

Figure 338: Population (All Ages) by Race/Ethnicity, Sandpoint, 2013-2017 Average330

---

On average from 2013 to 2017, 34.5% of children and teens under age 18 lived in poverty. Nearly 41% of students in the Lake Pend Oreille School District and about 53% of students in the West Bonner County District received free or reduced-price lunch during the 2017-18 school year.

In Bonner County, the seasonally adjusted unemployment rate was 4.1% in April 2019, the same rate as one year prior. On average from 2013 to 2017, the median household income was $36,706 in the city of Sandpoint and $45,607 in Bonner County.

Early Education and Educational Attainment
The graduation rate for the 2017-18 school year for the Lake Pend Oreille School District was 87.8%, while the graduation rate was 68.4% for the West Bonner County District during the same school year.

Food Insecurity
About 18% of children in Bonner County were food insecure in 2017, and two-thirds of those children were eligible for federal nutrition programs based on income level.

Figure 339: Percentage of Children Who Were Food Insecure in Bonner County, 2017

Spotlight on Montana
Montana is one of the largest states in total area, but has one of the lowest total populations. The average population of Montana from 2013 to 2017 was about 1.03 million, with 24.5% of the population under the age of 20. The most populated cities in the state are Billings, Missoula and Great Falls.

Community Social and Economic Context

---

The health of children, teens and young adults is influenced by a variety of environmental and social factors. Social risk factors, such as poverty and a lack of health insurance coverage, as well as racial/ethnic minority status, are all associated with poorer health outcomes for youth.

**Youth of Montana**

Across Montana, the total population has grown by 9.7% from 2007 to 2017 (a 4.5% increase over a five-year period from 2012 to 2017). Among youth under age 20, the population grew by 2% over a 10-year period from 2007 to 2017, with largest gains among children ages 5 to 9.

**Table 340: Population Change by Age Group Between 2007 and 2017, Montana**

<table>
<thead>
<tr>
<th>Ages</th>
<th>2007</th>
<th>2017</th>
<th>Percent change (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-4</td>
<td>59,387</td>
<td>61,405</td>
<td>3.4%</td>
</tr>
<tr>
<td>5-9</td>
<td>58,430</td>
<td>64,135</td>
<td>9.8%</td>
</tr>
<tr>
<td>10-14</td>
<td>62,261</td>
<td>65,625</td>
<td>5.4%</td>
</tr>
<tr>
<td>15-19</td>
<td>70,882</td>
<td>64,773</td>
<td>-8.6%</td>
</tr>
</tbody>
</table>

Montana has a predominately white, non-Hispanic/Latinx population, with 89% of the residents self-reporting as being white alone. About 3.6% of the population identified as Hispanic/Latinx.

**Figure 341: Population (All Ages) by Race/Ethnicity, Montana, 2013-2017 Average**

---

![Montana Population by Race/Ethnicity](image)

---


U.S. Census Bureau data shows that nearly 2.1% of the total population in Montana is foreign-born (about 7% of children under age 18). Nearly 4% of people ages 5 and over speak a language other than English at home.\textsuperscript{1396}

**Poverty among Youth**

In 2017, 15% of children and teens under age 18 in Montana lived in poverty, which has decreased over the years and is below the national average of 18%.\textsuperscript{1397} On average from 2013 to 2017, 17.6% of children under 18 in Montana lived in poverty.\textsuperscript{1398} During the 2017-18 school year, nearly 68,000 students participated in the free or reduced-price lunch program in Montana.\textsuperscript{1399}

**Figure 342: Percentage of Children Under 18 Living in Poverty in Montana, 2008-2017\textsuperscript{334}**
Housing Affordability and Other Basic Needs
In Montana, the basic needs most frequently mentioned included affordable housing, transportation, access to healthy and affordable foods, affordable childcare, access to safe and healthy places for children, and parenting resources.

Affordable housing is increasingly scarce as cost of living rises in places like Missoula, and families in several communities in Montana described rising housing costs affecting their families’ ability to afford other basic needs.

In rural communities, inadequate transportation affects families’ ability to access healthcare and other services. Missoula residents were glad to have a free bus system in town, though the limited hours and stops do not make it sustainable for families to go without a car. Families felt like they were living on an island if they did not have reliable access to a vehicle.

Mental and Behavioral Health
Mental health was identified by families and providers in both rural and urban communities as Montana’s biggest challenge. The stigma of depression and anxiety was described as a barrier to accessing services, as was the impression that many families do not know what mental health resources are available. Schools and primary care offices were seen as generally supportive environments for children with mental health needs.

Healthcare providers noted that, while they screen frequently for mental health problems, there are not enough services to provide therapy for the children who screen positive. Waitlists for formal evaluations are prohibitively long, and it takes many hours to drive from smaller communities for appointments.

Several pediatric primary care providers voiced their desire to have access to the Partnership Access Line (PAL) to support their management of children’s mental health needs. PAL is a Washington state-funded program operated by Seattle Children’s that provides mental health
consultation to primary care doctors for mental healthcare related questions, such as diagnostic clarification, medication adjustments or treatment planning.

Families discussed how children often “fall through the cracks” in a system that cannot offer adequate services, but that parents often have unmet mental health needs as well. They also talked about the relationship between substance abuse and mental health, and the concern over firearm access and teen suicide. Community members were concerned about the lack of adequate suicide crisis services, and the upstream services to prevent such crises.

**Healthy Lifestyle Opportunities and Challenges**

Access to healthy and affordable foods was a challenge for many families. Parents in the Montana sessions described helpful programs such as the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), food stamps, the Missoula Food Bank and programs to send food home in kids’ backpacks. In some communities, these backpack programs are covered by the school district or through other grant funding. A parent described how the cost of medical care created food insecurity for her family. After copays and deductibles that were beyond what she budgeted, her family had to choose between paying bills on time and buying enough food to eat.

**Suicide and Injury Prevention**

In Montana, the people interviewed were acutely aware of their children’s risks for serious outcomes from injuries and were keen on starting or improving injury prevention programs to keep their kids safe.

Families in Missoula praised the local fire department’s car seat fitting program. Some community members wished that bicycle helmet use was mandatory. Parents of a child with autism expressed concerns about supervision needs, and other parents of children with special healthcare needs shared similar worries. Parents of adolescents worried about risk-taking behaviors, especially when teens are driving. Caregivers also identified drowning and water safety as significant concerns.

Access to and the use of firearms were also a frequent safety topic. Many households in Montana have a firearm, either for hunting or personal protection. Many parents worried about firearms being around children and expressed a desire for better access to lockboxes and firearm safety education. They wished for parents to be more comfortable talking about whether guns are secured at the homes of their child’s friends and for medical providers to be more comfortable talking about this topic and offering resources.

**Access to Care, Insurance Coverage, Health Literacy and Navigating Healthcare Systems**

Almost every individual, whether during a listening group or an individual interview, commented on access to care as a significant concern, especially access to pediatric subspecialists and the long waitlist for services.
Many families currently drive long distances (sometimes longer than five hours) or travel to Seattle for a subspecialty appointment. The idea of taking medical transport to Seattle for every illness was a major financial and logistical challenge. Multiple families described sending their child by medical airlift to Seattle for life-saving care only to be saddled with an impossibly large transport bill. Many desired a medical home where they could go for reliable advice and evaluation closer to home, especially for children with special healthcare needs.

Multiple caregivers of children with special healthcare needs also expressed worry about the transition of adolescents to adult medical services, especially if there are long waitlists.

**Cultural Humility**

Parents and key informants mentioned challenges surrounding the stigma and cultural norms of mental health and receiving care.

![Graph showing percentage trends from 2008 to 2017.]

**Community Input and Inclusiveness**

Parents and caregivers described finding community in many places. Many individuals discussed turning to their relatives and friends for support, and several discussed the benefits of living in small, tight-knit communities.

In rural areas, families often look to older generations for support and health information. Schools and churches are an important source of community. In particular, families of children with mental or behavioral health issues described schools as important partners and support structures.

Parents of children with special healthcare needs frequently described Facebook and other social media communities as places to connect and share information with parents facing similar challenges. Several community members described a feeling of isolation related to their geographic location in Montana and/or their status as the caregiver of a medically complex child,
especially because they have no time for anything other than work and caring for their children’s needs.

**Housing Affordability and Availability**

According to the U.S. Department of Housing and Urban Development (HUD), households that spend more than 30% of their income on housing expenses — rent/mortgage payments, taxes, insurance and related expenses — are less likely to have enough money for food, clothing, medical care and other needs.\(^{1400}\)

In Montana in 2017, 22% of households with children had a high housing cost burden, where more than 30% of the monthly income went to housing expenses.\(^{1401}\) This is lower than the national average of 31% of households and is down from a high of 32% of households with children that had a high housing cost burden in 2011.\(^{1402}\)

**Figure 343: Percentage of Households With Children With High Housing Cost Burden in Montana, 2008-2017**\(^{335}\)

---

Among children in Montana living in low-income households — families with an income less than 200% of the federal poverty level — nearly half (45%) had a high housing cost burden in 2017. \(^{1403}\)

**Figure 344: Percentage of Children in Low-income Households With High Housing Cost Burden in Montana, 2008-2017** \(^{336}\)

---

About one in 10 children (11%) lived in crowded households in Montana in 2017. A crowded household is one where there is more than one person per room.\textsuperscript{1404}

**Youth Experiencing Homelessness**
The rate of homeless in Montana is below the national average. In 2017, an estimated 6.6 out of every 10,000 families were homeless in Montana, compared to the national average of 7.4 out of every 10,000 families.\textsuperscript{1405}
According to the 2018 Point in Time Count taken in January 2018, 1,405 people in Montana experience homelessness on any given day, which includes 135 families with children and 119 unaccompanied young adults ages 18 to 24.\textsuperscript{1406}

During the 2016-17 school year:\textsuperscript{1407}
- 3,606 youth enrolled in public schools in Montana were homeless at some point during the year — a 20\% increase over the previous school year.
- 692 children/youth enrolled in public schools were unaccompanied youth.

\textbf{Figure 346: Number of Homeless Children/Youth in Montana Enrolled in Public Schools by Year, 2016-2017 School Year}\textsuperscript{538}
The majority (71.2%) of the students who were homeless were doubled up, meaning they may be living with another family, and 9.3% were unsheltered.\footnote{National Center for Homeless Education. (2017). \textit{Montana}. Retrieved from http://profiles.nche.seiservices.com/StateProfile.aspx?StateID=32.}

**Figure 347:** Percentage of Homeless Children/Youth in Montana Enrolled in Public Schools by Type of Primary Nighttime Residence, 2016-2017 School Year\footnote{339}
Percentage of homeless children/youth enrolled in public schools by type of primary nighttime residence

Employment and Income
The unemployment rates in 2018 and the first four months of 2019 were at or under the national average. In April 2019, the unemployment rate in both Montana and the United States was 3.6% (seasonally adjusted). 1409

Figure 348: Montana Unemployment Rates Compared to United States, 2018 to 2019340

---

On average from 2013 to 2017, the median household income in Montana was $50,801, which is significantly lower than the U.S. median household income of $57,652 during the same time period. In households with children under age 18, the median family income in Montana was $65,297.
The median household income in Montana varies by race/ethnicity. On average from 2013 to 2017, individuals who were Asian (0.6% of the population) had the highest median income ($55,648), while people identifying as American Indian/Alaska Native (representing 4.4% of the population) had the lowest median household income ($31,277).\textsuperscript{1412}

**Early Childhood Education**

In 2016-17, the Montana Head Start program provided early childhood education services to 5,664 low-income children from birth through age five — 1,988 of the students were enrolled in the American Indian Head Start and Early Head Start programs.\textsuperscript{1413} Nearly half (47%) of children ages 3 to 5 had access to Head Start, and 17% of children under the age of 3 had access to Early Head Start.\textsuperscript{1414}

**Figure 350: Montana Head Start Program Statistics, 2016 to 2017\textsuperscript{342}**

---


High-quality early education, such as preschool or pre-kindergarten for children ages 3 and 4, can help with school preparedness. From 2015 to 2017, 58% of children ages 3 and 4 were not enrolled in school in Montana.1415

Table 351: Children Ages 3 and 4 Not in School in Montana, 2012-2017343

<table>
<thead>
<tr>
<th>Year</th>
<th>Number of children (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012-2014</td>
<td>15,000 (61%)</td>
</tr>
<tr>
<td>2013-2015</td>
<td>14,000 (60%)</td>
</tr>
<tr>
<td>2014-2016</td>
<td>14,000 (57%)</td>
</tr>
<tr>
<td>2015-2017</td>
<td>14,000 (58%)</td>
</tr>
</tbody>
</table>

Educational Attainment

For the 2017-18 school year, the four-year graduation rate in Montana was about 86%, and the dropout rate for high school students was about 3.4%. Both the graduation rates and dropout rates did not change much over a five-year period in Montana.

**Foster Care**
Foster placement services are provided when children need short-term or temporary protection because they are abused, neglected or involved in family conflict. Of the more than 256,000 children under age 18 who lived in Montana in 2016, 3,357 children were in foster care. This is a rate of 15 children in foster care per 1,000 children in the state, which is 2.5 times the U.S. rate of 6 children in foster care per 1,000 children. During that same year, 1,512 children exited foster care in Montana for various reasons, including adoption (17%) and being reunified with a parent or primary caretaker (56%).

**LGBTQ Youth**
Limited data are publicly available on LGBTQ youth in Montana. The 2019 Montana Youth Risk Behavior Survey included one question asking students if during the past 12 months they had been the victim of teasing or name calling because someone thought they were gay, lesbian, or bisexual. Approximately 13% of high school students reported teasing or name calling for this reason. Among students in grades 7 and 8, 20% reported teasing or name calling for this reason.

**Life Expectancy and Leading Causes of Death and Hospitalization**
Life expectancy rates and leading causes of death and hospitalization are often used as health measures to monitor progress in promoting well-being, preventing disease and disability, and reducing health disparities. Longer life expectancy rates indicate better health.

**Life Expectancy**
From 2010 to 2015, the life expectancy in Montana was 78.6 years, which is just below the national average of 78.7 years.

**Leading Causes of Death**
Across the United States, injuries were the leading causes of death among youth under age 19 in 2016. From 2013 to 2017, the leading cause of death in Montana for youth ages 1 to 9 and teens ages 15 to 19 were unintentional injuries. Suicide was the leading cause of death for adolescents ages 10 to 14. Congenital anomalies were the leading causes of death among children under age 1. Motor vehicle crashes, unintentional drownings and unintentional suffocations were leading causes of unintentional injury deaths for youth ages 1 to 19.

**Figure 352: Leading Causes of Death in Montana by Age and Number of Deaths, 2013-2017**

---

<table>
<thead>
<tr>
<th>Rank</th>
<th>Age Groups</th>
<th>&lt;1</th>
<th>1-4</th>
<th>5-9</th>
<th>10-14</th>
<th>15-19</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Congenital anomalies</td>
<td>Unintentional injuries</td>
<td>Unintentional injuries</td>
<td>Suicide</td>
<td>Unintentional injuries</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>81</td>
<td>35</td>
<td>20</td>
<td>23</td>
<td>105</td>
</tr>
<tr>
<td>2</td>
<td>SIDS</td>
<td>Homicide</td>
<td>Congenital anomalies</td>
<td>Unintentional injuries</td>
<td>Suicide</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>33</td>
<td>---</td>
<td>---</td>
<td>23</td>
<td>74</td>
</tr>
<tr>
<td>3</td>
<td>Short gestation</td>
<td>Malignant neoplasms</td>
<td>Homicide</td>
<td>Malignant neoplasms</td>
<td>Malignant neoplasms</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>32</td>
<td>---</td>
<td>---</td>
<td>23</td>
<td>74</td>
</tr>
<tr>
<td>4</td>
<td>Maternal pregnancy complications</td>
<td>Congenital anomalies</td>
<td>Malignant neoplasms</td>
<td>Benign neoplasms</td>
<td>Homicide</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>23</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>5</td>
<td>Placenta cord membranes</td>
<td>Influenza &amp; pneumonia</td>
<td>Perinatal period</td>
<td>Cerebrovascular</td>
<td>Heart disease</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>13</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>6</td>
<td>Unintentional injuries</td>
<td>Perinatal period</td>
<td>Cerebrovascular</td>
<td>Homicide</td>
<td>Congenital anomalies</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>13</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>7</td>
<td>Homicide</td>
<td></td>
<td>Heart disease</td>
<td>Septicemia</td>
<td>Tied: Aortic aneurysm; cerebrovascular; chronic lower respiratory disease; complicated pregnancy; influenza &amp; pneumonia; perinatal period</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>8</td>
<td>Circulatory system disease</td>
<td></td>
<td>Influenza &amp; pneumonia</td>
<td>Whooping cough</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>9</td>
<td>Necrotizing enterocolitis</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>10</td>
<td>Three-way tie: Influenza &amp; pneumonia; neonatal aspiration syndromes; respiratory distress</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
</tbody>
</table>

Note: counts less than 10 are suppressed as --- to prevent identification of individual cases
Children and Youth with Special Healthcare Needs and Chronic Conditions

Children with special health care needs are defined as children under age 18 who have or are at increased risk of a chronic physical, developmental, behavioral, or emotional condition, and who also require health and related services of a type or amount beyond that required by children generally. Because of their complex needs, these families often require services from multiple systems such as education and social services, in addition to health care. As such, the national Maternal and Child Health Block Grant, one of the largest federal block grant programs, outlines specific expectations for states related to meeting the health care needs of the CYSHCN population.

One in every five U.S. families has a child with a special health care need. Nationwide this is over 13 million children. The percent of children in a state who have a special health care need ranges from a low of only 13% (Hawaii) to a high of 24%; about 1 of every 4 children living in Kentucky, Mississippi, and West Virginia has a special health care need. Montana, like Washington, is on par with the nation with 19% of its children having a special health care need.

In 2016 to 2017, 43,541 children (19%) in Montana identified as children with special healthcare needs (based on the federal Maternal and Child Health Bureau’s definition). This represents the percentage of children under age 18 who are at increased risk of a chronic behavioral, emotional, physical or developmental condition, and who require health services or related services of an amount or type beyond what is required by most children.

In 2016, the National Survey of Children’s Health found that only 17% of CYSHCN in Montana receive care in a “well-functioning system.” Additionally, the survey found that 37% of children in Montana ages 3 through 17 who have a mental or behavioral condition, do not receive treatment or counseling. Montana has been working to assist CYSHCN, as well as those without special needs, on adolescent transition outreach and education. Montana partners with the Utah Medical Home Portal Project to disseminate information and educate parents about the importance of a medical home. Montana has also supported the Parent Mentor Program to have parents of CYSHCN mentor parents needing help navigating the “non-medical” aspects of the medical home.

Asthma

Asthma is one of the most common chronic diseases nationwide affecting nearly one in every 12 children (about 8.1%). On average from 2016 to 2017, 6% of children in Montana had problems associated with asthma over the past year. In 2016, 8.3% of children in Montana had reported ever having asthma.

Cancer

Cancer incidence in children from birth to age 20 in the United States was an average of 17.9 cases per 100,000 children/young adults on average from 2011 to 2015. About 70,000 teens and young adults ages 15 to 39 are diagnosed with cancer each year in the United States. This
accounts for 5% of cancer diagnoses in the country and is about six times the number of cancers diagnosed in children from birth to age 14.\textsuperscript{1439} Cancer is the leading cause of disease-related death in the United States among adolescents and young adults.\textsuperscript{1440}

In Montana, the incidence of cancer in children from birth to age 20 was an average of 14.6 cases per 100,000 from 2011 to 2015.\textsuperscript{1441}

**Transplants**

More than 113,000 people in the United States are waiting for a life-saving organ transplant.\textsuperscript{1442} An average of 18 people (children and adults) die each day from a lack of available transplant organs.\textsuperscript{1443} All patients waiting for a transplant from a deceased donor in the United States have equal access to donated organs and are listed with the United Network for Organ Sharing (UNOS). In the Northwest (UNOS region 6: Washington, Alaska, Idaho, Montana, Oregon and Hawaii), more than 3,000 people are currently in need of life-saving organ transplants — 85 of those under age 18.\textsuperscript{1444} UNOS does, however, allow for special allowances for children under certain circumstances. Since pediatric patients need smaller organs, for example, they will receive priority if the donor is younger than 18.\textsuperscript{1445}

**Healthcare Access and Preventative Care**

**Access to Care**

In 2017, 6% of children in Montana were uninsured — a rate that has declined from 16% in 2008.\textsuperscript{1446} This compares to 5% of children in the United States who were uninsured in 2017.\textsuperscript{1447} The term “uninsured” includes children without health insurance and children who have coverage under the Indian Health Service only.\textsuperscript{1448}

**Figure 353: Percentage of Children Ages 0 to 18 Without Health Insurance Coverage in Montana, 2008-2017\textsuperscript{345}**

\textsuperscript{341} Kaiser Family Foundation. (2017). *Health insurance coverage of children 0-18*. Retrieved from https://www.kff.org/other/state-indicator/children-0-18/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.
Immunization Rates

Immunization coverage in Montana is based on the immunization schedule developed by the Centers for Disease Control and Prevention (CDC). These estimates are collected through the National Immunization Survey.

According to the most recent data from 2017, 66.2% of children ages 19 to 35 months in Montana had completed the recommended 4:3:1:3:3:1:4 immunization series (combined seven-series).

Figure 354: Childhood Immunization Rate in Montana (4:3:1:3:3:1:4 Series), Ages 19 to 35 Months, 2008-2017

Oral Healthcare
In 2016 to 2017, 81% of children under the age of 18 in Montana had received preventive dental care within the past year, comparable to 80% of children in the United States over the same time period. \[1450\]

In 2017, 78.5% of high school students in Montana reported that they saw a dentist over the past 12 months — an increase from 74.9% in 2015. \[1451\] Students identifying as white were more likely than students identifying as American Indian/Alaska Native to see a dentist.

Figure 355: Percentage of High School Students in Montana Who Saw a Dentist in Past 12 Months, 2017 \[347\]
Mental and Behavioral Health

Mental and behavioral health encompasses a range of conditions, such as depression, lack of social support, bullying and suicidal behavior.

According to a 2019 report from Mental Health America, Montana ranked 40th in the country (which includes 50 states plus the District of Columbia) for the prevalence of mental illness and access to care for youth. This ranking means Montana’s youth have a high prevalence of mental illness and a low rate of access to mental healthcare services.

Figure 356: Rankings of States Based on Prevalence of Mental Illness and Access to Care for Youth, 2019

Of children with a special health care need, there is a significant subset comprised of children who have one or more emotional, behavioral, or developmental conditions. Specifically, this is defined as children age 2 to 17 who have autism, developmental delays, depression, anxiety, ADD/ADHD, or behavioral/conduct problems. Some of these children with emotional, behavioral, or developmental conditions also do have a chronic physical condition. Nationwide, 21% of children have one or more emotional, behavioral, or developmental conditions. State distribution ranges from a low of only 15% in Hawaii to a whopping 27% of children in Arkansas, Louisiana, Maine, Mississippi, and West Virginia. States in the WAMI region are on par with the national average; 22% of Montana’s children meet these criteria.

Bullying

---

Students who are bullied are more likely than their peers to be lonely, anxious, depressed, have low self-esteem, feel unwell and consider suicide.

In 2017, 21.6% of high school students in Montana reported that they were bullied on school property one or more times in the past year — down from 25.3% in 2015, 26.3% in 2013 and 26% in 2011.

Female students and ninth graders reported bullying at higher rates than male students and those in 10th, 11th or 12th grades in Montana.

Figure 357: Percentage of Montana High School Students Who Were Bullied on School Property One or More Times in Past Year, 2017

In 2017, 17.6% of high school students in Montana reported that they were electronically bullied (cyberbullied) in the past year, down from 18.5% in 2015, 18.1% in 2013 and 19.2% in 2011.

Figure 358: Percentage of Montana High School Students Who Were Electronically Bullied (Cyberbullied) During the Past Year, 2017


In 2017, 10.6% of students reported that they had been called names or teased over the past year because someone thought they were gay, lesbian or bisexual. This rate has decreased over the last few years, down from 13.2% in 2013 and 14.7% in 2015.

**Figure 359: Percentage of Montana High School Students Who Were Bullied Because Someone Thought They Were Gay, Lesbian or Bisexual, 2017**

In 2017, about 8% of high school students in Montana did not go to school because they felt unsafe at school or on their way to or from school during the past month — an increase over the rate in 2015 (5%).

It is important to consider the impact and prevalence of bullying in thinking about youth mental health. Students who reported being harassed or bullied were more likely to have lower grades in school, drop out of school, and may experience depression, anxiety, low self-esteem and have suicidal thoughts. Several studies have found an association between bullying and depression. Notably, youth who report bullying or cyber-bullying were at a higher risk for reporting suicidal ideation and attempts. In addition, students who bully others are more likely to have academic problems, substance abuse problems, and to experience violence later in life.

**Depression**

Depression is a mental illness that may go undetected and untreated, leading to adverse consequences for a person and those around them. Early signs of depression can include long durations of sadness or hopelessness that impacts a person’s day-to-day activities.

Nearly one in three high school students in Montana (31%) reported feeling so sad or hopeless almost every day for at least two weeks in a row over the past year that they stopped doing some usual activities. This rate has increased over the last 10 years, from 25.8% in 2007.

---

Rates of depressive feelings were significantly higher among female students compared to male students (39.9% compared to 22.8%). Students identifying as American Indian/Alaska Native also reported significantly higher rates of having depressive feelings than students identifying as white (42.6% compared to 29.3%).

**Figure 360: Percentage of Montana Youth Who Experienced Depressive Feelings Almost Every Day for More Than Two Weeks in a Row Over the Past Year, 2017**

Suicidal Ideation
Suicide was the second leading cause of death among youth ages 10 to 14 in Montana in 2015. The rates of suicidal ideation among high school youth in Montana have increased over the last decade. Montana has the highest suicide rate in the country and consistently ranks either 1st or 2nd in suicide deaths per capita. The youth suicide rate in Montana is almost triple the national rate; over the last decade, 65% of youth deaths by suicide were using a firearm.

According to the Youth Risk Behavior Survey:

- One in five high school students (20.8%) in Montana had seriously considered suicide — up from 15.1% in 2007.
- Female students were much more likely than male students to seriously consider attempting suicide (26.8% compared to 15.4%).
- Students who identified as American Indian/Alaska Native also reported higher rates of seriously considering suicide compared to students identifying as white (28.2% compared to 19.6%).

**Figure 361: Percentage of Montana High School Students Who Seriously Considered Attempting Suicide During the Past Year, 2017**

---


Over the past decade, the rate of high school students in Montana making plans to attempt suicide and attempting suicide have increased. In 2017, 16.6% of high school students reported making plans to attempt suicide — up from 13.2% in 2007.

**Figure 362: Percentage of Montana High School Students Who Made a Suicide Plan During the Past Year, 2017**

Nearly one in 10 (9.5%) of high school students in Montana said they attempted suicide one or more times over the past year — up from 7.9% in 2007. The rate was nearly double the state average for students identifying as American Indian/Alaska Native (18.3%).

About 3% of high school students in Montana had a suicide attempt that resulted in an injury, poisoning or overdose that had to be treated by a doctor or nurse in the past year.

**Figure 363: Percentage of Montana High School Students Who Attempted Suicide During the Past Year, 2017**

---


Substance Use
Across Montana, the rates of alcohol, smoking and marijuana use among high school youth have declined over the last decade.

Alcohol Use \(^{1464}\)
According to the 2017 Montana Youth Risk Behavior Survey, one in three high school students (33.1%) had at least one drink of alcohol in the past 30 days. Rates have declined by nearly 29% from 2007 to 2017 (from 46.5% to 33.1%).

About two-thirds of high schoolers (68%) reported that they drank alcohol during their lifetime — down from nearly 78% in 2007. Other than a few sips, 19.5% of students had their first drink of alcohol before the age of 13 — a rate that has also decreased over the last decade (from 25.9% in 2007). Four out of 10 (40.1%) high school students in Montana who reported drinking alcohol during the 30 days prior to the survey said that someone gave them the alcohol.

Figure 364: Percentage of Montana Youth in High School Who Drank at Least One Drink of Alcohol in Past 30 Days, 2017 \(^{356}\)

---


According to the survey, 17.6% of high school students in Montana reported binge drinking during the 30 days prior to the survey. The survey defined binge drinking as four or more drinks in a row for females or five or more drinks in a row for males, within a couple of hours.

**Figure 365: Percentage of Montana Youth in High School Who Were Binge Drinking During the 30 Days Before the Survey, 2017**

<table>
<thead>
<tr>
<th></th>
<th>Total</th>
<th>Male</th>
<th>Female</th>
<th>9th</th>
<th>10th</th>
<th>11th</th>
<th>12th</th>
<th>Native American</th>
<th>White</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amount</td>
<td>17.6</td>
<td>17.9</td>
<td>17.2</td>
<td>9.5</td>
<td>13.4</td>
<td>20.9</td>
<td>28.1</td>
<td>22.2</td>
<td>19.9</td>
</tr>
</tbody>
</table>

**Tobacco Use**

Over the last decade, there have been declines in tobacco use among high school students in Montana. In 2017, 12.1% of high schoolers in Montana reported smoking cigarettes at least once in the past 30 days — a decline from 20% in 2007.

Students in 12th grade reported higher rates of cigarette smoking compared to students in ninth, 10th and 11th grades. Students identifying as American Indian/Alaska Native also smoked cigarettes at higher rates than students identifying as white (19.3% compared to 10.6%) in 2017.

**Figure 366: Percentage of Montana High School Students Who Smoked Cigarettes at Least Once in Past 30 Days, 2017**

---

In 2017, 2.1% of Montana high school students smoked cigarettes daily, and 3.1% were frequent smokers, meaning they smoked 20 or more cigarettes in the past 30 days. Nearly 34% of students reported that they had tried smoking cigarettes (even one or two puffs) during their lifetime — a decrease from about 52% in 2007. Nearly one in 10 high school students (10.6%) reported that they had first tried smoking a cigarette before the age of 13.

About one in 10 (9.8%) high school students in Montana had used smokeless tobacco products at least once in the past 30 days in 2017. Smokeless tobacco products include chewing tobacco, snuff, dip, snus and dissolvable tobacco products.

**Figure 367: Percentage of Montana High School Students Who Used Smokeless Tobacco (i.e. Chewing Tobacco, Snuff or Dip) at Least Once in Past 30 Days, 2017**

The rates of smokeless tobacco use were highest among 12th grade students than other high schoolers and significantly higher among students who identified as American Indian/Alaska Native than students who identified as white (17.5% compared to 8.6%). Nearly 7% of students reported that they use smokeless tobacco products on school property.

In 2017, nearly one-quarter (22.5%) of high school students in Montana reported that they used electronic vapor products in the last 30 days, and nearly half of students (46.6%) had used an electronic vapor product at least once during their lifetime.

Students who identified as white were slightly more likely than students who identified as American Indian/Alaska Native to use an electronic vapor product in the past month. The rate of electronic vapor product use declined from 2015 (from 29.5% to 22.5%).

**Figure 368: Percentage of Montana High School Students Who Used Electronic Vapor Products at Least Once in Past 30 Days, 2017**

---


Marijuana Use\textsuperscript{1467}
Over the last decade, the percentage of Montana high school students who used marijuana at least once in the past 30 days decreased slightly — from 21\% in 2007 to 19.8\% in 2017.

More than one-third (35.2\%) of high school students in the state reported that they had used marijuana at least once in their life, down from 39.1\% in 2007. About 7\% had used marijuana for the first time before the age of 13.

\textbf{Figure 369: Percentage of Montana High School Students Who Used Marijuana at Least Once in Past 30 Days, 2017}\textsuperscript{361}

Students who identified as American Indian/Alaska Native reported using marijuana at least once in the past month at nearly twice the rate as students identifying as white.

\textit{Prescription Drug Use}\textsuperscript{1468}
In 2017, 13.7\% of high school students in Montana reported ever taking prescription pain medicine without a doctor’s prescription or differently than how a doctor told them to use the medicine.

Students who identified as American Indian/Alaska Native reported having used prescription drugs without a doctor’s prescription or differently than how a doctor told them during their lifetime at higher rates than students identifying as white (16% compared to 13%).

**Figure 370: Percentage of Montana High School Students Who Took a Prescription Drug Without a Doctor’s Prescription or Differently Than How a Doctor Told Them During Their Life, 2017**

![Percentage of Montana High School Students Who Took a Prescription Drug Without a Doctor’s Prescription or Differently Than How a Doctor Told Them During Their Life, 2017](image)

*Maternal and Child Health*

Maternal and child health outcomes are markers of a community’s overall health. Some of these markers include infant mortality, early prenatal care and the birth weight of babies.

**Early and Adequate Prenatal Care**

Beginning prenatal care early in the pregnancy and having regular visits with a provider can improve the chances of a healthy pregnancy. It is recommended that women begin prenatal care in their first trimester of the pregnancy (before the fourth month of pregnancy).

In 2017, 73.4% of women in Montana who gave birth received prenatal care in the first trimester of pregnancy, which is lower than the national Healthy People 2020 goal that 77.9% of pregnant women receive prenatal care in the first trimester.

**Infant Mortality**

One of the measures of the overall health of a population is the infant mortality rate because many of these deaths are preventable. The infant mortality rate refers to the number of babies per 1,000 live births who die before their first birthday in a given year.

The Healthy People 2020 goal for infant mortality is less than 6.0 deaths per 1,000 live births. In 2016, the infant mortality rate in Montana was 5.9 deaths per 1,000 live births, which was the same as the national infant mortality rate.

---

Low Birth Weight

Infants born weighing less than 2,500 grams (about 5.5 pounds) are considered low birth weight. This increases their risk of infant mortality and developing neurodevelopmental disabilities and respiratory disorders.

In 2017, 7% of infants born in Montana were low birth weight, which meets the Healthy People 2020 objective of 7.8% or fewer infants born at low birth weight.

Weight-Related Health and Behavior

Obesity and Overweight Prevalence

Children, teens and young adults are considered overweight if their body mass index (BMI) is in the top 15% for their age and gender. They are considered obese if their BMI is in the top 5% for their age and gender.

In Montana from 2016 to 2017, 12.3% of children ages 10 to 17 were considered obese, which is less than the national rate of 15.8%. There has been an increase in the rate of overweight teens in Montana over the last decade. Nearly 15% of students in Montana were considered overweight in 2017 — up from 13.3% in 2007.

Figure 371: Percentage of Montana High School Students Who Were Overweight, 2017

In 2017, 11.7% of high school students in Montana were obese, up from 10.1% in 2007. About 41% of students reported that they were trying to lose weight in 2017.

Overall, male high school students in Montana were more likely than female students to be obese (14.5% compared to 8.7%). The rate of obesity among high school students who identified as

---

American Indian/Alaska Native was almost twice as high as students identifying as white (20% compared to 10.4%).

Figure 372: Percentage of Montana High School Students Who Were Obese, 2017

Food Insecurity
In 2017, the rate of food insecurity among children in Montana was just under the national average (16.1% compared to 17%). Food insecurity is defined as an uncertainty of having or an inability to acquire enough food for all household members because of insufficient money or other resources.

Federal and state assistance programs have been shown to reduce child food insecurity rates and lessen the health impacts of food insecurity among children. These programs include the Supplemental Nutrition Assistance Program (SNAP), national school meal programs and the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC).

Just over half (57%) of children who were food insecure in Montana were eligible for federal nutrition programs based on income level. As of March 2019, almost 79,000 children in Montana participated in the National School Lunch Program, and nearly 39,000 children participated in the National School Breakfast Program. Also in March 2019, about 53,000 households (nearly 108,000 people) in Montana participated in SNAP, and almost 16,000 people participated in WIC.

Figure 373: Percentage of Children Who Were Food Insecure in Montana, 2017

Fruit and Vegetable Consumption ¹⁴⁸⁴

Eating fruits and vegetables lowers the risk of developing many chronic diseases and can support weight management.

In 2017, 62.7% of high school students in Montana reported that they ate vegetables one or more times per day in the past week, while 27.2% reported eating vegetables two or more times and 11.6% reported that they ate vegetables three or more times per day in the past week. The rate of vegetable consumption has not changed significantly over the last decade.

Figure 374: Percentage of Montana High School Students Who Ate Vegetables 3+ Times Per Day in Past Week, Grades 9-12 ³⁶⁶

More than half (58.4%) of high school students in Montana in 2017 reported that they ate fruit or drank 100% fruit juice each of the past seven days. This rate has stayed about the same over the past decade.

Nearly one in 10 (9.8%) high schoolers reported that they had not eaten fruit on any of the past seven days.

Figure 375: Percentage of Montana High School Students Who Ate Fruit or Drank 100% Fruit Juice Each of the Past Seven Days, 2017 ³⁶⁷

Youth Consumption of Sugar-Sweetened Beverages\textsuperscript{1485}

In 2017, 15.1\% of high school students in Montana reported that they drank soda or pop one or more times a day during the past seven days — down from 26.2\% in 2007 (a 42\% decrease). Rates were higher than the state average among males, 12th graders and students who identified as American Indian/Alaska Native.

One-quarter (25.1\%) of students in 2017 reported that they did not drink any soda or pop within the past seven days.

**Figure 376: Percentage of Montana High School Students Who Drank Soda or Pop At Least Once Per Day in the Past Seven Days, Grades 9-12, 2017\textsuperscript{368}**

Physical Activity\textsuperscript{1486}

For optimal health, children and adolescents should participate in at least 60 minutes of physical activity every day. In 2017, more than half (53.4\%) of high school students in Montana reported that they were physically active for at least 60 minutes per day on five or more of the past seven days. Male students were more likely than female students to be physically active for 60 minutes on five or more days within a week (62\% compared to 44.5\%).

About one in 10 (11.1%) high schoolers in Montana did not participate in at least 60 minutes of physical activity on any of the past seven days. More than one-quarter (28%) of students reported that they were physically active at least 60 minutes on all of the past seven days.

**Figure 377: Percentage of Montana High School Students Who Were Physically Active for 60 Minutes on Five or More of the Past Seven Days, 2017**

Youth are participating in sedentary activities at increasing rates. In 2017, 34.6% of students in Montana reported spending three or more hours on an average school day playing video or computer games or using a computer for something other than schoolwork. This is more than double the rate of 16.2% in 2007.

**Figure 378: Percentage of Montana High School Students Who Played Video Games or Used a Computer Three or More Hours a Day on an Average School Day, 2017**

In 2017, 18% of Montana high school students spent three or more hours watching TV on an average school day — a rate that has declined over the last decade (from 22.2% in 2007).

---


Suicide and Injury Prevention

Intentional and unintentional injuries are the leading cause of death for Montana children and youth age 0-24.\(^{1487}\) In 2014, Montana had the highest rate of suicide in all age groups.\(^{1488}\) One in 10 Montana high school students and one in seven middle school students reported attempting suicide in 2018.\(^{1489}\) 65% of suicides were committed using firearms in 2014 to 2016, followed by hanging, overdose, sharp objects, and others.\(^{1490}\) Montana has the second highest rate of suicide by firearm in the county at 14.6 for every 100,000 people. Additionally, Montana has the 6\(^{th}\) highest rate of gun ownership at 52.3% of the state.\(^{1491}\)

In 2018, Montana’s rate of injury deaths for children age 5-14 was 12.9 for every 100,000 people compared to the national rate of 5.6 for every 100,000 people. For children and young adults age 15-24 in Montana the rate was 70 for every 100,000 people compared to the U.S.’s 53.4 for every 100,000 people.\(^{1492}\) Nearly half of all unintentional injury deaths in Montana are from motor vehicle collisions.\(^{1493}\)

Community Input from Montana

We visited Montana in 2018 and met with community members and stakeholders to ascertain what they felt were the needs of their communities. We met with 17 parents, one grandparent, two social workers, a CYSHCN parent partner, a hospital chief medical officer, a pediatric hospitalist, a foodbank coordinator, two community pediatricians, and two parents of kids with special healthcare needs. The needs most frequently mentioned included affordable housing, transportation, access to healthy and affordable food, affordable childcare, access to safe healthy places for children, and parenting resources.

Cost of Living

---

Affordable housing is increasingly scarce as cost of living rises and affects families’ ability to access their other basic needs. One parent described how the cost of medical care created food insecurity for her family – after copays and deductibles beyond what she expected to budget, her family had to choose between paying bills on time and buying enough to eat.

In rural communities, inadequate transportation affects families’ ability to access healthcare and other services. Missoula residents were glad to have a free bus system, though the limited hours and stops do not make it sustainable for families. Families described being without reliable access to a car as like being on an island.

Access to healthy and affordable foods is also a challenge. Parents described helpful programs such as WIC, food stamps, the Missoula Food Bank, and backpack programs that send kids home from school with food. In some communities, these backpack programs are covered by the school district or through other grant funding; in one rural community interviewed, the school principal pays for these supplies out-of-pocket.

Many parents described the cost of childcare as a significant barrier, particularly for families relying on dual-caregiver income or for single-parent households.

Some parents indicated a need for better access to safe healthy places for their school age children as well supervised affordable activities for children to do during the summer or outside of school. Parents noted that there were several resources for infants and toddlers, even if some of those were expensive, but that school age children and teens sometimes had a harder time finding activities. For working parents, camps and other supervised activities for their kids could get expensive, limiting access.

Many caregivers and providers expressed a desire for reliable, accessible resources for parents covering anything from help on raising children to advice on common medical problems, particularly resources available virtually. One pediatrician described a local texting initiative about healthy habits which was very well-received in the community and hoped to try similar programs in the future.

**Access to Care**

Access to care was a common theme and includes access to inpatient and outpatient subspecialty providers, developmental therapies, and therapies that are in-home or in the local community.

- Many families feel content with their children’s primary care.
- There was a call for improved access to pediatric subspecialists in Montana.
- Many families currently needed to drive longer than 5 hours or travel to Seattle for a subspecialist appointment.
- The lack of adequate pediatric endocrinology and rheumatology providers was remarked upon by stakeholders in multiple Montana communities.
- Some parents also requested access to a developmental-behavioral pediatrician over a longer period of time (need years, not months with this kind of specialist).
- One parent shared his distress at the lack of Neurosurgery availability after his child had an intracranial injury.

Many shared concerns about immediate access to life-saving trauma care.
Medical transport costs created complex barriers to care. Multiple families described being put in the impossible position of choosing to send their child by medical airlift to Seattle for life-saving care only to be saddled with a prohibitively large transport bill. Families described having to use political connections and rather assertive advocacy to have the bill reduced or waived, and families without those connections or skills faced financial devastation. One parent described another family in the community who had lost their home in order to pay for medical transport. For non-emergent care, many families requested care options closer to home that could reduce these costs.

Many parents of children with developmental delays shared their concerns about losing access to early intervention services and lack of access to in-home therapies.

- Some were concerned that changes in political leadership will negatively impact their children’s access to medical services and even felt pressured to move to Seattle for easy access to healthcare resources.
- The lack of providers or coverage for home nursing and in-home therapies (such as physical and occupational therapy) has left some families to cover these costs out-of-pocket or to improvise. Families also mentioned long waitlists for therapy services and appointments with specialized healthcare providers of all types.

In Missoula, families appreciated having access to a 24-hour nurse advice telephone line. In more rural areas, primary care and urgent medical provider access can be limited. A healthcare provider in Polson noted that there is no pediatric nurse or provider triage line in town.

**Injury Prevention**
The community members we heard from were acutely aware of their children’s risks for serious outcomes from injuries and were keen on starting or improving injury prevention programs to keep their kids safe.

- Families in Missoula praised the local fire department’s car seat fitting program.
- Some community members wished that bicycle helmet use was mandatory.
- Parents of a child with autism and parents with kids with special healthcare needs expressed concerns about supervision.
- Parents of adolescents worried about risk-taking behaviors, especially when teens are driving.
- Caregivers also discussed drowning and water safety as a significant concern.

**Mental Healthcare**
Mental health was identified by families and providers as Montana’s biggest challenge. The stigma of depression and anxiety was described as a barrier to accessing services, as was a lack of knowledge about resources.

- Schools and primary care offices were seen as supportive environments.
• Healthcare providers noted that while they screen frequently for mental health problems, there are not enough services to provide therapy for the children who screen positive.
• Waitlists for formal evaluations are prohibitively long and far from smaller communities. Neuropsychological testing waitlist were as long as 18 months.
• This adds financial strain; until a diagnosis is made, many insurance providers will not cover services, leaving families to pay out-of-pocket.
• Access to child psychiatry was significantly limited, with waitlists at least six months long. The two child psychiatrists in Missoula are not accepting new patients, so many families have nowhere to go for pediatric psychiatry care.
• Some tele-psychiatry organizations had been improving access to mental health services, but many recently abruptly lost funding.
• Some providers noted that the tele-medicine approach had been very well-received, particularly in smaller rural communities where this type of patient-provider relationship allowed for the maintenance of better privacy and anonymity for stigmatized diagnoses.
• Several pediatric primary care providers voiced their desire to have access to the Partnership Access Line (PAL) to support their management of children’s mental health needs.
• Families remarked on the parent-child dyad, and that not only do children often “fall through the cracks” in a system that cannot offer adequate services, but parents also often have unmet mental health needs. One pediatric provider described how substance abuse impacts the entire family: addiction affects someone’s priorities, such that care of a child or other family member moves down on the priority list and this leads to fragmented family situations.
• Several parents worried about the prevalence of drinking and driving in Montana.
• Some parents made the link between firearm access and teen suicide. Community members were concerned about the lack of adequate suicide crisis services and preventative services. One provider described a common occurrence: admitting a pediatric patient to the hospital following a suicide attempt and waiting weeks for an inpatient psychiatric bed to open up, only to discharge the patient when a bed never became available. The lack of adequate inpatient psychiatric care was echoed by other providers and families.
• Firearms were a frequent safety topic. The majority of households in Montana have at least one firearm, either for hunting or personal protection. Many parents worried about firearms being around children and expressed desire for better access to lock boxes and firearm safety education. They wished for parents and medical providers to be more comfortable talking about whether guns are secured and their child’s friends’ homes.

Medical Home, Care Coordination, and CSHCN
There was a desire among community members for better coordinated care via medical home, especially with parents and caregivers of children with special healthcare needs (CSHCN).

• Parents described some community healthcare facilities that they would not trust with their children, and this concern about trust spanned both CSHCN and typically developing children. A rural community pediatrician described trust and barrier issues as
well; that families worried that there were strings attached to services, so they refused them.

- Parents of CSHCN without a unifying diagnosis noted difficulty navigating between multiple subspecialists, particularly for urgent or emergent medical care.
- Parents described the difficulty of “finding a medically complex hub” in Montana. Several families described the sudden loss of robust multidisciplinary services when transitioning home from Seattle Children’s with a medically complex child.
- Taking medical transport to Seattle for every illness is unfeasible for families, and many desired a medical home for reliable advice and evaluation closer to home.
- With so many subspecialists involved, it was difficult to know where to turn when a problem arose. Many families didn’t know what provider to turn to in certain situations.
- The distance from Seattle and likelihood that the provider performing the child’s initial evaluation would not be pediatrics-trained (in the local walk-in clinic or emergency room) can make getting guidance from the right subspecialist challenging.
- Children with specialized pediatric medical needs who lived in rural communities would travel long distances even for pediatric primary care.
- Providers expressed a desire for clear education and guidance for rural triage and initial medical care for these children.
- One pediatrician noted that mortality rates for children presenting to rural emergency care are higher than in urban settings, and that a “rural pediatric toolkit” with pathways and algorithms adapted for rural settings could help providers triage, stabilize, and transport more safety and with better outcomes.
- Multiple caregivers of CSHCN expressed worry about adolescent transition to adult medical services. A parent of a child with multiple therapy services shared that the waitlists for adult services were even longer than those for children. A parent of a child with cancer and associated complications worried that transition to adult care would mean losing a family-centered approach and multi-disciplinary services.
- Parents described both positive and negative experiences with coordination of primary and subspecialty medical care. One parent beamed about her child’s positive experiences in a well-coordinated multidisciplinary clinic that was oriented to his diagnosis and provided easy access for questions and remote help. Some families described difficulty successfully coordinating appointments through the Seattle Children’s scheduling center when schedulers did not have access to dates or locations of regional outreach clinics and instead encouraged families to scheduled appointments in Seattle.
- One parent described how this phenomenon resulted in his family traveling to Seattle for a Neurology clinic visit one day before the next Neurology outreach clinic in Missoula. Some parents have become their own care coordinators, at the cost of time and frustration.
- Primary care providers appreciated the amount of communication they received from Seattle Children’s inpatient providers while their patients were admitted in Seattle. When children are seen at local emergency rooms or hospitals, their primary care providers commented that they would like more facile access to documentation from those visits.
Building Community and Isolation
Many parents discussed turning to family and friends for support, and several remarked about the benefits of living in small communities.

- While the majority of Montana’s residents are white, Montana is also home to several tribal areas. These communities live separately from their non-native counterparts, and health disparities often fall along ethnic lines.
- In rural areas, especially in majority native communities, families find support and information from older generations in multi-generational families.
- Schools are an important source of community, and families of children with mental health or behavioral challenges described schools as partners and support structures.
- Community organizations such as churches are also a common source of support and information.
- Parents of CSHCN frequently described Facebook and online communities as a place to share information with parents facing similar challenges.
- Parents shared how they used communities to find ways to make life as normal as possible, such as how to go hiking with a ventilator-dependent child or how to find a wetsuit to allow a child with a central line to go swimming. In each of these cases, families described their communities as places where they sought both medical advice and parenting help.
- Several community members described a feeling of isolation, which was related either to their geographic location in Montana or to their status as the caregiver of a medically complex child, and these statuses frequently overlapped. Parents of CSHCN, who were often juggling work and parenting responsibilities while improvising home nursing care, described spending so much time caring for their children that there was no time to dedicate to anything else.

Parents as Advocates
- Parents often serve as advocates for their children, and this was no different among the parents interviewed in Montana.
- In between performing caregiving duties, parents of CSHCN called insurance providers, negotiated the acquisition and delivery of medical supplies, and kept meticulous notes to double check the many medical bills and other documents they would receive.
- They described taking on the role of nurses, accountants, and spokespeople in their families.
- Multiple parents described going as far as speaking with their elected state legislators regarding their children’s medical costs – particularly costs related to urgent medical transport – and successfully had those costs reduced.
- One parent help form a group of families that successfully engaged the FDA regarding a prohibitively expensive medication.
- Parents frequently described experiences in which their knowledge or expertise of their child was not acknowledged, particularly for parents of CSHCN. They described this leading to poor rapport and trust with medical providers.
Bozeman, Gallatin County

Demographic Overview of Bozeman

Bozeman is located in southwest Montana in Gallatin County. From 2013 to 2017, the average population of the city of Bozeman was more than 43,000 — about 22% under the age of 20. In Gallatin County, the population was nearly 108,000 (about 24% under the age of 20) in 2017. Over the last decade, the population of children under age 15 has increased in Gallatin County, especially among youth ages 10 to 14.

Table 380: Population Change by Age Group Between 2007 and 2017, Gallatin County

<table>
<thead>
<tr>
<th>Ages</th>
<th>2007</th>
<th>2017</th>
<th>Percent change (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-4</td>
<td>6,601</td>
<td>6,784</td>
<td>2.8%</td>
</tr>
<tr>
<td>5-9</td>
<td>5,263</td>
<td>5,747</td>
<td>9.2%</td>
</tr>
<tr>
<td>10-14</td>
<td>4,817</td>
<td>5,953</td>
<td>23.6%</td>
</tr>
<tr>
<td>15-19</td>
<td>7,404</td>
<td>6,921</td>
<td>-6.5%</td>
</tr>
</tbody>
</table>

Much like the state of Montana, the majority of the population in Bozeman (93.1%) identified as white (non-Hispanic or Latinx), according to U.S. Census Bureau data from 2013 to 2017. Rates were similar across Gallatin County, where 94.7% of residents identified as white (non-Hispanic or Latinx). About 3.3% of the population in Gallatin County identified as Hispanic or Latinx.

Figure 381: Population (All Ages) by Race/Ethnicity, Bozeman, 2013-2017 Average

---

On average between 2013 and 2017, one in 10 children and teens under age 18 lived in poverty in Bozeman. In Gallatin County, 9% of children and teens under age 18 lived in poverty over the same period of time. During the 2017-18 school year, 2,691 students in Gallatin County received free or reduced-price lunch.

In Gallatin County, the unemployment rate was 2.5% in 2018 — down from 2.7% in 2017 and 2.8% in 2016.

On average from 2013 to 2017, the median household income in Bozeman was $49,217. In households with children under age 18, the median family income was $77,255. People who identified as Asian (representing 2% of the population) had the highest median income ($71,583), while people who were multiracial (representing about 2% of the population) had the lowest median income ($33,056).

In Gallatin County, the average median household income from 2013 to 2017 was $59,397. In households with children under age 18, the median family income was $78,934. People who identified as Asian (representing about 1% of the population) had the highest median income ($75,595), while people who reported as American Indian/Alaska Native (representing nearly 1% of the population) had the lowest median income ($21,417).

For the 2017-18 school year, the graduation rate in Gallatin County was 89.7%, an increase over previous years. The high school dropout rate during the same school year was about 2.3%, which has declined over the years and is lower than the state average.

From 2011 to 2015, the average childhood cancer incidence was 13.3 cases per 100,000 children in Gallatin County.
In Gallatin County, 79.8% of women from the county who gave birth in 2017 received prenatal care in the first trimester of pregnancy. The percentage of infants born in Gallatin County at low birth weight was 6.6% in 2017, a rate that was lower than the state average.

In Gallatin County, 13.9% of children were food insecure, and about half of these children were eligible for federal nutrition programs based on income level in 2017.

Figure 382: Percentage of Children Who Were Food Insecure in Gallatin County, 2017

Community Input from Bozeman

We visited Bozeman in 2019 and met with community members and stakeholders to ascertain what they felt were the needs and assets of their communities. We met with eight parents, a school nurse, two pediatricians, the executive director of the science center, the executive director of a nonprofit serving Native and Latinx families, an employee at the Gallatin City-County Health Department, and a young-child wellness coordinator.

The themes that emerged from these interviews and listening sessions were better support for children with special healthcare needs and their families, more focus on behavioral and mental healthcare, the importance and challenges of achieving health equity, and the resources and assets in Bozeman to support health and wellness for children.

Children with Special Healthcare Needs

It is difficult to access pediatric subspecialty care when and where it’s needed.

- Limited services are offered in Bozeman.
- Families must travel, which often involves financial, logistical and/or social hardship.
  
  One parent said, “It was on me to try to get the prior authorization…This happened the

---

day before our trip and I was worried I needed to cancel. I had to be my own social worker. It was complete chaos.”

- Resources that do exist regionally are scattered across geography and health care systems.
- Providers are limited in their ability to build professional networks without an anchoring partner.
- Some mentioned a need for more intensive care coordination and wrap around services.
- Families are expected to navigate a complicated health care system, insurance issues, etc. on their own.
- More communication and partnership is needed between providers and between health care systems.
- Often subspecialty care and higher levels of acuity are managed in the primary care, school health, emergency department, or acute care setting, locally.
- There is variable provider comfort and parental trust in managing children with special health care needs, both for subspecialty needs and routine pediatric care. One pediatrician said, “As a PCP, you’re having to manage so much specialty care without enough training.”

There were suggestions from improvement. One pediatrician said, “It would be great to have Seattle Children’s as a hub/resource for subspecialty care. Possibilities include developing partnerships with doctors who live in Bozeman, sending more specialists more often, developing a telemedicine program, and improving the triage system and communication around acute phone consults.”

**Mental and Behavioral Health**

Behavioral and mental health were identified by parents and most stakeholders as a primary area of concern with significant needs and gaps.

- Some of the challenges include: Stigma and cultural norms around mental health; fragmented, under-resourced mental and behavioral health system, especially for children; not enough local counselors and providers who will see children; and lack of local placement for children needing higher levels of care.
- This contributes to family financial stress, logistical difficulties, loss of continuity or care coordination services, and potential to perpetuate cyclical institutionalization and feeling of “failure” among children who go in and out. One parent said, “Our Montana culture is that we’re ‘bootstrappers.’ You just pick yourself up. That makes it hard when you’re trying to talk about access to mental health.”
- The Medicaid reimbursement structure and policies make it difficult to provide appropriate services.
- One stakeholder summed up the climate like this: “Our public mental health system used to be the envy of the state but started falling apart about 5 years ago due to budget cuts and funding changes. This leaves places like Community Health Partners, and other clinics and local agencies trying to fill in the gaps.”
Despite these challenges, a lot is being done around behavioral and mental health.

- A grant was recently awarded to implement trauma-focused counseling and integrated services in the Bozeman School District.
- Home visits and screening for adverse childhood experiences (ACEs) were implemented through the health department. One parent said, “One of the counselors in the school comes in once a week to my daughter’s class and does mindfulness to help build coping skills. That kind of stuff is awesome.”
- There was a recent addition of integrated behavioral health at a pediatrics clinic.
- A partnership was forged between Youth Dynamics and the school district to provide local intensive outpatient services for high risk children.

**Equity and Access**

Inequities exist throughout Bozeman and the surrounding areas, largely along socioeconomic and geographic lines. Finances are a major barrier to accessing needed care and services.

- One stakeholder noted, “There are lots of opportunities for kids in the community, but not everyone can afford it.”
- Access to healthcare services is especially limited in rural settings.
- Aspects of the built environment that promote health and wellness differ significantly throughout the county (i.e. access to parks, sidewalks, etc.)
- Not all families are accessing community assets. Another stakeholder mentioned that “Not all families are utilizing all these outdoor recreation resources. It might be free and accessible, but completely foreign to you.”
- At least one parent perceived that she was treated differently in the medical system due to type of health insurance, and several parents felt finances significantly impacted the quality of care they had access to for their children.
- Affordable housing and affordable childcare were identified as significant social determinants of health contributing to inequity.
- One parent stated that “Cost of living here is high; it’s a relative affluent area. Some kids who don’t come from affluent families get overlooked. Those with money can travel to other hospitals. Some families cannot do that.”

**Community Assets that Support Child Health**

Bozeman has many assets that their population takes pride in. One parent said, “Medically, it would be easier to live somewhere else, but we live here because this town is great and our kids do get exposed to great things.”

- This is a small town where parents support each other.
- There are valuable social networks that provide support and information.
There are many safe places for children including parks and family friendly events around town.

The town has many community organizations including a food bank with a summer lunch program, a public library, a science center, and public health home visitation program.

Helena, Lewis and Clark County
Demographic Overview of Helena

Located in Lewis and Clark County, Helena had an average population of 30,345 from 2013 to 2017 (about 21% under the age of 20).\textsuperscript{1515} Helena is the state capital, located between Glacier National Park and Yellowstone National Park.

In Lewis and Clark County, the population was nearly 68,000 (about 24% under the age of 20) in 2017.\textsuperscript{1516} Since 2013, the population of children under age 10 has increased in Lewis and Clark County, but has decreased among children and teens ages 10 to 19.\textsuperscript{1517}

Table 383: Population Change by Age Group Between 2013 and 2017, Lewis and Clark County\textsuperscript{375}

<table>
<thead>
<tr>
<th>Ages</th>
<th>2013</th>
<th>2017</th>
<th>Percent change (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-4</td>
<td>3,594</td>
<td>3,919</td>
<td>9%</td>
</tr>
<tr>
<td>5-9</td>
<td>3,528</td>
<td>4,439</td>
<td>25.8%</td>
</tr>
<tr>
<td>10-14</td>
<td>4,508</td>
<td>3,850</td>
<td>-14.6%</td>
</tr>
<tr>
<td>15-19</td>
<td>4,312</td>
<td>4,195</td>
<td>-2.7%</td>
</tr>
</tbody>
</table>

Much like the state of Montana, the majority of the population in Helena (93\%) identified as white (non-Hispanic or Latinx), according to U.S. Census Bureau data from 2013 to 2017.\textsuperscript{1518} Rates were similar across Lewis and Clark County, where 93.8\% of residents were white (non-Hispanic or Latinx).\textsuperscript{1519} About 3\% of the population in Lewis and Clark County identified as Hispanic or Latinx.\textsuperscript{1520}

Figure 384: Population (All Ages) by Race/Ethnicity, Helena, 2013-2017 Average\textsuperscript{376}

\textsuperscript{375} U.S. Census Bureau, American Fact Finder. Retrieved from https://factfinder.census.gov.

\textsuperscript{376} U.S. Census Bureau, American Fact Finder. Retrieved from https://factfinder.census.gov.
On average between 2013 and 2017, one in five children and teens under age 18 lived in poverty in Helena. In Lewis and Clark County, 14.1% of children and teens under age 18 lived in poverty over the same period of time. During the 2017-18 school year, 4,064 students in Lewis and Clark County received free or reduced-price lunch.

In 2018, the unemployment rate in Lewis and Clark County was 3.3% — the same rate as 2016, but down from 3.4% in 2017.

In Helena, the average median household income from 2013 to 2017 was $53,892. In households with children under age 18, the median family income was $70,611. People who were white (representing about 94% of the population) had the highest median income ($55,776), while people who identified as American Indian/Alaska Native (representing nearly 2% of the population) had the lowest median income ($22,069).

On average from 2013 to 2017, the median household income in Lewis and Clark County was $60,789. In households with children under age 18, the median family income was $73,898. People who were white (representing about 95% of the population) had the highest median household income ($62,136), while people who were Black/African American (representing almost 1% of the population) had the lowest median income ($30,800).

The graduation rate in Lewis and Clark County for the 2017-18 school year was about 84.6%, a rate that has stayed fairly stable over the past few years. The dropout rate for high school students during that year was 4.4% — down from 6.3% during the 2013-14 school year.

Cancer
The incidence of childhood cancer was 21.1 cases per 100,000 children from 2011 to 2015 in Lewis and Clark County.

In 2017, 81.8% of women from Lewis and Clark County who gave birth received prenatal care in the first trimester of pregnancy. Of infants born in 2017, 6.8% were born at low birth weight, just under the state average.

In 2017, 15.9% of children were food insecure in Lewis and Clark County, and about half of those children were eligible for federal nutrition programs based on income level.

Figure 385: Percentage of Children Who Were Food Insecure in Lewis and Clark County, 2017

---

Missoula (City), Missoula County
Demographic Overview of Missoula

Missoula is located in the western part of Montana in Missoula County. The city is located in the northern part of Montana’s Rocky Mountains where three rivers meet.

In 2017, the population of the city of Missoula was more than 73,000 — nearly 23% under the age of 20. In Missoula County, the population was about 114,000 (about 23% under the age of 20) that same year. Over the last decade, there were large increases in the population of children under age 15 (especially young children) in the city of Missoula.

Table 386: Population Change by Age Group Between 2007 and 2017, Missoula (City)

<table>
<thead>
<tr>
<th>Ages</th>
<th>2007</th>
<th>2017</th>
<th>Percent change (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-4</td>
<td>3,444</td>
<td>4,750</td>
<td>38%</td>
</tr>
<tr>
<td>5-9</td>
<td>2,914</td>
<td>3,224</td>
<td>10.6%</td>
</tr>
<tr>
<td>10-14</td>
<td>3,444</td>
<td>3,691</td>
<td>7.2%</td>
</tr>
<tr>
<td>15-19</td>
<td>5,100</td>
<td>4,954</td>
<td>-2.9%</td>
</tr>
</tbody>
</table>

Much like the state of Montana, the majority of the population in the city of Missoula (more than 91%) identified as white (non-Hispanic or Latinx), according to U.S. Census Bureau data from 2013 to 2017. Rates were similar across Missoula County, where 92% of residents were white (non-Hispanic or Latinx).

Figure 387: Population (All Ages) by Race/Ethnicity, Missoula (City), 2013-2017 Average

---

In the city of Missoula, 15.2% of children and teens under age 18 lived in poverty on average between 2013 and 2017. During the 2017-18 school year, 5,867 students in Missoula County received free or reduced-price lunch.

In the city of Missoula, the seasonally adjusted unemployment rate was 2.9% in April 2019, compared to 3.1% in April 2018.

On average from 2013 to 2017, the median household income in the city of Missoula was $43,602. In households with children under age 18, the median household income was $70,655. People who identified as Asian (representing almost 2% of the population) had the highest median income ($50,837), while people who identified as Black/African American (representing 0.5% of the population) had the lowest median income ($25,785).

In Missoula County, the average median household income from 2013 to 2017 was $49,412. In households with children under age 18, the median family income was $72,093. People who were Asian (representing about 1% of the population) had the highest median income ($51,261), while people who were Black/African American (representing 0.3% of the population) had the lowest median income ($26,279).

In Missoula County Public Schools, the graduation rate for the 2017-18 school year was about 89% — a higher rate than the state average. The dropout rate that year in Missoula County Public Schools was 3.7%.

In the Missoula County area, the childhood cancer incidence was 16.3 cases per 100,000 children from 2011 to 2015.
In Missoula County, 77.4% of women who gave birth in 2017 received prenatal care in the first trimester of pregnancy. In 2017, 6.3% of infants born in Missoula County were low birth weight.

The rate of food insecurity among children in Missoula County was 16.3% in 2017. Among those children, half were eligible for federal nutrition programs based on income level.

**Figure 388: Percentage of Children Who Were Food Insecure in Missoula County, 2017**

---

### Community Input from Missoula

We visited Missoula in 2018 and met with community members and stakeholders to ascertain what they felt were the needs and assets of their communities. We met with 11 parents and caregivers, most of whom had at least one child with a special medical need as well as two social workers, a pediatrician, an office manager at a pediatrician’s office, a Chief Medical Officer of a medical center, and a program services coordinator at a food bank. This is what we found.

#### Affordable Housing

One of the main themes was affordable housing:

- Listening session participants commented that their incomes are not increasing commensurate to the increases in the cost of housing.
- The rental market is also challenging; there is a perception that rental vacancy rates are decreasing many of the renters in the listening session reported paying more than 30% of their income on hoysing costs.

#### Access to Mental Healthcare

There is difficulty accessing mental healthcare.

---

There are reported gaps in access to Medicaid, rural, Native American populations as well as few providers who are willing to treat young children.

Inpatient facilities are reported to often be at capacity and may limit patients by age.

**Transportation**

Transportation issues primarily affect families outside of the city of Missoula, who depend on cars for transportation.

- Within the city, there is a zero-fare bus system as the primary public transport infrastructure.
- There are also many bike trails throughout the city.
- The population tends to be more highly active than in most other US states, often attributed to Montana’s natural beauty and opportunities for outdoor recreation.

**Access to Care**

Missoula families are concerned that they do not have a medical home. They work with Seattle Children’s regarding specialty needs but are unsure where to go locally when their child becomes ill.

- Communication and care coordination between and within primary care pediatricians and specialists is a concern.
- One parent mentioned the need for increased open channels of communication between providers and the child’s school.
- Parents worry about losing access to medical supplies and services such as physical, occupational and speech therapy.
- They reported long waitlists as a limiting factor to optimize those services.
- Parents serve as advocates on behalf of their families.
- Families also expressed financial challenges exacerbated by expensive medical care and wondered how to keep services such as Medicaid.
- Numerous parents of older children expressed apprehension about the transition to adulthood and adult medical care.
- Many parents of children with special healthcare needs also expressed feeling isolated in Missoula. Despite being a relatively small community, parents felt limited in their ability to maintain the active lifestyles they hoped for or had before having children with special healthcare needs.
- Parents generally expressed gratitude and satisfaction with their child’s care, but wished there was additional specialty care with shorter wait times closer to home.
- They requested developmental behavioral pediatrics, pediatric orthopedics, endocrinology and additional days of rheumatology.
- One parent praised the care her child had received at Duchene Muscular Dystrophy multi-disciplinary clinic.
- Participants mentioned trouble in getting:
  - access to primary and/or specialty pediatric healthcare,
affordable childcare,  
- access to physical therapy, occupational therapy, speech language pathology and home nursing,  
- out of poverty and lack of economic security.

**Community Assets and Challenges**

- Missoula has many grocery stores and farmer’s markets with healthy, affordable food options. Yet access to these foods remains limited by affordability, which is a challenge in Missoula secondary to the burden of housing costs.
- A key asset to the community is the Missoula Food Bank (MFB), which provides free food to participating families. 34% of customers are under 18 years old. They are located in a new building and set up as a store with many food choices to decrease stigma of using a food bank.
- Another community asset is a free childcare and playplace for children over 5 years old called the EmPower Place, a partnership with Missoula Public Library and the University of Montana. They also have a new kitchen with free cooking classes and a conference room with English as a second language classes.
- Communities were particularly interested in having resources available virtually, either via text or internet. One pediatrician described a local texting initiative about healthy habits which was very well-received in the community, and hoped to try similar programs in the future.

**Appendix A: Methods**

Methods for this 2019 Seattle Children’s Pediatric Community Health Assessment and the Jointly Authored 2018 King County Hospital’s Community Health Needs Assessment (CHNA) are summarized in the introduction and explained in detail below.

**Identification of Health Needs and Selection of Indicators**

A committee of representatives from Hospitals for a Healthier Community (HHC), facilitated by Public Health-Seattle & King County (PHSKC) staff, revisited the original list of 2015/2016 community health indicators and opted to remove a short list of 12 indicators for which timely and/or actionable data are not currently available in King County. A few additional indicators were added to the CHNA to reflect emerging or more widely accepted community health needs, such as the opioid epidemic.

The final set of indicators were analyzed, using appropriate statistical methods, by Public Health-Seattle & King County. Data were compiled from local, state, and national sources such as the U.S. Census Bureau, U.S. Centers for Disease Control and Prevention, Washington State Department of Health, and King County.
For each assessment, representatives planned a succinct report, focused on key indicators relating to the hospitals’ and communities’ assets and resources, that could inform future collective strategies. These indicators are relevant for population-based preventive strategies and promote policy/systems/environmental change for maximum population health impact. It was also recognized that partnerships between hospitals, public health, community organizations and communities are key to successful strategies to address common health needs.

Representatives were subject matter experts who helped identify population-level health needs. The groups reached consensus to focus particularly on social determinants of health, access to care, weight-related health and health behaviors, maternal and child health, mental and behavioral health, and suicide and injury prevention. Each hospital could also gather additional data and community input to address more specific service areas, such as cancer care, pediatrics and rural health.

Representatives for both assessments developed criteria to select indicators for the King County CHNA and the Pediatric CHA recognizing that each assessment cannot provide all of the data for each specialized topic. All topic areas were previously identified as areas of concern in other assessments. We used the criteria below to identify indicators other than those specified in the mandated topic areas.

1. Ability to address health equity, particularly by age, gender, race/ethnicity, geography, socioeconomic status although not all demographic breakdowns may be available for all indicators.
2. Availability of high-quality data that are population-based (where possible), measurable, accurate, reliable and regularly updated. Data should focus on rates rather than counts.
3. Ability to make valid comparisons to a baseline or benchmark.
4. Prevention orientation with clear sense of direction for action for individual, community, system, health service or policy interventions that will lead to community health improvement.
5. Ability to measure progress of a condition or process that can be improved by intervention/policy/system change, and there exists a capacity to affect change.
6. Alignment with local and national healthcare reform efforts, including the “Triple Aim,” which involves enhancing the patient care experience, improving the health of populations and reducing the per capita cost of healthcare.

The Pediatric Community Health Assessment (CHA) team also had sector representatives and the two groups finalized the selection of indicators with feedback from public health and hospital staff. Beyond the stakeholder interviews conducted with the CHA, the pediatric assessment’s community input included input from 65 Seattle Children’s leaders, faculty and staff as well as the following:

2016-2017: 6 WAMI listening sessions, 1 site visit and 27 key informant interviews
2017-2018: 8 WAMI listening sessions, 5 site visits, 69 key informant interviews
2018-2019: 6 WAMI listening sessions, 2 site visits, 76 key informant interviews.
During this time (2016-2019) and in addition to the WAMI listening sessions, we also co-hosted 15 local (Seattle/ King County) listening sessions that we called community cafes. We conducted all of our listening sessions and community cafes in English, and provided Spanish translation at three events, Somali translation at five events, Amharic translation at five events, Oromo translation at one event and Vietnamese translation at one event.

**Limitations**

Key limitations of this report include incomplete or inadequate quantitative data on some topics of interest and our inability to summarize every asset and opportunity in the WAMI region. For example, although we report data on fruit/vegetable consumption, comprehensive population-based data on healthy eating are simply not available. In addition, resource limitations prevent us from mentioning all of the valuable organizations and assets in our communities.

We collected data from agencies that use varying data sets. A particular challenge was inconsistent age groupings in epidemiological and outcome data. Data were also inconsistent in defining life-stage categories, such as when a child is considered an adult.

Inconsistencies in terminology and definitions made it difficult to make side-by-side comparisons. For example, the definition of “Hispanic” varies from one community to another. The definition of “community” also varies. Individuals participating in a CHNA and CHA likely define their community differently: a community can be a geographic area, a racial/ethnic group, a school or a religious affiliation. This poses problems when analyzing interview and survey results.

**Description of the Data**

The 2018/2019 CHNA and 2019 Pediatric CHA took into account input from people who represent the broad interests of the communities served by hospitals and health systems in King County or Seattle Children’s specifically.

Three methods of gathering information from community members about identified health needs and assets were used:

1. For both the King County CHNA and Pediatric CHA, interviews were conducted with stakeholder coalitions with broad representation between the Fall of 2016 and the Fall of 2019. This method maximized the number and diversity of stakeholders who could provide input. Coalitions were identified that have expertise on health needs identified through quantitative data, have diverse membership, and have a regional or subregional focus. Stakeholders included those who represent the broad interests of the community; representatives of medically under-resourced, low-income and people of color populations, and populations with chronic disease needs; and representatives from local health departments. Stakeholder groups included human service providers; community health centers; behavioral health providers; state, county and local government staff; law enforcement; advocacy organizations; hospital staff; groups focused on health disparities in communities of color; faith communities; labor organizations; and managed care organizations.
2. Recent reports on health needs were also reviewed for themes and relevant assets and resources.

3. Listening Sessions or community cafes (as described above) with parents and/or caregivers of children ages 0-21.

The information collected through these methods was analyzed for themes about key issues, available assets and resources, and opportunities. Interviews were conducted with individuals belonging to the following coalitions, agencies and organizations:

- Eastside Human Services Forum
- Aging & Disability Services
- The Arc of King County
- City of Bellevue
- City of Kirkland
- City of Redmond
- Friends of Youth
- Hopelink
- Issaquah Human Services Commission
- Issaquah Sammamish Interfaith Coalition
- King County Council
- Kirkland City Council
- Overlake Medical Center
- Redmond City Council
- Youth Eastside Services
- YWCA Seattle-King-Snohomish
- North Urban Human Services Alliance
- Center for Human Services
- City of Lake Forest Park
- City of Shoreline Human Services
- Hopelink
- Northshore/Shoreline Community Network
- Shoreline Community College
- Seattle Human Services Coalition
- South King Council of Human Services
- King County Traffic Safety Task Force
- Burien Police Department
- Kent Police Department
- Kirkland Police Department
- Issaquah Police Department
- Maple Valley Police Department
- Newcastle Police Department
- Redmond Police Department
- Renton Police Department
• Seatac Police Department
• King County Emergency Medical Services
• Safe Kids Seattle/South King County
• Feet First Pedestrian Safety Coalition
• Harborview Spine Center and Concussion Program
• Safe Kids Eastside
• Brain Injury Alliance
• CarSafe Kids
• Duvall Fire Department
• Eastside Aid Community
• EvergreenHealth
• Nick of Time Foundation
• Olympic Physical Therapy
• Central Region EMS & Trauma Care Council
• EvergreenHealth Emergency Department
• Group Health Emergency Department
• Harborview Medical Center Emergency Department
• Highline Medical Center Emergency Department
• Multicare Auburn Emergency Department
• Northwest Hospital Emergency Department
• Overlake Medical Center Emergency Department
• Seattle Children’s Hospital Emergency Department
• Snoqualmie Valley Hospital Emergency Department
• St. Elizabeth Hospital Emergency Department
• St. Francis Emergency Department
• Valley Medical Center Emergency Department
• Airlift Northwest
• AMR Ambulance
• Falck Northwest Emergency Medical Services
• Tri-Med Ambulance
• Washington Ambulance Association
• Public Health-Seattle & King County Emergency
• Medical Services
• Washington State Department of Health

Representatives of medically under-resourced, low-income and people of color populations, and populations with chronic disease needs who assisted in the assessment included:

• Asian Counseling and Referral Services
• Behavioral Health Partnership Group
• Catholic Community Services
• Community House Mental Health
• Community Psychiatric Clinic
• Consejo Counseling
• EvergreenHealth
• Harborview Mental Health
Community Input Limitations
While we gathered a great deal of community input from a wide range of stakeholders, limited resources made it impossible to reach all of our constituents. While we were able to conduct listening groups with multiple communities and interview several community members, these qualitative results should be interpreted as the perspective of the people who participated. While they are intended to provide insight into the assets, needs and ideas of the communities, they should not be interpreted as representing the whole community. These limitations may inadvertently reinforce health inequalities.

Review of Existing Reports
For the CHA, recent reports including broad community needs assessments, strategic plans, or reports on specific health needs were reviewed for context and relevant assets, resources, and opportunities. The following reports were reviewed:

1. Advancing Equity and Opportunity for King County Immigrants and Refugees: A Report from the King County Immigrant and Refugee Task Force
2. Aging and Disability Services 2017 Community Engagement
3. Aging the LGBTQ Way: A Forum on Equity, Respect & Inclusion, 2017
4. Allyship 2015 Housing & Safety Survey
5. Area Plan – Area Agency on Aging, Seattle-King County, 2016-2019
6. City of Seattle Health and Equity Assessment, June 2016
7. City of Seattle 2016 Homeless Needs Assessment
8. Count Us In – Seattle / King County Point-In-Time Count of Persons Experiencing Homelessness, 2017, 2018
10. Community Dialogues 2018 Report
13. Generations Aging with Pride: Focus Groups and Town hall feedback
14. Growing in Solidarity: Examining Food Inequities in Auburn
15. How King County Tackles Health Food Affordability, Stanford Center on Longevity, 2017
16. King County, Best Starts for Kids Community Conversations, 2016 and 2018
17. King County Equity and Social Justice Strategic Plan, 2016-2022
18. King County Equity and Social Justice Strategic Plan Community Engagement Report (December 2015)
19. King County Local Food Initiative, 2016 and 2017 Annual Report
20. King County Department of Community and Human Services, including Veterans, Seniors and Human Services Levy
21. King County Update to Regional Health Improvement Plan
22. King County Youth Action Plan, 2015
23. Living Well Kent Focus Group Executive Summary
24. MultiCare Auburn Medical Center - Community Health Needs Assessment and Implementation Strategy, 2016
25. Northwest Hospital & Medical Center Community Health Needs Assessment 2016
28. 2017 Seattle Chinatown-International District Public Safety Survey Report
29. Seattle Cancer Care Alliance Community Health Needs Assessment, 2016
30. Seattle Children’s Hospital 2016 Community Health Assessment
31. Seattle Chinatown-International District 2020 Healthy Community Action Plan
32. Seattle Youth Violence Prevention Needs Assessment, 2015
33. Swedish Community Health Needs Assessment 2016-2018
34. Swedish Community Health Needs Assessment – Ballard, 2016-2018
36. Swedish Community Health Needs Assessment – First Hill Campus & Cherry Hill Campus, 2016-2018
37. Swedish Community Health Needs Assessment – Issaquah, 2016-2018
Evidence-based and Evidence Informed Practices

Additional information on evidence-based practices is available from the following sources. Hospitals should consult these guides when planning interventions.

2. The Centers for Disease Control and Prevention’s [Community Guide to Preventive Services](https://www.cdc.gov/Features/CommunityGuide/index.html)
3. [Blueprints for Healthy Youth Development](https://www.blueprints.org/)
4. The Substance Abuse and Mental Health Services Administration (SAMHSA)’s [National Registry of Evidence-based Programs and Practices](https://www.nationalregistryofprograms.org/)

Appendix B: Report Structure

Report Definitions and Structure

For each indicator, this report includes:

- A description of the indicator
- Overall estimate for geographic area
- Multiple-year averaged estimates for select subpopulations (e.g. race/ethnicity and region) in either a bar chart or map
- Narrative interpretation that highlights important findings – typically of disparities (by race, place, income, gender, or sexual orientation) and trends
- The Community Health Indicators website includes enhanced information for each indicator in the report and additional indicators including (where applicable):
  - King County estimate from the most recent year available, including rate and number of people affected (this estimate may differ from the multiple-year averaged estimates presented in the report). NOTE: This is typically the only
single-year data presented; for most analyses, data from multiple years are combined to improve the reliability of the estimates.

- A bar chart that shows multiple-year averaged estimates for all demographic breakdowns (e.g., age, gender, region, race/ethnicity, and income or neighborhood poverty level as a measure of socioeconomic status).
- A map of multiple-year averaged estimates by neighborhoods/cities, ZIP codes, or regions.
- A line chart of rolling-averaged estimates for King County and each region over time to show trends (please see definition of rolling averages below).
- More detail about each data point appears in a tool tip box when the pointer hovers on a bar or line.

- The following symbols are used in graphs throughout the report (*, ^, !):
  - * Denotes values that are significantly different from the average
  - ^ There are too few cases to protect confidentiality and/or report reliable rates
  - ! While rates are presented, there are too few cases to meet a precision standard and results should be interpreted with caution.
  - To protect confidentiality, presentation of data follows reliability and suppression guidelines.

- **Confidence Interval** (also known as error bar) is the range of values that includes the true value 95% of the time. If the confidence intervals of two groups do not overlap, the difference between groups is considered statistically significant (meaning that chance or random variation is unlikely to explain the difference). For some indicators, primarily those from the Census or the American Community Survey, results are reported with a 90% confidence interval, showing the range that includes the true value 90% of the time.

- **Crude, Age-Specific, and Age-Adjusted Rates:**
  - Rates are usually expressed as the number of events per 100,000 population. When this applies to the total population (all ages), the rate is called the crude rate.
  - Infant mortality, maternal smoking, and other maternal/child health measures are calculated with live births as the denominator and presented as a rate per 1,000 live births (infant mortality) or percent of births (preterm, low birth weight, etc.).
  - When the rate applies to a specific age group (e.g., age 15-24), it is called the age-specific rate.
  - The crude and age-specific rates present the actual magnitude of an event within a population or age group.
  - When comparing rates between populations, it is useful to calculate a rate that is not affected by differences in the age composition of the populations. This is the age-adjusted rate. For example, if a neighborhood with a high proportion of older people also has a higher-than-average death rate, it will be difficult to determine if that neighborhood’s death rate is higher than average for residents of all ages or if it simply reflects the higher death rate that naturally occurs among older people. The age-adjusted rate mathematically removes the effect of the population’s age distribution on the indicator.

- **Prevalence rates from the Behavioral Risk Factor Surveillance Survey (BRFSS)** are expressed as percent of the adult population, usually ages 18+. Exceptions to the age range are noted. These rates are not age adjusted.
• **Prevalence rates from the Healthy Youth Survey (HYS)** are for public school students in the specified grades, and weighted to the population. HYS is only asked of students in grades 6 (abbreviated version), 8, 10, and 12 every other year.

• **Geographies:** Whenever possible, indicators are reported for the geographic area (e.g., County) as a whole. If enough data are available for a valid analysis, they may also be reported by smaller geographic areas (cities, neighborhoods within large cities, and groups of smaller cities and unincorporated areas).

• **Education data** are reported by school district.

• **Cities/Neighborhoods (also known as Health Reporting Areas or HRAs):**
  - In 2011, new King County Health Reporting Areas (HRAs) were created to coincide with city boundaries in King County. These areas, recently re-named “Cities/ Neighborhoods,” are based on aggregations of U.S. Census Bureau-defined blocks. Where possible, Cities/Neighborhoods correspond to cities and, for larger cities, to neighborhoods within cities, and delineate unincorporated areas of King County. These geographical designations were created to help cities and planners as they consider issues related to local health status or health policy. Cities/Neighborhoods are used whenever we have sufficient sample size to present the data. These are represented in the report as “city/neighborhood” data. In areas outside of King County, WA, these are reported as city or county or even state data.

• **Federal Poverty Guidelines**, issued by the Department of Health and Human Services, are a simplified version of the federal poverty thresholds. The guidelines are used to determine financial eligibility for various federal, state, and local assistance programs. For a family of 4, the federal poverty guideline was $24,250 in 2015; in 2016 it was $24,300. Neighborhood poverty levels are based on the proportion of households in a Census tract in which annual household income (as reported in the U.S. Census Bureau’s American Community Survey) falls below the federal poverty threshold.
  - High poverty: 20% or more households in the neighborhood below poverty threshold. Using this criterion, 14.0% of King County households are in high-poverty neighborhoods.
  - Medium poverty: 5% to 19% of households below poverty threshold. Using this criterion, 62.7% of King County households are in medium-poverty neighborhoods.
  - Low poverty: fewer than 5% of households below poverty threshold. Using this criterion, 23.3% of King County households are in low-poverty neighborhoods.

*An interactive map of King County census tracks can be found on the Communities Count website ([http://www.communitiescount.org/](http://www.communitiescount.org/)).

This neighborhood-level characteristic is used where individual measures of income or poverty level are not available. The high-poverty area follows the definition of a Federal Poverty Area. The 5% limit for low-poverty areas was chosen to create a group markedly different from Federal Poverty Areas, and thus sensitive to differences in health outcomes that may be associated with socioeconomic differences, while maintaining enough tracts in each group for robust comparisons. For area-based measures of poverty, a census tract is considered a neighborhood. Data sources where census tract information are not available use ZIP codes to designate the neighborhood.
• **Race/Ethnicity and Discrimination:** Race and ethnicity are markers for complex social, economic, and political factors that can influence community and individual health in important ways. Many communities of color have experienced social and economic discrimination and other forms of racism that can negatively affect the health and well-being of these communities. We continue to analyze and present data by race/ethnicity because we believe it is important to be aware of racial and ethnic group disparities in these indicators.

• **Race/Ethnicity Terms:** Federal standards mandate that race and ethnicity (Hispanic origin) are distinct concepts requiring 2 separate questions when collecting data from an individual. “Hispanic origin” is meant to capture the heritage, nationality group, lineage, or country of birth of an individual (or his/her parents) before arriving in the United States. Persons of Hispanic ethnicity can be of any race. 2010 Census terms: (One race) white, Black or African-American, American Indian/Alaska Native, Asian, Native Hawaiian and Other Pacific Islander, Some Other Race; (Two or more races); Hispanic or Latinx origin, white alone (Not Hispanic or Latinx). Persons of Hispanic ethnicity are also counted in their preferred race categories. Racial/ethnic groups are sometimes combined when sample sizes are too small for valid statistical comparisons of more discrete groups. For small groups (American Indian/Alaska Native, Native Hawaiian and Other Pacific Islander) in which a high proportion of King County residents are that race and one or more others, the grouping, "(race) alone or in combination" is sometimes used to include all who identify as that group. Some surveys collect racial/ethnic information using only one question on race. These terms are: Hispanic, white non-Hispanic, Black, American Indian/Alaska Native (AIAN), Asian, Native Hawaiian/Pacific Islander (NHPI), white, and Multiple Race (Multiple).
  
  ○ **Limitations of Race/Ethnicity Categories:** When asked to identify their race and ethnicity in surveys, respondents are often offered a narrow range of options (see terms above); those broad categories are then used to make expansive racial/ethnic comparisons. The vast diversity within racial/ethnic categories does not allow us to distinguish among ethnic groups or nationalities within categories. Combining groups with wide linguistic, social, and cultural differences – such as African immigrants and Black Americans; Vietnamese, Korean, and East Indians in one Asian category; and white Americans with eastern Europeans, for example – does not allow for a careful analysis of the potential disparities within groups, or the varied sociocultural influences on those disparities. In addition, some racial/ethnic samples in King County and WAMI are too small for meaningful comparisons or generalizations.

• **Rolling Averages:** When the frequency of an event varies widely from year to year, or sample sizes are small, the yearly rates are aggregated into averages – often in 3-year intervals – to smooth out the peaks and valleys of the yearly data in trend lines. For example, for events occurring from 2001 to 2015, rates may be graphed as three-year rolling averages: 2001-2003, 2002-2004…2011-2015. Adjacent data points will contain overlapping years of data. Statistical tests comparing data points with overlapping times are not appropriate. Increases or decreases in rates are determined statistically using data for single years.

• **Rounding Standards:** Rates from the Behavioral Risk Factor Surveillance Survey (BRFSS) and Healthy Youth Survey (HYS) are rounded to the nearest full integer (for
example, 15%). Vital statistics and hospitalization rates are rounded to one decimal point (for example, 15.4%), as are estimates from the American Community Survey (ACS)/Census. Statistical Significance: Differences between sub-population groups and the overall county are examined for each indicator. Unless otherwise noted, all differences mentioned in the text are statistically significant (unlikely to have occurred by chance). The potential to detect differences and relationships (termed the statistical power of the analysis) is dependent in part on the number of events and size of the population, or, for surveys, the number of respondents, or sample size. Differences that do not appear to be significant might reach significance with a large enough population or sample size.

Appendix C: Evaluation of Our Community Benefit Implementation Strategies 2016-19

Background
Measuring the impact of our community health and benefit efforts is critical as we embrace our mission to provide hope, care and cures to help every child live the healthiest and most fulfilling life possible. Beginning in 2019, the federal government updated the community benefit requirements for tax-exempt hospitals to include evaluating the impact of the actions taken to address the significant health needs identified in their prior community health assessment. Our goal is to demonstrate results that include process, impact and outcome measures.

Together with public health, providers, community-based organizations and families, we made significant progress in each of the four priority areas from our 2016-2019 Community Health Improvement Strategies, developed in response to the most urgent health and safety needs of the children, teens and families in Washington state and King County, Washington, identified through our second Community Health Assessment in 2016. In this report, we summarize the results of our priority area strategies implemented over the past three years.

Summary
4 Community benefit priorities | 16 Strategies | 70 Tactics:
3 Closed successfully
59 On target/ongoing
8 Some issues
0 On hold
0 Critical issues
<table>
<thead>
<tr>
<th>CH Priority</th>
<th>Strategy</th>
<th>Project/Tactic</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coordinated Care for Children with Chronic Conditions</td>
<td>Develop a systematic approach to care transitions between Seattle Children’s and outpatient providers, and between adolescent and adult care providers.</td>
<td>Hospital to home</td>
<td>▲</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Apply learnings from the Pediatric Partners in Care (PPIC) grant.</td>
<td>▲</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Expand the Transitional Long Term Care (TLC) program.</td>
<td>▲</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Support Medical Legal Partnership, Patient Navigators, Health Homes, Center for Children with Special Needs, Guest Services.</td>
<td>▲</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Continue development and implementation of validated hospital-to-home transition process and outcome metrics.</td>
<td>▲</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Explore digital health tools to identify effective communication and care coordination tools.</td>
<td>▲</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Develop and fund a health educator role at Garfield High School.</td>
<td>▲</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Integrate best practices for the transition of youth to adult care.</td>
<td>▲</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Integrate Sub-specialty care coordination</td>
<td>▲</td>
</tr>
<tr>
<td></td>
<td>Enhance partnerships that enable care coordination in the community setting including increasing the capacity of primary care providers to care for children in the community.</td>
<td>Enhance partnerships with stakeholders and advocacy organizations.</td>
<td>▲</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Expand support for Medicaid Transportation for children and youth.</td>
<td>▲</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Advocate for care coordination that supports the needs of children and teens through the Accountable Communities of Health (ACHs).</td>
<td>▲</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Enhance our partnership with schools and early learning programs.</td>
<td>▲</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Partner with UW School of Nursing and School Nurse Corps.</td>
<td>▲</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Develop a pipeline program for youth of diverse backgrounds.</td>
<td>▲</td>
</tr>
<tr>
<td></td>
<td>Promote equity through care coordination by addressing social determinants of health, community resource expansion and increasing the number of providers and staff from diverse socioeconomic and ethnic backgrounds.</td>
<td>Continue development and implementation of effective patient navigation programs to reduce health disparities.</td>
<td>▲</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Anchor hiring and purchasing locally.</td>
<td>▲</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Improve hiring data by disaggregating by ethnic group</td>
<td>▲</td>
</tr>
<tr>
<td></td>
<td>Integrate advocacy as a core component of care coordination for children and teens with chronic conditions.</td>
<td>Maintain a leadership role on Health Coalition for Children and Youth.</td>
<td>▲</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Advocate for children and youth needs as part of the Accountable Communities of Health.</td>
<td>▲</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Increase patient centered medical homes.</td>
<td>▲</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Increase payment models for care management.</td>
<td>▲</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Decrease inefficiencies and increase role clarity by defining care teams and care mapping for medically complex kids.</td>
<td>▲</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Advocate for public transportation improvements in South King County with a focus on our work with Hopelink.</td>
<td>▲</td>
</tr>
<tr>
<td>CH Priority</td>
<td>Strategy</td>
<td>Project/Tactic</td>
<td>Status</td>
</tr>
<tr>
<td>----------------------------------------</td>
<td>---------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------</td>
<td>--------</td>
</tr>
<tr>
<td><strong>Suicide &amp; Violence Prevention</strong></td>
<td>Increase access to and proper use of safe firearm storage devices.</td>
<td>Hold at least 4 safe firearm storage giveaway events and distribute at least 1,200 lock boxes and 100 trigger locks each year.</td>
<td>▲</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Establish new and maintain existing relationships and partnerships.</td>
<td>▲</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Create and disseminate a Safe Firearm Storage Program Toolkit.</td>
<td>▲ ●</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Establish an internal distribution process for patient-families.</td>
<td>▲</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Conduct research into effective dissemination of storage devices.</td>
<td>▲</td>
</tr>
<tr>
<td></td>
<td>Distribute community education materials.</td>
<td>▲ ●</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Include “Firearms in the Home” flyer in DOH Child Profile Mailing.</td>
<td>▲ ●</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Maintain and grow online webpage(s) resources:</td>
<td>▲</td>
</tr>
<tr>
<td></td>
<td></td>
<td><a href="http://www.seattlechildrens.org/gunsafety">www.seattlechildrens.org/gunsafety</a></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Screening questions and anticipatory guidance by pediatricians.</td>
<td>▲</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Identify new ways to provide information using social media.</td>
<td>▲</td>
</tr>
<tr>
<td></td>
<td>Serve as community advocate and resource for youth, families, schools, community organizations, firearm retailers, healthcare providers and others that may be at risk in the future or already have been affected by a firearm tragedy.</td>
<td>Maintain leadership for WA State Firearm Tragedy Prevention Network</td>
<td>▲</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Recruit at least 50 people representing diverse groups and perspectives to attend WA Firearm Tragedy Prevention Network.</td>
<td>▲</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Establish 2 new partnerships per year.</td>
<td>▲</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Engage communities via task forces, coalitions, events etc.</td>
<td>▲</td>
</tr>
<tr>
<td></td>
<td>Conduct research on youth associated suicide, violence and firearm tragedies to inform prevention and intervention initiatives.</td>
<td>Pursue and support research projects aligned with youth suicide, violence and firearm tragedy prevention.</td>
<td>▲</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Promote positive parenting and Period of Purple Crying.</td>
<td>▲</td>
</tr>
<tr>
<td><strong>Healthy Eating, Active Living, Food Security</strong></td>
<td>Identify food insecurity and improve access to healthy, affordable foods among children in our region.</td>
<td>Assess the current status of food insecurity screening and increase the number of clinics that screen for food insecurity.</td>
<td>▲</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Establish procedures to refer families to resources.</td>
<td>▲</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Train providers to effectively screen for food insecurity.</td>
<td>▲</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Collaborate with organizations to improve food access.</td>
<td>▲</td>
</tr>
<tr>
<td></td>
<td>Invest in culturally and community tailored programs (e.g., healthy eating, cooking, nutrition) to promote food affordability as well as cooking and eating at home.</td>
<td>Launch a food pantry on site at main campus.</td>
<td>▲</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Continue research, assessment and evaluation around food insecurity and health outcomes.</td>
<td>▲</td>
</tr>
<tr>
<td></td>
<td>Implement or sustain evidence-based initiatives to increase the number of safe places to play, engage in physical activity, and help promote healthy growth.</td>
<td>Promote programs and services that result in a healthier lifestyle.</td>
<td>▲</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Expand the role of OBCC programming by collaborating with community organizations or increasing enrollment.</td>
<td>▲</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Expand Seattle Children’s Garden Project to include more patients, their families and children from the surrounding community.</td>
<td>▲</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Enroll participants in the Food Insecurity Nutrition Incentives (FNI) project by increasing their purchases of fruits and vegetables via a program called FreshTucks Rx.</td>
<td>▲</td>
</tr>
<tr>
<td></td>
<td>Integrate advocacy as a core component of healthy eating, safe and active living and food security initiative.</td>
<td>Conduct research related to healthy growth and neighborhood environments that impact physical activity and eating behaviors.</td>
<td>▲</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Establish a structure for community-based research between the Research Institute, Seattle Children’s Hospital and OBCC.</td>
<td>▲</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Increase involvement/partnerships with locations where children spend their time: childcare, school, afterschool programs</td>
<td>▲</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Invest in evidence-based practices like increasing local transportation options such as cycling and walking improvements.</td>
<td>▲</td>
</tr>
<tr>
<td></td>
<td>Work in partnership with organizations and efforts such as the Childhood Obesity Prevention Coalition (COPC) and the Anti-Hunger and Nutrition Coalition (AHNC), Healthy King County Coalition (HiCC) and the Governor’s Task Force to move forward policies that promote healthy eating, safe and active living and food security.</td>
<td>Maintain a leadership role with Healthy King County Coalition.</td>
<td>▲</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Advance policy, systems and environmental initiatives through Partnerships to Improve Community Health (PICH) grant.</td>
<td>▲</td>
</tr>
</tbody>
</table>
### Results

#### 1. Coordinated Care for Children with Chronic Conditions

**Highlights:**
- Provided intensive care coordination for 810 children in King and Snohomish counties using locally based, multidisciplinary care teams that included community health workers.
- Seattle Children’s Guest Services provided rides to and from the airport for 6,778 patients and families coming from out of the area.
- Over the last three years, the Hopelink Transportation Desk at Seattle Children's helped significantly reduce wait times for 31,200 families who needed a ride home from the hospital.
- Advancing Care for Exceptional (ACE) Kids passed by the U.S. Congress and was signed by the president in 2019.

#### 1.1: Develop a systematic approach to care transitions between Seattle Children’s and outpatient providers, and between adolescent and adult care providers.
1.1a) Improving outcomes and reducing the total cost of care for children with special needs is a national healthcare goal. As the lead agency for Pediatric Partners in Care (PPIC), a Centers for Medicare and Medicaid Services-funded initiative, Seattle Children's worked with health plans, schools, primary care providers, specialists, therapists, agencies and palliative care organizations to address gaps in care, reduce healthcare utilization, improve caregiver self-efficacy and improve primary care provider capacity to manage the needs of medically and socially complex children.

Over the course of three years, we provided intensive care coordination for 810 children, and indirectly improved outcomes for another 3,200 children who are on Supplemental Security Income (SSI) in King and Snohomish counties. Learnings from PPIC and the Health Homes project (as sponsored by the Washington State Health Care Authority) has helped in planning care coordination efforts.

1.1b) Through the Washington Children with Medical Complexity Collaborative Improvement and Innovation Network, we are helping to address gaps in the system of care for infants with special healthcare needs discharged from the hospital by:

- Standardizing the process for referring infants to early intervention and assuring that services are activated. Often, children don’t start early intervention services until they are close to age 2, missing the opportunity to mitigate physical and developmental milestones that are missed prior to the age of 2.
- Actively engaging parents of newborns in a “roadmap” of services that builds their resiliency and their child’s resiliency. This includes developing a deep relationship with a primary care medical home, having a clearly identified nutrition home, active involvement with early intervention services, addressing social determinants and connecting with peer support for parents.
- Providing a single point of contact with a care coordinator for the infant’s first year of life. This builds parent self-efficacy as they are mentored in how to navigate the complicated healthcare system.

We have increased support of the registered nurse case manager on the inpatient team to provide follow-up and transitional support once a patient is discharged. This provides continuity with a team member who has an established relationship with the family. We are tracking outcomes (post-discharge) using a modified version of the Boston Children's Care Coordination Measurement tool. Total enrolled since program started within this evaluation period (2016-2019): 1,242 patients.

1.1c) Seattle Children's researchers have developed outcome measures to assess how well the hospital prepares families to care for their child at home and supports them after discharge. There are eight concepts that are most important to families. These concepts include (a) did the family or caregiver have the opportunity to ask questions before discharge, (b) did they understand how to use medical equipment at home and who to call with questions (c) did they receive discharge education in their preferred language (d) did they receive assistance with scheduling follow-up appointments (e) did they receive written discharge instructions (f) were the written instructions easy to understand, useful and contain necessary follow up and
contingency plan information and (g) was there an emergency care plan and was it reviewed and updated. Related efforts include up-to-date care plans for children with medical complexity that are readily available to community providers once a child leaves the hospital.  

1.2: Enhance partnerships that enable care coordination in the community setting, including increasing the capacity of primary care providers to care for children in the community.

Care coordination is a major concern, particularly for families with special healthcare needs. In an effort to enhance partnerships that enable care coordination, we’ve deepened our partnership with Hopelink by significantly expanding support for Medicaid families needing a ride home from the hospital. In 2015, we assisted 7,680 families. In 2018, that number had increased to 12,240 families. Transportation to specialty care appointments is a burden and barrier for families on Medicaid. By having a Hopelink desk at the hospital, we are able to get families home more quickly and efficiently which can help reduce missed appointments. Seattle Children’s is also partnering with the Kent DesMoines Clinic by embedding mental health support right within the clinic. The Seattle Children’s Care Network (SCCN) is a clinically integrated network provided by Seattle Children’s to better link primary care with specialty care.

1.3: Promote equity through care coordination by addressing social determinants of health, expanding community resources and increasing the number of providers and staff from diverse socioeconomic and ethnic backgrounds.

1.3a) A satellite clinic of Seattle Children's, the Odessa Brown Children's Clinic (OBCC) serves children living primarily in Seattle's Central District as well as South Seattle and South King County. Clinical social workers and community care coordinators play an ever-expanding role in the clinic's mission. By participating in a child's medical appointments from infancy on, they help families talk about issues in their daily lives that may be affecting a child's health and connect families with assistance and resources. OBCC's team also works with schools that these children attend, providing a true medical home with coordinated care. Regardless of the reason for the appointment, each patient family seen at OBCC is routinely screened for social determinants of health needs and connected to resources beyond the walls of the clinic. For more on social determinants of health see figures 1 and 2.

1.3b) OBCC also operates a free Teen Health Center serving Garfield and Nova high schools in Central Seattle. Over the last three years, there were 2,394 student visits to the clinic. A nurse practitioner provides care five days a week, while a mental health specialist, a nutritionist and a psychiatrist see students on various other days. The center also provides referrals to community services and public health agencies.

1.3c) Seattle Children’s new Gender Clinic provides gender-affirming treatment for young people who identify as a gender that is different from their sex at birth. The clinic received 550 referrals in its first year when they opened in the fall of 2016. The clinic brings together providers with expertise in adolescent medicine, endocrinology and behavioral medicine who work closely to coordinate care and follow consistent guidelines. Requests for surgery are referred to external providers.
1.3d) As it relates to increasing the number of providers and staff from diverse socioeconomic and ethnic backgrounds: we have increased the racial and ethnic diversity of our overall staff by 14.1% over the past three years since 2016. Our key areas of focus have been nurses as well as managers across the organization. Over the past 5 years we’ve increased the diversity of our nursing staff from 16% to 21%, with work continuing with a focus on underrepresented candidates as we aspire to reflect our patient population.

1.4 Integrate advocacy as a core component of care coordination for children and teens with chronic conditions.
The Advancing Care for Exceptional Kids Act, or ACE Kids Act, was signed into law in April 2019. This legislation makes it possible for healthcare providers across the country, including in the Pacific Northwest, to coordinate care, lower costs and improve quality outcomes for children with complex medical conditions on Medicaid who require specialized care. The legislation addresses existing challenges facing these children, as identified by families and physicians. These include the provision and coordination of care across multiple providers and services, and easing access to out-of-state care.

2. Suicide and Violence Prevention

*Highlights:*
- Number of safe firearm storage devices distributed at community events with hands-on education and practice over the three-year period: 8,525.
- A telephone survey following attendance at a community safe firearm storage giveaway showed a significantly greater proportion of event attendees reporting household firearms were locked up and unloaded after the event.
- Increase in number of departments and/or clinics distributing safe firearm storage devices to patient families identified as having unsecured firearms: from zero clinics in 2015 to six clinics in 2019.

2.1: Increase access to and proper use of safe firearm storage devices.
More than 8,525 safe firearm storage devices were distributed across 10 events in the last three years in different communities across the state of Washington. This includes 2,933 lockboxes, 298 trigger locks and 5,294 cable locks for firearms. Through these events, we partnered with public health agencies and local hospitals in each community, Safe Kids Washington and sporting goods retailers who sell firearms.

Safe firearm storage devices have also been distributed through the emergency department, inpatient psychiatry and behavioral medicine unit, outpatient psychiatry clinics in two locations, one regional clinic and OBCC. Devices can now be ordered through the hospital purchasing department as a standard item for these providers and re-distributed at no cost to the patient. A We developed and published a toolkit that has been used to help replicate community events locally and nationally, which is available at: https://www.seattlechildrens.org/globalassets/documents/health-and-safety/firearm-safety/safe-firearm-storage-giveaway-event-planning-toolkit-final.pdf.
2.2: Increase awareness and educate families, caregivers, community organizations, firearm retailers, healthcare providers and others on the importance and effectiveness of safe firearm storage.

Child Profile is a regular mailing to parents who have children ages 3 or younger who were born and are living in Washington state. It includes educational information about keeping children safe from firearms in the home. There are about 82,000 mailings in English and 4,650 mailings in Spanish distributed annually.

2.3 Serve as community advocate and resource for youth, families, schools, community organizations, pediatric healthcare providers and others that may be at risk in the future or already have been affected by a firearm tragedy.

The Washington State Firearm Tragedy Prevention Network (FTPN) was developed in 2016 to provide a forum for organizations, individuals, businesses and others from a wide range of perspectives and backgrounds to work together to prevent firearm tragedies. Meeting topics could include but are not limited to: suicide prevention; violence prevention and response; injury prevention; safe firearm storage; community programming, tools, resources and education; and research. Network meetings take place twice per year in various locations around Washington state. Seven meetings of the FTPN have been held over the last three years in the Washington communities of Burlington, Federal Way, Seattle, Tacoma, Tri-Cities, Wenatchee and Yakima. Network members, which are comprised of individuals and organizations, now total 425.

2.4 Conduct research on youth-associated suicide, violence and firearm tragedies to inform prevention and intervention initiatives.

2.4a) In partnership with Harborview Injury Prevention & Research Center, four research studies have been conducted on the distribution of safe firearm storage devices to community members; two of which have been published to date. In one study published by Joseph Simonetti and others, a significantly greater proportion of community safe firearm event attendees reported that after attending the event, all household firearms were locked up and unloaded.1558

2.4b) In another study by Elizabeth McCauley and others, a clinical trial of a psychotherapy called dialectical behavior therapy (DBT) – which has been shown to be effective in reducing suicide-related behavior in adults – showed that DBT can also reduce suicide attempts and suicidal behavior in adolescents.1559

2.4c) With coordinated leadership from Seattle Children's, 48 out of 62 hospitals in Washington state are delivering the evidence-based child abuse prevention education program, known as the Period of PURPLE Crying, to 83% of parents delivering babies, totaling more than 72,000 births each year. Washington state’s Child Protective Services department distributes information about "PURPLE" to nearly 2,000 families each year. Seattle Children's provides education to about 800 families annually.

3. Healthy Eating, Active Living, Food Security
**Highlights:**
- In 2018, we began screening for food insecurity in two specialty clinics at Seattle Children’s and have now expanded to seven clinics. At the same time, Seattle Children's Food Pantry opened to serve these families.
- We have provided groceries to 594 inpatient families from February 2018 through July 2019, in partnership with University District Food Bank.
- In one year, 106 families experiencing food insecurity received 2092 vouchers to help purchase fruits and vegetables.

**3.1: Identify food insecurity and improve access to healthy, affordable foods among children in our region.**

**3.1a) At Seattle Children’s,** we recognize that food insecurity is associated with a higher risk of obesity and diet-related chronic diseases, including type 2 diabetes even in youth. Food insecurity is a lack of reliable access to sufficient, affordable and nutritious food. It is also associated with poorer management of diet-sensitive health conditions and greater healthcare costs, including avoidable emergency department visits.

At OBCC, we ask families about food insecurity during well-child visits. This evidence-based screening is also now occurring in six other Seattle Children’s clinics, including the hemodialysis, peritoneal dialysis, cystic fibrosis, insulin resistance, immunology and hypertension clinics. We also screen in our emergency department, surgical inpatient unit and our inpatient psychiatry and behavioral medicine unit. At least one more clinic will be starting before the end of 2019. If a patient family screens positive, a variety of resources are offered, including food provided by our on-site food pantry.

Providers and staff have been trained on how to screen for and provide interventions around hunger. Along with other food security stakeholders, providers attend periodic training with national leaders, such as Hunger Vital Sign webinars. The food pantry intervention is being offered to the patient families affiliated with the aforementioned clinics, but no one is ever turned away.

Results from the first year of the program include the fact that 10 out of 28 dialysis patients improved their food security. For these patients, there was an 83% reduction in total intensive care unit (ICU) days, a 46% reduction in total hospital days (including the ICU), and a 47% reduction in the number of infections. It should also be noted that in 2018 alone, our on-site food pantry hosted 258 visits, serving 1,312 individuals. Half of the individuals served were children ages 3 to 18, 14% were between the ages of 0 and 2, and the remaining 36% were over 19 years old.

**3.1b) To address food insecurity and to increase fruit and vegetable consumption with our patient families and in our community,** we deepened our collaborative relationship with the University District Food Bank (UDFB) and Northwest Harvest in 2018. We now partner with UDFB for inpatient grocery delivery and with Northwest Harvest, our main food donor to the hospital-based food pantry. The inpatient grocery delivery program is for families experiencing food insecurity whose loved one is in the hospital. Our partners at UDFB deliver up to six bags
of groceries to inpatient families. UDFB and Northwest Harvest work with us to tailor nutritious foods to meet the special diets of our diverse clinic populations. We also maintain an onsite organic vegetable garden that provides seasonal, fresh fruits and vegetables for the food pantry. Families can visit the pantry once a week and receive a two-day supply of food. We also collaborate with WithinReach for families needing ongoing food resources beyond their clinic or hospital stay.

3.1c) OBCC has been an active participant in the Food Insecurity Nutrition Incentives (FINI) project, which aims to improve the nutritional status of low-income households participating in Supplemental Nutrition Assistance Program (SNAP), also known as food stamps. FINI incentivizes purchases of fruits and vegetables through a program called FreshBucks Rx. Since February 2017, 321 families have been enrolled. In the first seven months of 2019, families received 2,035 vouchers for fruits and vegetables to be redeemed at a local grocery store or farmer's market.

3.1d) In a study conducted by Michelle Starr and others, nearly 35% of 118 patients treated by Seattle Children’s outpatient Nephrology Clinic lived in food insecure households, which is almost double the prevalence of food insecurity among the general pediatric population (16%).156 Families with food insecurity were further surveyed to better understand barriers to food security. Barriers cited included challenges with restricted diets and available food, identifying and accessing community resources, and not qualifying for benefits.

We have taken an active part in regional councils to address food access and food insecurity including:
- Food Insecurity Community of Practice with 10 healthcare organizations and family advisors, led by Public Health – Seattle & King County
- Commercial food rescue “Food Rescue Innovation Lab” workgroup led by Seattle Public Utilities and Mary’s Place
- HealthierHere clinic-to-community design collaborative
- Washington Women in Food Systems child hunger advocacy work
- Coaching and workshops with Health Leads, Moving Health Care Upstream and Health Care Without Harm

3.2: Invest in culturally and community tailored programs (e.g., healthy eating, cooking, nutrition) to promote food affordability as well as cooking and eating at home.
OBCC continues to provide free cooking classes for families at Wellspring and Beacon Hill Elementary School. There are 10 to 20 families at Wellspring and 30 to 35 Beacon Hill families served each year. In 2017, OBCC also offered a Green Plate Special Class for OBCC families. Families paid just $10 for eight weeks of cooking and gardening classes.

3.3: Implement or sustain evidence-based initiatives to increase the number of safe places to play, engage in physical activity, and help promote healthy growth.
Seattle Children's Research Institute partnered with students and researchers across the United States and Canada.

Examples of studies include:
3.3a) A study on active commuting to school where kids walk or bike. This is associated with increased physical activity and lowered risk of obesity. In partnership with University of Washington (UW) graduate students from the Nutritional Sciences Program, a randomized control study by Nicole Cramer and others, showed that a Walking School Bus intervention was associated with an increase in child and parent beliefs in their own capacity to increase their physical activity over the course of the school year. In a study by Cathy Huang and Jason Mendoza (from Seattle Children’s Research Institute) and others, a randomized control trial involving fourth and fifth grade students from four schools serving low-income populations in Seattle evaluated the impact of a Bicycle Train, where students and an adult cycled together to and from school daily. The intervention group had increases in child self-efficacy, parent self-efficacy and parent outcome expectations.

3.3b) During this evaluation time period, researchers at the Seattle Children’s Research Institute sponsored and led studies that worked to add evidence about how to increase physical activity in youth. A study by James Sallis and others, focused on adolescents in neighborhoods with high and low walkability. Walkability was significantly related to increased physical activity and increased walking for transportation, regardless of whether the area had high or low median income. In addition, adolescents living in walkable neighborhoods reported less time watching television and less time in vehicles. In another study by Brian Saelens (Seattle Children’s Research Institute) and others, neighborhoods that were more walkable, had access to a high-quality park and had a healthy nutritional environment were associated with better child weight outcomes and weight-related behavior changes.

3.3c) OBCC has established a free soccer wellness program for children ages 7 to 13, in partnership with Rainier Vista Boys and Girls Club and the Nowland Premier Soccer Academy. Not only do kids receive premier-level coaching, they also spend time building social and emotional skills. Approximately 20 children attend each six-week session.

3.4: Integrate advocacy as a core component of healthy eating, safe and active living and food security initiative.

3.4a) We have been part of coalitions, including the Childhood Obesity Prevention Coalition (COPC), the Anti-Hunger and Nutrition Coalition (AHNC), Healthy King County Coalition (HKCC), the Children’s Alliance, Solid Ground and the Governor’s Task Force to move forward policies that promote healthy eating, safe and active living, and food security.

In partnership with these organizations, the following policy and system changes occurred to support healthy eating and active living for kids:

- In 2016, $1 million was awarded in capital funds to schools in Washington state as part of the Healthy Kids, Healthy Schools grant and included funding for water bottle filling stations.
- Seattle Parks and Recreation has amended an advertising policy to include a provision that “staff will limit advertising for food and drink products to those that are consistent with healthy nutrition guidelines developed by the WA State Department of Health whenever practicable.”
When healthy eating and physical activity habits are learned and practiced during the early years, they can last a lifetime. In an effort to improve physical activity, nutrition and screen time standards in licensed child care facilities across Washington state, the Department of Children, Youth and Families (previously the Department of Early Learning) signed off on new rules in 2019. There are close to 6,000 licensed day care providers in Washington state that serve approximately 130,000 children.

The licensing requirements in licensed care sites include:

- **Nutrition standards**: requiring snacks to include a fruit or vegetable; prohibiting the serving of flavored milk and sugar-sweetened beverages; making water readily available; and accommodating/supporting breastfeeding mothers
- **Physical activity standards**: promoting both moderate and vigorous activity, including time outdoors and a mixture of activities
- **Screen time standards**: limiting screen time for kids over age 2; intentional screen time is prohibited for kids under age 2.

In 2018, Breakfast After the Bell (HB1508) was passed. Schools that serve a significant number of low-income students now offer a Breakfast After the Bell program to provide no-cost, nutritious, in-classroom breakfast to all students.

In 2017, legislation was passed to require Washington state to conduct a K-12 assessment of public school physical education practices with a report due in 2019. This will help provide the data needed to guide future efforts to update physical education standards and address barriers that inhibit access to physical education.

Washington state is investing $2.5 million for SNAP Healthy Food Incentive Funds and the Healthy Kids, Healthy Schools grant program has received $3.25 million.

**3.4b** The Partnerships to Improve Community Health (PICH) program is aimed at improving health equity and the health of youth, families and communities in South King County. A grant from the Centers for Disease Control and Prevention helped make it possible for Seattle Children’s, Public Health – Seattle & King County, and the HKCSS together with communities, to make improvements in health that will last long beyond the three-year grant that ended in September 2017. Through small grants, technical assistance and collaboration at the community level, the program involved more than 29 different local initiatives promoting healthy and affordable food systems, physically active communities, and tobacco use cessation. Results include: a golf course turned into a farm for food banks; evidence-based physical education built into alternative high schools’ curricula; training for diverse child care providers on healthy eating and active living; and helping landlords convert low-income housing to smoke-free housing.

In total, PICH helped to:

- Increase the number of farmer’s markets with nutrition incentives for SNAP recipients from 21 to 27 by August 2017, reaching 7,714 new and unique shoppers.
- Increase the number of communities with youth-led interventions to improve policies for healthy food affordability
- Increase the number of outside of school care providers with healthy nutrition environments from 44 to 100.
- Increase the number of outside of school care providers with improved physical activity environments from 37 to 100 by August 2017.
Increase the number of cities with healthy beverage environments from zero to one by August 2017.

Increase the number of communities with improved access to healthy and affordable foods from 10 to 20 by August 2017.

Increase the number of K-12 schools with improved physical activity environments from 57 to 70 by August 2017.

Increase the number of non-profit organizations with brief tobacco interventions integrated in community health worker service models from six to 12 by August 2017.

3.4c) In 2017, we partnered with the City of Seattle (funder), Public Health – Seattle & King County, the University of Washington and various community partners (including low-income housing providers and food banks) to collect information about beverage and other dietary patterns from lower income and ethnically/racially diverse children and families in Seattle and other South King County cities. This data helped establish a baseline to examine the long-term impact of the new sugary beverage tax that just launched in Seattle effective January 1, 2018. We have plans to follow this cohort of children and families through the next two years to understand ongoing beverage and food consumption. This is part of a larger, more comprehensive assessment of the tax effects on food/beverage retail changes, food/beverage consumer purchasing, jobs in food/beverage retail and distribution, and acceptance of electronic benefits transfer (EBT) SNAP benefits at farmer's markets.

3.4d) Seattle Children's staff and leaders are active participants in the Healthy King County Coalition, Governance Team, Equity workgroup and Build Environment workgroup.

4. Mental and Behavioral Health

Highlights:
- The Partnership Access Line (PAL) responded to 1,729 calls in 2018 in Washington state (more than 9,500 calls since its inception in 2008).
- Partnership Access Line-Pediatric Alaska (PAL-PAK) and Washington's Mental Health Referral Service for Children and Teens launched in April, 2019.
- Suicide screening compliance rate in the Emergency Department: 90%
- 805 enrolled in Youth Mental Health First Aid classes since May 2018.

4.1: Expand current programs such as the Partnership Access Line (PAL) and the Program to Enhance Attention, Regulation and Learning (PEARL) to include in-person consultation and mental health care coordination in primary care settings.

4.1a) The Partnership Access Line (PAL) is a state-funded program providing mental health consultation to primary care providers for questions such as diagnostic clarification, medication adjustment or treatment planning. There were 1,729 calls in 2018 from providers in Washington state. The Partnership Access Line-Pediatric Alaska (PAL-PAK) launched in Alaska in April of 2019 and has fielded 17 calls already to date.
4.1b) A PAL Plus pilot program was completed, which provided in-person counseling sessions with local behavioral health providers for children from under-resourced families in Benton and Franklin counties. A local therapist delivered brief depression and disruptive behavior interventions.

4.1c) The UW Neighborhood Kent-Des Moines Clinic now offers access to a Seattle Children's child psychiatrist one day a week to supplement their in-office social work therapist to do more collaborative care.

4.1d) In February 2019, Seattle Children's launched a two-year, statewide pilot of a mental health referral assistance service for families and primary care providers, with funding granted by the Washington State Legislature. In the first six months, 280 families received support to help them connect with mental health providers who have openings in their schedule and can meet their child's needs. The service worked closely with the PAL.

4.1e) The Program to Enhance Attention, Regulation and Learning (PEARL) at Seattle Children's provided multidisciplinary evaluations, in collaboration with primary care physicians, to guide the treatment of patients with learning, attention and behavior challenges. In just one year (2017), the clinic served more than 700 children ages five and older at Seattle Children’s main hospital campus in Seattle and the Bellevue clinic.

PEARL also provides group-based behavioral parent training, which has a strong evidence base for early onset behavior problems, yet is hard to access. Other services include a summer treatment program for youth with attention deficit hyperactivity disorder (ADHD), medication consultations, and access to several cutting-edge research programs, such as the LEAP (Lifestyle Enhancement for ADHD) parenting program. LEAP promotes positive health behaviors, such as increasing activity and sleep while decreasing screen time. PEARL providers are also working to help build capacity and support for primary care providers throughout the region. PEARL providers currently provide consultation services at UW Medical Center-Roosevelt and UW Neighborhood Kent-Des Moines clinics. As part of a new National Institutes of Health-funded research study, PEARL will work with several primary care sites to screen young children for problems and parental ADHD, and to offer behavioral parent training through telehealth.

4.1f) Given the increasing number of youth presenting in our Emergency Department (ED) with mental health concerns, we initiated a pilot in early 2019 to test a model of outpatient care that would offer families and youth in crisis an alternative to the ED or possible psychiatric hospitalization. This program, called Behavioral Health Crisis Care Clinic (CBHCCC), provides assessment, brief intervention and access to a care manager who assists in connecting families/youth to needed services. In its first 6 months, the program has served more than 30 families. Families and youth indicate high satisfaction with the service. Plans for further program evaluation and expansion are in progress.

4.1g) Given the significant rates of anxiety among youth, the Anxiety Program at Seattle Children's has overhauled its services to provide thorough evaluations and treatment for anxiety disorders within a stepped-care framework. As such, families start with lower intensity interventions (e.g., anxiety group) and are stepped up to higher levels of care based on clinical
need and informed by measurement-based care (collection of pre- and post-intervention measures of anxiety and interference, as well as weekly measures of individual patient goals and exposure practice). This allows for families to receive the level of care that is indicated based on clinical need and allows Seattle Children’s to make a more significant public health impact on anxiety in youth. From November 2018 to August 2019, we served 120 families through the Anxiety Group across both the main hospital campus in Seattle and the Bellevue clinic. We are seeing a reduction in interference related to anxiety (including parental accommodation) and only one-third of patients need individual therapy afterward, improving the efficiency of care.

4.1h) Telepsychiatry is working with community mental health centers to increase access for direct service to some of the most severely affected youth with mental, behavioral and developmental difficulties. Youth transition back to their primary care providers, sometimes after a single evaluation session, other times after stabilization or long-term care with a psychiatrist. We serve sites in Ketchikan, Alaska, and seven communities in Washington, including: Bellingham, Everett, Moses Lake, Mount Vernon, Richland/Tri Cities, Wenatchee and Yakima. Through Telepsychiatry, we also provide services to Seattle Children's satellite clinics and have started to provide in-home services to select patients to further reduce the burden of travel and increase access.

4.1i) An additional telemental health service is provided at Seattle Children’s Autism Center, where behavioral interventions are conducted for children with autism and comorbid conditions and for kids with feeding disorders.

4.2: Develop, model, implement and share our integrated mental health care approaches with others. Support the development of these innovative models with primary care and community providers as well as other medical specialty clinics.

4.2 a) Seattle Children’s has almost doubled the percent of service lines with embedded mental/behavioral health providers (from 16% to 31%). We now have behavioral health providers embedded in Endocrinology, Nephrology, Adolescent Medicine, Cardiology/Cardiac Transplant, Hematology, Cystic Fibrosis and Gastrointestinal specialty clinics.

4.2b) We have increased access to evidence-based mental health services by offering both direct care and collaborative outpatient services with primary care providers through videoconferencing. For example, telemental health brings specialty mental healthcare services to the Gastroenterology Clinic at Seattle Children's South Clinic in Federal Way. Another example is using telemental health to bring services to youth who preferentially obtain their mental health treatment at home due to medical illness, such as youth with cystic fibrosis.

4.2c) OBCC implemented a “parent confidence” screener to all families with children ages 0 to 3 for their well-child visits. This is done by Birth-to-5 staff who are embedded in the primary care clinic. The information from this screener allows for deeper conversations so that OBCC providers and staff can provide better family-centered care.

4.2 d) Over the last decade, we have worked with Public Health – Seattle & King County’s Mental Health Services to provide consultation and training for school-based health providers.
In the last few years, these services have expanded from programs in the Seattle Public Schools to now include Issaquah, Highline, Bellevue and Vashon Island school districts and now include elementary through high school programs. Faculty and child psychiatry fellows provide monthly consultation to school-based advanced registered nurse practitioners (ARNPs) and mental health providers regarding assessment, diagnosis and treatment of youth, including both psychotherapeutic and psychopharmacological issues. This program currently partners with six community agencies (including OBCC) and more than 30 schools across the Puget Sound region.

4.3: **Evaluate, support and explore potential strategies for expansion (both physical and virtual) to increase access to care and provide appropriate level of care.**

4.3a) The National Institute of Mental Health (NIMH) recommends universal suicide screening. Seattle Children’s adopted the Zero Suicide Initiative. All patients ages 10 and older who are not in medical distress and are developmentally able to answer questions are screened for current and past suicidality. An Emergency Department (ED) nurse or inpatient nurse use the Ask Suicide Screening Questions (ASQ), a validated tool for this age group, when patients present to the ED or upon admission to inpatient units. More than 5,000 kids have been screened since March 2019, with 10% indicating passive suicidal ideation. These patients meet with a mental health provider for further assessment and recommendations for care after discharge. About 1% have reported current or active suicidal ideation with their medical presentation. These patients receive the same high-quality care that patients presenting for a primary mental health concern receive: assessment, mental health education, crisis prevention planning and resources in the community. This proactively impacts about 115 kids each month who presented to Seattle Children’s for a medical issue and would not have otherwise been connected to mental health assessment and resources.

4.3b) More than 35 pediatric mental health specialists from the inpatient Psychiatric and Behavioral Medicine Unit have been trained as ED navigators who lead families through the mental health evaluation process and assist with communication and updates between the team and family. While pediatric mental health specialists have been part of the ED Mental Health team for a number of years, the implementation of the Navigator role in May 2017 was designed to facilitate more efficient care and more connection and support for families. In June 2018, two navigators joined the ED mental health team for full-time evening shift coverage and continuity. Despite increases in volume, length of stay in the ED has remained the same.

4.4: **Utilize Seattle Children’s unique expertise to provide training for health professionals and families around identifying and treating mental and behavioral health issues. Integrating advocacy as a core component of the mental and behavioral health initiative as well as increase community partnerships and collaborations.**

4.4a) Youth Mental Health First Aid is designed to teach parents, family members, caregivers, teachers, school staff, peers, neighbors, health and human services workers, and other caring citizens how to help an adolescent (age 12-18) who is experiencing a mental health or addictions challenge or is in crisis. Youth Mental Health First Aid is primarily designed for adults who regularly interact with young people. The course introduces common mental health challenges
for youth, reviews typical adolescent development, and teaches a 5-step action plan for how to help young people in both crisis and non-crisis situations. Topics covered include anxiety, depression, substance use, disorders in which psychosis may occur, disruptive behavior disorders (including AD/HD), and eating disorders. Since launching Youth Mental Health First Aid classes in May 2018 at Seattle Children's there have been 805 enrollments. What began as a pilot has now been added as a regular community education class offering.

**4.4b)** Promoting First Relationships in Pediatric Primary Care (PFR-PPC) is a pediatric resident training program that focuses on children’s social-emotional development through responsive, nurturing caregiver-child relationships in the clinical setting. The program now serves 45 to 49 new medical residents and their supervisors annually, impacting thousands of families during routine well-child checks. More than 80% of participating residents (trainees) who have no prior training in promoting first relationships are increasing their ability to support children and their parents around social-emotional development.

**4.4c)** Seattle Children’s partnered with schools to provide information on anxiety disorders in elementary-aged children, in coordination with a member of our Psychiatry Family Advisory Board. Additionally, we discussed outpatient care at an event for high school youth. This event could serve as a model for similar events to be replicated in the community; Seattle Children’s has helped connect community partners in order to support future related events.

**4.4d)** In an effort to increase access to care and help community providers provide the appropriate level of care, Seattle Children’s is offering education on pediatric behaviors, aggression management and current pediatric mental health trends to other hospitals in the region. In addition to outreach in the healthcare environment, shelters that support women, children and immigrants have requested and received training for their staff.

**Looking Forward**

Our community benefit evaluation is an on-going process of learning about the effectiveness of our strategies to address pediatric health and safety needs and build on community assets. We will continue to listen to communities, collect information about how we are doing and use it to make informed decisions about our efforts, including how to address future health needs.

From 2016 to 2019, we sought to make an impact in four priority areas by embarking on 16 strategies and 70 tactics. In total, we proudly made progress on 59, finalized three, and are reevaluating the remaining eight. While there is still much work to be done, we are proud of the progress we’ve made the past three years. To learn more about our Community Benefit work, please visit: [www.seattlechildrens.org/communitybenefit](http://www.seattlechildrens.org/communitybenefit).
Endnotes


13 Ibid.


15 Ibid.

16 Ibid.

17 Ibid.

18 Ibid.


25 Ibid.

26 Ibid.


29 Delgado R and Stefanie J, Critical Race Theory.


71 Ibid.
87 Ibid.
88 Ibid.
90 Ibid.
96 Ibid.
98 Ibid.
100 Ibid.
101 Ibid.
102 Ibid.
103 Ibid.
104 Ibid.
105 Ibid.
106 Ibid.
107 Ibid.
108 Ibid.
109 Ibid.
110 Ibid.
111 Ibid.
112 Ibid.
114 Ibid.
118 Ibid.
119 Ibid.
126 Ibid.
128 Ibid.
129 Ibid.

506 | P a g e
167 Ibid.
165 Ibid.
160 Ibid.
144 Ibid.
Ibid.


Special tabulations prepared by the State Health Access Data Assistance Center (SHADAC) from the 2013 American Community Survey.

Special tabulations prepared by the Data Resource Center for Child and Adolescent Health from the 2011/12 National Survey of Children’s Health.


Special tabulations prepared by the Data Resource Center for Child and Adolescent Health from the 2011/12 National Survey of Children’s Health.


programs access for children, establishes criteria for programs performing pediatric transplants. Retrieved from https://optn.transplant.hrsa.gov/data/view#results


---


248 Ibid.


261 Ibid.

262 Ibid.


264 Ibid.


267 Ibid.


Ibid.


Ibid

Ibid


Ibid.

Ibid.


Ibid.

Ibid.


Ibid.

Ibid.

Ibid.


Ibid.

Ibid.

Ibid.


558 Ibid.
567 Ibid.
570 States use different terminology to refer to the status of maltreatment reports that have, upon investigation, yielded evidence that abuse or neglect has occurred. Trends in child maltreatment, 2019. Retrieved from: https://www.childtrends.org/indicators/child-maltreatment.
67 Ibid.
68 Ibid.
71 Ibid.
74 Ibid.
75 Ibid.
78 Harborview Medical Center, Seattle Children’s Hospital, Public Health Seattle & King County. (2004-2006). Injury Free Coalition for Kids Seattle. Report to the Community.
82 Ibid.
86 Ibid.
Preventing concussions in sports


649 Ibid.


652 Ibid.


655 Ibid.


666 Ibid.


672 Ibid.


678 Ibid.

693 Ibid.
695 Ibid.
696 Ibid.
703 Ibid.
704 Ibid.
706 Ibid.
707 Ibid.
708 Ibid.
709 Ibid.
710 Information provided by Washington State Department of Health, via email request.


Ibid.

Ibid.


Ibid.

Ibid.

Ibid.

Ibid.

Ibid.


Ibid.

Ibid.


Ibid.

Ibid.

Ibid.

Ibid.

Ibid.

Ibid.

Ibid.

Ibid.

Ibid.

Ibid.

Ibid.

Ibid.

Ibid.

Ibid.

Information provided by Washington State Department of Health, via email request.


Ibid.

Ibid.

Ibid.


526 | Page

826 Ibid.

827 City of Seattle Department of Education and Early Learning. Results and reports, retrieved from: https://www.seattle.gov/education/about-us/about-the-levy/results-and-reports


831 Ibid.

832 Ibid.


835 Ibid.


840 Ibid.

841 Ibid.


843 Ibid.

844 Ibid.


849 Ibid.


851 Ibid.

852 Ibid.


897 Ibid.
898 Ibid.
899 Ibid.
901 Ibid.
908 Ibid.
909 Ibid.
910 Ibid.
911 Ibid.
912 Ibid.
913 Ibid.
914 Ibid.
915 Information provided by Washington State Department of Health, via email request.
919 Ibid.
922 Ibid.
927 Ibid.
928 Ibid.
929 Ibid.
930 Ibid.
934 Ibid.
935 Ibid.
936 Ibid.
945 Ibid.
946 Information provided by Washington State Department of Health, via email request.
952 Ibid.
953 Ibid.
958 Ibid.
960 Ibid.


966 Ibid.

967 Ibid.

968 Ibid.

969 Ibid.

970 Ibid.

971 Ibid.

972 Ibid.

973 Ibid.

974 Ibid.


982 Ibid.

983 Ibid.


988 Ibid.

989 Ibid.


991 Ibid.

992 Ibid.


999 Ibid.

1000 Ibid.


1073 Ibid.


1077 Ibid.


1082 Ibid.


1086 Ibid.


1092 Ibid.

1093 Ibid.


1095 Ibid.


Ibid.

Ibid.


Ibid.

Ibid.


Ibid.

Ibid.

Ibid.


Ibid.

Ibid.

Ibid.


Ibid.

Ibid.


Ibid.

Ibid.

Ibid.


Ibid.

Ibid.

Ibid.


Ibid.

Ibid.

Ibid.

Ibid.

Ibid.

Ibid.

Ibid.

Ibid.

Ibid.

Ibid.

Ibid.

Ibid.

Ibid.

Ibid.

Ibid.

Ibid.

Ibid.

Ibid.
Ibid.


1272 Ibid

1273 Ibid


1279 Ibid.


1287 Ibid.


1292 Ibid.


1296 Ibid.

1297 Ibid

1298 Ibid.


References


1414 Ibid.


1418 Ibid.


1423 Ibid.

1424 Ibid.

1425 Ibid.


1432 Ibid, page 143.

1433 Ibid, page 145.


Ibid.


1447 Ibid.

1448 Ibid. 


1453 Ibid.

1454 KIDS COUNT Data Center. (2017). Children who have one or more emotional, behavioral, or developmental conditions in the United States. Retrieved from https://datacenter.kidscount.org/data/tables/9699-children-who-have-one-or-more-emotional-behavioral-or-developmental-conditions?loc=1&loct=1#detailed/1/any/false/1603/any/18942,18943.

1455 Ibid.

1456 Ibid.


1462 Ibid.


1465 Ibid.

1466 Ibid.

1467 Ibid.

1468 Ibid.


Ibid.

Ibid.

Ibid.

Ibid.

Ibid.


Ibid.

Ibid.

Ibid.

Ibid.

Ibid.

Ibid.

Ibid.


Ibid

Ibid.


Ibid.

Ibid.

Ibid.

Ibid.

Ibid.

Ibid.

Ibid.

Ibid.

Ibid.

Ibid.

Ibid.

Ibid.

Ibid.

Ibid.

Ibid.

Ibid.

Ibid.

Ibid.

Ibid.

Ibid.

Ibid.

Ibid.

Ibid.

Ibid.

Ibid.

Ibid.

Ibid.

Ibid.

Ibid.


Ibid.

Ibid.

Ibid.

Ibid.

Ibid.


Ibid.

Ibid.

Ibid.

Ibid.

Ibid.

Ibid.

Ibid.


Ibid.

Ibid.

Ibid.

Ibid.

Ibid.

Ibid.

Ibid.

Ibid.

Ibid.

Ibid.

Ibid.

Ibid.

Ibid.

Ibid.

Ibid.

Ibid.
1561 Poster: Impact of Walking School Bus Programs: Changes in Self-Efficacy and Outcome Expectations as funded by This work was funded by the National Institutes of Health (PI: J. Mendoza, Grant Number R01CA163146).