Seattle Children's 2022

Community Health Assessment

Seattle Children's®
HOSPITAL • RESEARCH • FOUNDATION

Our Mission

We provide hope, care and cures to help every child live the healthiest and most fulfilling life possible.

Our Vision

Seattle Children's will be an innovative leader in pediatric health and wellness through our unsurpassed quality, clinical care, relentless spirit of inquiry and compassion for children and their families.

Our founding promise to the community is as valid today as it was over a century ago. We will care for every child in our region, regardless of their family's ability to pay.

We will:

- Practice the safest, most ethical and effective medical care possible.
- Discover new treatments and cures through breakthrough research.
- Promote healthy communities while reducing health disparities.
- Empower our team to reach their highest potential in a respectful work environment.
- Educate and inspire the next generation of faculty, staff and leaders.
- Build on a culture of philanthropy for patient care and research.

Our Values

Compassion
Excellence
Integrity
Collaboration
Equity
Innovation

Suggested Report Citation

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Condition of Not-for-Profit Status

This report is provided in fulfillment of the requirement of IRS Notice 2011-52 addressing the Community Health Needs Assessment (CHNA) for charitable hospitals in section 501(r). At Seattle Children's this assessment process is called a Community Health Assessment (CHA) and as such this CHA was adopted by the Seattle Children's Board of Trustees on July 27, 2022. This copy of the CHA is dated 9/30/2022.

Written Comments

Individuals are encouraged to submit written comments, questions, or other feedback about this assessment to: communitybenefit@seattlechildrens.org

These comments provide additional information to the hospital regarding the broad interests of the community and help to inform future CHAs and implementation strategies.

Electronic Access

This publication can be accessed electronically at: www.seattlechildrens.org/communityhealthassessment

Community Health Assessment 2022

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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 we 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 2021 and continuing in 2022, 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 third comprehensive and jointly authored 2021/2022 CHNA Report.[1]

In this, our own independently authored 2022 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. Although the IRS and many hospitals refer to the assessments as community health needs assessments, some authors and hospitals, including us here at Seattle Children's, agree that there can be negative connotations when using the word *needs* to describe the assessment reports and processes. Kretzmann and McKnight note that not only are there varying understandings and definitions of "needs," focusing solely on needs paints an incomplete picture of the community.[2] [3] Pennel adds that only assessing needs insinuates that community members are powerless, dependent on outside assistance, and community leaders are to blame for the local issues.[4] Seattle Children's chooses to not include the word *needs* in their report because we believe that the communities we serve offer more than a list of needs or challenges. Instead, it is crucial that health assessments are conducted using an assets-based approach by identifying a community's unmet needs alongside and to amplify their existing strengths and assets. Approaching this work through the lens of the community's strengths helps recognize communities as places that actively develop and harness their own capabilities and strengths, which in the long run, can empower residents and create community-based funding decisions. [5]

The assessment process and corresponding report will be referred to as a community health assessment (CHA) throughout the remainder of this document.

Our CHA pulls data from various sources to provide insights into several factors impacting the health and well-being of communities 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 2023 through 2026.

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 2022 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
    - 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." [6] Only 20% of overall health outcomes are affected by quality of healthcare and access to care.[7] 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. 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.

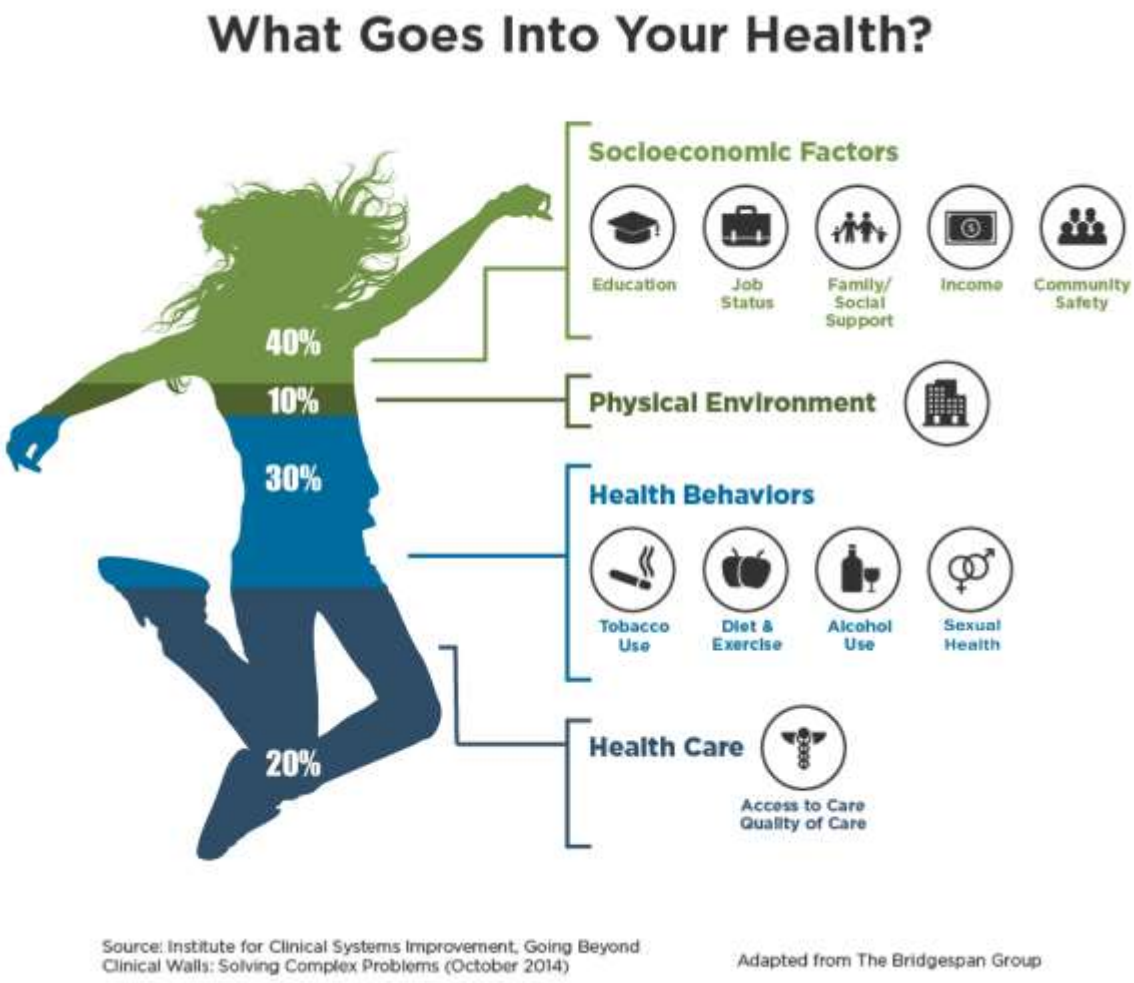


Figure 1: Impact of Social Determinants of Health on Pediatric Health Outcomes[8]

Health inequities cause health disparities-- defined as health differences that are closely linked to social, economic or environmental disadvantages.[9] 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 2030 objectives, when possible.

The report also features both qualitative and quantitative data. Each specific health need has a corresponding section with epidemiological data, community input, and a description of community assets 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 (345 beds currently in operation as of 12/31/2021), more than 8,716 total employees and an active medical staff of 1,836. We employ 1,766 Washington State Nursing Association member nurses. We also had 1,018 total physicians in training and 306 medical students in training during the 2020-2021 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. Our research institute as a workforce of 2,088 with 500 research support staff and 296 Principal Investigators.

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.

Working Together Toward Healthier Communities

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.

Healthcare reform and, more recently, Washington state's 1115 Medicaid Transformation Waiver also known as Medicaid Transformation Project (MTP) 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. To achieve the "Triple Aim," these groups recognize the need for more collaboration. [10] 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 with an agreement that was to be in place through 2021. However, in early 2021, our state requested an MTP one-year extension because of disruptions from the COVID-19 pandemic. CMS approved our request, and MTP will continue for a sixth year. MTP will now end December 31, 2022, unless CMS authorizes additional renewal/extensions.

Seattle Children's is involved in several 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

Read more about our methods and design in our Appendix A: Methods.

Some of the data referenced in this CHA were collected as part of the comprehensive King County 2020/2021 CHNA, which was a 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 2022 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 2021/2022 CHNA and Seattle Children's 2022 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 2019 through

2022. 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 2019 and 2022 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 residency 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 CHAs/CHNAs. This program existed until these residents were re-deployed to the Washington State Department of Health to help with COVID-19 response in August of 2021.

Data Sources

Between 2019 and 2022, these pediatricians and the community health and benefit team members at Seattle Children's who trained them conducted 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 with interpreter services available as needed.

Many, if not all, of the following interview questions were used for key informant interviews and/or listening sessions with community participants (also see Appendix C for more information):

1. Help us understand a little more about you all. What are some things you like to do as a family?
2. When you think about your kids, what keeps you up at night or what worries might you have?
3. When you think about your kids, what do you hope for?
4. Do you feel it is easy to find information about:
    a. raising kids?
    b. health and safety information?
    c. mental or behavioral health, such as depression, anxiety or ADHD?
    d. healthy eating or physical activity for kids and families?
        i. If it isn't "easy" per se, what resources are you looking for that you haven't been able to find?
5. 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.
6. 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 number 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?
7. 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?
8. 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.

9. 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?
10. 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?
11. 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?
12. What local resources are available to families that are hungry?
13. What would you like to see Seattle Children's do or provide here related to the health and well-being of kids?
14. Do you have anything else you'd like to share with us?

In addition to virtual and in person listening sessions conducted over the past three years, for this 2022 CHA we also launched an online survey in March of 2022. Given that we have previously relied on in-person data collection methods, this was the first time a survey was used to gather data for the CHA. Building off Seattle Children's 2019 CHA listening session guide, feedback from Seattle Children's employees, and CHA surveys deployed by other pediatric hospitals, we worked to create a health survey to elicit feedback on the quality of life in communities across WAMI. The intended audience was three-fold:

- Parents / caregivers / guardians of children 0-21 in WAMI
- Professionals working with children 0-21 in WAMI
- Community members at large

The survey incorporated branching logic depending on the type of survey respondent (parent / caregiver / guardian or professional or community member). Questions focused on child health concerns, availability and accessibility of community services, quality of life, experiences with racism and discrimination, and demographic data. After completing the 5-minute survey, participants were able to submit their email or physical address and receive a $5 gift card redeemable at their choice of retailer through a gift card catalog system called Tango. Respondents were also able to indicate their interest in providing additional in-depth feedback through a focus group session in exchange for a $25 gift card (focus group sessions to be held at future dates). The survey development and deployment process took approximately five months. See Appendix C for survey.

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
- **Births, deaths and hospitalizations:** Washington State Department of Health, Center for Health Statistics. Where available, U.S. data from the National Center for Health Statistics, public use data file.
- Behavioral Risk Factor Surveillance System**:** Behavioral Risk Factor Surveillance System (BRFSS) supported in part by the Centers for Disease Control and Prevention Cooperative Agreement. Data includes state level data from the Youth Risk Behavior Survey (YRBS) for Alaska, Idaho, and Montana. State level BRFSS data from Alaska, Washington, Idaho, and Montana.
- 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).

- **Population estimates:** U.S. Census Bureau, Washington State Department of Health, Washington State Office of Financial Management, and Washington State Population Estimates for Public Health. State of Alaska Department of Labor and Workforce Development. Montana State Department of Commerce, Census and Economic Information Center. Idaho Department of Labor.
- 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.
- Healthy People 2030: U.S. Office of Disease Prevention and Health Promotion, U.S. Department of Health and Human Services.

Limitations

Read more about limitations in our Appendix A: Methods.

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 2019 or 2020 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 and COVID-19 shelter in place orders as well as travel restrictions 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.

Figure 2: Community Health Assessment Focus Area[11]

The definition of our community is due, in part, to our patients' origins in fiscal years 2020- 2022: 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.

Given that 96% of our patient families hail from Washington, this assessment will tend to primarily focus that portion of the region. When we speak to the communities we serve, we need to note that in 2015 the state of Washington formally created the Accountable Communities of Health (ACH) network in an effort to promote health equity and address social determinants of health[1]. This network is made up of 9 regional organizations, which serve specific areas of the state. These organizations collaborate with healthcare providers, local health jurisdictions, community-based

organizations, and others to address community needs. Each region is made up of between one and nine counties that often have similar health characteristics, challenges, and strengths. Viewing pediatric health through this lens can be useful to create strategies that target the specific challenges that these unique regions face.

Figure 3: Accountable Communities of Health Regional Map [12]

Demographics

In 2021, there were 1,868,538 residents in the state of Washington between the ages of 0 and 19.[13] The distribution of individuals in this age group was approximately equal. From 2018 to 2021, there has been a 4.5% decrease in children ages 0-4, and increases in children 5-19, equaling out to a 0.77% increase in the total pediatric population. [14]

Washington Pediatric Age Distribution (2018-2021)

Age Group	2018	2020	2021	Percent change 2018 to 2021 (%)
0-4	455,075	444,779	434,901	-4.43%
5-9	470,073	477,010	480,221	2.16%
10-14	469,139	482,036	486,011	3.60%
15-19	459,979	467,422	467,405	1.61%
Total	1,854,266	1,871,247	1,868,538	0.77%

Figure 4: Washington Pediatric Age Distribution (2018-2021)[15]

In 2020, approximately 25% of the 7.7 million residents of Washington were under the age of 19.[16] Of those under 19 years old, 72% identified as White, 5% as Black or African-American, 9% as Asian, 2% as American Indian or Alaska Native

(AI/AN), 1% as Native Hawaiian or Other Pacific Islander (NHOPI), and 11% as two or more other races. Compared to data including all ages, there is a slight increase in diversity within the younger population. The trend of an increasingly diverse population has been observed nationwide and we see similar trends when monitoring changes in ethnicity. About 15% of the entire population of Washington self-reported being Latinx or Hispanic. In comparison, 22% of the population under age 19 reported as Latinx or Hispanic. [17]

Washington state census data also shows that nearly 14.5% of the population is foreign born, with about 20% speaking a language other than English at home[8]. 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% in the years 2000 to 2014[8].

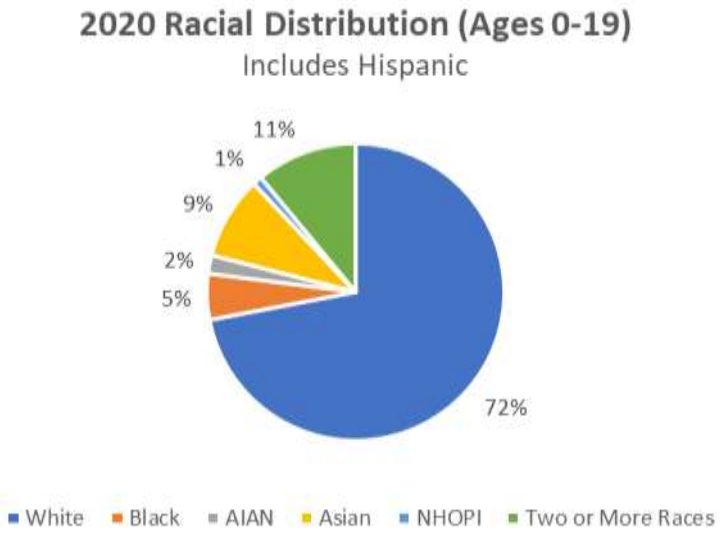


Figure 5: Washington Racial Distribution Ages 0-19 (2020) [18]

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 2022 CHA. After integrating and analyzing all the qualitative and quantitative data and feedback we gathered since 2019, our community benefit priority areas are: Primary Priority Area: Mental and Behavioral Health, followed by healthy lifestyles, **Error! Reference source not found.**, and economic opportunity. Each of these areas of f ocus and resulting community health implementation strategies will have a focus on Health Equity and Anti-Racism.

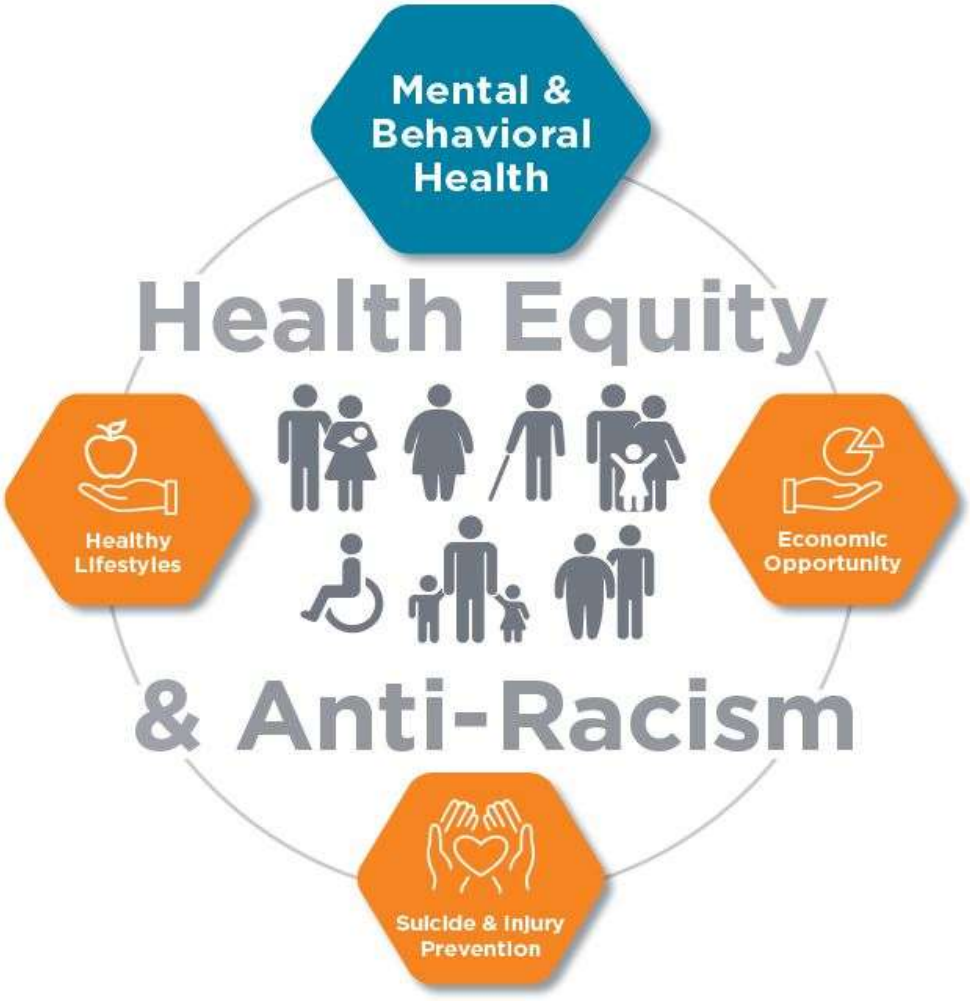


Figure 6: 2022-2025 Seattle Children's Community Health & Benefit Priority Areas [19]

These priority areas were approved by our Board of Trustees in July 2022. 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. 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 when we were allowed to before the pandemic and safely during the pandemic. We worked 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 in person or virtual listening sessions in as many communities in the WAMI region with parents or caregivers of children ages 0-21 years of age. We deployed a survey to more than 6,000 parents, guardians, and caregivers in the WAMI region and interviewed over 100 key informants in the WAMI region too. 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 all using a lens of health equity and anti-racism. The following chapters of this CHA illustrate more as to how and why we landed on these four areas of focus.

We would not have been able to land on these areas of focus without the guidance and input of our community members, their strengths and recommendations on how Seattle Children's can embellish the already robust resources that our community brings to bear and apply to any community health challenge. You will read throughout about each area of focus, and community strengths and resources.

Centering Health Equity and Anti-Racism

Why This Work Is Foundational to Our Pediatric Community Health Assessment

You'll notice in Figure 6 above that Health Equity and Anti-Racism are at the center of our work. Across our region and nation, gaps in health are large, persistent, and increasing—many of them caused by barriers set up at all levels of our society. After all, it's hard to be healthy without access to good jobs and schools and, safe, affordable homes replete with healthy affordable food and safe places to recreate. Health equity means increasing opportunities for everyone to live the healthiest life possible, no matter who we are, where we live, how much money we make or how old we are. Health is about much more than genetics and medical care (see Figure 1). Research has shown that the conditions we face as we live, learn, work and play—what we call the social determinants of health or determinants of health—also have a lot to do with how healthy we are. These conditions impact health outcomes and are drivers of the disparate health outcomes some of us experience. For years, the health care industry focused on "health disparities" while failing to understand inequities. Inequities are the avoidable and unjust differences, and it is the inequities that cause these disparities, not the other way around. Because pediatric health inequities are driven by structural racism, historic discriminatory practices, and geography, we can't really assess the pediatric health of our community without also delving deeper to removing obstacles to health. Obstacles such as racism, poverty, discrimination (and their consequences) including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care. Equity is not the same as equality. To create equitable opportunities, and therefore community health improvement opportunities, those with worse health and fewer resources need more efforts expended to improve their health, children included.

Health equity and anti-racism is foundational to our work perhaps now more than ever: in the past three years since our last Pediatric Community Health Assessment, the pandemic and social movements have put a spotlight on health care and the important ways the field must become explicitly anti-racist to advocate for institutional and systemic changes that will in turn, facilitate good health. When we invoke anti-racist principles, we're taking an active approach to the dismantling of structures and systems that were built within the context of prejudice and oppression. We are recognizing that racism lives within policies, attitudes, and perspectives that are ingrained in society and continue to marginalize people, and we must aim to change those structures and center health equity and anti-racism as a core value to our work.

A Note on Language and Definitions: Race, Racism, Structural Racism, and Social Determinants of Health

When discussing structural racism in healthcare, the definitions of race, racism, and structural racism must be reviewed. Race is a social interpretation of the physical features of individuals and has no inherent genetic, biologic, or scientific foundation. It is a social construct understood to be a collective way of categorizing individuals that is not based on scientific fact. More importantly, the concept of race has been used in order to assert one group's superiority over another. Racism is a belief that phenotypical traits are the primary determinant of an individual's capacity, and that race determines an inherent superiority or inferiority. Racism, which is experienced on the individual level, has been shown to be a predictor of worse health outcomes.[20]

Structural racism is defined as "the macrolevel systems, social forces, institutions, ideologies, and processes that interact with one another to generate and reinforce inequities among racial and ethnic groups."[21] Structural racism is not solely addressed by changes at the individual level. Even if interpersonal discrimination were eradicated, structural racism would persist, and racial and ethnic inequities would continue to exist. Structural racism dictates the systems into which children are born. It influences the environment children grow up in, their family's economic wealth, how their rights are respected and honored, and describes non-equitable treatment and policies within organizations or institutions. Structural racism is inherently tied to the racial and ethnic inequity we observe in the healthcare field. It is only by recognizing and addressing the structural problems within our systems that we will be able to make significant advancements in making those systems anti-racist.

As stated above, social determinants of health are defined by the World Health Organization as "the conditions in which people are born, grow, live, work, and age."[22] These factors are further influenced by the economic, political, and social context for everyone. The social, political, economic, ecologic, environmental, and historical contexts in which people live, collectively understood as the social determinants of health, profoundly impact overall health and well-being.

Health Inequities and Resulting Disparities

Healthy People 2030 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."[23] Equity does not mean equal treatment, since some populations may need more or different services to achieve health equity.

The Healthy People 2030 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."[24]

Health disparities are evident in WAMI 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.[25] 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.[26] 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.[27]

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.[28] Here at Seattle Children's we will use the term Black, Indigenous, People of Color (BIPOC) more than communities of color or people of color as a community descriptor. Unlike individual racism, structural racism encompasses larger systems that work to create and maintain dominant white culture to the detriment of the BIPOC community. Poverty and economic insecurity are underlying issues that are closely linked to embedded racial inequities. BIPOC are disproportionately poor as a result of oppression, historical disadvantages and discriminatory practices that have been institutionalized.[29] 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.[30] Utilization of medical services is often lower for BIPOC 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.[31] 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.[32]

Racism and Discrimination

The Impact of Racism on Pediatric Health

In the early part of 2020, our community was confronted with the rise of the COVID-19 pandemic, which in turn, brought to light the long-standing health and socio-economic inequities that have plagued our communities. In New York, for example, African Americans and Hispanics made up 22% and 29% of the population whereas they were 28% and 34% of the deaths due to COVID-19, respectively. [33] Social inequity and structural racism became even more apparent with the murder of George Floyd by police in May, 2020 which re-ignited the Black Lives Matter movement and stirred a national and international awakening to the ever-present injustices of racism in our society.

Even prior to the pandemic, multiple examples of racial health disparities and associated structural inequities have been identified, including but not limited to poorer asthma-related outcomes in Black and Hispanic Children, increased infant mortality among Black infants, and increased hospital admission rates for common pediatric medical conditions such as asthma, bronchiolitis, gastroenteritis, and urinary tract infections among BIPOC children.

According to the American Academy of Pediatrics, "racism is a social determinant of health that has a profound impact on the health status of children, adolescents, emerging adults, and their families. Although progress has been made toward racial equality and equity, the evidence to support the continued negative impact of racism on health and well-being through implicit and explicit biases, institutional structures, and interpersonal relationships is clear. Failure to address racism will continue to undermine health equity for all children, adolescents, emerging adults, and their families."[34] Racism is a key driver of health inequities worldwide, nationally, and in the WAMI region.

Impact of Racism on Youth and Families in the WAMI Region

Evidence of race and racism affecting the health and wellbeing of youth emerges in almost all themes discussed in this CHA, from mental and behavioral health, increased rates of police violence and incarceration, the COVID-19 pandemic, to economic security, and beyond. Race and racism will be discussed throughout this document, but a few select examples of the effects of racism on the health of youth locally are discussed in the following paragraphs.

Poverty is one of the largest indicators of health status and is unequally distributed among different races and ethnicities. 61% of Black children, 59% of Hispanic children, and 60% of AI/AN children in the United States reside in households that are defined as low-income. This is in stark contrast to about 28% of all white children in the US. Census data from Seattle has demonstrated that economic insecurity and poverty are more common in BIPOC communities. In 2019 in Seattle, for a "household headed by a white or Asian person, the median income was about $112,000. For households headed by a Black person, the median income was $43,500. For a household headed by an AI/AN person, the estimate was even lower: $34,500."[35]

The Washington, Alaska, Montana, and Idaho area has a large AI/AN population, which is another group that deserves special attention when considering the health effects of structural racism. Washington state is 6th in the country for highest percentage of American Indians and Alaska Natives affiliated with federally recognized tribes, and Alaska is 8th.[36] American Indians/Alaska Natives continue to have poorer health outcomes and markers of socioeconomic attainment than other racial groups in the United States as a direct result of inequities in our sociopolitical and healthcare systems, collectively understood as structural racism. The effect of structural racism on indigenous populations is evidenced by multiple statistics. For example, the average percentage of students in King County who graduated on-time from high school in 2015 was 80%, but the average for AI/AN students was 55%. Life expectancy averaged for King County at 81.4 years, but residents who identified as AI/AN had a life expectancy of 75 years – a 6.4-year difference.[37] Approximately one in four AI/AN children aged 17 and under (27.1%) in King County lived in households with an income below the federal poverty level. This proportion is 4.0 times that of the non-Hispanic white population (6.7%).[38]

When considering specific health conditions, an area in which racial disparities are well known is the disproportionate incidence of asthma and allergy in patients identifying as Black and Hispanic. Multiple studies have found that children covered by Medicaid have a higher incidence of asthma diagnosis and asthma-related hospital visits. In the greater Seattle area, the highest density levels of asthma-related hospital visits in children with Medicaid was along the Interstate-5 and Interstate-405 highways and along the Seattle and Tacoma ports. This indicates one way in which children with Medicaid are at risk for worse health outcomes, likely related to greater exposure to poor air quality. There are similar inequities seen within food allergy, with food-induced anaphylaxis and food allergy-related emergency department visits being twice as common in patients of Black and Hispanic backgrounds.[39]

Another example of structural racism in the healthcare setting is appropriate use of interpreters for families who prefer a language other than English. Lack of appropriate and equitable interpreter use contributes to pediatric health disparities locally. Patients and families who prefer a language other than English (LOE) receive lower quality and less equitable care when compared to non-LOE patients and families. A study in the Seattle Children's Emergency Department (ED) showed that interpreters were used in only 45% of LOE patient encounters in the ED. Patients who spoke English as their first language were admitted in higher numbers than patients who prefer a language other than English however patients who prefer a language other than English were more likely to be transferred to the Intensive Care Unit after they were admitted. The correlation between interpreter use (or lack thereof) in the ED and the LOE patients that were admitted need more intensive interventions signifies that interpreters were being underutilized and not utilized equitably. Significant differences in patient outcomes can, in part, be traced back to inequitable and insufficient interpreter use. Ongoing efforts to understand barriers to appropriate, effective, and equitable communication with children from LOE families remains an ongoing effort and a priority for Seattle Children's.[40] [41] [42]

"Be it in medical settings, schools, or the community, I want refugees and non-native English speakers to feel welcomed, embraced, that they belong, that they are residents. Just because this isn't their home country, doesn't mean they are different; they have struggles, they have jollies, they are human. Three years from now, I hope we have empathy, understanding, and an appreciation for the diversity this population brings to our community."
-Key Informant

The effect of structural racism on the health and wellbeing of youth locally can be demonstrated with many different statistics. The qualitative data provided by families discussing their experiences of racism in our healthcare settings is also critical to consider. In listening sessions performed in 2021 involving mothers from the Somali community, several mothers shared challenging experiences of discrimination in seeking care at the University of Washington and Seattle

Children's. One mother stated, "[During my delivery] I was treated really badly and until today, I have anxiety to have more children." In the words of another mother, "Gaps [are] found especially in low-income communities. It feels that we're not looked at like we're important. It's harder if you're African American, even harder if you're an immigrant."

Learning or Re-learning Cultural Humility

Foundational to being anti-racist is feedback we received in multiple listening sessions and interviews. The importance of, knowledge of, and respect for cultural nuances emerged in a listening session with Somali mothers; one mother shared that when she was pregnant, her doctor knew that it was almost Ramadan and told her that she did not have to fast if she felt that it was difficult for her because of her diabetes and knew that she could make Ramadan up after giving birth. In most western healthcare institutions, there has historically been no space for culture or ceremony. Families who come from distant geographic locations or cultures that are distinct from the mainstream culture experience significant distress when hospitalized away from their traditional support systems. If providers and medical staff are not understanding of the importance of culture and the distance patients might be from home, communication can break down. A key stakeholder stated that it is important for healthcare providers to ask, "'how do we support this family and this community while this child is having the worst stress of their entire life?'" but "I don't see people asking that."

Abigail Echo-Hawk, an Indigenous researcher with the Urban Indian Health Institute (UIHI), posits that the reason efforts to reach health equity for AI/AN people have failed is because the movement for health equity has always been based in western cultural norms. She explains that many of these western norms are influenced by the institutional and structural barriers that continue to inhibit Indigenous health outcomes, and that health equity will be achieved when efforts are grounded in culture and traditional knowledge systems. Therefore, the need is for Indigenous folks to reclaim their health in a culturally rigorous way.[43] It is critically important to acknowledge that western cultural norms are not universal and reflect only a small fraction of our patients' cultures and experiences. Western culture pervades our healthcare system and the concept that even our understanding of health equity is based in this culture can be applied not only to our Indigenous patients and families, but to all patients and families who identify with a culture or experience that is not typically western. We cannot hope to move towards achieving health equity until our patients' cultures are acknowledged, respected, and held at the forefront of all interactions.

Reckoning on Racism at Seattle Children's

A discussion of structural racism and its impact on health and healthcare within the region would not be complete without mention of the recent reckoning on racism within Seattle Children's (SC), sparked by the resignation of Dr. Ben Danielson, Medical Director of Odessa Brown Children's Clinic (OBCC). OBCC is the only primary care satellite of Seattle Children's and primarily serves BIPOC and low-income families. At the end of 2020, a year plagued by the global COVID-19 pandemic, which disproportionally killed Black Americans, Dr. Danielson resigned citing allegations of overt and systemic racism within the Seattle Children's pediatric system of care. The resignation of Dr. Danielson deeply affected the OBCC and SC community. It forced inward reflection on behalf of SC and ultimately prompted an independent assessment of SC's efforts to combat racism and promote diversity, equity and inclusion led by Former U.S. Attorney General Eric Holder. In a listening session with the OBCC community after Dr. Danielson's resignation, erosion of trust in SC was a recurring theme. The OBCC community felt that SC's response to Dr. Danielson's resignation and allegations lacked an apology or statement refuting or confirming the accuracy of the allegations and lacked transparency about problems within our organization. Responding in January of 2021, the Seattle Children's Board of Trustees created an independent Assessment Committee to oversee an external review of Seattle Children's efforts to dismantle systemic racism and promote equity, diversity and inclusion. This aforementioned assessment was conducted by Covington & Burling LLP, an independent law firm and as mentioned, was led by former Attorney General Eric Holder. The assessment found inequities and disparities that impact our workforce as well as patients and families. The assessment resulted in a September 2021 publication of Seattle Children's Health Equity and Anti-Racism[44] plan which Seattle

Children's leadership says marks a beginning, as there is a great deal of work for us to do to eliminate the systemic racism that exists at Seattle Children's. Creating a plan does not make an organization anti-racist. Leadership acknowledges that Seattle Children's is not an anti-racist organization now, but they commit to their workforce, patients and families and community that it will be. It will be through their actions, their decisions, their investments and most importantly their outcomes.

Background

Seattle Children's has not lived up to its promise and commitment to our community. Too many injustices, large and small, have occurred throughout our history and stand in contrast to our intention and our mission to provide the best, most compassionate care to all of our patients and families. Seattle Children's is not an anti-racist organization yet but is committed to being one. It is against this backdrop, and in the face of criticism against some of these systemic inequities, that the Seattle Children's Board of Trustees created an Assessment Committee in early 2021. The Assessment Committee oversaw an independent review of efforts to combat systemic racism and promote equity, diversity, and inclusion (EDI) at Seattle Children's. As stated earlier, the Assessment Committee chose Covington & Burling LLP, led by former U.S. Attorney General Eric Holder, to spearhead the review. The review included hundreds of interviews with workforce, patients and families and community members, as well as focus groups where over 1,000 people were heard. Following this process, Covington produced a full report including Finding Statements and Detailed Recommendations that were approved by the board. The board then released the 11 Finding Statements and Detailed Recommendations.

This Action Plan takes Covington's findings and recommendations and establishes clear priorities to eliminate the disparities in patient health outcomes and experience. Through change, transparency and accountability, Seattle Children's will confront and address systemic racism in the organization. The Covington Recommendations and Finding Statements create the core of this Health Equity and Anti-Racism Action Plan (Action Plan) and will be integrated into Seattle Children's existing Anti-Racism Organizational Change (AROC) and Accelerated Equity, Diversity and Inclusion (EDI) Plan. The Action Plan aims to drive systemwide change that will be measured and reported out publicly on a quarterly basis. It should be noted that the Anti-Racism Organizational Change and Accelerated Equity, Diversity and Inclusion Plan began in 2020 driven by leaders Alicia Adiele, senior director and Chief Diversity Officer at Seattle Children's and the Center for Diversity and Health Equity and Workforce Diversity and Inclusion, Dr. Shaquita Bell, senior medical director, Odessa Brown Children's Clinic and Dr. Tumaini Coker, associate professor and chief, Division of General Pediatrics; they built the foundation of the AROC Plan.

A cross-functional Task Force comprised of team members in both clinical and non-clinical roles partnered with Seattle Children's Executive Leadership Team to develop the Action Plan. Members were selected because of their expertise in anti-racism and EDI. Additionally, some members are also parents who represent our patient families. Seattle Children's is committed to this work because dismantling systemic and institutional racism in health care is critical. It is also the right thing to do. This is a pivotal moment in our history, and a challenge we fully embrace.

The Work Ahead

Following the release of the Action Plan, Seattle Children's committed to providing quarterly updates on goals and metrics as well as share any challenges. Implementing the Action Plan is essential for Seattle Children's to live out its mission and values and accelerating this work in a thoughtful way remains a top priority. We are committed to examining Seattle Children's current systems and efforts to make meaningful changes that center racial equity. New policies, new trainings, and new ways to engage with workforce, patients and families and community are central to this work. This includes reforming security practices and taking action to dismantle Code Purple (i.e. the code in which staff call for security and a mental health consult), taking action to achieve health equity where the data shows disparities, and working to increase access to care using the language that best serves patients and families. Seattle Children's has

also invested in efforts to diversify our workforce while creating an inclusive environment with opportunities for development and advancement. Sharing progress on the actions taken each quarter is also a way for the workforce and communities we serve to hold the organization and its leadership accountable.

Priority Children's Health Issues

This Community Health Assessment aims to capture the complexities of childhood health in the Washington, Alaska, Montana and Idaho region through quantitative data and input from family members, as well as leaders within Children's, public health, and the community. The results will help us focus our efforts on urgent community health needs and develop our resulting Community Health Implementation Strategies (CHIS) by early 2023. Based on internal and external prioritization and input, our priority health issues are:

- Primary: Mental and Behavioral Health
- Suicide and Injury Prevention
- Healthy Lifestyles (Healthy Eating, Safe Active Living and Food Security)
- Economic Security

Primary Priority Area: Mental and Behavioral Health

A Note on Language and Definitions

In discussing mental and behavioral health in this assessment, defining terms and using language intentionally is critical – it is a component of stigma reduction. "Mental health" (sometimes called "mental wellness") includes emotional, psychological, and social well-being.[45] There is more to being mentally healthy and well than simply the absence of mental illness or mental health concern. The social determinants of health that impact physical health and well-being also impact mental health and well-being.

A "mental illness" is a condition that affects someone's thinking, feeling, behaviors, or mood and deeply impacts their daily life.[46] Mental illness can vary in impact, ranging from no impairment to mild, moderate, and even severe impairment;[47] this may also be referred to as a mental health concern, issue, or condition. The term "serious mental illness" refers to mental, behavioral, or emotional disorders that seriously impair functioning or life activities – sometimes contributing to disability – and is a term typically applied only to adults. While youth may have a serious mental health concern, they are rarely referred to as having a serious mental illness, thus this assessment will not use that term.

"Behavioral health" is a term that covers the range of mental and emotional well-being including addiction,[48] thus the term is used to cover both mental health and substance use concerns. There are differing opinions on whether the term "mental health" or "behavioral health" is more supportive and less stigmatizing. This assessment will intentionally use the combined term for inclusivity: "mental and behavioral health" or "MBH".

This assessment will also intentionally use terms that are person-centered and person-first when discussing MBH conditions or MBH issues. For example, this assessment will use phrases like "teen with depression" or "child with anxiety" rather than "a depressed teen" or "an anxious child." While a diagnosis or an MBH issue are facets of who people are, it is not their defining characteristic, nor does it represent their full self. Person-first language is one of the ways this assessment can reduce mental health stigma and affirm that people are more than their diagnoses.

Lastly, this assessment will follow best practice for discussing and reporting on suicide.[49] This assessment will use matter-of-fact terms that do not sensationalize, stigmatize, or criminalize suicide or suicidality. This assessment will use

terms like “died by suicide” rather than “committed suicide” and will use “attempted suicide” rather than “made a failed suicide attempt.”

Language matters. We encourage you to use similarly intentional language when you speak about mental and behavioral health.

Trends and Prevalence of MBH Issues in Youth

The United States is facing a national youth mental health crisis, exacerbated by the COVID-19 pandemic. In October 2021, the American Academy of Pediatrics (AAP), the American Academy of Child and Adolescent Psychiatry (AACAP), and the Children’s Hospital Association (CHA) jointly declared a national emergency in child and adolescent mental health.[50] In December 2021, the U.S. Surgeon General Dr. Vivek Murthy released an Advisory on the Youth Mental Health Crisis.[51]

This crisis, while worsened by the pandemic, was burgeoning beforehand. Seattle Children’s named mental and behavioral health its primary community health priority as a result of the 2019 Pediatric Community Health Assessment. Pre-COVID data indicates the percentage of youth who experienced a major depressive episode had doubled over the past decade[52]and suicide rates among youth aged 10-19 increased steadily from 2007 to 2016.[53] A study using data from the 2016 National Survey of Children’s Health found that half of the estimated 7.7 million U.S. children with a treatable mental health disorder did not receive needed treatment from a mental health professional.[54] These troubling statistics likely persist and were worsened by COVID-19 given the limitations in access to care and workforce shortages.

In 2020, Mental Health America ranked all states in the Washington, Alaska, Montana and Idaho (WAMI) region among the 10 worst states for youth mental health. Washington ranked 43rd in the nation, Montana ranked 45th, Idaho ranked 46th, and Alaska ranked 49th.[55] In 2022, all 4 WAMI states were still among the 15 worst states for youth mental health: Montana ranked 38th, Washington ranked 39th, Alaska ranked 46th, and Idaho ranked 50th.[56]

While comparative ranking against other states may have improved between 2019 and 2021, it is no reason to celebrate, as the suicide rate actually worsened.[57] Between 2019 and 2021, the teen suicide rate rose in all four WAMI states: from 15.0 deaths per 100,000 adolescents ages 15-19 in Washington in 2019 to 15.7 in 2021; from 19.3 to 20.7 in Idaho; from 24.1 to 27.2 in Montana; and from 35.7 to 44.9 in Alaska.

MBH and the COVID-19 Pandemic

Since the onset of the COVID-19 pandemic, providers have expressed concern about the impact on child and youth mental and behavioral health.

Mental and behavioral health was a key area of concern resulting from interviews conducted with pediatric providers in Washington during April 2020 – it was a top concern for every provider interviewed. Many predicted not only worsening of mental health among children who already have mental health conditions, but also increases in anxiety and depression as a result of the pandemic. During these interviews, it was near impossible to predict how long COVID-19 would stretch on in the U.S. and in the WAMI region; since then, COVID-19 has impacted almost every facet of daily life for children, youth, and families.

Significantly, in just a year (April 1, 2020 – June 30, 2021), data suggests that across the country, more than “140,000 children under age 18 in the United States lost a parent, custodial grandparent, or grandparent caregiver who provided the child’s home and basic needs, including love, security, and daily care. Overall, the study shows that approximately 1 out of 500 children in the United States has experienced COVID-19-associated orphanhood or death of a grandparent caregiver. There were racial, ethnic, and geographic disparities in COVID-19-associated death of caregivers: children of

racial and ethnic minorities accounted for 65% of those who lost a primary caregiver due to the pandemic."[58] Researchers estimate that 1,428 children in Washington State have suffered such a loss.[59]

Additionally, COVID-19's impact on mental health includes fear of COVID-19 infection, school closures, significant impacts on social determinants of health, potential increase in abuse and neglect, amplification of existing inequities, and direct impacts on provision of mental health care. Previous studies have demonstrated that about 13% of adolescents receive some form of mental healthcare in schools. Among adolescents who receive any mental healthcare, 57% receive some form of that care through school. Importantly, members of racial and ethnic minority groups, students with lower family income, and those with public insurance are disproportionately more likely to receive care through school.[60] Thus, school closures during the COVID-19 pandemic have affected access to school-based mental healthcare services, which will likely affect youth who are already disproportionately being affected by COVID-19, specifically youth of color and those of lower socioeconomic status.

In addition to limiting access to school-based care, lockdown and 'stay home' orders contributed to isolation of youth from peers. Data from the CDC found that school connectedness was a critical protective factor for youth: "youth who felt connected to adults and peers at school were significantly less likely than those who did not to report persistent feelings of sadness or hopelessness (35% vs. 53%); that they seriously considered attempting suicide (14% vs. 26%); or attempted suicide (6% vs. 12%). However, fewer than half (47%) of youth reported feeling close to people at school during the pandemic."[61]

This isolation is not without consequence, one study noted: "the containment measures like school and activity centers closures for long periods together expose the children and youth to the debilitating effects on educational, psychological, and developmental attainment as they experience loneliness, anxiety, and uncertainty."[62] A systematic review on the impact of social isolation on child development concluded: "the review shows a strong association between social isolation and anxiety and depression in children and adolescents. Social isolation leads to higher levels of cortisol and worse cognitive development. Therefore, the mental and physical health of children and adolescents need a careful follow up by health professionals during and after the COVID-19 pandemic."[63]

A 2021 Spotlight Report from Mental Health America – a supplemental report to MHA's overall State of Mental Health in 2022 report – shared: "young people are struggling most with their mental health. The proportion of youth ages 11-17 who accessed screening was 9 percent higher than the average in 2019. Not only is the number of youth searching for help with their mental health increasing, but throughout the COVID-19 pandemic youth ages 11-17 have been more likely than any other age group to screen positive for moderate to severe symptoms of anxiety and depression."[64]

The CDC summarized the impact of COVID-19 on youth mental health clearly:

> "Before the COVID-19 pandemic, CDC's Youth Risk Behavior Surveillance System (YRBSS) data indicated adolescents in the United States were already experiencing a mental health crisis. All indications are that the COVID-19 pandemic might have made this worse, particularly among youth most affected by school closures and social isolation, including low-income and racial and ethnic minority students."[65]

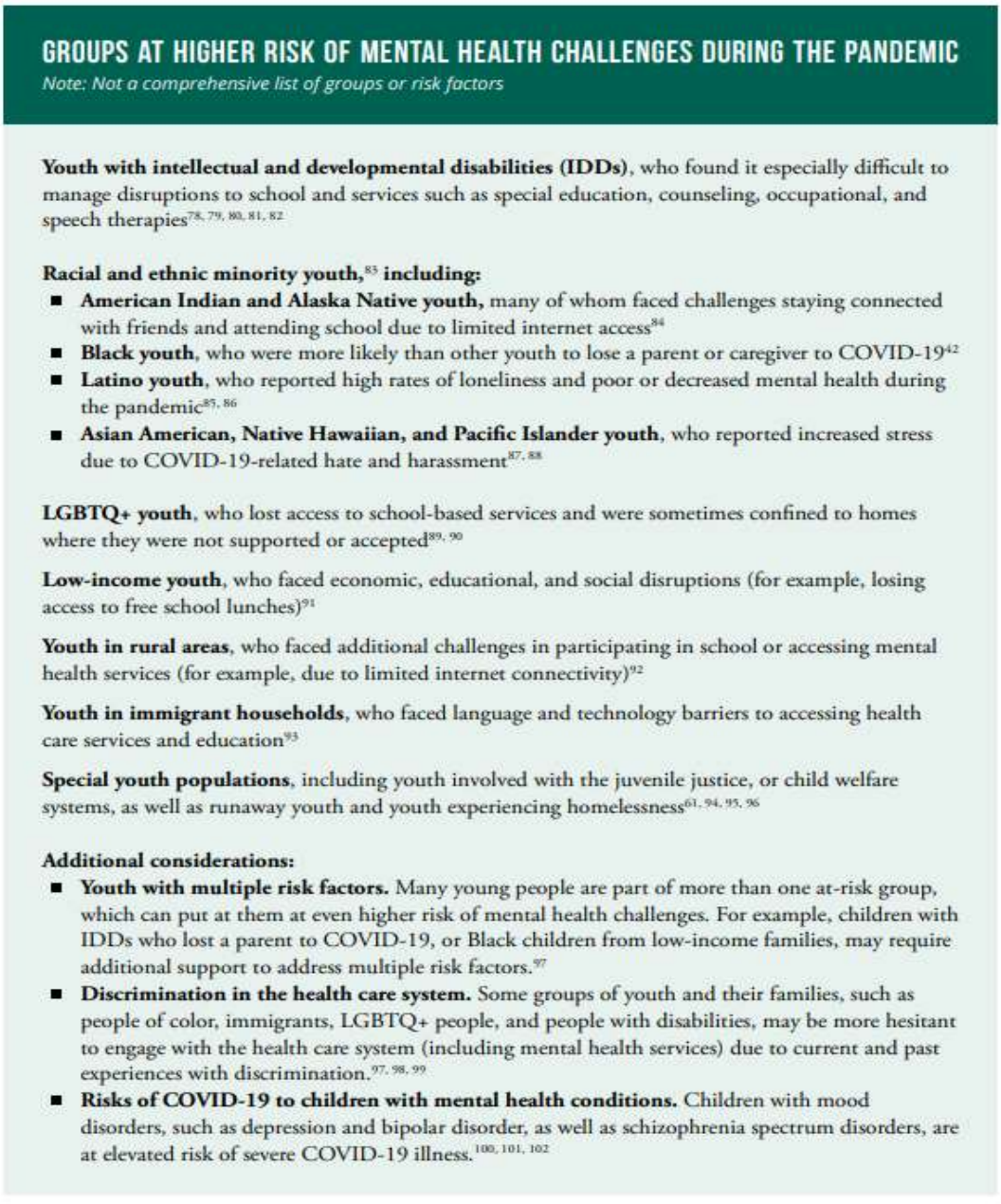
Ultimately, over the past two years, the COVID-19 pandemic has significantly exacerbated the crisis around mental and behavioral health, both nationally and locally. In the setting of the pandemic, mental and behavioral health were a focus of many family and other stakeholder interviews as well as a top concern for providers.

MBH Specific Populations at Risk

There are specific populations at higher risk for mental and behavioral health issues and/or suicidal ideation. Many of these groups or populations have been disproportionately impacted by the COVID-19 pandemic. When this assessment

talks about populations of youth more at risk, it is critical to highlight that typically these populations are more at risk because of systemic racism, sexism, homophobia, and other types of oppression and marginalization not because of inherent characteristic or identity.

The U.S. Surgeon General's 2021 Advisory on the Youth Mental Health Crisis listed a number of groups or sub-populations at higher risk of mental health challenges during the pandemic. These are also consistent with the populations at higher risk of mental health challenges independent of COVID-19. This assessment will highlight some of these groups and the impact of COVID-19. It is also critical to note that while these groups have unique risk factors, they also have unique protective factors that contribute to their resilience and overall well-being.



GROUPS AT HIGHER RISK OF MENTAL HEALTH CHALLENGES DURING THE PANDEMIC

Note: Not a comprehensive list of groups or risk factors

Youth with intellectual and developmental disabilities (IDDs), who found it especially difficult to manage disruptions to school and services such as special education, counseling, occupational, and speech therapies[78, 79, 80, 81, 82]

Racial and ethnic minority youth,[83] **including:**

- **American Indian and Alaska Native youth,** many of whom faced challenges staying connected with friends and attending school due to limited internet access[84]
- **Black youth**, who were more likely than other youth to lose a parent or caregiver to COVID-19[42]
- **Latino youth**, who reported high rates of loneliness and poor or decreased mental health during the pandemic[85, 86]
- **Asian American, Native Hawaiian, and Pacific Islander youth**, who reported increased stress due to COVID-19-related hate and harassment[87, 88]

LGBTQ+ youth, who lost access to school-based services and were sometimes confined to homes where they were not supported or accepted[89, 90]

Low-income youth, who faced economic, educational, and social disruptions (for example, losing access to free school lunches)[91]

Youth in rural areas, who faced additional challenges in participating in school or accessing mental health services (for example, due to limited internet connectivity)[92]

Youth in immigrant households, who faced language and technology barriers to accessing health care services and education[93]

Special youth populations, including youth involved with the juvenile justice, or child welfare systems, as well as runaway youth and youth experiencing homelessness[61, 94, 95, 96]

Additional considerations:

- **Youth with multiple risk factors.** Many young people are part of more than one at-risk group, which can put at them at even higher risk of mental health challenges. For example, children with IDDs who lost a parent to COVID-19, or Black children from low-income families, may require additional support to address multiple risk factors.[97]
- **Discrimination in the health care system.** Some groups of youth and their families, such as people of color, immigrants, LGBTQ+ people, and people with disabilities, may be more hesitant to engage with the health care system (including mental health services) due to current and past experiences with discrimination.[97, 98, 99]
- **Risks of COVID-19 to children with mental health conditions.** Children with mood disorders, such as depression and bipolar disorder, as well as schizophrenia spectrum disorders, are at elevated risk of severe COVID-19 illness.[100, 101, 102]

Figure 7: Groups at Higher Risk of Mental Health Challenges During the Pandemic from the U.S. Surgeon General's 2021 Advisory on the Youth Mental Health Crisis[66]

LGBTQIA2S+ Youth

Wherever possible, this assessment uses the acronym LGBTQIA2S+ to be inclusive of youth who are lesbian, gay, bisexual, transgender, queer or questioning, intersex, asexual, Two Spirit, and more. When referring to existing surveys, research, data, or lived experience, this assessment will use the acronym used by the report or data source; for example, a Trevor Project survey may provide results on LGBTQ youth only – thus this assessment will not purport that the survey is reflective of the experience of youth who are intersex, asexual, or Two Spirit and will use the same acronym as the source (LGBTQ in this example).

As a reminder, highlighted by the Trevor Project, a national LGBTQ+ organization: "LGBTQ youth are not inherently prone to suicide risk because of their sexual orientation or gender identity but rather placed at higher risk because of how they are mistreated and stigmatized in society."[67]

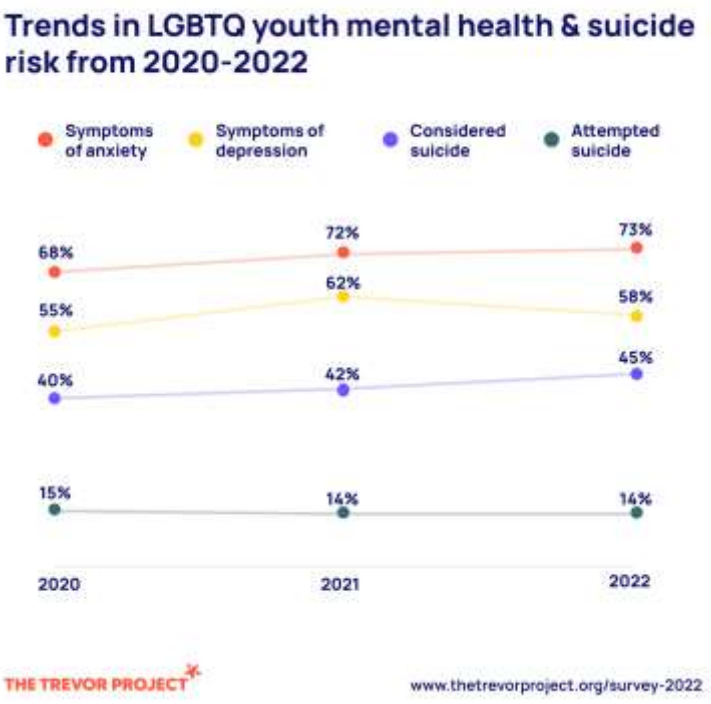


Figure 8: Trends in LGBTQ Youth Mental Health and Suicide Risks[70]

This survey found that 45% of LGBTQ youth seriously considered attempting suicide in the past year – and that 60% of LGBTQ youth who wanted mental health care in the past year were not able to get it. Fewer than 1 in 3 transgender and nonbinary youth found their home to be gender-affirming. High familial social support, affirming schools, and accepting communities were all found to significantly lower rates of attempted suicide among LGBTQ youth.

It is also critical to recognize the intersectionality of identity and experience as we look at these numbers. Rates of attempted suicide among LGBTQ youth were higher among Black, Indigenous, and people of color (BIPOC) youth than among white youth.

The 2021 Spotlight Report from Mental Health America found: "Rates of suicidal ideation are highest among youth, especially LGBTQ+ youth. In September 2020, over half of 11-17-year-olds reported having thoughts of suicide or self-harm more than half or nearly every day of the previous two weeks. From January to September 2020, 77,470 youth reported experiencing frequent suicidal ideation, including 27,980 LGBTQ+ youth." Data shared by the Trevor Project indicates that LGBTQ youth are more than four times as likely to attempt suicide than their peers.[68]

The Trevor Project's 2022 National Survey on LGBTQ Youth Mental Health demonstrates that rates of suicidal thoughts have trended upward among LGBTQ young people over the last three years.[69]

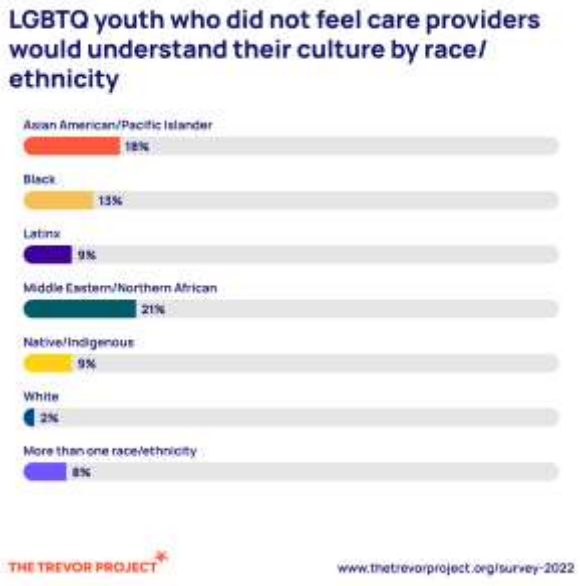


Figure 9: LGBTQ Youth who did not feel care providers understood their culture by race/ethnicity[71]

BIPOC Youth

This section will also begin with the reminder that race and ethnicity are not the risk factors for increased mental health challenges – it is racism, marginalization, and oppression that increase the risks faced by BIPOC youth. The American Academy of Pediatrics states clearly that "racism is a core social determinant of health and a driver of health inequities" and notes "the impact of racism has been linked to birth disparities and mental health problems in children and adolescents."[72]

National statistics from Mental Health America indicate that BIPOC youth may experience higher rates of mental health challenges and less access to care than white youth. Black and African American teenagers are more likely to attempt suicide than White teenagers.[7374] According to the American Psychological Association, "bilingual patients are evaluated differently when evaluated in English versus Spanish, and Latinx/Hispanic people are more frequently undertreated than White [patient]s."[75] In 2020, Black and Latinx children were 14% less likely than White children to receive treatment for their depression.[76] The rate of death by suicide among Native and Indigenous youth ages 15-19 is more than double that of non-Hispanic White youth.[77]

A 2021 American Psychological Association (APA) Guide for Practitioners on Addressing the Mental Health Needs of Racial and Ethnic Minority Youth states: "Racial and ethnic minority youth demonstrate low rates of mental health service use in both community and school settings. Moreover, when they enter treatment, they often face barriers that make it difficult for them to remain in treatment and to improve. Less than 40% of youths with mental health needs receive mental health services, and racial and ethnic minority youths are more likely to have unmet mental health needs compared with their non-Latino White counterparts."[78]

In outlining the factors contributing to the disparities in care and outcomes, the APA Guide indicates:

> "While minority youths have higher rates of unmet needs overall, research also suggests that individual factors, such as the types of problems youths have, contribute to patterns of service use. For example, racial and ethnic minority youths with externalizing problems have a high probability of being connected with mental health services, whereas those with internalizing problems have higher rates of unmet needs relative to their non-Latino White counterparts. Beyond initial access to services, racial and ethnic minority youths are less likely to receive quality care and more likely to experience ongoing factors that impact engagement in and retention of services. Thus, disparities in service use can result from a range of factors affecting referral, access, and/or engagement.
>
> When considering the service use of children and adolescents, it is also important to note that they rarely refer themselves for services. Thus, adult gatekeepers of mental health services (e.g., caregivers, teachers, and service providers) are largely responsible for identifying need and facilitating referrals and access to services. Barriers and facilitators to service use likely occur at this adult-gatekeeper level. In this manner, practitioners represent an important gatekeeper with the ability to identify mental health needs and support families in accessing and engaging with needed services."[79]

These disparities are also visible in the school setting. Data from the CDC indicates that "more than a third of all U.S. high school students felt they had been treated badly or unfairly at school because of their race or ethnicity" with Asian, Black, and Multiracial students reporting the highest levels of experiencing racism.[80] Critically, "students who reported racism were also more likely to experience poor mental health and less likely to feel connected to people at school."[81]

These inequities are compounded by a lack of non-White mental health clinical professionals who can provide those culturally competent mental health services. For example, only 4% of psychologists in the United States are Black. [82]

BIPOC youth are also at higher risk of having been impacted by the dual pandemics of COVID-19 and systemic racism. No assessment of children's health conducted during 2020 should ignore the racial reckoning in the United States catalyzed by the murders of Breonna Taylor, Ahmaud Arbery, and George Floyd. In May of 2020, following racist incidents across the country, the CEO of the National Alliance on Mental Illness (NAMI), Daniel H. Gillison, Jr., released a statement on behalf of NAMI that began with: "The effect of racism and racial trauma on mental health is real and cannot be ignored. The disparity in access to mental health care in communities of color cannot be ignored. The inequality and lack of cultural competency in mental health treatment cannot be ignored."[83] In contextualizing BIPOC youth mental health, the National Black Women's Justice Institute shares: "We know that youth of color experience both direct and indirect harms to their mental health and well-being from racialized police violence, including immigration enforcement, which triggers a stress response in children and youth that accumulates over time, adding to existing social and cultural harms based on race and ethnicity."[84]

During the summer of 2020 and in the months following, multiple local and state organizations declared "racism is a public health crisis." To-date, there are 10 declarations of racism as a public health crisis in Washington State, one declaration in Alaska, and no declarations to-date in Montana or Idaho.[85]

Youth Living in Rural Communities

While research and data are sparser for this population, they are still a critical group to focus on. Youth who live in rural communities often face additional barriers to accessing mental health care, resources, and supports. Researchers from Washington State University, examining national data, found that "highly rural areas had fewer mental health facilities serving youths—and fewer suicide prevention services—than more urban areas."[86] They found that "only 3% of rural areas had a mental health facility that offered suicide prevention services for youths. This is compared to 8% of metropolitan areas, 9% of micropolitan areas, and 12% of small towns."[87]

Their research also indicates that "about 64% of all U.S. counties had at least one mental health facility serving young people. However, only about 30% of highly rural counties had such facilities. Suicide prevention services were also much less likely to be offered in rural counties." They concluded that given higher rates of suicide among rural youth, their findings highlight the critical need to improve access to mental health services in rural communities – including increasing awareness, reducing stigma, and reducing access to lethal means of suicide.[88]

Youth in rural communities also may face the compounding issues of challenging access to mental health care and easier access to lethal means of suicide since there can be high rates of firearm ownership in rural communities.[89]

Youth with Autism and Intellectual or Developmental Disabilities

Researchers surveyed 3,502 parents/caregivers of individuals with an autism spectrum disorder (ASD) enrolled in Simons Powering Autism Research for Knowledge (SPARK) regarding impact on services during COVID-19, and found that most individuals with ASD experienced significant, ongoing disruptions to therapies. They noted, that "disruptions were more commonly reported for high intensity (e.g., daily or weekly) services such as [applied behavior analysis] ABA, special education, [speech and language therapy] SLT, and [physical/occupational therapy] PT/OT."[90] Critically, they highlighted that "most services were disrupted for a majority of individuals with ASD across all age groups."

The researcher's conclusion highlights what Seattle Children's has witnessed in this patient population and is perhaps the best summary of the ways COVID-19 has negatively impacted children and youth with ASD and their families:

> "Disruption to services and therapies is an additional stressor on families with a child or dependent with ASD during an already stressful time due to the COVID-19 pandemic. A majority of dependents with ASD at all ages experienced worsening ASD symptoms. Increased ASD symptoms, some of which may be extreme (e.g., aggression, self-harm), along with skill loss or stagnation are likely to be stressful for both child and family. While

a large majority of parents reported extreme to moderate stress specifically due to the loss of services and therapies, parents of preschool aged children were most stressed. This may be due to the emphasis on skill acquisition at this critical developmental period, with lost time being perceived as more impactful for this group. Parents/caregivers of school-aged children reported higher levels of overall distress than those of dependents of other ages. A higher percentage of older children have co-occurring mental health conditions, such as attention deficit/hyperactivity disorder (ADHD), anxiety, and disruptive behavior disorder, that would be exacerbated by increased stress, which may contribute to challenges for this age group. It is notable that nearly 50% of families surveyed are endorsing distress at a level of moderate/marked impairment. This increased distress may put these families at higher risk of acute crisis and warrants monitoring by clinicians and other service providers in contact with these families as well as attempts to develop and share resources that may increase coping and reduce stress.

Overall, families with a child or dependent with ASD are experiencing major service disruptions and reporting feeling increased stress/distress due to the COVID-19 pandemic. Even when services and therapies are adapted into an online or telehealth format, many parents/caregivers report that these adaptations are not successful for a majority of therapy types."[91]

Youth with Co-Occurring Substance Use Disorder and Mental Health Challenges

There are conflicting reports about the impact of COVID-19 on youth substance use. A systematic review of 49 studies of youth substance use during COVID-19 "suggests that the prevalence of youth alcohol, cannabis, tobacco, and e-cigarette/vaping use has declined during the pandemic."[92] However, they were quick to note that these findings should be viewed with caution, noting that for youth with pre-existing mental health issues, using substances may have been a coping mechanism during the pandemic.[93] While youth were unable to see friends and peers at the start of COVID-19, the authors also noted that "spending more time in the household is not always a consistent protective factor."[94] Ultimately they concluded the long-term effects of the pandemic on youth substance use are not likely to be fully understood until years later.

A 2021 study indicated similarly mixed results: "studies have yielded mixed findings regarding changes in adolescent substance use during the COVID-19 pandemic; some report increased alcohol and cannabis use, others show less binge drinking and vaping behaviors, and others no change."[95] This study cited variable impacts of COVID-19 on risk and protective factors for youth substance use, stating "stressors such as uncertainty, fears about contracting the virus, social isolation, boredom, and sheltering in place potentially increase the risk of use, whereas increased parental monitoring and reduced access to substances and substance-using peers likely decrease the risk. Regardless, the sustained social disruption related to the COVID-19 pandemic will have lasting effects on adolescents."[96]

Importantly, COVID-19 also impacted the treatment landscape for substance use disorder, similar to the treatment landscape for mental health. Social distancing guidelines limited in-person treatment, forcing partial closures or temporary suspensions of treatment. Many therapies moved to online or video conferencing, but not all were able to be provided electronically. This switch to electronic service delivery also exacerbates existing inequities for youth with low access to technology. In discussing this group, the study notes:

"Adolescents who are members of at-risk groups likely face additional barriers to receiving treatment during the COVID-19 pandemic. Impoverished and homeless youth, for example, appear to be facing even greater resource insecurity during the pandemic than pre-pandemic. Many of these adolescents are likely unable to engage in telehealth services owing to a lack of internet, phone, or computer access. Additionally, the halt of in-person services and decreased admissions to community service providers/shelters may also create barriers to obtaining mental health and substance use disorder treatment. Not only do health risks associated with both

homelessness/poverty and substance use disorder put these adolescents at heightened risk for COVID-19 infection, but lack of treatment may result in an increase in engaging in risky behaviors to obtain substances."[97]

Adverse Childhood Experiences (ACEs)

Adverse childhood experiences (ACEs) are traumatic events that occur in childhood that negatively impact health and well-being across the entire lifespan. Examples of ACEs include experiencing violence, abuse, neglect, a family member attempting or dying by suicide, or growing up in a household with instability, substance use, and mental health problems.[98] ACEs can have permanent negative health effects on well-being, education, life, and job opportunities.[99] These negative health effects can increase the risks of injury, sexually transmitted infections, maternal and child health problems (including teen pregnancy, pregnancy complications, and fetal death).[100] This can also lead to involvement in sex trafficking and wide ranges of chronic diseases that lead to death around cancer, diabetes, heart disease, and suicide.[101]

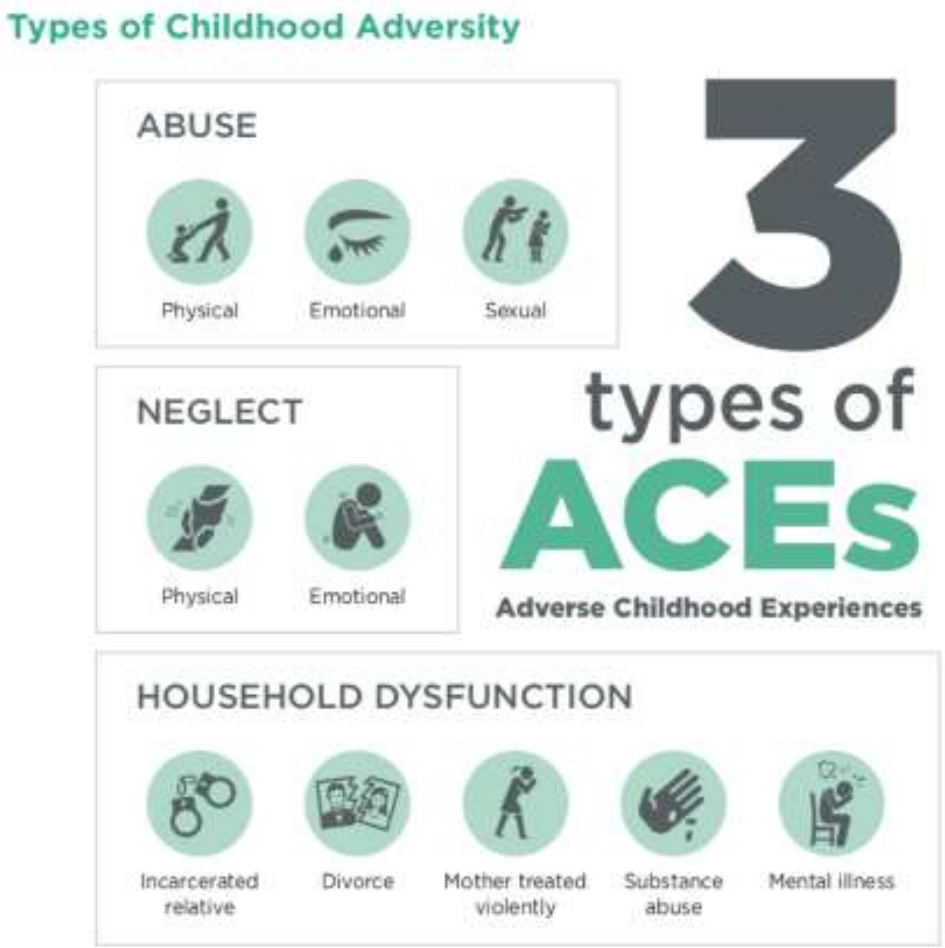


Figure 10: Types of Adverse Childhood Experiences (ACEs) [102]

The social determinants of health, like living in under-resourced or racially segregated neighborhoods, frequently moving, and experiencing food insecurity mixed with ACE's can lead to toxic stress (extended or prolonged stress).[103] Toxic stress from ACEs can negatively affect a child's brain development, immune systems, and stress-response systems.[104] Toxic Stress and ACE's can also affect the attention, decision-making, and learning of children.[105] This leads to children having difficulty forming a healthy and stable relationships in the future.[106] Children may also have unstable

work and job histories, struggle with finances, and depression throughout their lives.[107] These effects can also be multi-generational passing along these traits to their own children.[108] Children can also be exposed to toxic stress from historical and ongoing traumas due to systemic racism or the impacts of poverty resulting from limited educational and economic opportunities.[109] A study of ACEs on adolescent health indicators found "multiple ACEs is strongly related to a wide range of mental health, violence, and substance use histories" and concluded their "findings indicate a serious burden of ACEs on adolescent social emotional well-being."[110]

Numerous key informants noted the intergenerational aspect of trauma. For example, one participant shared, "Parents of kids who have ACEs are likely to have faced similar experiences of abuse and neglect when they were kids themselves. This creates a vicious and lasting cycle." Another key informant added, "Typically my patients are physically healthy. But they have experienced a lot of trauma, neglect, and abuse…sometimes it's from parents' addiction issues, or seeing someone die, or having a parent go to jail…so we have to treat the psychosocial consequences of that." LGBTQIA+ youth also report alarmingly high rates of ACEs, due in part to the prevalence of family dysfunction, emotional abuse, trauma exposure, and stress among this population. A key informant stated, "To understand their health concerns, we must look back at ACEs. Transgender adults and youth are disproportionately affected and overrepresented in ACEs. They are likely to have 3-4 scores higher, which we know has significant impacts later in life in terms of cardiovascular issues, heart disease, obesity, multiple sexual partners, and riskier sexual behaviors."

Below is an overview of the percentage of children in WAMI who have experienced 0, 1, and 2+ ACEs by race/ethnicity.

		Total	Hispanic	White, non-Hispanic	Other Races
0 ACEs	*U.S.*	60.2%	57.70%	64.30%	64.20%
	WA	62.4%	51.40%	65.30%	68.40%
	AK	59.4%	50.00%	69.10%	49.70%
	MT	54.7%	38.20%	55.60%	40.10%
	ID	60.4%	54.40%	56.80%	37.70%
1 ACE	*U.S.*	21.7%	22.80%	19.30%	18.70%
	WA	21.8%	33.70%	19.20%	15.10%
	AK	19.2%	20.90%	16.20%	20.50%
	MT	20.2%	40.00%	20.70%	15.50%
	ID	20.8%	33.30%	18.90%	29.80%
2+ ACEs	*U.S.*	18.0%	19.60%	16.50%	17.10%
	WA	15.9%	14.90%	15.60%	16.40%
	AK	21.4%	29.10%	14.70%	29.80%
	MT	25.2%	21.90%	23.60%	44.40%
	ID	18.7%	12.20%	24.30%	32.60%

Figure 11: Percentage of Children in WAMI who Experienced 0, 1, or 2+ ACEs by Race/Ethnicity.[111]

According to 2018-2019 KIDS COUNT data, 18% of children in the U.S. have experienced two or more ACEs; Alaska (21.4%), Idaho (18.7%), and Montana (25.2%) all have higher rates of children who have experienced 2+ ACEs, whereas Washington has a lower rate (15.9%).[112] Nationally, about 10% of children have experienced three or more ACEs, but

over 14% of children in Montana have experienced three or more ACEs, placing them in a category of especially high risk.[113] While county-level ACEs data were not available, a 2020 study of 34 states (including Idaho) found that children living in rural areas who have higher rates of poverty, lower guardian education, and higher probability of nonparental household are more susceptible to ACEs. It is not that these factors themselves cause ACEs, but rather they are mechanisms through which children experience hardship, stress, and reduced parental attention.[114]

Protective Factors

While ACEs negatively impact physical and mental health, there are protective factors that contribute to resilience and health. Potentially mitigating the impact of ACEs, Positive Childhood Events (PCEs) can positively impact mental health. Research suggests screenings and interventions should focus on both ACEs and PCEs in order to take into account positive experiences that "both reflect and generate resilience within children, families, and communities."[115] Promoting PCEs may reduce the risk of adult mental health issues and promote relational health – the findings of a study on PCEs and adult mental health concluded: "findings support prioritizing possibilities to foster, safe, stable nurturing relationships for children that consider the health outcomes of positive experiences."[116]

It is critically important to recognize that while each of these sub-populations or groups of youth has unique risk factors, there are also unique protective factors that positively impact resilience and wellbeing. The Trevor Project notes numerous protective factors for LGBTQ+ youth: social support from parents, family, teachers, peers and classmates; role models; supportive environments and school climates; and healthy coping mechanisms.[117]

For racial and ethnic groups, there can be protective factors because of cultural practices and unique community supports. For their 2022 BIPOC Mental Health Month campaign, Mental Health America chose a theme of "Beyond the Numbers", intentionally sharing protective factors for specific racial/ethnic communities. Some of these concepts draw from research shared by the Suicide Prevention Resource Center (SPRC).

> For American Indian and Alaska Native communities, they noted: strong family and community bonds, strong connections to traditional spirituality, self-identification with AI/AN culture, and involvement in traditional activities such as ceremonies, music, and healing practices.[118]
>
> For Arab, Middle Eastern, Muslim, and South Asian communities, they noted: strong connections to faith, strong family bonds and community connections, and high use of Imams as mental health and spiritual counselors.[119]
>
> For Asian and Pacific communities, they noted: identification within one's own Asian/Pacific culture, strong family and community bonds, and seeking help with native healers or community members.
>
> For Black and African American communities, they noted: strong family and community bonds, expression through spirituality or art, connection to one's own Black identity, and the importance of religion and spirituality.
>
> For Latinx and Hispanic communities, they noted: strong family and community bonds as well as largely multi-generational communities, more trust in primary care physicians and willingness to report mental health concerns there, and use of community care resources such as church, prayer circles, and traditional healers.
>
> For multiracial individuals, they noted: pride in multicultural heritage, the highest estimates of getting mental health care among all BIPOC groups, and culturally diverse identities leading to a better empathy and appreciation of other identities.

While no community is a monolith, it is important to recognize that racial and ethnic groups have unique protective factors and not just highlight the additional risk factors they face.

Access to MBH Care

Access to mental health care is impacted by a myriad of factors including cost of care, insurance coverage, and geographical location. The inability to access mental health care is another crisis that pre-dates COVID-19. A 2018 study assessing mental health services revealed "American mental health services are insufficient, and despite high demand, the root of the problem is lack of access – or the ability to find care."[120] COVID-19 significantly exacerbated existing challenges in accessing mental health care for children and youth. Many services were suspended, scaled-down, or shuttered due to the pandemic. The behavioral health workforce was inadequate to meet the demand pre-COVID, and countless providers have left the field in the past few years.

A 2021 Fact Sheet released by the White House under the Biden Administration called attention to the need to improve access and care for youth mental health and substance use conditions, highlighting both the crisis and the disparities in access: "Unfortunately, a significant proportion of our nation's youth still lack access to affordable health care coverage. Even for those with coverage, gaps in access to behavioral health care services remain. Significant disparities also exist for young people of color, Indigenous youth, and LGBTQ+ youth, denying many young people the behavioral health services and supports they need to thrive."[121]

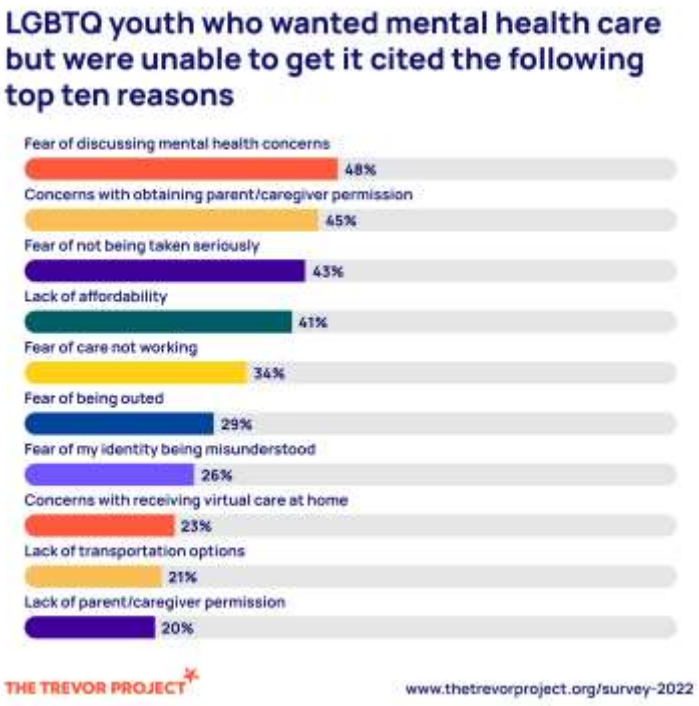


Figure 12: Top 10 Reasons LGBTQ Youth Cited for Being Unable to Access Desired Mental Health Care[1]

The Trevor Project's 2022 National Survey on LGBTQ Youth Mental Health found that 82% of youth wanted care and 60% of those who wanted care in the past year were not able to get it.[122] In asking LGBTQ youth why they were unable to get the mental health care they wanted, youth cited a variety of concerns (see Figure). While some of these are specific concerns for LGBTQ+ youth, there are some concerns that likely generalize to other youth as well. For example, the fears around discussing mental health concerns, of not being believed, or of care not working could be shared by youth regardless of gender identity and sexual orientation. Barriers to care including transportation and parental involvement are known issues in access to both physical and mental health care for youth.

There are also disparities in access to care/treatment by race/ethnicity – it is critical to reiterate that these disparities exist because of systemic racism not because of race or ethnicity. "Black and Latinx children are less likely than White youth to receive treatment for their depression, including inpatient treatment, though they are no less likely to have a major depressive disorder."[123] Emerging data from Mental Health America's online self-screening tool indicates COVID-19 worsened these trends: "youth ages 11-17 who identified as Native American or American Indian and those who identified as multiracial had the highest rates of depression. The largest increases in the proportion of youth experiencing suicidal ideation between 2019 and 2020 were for Black or African American screeners and Hispanic or Latinx screeners."[124]

The increase in need for services among children and youth has been exacerbated by national shortage of youth-specific mental and behavioral health providers across the workforce continuum from psychiatrists, to psychologists, to therapists. Sullivan and colleagues note this is a longstanding issue: "for decades, the medical community has been dealing with a child psychiatrists in the United States."[125] According to the American Psychological Association (APA), only 4,000 out of more than 100,000 U.S. clinical psychologists are child and adolescent clinicians. These trends are consistent across a range of youth-serving providers including school psychologists,[126] developmental pediatricians,[127] and more.

Severe shortages in child and adolescent psychiatrists exist nationally and in all 4 WAMI states.[128] Many counties in Washington, Alaska, Montana, and Idaho actually have no child and adolescent psychiatrists.[129] Similar shortages also exist for mental health therapists and counselors. There are fewer therapists trained to work with children and adolescents specifically, compared with adults. Insurance reimbursement rates tend to be lower for children, further limiting the number of providers who can see children. More children are insured by Medicaid than adults, and Medicaid reimbursement rates are roughly half that of Medicare. During the 2020 Washington State legislative session, gains were made for access to mental health care for children, including an increase in Medicaid reimbursement for therapy, funding of pilot intensive outpatient/partial hospitalization programs, and continued funding for the Mental Health Referral Service for Children and Teens. However, budget changes put in place in the face of the COVID-19 pandemic have tempered this progress.

Children who are privately insured may theoretically have more options, but existing mental health therapists are overwhelmed by the need, and their patient panels are often full. In addition, private insurance does not fully cover mental health therapy. So, for patients who require ongoing therapy, this weekly or biweekly expense becomes prohibitive unless they have significant financial means. Because of these insurance and financial concerns, navigating the mental healthcare landscape is incredibly difficult for families.

Community Findings Regarding Access to Care

Key informants from South King County highlighted the challenges with accessing mental healthcare and the need for increased mental health services. They focused on the need for mental healthcare services, especially crisis services, to be embedded in schools. Such services are important for reducing barriers to care for teenagers in particular, and for ensuring kids get the support when they need it. Informants noted that initial efforts to increase mental health services in schools has begun in multiple districts, but to date these efforts have been underfunded and under prioritized. Additionally, not enough counselors are presently available, particularly in high schools.

Examples of challenges with mental healthcare access in a non-urban setting was illustrated in interviews with stakeholders from Yakima County, Washington, a county made up of small rural farming communities. As the demand for mental health services has increased, accessing services has become more challenging. The time to see a counselor has increased from 3-4 weeks to upwards of 6 months. Many families have Medicaid, which further limits providers they can see. This constraint is also seen on the inpatient side. When patients present to the Emergency Department (ED) and qualify for inpatient services, they can wait days for a psychiatric bed, which is often located in a separate part of the state. Additionally, the area does not have mental health providers who are trained in working with specific populations, including patients who are LGBTQIA2S+ and patients with eating disorders. Stakeholders in Yakima County reported the low reimbursement rates for mental health providers and the difficulty of recruiting specialists to rural areas as the primary barriers to having more providers in the area. Barriers to obtaining mental healthcare also include challenges with transportation and limited ability for family members to take time off from work in order to take youth to appointments. Precautions during COVID-19 have also meant families could not bring other children to appointments so had to arrange childcare. Although there are many counseling services that provide telehealth, many families do not

have access to reliable internet or devices in their homes. When asked about some of the online services available to families, one of the stakeholders noted that the system is not built for people who face numerous barriers.

Interviews with healthcare and mental healthcare providers, as well as families, both locally in Seattle and in rural areas of the state all revealed the challenges that families encounter when trying to access mental healthcare. This compounds MBH concerns and often means that youth don't receive appropriate mental healthcare until they are in crisis. The need for more options for mental healthcare, both generally in the community as well as in schools specifically, was reiterated frequently, demonstrating why MBH and access to mental healthcare must remain areas of focus in the coming years for the WAMI region.

Parent/Caregiver MBH and Well-Being Impact Pediatric Health

Mental and behavioral health is not only a concern for youth, but for parents as well. Mental health challenges in youth or parents affects all family members; these connections cannot be disentangled. It is well established that chronic stress leads to poor health outcomes for individuals. Youth are often exposed to family members' stress and trauma, contributing to their own historical stress in addition to stress from contemporary traumas. Additionally, there is emerging evidence that historical trauma can affect subsequent generations via epigenetics. These mechanisms provide insight into the higher rates of adverse health outcomes among individuals from populations that have historically endured collective trauma. Significantly, the potential reversible nature of epigenetic modifications suggests that these trauma-induced epigenetic effects are not necessarily permanent and that improvements in environmental and social conditions could reduce the high prevalence of poor health among historically disadvantaged communities.[130]

With respect to the pandemic, providers and families in Washington have shared how parental and community anxiety and worry have been imparted to children. Many providers told stories of parents relaying concerns that the children are able to sense the anxiety within their parents and even if they are not able to fully understand the pandemic, it is affecting them nonetheless. Children are attuned to the well-being of their parents and increased stress in the home is picked up by children.

Providers also noted that school closures have placed a tremendous amount of stress on parents, which they expect is impacting their children. Parents had to juggle multiple roles, as caretakers, educators and employees, in addition to the stressors that already existed in their daily lives prior to the pandemic. One stakeholder reported, "For the parents I think it's just a huge stressor because they're now having to be not just caretakers but teachers and still having to be provider of the household."

Mental and Behavioral Health Crisis at Seattle Children's

Seattle Children's named Mental and Behavioral Health our primary community health priority in 2019. We were facing a crisis a youth MBH crisis then: In 2018 and 2019, we were setting new record high volumes of patients presenting to the ED for MBH crisis, and the 41 beds on our inpatient Psychiatry and Behavioral Medicine Unit (PBMU) were always full. We had extensive waitlists for outpatient psychiatric services and services at our Autism Center.

Across the MBH continuum of care, data from 2019-2022 validates MBH as an on-going crisis and a critical community health priority.

Emergency Department

Between October 2019 and February 2020, we saw more than 300 patients each month in our ED for mental health. In March 2020, we saw significant reduction in presentation to the ED overall given the onset of COVID-19. While we saw a higher proportion of MH visits to the ED, the overall visit volumes were significantly lower, so this data should be taken with caution.

At the beginning of 2021, our ED volumes started to look like they did in 2019. Initially, there was a narrative that things were "returning to normal." This is a misleading characterization as we saw crisis levels of need in 2019. However, by the end of 2021, we saw MH visits outpace 2019 volumes. In October 2021, 366 patients presented to the ED in MBH crisis – the highest number since the onset of the COVID-19 pandemic. The following month, November 2021, a record-high of 380 patients came to our ED in MBH crisis. Within 6 months, in March 2022, a new record-high of 411 patients came to our ED in MBH crisis. In both February and March of 2022, more patients came to the ED in MBH crisis than in those months in previous years. In the summer of 2022, we saw higher acuity behaviors and symptoms among youth who presented to our ED in MBH crisis – contributing to the highest ED length of stay since the onset of the COVID-19 pandemic.

Psychiatry and Behavioral Medicine Unit (PBMU)

The PBMU almost always runs at full census – if not fully at 41, it is always fully staffed to staffing capacity. There are more than 1,000 admissions each year. Notably, the average length of stay has increased since pre-COVID and the last Seattle Children's CHA. In FY18, the average length of stay was 7.2 days whereas in FY21, it was 12.0 days. An increase of 5 days in just 3 years is notable and concerning. Leaders attribute this increase in part to increased acuity of behaviors and symptoms in patients who are admitted and also significantly reduced community services/capacity to serve patients with higher needs.

Outpatient Psychiatry

Referrals to Seattle Children's Outpatient Psychiatry increased during the pandemic. The number of patients seen each month both in Outpatient Psychiatry and the Autism Center has steadily increased since an initial drop during the onset of COVID-19 in March 2020. Since Spring of 2021, there have been an average of over 1,200 referrals to outpatient psychiatry and Autism Center services each month. Referrals for anxiety and depression specifically increased 53% between the last quarter of 2021 and first quarter of 2022. For almost every service line, the need outpaces the capacity resulting in lengthy waitlists. Many outpatient psychiatric services have pivoted to a group care based model in order to see as many patients as possible.

Washington's Mental Health Referral Service for Children and Teens

Seattle Children's operates a statewide mental health referral service for parents, which connects families to community outpatient services – funded by the WA Health Care Authority and state legislature. That service has found it increasingly difficult over time to identify community therapists with current availability, which is likely a result of both increased need for care and what has been reported to us as a net reduction of the number of state therapists seeing youth patients though the pandemic. In December 2020, it took our referral specialists 12 days, on average, to locate at least 1 provider matching the family's insurance with current availability. In January 2021, it took 11 days on average, then July 2021 it was taking 21 days on average. For both community outpatient care and hospital-based outpatient care, there is more need than there is capacity.

The majority of family requests for help (72%) continue to be for families with commercial insurance.

In October 2021, the medical director of the Referral Service reported: "access for families remains poor, in that for this majority-commercially insured population it takes an employed referral specialist an uncomfortably long time to identify one therapist covered by an insurer who is in the family's area, provides the specific service needed by the child, and accepting new clients. Over the course of the previous state fiscal year, it would take the referral team about 11 days on average to locate available providers (once they are actively working a case, which separates out any team staffing backlogs). Then in July this spiked up to 21 days to locate a provider. Current active working time [as of Oct 2021] per case stands at 14-20 days. The number of calls from families seeking services has spiked in the last two weeks, as we

expected would happen from children's back to school stressors, which will only worsen the state's access issues further."

Over the past few years there have been variations in community mental health agencies' capacity to serve new referrals. In multiple months over the past couple years, community mental health agencies in multiple counties have reported no openings – some even closing to new intakes.

Integrated Behavioral Health at Seattle Children's Care Network

Cohorts of practices who are part of a clinically integrated network – Seattle Children's Care Network – have integrated behavioral health services into their settings. Since the launch of the program in January 2021, they have seen increasing need for appointments and care. In 2021, on average there were more than 600 MBH visits each month.

While it is too early to understand the long-term impacts on access to care, in 2021 almost 2,000 children were seen in the integrated behavioral health program setting in their primary care practice. These are 2,000 patients who needed mental and behavioral health care who were able to be served quickly in primary care as opposed to sitting on a waitlist for care in the community. Additionally, in 2020, the 5 practices who integrated behavioral health services screened more than 11,000 patients for either behavioral health, developmental milestones, postpartum depression, or social determinants of health – allowing for earlier identification of needs. In 2021, these 5 practices screened more than 18,000 patients.

Opportunities for Mental and Behavioral Health

Seattle Children's organization-wide mental health initiative – Generation REACH – outlines five priority focus areas using the acronym "REACH". This report will highlight just a couple opportunities within each pillar of this framework, as well as the work that is foundational to the five focus areas.

Research & Innovation

- Continue to innovate new, strengths-based models of care that cultivate children's and teens' social and emotional intelligence and abilities.
- Understand outcomes of ongoing pilot programs and innovative models to broadly apply learnings and increase access to care both at Seattle Children's and in the community.

Ecosystem & Equity

- Explore continued ways to provide culturally responsive mental and behavioral health care as well as care in languages other than English.
- Increase options for mental and behavioral health care where and when people need them – virtually as well as geographically accessible in community, closer to home.
- Expand services offered by Seattle Children's and in the community so children and youth in WAMI can equitably access a full continuum of mental and behavioral health care.

Access

- Continue to expand capacity and capability of clinical services throughout the continuum of care both at Seattle Children's and in the community.
- Expand programs such as ECHO programs and Treatment Networks that share learnings among experts and increase the competency and capacity of cohorts of community-based mental and behavioral health providers.

Capital

- Continue to expand physical spaces where youth-specific mental and behavioral health care can be provided.
- Open the newly constructed Seattle Children's Magnuson location (planned for late 2022), where outpatient psychiatry and behavioral health services in addition to Autism Center services will be co-located.

Healthy Families & Communities

- Support and collaborate with partners and stakeholders for the Statewide Prenatal-25 Mental and Behavioral Health Strategic Planning work that the state legislature is undertaking starting in 2022.
- Promote mental wellness and mental health conversations internally within Seattle Children's and externally in community alongside community partners.

Foundations for REACH

- Advocate for – and pioneer – workforce development strategies focused on both recruitment and retention.
- Continue to build, cultivate, and participate in coalitions to advance pediatric mental and behavioral health care, resources, services, and supports.
- Continue to advocate for policies that align with the pillars of REACH and generally support pediatric mental and behavioral health.

Assets for Mental and Behavioral Health

Although never all-inclusive, identification of community assets and resources is essential to the community health improvement process and strategy development. In the area of mental and behavioral health, there are community assets and resources in multiple arenas: clinical care, public policy-level improvements, as well as countless community partners and coalitions.

Clinical Mental and Behavioral Health Care

There are numerous mental and behavioral health providers and organizations who provide exceptional, quality care that is tailored to children, youth, and families. This report would certainly accidentally omit a deserving provider if there was an attempt to list all the providers – instead this report would like to recognize that youth-serving mental and behavioral health providers across the continuum of care in Washington, Alaska, Montana, and Idaho have provided care for some of our most vulnerable children and families during some of the most challenging years in recent memory. Providers who serve children, youth, and families are an asset to our region and make a difference.

Some of the unique or innovative programs/services in WAMI are outlined below.

- State pilot-funded intensive outpatient programs (IOPs) and partial hospitalization programs (PHPs) at Seattle Children's, Sacred Heart Children's Hospital, and Mary Bridge Children's Hospital.
- New programs in Washington State that will provide youth-specific mobile crisis response.
- Throughout Washington State, there will soon be Youth Behavioral Health Inpatient Navigators modeled after Kids Mental Health Pierce County, a multi-system response designed to support youth who are struggling to access needed care.
- Washington's Mental Health Referral Service for Children and Teens supports families in accessing outpatient mental and behavioral health care in their community.
- The Partnership Access Line, which serves Washington and Alaska, enables primary care providers to call a child psychiatrist and consult on case needs and/or medication prescription.
- Multiple primary care practices are implementing Integrated Behavioral Health programs – including cohorts in Seattle Children's Care Network (SCCN).

Ongoing Policy-Level Improvements

A number of new programs, services, and initiatives have been funded by state legislatures in the past 3 years that will improve child and youth behavioral health. A few of these policy assets are highlighted in this sub-section.

- In Washington State, the legislature passed a bill to enable the state's legislatively formed Child and Youth Behavioral Health Workgroup (CYBHWG) to create a statewide strategic plan for behavioral health from perinatal phase through age 25. This strategic plan will assess current state, articulate the vision for desired state, and make a plan to close those gaps. Seattle Children's will actively collaborate and partner with the advisory group.
- In 2021, the Washington State Legislature passed HB1477, establishing the Crisis Response Improvement Strategy (CRIS) Committee and the Steering Committee. These committees were created in order to develop recommendations that will support implementation of the new national 988 suicide prevention hotline and will also include recommendations that contribute to statewide improvement of behavioral health crisis response and suicide prevention services.
- Starting January 1, 2024 thanks to SB5736, intensive outpatient programs (IOPs) and partial hospitalization programs (PHPs) will be covered as a Medicaid benefit in Washington State. These critically-needed levels of care will "fill in" the middle of the continuum of care – enabling youth to "step up" to more intensive treatment if needed and "step down" safely out of inpatient care.

Community Partners and Coalitions

- Public Health – Seattle and King County serves such a critical role in our community, providing needed information to community, convening cross-system coalitions, and funding innovative pilots.
- State agency partners including: the Washington State Department of Health, the Washington State Health Care Authority, the Office of the Superintendent of Public Instruction, the Developmental Disabilities Administration, and the Office of Homeless Youth.
- Local Health Boards including the Seattle Indian Health Board and the Urban Indian Health Institute and the Community Health Board Coalition and their members: the Afghan Health Initiative, African American Health Board, African Leaders Health Board, Afrodescendant and Indigenous Health Board, Cham Health Board, Congolese Health Board, Eritrean Health Board, Ethiopian Health Board, Filipino Health Board, Iraqi/Arab Health Board, Khmer Health Board, WA Latinx Health Board, Pacific Islander Health Board of WA, Somali Health Board, and Vietnamese Health Board.
- Formed during the COVID-19 pandemic, the Community Well-Being Task Force includes colleagues from Public Health – Seattle & King County, Best Starts for Kids, the Puget Sound Educational Service District, Seattle Children's, and Reconnect to Opportunity.
- The Washington Coalition for Homeless Youth Advocacy (WACHYA) advocates to improve the lives of youth and young adults experiencing homelessness. There are many other community organizations who work to support homeless and unhoused youth including: Mockingbird Society, North Star Advocates, A Way Home WA, Legal Counsel for Youth and Children, TeamChild, and numerous shelter providers.
- There are a number of organizations who advocate for and provide resources to those with autism spectrum disorders (ASD) and/or intellectual and developmental disability (IDD) including the Arc of Washington, Washington Autism Alliance and Advocacy, and Disability Rights Washington. These organizations play a critical role in informing those living with ASD/IDD and advocating for improvements in access and support.
- The Washington Council for Behavioral Health is an advocacy organization specifically comprised of community behavioral health agencies throughout Washington.
- Chad's Legacy Project in partnership with the University of Washington School Mental Health Assessment, Research, and Training (SMART) Center created a Mental Health Literacy Library.

- The University of Washington CoLab brings together community expertise and research evidence to catalyze creative change in behavioral health policy and systems.
- Alaska Children's Trust leads work to prevent child abuse and neglect as well as work to ensure that all Alaskan children grow up healthy and safe.

Spotlight on Washington State: Mental & Behavioral Health

Washington Community Input

On March 26, 2021 Washington State Governor Jay Inslee issued an emergency proclamation regarding the Child and Youth Mental Health Crisis.[131] This proclamation cited data and trends from pediatric physicians, the Washington Chapter of the American Academy of Pediatrics, Sacred Heart Children's Hospital in Spokane, Swedish Medical Center, Mary Bridge Children's Hospital in Tacoma, University of Washington Medical Center, Seattle Children's, the Centers for Disease Control and Prevention, and the Office of the Superintendent of Public Instruction. The resounding conclusion of the data and trends from these sources throughout Washington was obvious: we are experiencing a child and youth mental health crisis.

It is critical to reiterate that for Washington, this crisis pre-dates COVID-19. The Healthy Youth Survey (HYS), which is administered every other year to 6th, 8th, 10th, and 12th graders in WA, provides valuable insight into the well-being of youth. Data from the 2018 HYS indicates the concerning prevalence of MBH issues pre-COVID:

> "For all grades, the prevalence of students who felt sad or hopeless almost every day during a two week period in the past year has risen steadily since 2008. From 2008 to 2018, students who experienced a two-week episode where they felt sad or hopeless, stopping their usual activities, in the past year increased:
>
> - 8th grade – up from 24% to 32%
> - 10th grade – up from 30% to 40%
> - 12th grade – up from 29% to 41%"[132]

COVID-19 disrupted the usual cadence of HYS surveys. However, in addition to the Healthy Youth Survey, there were two COVID-19 Student Surveys (CSS) administered during the pandemic to assess the impact on students. CSS 1.0 was administered in March 2021, HYS was delayed from 2020 and administered in Oct 2021, and CSS 2.0 was administered in Feb 2022. Across HYS and the two CSS, a total of 293,000 students were surveyed. According to the Washington State Health Care Authority, the key takeaway was: "self-reported mental health did not change a lot from pre-pandemic levels, but it was already at crisis levels."

The 2021 HYS also found that 70% of Washington's 10th graders reported feeling nervous, anxious, on edge, or not being able to stop or control worrying. Consistent with data outlined in the Key Findings section of this assessment, Washington State data show "some student populations are more heavily affected than others, including students who identify as female, students who identify as LGBTQ+, students with disabilities, and students from lower income households."[133]

Encouragingly, the report shares that many youth in WA do remain hopeful: "about 7 in 10 10th -graders reported feelings of moderate to high hope – meaning they have set meaningful goals or pathways and are motivated to achieve them."[134]

Access to Mental Health Care

This increasing need for care has not been met with increasing capacity. Unfortunately, when it comes to access to mental and behavioral health care, many areas in Washington lack sufficient services to meet the demand. Roughly 37% of Washingtonians live in areas that has a shortage of mental health providers.[135] Only about 12% of residents live in an area where they anticipate their mental health care needs to be met.[136] According to the American Academy of Child and Adolescent Psychiatry (AACAP), there should be 47 child and adolescent psychiatrists for every 100,000 children; Washington is categorized as facing a "severe shortage" of child and adolescent psychiatrists, with only 11 per 100,000 children. Less than 1% of Washington's school districts meet the recommended ratio of students to school psychologists and students to school counselors.[137] Similar shortages also exist for mental health therapists and counselors. There are many fewer therapists trained to work with children and adolescents specifically, compared with adults. Anecdotal reports from youth mental health providers in Washington indicate that community providers are closing, not accepting new clients, or running with months-long waitlists.

Insurance reimbursement rates tend to be lower for children, further limiting the number of providers who can see children. More children are insured by Medicaid than adults, and Medicaid reimbursement rates are roughly half that of Medicare. Children who are privately insured may have more options, but existing mental health therapists are overwhelmed by the need, and their patient panels are often full. In addition, private insurance does not always fully cover mental health therapy. So, for patients who require ongoing therapy, this weekly or biweekly expense becomes prohibitive unless they have significant financial means. Because of these insurance and financial concerns, navigating the mental healthcare landscape is incredibly difficult for families.

This increasing need/prevalence of youth mental and behavioral health issues, coupled with inadequate capacity to meet the demand, is contributing to significant need at every level of the mental and behavioral health continuum of care. Emergency departments around Washington report record high numbers of pediatric patients presenting in mental health crisis – sometimes as many as 30 youth are boarding each day around the state, awaiting inpatient psychiatric care. There are fewer than 200 inpatient pediatric psychiatric beds for the state's children, so inpatient units are almost always full and running with waitlists.

Telehealth

Before the COVID-19 pandemic, telehealth was minimal, there were fewer than 25,000 claims for mental health-related appointments in state health care plans.[138] Since the onset of COVID-19, there are an average of 225,000-300,000 claims monthly for telehealth appointments.[139] Telehealth claims for mental health concerns among children jumped from a couple of thousand a month to nearly 30,000 claims between February and March of 2020 and currently totaling around 80,000-100,000 claims each month.[140]

While COVID-19 precipitated significant gains in telehealth access, it is critical to remember that there are barriers (and thus, disparities) in access to telehealth as there are with in-person care. A Health Affairs Report noted both the pros and cons of telemedicine:

> "The COVID-19 pandemic has revealed telemedicine's potential to improve health care delivery and access. In the past year, we have seen rapid expansion of telemedicine, in the form of video and telephone services, the extent of which our health system has never experienced. This expanded access has been most notable for patients with private insurance and ready access to digital technology. However, some historically marginalized populations may also be experiencing improved health care access with the advent of increased telemedicine services. Complicating this trend are recent reports showing persistent disparity in telemedicine uptake based on age, poverty, and urbanicity."[141]

Seattle Children's has also heard from community that telehealth appointments for mental and behavioral health care require a private, confidential space where one can speak freely about their struggles and their concerns – not every child has access to the internet connection, the technology, and the safe space to utilize telehealth. There is significant potential to increase equity in access to telehealth by ensuring equitable access to technology and physically safe spaces for conducting appointments.

Key Informant Interviews

Key informants from South King County highlighted the challenges with accessing mental healthcare and the need for increased mental health services. They especially focused on the need for mental healthcare services, especially crisis services, to be embedded in schools. Such services are important in reducing barriers to care for teenagers in particular, and ensure children get the support when they need it. Informants noted that initial efforts to increase mental health services in schools has begun in multiple districts, but to-date these efforts have been underfunded and under prioritized. Additionally, not enough counselors are presently available, particularly in high schools.

Examples of challenges with mental healthcare access in a non-urban setting was illustrated in interviews with stakeholders from Yakima County, Washington, a county made up of small rural farming communities. As the demand for mental health services has increased, accessing services has become more challenging in Yakima County. The time to see a counselor has increased from 3-4 weeks to upwards of 6 months. Many families have Medicaid, which further limits providers they can see. This constraint is also seen on the inpatient side. When patients present to the Emergency Department and need inpatient psychiatric care, they can wait days for an inpatient bed, which is often located in a different part of the state. Additionally, the area does not have mental health providers who are trained in working with specific populations, including LGBTQIA2S+ and patients with eating disorders. Stakeholders in Yakima County reported the low reimbursement rates for mental health providers and the difficulty of recruiting specialists to rural areas as the primary barriers to having more providers in the area. Barriers to obtaining mental healthcare also include challenges with transportation and limited ability for family members to take time off from work in order to take youth to appointments. Precautions during COVID-19 have also meant families could not bring other children to appointments so had to arrange childcare. Although there are many counseling services that provide telehealth, many families do not have access to reliable internet or devices in their homes. When asked about some of the online services available to families, one of the stakeholders noted that the system is not built for people who face numerous barriers.

Interviews with healthcare and mental healthcare providers, as well as families, both locally in Seattle and in rural areas of the state all revealed the challenges that families encounter when trying to access mental healthcare. This compounds MBH concerns and often means that youth don't receive appropriate mental healthcare until they are in crisis. The need for more options for mental healthcare, both generally in the community as well as in schools specifically, was reiterated frequently, demonstrating why MBH and access to mental healthcare must remain areas of focus in the coming years for the WAMI region.

Anxiety

Anxiety, fear, and worry are normal emotions for children and youth; however, if these fears or worries start to interfere with daily life or activities, this may be a diagnosable anxiety disorder.[142] Children who feel anxious or worried may display behaviors that are irritable or angry.[143] Other anxiety symptoms can include having trouble sleeping, physical symptoms like fatigue, headaches, or stomachaches.[144] Symptoms of anxiety can be easily missed, as some children tend to keep their worries to themselves.[145]

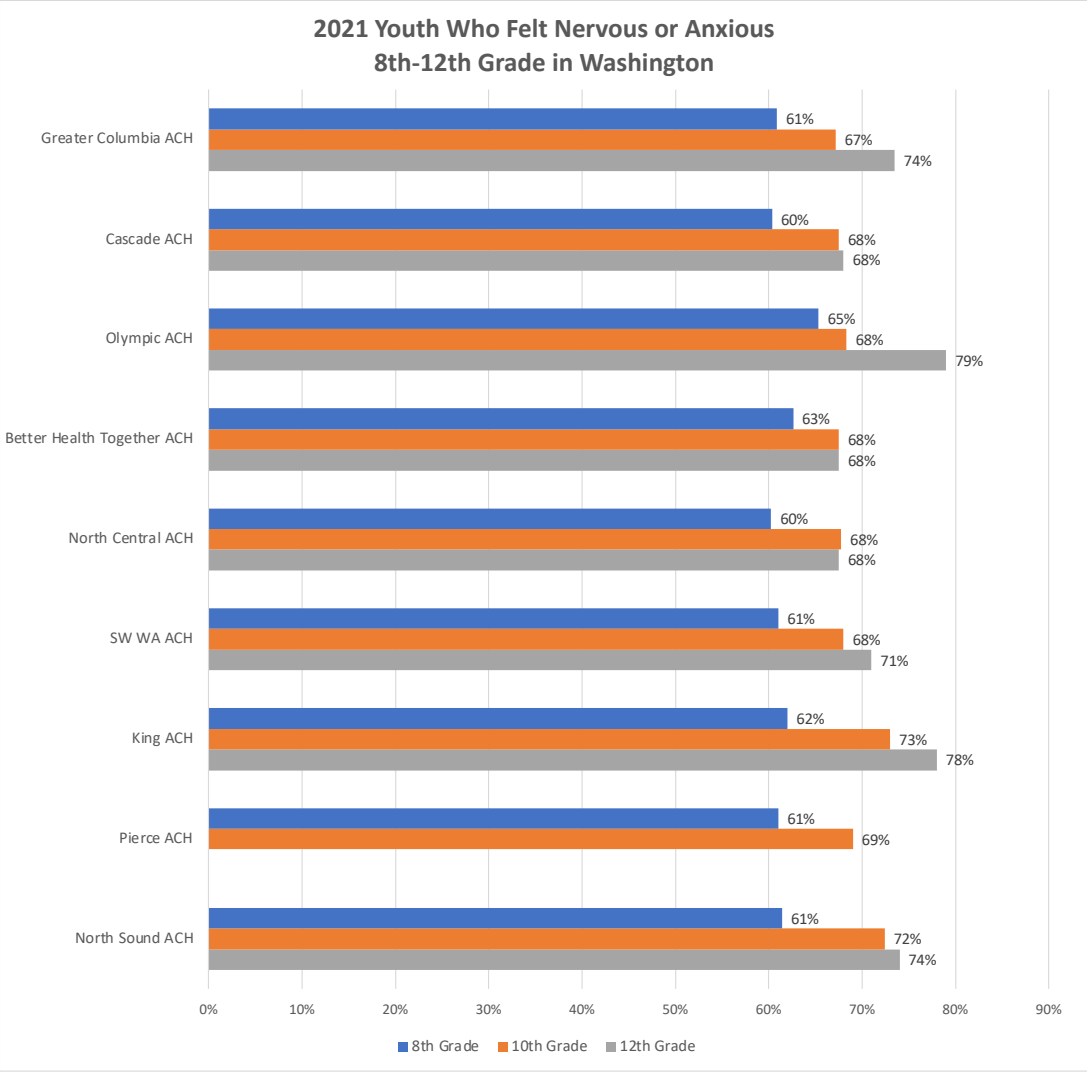


Figure 13: 8th-12th Graders Who Felt Nervous or Anxious in Washington (2021)[146]

According to the Washington Healthy Youth Survey, students who experienced the highest feeling of nervousness or anxiety were 12th grade youth.[147] This was present across each of the nine ACH's, where 8th grade youth had the lowest percentages.[148] Percentages for 8th grade youth ranged from 60-65%, 67-73% for 10th grade youth, and 68-79% for 12th grade youth.[149] This indicates that more than half of the students have experienced nervous or anxious feelings in 2021.

Bullying

Bullying affects everyone, those who are bullied, those who bully, and those who witness bullying. Bullying is connected to negative outcomes related to mental health, substance use, and suicide.[150] Negative physical, social, emotional, academic, and mental health issues are concerns kids who are bullied can experience.[151] Kids who are bullied are more likely to experience:

1. Increased feelings of sadness and loneliness, depression and anxiety, variations in sleeping and eating patterns, and loss of interest. These issues may be present as children move into adulthood.[152]
2. Health complaints[153]
3. A decrease academic involvement and achievement. Presenting low GPA, standardized test scores, and school participation. They are also more likely to miss, skip, or drop out of school.[154]

Bullying is considered to fall under ACE's, as it has the potential to lead to traumatic events that can have long-lasting effects on a person's development, the way they interact with others, and how they perform in school.[155] The impact of bullying involves everyone, the person being bullied, the person who bullies others and bystanders who witness the bullying.[156]

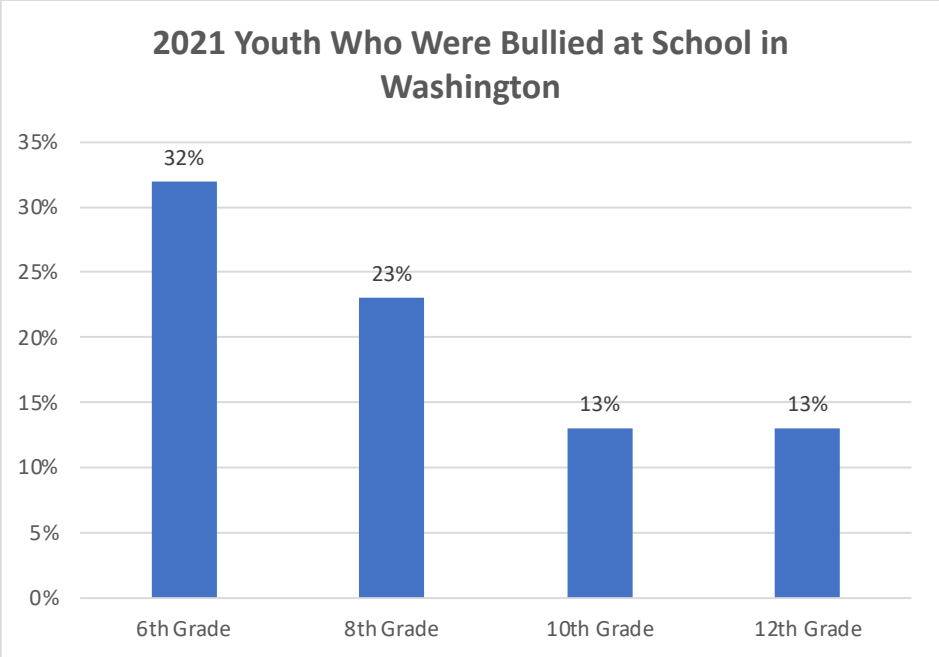


Figure 14: Washington Youth Who Were Bullied at School (2021)[157]

"Bullying in this survey is 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."[158]

According to the 2021 Washington Healthy Youth Survey, 6th grade youth (32%) in Washington state experienced higher rates of bullying compared to any other grade level.[159] As grade levels begin to increase, bullying percentages among youth began to decrease.[160] 10th and 12th grade youth experienced the lowest rates of bullying at 13% in 2021.[161]

Depression

The feeling of sadness and hopelessness is occasionally a part of every child's life.[162] Some children may feel sad or uninterested in things they used to enjoy and feel helpless or hopeless in situations they are able to change.[163] If feelings of sadness and hopelessness interfere with daily life, a child may be diagnosed with depression.[164] Some children who have depression may also experience thoughts of suicide, make plans to attempt suicide, and make a suicide attempt.[165] For youth aged 10-24 years old, suicide is the second leading cause of death.[166] Children may not feel open to talking about their hopeless and helpless thoughts and may not appear sad;[167] they may experience more challenging behaviors such as irritability or self-isolation, which can overshadow the underlying depression.[168] Depression is both common and should be taken seriously – it is treatable in children, youth, and adults.

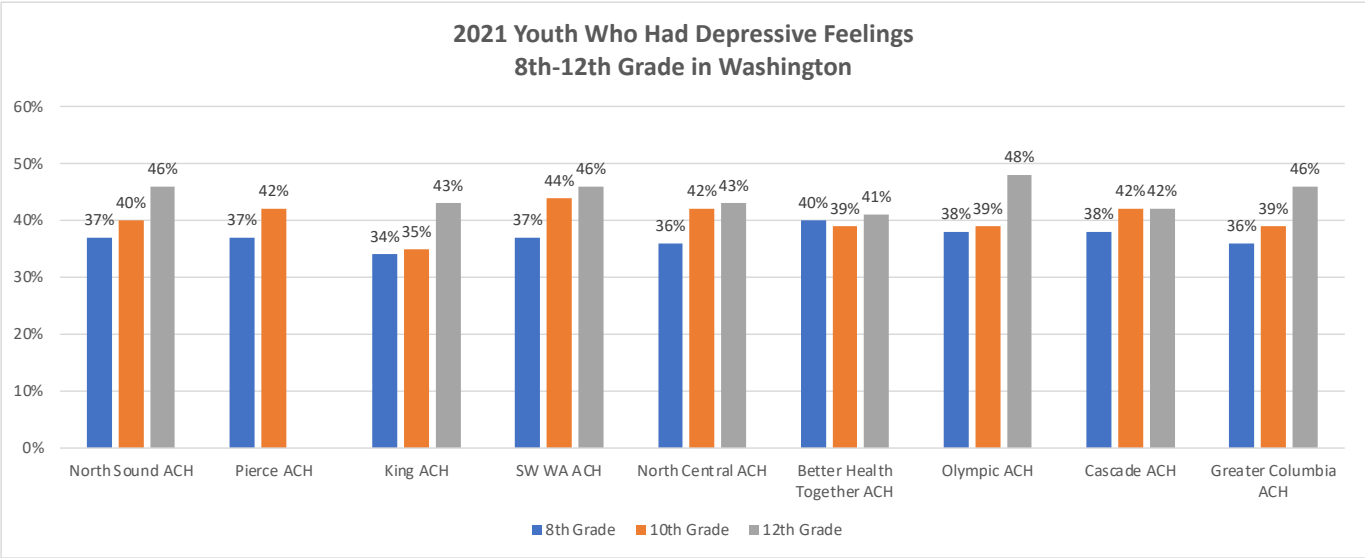


Figure 15: Washington 8th-12th Grade Students Who Had Depressive Feelings (2021)[169]

12th grade youth experienced higher percentages of depressive feelings compared to 8th and 10th grade students.[170] The percent range for 8th grade students were from 34-40%, 35-44% for 10th grade students and 41-48% for 12th grade students.[171] The percent of students who have experienced depressive feelings have either increased or remained constant as student grade level increased. The region served by the Accountable Community of Health, Better Health Together, is the only exception, where 8th grade youth had higher feelings of depression than 10th grade youth[50].

Suicide

Suicide is the second leading cause of death in the state of Washington for youth 10-24 years old[172] and a significant concern regarding youth mental and behavioral health. Results from the 2021 HYS indicate: "the pandemic has raised concerns regarding depression and suicidal ideation in youth. In 2021, 7 in 10 10th -graders reported feeling nervous, anxious, on edge, or not being able to stop or control worrying. Among the 10th grade participants:

- 38% reported feeling sad/hopeless in the past 12 months
- 20% reported they seriously considered attempting suicide in the past 12 months
- 16% reported they made a suicide plan in the past 12 months
- 8% reported they attempted suicide in the past 12 months"[173]

This is consistent with data from the 2018 HYS and indicates persistently high rates of suicidal ideation and attempt among high-school aged youth in Washington State. For a more thorough discussion of youth suicide and suicide prevention, see the Suicide and Injury Prevention section of this report.

Substance Use

Alcohol Use

Alcohol is a common substance used by teenagers and young adults, making underage drinking is a significant public health issue in the United States. While rates of drinking have decreased among high school students in recent years, alcohol use continues to be dangerous to youth health. Each year, alcohol leads to more than 3,900 deaths among people under the age of 21.[174] Additionally, youth who drink alcohol are more likely to experience problems in school, social problems, unwanted, unplanned, and unprotected sexual activity, disruption of normal growth and development, physical and sexual violence, increased risk of suicide and homicide, alcohol-related motor vehicle crashes and other unintentional injuries, memory problems, and changes in brain development that may have life-long effects.[175]

In 2019, the Youth Risk Behavior Survey found that among high school students in the United States, 29% drank alcohol, 14% binge drank, 5% of drivers drove after drinking alcohol, and 17% rode with a driver who had been drinking alcohol during the past 30 days.[176]

Over the years, youth alcohol consumption has continued to decrease in Washington. In 2021, students across the state reported that 2% of 6th graders, 4% of 8th graders, 8% of 10th graders, and 20% of 12th graders used alcohol in the past 30 days.[177] Most students report that they get alcohol from friends, at partiers, or at home with permission from their family.[178]

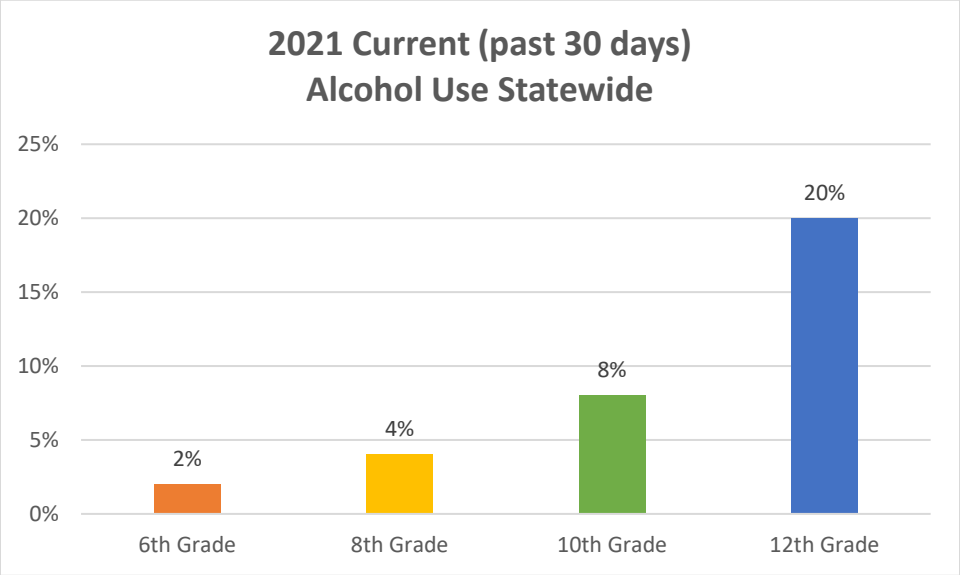


Figure 16: Washington Students Current Alcohol Use (2021)[179]

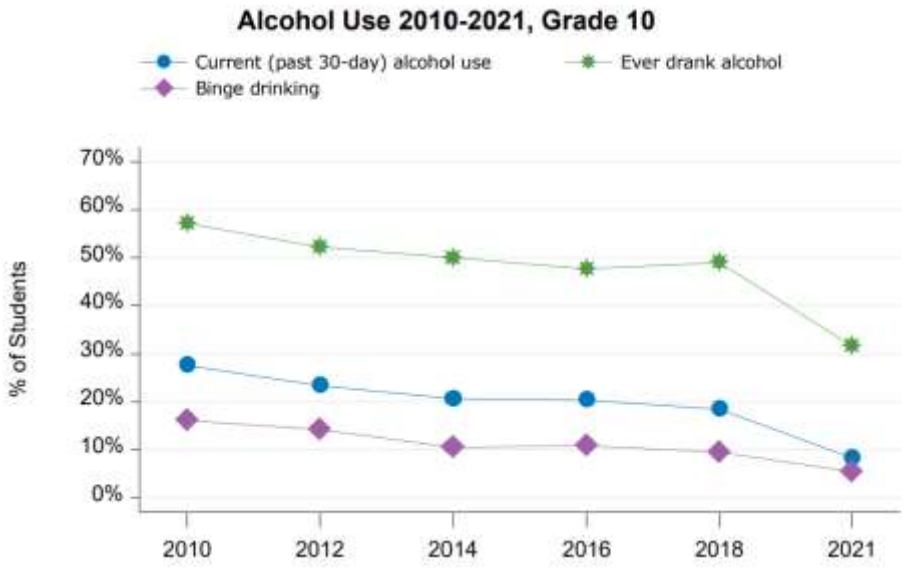


Figure 17: Washington 10th Grade Student Alcohol Use (2021)[180]

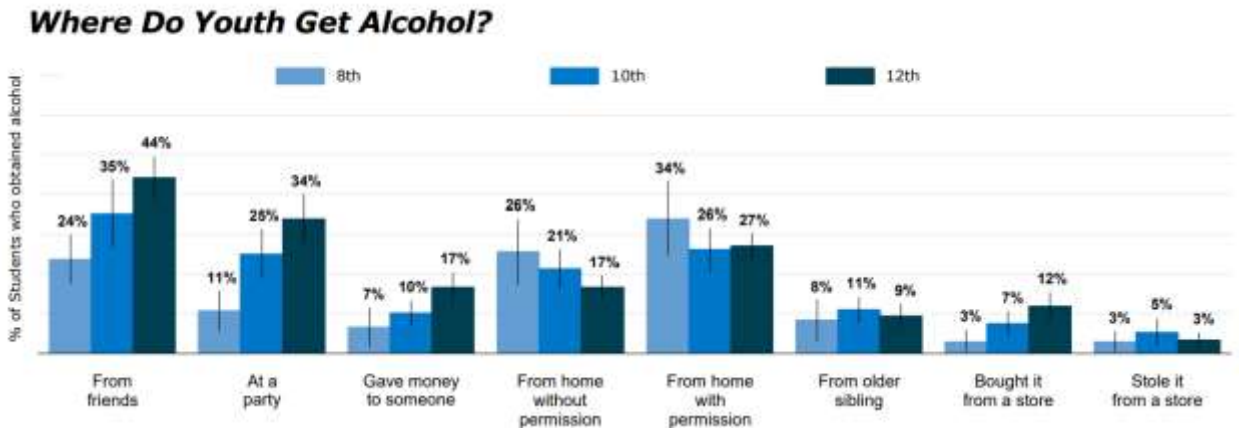


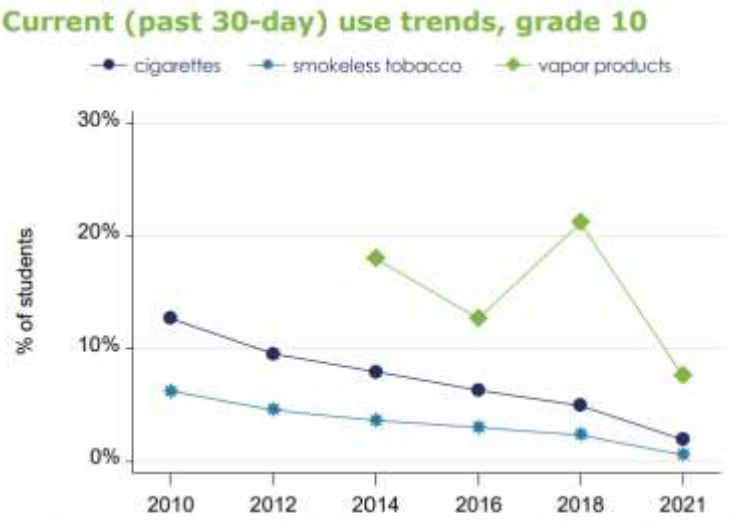
Figure 18: Washington 10th Grade Student Reports on Alcohol Sources (2021)[181]

Cigarette and Vaping Use

Vapor products such as electronic cigarettes, JUULs, and vape pends have become the most common method of consuming nicotine among youth in recent years. Youth under the age of 18 are far more likely to start using tobacco than adults, with almost 90% of adults who smoke starting by the age of 18.[182] Because of this, this demographic is especially important in the effort to reduce tobacco-related mortality, morbidity, and economic costs.[183]

It is also important to note that vapor products can also be used to consume marijuana so not all vapor product users consume nicotine. Among 10th graders in Washington, 56% used vapor products containing nicotine, 41% used THC or marijuana, 3% used flavor only (no nicotine or THC), and 31% were unsure of the substance they were using.[184]

From 2018 to 2021, vapor product usage among 10th grade students in Washington decreased by 13%.[185] Cigarette and smokeless tobacco usage also decreased to 2% and 1% respectively.[186] This decrease may be attributed to the COVID-19 pandemic and stay-at-home orders, which limit the availability of these products to youth.



Prevalence	2010	2012	2014	2016	2018	2021
cigarettes	13% ±2	10% ±1*	8% ±1	6% ±1*	5% ±1*	2% ±0*
smokeless tobacco	6% ±1	5% ±1*	4% ±1	3% ±1	2% ±1	1% ±0*
vapor products	N/S	N/S	18% ±2	13% ±2*	21% ±3*	8% ±1*

Figure 19: Washington 10th Grade Student Tobacco Usage (2021)[187]

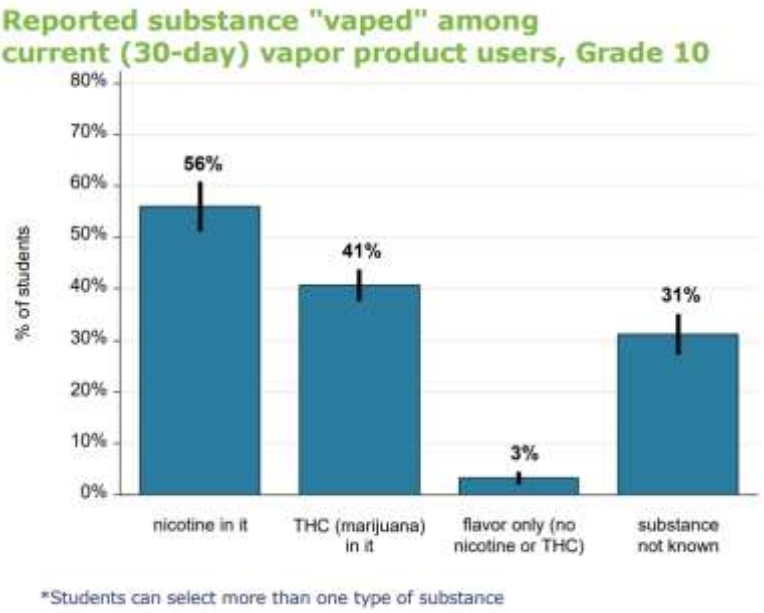


Figure 20: Washington 10th Grade Student Current Vapor Product Usage (2021)[188]

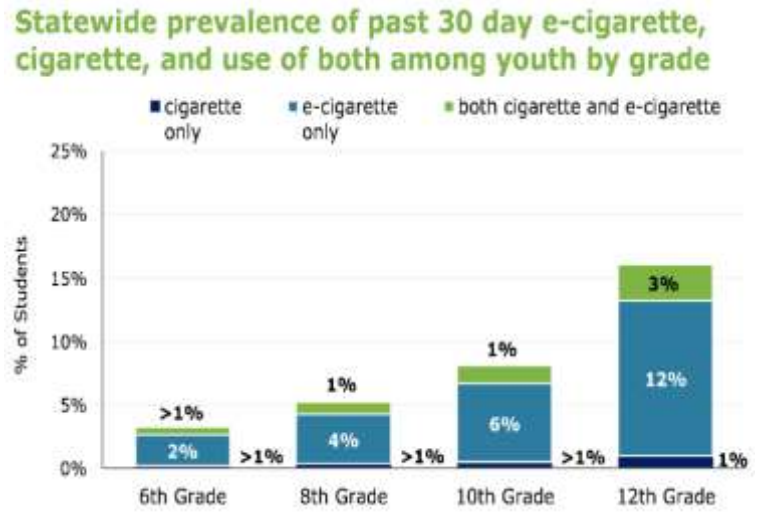


Figure 21: Washington Student Cigarette and E-Cigarette Usage (2021)[189]

Marijuana

Marijuana is another substance that is commonly used among youth and young adults. In 2021, students across the state reported that 1% of 6th graders, 3% of 8th graders, 7% of 10th graders, and 16% of 12th graders used marijuana in the past 30 days.[190]

Most youth who enter drug treatment programs report that marijuana is the primary drug that they use, which demonstrates that it can be addictive.[191] Marijuana use can have negative effects on mental health and has been associated with anxiety and depression.[192] Youth who use marijuana can also have issues with learning and memory and are more likely to struggle in school.[193] An average of 61% of students between 8th and 12 grade believe that there is no to little risk from trying marijuana once or twice, and an average of 30% of students in this age group believe that there

is no to little risk of using marijuana regularly (once to twice a week).[194] These perceptions do not match the reality that marijuana can be harmful to health, indicating that youth education around this topic could be beneficial.

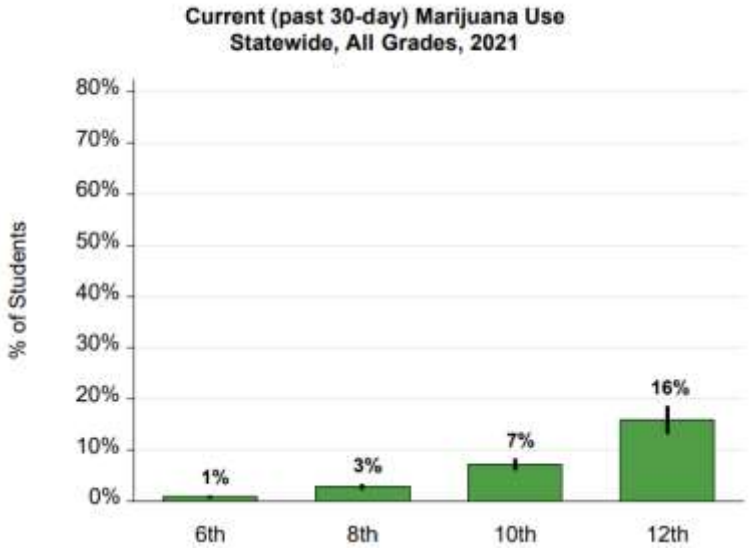


Figure 22: Washington Student Current Marijuana Use (2021)[195]

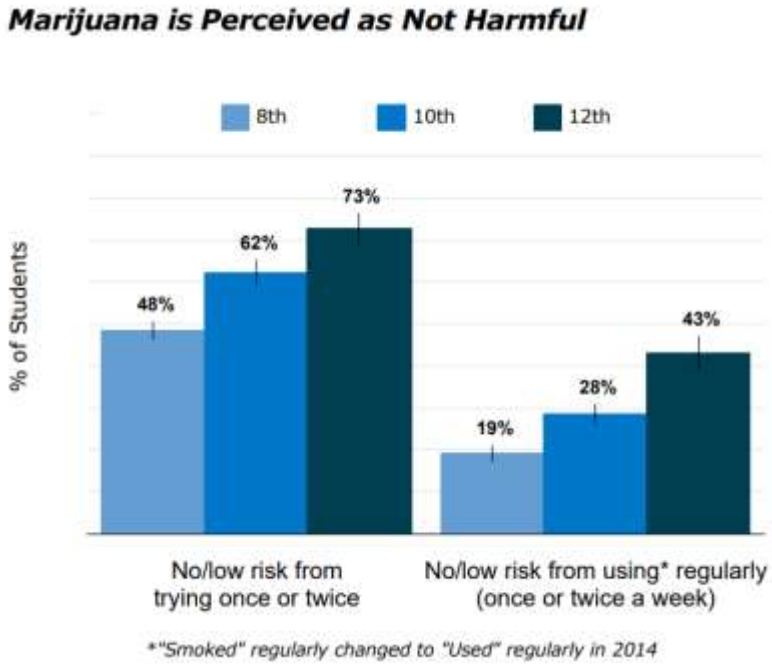


Figure 23: Washington Student Perceptions on Marijuana Harm (2021)[196]

Prescription Medication Use

The opioid crisis has been an important topic across the nation and within healthcare in recent years. Prescription drug misuse is defined as times when an individual takes a medication (prescribed to themselves or someone else) in a way

that was not intended by the prescriber.[197] Substance use, overdose (both fatal and nonfatal), and worsened mental health have increased throughout Washington, and have continued to worsen throughout the COVID-19 pandemic.[198]

The number of opioid cases managed by the Washington Poison Center have increased by 3.6% across the state from 2019 to 2020.[199] The figure below shows that synthetic opioid deaths, which includes fentanyl, have been climbing at an alarming rate in Washington, particularly in recent years. In December of 2021, there were 1,183 reported deaths from synthetic opioids, which is an almost 249% increase from the number of deaths reported in January of 2020 (339 deaths).[200] In 2020, 57% of opioid cases among 13-20 year-olds were due to suicide/self-harm.[201] Many youth opioid exposures are unintentional as well, with 116 accidental exposures occurring among 0-5 year-olds in 2020.[202] Rural counties in Washington experience adverse opioid events at a higher rate than urban counties, with Garfield, Lincoln, Okanogan and Pend Oreille experiencing the highest rates.[203]

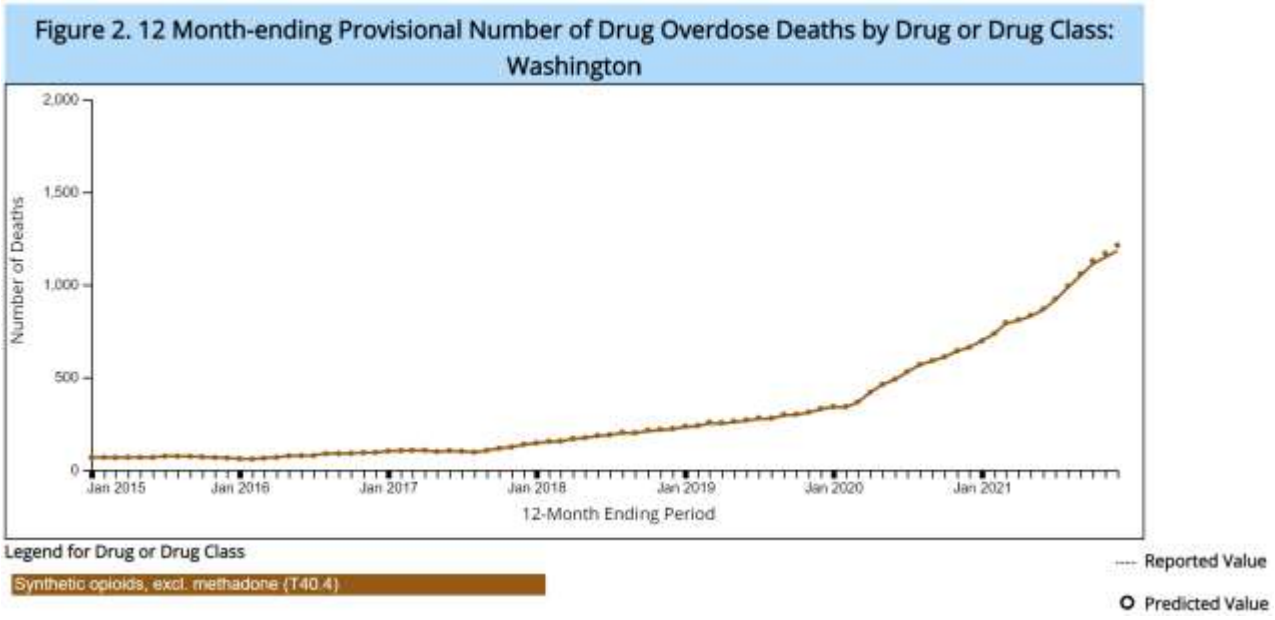


Figure 24: Washington Synthetic Opioid Deaths (2015-2022)[204]

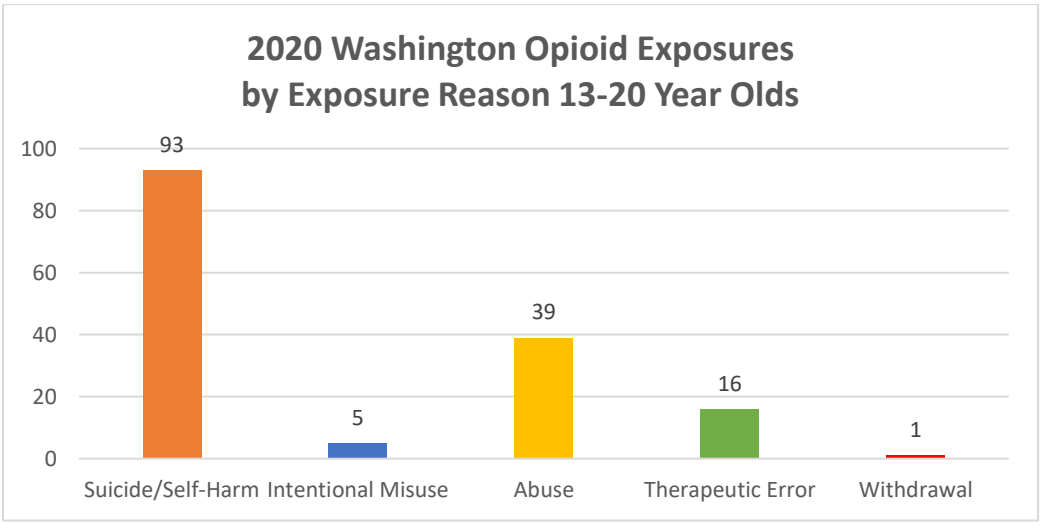


Figure 25: Washington Youth Opioid Exposures by Reason (2020)[205]

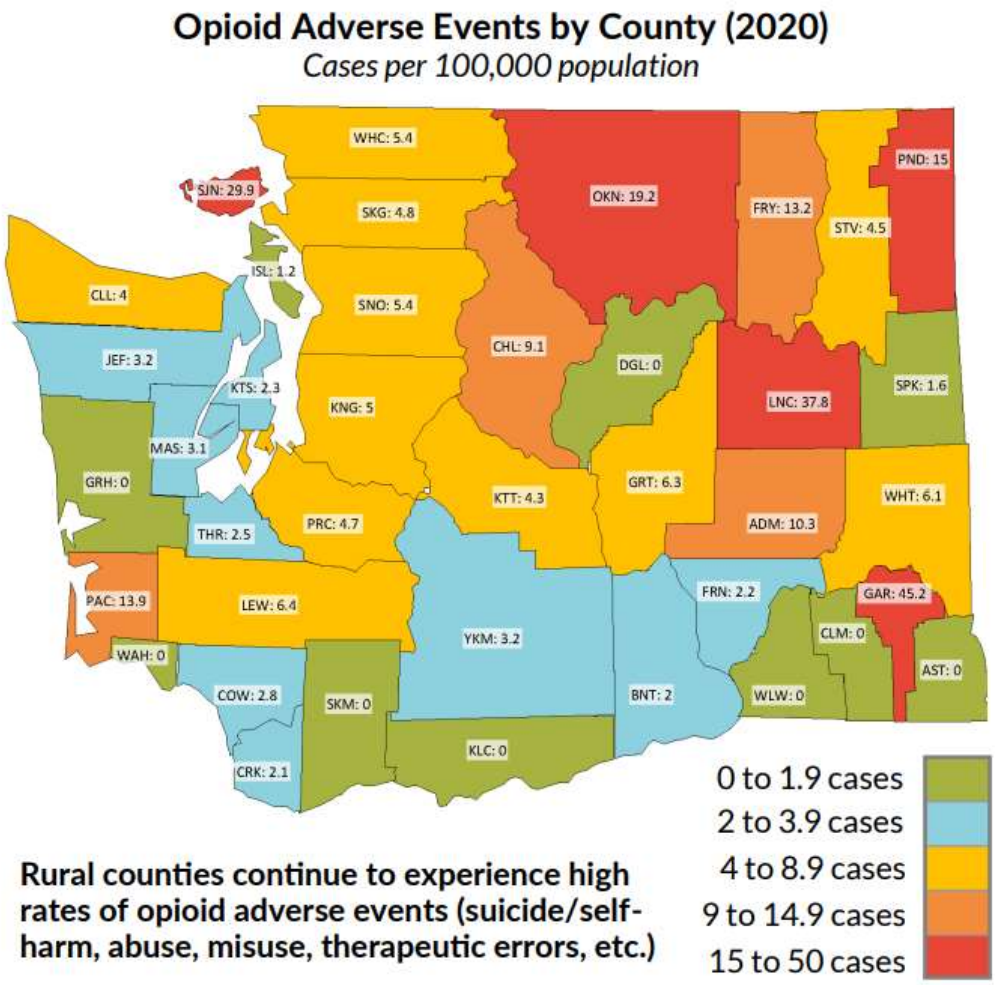


Figure 26: Opioid Adverse Events by County (2020)[206]

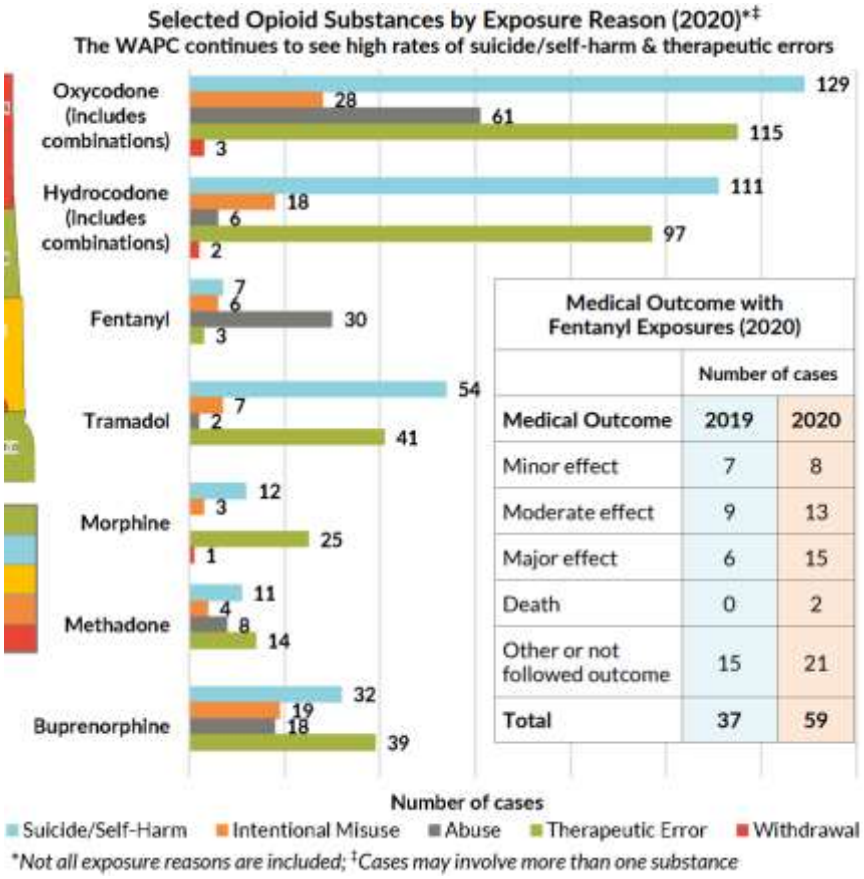


Figure 27: Washington Opioid Substance by Exposure Reason (2020) [207]

Provider Concerns about Mental and Behavioral Health Impacts on Children During COVID-19

This sub-section was written in April of 2020 while the stay-at-home order and quarantine were still in place in Washington. Interviews were conducted with community pediatric providers to begin to understand the impact of COVID-19 on pediatric health. This section is included as it was originally written to highlight the concerns raised by providers contemporaneously to the onset of COVID-19 pandemic.

> *"Fear. Fear of the unknown. Fear of uncertainty. I'm worried about what's to come. We know mental health worsens after times of crisis."*
>
> *-Key Informant, as quoted in April 2020, Washington state*

The major themes that arose from the key informant interviews were: 1) changes in clinical practices as a result of the COVID-19 pandemic; 2) the introduction of telemedicine and its impacts, both good and bad; 3) the Impact on education; 4) the large-scale economic impacts, both current and future; and 5) mental and behavioral health impacts on children.

Mental and behavioral health were a focus of a lot of the interviews as well as a top concern for every provider. Fear, anxiety, and isolation seem to be key drivers of worsening child and adolescent mental health during the pandemic.

Many providers predict not only worsening of mental health of children who already have mental health conditions but also increases in anxiety and depression because of this pandemic.

Providers and families are noticing how parental and community anxiety and worry is being imparted to children. Many providers told stories of parents relaying concerns that the children can sense the anxiety within their parents and even if they are not able to fully understand the pandemic it is affecting them. Children are very tuned into the well-being of their parents, and increased stress in the home is picked up by the children.

Providers note that parents are reporting behavioral issues with children at increased rates. Many providers have been overwhelmed with requests for the ADHD testing and access to mental health professionals. With poor access to community mental health care in Washington, community pediatricians have long been helping provide frontline mental health services and visits for children and they anticipate this will only increase with the pandemic

Interestingly, providers did report that the pandemic has been beneficial for a subset of children and adolescents. Mainly, children whose mental health conditions arise from school and social interactions. These children have done well with the stay-at-home order and move to remote schooling. One provider told a story of a family who reports that their daughter is the best she has ever been and even if school returns next year they may elect to move towards homeschooling.

By and large, however, providers were concerned of the far-reaching impacts that the COVID-19 pandemic will have on child behavioral and mental health. Even outside of the acute phase of the pandemic it is likely that mental and behavioral health will continue to be impacted in the coming months and years as Washington works through the economic and societal impact that will follow in the wake of the pandemic.

Community Findings: COVID-19 and Children's MBH in King County

This sub-section was written in May of 2020 while the stay-at-home order and quarantine were still in place in Washington. This section is included as originally written to reflect contemporaneous concerns regarding the impact of COVID-19 on children's mental and behavioral health in King County. The COVID-19 pandemic has brought so many changes to pediatric health, the assessment of it, and has worsened existing inequities and created new inequities. You'll notice that the impact of COVID-19 is interspersed throughout the entirety of this assessment.

COVID-19 is changing the mental health needs of children and teens in King County, as well as the landscape of mental health care. These impacts are multi-factorial and will likely take months to years to fully understand. Early data from impacted counties in China shows increased rates of anxious and depressive symptoms among children.[208] The Washington Department of Health recently released a report outlining an expected surge of mental health need among all citizens, with the highest risk of suicide this fall and winter, coinciding with high rates of seasonal affective disorder symptoms.

Likely impacts of COVID-19 on mental health include fear of COVID-19, school closures, significant impacts on social determinants of health, potential increase in abuse and neglect, amplification of existing inequities and direct impacts on mental health care. Many resources have been created to aid parents, educators and providers in talking to children about COVID. Schools closed on March 12, 2020 in King County, creating a loss of structure for children and additionally representing a significant loss of healthcare. Previous studies have demonstrated that about 13% of adolescents receive some form of mental healthcare in schools. Among adolescents who receive any mental healthcare, 57% receive some form of that care through school (and 35% receive care exclusively through school).[209] Importantly, members of racial/ethnic minority groups, students with lower family income and those with public insurance are disproportionately more likely to receive care through school.

It is also clear that COVID-19 is having significant impacts on social determinants of health, with rising rates of unemployment, unstable housing and food insecurity. These stressors have significant impact on family dynamics and mental health, and data from previous economic downturns suggests that children have poorer mental health outcomes as the economy worsens.[210] Simultaneously, COVID-19 seems to be amplifying existing inequities. Communities of color are affected at higher rates, and testing is not equitably distributed. Frontline workers are disproportionately from communities of color, and the existing wealth gap means that people of color are less likely to be able to safely take unpaid time off.

As children spend more time at home and out of school, there is also concern that rates of abuse and neglect will increase. During this pandemic, children are having fewer interactions with mandated reporters, including educators and healthcare providers. In the week following Governor Inslee's announcement of the stay-at-home order, there was a 40% drop in hotline calls in Washington. Nationally, there was a 22% increase in calls to the National Sexual Assault Hotline from children <18 as they spend more time at home with possible perpetrators.[211]

Finally, COVID-19 has changed the ways in which mental health care is provided to children and teens. Most mental health providers are now interacting with patients via telehealth, and early data from other settings suggests that use of telehealth is not equitable.[212]

In May 2020, a pediatrician in their second year of Pediatric Residency at Seattle Children's conducted a month-long project to begin to understand the current and projected impact of COVID-19 on the mental and behavioral health needs and care of children in King County, and to identify key resources and best practices in responding to these changing needs, the results of which are outlined in the rest of this subsection.

The major themes that emerged from the King County stakeholder are as follows: 1) mental health providers are seeing fewer patients during COVID, across the spectrum of care, 2) families' basic needs have been affected by COVID which is impacting mental health of children and families, 3) school closures have had a significant and multi-factorial impact on children and teens' mental health, 4) accessing mental health care looks very different during COVID, 5) the move to telehealth has increased access to care for some while creating poorer access for others, and 6) COVID has exposed and worsened existing inequities while additionally creating new inequity. These themes will be discussed individually below.

Providers are Seeing Fewer Patients

Across the spectrum of mental health care, providers are seeing fewer patients. Community outpatient providers report seeing overall fewer visits, continuing to accept new patients, and receiving fewer referrals. They do not believe this is due to a decreasing need for their services, but rather represents school closures, as schools are an important source of referrals for their pediatric patients, as well as a fear of seeking in-person care. Seattle Children's providers additionally report an overall decrease in patient visits, continuing to accept new patients and increasing waitlist times during the transition to telehealth.

The Washington Mental Health Referral Service for Children & Teens reported an initial decrease in daily calls, which has since slowly been increasing back to close to daily numbers pre-COVID.

The Intensive Outpatient and Partial Hospitalization Program provider interviewed reported an initial decrease in patients enrolling in their programs, followed by a gradual increase to pre-COVID patient numbers. Of note, the one exception to this initial decrease was in teenagers requiring Partial Hospitalization, as this patient group was referred in increased numbers initially, requiring the creation of an additional cohort.

The Emergency Department at Seattle Children's is seeing a decreasing number of mental health encounters compared to previous years. This is especially notable as March-May is typically a time of increasing mental health-related visits. In

April of 2020, there were 170 encounters for mental health in the ED, down from 313 total in April 2019. Similarly, there were 217 encounters in March 2020, compared to 306 in March 2019. The ED has noted that, although the total number of encounters has decreased, the cases they have been seeing seem to be more complex. Key stakeholders from the ED stated, "people aren't coming to the ED until too late. If they came in earlier, maybe we would have prevented a suicide attempt."

The Psychiatry and Behavioral Medicine Unit at Seattle Children's has also seen decreasing patient volumes, with an average daily census of around 22 patients compared to 40 last May. This decrease was at least partially intentional in order to create an environment which allows for appropriate infection prevention and social distancing. PBMU stakeholders noted that this decreased census and need for social distancing does have a significant disruption to their typical milieu therapy.

COVID has Impacted Families' Basic Needs

Families are experiencing economic, housing and food insecurity which is impacting mental health. One stakeholder reported, "We always ask families about their biggest stress, and now we're hearing answers like 'I've lost a job'." Care coordinators reported hearing from families about stress surrounding upcoming evictions after not being able to pay rent for several months, despite the Seattle moratorium on evictions. Coordinators also reported that, although existing food bank partnerships were functioning well, less food seemed to be available as they needed to serve more people. Many stakeholders interviewed reported an abundance of COVID-related resources but difficulty sustainably connecting them to people in need. One stakeholder reported, "There's a plethora of resources but navigating all of that is very confusing, so we have people at the ready to… help connect people to the right resource instead of just sending a list."

School Closures

School closures have simultaneously removed some stressors and created or worsened others for children and parents. For children who found school to be a significant stressor, spending more time at home seems to be a positive change. Providers described other children who seemed to thrive with the structure of school, and now seem to be "floundering" as they spend their days at home. As one provider summarized, "Some kids do better when not at school in terms of psychosocial stress. A lot of kids feel relief. But there's a certain number of kids where their primary social support was actually coming from the school." School closures have also created difficulties for children with different learning styles, for whom "staring at a screen for several hours is just not going to work." It additionally has created barriers to education for children who receive specialized services at school, as providers report that not all families receiving these services have heard from their schools with virtual support or instructions. However, one school-based provider did note that virtual individualized education plan (IEP) meetings have had some success as they have allowed parents and guardians to more easily attend the meetings because transportation barriers have been removed.

School closures also represent loss of important social interaction, which seems to be having significant impact on children and teens. This loss is especially hard in cases where children's primary source of support was at school, and providers worry is dangerous in cases where home is not a safe place, noting that schools are the most common source of calls to the state's child protective agency the Department of Children Youth and Families (DCYF). Providers frequently voiced concerns about the impact of missing major school-related milestones, including prom and graduation for high school students.

Interviewed providers and stakeholders also identified inequities in students' access to education. Inequities were particularly identified around access to appropriate technology to allow participation in school. As one care coordinator said, "Ok, you're sending laptops, but how are the kids able to help obtain internet that they need? Even if it's $10-12 monthly, that's still money that could be used for other bills. And families don't have another choice because they say 'I want my kids to still receive their education.'" Another provider noted, "I have a certain number of kids who have just stopped their educational process."

Finally, providers universally noted that school closures have placed a tremendous amount of stress on parents, which they expect is impacting their children. Many parents are now juggling multiple roles, as caretakers, educators and employees, in addition to the stressors noted above related to food, housing and economic insecurity. One stakeholder reported, “For the parents I think it’s just a huge stressor because they’re now having to be not just caretakers but teachers and still having to be provider of the household.”

Access to Mental Health Care

Accessing mental health care for children and teens looks very different during COVID. Multiple interviews highlighted that appointment availability for therapy and medication management has been changing over time. Seattle Children’s providers have described increasing waitlist times as the ability to take new patients has decreased while providers have been rapidly initiating telehealth. The Seattle Children’s ED found that initially it was difficult to coordinate outpatient follow up for their patients, but that this has actually become easier and faster over time as more of their community providers have set up telehealth. The Mental Health Referral Service reports that it was easier to place new referrals with community providers initially, but that it seems to be taking slightly longer now. The Intensive Outpatient provider reported that their waitlist for IOP has been increasing over time, as patients are particularly interested in receiving virtual care. It is also important to note that the Referral Service has also noted an increase in the number of Medicaid referrals they have received.

Availability of mental health care is also impacted by school closures for many teenagers. School-based health centers are a major source of mental healthcare for teens, and while they adapt their models to virtual care, it has been difficult to identify and care for new patients. Many of their existing patients also seek care in schools confidentially and have been hesitant to continue care while at home with their patients. As one provider noted, “Some have found ways to still keep in contact, but a lot of them really don’t want their families to know that they’re in counseling. I think that a lot of youth are not being served who unfortunately do need more support during this time and that’s really hard.”

Telehealth

The shift to providing mental health care virtually has seemed to improve access to care for some, while creating poorer access for others. Providers noted that for many patients, access to virtual mental health care has eliminated previous barriers to care and has made reaching out to providers more approachable. The Referral Service reports seeing higher rates of families following through with appointments, which they attribute in part to being able to offer more provider options as geographic constraints are loosened. One provider described the benefit of eliminating the burden of transportation to clinic on families: “We knew this was an issue for years, the burden we put on parents and families to navigate to our clinic, creating a high no-show rate and stressed families by the time they get to clinic. The waste that goes into transportation, we’re seeing the potential to overcome a lot of these barriers to access to care through this experiment.”

However, access to virtual care is not possible for families without access to necessary technology. As noted above in discussing inequitable access to education, not all families have easy access to computers and the internet. Access to privacy is not universal, and this is especially important when trying to seek mental health care. Finally, many teens were previously seeking confidential care but feel unable to do so while at home with their parents.

Providers described successes and challenges of providing virtual mental health care. Many reported that many children and teens seem to feel more comfortable with virtual mental health care, disclosing more than they might have previously. Providers also noted that seeing patients in their home environment can be very helpful in understanding the context of their symptoms and their own recommendations. However, it is also much more difficult to create a therapeutic relationship with patients virtually, and providers reported particular worry around conducting virtual safety assessments. One provider shared, “I know that I cannot physically stop them from harming themselves, which makes

me worry." Providers noted that it has seemed to be particularly difficult for patients with significant trauma history to feel comfortable with virtual care.

New and Worsening Inequities

COVID has exposed and worsened existing inequities, while creating new disparities in disease incidence, outcomes and testing. When asked about their biggest worries about COVID's impact going forward, providers most commonly answered with a focus on worsening inequities. Specifically, providers shared concerns about inequitable access to telehealth and to education, related to technology access, ability for parents to be home from work and access to privacy, as well as inequitable effects on basic needs and social determinants of health, including housing, food and economic stability.

Innovative Best Practices

Providers and organizations have been innovative and flexible in their response to COVID. Examples of this innovation include the creation of the ED Extension Service at Seattle Children's, which established close outpatient follow up for patients seen in the ED in crisis who did not require full inpatient hospitalization and could establish care with an outpatient provider in the near future. Additionally, the PBMU was able to create a Special Isolation Unit so that they could care for patients with COVID who required hospitalization for behavioral or psychiatric care.

Many providers and stakeholders identified the importance of proactively and systematically reaching out to children and families, checking in with those families who were not being seen through virtual care and may have otherwise fallen through the cracks, and sharing available resources and services with families. This outreach also often involved care coordination, matching families in need with the appropriate COVID-related resources. As noted above, many resources exist but the system often feels difficult to navigate.

Providers and organizations highlighted relying on support and resources from community organizations. Examples shared included virtual support for children and teens (groups like Lambert House and Grow Girl), as well as training, support and best practices for providers practicing virtual care (King County Behavioral Health, Washington Chapter of the American Academy of Pediatrics, Seattle Children's, Harborview Abuse & Trauma Center).

A few organizations also highlighted addressing barriers to telehealth which are creating inequities. Several organizations have created private physical space with access to technology, maintaining appropriate infection prevention methods, which patients can come in to use if they do not have access at home.

Looking to the Future

When asked about their hopes for the positive future impacts of COVID on behavioral and mental health, many providers shared that they are hoping to continue to offer telehealth even after COVID. Providers hope to be able to be flexible in addressing families' particular barriers to care, noting that telehealth is a better option for some but worse for others and that it seems to improve care for some teens but not for others. Some stakeholders also noted that this time seems to be allowing for more open conversations around anxiety and mental health, which they hope to see continue after COVID.

When asked about future worries, providers noted concern about an increasing need for mental health care over the coming months as we reopen. Providers are also worried that we are missing children and families who need support currently but may not have access to care or may be fearful of seeking care. Concern about the long-term impact on education for many families was also noted. Finally, many stakeholders shared concern about overall decreased funding for community organizations at a critical time when more people are relying on their services. Similarly, many shared concerns about what the decreased patient volumes mean for community mental health and providers who see high rates of Medicaid patients, especially given the lack of increased reimbursement.

May 2020 COVID-19 Impact Summary

As of May 2020, COVID-19 has already made a significant impact on the mental and behavioral health of children and teens in King County. It will likely continue to do so over the coming months as the effects of this pandemic continue and evolve. These representative interviews with stakeholders and providers in the mental health field highlighted a few key themes.

First, virtual mental health care seems to have some important benefits. However, we are only beginning to understand the ways in which it leaves people behind. Many interviews showcased the ways in which telehealth has addressed barriers to care for some patients and families. Providers hope that they will be able to offer multiple visit formats in the future to best meet patients' needs. However, interviews also demonstrated that we are missing many families who are not able to seek care virtually. We need to systematically study these trends and inequities in order to address them, and we need to listen to patients and families to better understand their experience and how to address barriers to accessing care.

Second, the initially decreased number of mental health visits likely does not represent a decreased need for care. In fact, providers are expecting increasing demand as our community continues to re-open. Access to pediatric mental health care in Washington was relatively poor prior to COVID, and this time may only increase the need. Interventions including virtual groups to reach multiple patients as well as training primary pediatricians in virtual mental health care are critical to increase our community's capacity to provide mental health care.

Finally, many resources exist to support families and children in need during COVID. However, it has been challenging to sustainably connect these resources with the people who need them. Care coordinators and case managers are essential in proactively reaching out to families and connecting them with the resources they need, both because they help to connect with families who might otherwise fall through the cracks and because they are able to best connect families with needed resources in the community.

Washington State MBH Summary

Over the last 3 years in Washington State, the mental and behavioral health needs of children and youth have increased while the landscape of services to meet their needs has shifted and shrunk. Washington State is fortunate to have many communities with unique strengths, a recognition of the crisis among legislators and philanthropic organizations, and a spirit of collaboration to meet these needs. We need to continue to build out a full continuum of mental health care and services for children and youth, so they don't have to sit on a weeks-long waitlist for a therapy appointment, so they don't end up in crisis and having to come to an emergency department – but instead they get the care they need wherever they need it. Washington desperately needs increased school-based, community-based, and in-home services to meet kids and families where they are, as well as more intensive resources and more nimble crisis responses. COVID-19 exacerbated existing inequities in our mental and behavioral health system – worsening workforce shortages, increasing demand, shrinking capacity – and it also gave us a unique opportunity to innovate, to collaborate, and to rise to meet the challenge. In the coming years, we will need that spirit of partnership and ingenuity as we continue to meet the needs of our vulnerable children, youth, and their families.

Spotlight on Alaska, Idaho & Montana: Mental & Behavioral Health

Alaska Community Input

Anxiety and Depression

Data published in the 2022 Kids Count Data Book indicated that between 2016 and 2020, the percentage of children in Alaska who had anxiety or depression increased 51.9% from 5.4% in 2016 to 8.2% in 2020.[213] Between 2018-2019,

approximately 23% of Alaskan children had one or more emotional, behavioral, or developmental condition.[214] The 2022 Kids Count Data Book ranks states regarding overall child wellbeing, Alaska ranks 41st out of 50 states.[215]

Alaska Children's Trust and Kids Count Data published a 2020 report on the health of Alaska's children – they shared: "the data indicate that Alaska's high school students are experiencing increasing levels of sadness and hopelessness. The proportion of students meeting the indicator definition has jumped from 25 percent in 2009 to 38 percent in 2019; a 52 percent increase."[216]

Importantly, Alaska is not a monolith – there are regional variations in rates. The report continues: "these increases have been seen across all regions of the state, with regional increases in hopelessness ranging from 10 percent in Southwest Alaska to 54 percent in the Matanuska-Susitna region."[217]

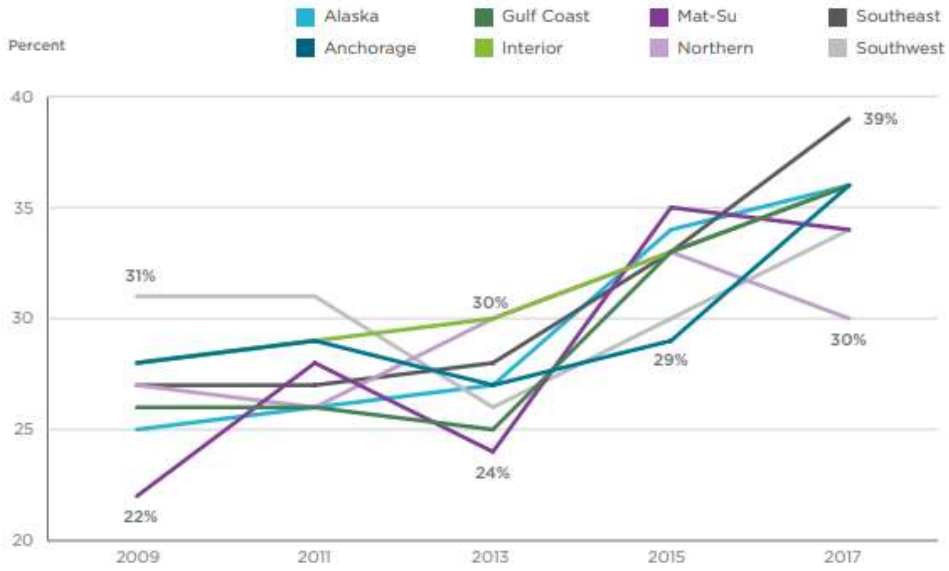


Figure 28: High School Students Reporting Feeling Sad or Hopeless, Past 12 Months, by Region, Percent (2009, 2011, 2013, 2015, 2017, 2019).[218]

This report also noted a growing racial and ethnic in terms of which students are more likely to feel sad or hopeless.[219] In the past decade, rates of sadness and hopelessness have increased for all youth but disproportionately so for American Indian/Alaska Native youth.

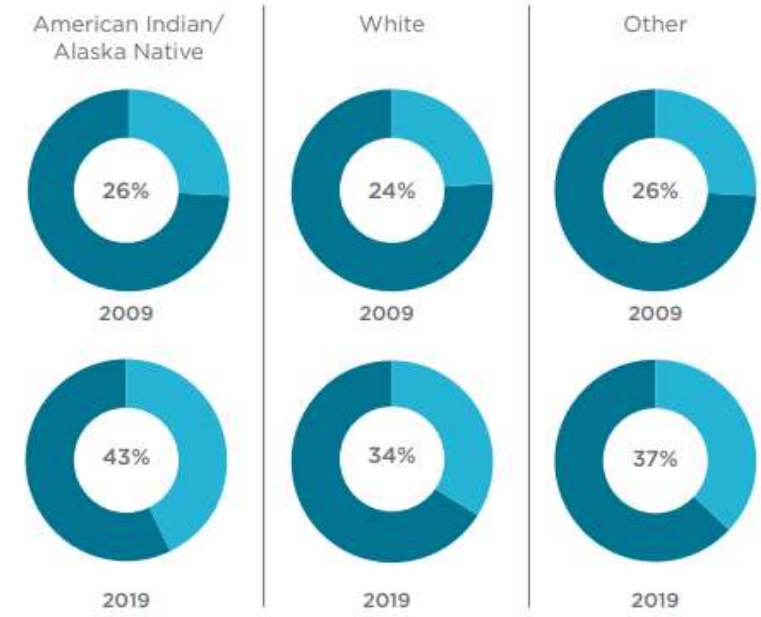


Figure 29: Traditional High School Students Reporting Feeling Sad or Hopeless in Past 12 Month, by Race, Percent (2009, 2019).[220]

An article published in the Anchorage Daily News highlighted limited mental health resources for teens in Alaska, including limited mental health education in schools, a lack of in-state inpatient beds, limited options for eating disorder treatment, and generally not enough support for youth with mental health issues.

Suicide

Alaska's adolescent suicide rate has long been among the highest in the country. Alaska's average annual adolescent suicide rate from 2016 to 2019 was about three times higher than the national average.[221]

In 2019, 1,875 Alaska students in 39 traditional high schools statewide completed the anonymous and voluntary Alaska Youth Risk Behavior Survey (YRBS) that reports on numerous health behaviors. The 2019 survey showed a significant increase in the percentage of adolescents attempting suicide.[222] The rates of attempted suicide have nearly doubled in a decade – from 10.7% in 2007 to 19.7% in 2019 – and increased significantly even since the last survey in 2017 (12.1%); additionally, a quarter of students surveyed reported they had seriously considered suicide.[223]

Unfortunately, the 2021 Alaska YRBS was cancelled due to COVID-19, so updated data on adolescent mental health will come from the survey administered in 2023.

An article published in the Anchorage Daily News shared that "during 2019, suicide was the leading overall cause of death for Alaska youths and young adults ages 15 to 24 — the only age group where that was the case," according to the suicide prevention coordinator with the Alaska Department of Health and Social Services.[224] This article also reported that "suicide rates were also highest among Alaska Native people, men, and people ages 20-24, state data showed."[225]

According to the article, "the latest state data showed that Alaska is seeing an increase in the number of youths ages 11 to 14 who have attempted suicide. But in 2020, Alaska actually experienced a 50% decrease in the number of youths ages 10 through 19 who took their own lives" which is an encouraging sign.[226]

Alcohol and Substance Use

Data from 2017 cited in the 2021 Kids Count report indicates that 23% of Alaskan teens used alcohol in the past month, 13% used tobacco, 23% used marijuana, and 26% reported vaping within the last month.[227]

Alaska Children's Trust and Kids Count Data published their 2020 report on the health of Alaska's children and cited YRBSS data regarding substance use among Alaskan adolescents. While the portion of teens using alcohol or tobacco has decreased between 2009 and 2019, the rates of marijuana use and vaping are increasing. Prescription drug use was consistent at 6%.[228] There is still regional variation regarding substance use:

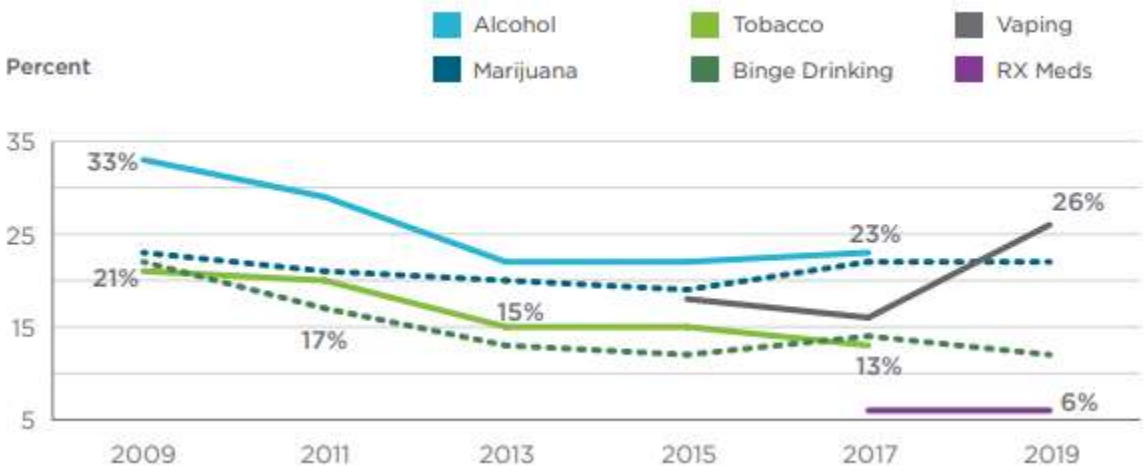


Figure 30: Substance Use in Past Month Among High School Students, All Regions, Percent (2009, 2011, 2013, 2015, 2017, 2019).[229]

The report notes that progress has been made in reducing alcohol use – especially among American Indian/Alaska Native youth – in many regions, but specifically highlighted concerns about the Southeast region: "the study wishes to highlight that data indicate a major resurgence in teen drinking in the Southeast region between 2015 and 2017 with usage increasing by almost 50% and returning to 2009-2011 levels. As previously discussed, teen sadness and hopelessness increased more in the Southeast region than in any other Alaska region. This change is concurrent with increased alcohol usage."[230]

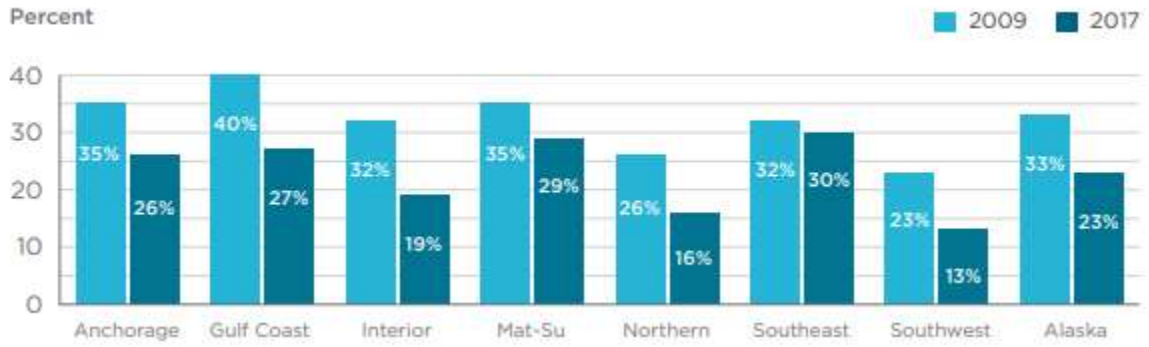


Figure 31: Alcohol Use in Past Month Among High School Students, All Regions, Percent (2009, 2011, 2013, 2015, 2017)[231]

Regarding marijuana use, the report indicates: "statewide, the proportion of students who reported marijuana use in the past month didn't change much between 2009 and 2017, but as previously noted use dipped slightly between 2009 and 2015 before rebounding to prior use levels."[232] It is important to recognize this data is prior to COVID-19, and it is unclear the impact the pandemic has had on youth substance use in Alaska.

Pre-COVID data also indicate that "American Indian/Alaska Native teens are about 50 percent more likely than White teens and twice as likely as teens of 'all other races' to use marijuana."[233]

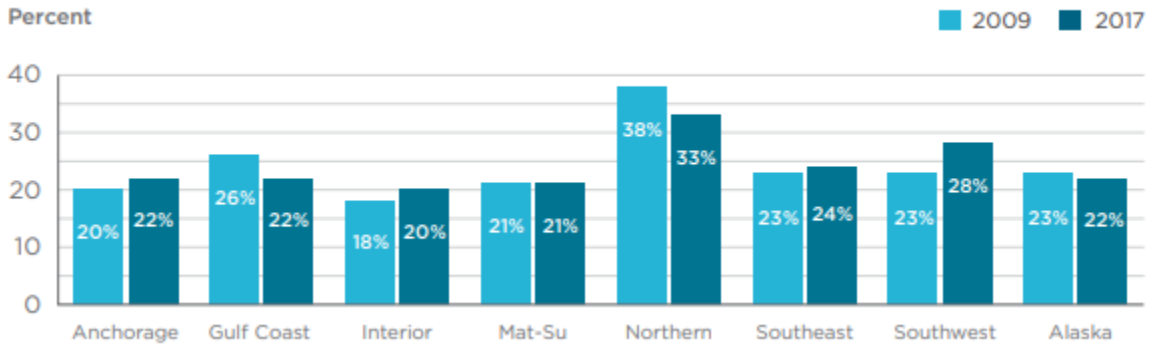


Figure 32: Marijuana Use in Past Month Among High School Students, All Regions, Percent (2009, 2017)[234]

Idaho Community Input

Please note that interview responses and survey responses were collated for Montana and Idaho, so some information is presented in both sub-sections.

Based on the results of a survey administered in WAMI, survey respondents in Montana and Idaho were asked to select up to five concerns for their children's health today. Mental and behavioral health was identified as the top health issue for parents in Montana and Idaho, followed by not enough healthy and affordable food options, lack of physical activity, crime / violence in the community, and learning abilities/disabilities:

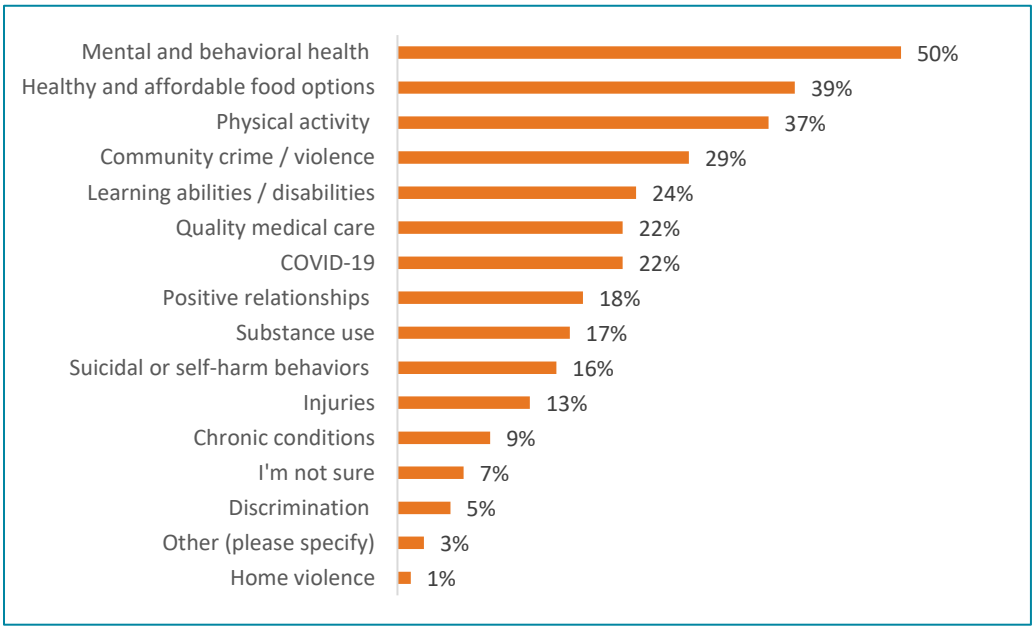


Figure 33: Survey results: "When you think about your child's health today, what concerns you?"

Anxiety and Depression

Mental health affects how children think, act, and feel and it plays a role in how kids handle stress, interact with others, and make decisions. Mental health was a common concern in interviews, with key informants specifically noting "high levels of anxiety and depression among the adolescents in the community in the wake of the COVID-19 pandemic." Anxiety, which is characterized by high levels of fear and worry, and depression, which is described as feelings of sadness and hopelessness, are two of the most common mental health disorders among youth. While youth mental health has been worsening in the U.S. for more than a decade, the ongoing COVID-19 pandemic has led to a dramatic increase in depression, anxiety, and social risks among urban, racial, and ethnic minority school-age children compared to before the pandemic.[235] "Because of stigma, discrimination, and exclusion, LGBTQ youth are at risk of depression and anxiety. The pandemic cut them off from their friends and supportive resources, and the isolation was really bad for their mental health." As one key informant noted, parents' concerns about pandemic-induced housing, food, and job insecurity exacerbated the situation: "Parents were worried about paying rent and putting food on the table which caused immense stress. That stress manifested as anxiety and depression in their kids, negatively impacting their ability to learn, play, and just be kids." LGBTQIA+ youth were also described as particularly vulnerable to heightened mental health issues.

Suicide

Suicide is the second leading cause of death among 10-24 years old in Idaho, and nationwide, and the most recent results from the 2019 YRBS show upward trends. When compared to national averages, a higher percentage of Idaho youth had seriously considered suicide (US 18.2%, ID 21.6%) and attempted suicide one or more times during the past 12 months (US 7.3%, ID 9.6%).[236] Christine Tiddens, the Director of Idaho Voices for Children, shared this is approximately 1 in 10 high school students who attempted suicide.[237] In 2020, Idaho had the eighth highest suicide rate among adolescents, so it is not surprising that suicide was mentioned in many key informant interviews:

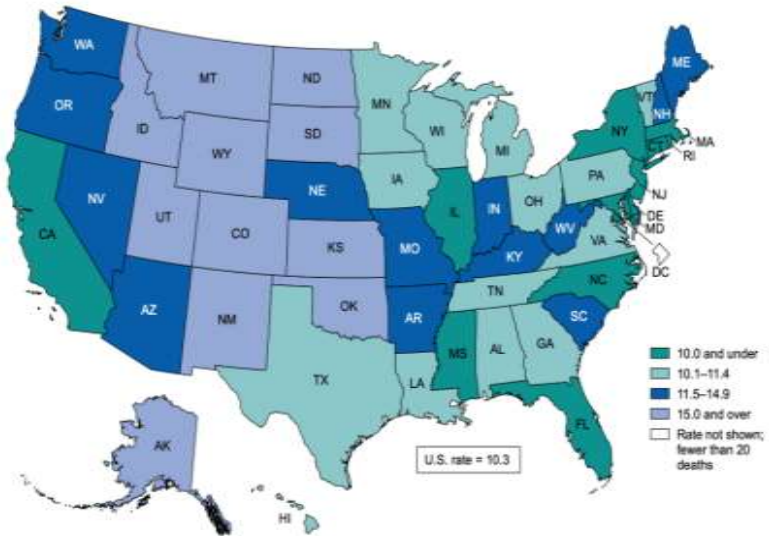


Figure 34: Suicide Death Rates by State for Ages 10-24, 2016-2018 (Source: NCHS)[238]

Firearms were involved in nearly half of youth suicides in Idaho and over 63% of all suicides in Montana since 2010.[239] While suicide is complex, involving many layers of biological and environmental risk factors, children with historically marginalized identities appear to be particularly vulnerable, due in part to the racism, discrimination, and trauma they experience because of their identities. Bullying is a strong and consistent risk factor for suicide and key informants suggested that the amplification of cyberbullying via social media during the pandemic likely plays a role in the recent suicide growth. “Kids are struggling, and mental health is becoming an increasing concern. It’s just hard to be a teenager today, with increased internet access, academic pressure, then trying to navigate those challenges amid increases in isolation, screen time, economic difficulties, and school interruptions.”

Twelve percent of LGBTQIA+ students in Idaho report being victims of teasing, name calling, and bullying because of their gender identity and sexual orientation, which contributes to poor mental health outcomes. The suicide rate among LGBTQ+ youth is nearly four times higher than straight and cisgender peers,[240] it’s impractical to separate this concerning indicator from the political landscape in Idaho. In the 2022 Idaho State Legislative Session, there was a near-successful attempt to criminalize gender-affirming care. Restricting access to gender affirming care worsens mental health outcomes among youth: “Inability to access gender affirming care, such as puberty suppressors and hormone therapy, has been linked to worse mental health outcomes for transgender youth, including with respect to suicidal ideation, potentially exacerbating the already existing disparities. Conversely, access to this care is associated with improved outcomes in these domains. Policies that aim to prohibit or interrupt access to gender affirming care for youth can therefore have negative implications for health in potentially life-threatening ways.”[241]

On March 8, 2022, the Idaho House approved legislation that makes it a felony for a doctor to provide age-appropriate, medically necessary, best practice gender affirming care for transgender children. This came at a time when there were more than 300 anti-LGBTQ+ bills under consideration in state legislatures across the country. Idaho's Senate blocked the advancement of the bill at the end of March, but they affirmed their staunch opposition to trans-related medical care. Health is a human right, and all people deserve equitable, culturally competent, affirming care. Gender-affirming health care has been proven to reduce depression, anxiety, and suicidality. One physician who provides gender-affirming care described her experience challenging HB 675: "Amidst a political dark time, it was really inspiring to see the efforts of youth, parents, providers, and community members to halt this awful bill. That said, the work is not done – the bill is tabled for now, but there will be more policies aimed at harming Transgender youth and their care providers."

Figure 35: Spotlight on Idaho HB 675 - Discriminatory Bill to Criminalize Gender Affirming Care for Transgender Youth (Sources: HRC.org and Journal of Adolescent Health)

Alcohol and Substance Use

About 27% of Idaho students reported current alcohol consumption, with observed differences in certain demographic groups. Reported rates of alcohol use were higher among female students than male students, and significantly higher among White students compared to Black, Hispanic, and Native American students.[242] While rural youth are slightly more likely to have their first drink of alcohol before age 13, urban youth are more likely to be current drinkers and engage in binge drinking.[243] Both states have seen a substantial decrease since the early 2000s, although data from more recent year show rates are plateauing.[244]

Using illicit drugs in early adolescence dramatically increases the risk of substance use disorder later in life, and many key informants expressed concern about rising youth substance use in their communities (see figure below). Though often perceived to be a problem of the inner city, substance use, and misuse have long been prevalent in rural areas and key informants identified methamphetamines and prescription opioids as specific concerns, especially in the wake of the pandemic. As one key informant put it, "COVID has led to a population that is more depressed and anxious, so we've seen a corresponding increase in substance use as a way of coping with the stress and emotions related to the pandemic." They have also noticed increases in parental substance use and substance use disorder during the pandemic, which "correspond with multigenerational cycles of abuse, neglect, emotional harm, and trauma."

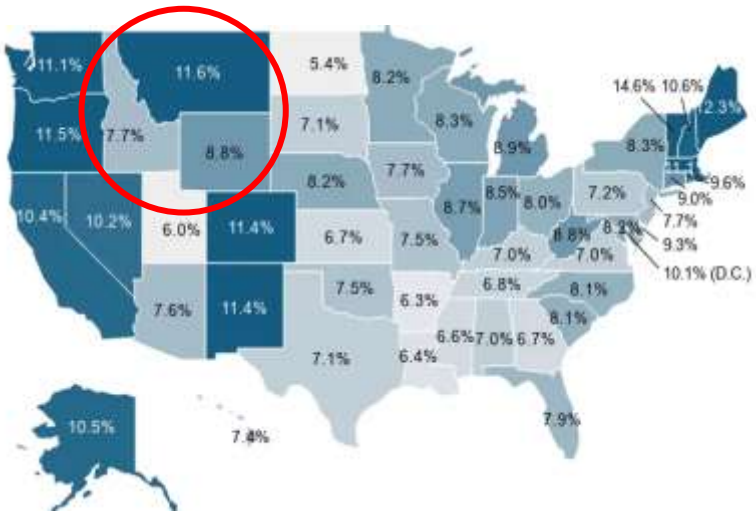


Figure 36: Illicit Drug Use in the Last Month Among 12-17 Year Olds by State[245]

Barriers to Mental Health Care

Key informants shared that mental health and behavioral health issues persist because of difficulties preventing and treating these illnesses. Some of the identified barriers include:

- Lack of education and awareness
- Cost of care and insurance coverage
- Social stigmatization (visibility in communities, gossip, social exclusion)
- Personal stigmatization and difficulties admitting or asking for help
- Scarcity of services and providers that leads to increased reliance on emergency departments
- Lack of drug treatment options
- Delays seeking care until mental health crisis
- Language barriers, cultural incompetency, Lack of diverse representation in the field
- Co-occurrence of mental health and substance abuse which compounds existing challenges
- The COVID-19 pandemic

"We have a long way to go in terms of mental and behavioral health. But three years from now, I would like to see an expanded network of providers willing to help rural families experiencing severe mental health challenges; higher wages for providers who are willing to do this emotionally draining work; universities adding programs to turn out new mental and behavioral health programs; and embedding parents with lived experiences into the design of educational programs. My goal is that someday, no one remembers me – that families get the mental health care they need so easily that it never occurs to them that someone had to fight so hard for this."

Montana Community Input

Please note that interview responses and survey responses were collated for Montana and Idaho, so some information is presented in both sub-sections.

Based on the results of a survey administered in WAMI, survey respondents in Montana and Idaho were asked to select up to five concerns for their children's health today. Mental and behavioral health was identified as the top health issue for parents in Montana and Idaho, followed by not enough healthy and affordable food options, lack of physical activity, crime / violence in the community, and learning abilities / disabilities:

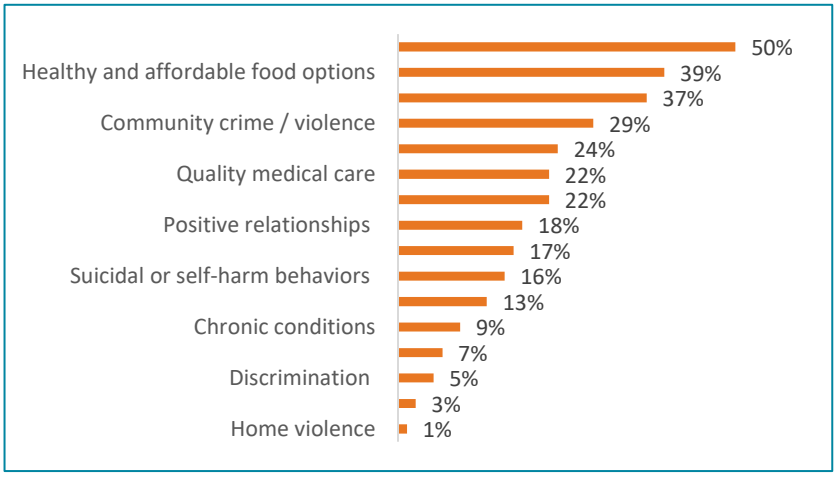


Figure 37: Survey Results – "When you think about your child's health today, what concerns you?" Select up to 5."

Anxiety and Depression

Mental health affects how children think, act, and feel and it plays a role in how kids handle stress, interact with others, and make decisions. Mental health was a common concern in interviews, with key informants specifically noting "high levels of anxiety and depression among the adolescents in the community in the wake of the COVID-19 pandemic." Anxiety, which is characterized by high levels of fear and worry, and depression, which is described as feelings of sadness and hopelessness, are two of the most common mental health disorders among youth. While youth mental health has been worsening in the U.S. for more than a decade, the ongoing COVID-19 pandemic has led to a dramatic increase in depression, anxiety, and social risks among urban, racial, and ethnic minority school-age children compared to before the pandemic.[246] 2021 Montana YRBS data show a similar trend with 50.2% of Hispanic students and 49% of Native American students reporting they "felt so sad or hopeless almost every day for two weeks or more in a row that they stopped doing some usual activities."[247] "Because of stigma, discrimination, and exclusion, LGBTQ youth are at risk of depression and anxiety. The pandemic cut them off from their friends and supportive resources, and the isolation was really bad for their mental health." As one key informant noted, parents' concerns about pandemic-induced housing, food, and job insecurity exacerbated the situation: "Parents were worried about paying rent and putting food on the table which caused immense stress. That stress manifested as anxiety and depression in their kids, negatively impacting their ability to learn, play, and just be kids." LGBTQIA+ youth were also described as particularly vulnerable to heightened mental health issues.

Suicide

Suicide is the second leading cause of death among 10-24 years old in Montana and nationwide, and the most recent results from the 2019 YRBS show upward trends. When compared to national averages, a higher percentage of Montana youth had seriously considered suicide (US 18.2%, MT 23.4%) and attempted suicide one or more times during the past 12 months (US 7.3%, MT 10.0%).[248] In 2020, Montana had the second highest suicide rate in the nation, so it is not surprising that suicide was mentioned in many key informant interviews:

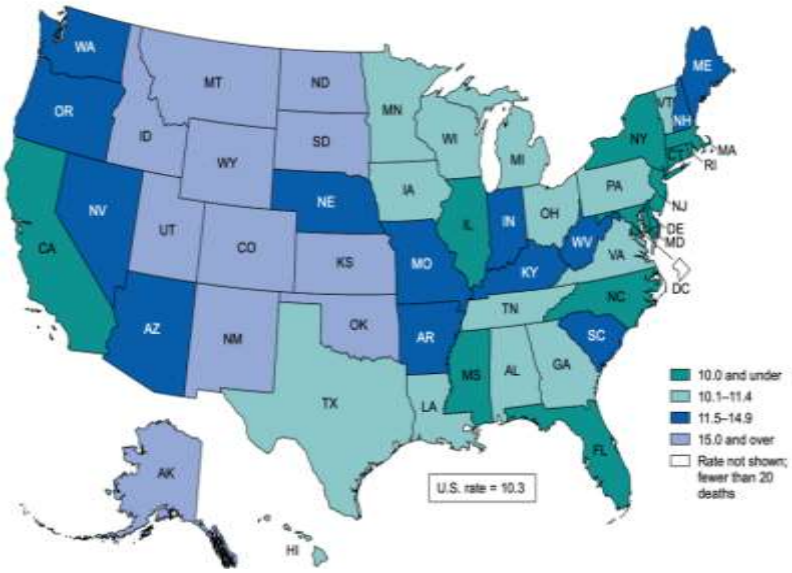


Figure 38: Suicide Death Rates by State for Ages 10-24, 2016-2018[249]

Firearms were involved over 63% of all suicides in Montana since 2010.[250] While suicide is complex, involving many layers of biological and environmental risk factors, children with historically marginalized identities appear to be particularly vulnerable, due in part to the racism, discrimination, and trauma they experience because of their identities. For example, Hispanic and Native American students in Montana had the highest rates of suicide ideation and attempts of all races/ethnicities, and 42% of Black students who had made a suicide attempt had to be treated by a doctor or nurse.[251] Bullying is a strong and consistent risk factor for suicide and key informants suggested that the amplification of cyberbullying via social media during the pandemic likely plays a role in the recent suicide growth. "Kids are struggling, and mental health is becoming an increasing concern. It's just hard to be a teenager today, with increased internet access, academic pressure, then trying to navigate those challenges amid increases in isolation, screen time, economic difficulties, and school interruptions." In Montana, 13.6% of LGBTQ+ students report being victims of teasing, name calling, and bullying because of their gender identity and sexual orientation, which corresponds to a suicide rate nearly four times higher than straight and cisgender peers.[252]

> *"Montana is consistently ranked in the top three for most suicides in the country and our county is number one. Because this issue is becoming so common, we are beginning to break down the stigma of mental health – that is the only silver lining here – but the high suicide rate means we are still not reaching a significant portion of the population that needs our help the most."*
> – Montana Social Worker

Alcohol and Substance Use

About 32% of Montana students reported current alcohol consumption, with observed differences in certain demographic groups. Reported rates of alcohol use were higher among female students than male students, and significantly higher among White students compared to Black, Hispanic, and Native American students.[253] While rural youth are slightly more likely to have their first drink of alcohol before age 13, urban youth are more likely to be current drinkers and engage in binge drinking.[254] Both states have seen a substantial decrease since the early 2000s, although data from more recent year show rates are plateauing.[255]

Using illicit drugs in early adolescence dramatically increases the risk of substance use disorder later in life, and many key informants expressed concern about rising youth substance use in their communities (Figure 19 below). Though often perceived to be a problem of the inner city, substance use, and misuse have long been prevalent in rural areas and key informants identified methamphetamines and prescription opioids as specific concerns, especially in the wake of the pandemic. As one key informant put it, "COVID has led to a population that is more depressed and anxious, so we've seen a corresponding increase in substance use as a way of coping with the stress and emotions related to the pandemic." They have also noticed increases in parental substance use and substance use disorder during the pandemic, which "correspond with multigenerational cycles of abuse, neglect, emotional harm, and trauma."

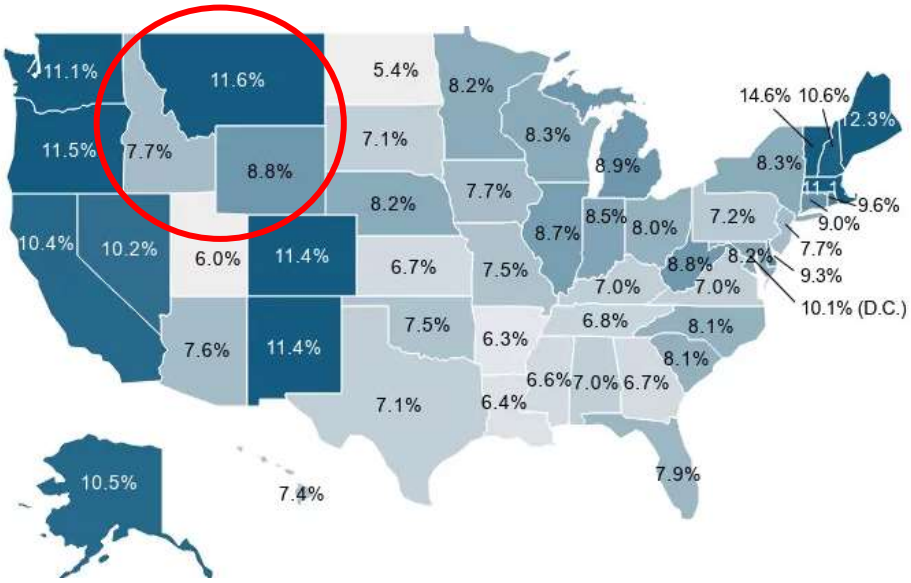


Figure 39: Illicit Drug Use in the Last Month Among 12-17 Year Olds by State[256]

Barriers to Mental Health Care

Key informants shared that mental health and behavioral health issues persist because of difficulties preventing and treating these illnesses. Some of the identified barriers include:

- Lack of education and awareness
- Cost of care and insurance coverage
- Social stigmatization (visibility in communities, gossip, social exclusion)
- Personal stigmatization and difficulties admitting or asking for help
- Scarcity of services and providers that leads to increased reliance on emergency departments
- Lack of drug treatment options
- Delays seeking care until mental health crisis
- Language barriers, cultural incompetency, Lack of diverse representation in the field
- Co-occurrence of mental health and substance abuse which compounds existing challenges
- The COVID-19 pandemic

Priority Area: Suicide and Injury Prevention

A Note on Language and Definitions

Throughout this assessment, we intentionally use people-first language and terminology that is respectful, factual, inclusive, and non-stigmatizing. This assessment will follow best practice for discussing and reporting on suicide.[257] This includes using matter-of-fact terms that do not sensationalize, stigmatize, or criminalize suicide or suicidality. Most notably, we will state “died of suicide” or “died by suicide” when discussing a suicide death.

The use of “unintentional injury” is synonymous with what may be referred to as “accidental injury”, and we choose to use “unintentional” to imply that there are things that can be done to prevent said injury.

Additional terms will be defined throughout this assessment.

Leading Causes of Death

Injuries, suicide, and homicide are leading causes of death for children and teens in the United States and can be categorized as intentional or unintentional. [258] Unintentional injuries occur due to unintentional causes that result in harm, while intentional injuries are self-inflicted or inflected by another person with the intent to cause harm. Suicide attempts, child maltreatment, and assault are examples of intentional injuries, and deaths occurring from these injuries are categorized as homicide or suicide.

Between 2016 and 2020, unintentional injuries remained the overall top leading cause of death for children 1-24 in Washington, Alaska, Montana, and Idaho (WAMI). [259] Suicide is the second leading cause of death for those 10-24 in WAMI. [260]

Notably, as of 2017, nationwide firearm-related injuries surpassed motor vehicle crashes as the most common cause of death from injury in children and adolescents.[261]

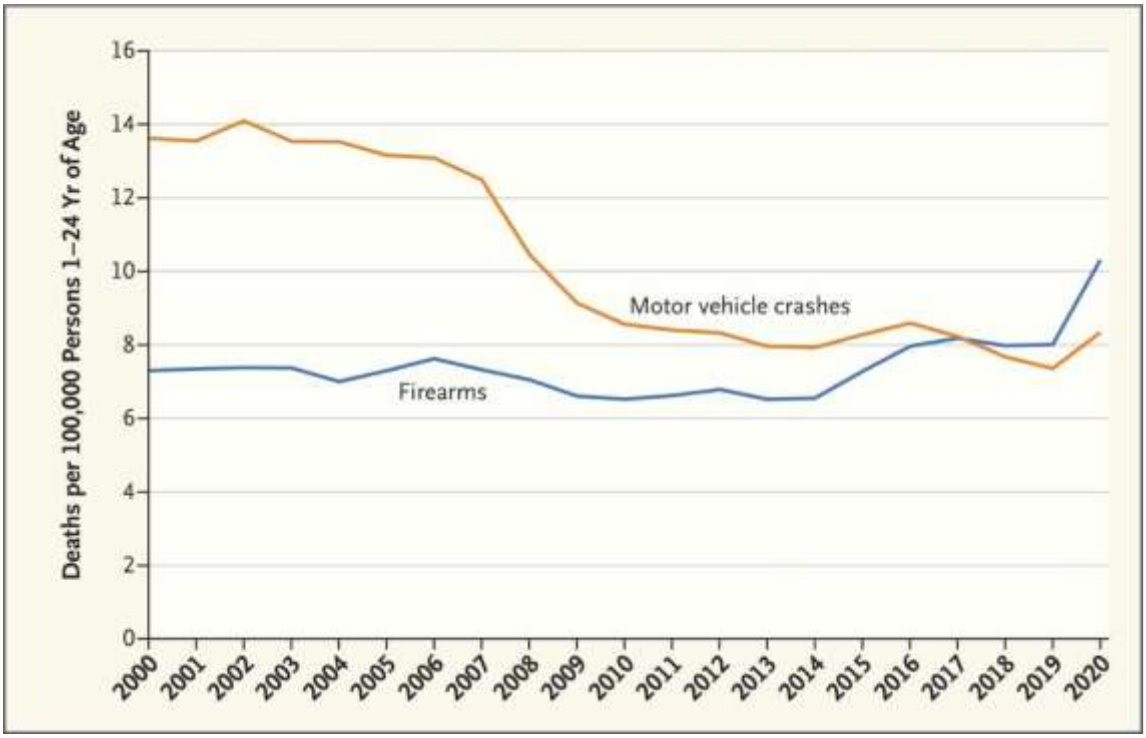


Figure 40: Mortality from Motor Vehicle Crashes and Firearms among Children, Adolescents, and Young Adults, United States, 2000–2020. [262]

This switch in trends between motor vehicle crashes and firearms is important to note as journalist Eric McWhinnie writes in June 2022:

> As the New England Journal of Medicine recently reported, gun-related deaths increased 13.5% between 2019 and 2020. But for those between the ages of 1 and 19, the number of deaths caused by a firearm increased nearly 30%. About 10% of the total gunfire deaths during that period involved children, for a total of 4,357. This switch from cars to guns as the leading cause of death among children represents a significant societal change. As NPR explains, vehicles led the list of causes of death in this country for over 60 years. But as car safety has improved, vehicle-related deaths have declined. Unfortunately, the same cannot be said of gun-related deaths, which have continued to increase year over year. Despite the fact that mass shootings have increased in the past

three decades, most children who die from gunfire are involved in non-mass shooting incidents. Around 65% of child gun-related deaths are the result of homicides, and around 35% are classified as suicides.[263]

This chapter will share additional pediatric community health assessment firearms-related data with a focus on Washington, Alaska, Montana and Idaho.

5 Leading Causes of Death Alaska, Idaho, Montana, and Washington (2016-2020)

Figure 41: 5 Leading Causes of Death, Alaska, Idaho, Montana, and Washington Ages <1 to 24 (2016-2020, both sexes, all races)[264]

5 Leading Causes of Injury Death Washington State (2016-2020)

	<1	1-4	5-9	10-14	15-24
1	Unintentional Suffocation 73	Unintentional Drowning 22	Unintentional Mv Traffic 20**	Unintentional Mv Traffic 44	Unintentional Mv Traffic 524
2	Homicide Unspecified 12**	Unintentional Suffocation 14**	Unintentional Drowning	Suicide Suffocation 34	Unintentional Poisoning 515
3	Unintentional Mv Traffic --	Homicide Unspecified 12**	Unintentional Fire/Flame --	Suicide Firearm 19**	Suicide Firearm 401
4	Homicide Other Spec., Classifiable --	Unintentional Mv Traffic 11**	Homicide Firearm --	Unintentional Drowning Homicide Firearm 11**	Suicide Suffocation 305
5	Unintentional Drowning --	Unintentional Fire/Flame --	Unintentional Other Spec., Nec Unintentional Struck By Or Against Unintentional Suffocation Homicide Fire/Flame --		Homicide Firearm 242

Figure 42: Washington State 5 Leading Causes of Injury Related Deaths by Age Group Ages <1 to 24 (2016-2020, both sexes, all races). [265]

5 Leading Causes of Injury Death, Alaska, Idaho, and Montana (2016-2020)

	<1	1-4	5-9	10-14	15-24
1	Unintentional Suffocation 48	Unintentional Mv Traffic 24	Unintentional Mv Traffic 37	Unintentional Mv Traffic 41	Unintentional Mv Traffic 485
2	Homicide Suffocation --	Unintentional Drowning 23	Unintentional Drowning 10**	Suicide Suffocation 36	Suicide Firearm 453
3	Undetermined Suffocation --	Unintentional Suffocation 13**	Unintentional Fire/Flame --	Suicide Firearm 31	Suicide Suffocation 238
4	Homicide Unspecified --	Unintentional Fire/Flame 10**	Unintentional Firearm --	Unintentional Other Land Transport 13**	Unintentional Poisoning 206
5	Unintentional Mv Traffic Homicide Other Spec., Nec Homicide Other Spec., Classifiable --	Unintentional Pedestrian, Other --	Homicide Firearm --	Unintentional Drowning Homicide Firearm 10**	Homicide Firearm 89

Figure 43: 5 Leading Causes of Injury Death, Alaska, Idaho, and Montana Ages <1 to 24 (2016-2020, both sexes, all races). [266]

Teens ages 15-19 experience higher rates of fatal injury compared to other child and teen age groups. [267]

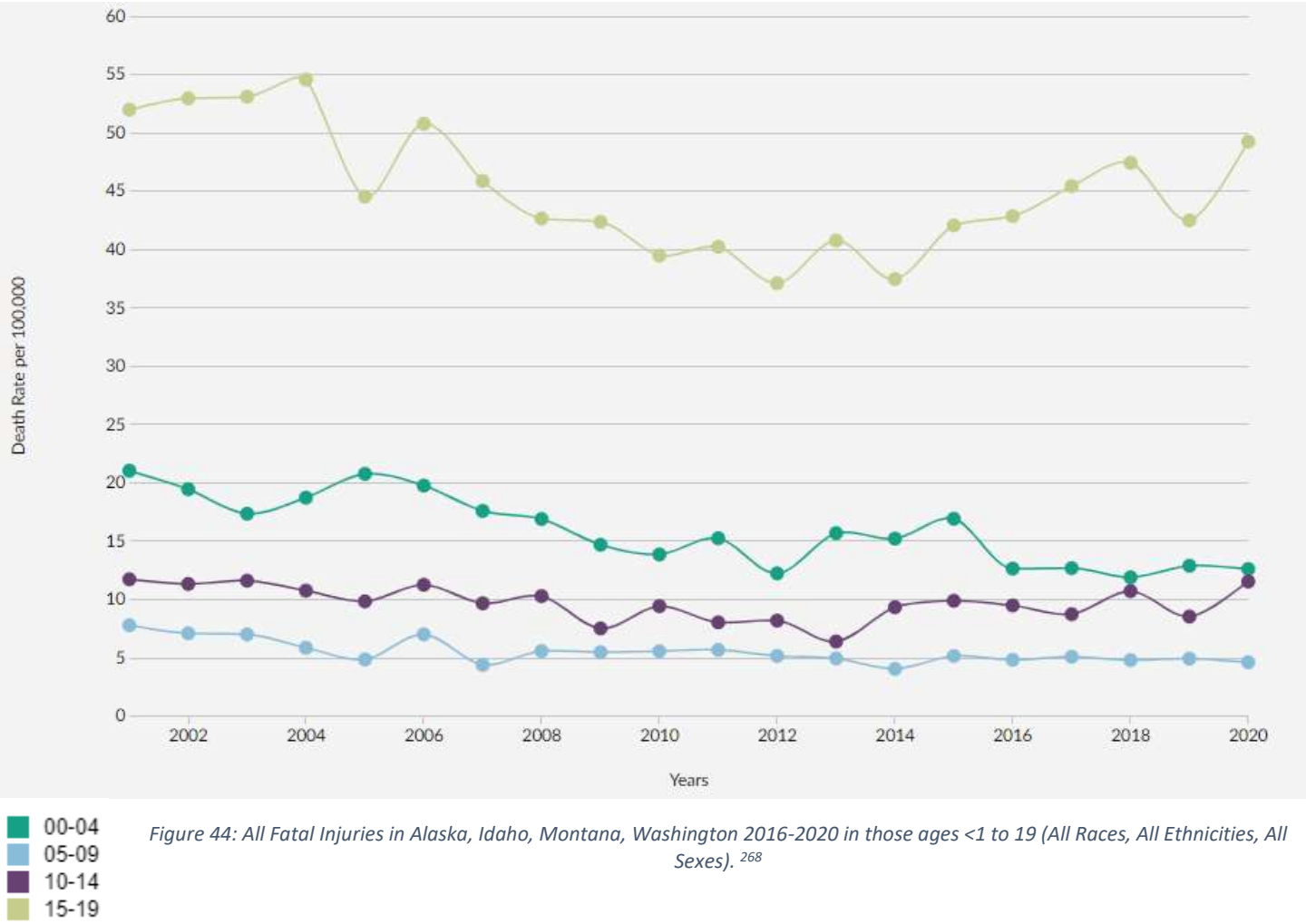


Figure 44: All Fatal Injuries in Alaska, Idaho, Montana, Washington 2016-2020 in those ages <1 to 19 (All Races, All Ethnicities, All Sexes). [268]

Fatal and nonfatal injuries bear significant costs including spending on health care, lost productivity, lost quality of life, and take a great personal toll on families and communities.[269,270] Childhood injuries are preventable and should be addressed within pediatric health.

Unintentional Injuries

Despite an 11% decrease in child unintentional injury death rates from 2010 to 2019, injury remains the leading cause of death and hospitalization for children and teens in the United States. [271] The Centers for Disease Control and Prevention identified certain groups at higher risk for injury death including male children, American Indian and Alaska Native and Black children, and babies under age 1 and teens ages 15-19. [272]

The leading causes of unintentional injury among children between 2016 and 2020 included motor vehicle traffic, poisoning, drowning, and suffocation. [273]

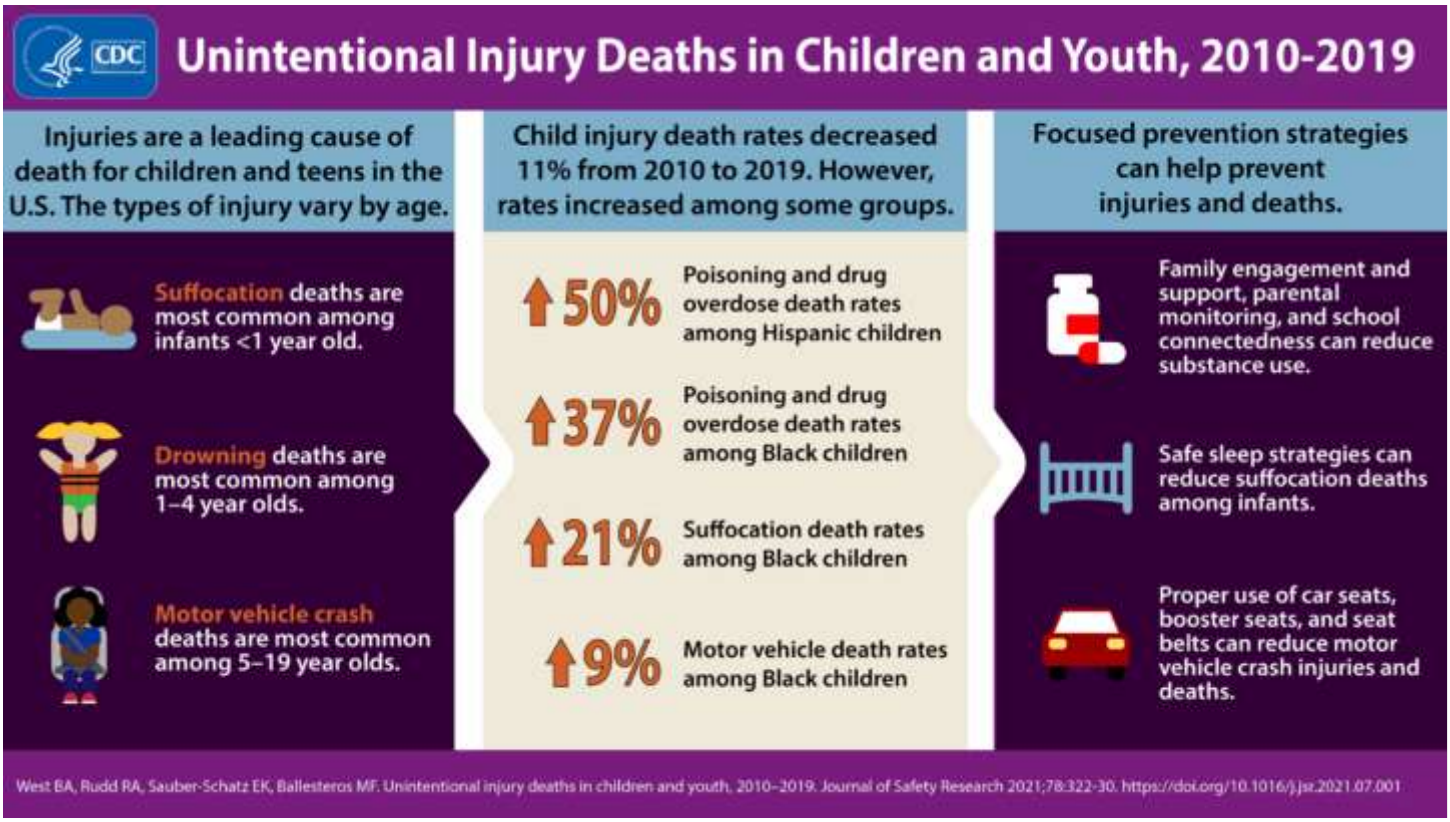


Figure 45: Unintentional Injury Deaths in Children & Youth, 2010-2019, nationwide. [274]

Motor Vehicle Injuries

Death and injury from motor vehicles can result from motor vehicle collisions with other vehicles, motorcyclists, bicyclists, and pedestrians. Risk factors for pediatric mortality from motor vehicle crashes include non-use of restraints, sitting in the front seat, alcohol-impaired driving, younger driver age, high speed roads, and rural road condition. [275] While all these factors can influence the risk of death, the American Academy of Pediatrics notes that the strongest and most modifiable predictors are child restraints and seat position. [276]

Between 2016 to 2020, there were a total of 161 child fatalities across WAMI, with the highest child fatality rates per 100,000 in Montana (4.09) followed by Alaska (2.33), Idaho (2.23) and Washington (0.91).[277] In 2020, a total of 35 children ages 0-17 died from a crash involving a motor vehicle in Washington, which is a 106% increase from 2019.[278] Most of these children were between the ages of 10 and 17. [279]

From 2016 to 2020, in the United States, unintentional motor vehicle occupant related injury was the 3rd leading cause of nonfatal emergency department visits for those ages 15 to 24, and the 5th leading cause of nonfatal emergency

department visits for those ages 10 to 14. [280] During this time, there was a total of 4,864 motor vehicle (motorcyclist or occupant) related hospitalizations of youth ages 0 to 24 in Washington.

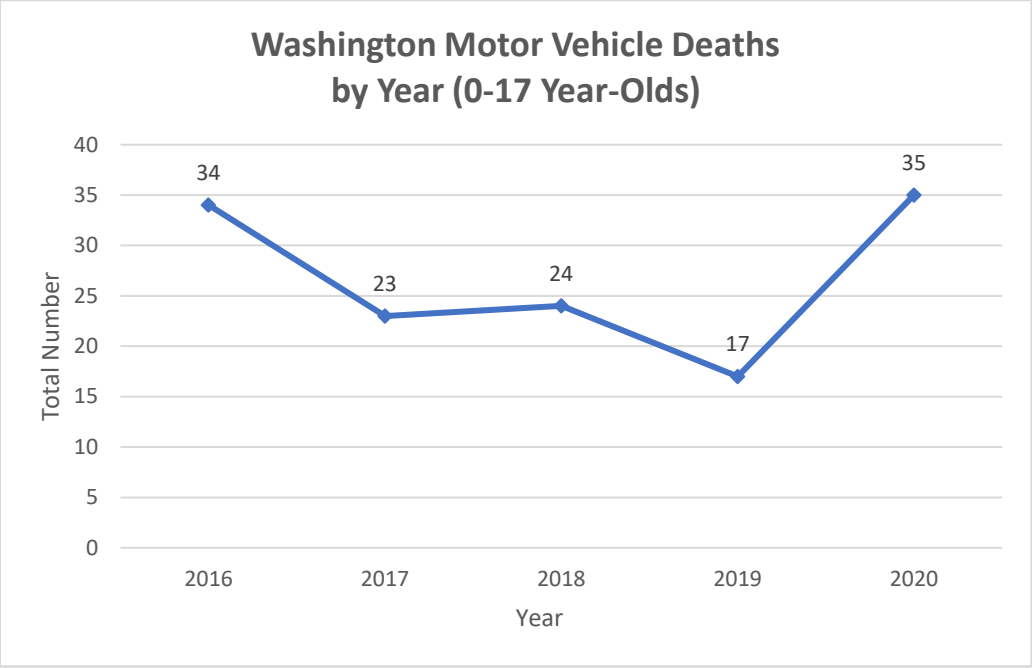


Figure 46: Washington Motor Vehicle Deaths by Year 0-17 Year Olds. [281]

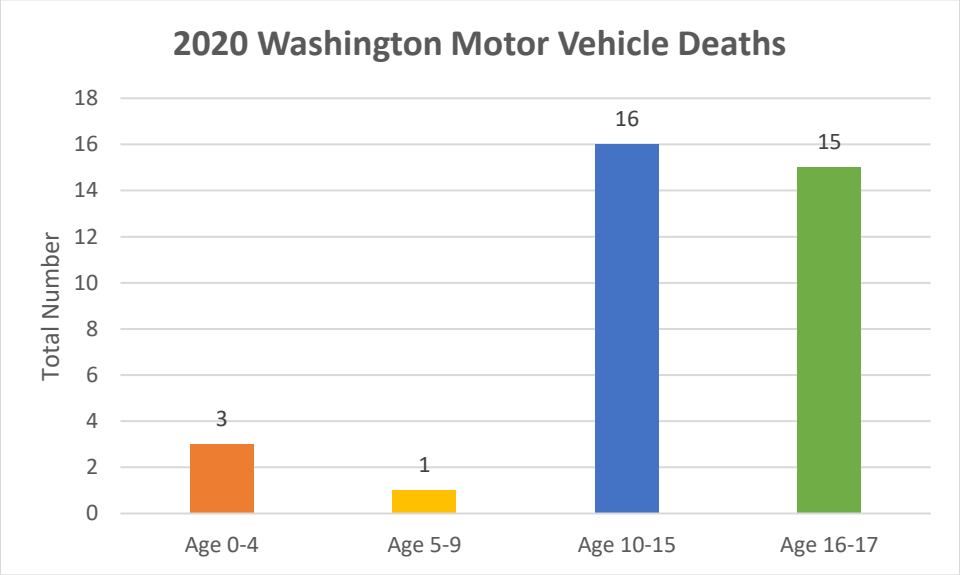


Figure 47: Washington Motor Vehicle Deaths by Age Group (2020). [282]

Child Passenger Safety

Proper use of car seats, booster seats, seat belts, and safety restraints are effective ways to reduce the risk of serious injury among children in motor vehicle accidents. Child safety seats have been shown to reduce fatal injury by 71% for infants and by 54% for toddlers.[283] The Washington Safety Commission provides recommendations on which types of safety seats are appropriate for different age groups. While they can be lifesaving, nearly 60% of car seats are installed

incorrectly. [284] Many programs across the state offer free assistance installation of car seats to ensure that they are used correctly. [285] Some locations offer virtual inspections to increase access to expertise. [286]

Age Group	Type of Seat	General Guidelines
Infants and Toddlers	Rear-facing only Rear facing convertible	All infants and toddlers should ride in a rear-facing seat until they are at least 2 years of age or reach the highest weight or height allowed by the car seat manufacturer.
Toddlers & Preschoolers	Convertible Forward-facing with harness	Children who have outgrown the rear-facing weight or height limit for their convertible seat should use a forward-facing seat with a harness for as long as possible, up to the highest weight or height allowed by their car safety seat manufacturer.
School-aged Children	Booster seat	All children whose weight or height exceeds the forward-facing limit for their car safety seat should use a belt positioning booster seat until the vehicle seat belt fits properly, typically when they have reached 4 feet 9 inches in height and are 8 through 12 years of age. All children younger than 13 should ride in the back seat.
Older Children	Seat belts	When children are old enough and large enough for the vehicle seat belt to fit them correctly, they should always use a lap and shoulder seat belts for the best protection. All children younger than 13 should ride in the back seat.

Figure 48: Car Seat Recommendations by Age Group. [287]

Poisoning

Any product or substance can be harmful if used in the wrong way, by the wrong person, or in the wrong amount. [288] Poisoning can occur from consumption, breathing, injection, skin contact, and eye contact. [289] Medicine misuse is when someone takes someone else's medicine, consumes too much medicine, or takes medicine any other way than how it was described. [290] Teens often get prescription drugs and other medicines they misuse from their own home or friends and relatives. [291] Fentanyl has become a significant concern as most overdose deaths nationally involved illicitly manufactured fentanyls. [292] To read more about opioid use, synthetic and other, please also see our section on Prescription Medication Use.

According to the Centers for Disease Control and Prevention (CDC), poisoning death rates among White children decreased 24% between 2010 to 2019 but increased among Hispanic children (50%) and Black children (37%). [293]

Between January to June 2021, overdose was the top critical diagnosis requiring emergency medical helicopter landing at Seattle Children's. [294] In 2021, the Washington Poison Center responded to 122,111 phone calls, with 53,778 human poison exposures related to children 5 years and younger (42% of all poison exposure cases). [295] Fifty-four percent of calls regarding children under 6 years old were non-medication exposures. [296]

2021 Top 5 Poison Exposures by Substance Category in Washington			
Rank	**Ages 0-5**	**Ages 6-12**	**Ages 13-19**
1	Cosmetics/ personal care products	Analgesics	Analgesics
2	Household cleaning substances	Foreign bodies/ toys/ miscellaneous	Antidepressants
3	Analgesics	Cosmetics/ personal care products	Antihistamines
4	Dietary supplements/ herbals/ homeopathic	Plants	Sedative/ hypnotics/ antipsychotics
5	Foreign bodies/ toys/ miscellaneous	Antihistamines	Stimulants and street drugs

Figure 49: Top Poison Exposure Substances by Age Group in Washington. [297]

Seattle Children's care teams note the need for safe storage of medicines at home for families – especially those with children and teens experiencing suicidal ideation.[298]

Drowning

Drowning is the second leading cause of unintentional injury death for children and teens across the United States, and between 2016 and 2020 drowning was the leading cause of injury death for children aged 1-4 years old. [299] It's estimated that for every child who dies from drowning, another 8 receive emergency department care due to drowning and oftentimes live with life altering outcomes including brain damage and long-term disability. [300] Between 2018 and 2020, 47 children and youth ages 0-19 died from drowning in Washington. [301] Individuals identifying as American Indian/Alaska Native and Pacific Islander had higher rates of drowning compared to individuals from other racial/ethnic groups, and males had a higher rate of drowning than females across all demographic groups. [302]

Most unintentional drowning deaths in Washington occur in open water areas. In 2020, 59% of deaths occurred in bodies of water such as lakes and rivers.[303] In 2021 alone, 13 people in Washington died in a recreational boating accident; 77% of those deaths could have been prevented by wearing a life jacket.[304] Factors such as not knowing how to swim, weak swimming skills, not wearing a life jacket, missing or ineffective fences around water, and lack of close supervision increase the risk of drowning. [305]

Wearing a properly fitted life jacket and swimming in designated swimming areas with lifeguards are a couple of important ways to prevent drowning, but availability of these resources varies between cities and counties. The COVID-

19 pandemic led to the closure of many beaches and life jacket loaner stations across Washington State, and in May 2021, the Washington State Department of Health urged life jacket loaner stations to reopen safely. [306] In 2022 a lack of lifeguards was highlighted as many pools and beaches across the nation faced a lifeguard shortage leading to reduced operating hours or full closures. [307]

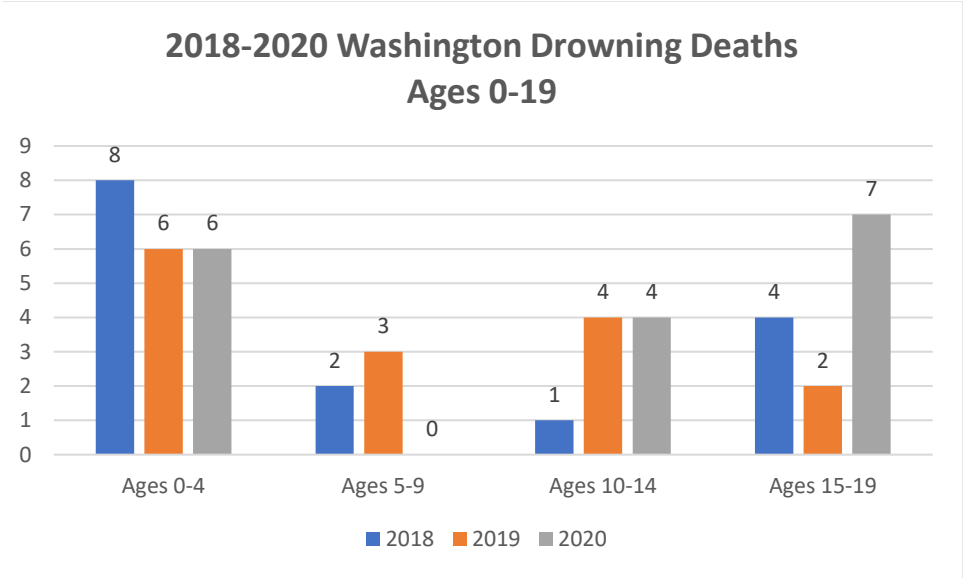


Figure 50: Washington Drowning Deaths by Age Group (2018-2020).[303]

Natural waters in Washington, like lakes, rivers and oceans are cold year-round and can cause cold-water shock that leads to drowning. Communities believe there is a need to increase awareness and messaging around cold-water shock to prevent future drownings. [308,309] During conversations with parents and caregivers around water safety, parents and caregivers frequently described concerns that children overestimate their own swimming abilities. Furthermore, they were also unsure of their own water safety knowledge and skills to confidently provide adequate supervision to children swimming and how to respond in an emergency. [310]

Communities in Snohomish and South King County consider that language and cultural challenges around water recreation and safety may have been factors in more recent child drownings, including misunderstanding of how to identify someone struggling in the water and how to respond to a drowning emergency.[311,312]

Suffocation and Safe Sleep

Between 2016 and 2020, unintentional suffocation was a top 5 leading cause of unintentional injury death for infants and children ages <1 to 14 across the United States with the greatest prevalence in infants under 1 year. [313] Most (82%) incidences of unintentional suffocation are attributable to accidental suffocation and strangulation in bed. [314] Suffocation is the fourth leading cause of unintentional injury for adolescents 1 to 18 in the WAMI region with 23 reported deaths (2016-2020) in Washington alone. [315]

Research demonstrates the importance of safe sleep environments for infants to prevent suffocation deaths. [316] The National Institutes for Health (NIH) describes components of a safe sleep environment including placing a baby in a crib on their back without pillows, blankets, crib bumpers, etc. [317]

Some patient families with infants who receive medical care at Seattle Children's are not prepared with tools for a safe sleep environment at home. This can interfere with hospital discharge, placing added stress on families and clinical care

teams. There is opportunity for clinical teams to provide just-in-time safe sleep education and resources, like travel beds, to these families. [318]

Pedestrian, Bicycle, and Other Micromobility Related Injuries

Children and youth ages 10-24 represent approximately one-third of all bicycle-related injuries seen in United States Emergency Departments. [319] The incidence of preventable deaths from bicycle accidents increased nationally by 16% in 2020, with most accidents occurring between May and October. [320] Males account for 89% of all bicycle deaths, eight times the rate of fatalities for females. [321] In 2020, there were a total of 102 preventable bicycle deaths and 136,753 preventable bicycle injuries among children ages 0-19. [322]

There were 12 total child (ages 1 to 14) bicycle-related fatalities in WAMI between 2016 and 2020, most of which occurred during the weekend and/or during the afternoon and evening hours. Furthermore, 91.7% of these fatalities occurred in male children. During this time, child bicycle-related fatalities occurred equally in rural (50%) and urban areas (50%). [323]

Emergency Department (ED) visits due to micromobility products, including e-bikes, electric scooters, and hoverboards, have steadily increased since 2017 with more than 190,000 visits from 2017 through 2020. [324] The American Academy of Pediatrics (AAP) has expressed concerns for children's use of these following spikes in ED visits and recommends that children under 16 should not operate or ride on motorized or e-scooters; those over 16 should wear a helmet and protective gear. [325]

In recent years, many cities across the country have launched bicycle and scooter sharing programs where individuals are able to rent immediately and pay hourly. While it is known that wearing a helmet while bicycling prevents traumatic brain injury in the event of a crash, these rental programs do not offer access to helmets or safety equipment. [326] A study at the University of Washington found that only 20% of bike share riders wore helmets, while more than 90% of cyclists wore helmets while riding their own bikes. [327]

Many counties and states across the country have laws that require bicycle users to wear a helmet to reduce the risk of head injuries. While many counties and cities in Washington do require a helmet, the state as a whole does not. [328] In early 2022, the King County Board of Health voted to repeal its mandatory helmet law for bicycle riders after finding that enforcement has been minimal, as well as disproportionate helmet law citations issued by Seattle Police to BIPOC and homeless cyclists. [329,330] This repeal impacts most of King County but excludes 17 cities that have their own laws mandating helmet use. While this repeal makes it legal for individuals to not wear a helmet while bicycling, the county continues to encourage helmet usage and has budgeted more than $200,000 to purchase helmets and expand education. [331] Injury prevention experts and trauma-care providers express concerns for unjust enforcement of bicycle helmet laws against communities of color and recommend "equitable enforcement of these lifesaving laws…accompanied by other efforts to protect the public" like investments in outreach and safe cycling structures, low-cost helmet availability, and supportive safe-cycling messaging. [332]

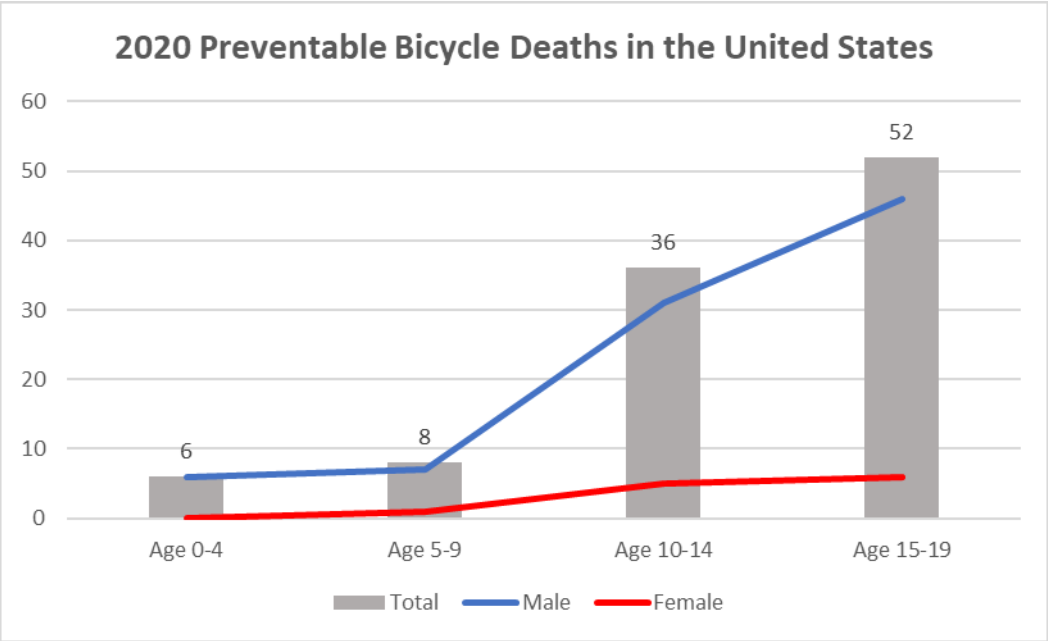


Figure 51: Preventable Bicycle Deaths in the United States by Age Group (2020). [333]

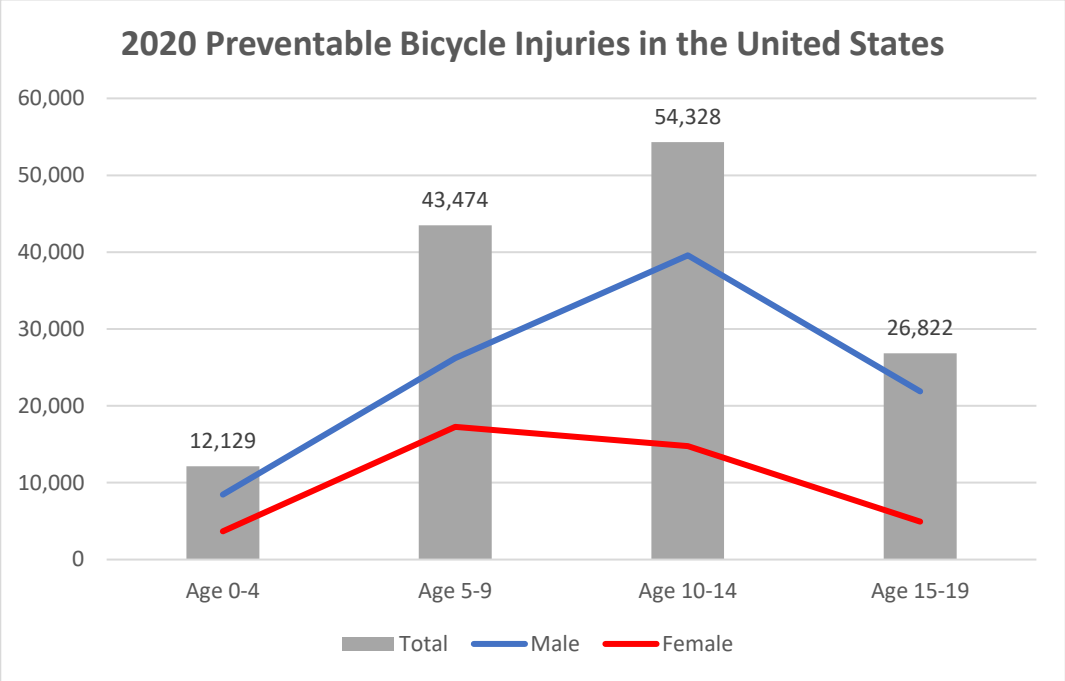


Figure 52: Preventable Bicycle Injuries in the United States by Age Group (2020). [334]

Falls

While most falls are harmless, some can result in serious injuries such as open wounds, fractures, and brain injury.[335] It is estimated that 2.2 million children ages 14 and under are treated annually for fall-related injuries and reports show that about 100 children ages 14 and under die from falls every year.[336] Infants are more likely to fall from furniture, baby walkers, and stairs, while toddlers and older children are more likely to fall from windows and playground equipment. [337]

Between 2016 and 2020, unintentional falls were the top leading cause of nonfatal emergency department visits for children and teens 1 to 14 years in the United States. [338] From 2017 to 2020, there were 22 total unintentional fall deaths for children and teens (ages 0 to 19) across Washington, Alaska, Montana, and Idaho; this equates to 1,120 years of potential life lost.[339]

Researchers recommend population-based targeted education for caregivers, including education on available products and age-appropriate best practices for supervision and care of young children both indoors and outdoors to prevent falls.[340]

Sports Injuries

Sports injuries are the second leading cause of emergency room visits for children and adolescents, and the second leading cause of injuries in school. [341] Each year, over 3.5 million children under the age of 15 receive medical treatment due to sports injuries. [342] The most common sports injuries include bone sprains, muscle sprains, bone injuries, repetitive motion injuries, and heat-related injuries. [343]

62% of injuries from sports occur during practice rather than games. According to a national survey, 27% of parents do not always take the same safety precautions during practice as they do during games. [344]

Sports and recreational injuries were reported to have decreased by 27% during 2020, with the largest reduction being among sports injuries. [345] Injuries related to track and field, lacrosse, hockey, soccer, baseball, softball, football, and basketball all saw decreases of more than 60% from March through September 2020. [346] This is likely due to stay-at-home orders that impacted schools and sports leagues for a large portion of the year.

Intentional Injuries

Suicide

Note: Suicide is also highlighted in our chapter on Mental and Behavioral Health.

Suicide is a pervasive and preventable public health issue across the United States. It's estimated that 135 people are affected by a single suicide death. [347] In 2020, suicide was the second leading cause of death for youth between the ages of 10 and 14, and the third leading cause of death for youth between the ages of 15 and 19 nationwide. [348]

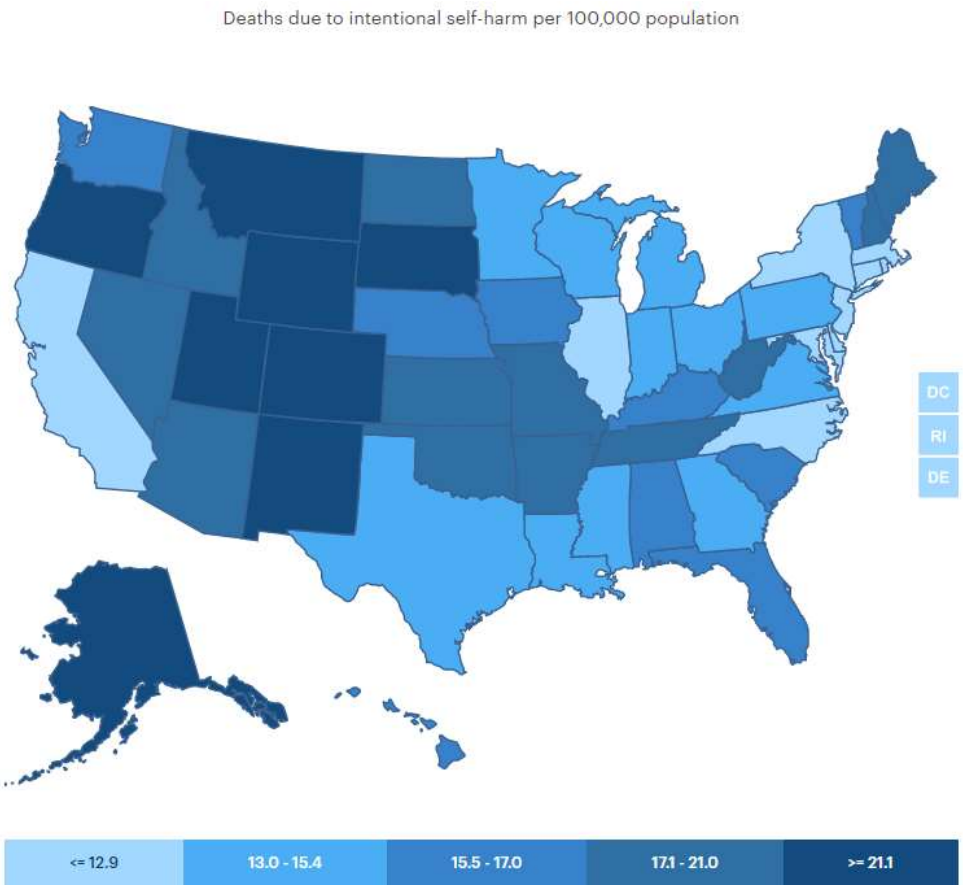


Figure 53: Nationwide Deaths Due to Intentional Self-Harm per 100,000 Population (All Ages). [349]

Between 2017 and 2020, there were over 1,400 suicide deaths reported for those ages 10 to 24 in WAMI. [350] Suffocation, firearms, and poisoning are the most common methods of suicide deaths among youth in WAMI, with firearms being deadliest.

According to the Washington Poison Center, from 2019 to 2021, reported cases of self-harm or suspected suicide increased 58% in those ages 6 to 12 years and 37% in those ages 13 to 17 years. [351] Top substances used in self-harm/suspected suicide cases for both age groups included antidepressant acetaminophen, ibuprofen, and antihistamine.

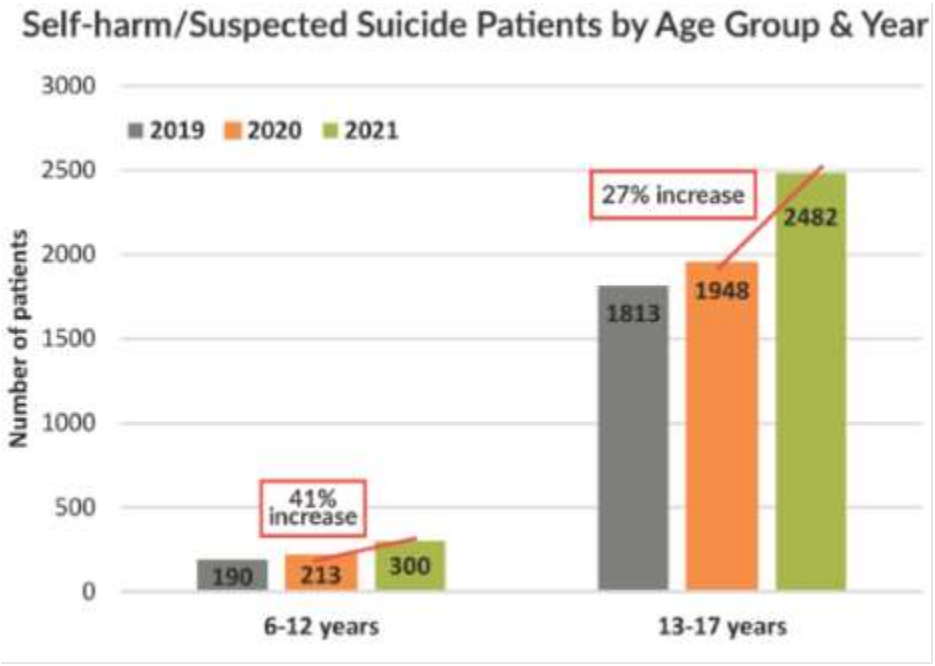


Figure 54: Washington Poison Center Adolescent Self-Harm/Suspected Suicide Patients by Age Group & Year. [352]

In Washington (2021), 20% of 8th to 12th grade students reported that they considered suicide in the past year, and 8% reported that they had attempted suicide in the past year. [353] Between 2016 and 2020, 570 youth ages 10-21 years-old died by suicide in the state of Washington. [354] The highest rates of suicide were in Ferry, Pend Oreille, and Jefferson County. [355]

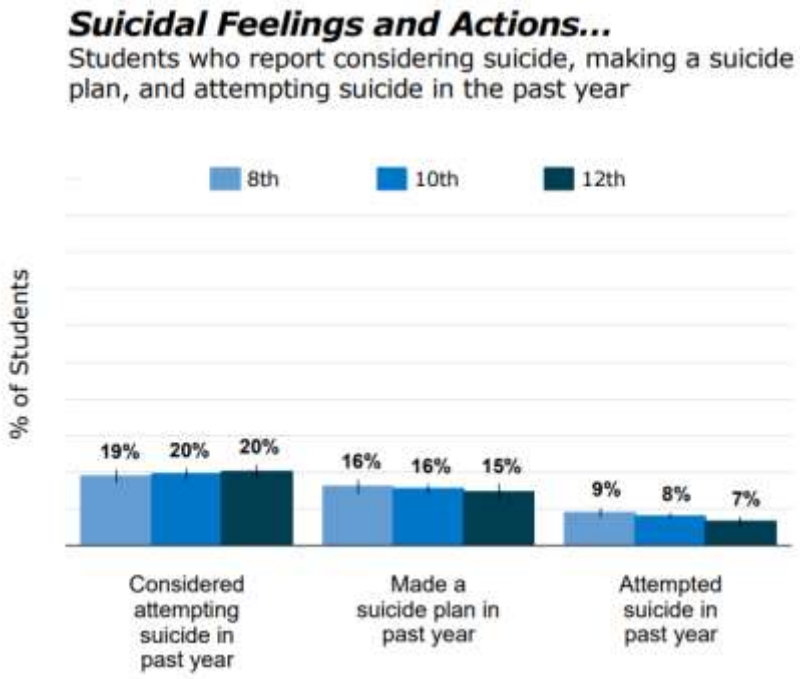


Figure 55: Washington Students Who Have Had Suicidal Feelings or Actions (2021). [356]

In recent years, the firearm suicide rate among young people has increased faster than any other age group. [357] Between 2016 and 2020, 454 Washington youth ages 10 to 21 died by firearm. [358] Out of the 454 firearm deaths that occurred, 56% were suicides, 39% were homicides, and 5% were either unintentional, legal intervention or a death of undetermined intent. [359] Studies have found that most firearm suicide deaths in adolescents occur in the home with a firearm owned by someone in the household. [360]

Suicide rates vary by geography, sex, sexual orientation, race, and ethnicity, with the highest rates being among American Indian and Alaska Native populations. [361] While suicide is complex, involving many layers of biological and environmental risk factors, children with historically marginalized identities appear to be particularly vulnerable, due in part to the racism, discrimination, and trauma they experience because of their identities. For example, Hispanic and Native American students in Montana had the highest rates of suicide ideation and attempts of all races/ethnicities, and 42% of Black students who had made a suicide attempt had to be treated by a doctor or nurse. [362]

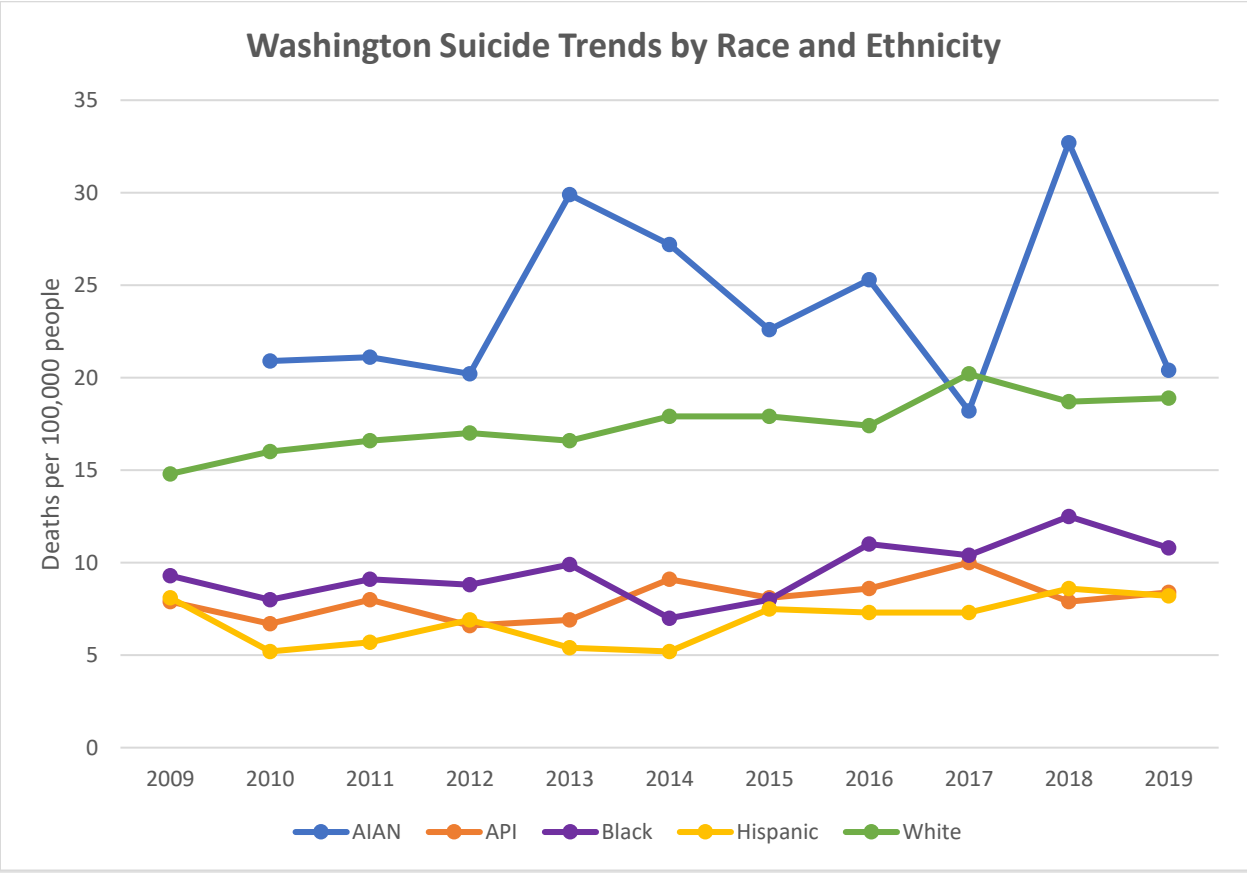


Figure 56: Washington Suicide Trends by Race and Ethnicity. [363]

Additionally, suicide risk is higher among people who identify as lesbian, gay, or bisexual. [364] Nearly 1 in 4 high school students identifying as lesbian, gay, or bisexual reported attempting suicide within the last year – a rate nearly four times higher than reported by their heterosexual counterparts. [365] Over the past decade, suicides among female youth (ages 10 to 14) have disproportionately risen. [366] In King County, youth ages 14 to 17 have the highest rates of ED visits for suicidal ideation and suspected attempt. [367] ED visits for suicide attempts and suicidal ideation among children and teens have contributed to the ongoing strain on health systems locally and nationally. [368] It's important to keep in mind that ED visit rates involving suicidal ideation only represent individuals who access services – there are even more who

youth who don't access services for suicidal ideation or attempts so data doesn't ultimately don't reflect the full burden of need. Twelve percent of LGBTQIA+ students in Idaho and 13.6% in Montana report being victims of teasing, name calling, and bullying because of their gender identity and sexual orientation, which corresponds to a suicide rate nearly four times higher than straight and cisgender peers. [369,370,371] Bullying is a strong and consistent risk factor for suicide and key informants suggested that the amplification of cyberbullying via social media during the pandemic likely plays a role in the recent suicide growth.

Risk and Protective Factors for Suicide

It's important to consider the circumstances that could increase someone's risk for suicide and components that decrease someone's risk for suicide. Risk factors are the characteristics of people or environments that are associated with an increase in health-related conditions like suicide. [372] Protective factors are the characteristics of people or environments that reduce the effect of risk factors and can protect people from risks. Risk and protective factors can vary by age group, culture, sex, and other characteristics. Risk and protective factors exist at the individual, relationship, community, and societal levels. Below are a few examples of both sets of factors.

Risk factors for suicide	Protective factors for suicide
Prior suicide attempt(s); knowing someone who died by suicide	Effective care for mental health, physical health, and substance use disorders (e.g., diagnosis and treatment)
Mood and anxiety disorders; challenges regulating emotions	Problem-solving and coping skills (e.g., ability to handle conflict and stress)
Access to lethal means (e.g., firearms, medicine)	Reduce access to lethal means through temporarily removal from the home or safe storage.
Social isolation; relationship problem(s); experiencing bullying	Connectedness to people, family, community, and social institutions; involvement in extracurricular activities
Hopelessness for the future; life transitions	Self-esteem and a sense of purpose or meaning in life.
Alcohol and substance use/abuse	
Experience of trauma or crisis	

Figure 57: A few examples of risk and protective factors for suicide. [373,374]

Community Input on Suicide Prevention

Parents, caregivers, and community stakeholders who support families continually underscore the significant needs for suicide prevention and mental and behavioral health services and support. Parents and caregivers desire guidance and resources for how to have discussions around mental health and suicide with their children. [375] According to a national survey, most (93%) of adults feel suicide is preventable at least sometimes, and 78% would be interested in learning how to play a role in helping someone who may be suicidal. There is continued opportunity to actively destigmatize suicide and promote help seeking for suicidal thoughts or actions. [376]

Adolescent suicide prevention partners recognize a lack of celebration for LGBTQ+ youth as they come to terms with their sexuality. [377] They recommend creating inclusive spaces for adolescents and involving adolescents in prevention strategies. When people feel connected to their community and supported by their friends and family their risk for suicide decreases.

Some people with eating disorders simultaneously struggle with suicidal thought or actions and may be considered at increased risk of suicide attempt. [378,379] Since the start of the COVID-19 pandemic, eating disorder referrals at Seattle Children's quadrupled. [380] Adolescent suicide prevention partners encourage opportunities to address eating disorders and links to suicide. [381]

Medical professionals in both primary care and specialty care settings also identified the importance of screening for suicide in pediatric patients and acknowledge the necessity of counseling on access to lethal means with families whose child is experiencing suicidal ideation.

Given the accessibility to medicines and prevalence of medicine misuse, clinical teams at Seattle Children's have identified a great need for families to safely store medicines at home as part of home safety and suicide prevention. Washington Poison Center colleagues shared: "Easily accessible substances such as over the counter (OTC) products are frequently involved in adolescent cases of suicide or self-harm. From a poison center perspective, limiting access to these products or prescriptions can decrease potential harm. Consider locking up all medications (including OTC) and portioning out prescription medications a week at a time."

Firearm-Related Injuries

Nationwide organizations, like the Children's Hospital Association, recognize gun violence as a public health crisis for children and families. In just one year (2019-2020), the firearm homicide rate increased about 35%, with the largest increase among Black people (39%); during this time the firearm suicide rate remained high with the largest increase among American Indian and Alaska Native people (42%). [382] The reasons for these increasing rates of firearm deaths and associated disparities are complex, and stressors associated with the COVID-19 pandemic may play a part. [383]

Firearm-related injuries are the leading cause of death for children under 19 after a 29.5% spike from 2019 to 2020.

In 2020, the United States experienced record high firearm sales (including first time purchasers) and firearm deaths. [384,385] In fact, 7.5 million U.S. adults became new firearm owners between January 1, 2019, to April 26, 2021, including many first-time owners, exposing more than 5 million children to household firearms. [386] Approximately half of all new firearm owners were female, 20% were Black, and 20% were Hispanic. [387]

Mass shootings are when four or more people are injured or killed, not including the shooter. [388] In 2021, there were nearly 700 mass shootings exceeding the 611 incidents that occurred in 2020. [389] As of July 5, 2022, there were already over 300 mass shootings in the United States that occurred before the calendar year end. [390] Most (80%) individuals who engage in K-12 school shootings stole firearm(s) from family members. [391]

Several key informants shared that gun violence is a concern in their communities, especially in Montana where 66.3% of adults live in home with guns, the highest rate in the nation. [392] One key informant described, "Gun violence is on the rise in our adult population (18-65 years) which means our youth population is being exposed, too. Children are more likely to witness violent acts, be injured by guns themselves, and be exposed to violence at school. Gun violence absolutely has public health impact."

Key informants who work in healthcare settings described difficulties in navigating health-related discussions that have become politicized. "We always ask parents if there are guns in the home. Parents can get defensive and tell me it is none of my business, but we are just concerned about keeping children safe. Sometimes they seem more worried about individual freedoms than collective safety."

In King County Washington, 18% of adults with children have a firearm in or around their home, 20% of firearm owners with children report storing their firearms loaded, and 50% of firearm owners reported storing firearms locked up and unloaded. [393] According to studies by the Pew Research Center, the most reported reason for firearm ownership is personal protection from other people, followed by hunting. (PEW) Roughly half of people who own firearms consider ownership to be important to their overall identity. (PEW) Though many people own firearms for personal protection and home defense, research in urban areas confirm that firearm-related deaths in the home are more likely due to suicide or criminal homicide than self-defense homicide. [394] The American Foundation for Suicide Prevention has identified firearms as one of the 4 critical areas to address in Project 2025, the nationwide initiative to reduce the suicide rate 20% by 2025.

To better understand and reduce firearm violence, the Washington State Legislature created the Office of Firearm Safety and Violence Prevention (OFSVP) in 2020 to work alongside policymakers, public health officials, government entities, law enforcement agencies, researchers, community organizations and individual community members to implement evidence-based policies, strategies, and interventions to address firearm violence across the state. [395]

Seattle Children's clinical care teams, including the Emergency Department and the Psychiatry and Behavioral Medicine Unit, identified the patient family need for safe firearm storage devices to lock up firearms more than doubled between 2020 and 2022 – especially for suicidal patients. [396]

Violence

In a listening session held in the greater Seattle area, multiple adolescents noted that violence was a vital reality in their lives and often impacts their interactions and decisions. Teenagers from South King County who were interviewed described concerns about violence both at school and in the broader community. One teenager said that when he thinks about how bad violence has gotten from the prior generation to his, it makes him not want to have children out of fear over how bad the violence will be for future generations. The teens recounted many fights occurring at school seemingly triggered by an array of issues (at times related to gangs) but mostly perpetrated by individuals or small groups of bullies. They also emphasized the compounding effect social media can have on the amplification of violence and humiliation caused by bullying, which they described as significantly adding to the mental health pain caused by the act. With respect to concerns over violence in the broader community, a teen described how he and his family do not go out of their home into the neighborhood in the evenings due to concerns about shootings.

Crime and violence were identified by teenagers as key topics that impact their health. They referred to frequent shootings making them feel unsafe at school, preventing them from being able to walk outside to improve their health, and making them fear the quality of life their own children will have. Violence impacts everything from their physical safety, what they eat, the quality of their studies, how they exercise, how they perceive others, and the social network of their community and the country. It is critical that healthcare organizations stand by teenagers within the community who are advocating for their health and wellbeing when they demand improved violence prevention.

Figure 58: Teens' Concerns about Violence in South King County.

In addition to concerns over violence perpetrated by peers and other community members, police violence also greatly affects the health and wellbeing of youth; the significant racial disparities in police violence cannot be overstated. Among pediatric and young adult populations, police violence affects patients' health in two large categories: a direct increased risk of harm or injury, and/or increased exposure to violence, trauma, and death. For every 100,000 Black men aged 25-29 years, 2.8 to 4.1 are killed by police, a number significantly higher than any other racial and age category. This analysis estimates a mortality rate of 1.8 in 100,000 for Black men 25-29 years of age, making police violence one of the leading causes of death for this age group.

In addition to the directly elevated risk of dying by police use of force, racial and ethnic minority children are at higher risk of experiencing long lasting mental and physical harm from experiencing trauma. The pediatric community along with the CDC have defined Adverse Childhood Experiences (ACEs) as potentially traumatic events that occur in childhood (0-17 years). ACEs include direct exposure to violence, abuse, neglect or witnessing violence in the household and community. They also include having family members attempt suicide as well as being exposed to individuals with substance misuse. Notably, however, ACEs also include any instability caused by family separation or exposure to household members being imprisoned. [397] Importantly, ACEs have been directly linked to chronic health problems including cardiovascular disease, substance abuse, increased risk of STDs, and depression. [398] Studies also show that women in multiple racial and ethnic minority groups were at greater risk of experiencing a greater number of ACEs, further elucidating the racial/ethnic disproportionality in the healthcare system. [399]

Indigenous people are killed by police at disproportionately higher rates as well, and face disproportionately higher incarceration rates compared to non-Hispanic Whites. [400] There is also an epidemic of violence against Indigenous women in America and locally in Seattle. In 2019, the Urban Indian Health Institute (UIHI) partnered with the CDC to conduct a study in Seattle to investigate rates of sexual violence against Indigenous women. Of the 148 Native women in Seattle interviewed by UIHI, 139 (94%) of them had been raped or coerced at some point in their lives. Shockingly, 82% reported that the incident happened before they were 18 years old, demonstrating that this violence significantly affects youth. [401]

The COVID-19 pandemic has also brought up new concerns over violence and abuse toward children. As children spend more time at home and out of school, there is concern that rates of abuse and neglect will increase. Throughout the

pandemic, children have had fewer interactions with mandated reporters, including educators and healthcare providers. In the week following Governor Inslee's announcement of the stay-at-home order in Spring, 2020, there was a 40% drop in CPS hotline calls in Washington. There is also concern over increased rates of domestic violence and the decreased ability to detect it. In Yakima County, community organizations that typically conducted in-home visits and completed in-person screening for domestic violence were not able to do this during the pandemic.

Injuries, child abuse and neglect, community violence, and discrimination contribute to childhood adversity. Childhood adversity refers to a wide range of circumstances or events that pose a serious threat to a child's physical or psychological well-being. Although childhood adversity can have serious consequences, including lifelong physical and mental health challenges, proper supports can lessen negative outcomes. Even more childhood adversity, it is preventable.

Figure 59: A Note on Childhood Adversity from Child Trends. [402]

Homicide

In 2020, 45 children in Washington between the ages of 0 and 19 died from homicide, the majority being with the use of a firearm. [403] Males were more likely than females to die from homicide with nearly 4 male and 1 female deaths per 100,000 people. [404] The rate of homicide deaths among BIPOC youth was higher than White youth, with homicide rates for Black youth being nearly 4 times higher than for White youth. [405] In 2020, 29% of all homicides involved firearms. [406]

Figure 60: Washington Homicide Deaths Ages 0-19 (2018-2020). [407]

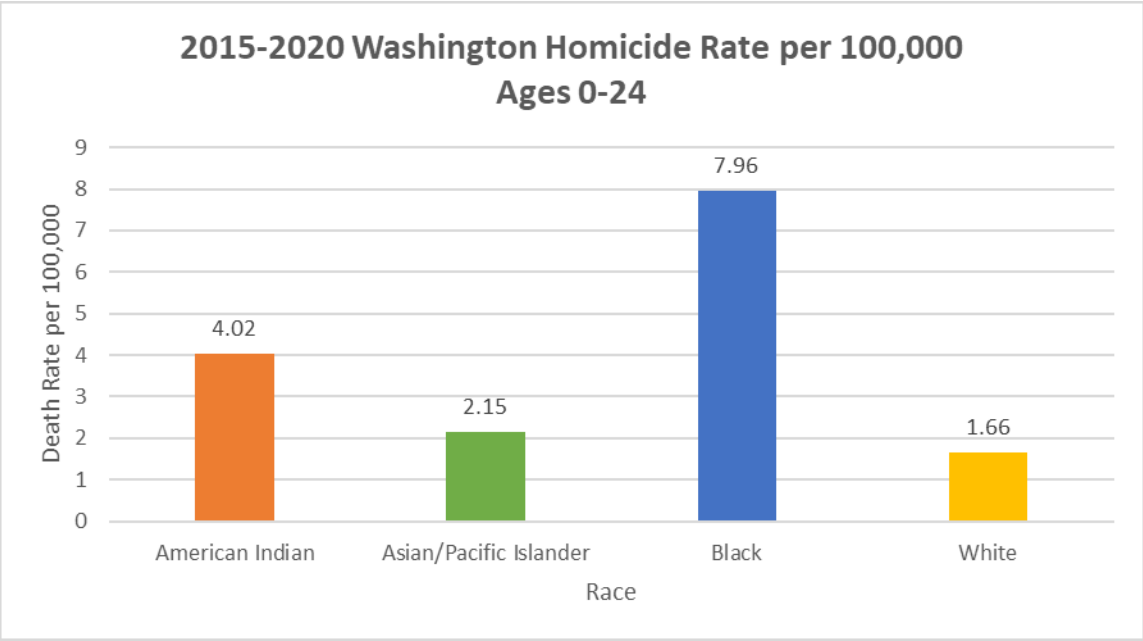


Figure 61: Washington Homicide Rates by Race and Ethnicity Ages 0-24 (2015-2020). [408]

Child Maltreatment

Definitions of child maltreatment vary by state. In the state of Washington, the law defines child maltreatment as injury, sexual abuse, sexual exploitation, negligent treatment, or maltreatment of a child by any person under circumstances which indicate that the child's health, welfare, and safety is harmed. [409] The four broad categories of maltreatment include physical abuse, sexual abuse, emotional abuse, and neglect (which is failure to meet the basic physical and emotional needs of the child). [410] Neglect was the most common form of maltreatment among children in 2020. [411] Outside of immediate physical or emotional pain, child maltreatment can have lifelong and even intergenerational consequences. [412] Childhood maltreatment can be linked to long-term physical, psychological, and behavioral consequences. [413] Maltreatment during infancy and early childhood can negatively impact early brain development and lead to negative behavioral health outcomes later in life. [414] Age is an important factor and inversely related to child maltreatment rates: youngest children are most at risk and risk decreases with increase age.

At least 1 in 7 children in the United States have experienced child abuse or neglect in the past year, and approximately 1,750 children died from abuse and neglect in 2020. [415] In King County, 20.8% of 8th, 10th, and 12th graders reported being abused by an adult. [416]

In 2020, 4 out of every 1,000 Idaho children and 16 of 1,000 Montana children under 18 years old were victims of maltreatment. In Montana and Idaho, children 0-4 account for almost half of all child maltreatment incidents, followed by children ages 5-10 who are involved in about a third of cases. [417]

Rates of child maltreatment are 5 times higher for children in families with low socioeconomic status. [418] Throughout 2020, 102,642 referrals were made to child welfare agencies, 47,375 of which were investigated further for abuse and neglect. [419] This was a 16.1% increase from rates in 2016. [420]

In 2020, 66.7% of reports alleging child abuse and neglect came from mandatory reporting professionals such as law enforcement, education personnel, and medical professionals. [421] While schools are often a personal safe haven for children experiencing child abuse at home, schools also play a critical role in the reporting of suspected child maltreatment. Teachers, guidance counselors, and school psychologists are mandatory reporters of suspected child

maltreatment, and education personnel are the primary reporting source of child maltreatment. But when school buildings closed in the wake of the pandemic, child maltreatment reporting dropped 60%. [422,423] This decline led many to believe child maltreatment rates were down, but concerning indicators from emergency room visits, teen self-reports and domestic violence data suggest there has actually been an increase in child abuse and neglect during COVID-19. A key informant summarized the issue, "Students are not in schools, teachers don't have eyes on them, so the number and severity of child abuse cases drastically increased during Covid…and I don't think we know the full extent of the impact quite yet." Economic hardship is considered a strong predictor of child abuse and neglect; the declining rate of employment and financial security among rural families during the pandemic put vulnerable children at an increased risk of maltreatment. One key informant described this domino effect: "Money is tight, tension is high; this leads to household instability and food insecurity and put kids in danger of abuse and neglect."

Child maltreatment is a preventable public health issue and communities have an essential role to play to help relieve and alleviate the stressors that parents and families experience. [424]

Spotlight on Alaska, Idaho & Montana: Suicide and Injury Prevention

Between 2018 and 2020, 112 children under the age of 19 died in Montana (14.6/100,000) and 168 (11.3/100,000) in Idaho due to unintentional injuries. [425] Motor vehicle crashes, suffocation, drowning, falls, and poisoning are particularly common causes. Disparities in the risk of intentional and unintentional child and adolescent injury are found across several distinct populations. For example, children in rural areas are at increased risk of unintentional injury and death, and there are often place-based differences in environmental and occupational hazards that put rural kids more at risk for certain injuries. [426]

> ***"Montana is consistently ranked in the top three for most suicides in the country and our county is number one. Because this issue is becoming so common, we are beginning to break down the stigma of mental health – that is the only silver lining here – but the high suicide rate means we are still not reaching a significant portion of the population that needs our help the most."***

Per a key informant in Idaho, "Kids in different areas face different challenges, dangers, and resources available to them. Falls are a leading cause of injury in our state but falls from windows occur more frequently in metropolitan areas, and falls from ATVs, farming equipment, and machinery are more common in rural areas. We can't do broad health programming for all kids; we must tailor it to the population we are working with." While injury-related death is often associated with injury severity, key informants suggested that social determinants of health also create worse injury outcomes in rural communities. One injury-prevention specialist shared, "Parents are working two jobs, childcare is unaffordable and unavailable…when kids get injured, they have to travel longer distances to emergency and specialty care and might not have transportation to get there." Injuries can affect kids anywhere, but there are racial, ethnic, and gender disparities in the distribution of pediatric injuries in Montana and Idaho. 2016-2020 data show that Hispanic/Latino and American Indian and Alaskan Native children under 19 were disproportionately killed by unintentional injuries compared to White children, and males had higher mortality rates than females (although crude rates were deemed unreliable due to small sample size). [427]

There are behavioral risks that contribute to worse injury outcomes. YRBS explored trends in the prevalence of these experiences among MT and ID high school students:

I. **Seatbelt Use: 5.8% never/rarely; 2x higher rates for AIAN, Black, & Hispanic students**
II. **Text & Drive: 54%, rates increasing annually**
III. **Rode With Driver Who Had Been Drinking: 17%**
IV. **Experienced Sexual Violence: 22% of females, 3x the risk of male students**
V. **Physical Fight at School: 15%**
VI. **Carried a Weapon at School: 8%**

Figure 62: Injury Risk Factors Among High School Students, 2019-2021. [428,429]

Motor vehicle injuries: as stated previously, between 2016 to 2020, there were a total of 161 child fatalities across WAMI, with the highest child fatality rates per 100,000 in Montana (4.09) followed by Alaska (2.33), Idaho (2.23) and Washington (0.91). [430] In 2020, a total of 35 children ages 0-17 died from a crash involving a motor vehicle in Washington, which is a 106% increase from 2019. [431] Most of these children were between the ages of 10 and 17. [432278]

Suicide: Suicide is the second leading cause of death among 10-24 years old in Montana, Idaho, and nationwide, and the most recent results from the 2019 YRBS show upward trends. When compared to national averages, a higher percentage of Montana and Idaho youth had seriously considered suicide (US 18.2%, MT 23.4%, ID 21.6%) and attempted suicide one or more times during the past 12 months (US 7.3%, MT 10.0%, ID 9.6%). [433,434] In 2020, Idaho had the fifth highest suicide rate and Montana ranked third highest, so it is not surprising that suicide was mentioned in many key informant interviews. [435]

Child maltreatment: In 2020, 4 out of every 1,000 Idaho children and 16 of 1,000 Montana children under 18 years old were victims of maltreatment. In Montana and Idaho, children 0-4 account for almost half of all child maltreatment incidents, followed by children ages 5-10 who are involved in about a third of cases. [436]

Firearms: Firearm-related death rates in Alaska (23.5/100,000), Montana (20.9/100,000), and Idaho (17.6/100,000) exceed the national rate of 13.6 per 100,000. [437] Several key informants shared that gun violence is a concern in their communities, especially in Montana where 66.3% of adults live in home with guns, the highest rate in the nation. [438] One key informant described, "Gun violence is on the rise in our adult population (18-65 years) which means our youth population is being exposed, too. Children are more likely to witness violent acts, be injured by guns themselves, and be exposed to violence at school. Gun violence absolutely has public health impact."

Opportunities for Injury and Violence Prevention

- Continue to partner with community to promote **injury** prevention awareness, education, and increase access to **safety devices** like bike helmets, life jacket, firearm storage.
- Consider opportunities for **injury** prevention education tailored to children with different learning abilities and/or chronic medical conditions.
- Support school outreach on **injury** prevention topics (e.g., guest speakers at assemblies).
- Promote layers of protection for **water safety** and support self-efficacy of parents, caregivers, and other adults who care for children to safely supervise children and teens while swimming and to recognize and respond to a drowning emergency.
- Improve community infrastructure to create safer walking environments to promote **pedestrian** safety.
- Identify credible and feasible options for secure storage of **medicines** at home to prevent medicine misuse, self-harm, and suicide in adolescents.

- Support/advocate for funding of **firearms** research and groups, such as the Firearm Safety Among Children and Teens consortium to advance the science of firearm-injury prevention.**Error! Bookmark not defined.** [439]
- Develop culturally informed **suicide** and **injury** prevention education – especially on topics like **firearms safety, suicide prevention, water safety**.
- Increase **suicide** prevention education in schools and communities,
- Implement, expand, and evaluate the Zero Suicide framework for **suicide** prevention in clinical settings and supplement with resources to decrease access to lethal means.
- Accurately share emergency department data with Washington State Department of Health to provide timely information and to contribute to the understanding of the impact of **suicide**, **violence**, and **injuries** on youth.
- Seek to understand and practice more ways to engage in culturally respectful, conversation-promoting language related to **firearms**, **suicide** by firearm, and community **violence** involving firearms. [440]
- Apply trauma-informed practices to all components of **suicide and injury** prevention.
- Identify shared risk and protective factors to inform suicide and injury prevention efforts and promote collaboration.

Seattle Children's has made significant progress in increasing access to safety devices and expanding suicide and injury prevention awareness and education, but there is always more work to do in making these services more available for rural families across the region.

Assets for Injury and Violence Prevention

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 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.

- Washington State Department of Health's Watch Me Grow Program provides families with information and education related to child passenger safety (booster seats)

Poisoning 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.
- King County Secure Medicine Return promotes drop boxes at pharmacies and law enforcement offices.
- Washington's Safe Medication Return lets people dispose of household prescription and over-the-counter medications.
- King County Laced & Lethal campaign to prevent overdose (Fentanyl focus).

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.
- No More Under works to increase equitable access to water safety tools, education and swimming lessons.
- SPLASHFoward – a community advocacy group serving the broad aquatic needs for a full range of fitness, recreation, health, wellness, and competitive aquatics programs for all ages, abilities, and backgrounds.
- In partnership with Panda Cares, Seattle Children's Health and Safety Program provides free bike helmet and life jacket fittings and giveaways along with education on proper fit to families across Washington State. Seattle Children's clinical teams offer water safety education and free fitted life jackets to patient families as needed.
- Washington State Department of Health's Watch Me Grow Program provides families with information and education related to water safety.

Safe Sleep

- The TEARS Foundation is partnering with first responders, social service agencies and chaplains to provide baby boxes for families with babies (newborn to 4 months).
- Parent Trust for Washington Children offers education for parents and caregivers on safe sleep.

- Baby Corner helps children have what they need to grow, play, learn and thrive and provides tangible goods, like travel beds, to families in need.
- WestSide Baby meets the basic needs of children to promote safety, security, and healthy development. This includes providing families essential items, like travel beds, to keep children safe.

Bicycle and Pedestrian 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.
- 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.
- In partnership with Panda Cares, Seattle Children's Health and Safety Program provides free bike helmet and life jacket fittings and giveaways along with education on proper fit to families across Washington State. 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.
- Washington State Department of Health's Watch Me Grow Program provides families with information and education related to bike helmet safety
- Everett Public Schools partners with Seattle Children's North Clinic to deliver bike helmet safety education and free fitted bike helmets to children.
- 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 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.

Suicide Prevention

- 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 implementation continues at Seattle Children's. All patients 10 years and older are screened for suicide risk in both inpatient and outpatient settings.
- 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.
- Washington State Action Alliance for Suicide Prevention – goal is to use strategy, momentum, and input to guide policy, financial, legislative, and programmatic change in accordance with Washington State Suicide Prevention Plan.
- King County Youth Suicide Prevention Coalition started in 2022.
- Crisis Connections, includes focused programs and services serving the emotional and physical needs of individuals across Washington State, (e.g., youth suicide prevention school curricula, support after suicide).
- Suicide Prevention Coalition of North Central Washington helps reduce the incidence of suicide through greater access to information, training and resources, reducing barriers and stigma, and serves as a clearinghouse for information related to suicides within North Central Washington.
- The Washington Poison Center (WAPC) coordinates with emergency services and can begin treatment for a self-harm or suspected suicide exposure.
- Washington Office of Superintendent of Public Instruction (OSPI) provides resources and support to help inform ESDs, school districts, and schools in the development of suicide prevention plans and postvention guidance.
- Native and Strong is a campaign within the Washington State Department of Health designed to inform and educate tribal communities about suicide prevention.

Firearms 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 6,000 safe firearm lock boxes, along with demonstrations and practice, to firearm owners across Washington state.
- Seattle Children's co-leads the Washington State 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 inpatient and outpatient clinics and Odessa Brown Children's Clinic provide safe firearm storage education and 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.
- HIPRC's Firearm Injury & Policy Research Program – mission to reduce the impact of firearm injury and death on people's lives through interdisciplinary research and collaboration with institution, community, and governmental partners.

- In March 2021, The Legislature created the Washington Office of Firearm Safety and Violence Prevention (OFSVP) in the Department of Commerce to support and coordinate the implementation of evidence-based firearm violence intervention and prevention strategies across the state.
- Washington State Department of Health's Watch Me Grow Program provides families with information and education related to firearms safety.

Homicide and Violence Prevention

- Port of Support focuses on creating equitable and innovative programs that will disrupt the cycles of poverty, promote self-sufficiency, and strengthen our most disadvantaged neighborhoods. Goals are to improve the health of marginalized families and individuals by evaluating and engineering effective opportunities geared towards promoting healthier communities. Understanding diverse environments that offer concrete and specific information to help solve community impacts, prevent community violence, health disparities and social inequalities for disadvantaged families is what we strive for. Hopes are to advance injury and youth violence prevention through intrapersonal research and evidence-based programs that target the root causes of violence.
- The Regional Peacekeepers Collective (RPKC) launched in 2021 by Zero Youth Detention, a pilot program that employs a responsive "go-first" strategy to address the increase in gun violence and firearm homicides in King County.

Child Maltreatment Prevention

- Strengthening Families Program in Washington state, 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.
- Harborview Abuse & Trauma Center provides resources and assistance related to sexual assault and traumatic experiences; crisis response, counseling, medical care, and support; general, legal, and medical advocacy, evidence-based therapy and parenting interventions.
- University of Washington's Barnard Center for Infant and Early Childhood Mental Health promotes interdisciplinary research and training related to infant and early childhood mental health.
- Seattle Children's promotes and trains professionals state-wide to educate new parents about normal infant crying, the dangers of shaking a baby and strategies to cope with crying utilizing the Period of PURPLE Crying education program.

Priority Area: Healthy Lifestyles

A Note on Language and Definitions

When we speak about Healthy Lifestyles in this pediatric WAMI community health assessment, we mean a combination of factors that contribute to a healthy lifestyle as a priority area for children's health improvement. These factors include, but are not limited to:

- good nutrition and access to three nutrient dense meals per day for children that are affordable for any family;
- adequate physical activity;
- healthy body weight;
- the built environment that surrounds a child which include safe places to recreate.

These are essential components of achieving a healthy lifestyle; however, these issues were commonly identified as concerns among key informants. Together these factors can help decrease a child's risk of developing chronic conditions in their teen years and into adulthood. Illnesses such as diabetes, heart disease, high cholesterol, hypertension, and cancer. Additionally, the physical environment of a community—such as availability of affordable, fresh food and safe places to be physically active—affects residents' ability to exercise, eat a healthy diet, and a maintain a healthy body weight –again this confluence of factors is what we mean when we say "healthy lifestyles." Those who have limited access to healthy foods, including from supermarkets, have a higher risk of developing obesity and diabetes. Along with a healthy diet, physical activity is key to preventing and reducing complications of diabetes and other chronic diseases.

Healthy Lifestyles: Healthy Weight, Nutrition, Physical Activity, Built Environment & Food Security

In 2022, about one in three children and adolescents in United States were either obese or overweight.[441] The state of Washington's childhood obesity rate is similar to the national average. About 12% to 14% of high school students in Washington are obese and about 14% to 16% are overweight.[442] In King County, 9% of high school students are obese and 21% are considered overweight[443] and the obesity rate among youth of color is twice that of white youth.[444] Good nutrition, particularly in the first three years of life, is important for establishing a good foundation that has implications for a child's future physical and mental health. In addition, physical activity is essential for a healthy childhood. Regular physical activity has beneficial effects on weight, muscular strength, cardiorespiratory fitness, bone mass, blood pressure, anxiety, stress, and self-esteem.[445] It is recommended that children and adolescents participate in at least 60 minutes of physical activity most days of the week, preferably daily and only 43% of Washington children were physically active at recommended levels last year.[446] During listening sessions with families, this was reiterated.

Although there is no one simple solution to reverse youth obesity, Seattle Children's can increase focus on healthy lifestyles through policies that promote access to healthy foods, decrease access to unhealthy foods like sugary drinks, and support opportunities for physical activity such as safe routes to school, active transportation and investing in the built environment. Unfortunately, food insecurity is an obstacle that threatens that critical foundation exacerbated by the COVID-19 pandemic. In the United States, 15.3 million children under 18[447] live in households that are unable to consistently access enough nutritious food. In Washington state, 1 in 5 kids live in a household that struggles to put food on the table and 1 in 7 Washingtonians relies on food stamps.[448] Half of all people on Supplemental Nutrition Assistance Program (SNAP), also known as food stamps, are kids.[449] While SNAP provides families with electronic benefits they can use like a debit card to purchase breads, cereals, fruits, vegetables, meat, and dairy products from approved stores, the average SNAP benefit averages $1.40 per person per meal.[450] Food availability, food access and food utilization impact health. During our listening sessions and in our survey, families in Washington, Alaska, Montana and Idaho told us that some of them do not have sufficient resources to purchase food or nutritious food and are forced to make choices between other basic needs, like housing, and food. Some families described their immediate neighborhoods where a grocery store was not within a 10-mile radius and the corner stores where they sometimes shop do not sell what they consider healthy food. These same families share with us that they do not have sufficient incomes or resources in order to obtain food and utilize food banks when they are available in the area. Families shared many concerns about nutrition and access to healthy affordable foods. Parental joblessness during the pandemic only heightened these concerns and realities for many of our region's families.

Healthy at any Weight

Here at Seattle Children's in community heath we struggle to align the clinical term "obesity" with the way in which our community discusses challenges they experience when trying to maintain what they consider a healthy weight. While we will use the term obesity in this next section, we will endeavor to intersperse healthy weight as part of our narrative

change and in an attempt to be aspirational in this space while discussing pediatric health in relation to weight and body size as we firmly believe children can be healthy at any weight.

Broaching the topic of obesity can be difficult for health care providers because weight is a sensitive issue. When used by the public, terms such as “obese” and “fat” often carry negative, demeaning social connotations. [451] [452] The term “obesity” also is perceived to have negative connotations when used by health care providers to discuss patients' excess weight. [453] [454] Health care practitioners are sending incorrect and destructive messaged about the relationship between weight and wellness and we endeavor in this CHA to introduce some of that counter narrative. In a 2019 article in Scientific American, the author says, “You cannot wage war on obesity without waging war on the people who live in those ‘obese’ bodies. Moreover, the dignity of a group should not be contingent on whether its members are deemed healthy, eating ‘right,’ or exercising regularly. It should be obvious, but weight stigma does not reduce 'obesity'—and health care should be about self-care and promoting the health of the person in all its forms.”[455] She continues, “focusing on weight—or health behaviors—puts the burden on the individual, deflecting attention from the more pernicious problem: systemic injustice. Conditions in the places where people live, work, and play affect health outcomes to a much larger degree than health behaviors, which, all told (including eating, activity, and other behaviors), account for less than 25 percent of differences in health outcomes. While health behavior change is valuable, to truly improve public health, we can work harder to create an inclusive society where everyone feels valued and has the opportunity to create a good life for themselves.” [456]

Children that weigh more than their peers (e.g. children who are obese) has been an ongoing epidemic in this country for a generation. The national childhood obesity rate has been rising for decades putting millions of children at greater risk for type 2 diabetes, high blood pressure, asthma, and other serious conditions. The newest available data show that 15.5 percent of youth ages 10 to 17 have obesity[457] and reaffirm persistent racial and ethnic disparities, with rates remaining significantly higher among Black, Hispanic, American Indian/Alaska Native, and Native Hawaiian/Pacific Islander youth than among white or Asian youth.

Children, teens and young adults are considered overweight if their body mass index (BMI) is greater than the BMI of 85% of children of the same age and sex, and obese if their BMI is greater than the BMI of 95% of children of the same age and sex.[458] What that means is that obesity is defined as a BMI that is at or above the 95th percentile for children and teens in the same age grouping and same gender. Overweight is defined as a BMI that is at or above the 85th percentile and below the 95th percentile for children and teens of the same age and sex. Again, a child’s weight status is determined using an age- and sex-specific percentile for BMI, which is different from BMI categories used for adults. Because children’s body fat levels change over the course of childhood and vary between boys and girls, their BMI levels are expressed relative to other children of the same age and sex.[459] Therefore, obesity is a complex disease that occurs when an individual’s weight is higher than what is considered healthy for their height.[460] Many factors can lead to obesity, including eating patterns, physical activity, sleep routines, social determinants of health, and genetics.[461] Obesity rates among youth have been on the rise in recent years, with a total increase of 4.5% since 2016.[462] Between 2019 and 2020, 13.2% of children ages 10 to 17 in Washington were obese,[97] and many counties in Washington report that over 40% of students are obese or overweight. [463]

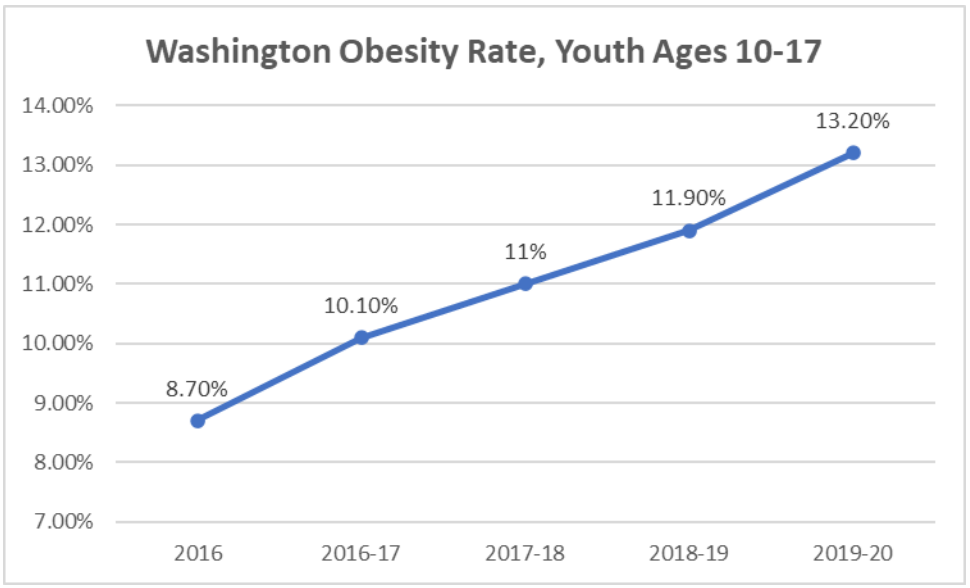


Figure 63: Washington Youth Obesity Rate (2016-2020) [464]

Figure 64: Washington 8th-10th Grade Obesity and Overweight Percentage by County (2021) [465]

Food Insecurity

The United States Department of Agriculture (USDA) refers food insecurity as at times, the lack of access to enough food for an active, healthy life for all household members and limited or uncertain availability of nutritionally adequate foods. Food insecure children are children who live in homes experiencing food insecurity. Households that experience food insecurity are not necessarily permanent. Household may exchange important basic needs, such as housing, medical and personal bills, and purchasing nutritious foods. [466] 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."[467] Very low food insecurity is defined as "reports of multiple

indications of disrupted eating patterns and reduced food intake."[468] Children who experience hunger are more likely to be hospitalized and experience medical conditions, including asthma and anemia.[469] 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.[470] Federal and state assistance programs have been shown to reduce child food insecurity rates and lessen the health impacts of food insecurity among children.[471] 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).

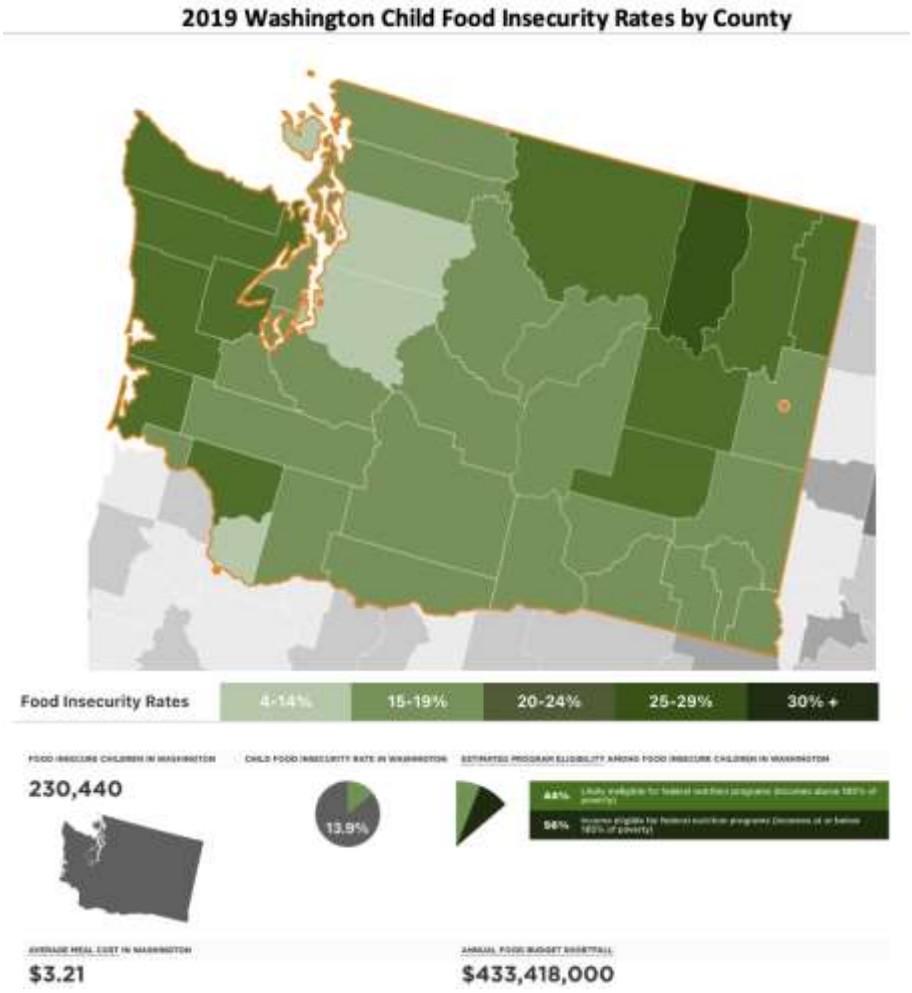


Figure 65: Washington Child Food Insecurity Rates by County (2019) [472]

According to a report published recently by Feeding America entitled "child hunger and poverty in Washington," in Washington State:

> …food insecurity rates were highest in Ferry County at 28.4% and 79% of children were eligible for federal nutrition programs. King (10.2%) and Snohomish (11%) counties had the lowest percent of food insecure children among all counties in Washington Generally, rural (Eastern and Western) Washington counties have higher rates of food insecure children, compared to urban counties. In 2019, there were 230,440 children who had food insecurities in Washington. The child food insecurity rate was 13.9%, where the average meal cost was $3.21. Among food insecure children, 56% are income eligible for federal nutrition programs (income at or below 185% poverty level).[473]

Food insecurity can affect children and families in many different ways. Some people experiencing food insecurity may feel significant anxiety about food, others may have obesity due to low food quality, and others may have nutrient deficiencies or undernutrition due lack of food variety and quantity. [474,475] There are robust data for the many ways in which food insecurity has a negative impact on child health. The American Academy of Pediatrics groups these health effects into four main categories: poor health status, developmental risk, mental health problems, and poor educational outcomes:

Figure 66: American Academy of Pediatrics Childhood Food Insecurity Source [476]

The US Department of Agriculture (USDA) produces an annual report on household food security. Rates of food security have overall down-trended over approximately the past ten years. However, food insecurity more greatly affects communities of color, the COVID-19 pandemic has also led to significant increases in food insecurity, and food insecurity more greatly affects households with children, both before and during the pandemic.

Both nationally and locally in King County, food insecurity trends of combined populations do not adequately reflect the high impact of food insecurity on BIPOC communities. The 2020 USDA Report, which includes data recorded through 2019, showed that 19.1% of Black households and 15.6% of Hispanic households experienced food insecurity.[477] These values are significantly higher than rates of food insecurity in white households (7.9%) and all households (10.5%). Thus, the "improvements" seen in general food insecurity trends hide the continued high rates of food insecurity seen in Black and Hispanic households. In King County, rates of food insecurity have increased approximately 4-fold among households identifying as black compared to those identifying as white from 2013 to 2018. Per the Behavioral Risk Factor Surveillance System (BRFSS), an annual telephone interview survey of adults in King County, 17.4% of Black and 10.4% of white households reported food insecurity in 2013 compared to 39.9% of Black and 8.9% of white households in 2018.[478] These data provide clear evidence that Black communities in King County have had worsening burden of food insecurity over the past several years.

Increases in food insecurity have been seen both national and locally during the course of the COVID-19 pandemic. Rates of "very low food security," meaning decreased quality, variety, and quantity of food, almost doubled in King, Pierce, and Snohomish Counties from March to June 2020. Additionally, enrollment in Basic Food Assistance (SNAP and pandemic EBT) in King County increased by 18% from January to June 2020.[479] Seattle Children's Hospital has seen a significant increase in utilization of food resources, specifically the hospital's food pantry for patients screening positive for food insecurity and inpatient orders to the local food bank.

Households with children have experienced higher rates of food insecurity compared to those without children, both before and during the pandemic, and this gap has grown wider during the pandemic.[480] In one national survey, a staggering 40.9% of mothers with children under age 12 reported food insecurity.[481]

Despite some opportunities for increased availability of resources related to food insecurity (discussed in section "The COVID-19 Pandemic has Presented Some Opportunities for Innovation" above), the pandemic has also increased many barriers to food insecurity resources. Almost all stakeholders mentioned the increased barriers that people experienced with accessing food during the pandemic. Especially relevant for children, there was a significant gap in transportation to school meal sites when public schools were shut down. As one interviewee put it, "when they didn't go to school, the school still had food for them, but now parents need to drive to school to get them free food. Same thing goes for food

banks." As a result, while many food resources were expanded during the pandemic, the access to those same resources was not always equally expanded. Even in March of 2022 when we surveyed more than 6,000 residents of WAMI, "healthy and affordable food options" ranked high when asked what their top 5 items of concern were in relation to their child's health:

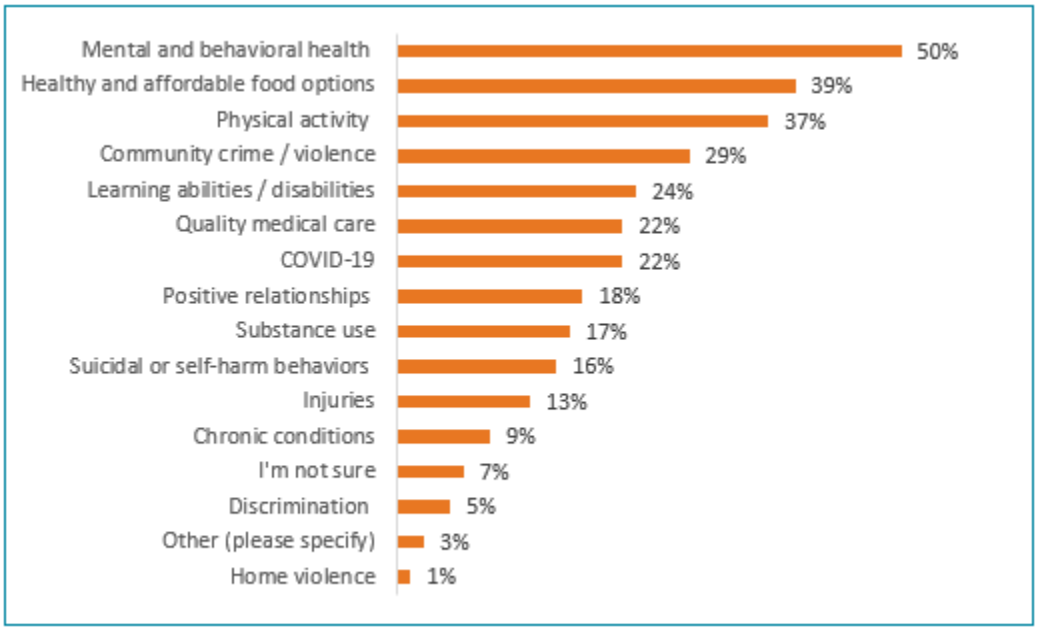


Figure 67: Survey Results – "When you think about your child's health today, what concerns you?" Select up to 5."

Top 7 'Very Hard to Access' or 'Hard to Access' Community Services		
1	Affordable & Quality Housing	72%
2	Healthy & Affordable Foods	50%
3	Childcare	47%
4	Affordable Quality Health Care	45%
5	Job Opportunities	39%
6	Mental & Behavioral Health Services	36%
7	Information about Mental & Behavioral Health	33%

Figure 68: Table of survey results 'very hard to access' or 'hard to access' services

Key informants pointed to an interplay of determinants – increasing food prices, high cost of living, generational poverty, and centuries of racism – that puts rural families at risk for food insecurity. Shortages of workers and resources due to the COVID-19 pandemic have impacted the supply chains that help move food from ports to plates, causing food prices to exponentially rise over the past two years. By the end of 2021, global food prices were the highest in a decade and Americans were spending 12-36% of their income on food, and BIPOC, low-income, and rural residents were feeling the pinch the most.[146,147] As one key informant explained, "The price of groceries and daily living has skyrocketed. Even though dairy and beef are local, they have tripled in price. Inflation has led to food insecurity and when families cannot afford healthy food, they turn to unhealthy, processed options." Conversations with key informants suggest that BIPOC living in rural areas are disproportionately burdened by food insecurity because centuries of discrimination have

concentrated economic disadvantage along racial/ethnic lines, making it more difficult for Black, Latinx, and American Indian and Alaska Native households to afford healthy food. Multiple key informants mentioned that food banks and food pantries are great assets for combatting food insecurity, but they cannot keep up with the widespread community need. In describing challenges faced by Indigenous families, one participant noted the vicious cycle of finances, food, and nutrition outcomes: "Even with college degrees, parents are making minimum wage, so they are forced work one-and-a-half jobs to afford food for their family. There are so many ramifications of this…parents are busy, so they don't have time to cook nutritious foods, which puts their kids at risk for obesity, and obese individuals have lower wages than those who are not obese."

When considering the significantly increased impact of food insecurity on people of color, stakeholders acknowledged that food security organizations need to center race and racism in their work. While most stakeholders commented that food security work has always involved some attention to the disparities of race, they also recognized that race and racism have not been an adequate focus of the work. One interviewee stated, "food security is anti-racist work." She went on to say that this has always been true, but that more organizations need to make active efforts to make sure food security efforts continue to be anti-racist. Stakeholders further highlighted the need to include historically excluded groups in decision-making by involving BIPOC communities in deciding organizational goals, as well as increasing diversity in staff members of food security groups. Several people also noted that immigrants, especially those who are undocumented, often have increased barriers to accessing food resources. These respondents expressed the need to decrease the amount of information that people are required to provide at food banks and organizations, as this can be a deterrent or explicit restriction to who is allowed to obtain resources.

The national and local trends in food insecurity make it clear that racism has led to stark inequities in who experiences food insecurity and these trends mean that much work is needed within this field. We must use a lens of anti-racism moving forward with food insecurity work. This means actively working to promote health and economic security in historically excluded communities, especially Black, Latinx, and Indigenous communities in the Pacific Northwest.

With respect to food security, several interviewees described how food security work needs to focus on the long-term goals of helping families out of poverty entirely so that emergency resources are less necessary. With this emphasis of relieving poverty rather than food insecurity alone, several people highlighted how food insecurity does not occur in a vacuum. One respondent put it this way: "When we have people with food insecurity, they typically have other needs, as well," such as housing and transportation concerns. The concept that families who would benefit from a resource in a specific domain, such as food security, would likely benefit from other resources as well demonstrates the need for community organizations with different areas of focus to partner to best serve families and strengthen supports in all domains. To that end, in 2021, Seattle Children's launched a pilot that is designed to scale organization-wide quickly about screening all patients/families for social determinants of health with positive screens getting a resource referral. The Social Needs Questionnaire is a questionnaire for Seattle Children's to better understand a patient or family's social situation. Research shows that social determinants of health (SDOH) — which include access to food, housing, transportation, and other social and environmental factors — have a direct impact on a person's health and well-being. Seattle Children's is asking these questions so we can better support our patients and families by connecting them to the resources and services they may need to improve their health and well-being. These questions are the same for all patients and families that have appointments in the clinics where we are doing this questionnaire. None of the questions are specific to one patient or family. In some cases, we may be able to offer more follow-up or resources to a patient or family based on how they answer some of these questions. Sometimes, this may mean that you connect a patient or their family to an internal resource such as Social Work or another team. Other times, it may mean that you connect them with services offered through external, community-based organizations. Food insecurity is one of the 4 modules we are using our electronic health record to screen for; others include financial security, transportation and housing/lodging or other complex resource needs.

Nutrition

Fruit and Vegetable Consumption

Incorporating enough fruits and vegetables into one's diet can lower blood pressure, reduce the risk of heart disease and stroke, prevent some types of cancer, lower risk of eye and digestive problems, and have a positive effect on blood sugar.[482] Additionally, poor nutrition has the potential to impact the growth, development, health status and academic achievement of youth. There are many factors that influence the number of servings of fruits and vegetables that children should consume daily, such as activity level, sex, and age. According to the Centers for Disease Control and Prevention, children between the ages of 2 and 18 should consume 1-2 cups of fruit and 1-3 cups of vegetables daily.[483]

"I wish I could prescribe healthy food. How cool would it be if I could write a prescription for healthy food and my patients could get a box of fruits, vegetables, produce, and nutrient-dense meals delivered to their doorstep? This could have a significant effect on childhood chronic disease and help reduce the disparities we see in obesity, diabetes, and food insecurity."

According to the 2021 Washington Healthy Youth Survey, 77% of youth consume less than 5 servings of fruit and vegetables per day. Rates of adequate fruit and vegetable consumption varied between 15% and 29% among students in Washington, as highlighted above.[484] Fruit and vegetable consumption is important in pediatric health because a diet rich in vegetables and fruits can lower blood pressure, reduce the risk of heart disease and stroke, prevent some types of cancer, lower risk of eye and digestive problems, and have a positive effect upon blood sugar, which can help keep appetite in check. Eating non-starchy vegetables and fruits like apples, pears, and green leafy vegetables may even promote weight loss. Their low glycemic loads prevent blood sugar spikes that can increase hunger.[485]

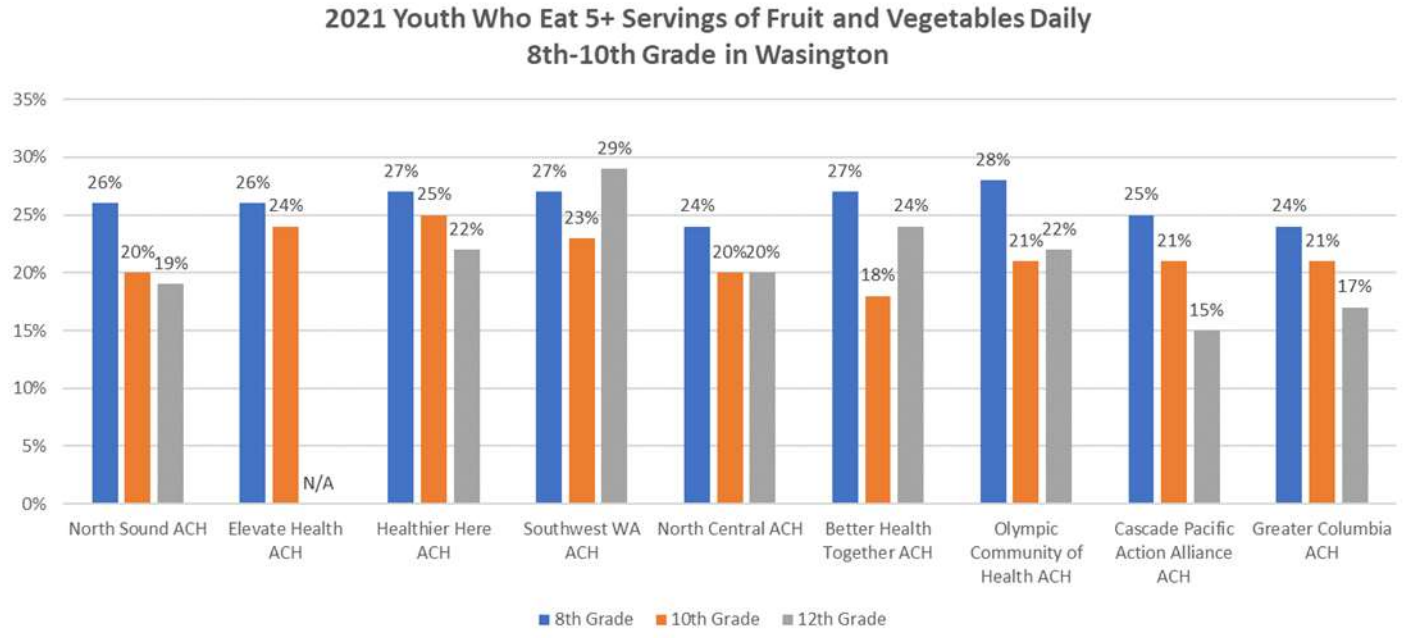


Figure 69: Washington Youth Fruit and Vegetable Consumption (2021)[486]

Access to Nutritious Foods

Nearly 40% of survey respondents ranked 'not enough healthy and affordable food' as a top child health concern and 50% identified healthy and affordable food as a community service that is hard or very hard to access. Key informants elaborated on the challenges associated with accessing healthy and nutritious foods, especially in rural areas of WAM

Sweetened Beverages

Sugar-sweetened beverages are one of the top sources of added sugars in the United States. Sugar-sweetened beverages are defined as any liquids that are sweetened with added sugars, including soda, fruit drinks, energy drinks, and coffee and tea beverages with added sugars.[487]

Frequent consumption of these beverages is associated with weight gain, obesity, type-2 diabetes, heart disease, kidney diseases, non-alcoholic liver disease, tooth decay and cavities, and gout.[488] While sugar-sweetened beverage consumption has declined in the past 15 years,[489] many children continue to consume these drinks regularly. In 2021, 83% of youth in Washington reported drinking sugar-sweetened beverages in the past week. On average, 18% of students in the state indicated that they purchased sweetened drinks at school, with 3% reporting that they consumed sweetened drinks daily at school. [490]

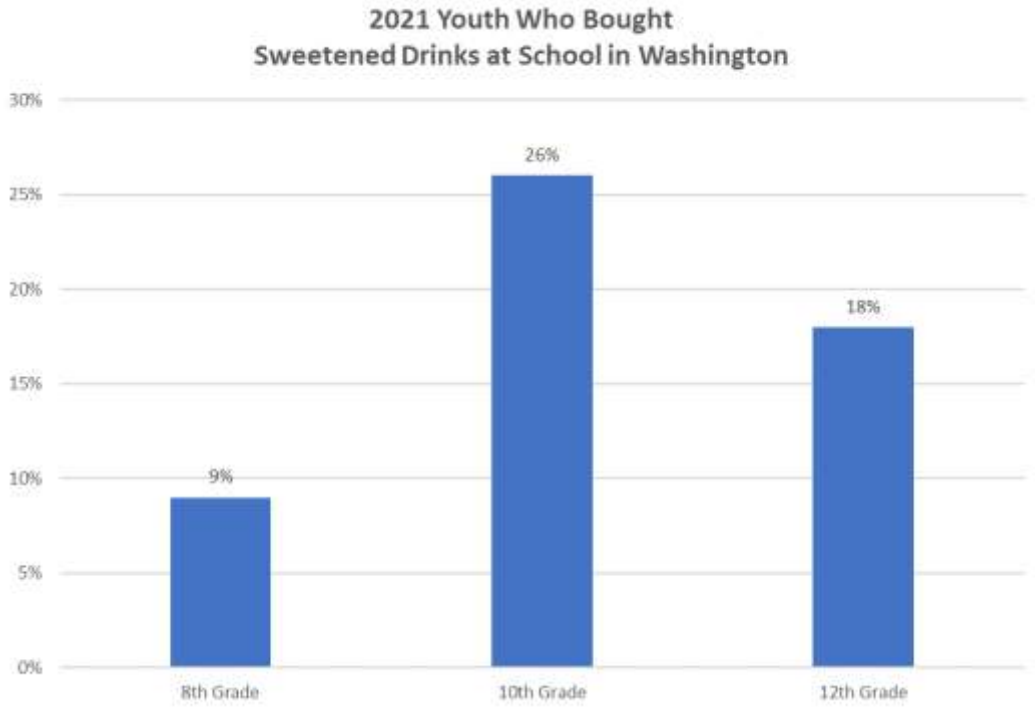


Figure 70: Washington Youth Sweetened Drink Purchases (2021) [491]

Physical Activity

It is recommended that children and youth ages 6 to 17 have 60 minutes or more of moderate to intense physical activity each day, however, many youth in Washington do not meet this activity recommendation.[492] There are many benefits to physical activity, including improvement of cardiorespiratory fitness, strong bones and muscles, weight

control, reduction of symptoms of anxiety and depression, and reduction of risk for many chronic health conditions. Additionally, adequate physical activity can also positively impact academic achievement. Higher physical activity levels are associated with improved cognitive performance, and students who are physically active tend to have better grades, school performance, and classroom behaviors.[493] Physical activity remains a 'top concern' of parents in WAMI too (See Figure above).

In Washington, the percentage of students who did not meet the recommended level of physical activity was relatively similar across the state, averaging 78%. Elevate Health ACH (Pierce County) was an outlier, with only 35% of students not meeting the recommended level. Further investigation into what sets this ACH apart in terms of physical activity could be beneficial, as findings could inform recommendations to other ACHs.

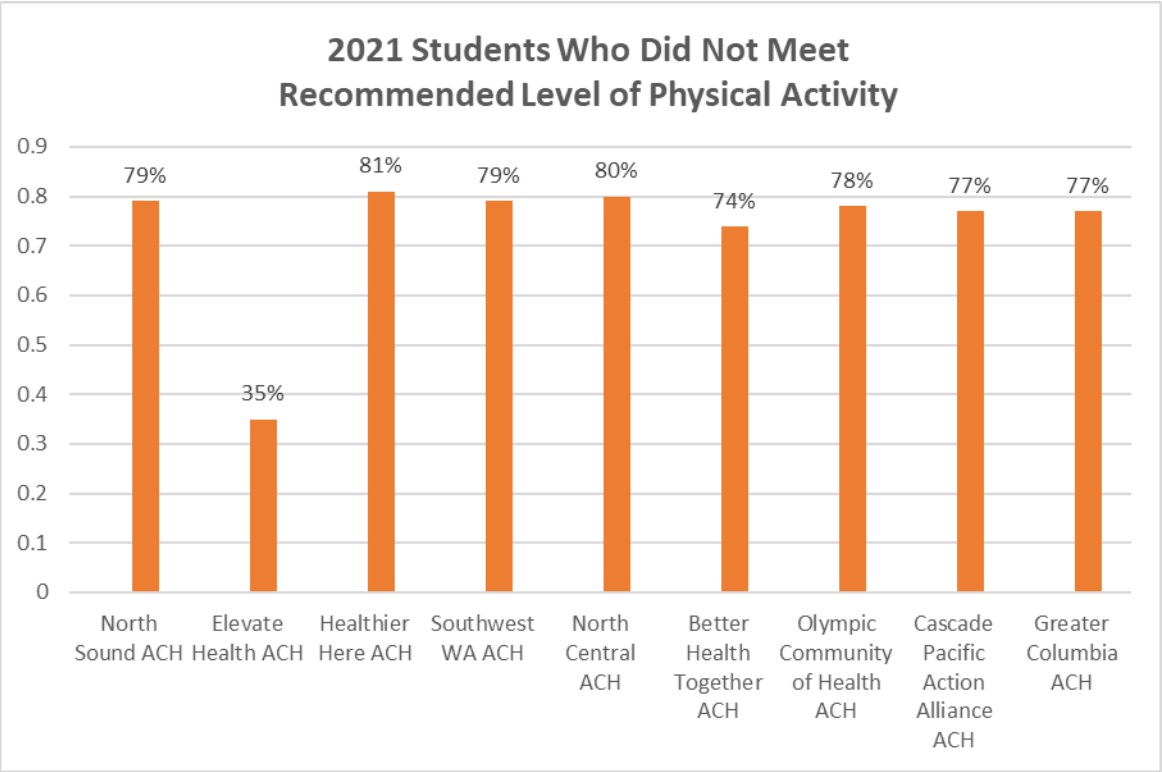


Figure 71: Washington Students Who Did Not Meet Recommended Level of Physical Activity by ACH Region [494]

Spotlight on Montana, Idaho, and Alaska: Healthy Lifestyles

Montana and Idaho

According to 2019-2020 data for children ages 10-17, Montana's 10% obesity rate is the lowest of all states, and Idaho's 13.3% obesity rate is significantly better than the national average of 19.3% for this age group.[495] Montana and Idaho also have the third and fifth lowest obesity rates for high school students, respectively.[496] However, racial and ethnic disparities exist: American Indian/Alaskan Native (AIAN) youth in Montana and Hispanic/Latino youth in both states have significantly higher rates of obesity compared to white students (Figure below). While recent data on rural-urban adolescent obesity rates in Montana and Idaho were not available, national data suggests children living in rural areas

have about 20-25% higher odds for overweight / obesity compared to those living in urban areas.[497] Key informants also expressed concerns about excessive screen time, defined as 3+ hours per school day in front of the TV, computer, phone, social media, etc.[498] The 2021 YRBS reported that 72% of Montana high schools students engaged in excessive screen usage, a number that has exponentially risen in the past few years. Excessive screen time is certainly a contributor to obesity, but it is also associated with higher rates of depression, suicide attempts, marijuana usage, and dangerous driving behaviors among high schoolers.[499]

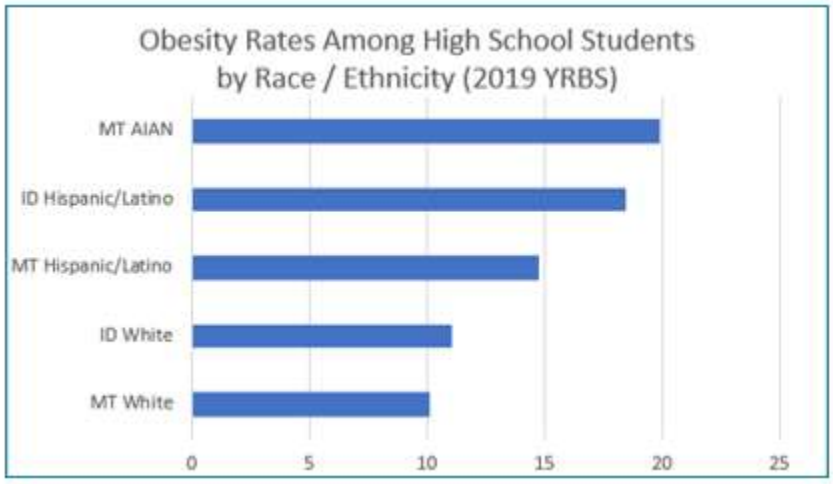


Figure 72: Obesity Rates Among High School Students by Race/Ethnicity [500]

Access to Nutritious Foods

Nearly 40% of survey respondents ranked 'not enough healthy and affordable food' as a top child health concern and 50% identified healthy and affordable food as a community service that is hard or very hard to access. Key informants elaborated on the challenges associated with accessing healthy and nutritious foods. Limited local food stores with nutrient-dense meals, lack of reliable transportation, and the sheer distance to healthy options were cited as barriers to eating healthy. Sixty-two percent of rural Idaho counties and 78% of rural Montana counties are considered to have "low food store access," meaning over 20% of the population in these counties lives 10 or more miles from a supermarket or large grocery store.[501] These challenges often force children and families to rely on the unhealthy foods available at convenience stores. One physician from Ronan, MT shared, "No transportation or safe walking paths to get to the store, no healthy restaurants, so these kids eat what the gas station carries." Another doctor noted, "We live in a food desert…there is one supermarket, but you have to travel by bus to get there. Otherwise, it's gas station food and there's only one of those, too." While Montana and Idaho are large agricultural states, most produce shipped out of state, so for some rural families, accessing fresh fruits and vegetables is impossible. For less remote areas, fresh produce may be available, but it is expensive.

62% percent of rural Idaho counties and 78% of rural Montana counties are considered to have "low food store access," *meaning more than one-fifth of the population in these counties lives 10 or more miles from a supermarket or large grocery store.*

Food Security

In addition to accessibility, the affordability of food is an important component of health. Food security is a measure of the availability of enough safe, nutritious, affordable, and preferred food to have an active and healthy lifestyle.[502] Food

insecurity has a serious negative impact on cognitive development among children, and is linked to poorer school performance, learning, social interaction, and productivity.[503] Key informants pointed to an interplay of determinants – increasing food prices, high cost of living, generational poverty, and centuries of racism – that puts rural families at risk for food insecurity. Shortages of workers and resources due to the COVID-19 pandemic have impacted the supply chains that help move food from ports to plates, causing food prices to exponentially rise over the past two years. By the end of 2021, global food prices were the highest in a decade and Americans were spending 12-36% of their income on food, and BIPOC, low-income, and rural residents were feeling the pinch the most.[504] [505] As one key informant explained, "The price of groceries and daily living has skyrocketed. Even though dairy and beef are local, they have tripled in price. Inflation has led to food insecurity and when families cannot afford healthy food, they turn to unhealthy, processed options." Conversations with key informants suggest that BIPOC living in rural areas are disproportionately burdened by food insecurity because centuries of discrimination have concentrated economic disadvantage along racial/ethnic lines, making it more difficult for Black, Latinx, and American Indian and Alaska Native households to afford healthy food (Figure below). Multiple key informants mentioned that food banks and food pantries are great assets for combatting food insecurity, but they cannot keep up with the widespread community need. In describing challenges faced by Indigenous families, one participant noted the vicious cycle of finances, food, and nutrition outcomes: "Even with college degrees, parents are making minimum wage, so they are forced work one-and-a-half jobs to afford food for their family. There are so many ramifications of this…parents are busy, so they don't have time to cook nutritious foods, which puts their kids at risk for obesity, and obese individuals have lower wages than those who are not obese."

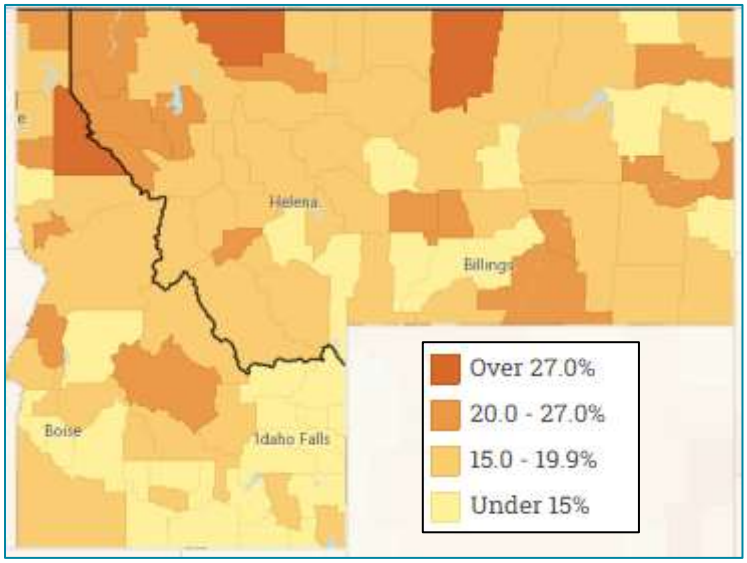


Figure 73: Montana & Idaho Child Food Insecurity Rates by County, 2021 Projections [506]

Physical Activity

Key informants consistently described barriers for youth to engage in physical activity. While Montana and Idaho are known for their great outdoors, accessing the states' green spaces requires transportation, money for gas and appropriate equipment, and the ability to take time off from work or school. Other key informants described challenges for recreating closer to home due to the built environment, such as lack of sidewalks and safe walking paths and proximity to highways and busy roads. The extreme cold temperatures that plague Montana and Idaho half the year, coupled with limited indoor sites for recreation, were also cited as reasons that youth are unable to engage in appropriate levels of physical activity. Due to social and structural influences, Hispanic and Latino youth, especially females, have the highest rate of physical inactivity. [507] [508] Family encouragement is an important factor for increasing a child's activity levels, but oftentimes, kids do not receive the support or modeled behavior from parents, which hinders their motivation to be active. One key informant shared, "We have a lot of kids who are stuck in front of the TV or told to figure it out themselves, so they lack access, motivation, and awareness of the importance of healthy activity…this correlates with negative health outcomes."

Kids with immunodeficiency states are often at an increased risk of acquiring infections in indoor and outdoor community settings. Outdoors, parents of immunocompromised kids often worry about their kids playing in the dirt, on public playgrounds, or accidentally consuming something in the grass; similarly, germs, unsanitary objects, and close social interactions are indoor concerns. Building protective environments and safe places to play is critical for this population; however, one key informant noted that, "There are lots of kids with immunocompromised systems who have been overlooked, there are not resources available to these families. I just want to have a safe place for my child to play that is sanitary!"

Figure 74: Spotlight on Access to Physical Activity for Immunocompromised Children (Source: Key Informant)

Alaska

The Alaska Physical Activity, Nutrition and Obesity Facts Report from 2022:

> Alaskans can prevent many diseases and early deaths if they are physically active, eat a healthy diet and maintain a healthy weight throughout their life. About 1 out of 3 Alaska children is overweight or obese, as are 2 out of 3 adults. Many Alaskans drink too many sugary drinks, eat too few fruits and vegetables, and are not meeting physical activity recommendations. These behaviors and having an unhealthy weight increase their chances of getting serious health conditions, like type 2 diabetes, high blood pressure, high cholesterol and several types of cancer. Overweight and obesity affect individuals of all ages, from all areas of the state, of all racial and ethnic backgrounds, and with all levels of education and income. Both conditions increase the risk of a number of health problems, including chronic diseases, which can lead to reduced quality of life and premature death. No single strategy alone will increase physical activity, improve nutrition nor reduce obesity and its associated health consequences. Meaningful improvements in population-level physical activity and nutrition and a reduction of obesity prevalence will only occur when a set of sustained, comprehensive prevention strategies are implemented by childcare centers, schools, worksites, within the community, the health care sector, private industry, NGOs, governmental agencies, and individual families. These strategies will need to address policy issues; alter where we live, work, play and eat; modify the systems to make the healthy choice the easy choice; and increase the knowledge and change the behaviors of families, children and adults.[509]

Among Alaska high school students:

- 68% of students are in the healthy weight range, but 30% are either overweight or obese
- As with adults, the decrease in healthy weight is due to an increase in obesity prevalence, while overweight prevalence remained the same.
- 82% do not get the recommended 60 minutes of daily physical activity.
- 90% are eating less than the recommended daily servings of fruit and vegetables o 49% drink a sugary drink every day.
- 57% spend 3 or more hours per day using social media, watching TV, or playing video or computer games. o Information about school wellness policies and other school-based support for physical activity and nutrition are included in this report.

Among Alaska students in Kindergarten through 8th grade:

- Among K-8 students in selected school districts, 63% are in the healthy weight range.
- There are disparities in healthy weight; White students are more likely than Alaska Native students to be in the healthy range (69% vs. 57%).

Among Alaska 3-year-olds:

- 38% are either overweight or obese.
- 73% spend an hour or more each day in front of a screen.
- 31% drink a sugary drink every day.
- There are disparities in consumption of sugary drinks; 3-year-olds in Northern and Southwest Alaska are more likely than those in other regions to be given any sugary drinks on a given day (70-74% vs. 14-28%).

More detailed information about Alaska's youngest children can be found in the 2019 publication "Early Childhood Physical Activity, Nutrition and Obesity Data Facts Report".[510]

Priority Area: Economic Opportunity

A Note on Language and Definitions

When discussing economic opportunity, we will speak to its impacts throughout the WAMI region rather than break out state by state as we have in other sections of this assessment.

Poverty Impacts Child Health

Poverty is unequivocally linked with poorer child outcomes, particularly when poverty persists throughout childhood.[511] This relationship is known but bears repeating. Lack of nutritious food, clothing, safe and stable housing, health care, and education—as well as the chronic stress that this lack of resources creates—can, in turn, have deleterious consequences for children's health, academic achievement, social-emotional functioning, and long-term well-being and economic success.[512] Reducing child poverty and promoting economic security and mobility not only improves well-being for children and their families, but also has long-term net benefits for society, such as higher taxes paid, lower health care costs, and less crime. The healthy development of our children—our nation's future workers, leaders, taxpayers, parents, and neighbors—is critical for a thriving region.[513]

In America, nearly 11 million children are poor. That's 1 in 7 kids, who make up almost one-third of all people living in poverty in this country. This number should be unimaginable in one of the world's wealthiest countries, and yet child poverty has remained stubbornly high for decades Across the Organization for Economic Cooperation and Development, which is made up of 37 countries including Denmark, New Zealand, Spain, and the United Kingdom, the United States is consistently ranked as one of the worst in child poverty rates.[514] As the COVID-19 pandemic and resulting recession continue child poverty remains high; 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.[515] This pattern is especially clear for the poorest and youngest children and those who remain in poverty a long time during childhood. [516] 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.[517] It is because of this correlation and hundreds of key informant interviews with adult allies of youth, parents, guardians, and caregivers that Seattle Children's has chosen Economic Opportunity as a priority community health improvement area in 2022.

Poverty is one of the largest indicators of health status. Concerns around economic security, including job and financial security, housing security, and food security, were brought up repeatedly by families, providers, and other stakeholders, and each has a significant effect on child health. Community organizations have seen significantly increased needs during the COVID-19 pandemic, particularly surrounding food assistance, health insurance, as well as rent and housing assistance. Supporting families in navigating the healthcare system and health resources is crucial yet can be stigmatizing and retraumatizing. Many people may not feel comfortable talking about their needs for fear of appearing ungrateful, being judged, undergoing legal repercussions, or retelling their hardships without anything being done to

help them. One key informant reflects, “It’s important that we don’t just collect stories that perpetuate people’s trauma… Talk with your community partners to know what resources are available first.”

We know that more than 4 in 10 children live in a household struggling to meet basic expenses, and between 7 million and 11 million children live in households in which they are unable to eat enough because of the cost.[518] When the pandemic forced schools to shift to distanced and virtual learning, it worsened the barriers to quality education for low-income children[519] and pushed their parents, particularly mothers, to choose between caregiving and employment. [520] Without serious interventions, an economic recovery will leave low-income and marginalized people—and their children—behind. Some 2020 calculations are finding that the child poverty rate has increased dramatically since the onset of the coronavirus crisis.[521] Conversely, in 2022 a comprehensive new analysis shows that child poverty has fallen 59 percent since 1993, with need receding on nearly every front.[522] Some posit that child poverty has fallen in every state, and it has fallen by about the same degree among children who are white, Black, Hispanic and Asian, living with one parent or two, and in native or immigrant households. Deep poverty, a form of especially severe deprivation, has fallen nearly as much.[523]

Readily available community resources to support families in the face of economic security concerns has become even more imperative during the COVID-19 pandemic. Local key informants have expressed the wish for “more coalition building” with “sharing of resources” across organizations whose missions and work overlap, in order to better serve families and communities.

Poverty Percentages

Poverty is measured using the Federal Poverty Line (FPL), which is a national guideline that measures income for individuals and families. In 2022, the Federal Poverty Level for a family of four was $27,750 (100% FPL). [524] America’s child poverty problem is persistent and structural—and in many ways, the official statistics undercount the severity of need across the nation. [525] The official poverty measure, as calculated by the U.S. Census Bureau, has long been criticized as narrow and outdated, in large part because it determines the resources a family needs based on a bare-bones food budget from the 1960s. It does not take into account major expenses such as housing or child care, nor does it account for geographical differences in costs of living.[526]

Because of this recognized failure in capturing the experiences of people facing economic deprivation, another measure, known as the Supplemental Poverty Measure (SPM), was introduced in 2011. That measure counts resources such as nutrition benefits and housing subsidies, along with costs such as taxes and out-of-pocket medical expenses; it also determines a poverty threshold using a more diverse set of necessary expenses—not just food. The SPM isn’t perfect either, but it does help show the impact that government programs can have on reducing poverty.[527]

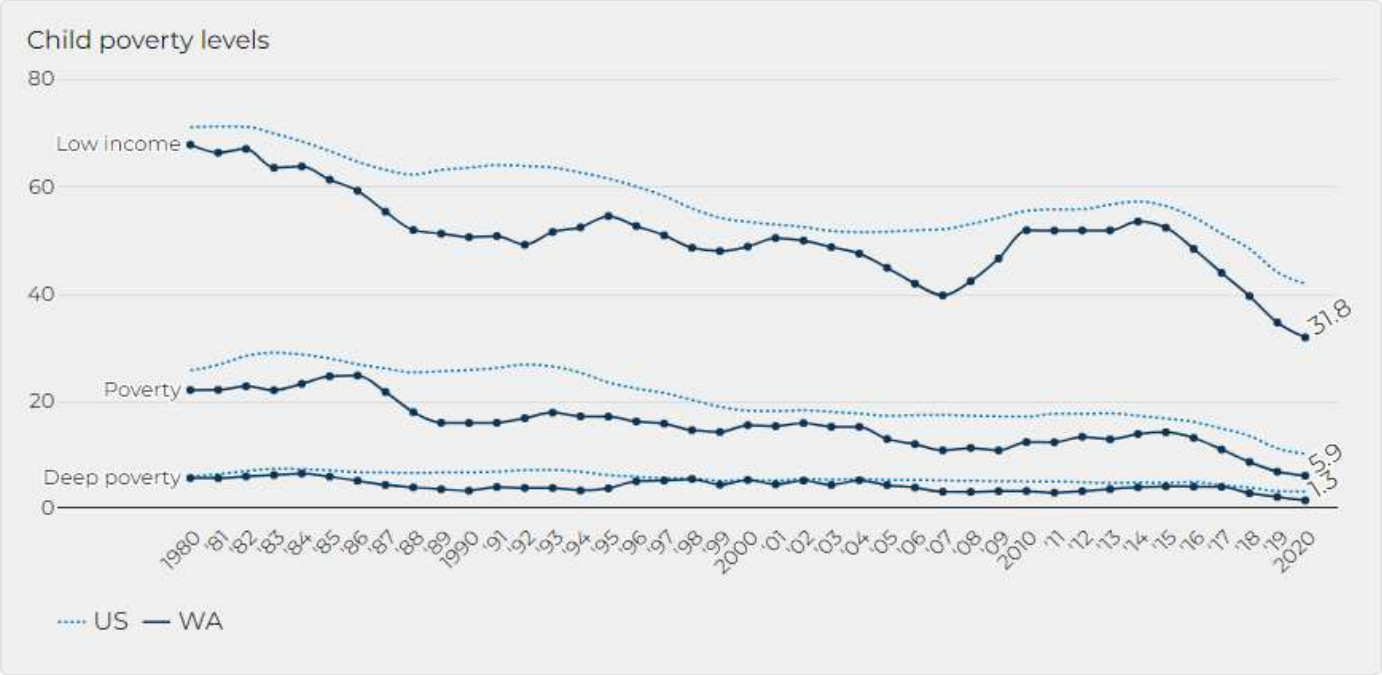


Figure 75: Figure: Washington State trends in child poverty rates measured by Supplemental Poverty Measure, by level

While the effects of living in poverty impact all age groups, children living in poverty are susceptible to long-term impacts on academic achievement, health, and income into adulthood[42]. Children living in poverty are also at a higher risk of developing chronic diseases, poor access to healthcare, food insecurity, accidental injury and mortality, obesity, and other health consequences. [528]

In 2021, approximately 9.5% of individuals in Washington were living in poverty. [529] When looking at ACH regions, percentages of individuals living in poverty varied from 7.60% the Healthier Here ACH to 14.27% in Better Health Together.[530] This indicates that poverty levels vary significantly across the different regions of Washington.

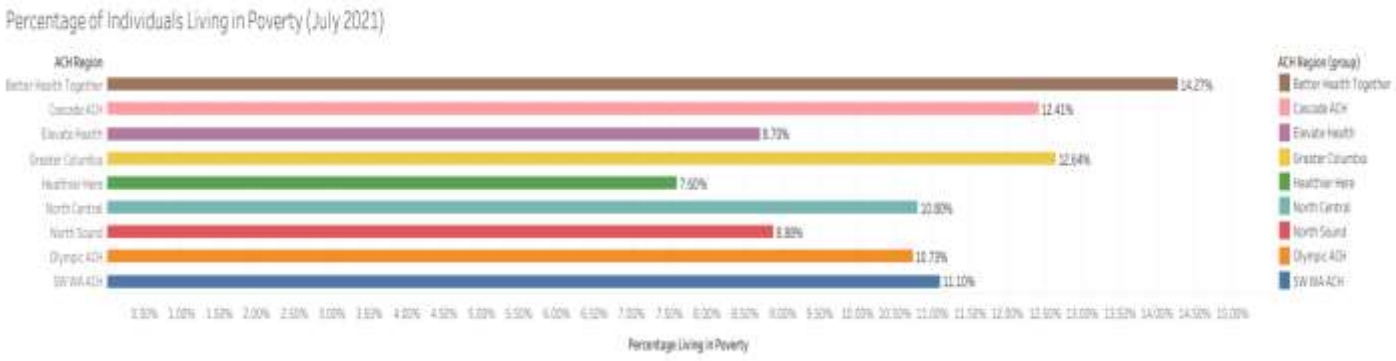


Figure 76: Percentage of Individuals Living in Poverty by ACH Region (2021) [531]

About 10% of the population in Washington state lives in rural areas.[532] 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.[533] 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.[534] During that same time period, 24.2% of residents from rural communities completed college, compared to 35.6% of residents living in urban areas.[535] 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.[536]

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.[537] 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.[538]

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).[539]

Washington state had one of the lowest poverty rates among children in the country, ranking 17th among all states in 2017.[540] 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.[541] 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).[542]

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.[543] The percentage of individuals living in poverty in 2017 was higher in rural Washington (15.9%) than in urban Washington (10.5%).[544]

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.[545] 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.[546] 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.[547] Creating environments for kids to thrive requires policies that improve the economic well-being of parents and children.[548]

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.[549]

As discussed in earlier sections of this CHA, 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.[550] 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.[551] 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.[552]

Housing Affordability

Community Context and Socioeconomic Factors

Housing has a profound impact on children's lives and can shape their future economic and physical well-being.[97] The massive influx of people moving to Montana and Idaho in the last decade, and especially in the last few years, has caused the cost of housing to soar and the availability of housing to plummet. Because of this, housing was identified as one of the biggest challenges for rural kids and families in both key informant interviews and in the community health survey. A key informant shared a personal account of the housing burden, "My rent skyrocketed, so my son and I moved in with my parents. But then they decided to sell their house and move out of state. I couldn't afford any other housing in town, so I had no other option than to become a travel nurse." Participants blamed this housing crunch on remote workers from California and Washington driving up prices with their big-city salaries, AirBnB and VRBO short-term rentals eating up rental supply, and rising building costs. These trends are particularly pronounced in destination spots like Flathead, Gallatin, Blaine, and Madison Counties (home to Kalispell, Bozeman, Sun Valley, and Idaho Falls, respectively), but has spilled over to many of the more remote areas as well. Another key informant shared, "I bought my house four years ago and it has tripled in price. It is not big enough for my family of four, but we cannot afford to move anywhere else in the state."

> *"People who tend lawns and stock grocery store shelves can't afford to live in the community as renters and they are being shut out as homeowners, too. Research shows that homeowners are more likely to vote, are more involved in their community, more involved in their schools, more involved in their neighborhoods. The housing crisis is changing the community."*

While housing prices are rising, wages are not keeping pace. One key informant explained, "For tech folks, our housing prices looked so cheap, so it became attractive for folks to move here during Covid. The median house price skyrocketed, the cost of living is exorbitant, but our wages have not gone up at the same rate. The local economy can't keep up with out-of-towners' wages." Housing is typically one of the largest expenses that families face, but for low-income households, housing typically consumes a larger portion of their income. Figure 78 below shows children living in households with a high housing cost burden, defined as the share of kids living in homes where more than 30% of the families' monthly income is spent on rent, mortgage, insurance, or other housing-related expenses.[553] [554] Low-income households are disproportionately burdened by housing costs and therefore, are less likely to be able to meet all of their other basic needs. Per key informants, finding adequate and affordable housing, especially for low-income families, is extremely challenging. "We have no affordable, quality housing for anybody. You have to have a lot a lot of money to find a reasonable home. If you are low-income, there are just no options. I know one family that has six kids, two parents, and they live in a 3-bedroom apartment. They are breaking the housing occupancy codes but they cannot afford a home to fit the entire family." In addition to housing affordability and availability, key informants expressed concerns about housing quality, mentioning lead, mold, non-functioning appliances, and unethical landlords. Children who experience poor housing conditions have worse psychological health initially and over time, and higher baseline symptoms of depression, anxiety, and aggression from elementary school through young adulthood. [555]
Numerous key informants referenced the link between the declining stock of quality, affordable housing, and surging rates of poverty and houselessness. "Wages do not support the rental prices, so people are being kicked out and the unhoused population is growing. There are so many people on waitlists for low-income housing – it is out-of-control and out of *their* control." Due to longstanding racism and discrimination, minority groups and those with marginalized

identities are more likely to be unhoused. As such, African Americans, Native Americans, Pacific Islanders, and people with mental health struggles are considerably overrepresented among the unhoused population compared to the overall U.S. population. [556] A key informant described this situation: "I am trying to explain to decision makers why housing and mental health are related. If you have someone with a mental health crisis who seeks care, what happens when they come out and they don't have housing? The problem is exacerbated. When people have their basic needs met, they may still have mental health issues, but it becomes easier to support them."

Rural Montana and Idaho are experiencing extreme population growth, which is incrementally diversifying the racial, ethnic, and linguistic composition of the community. The growth is also causing drastic increases in housing prices, but wages are not keeping up; this has led to a housing crisis in much of Montana and Idaho and widespread economic instability among residents. Community members are also concerned about ongoing racism and discrimination experienced by certain people, and the long-term consequences of learning losses and political divisiveness in the wake of the COVID-19 pandemic.

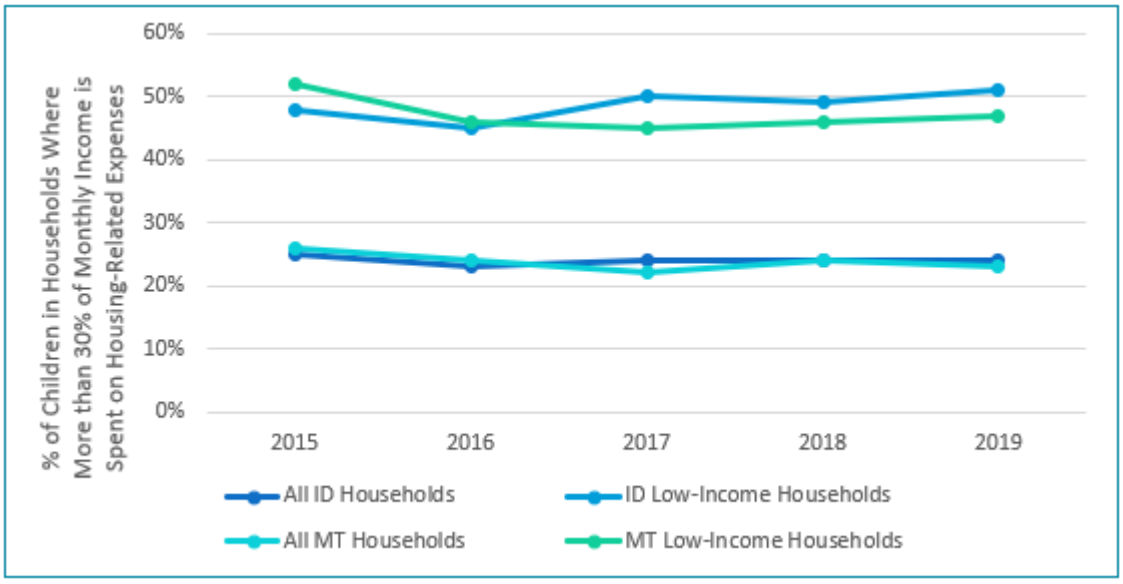


Figure 77: Percent of MT & ID Children Living in Households with a High Housing Cost Burden - Comparison of Children in Low-Income Households v. All Households, 2015-2019 (Source: KIDS COUNT) [557]

In Alaska, the situation is equally dire. Across Alaska, there is a shortage of rental homes affordable and available to extremely low income (ELI) households, whose incomes are at or below the poverty guideline or 30% of their area median income. Many of these households are severely cost burdened, spending more than half of their income on housing. Severely cost burdened poor households are more likely than other renters to sacrifice other necessities like healthy food and healthcare to pay the rent, and to experience unstable housing situations like evictions.

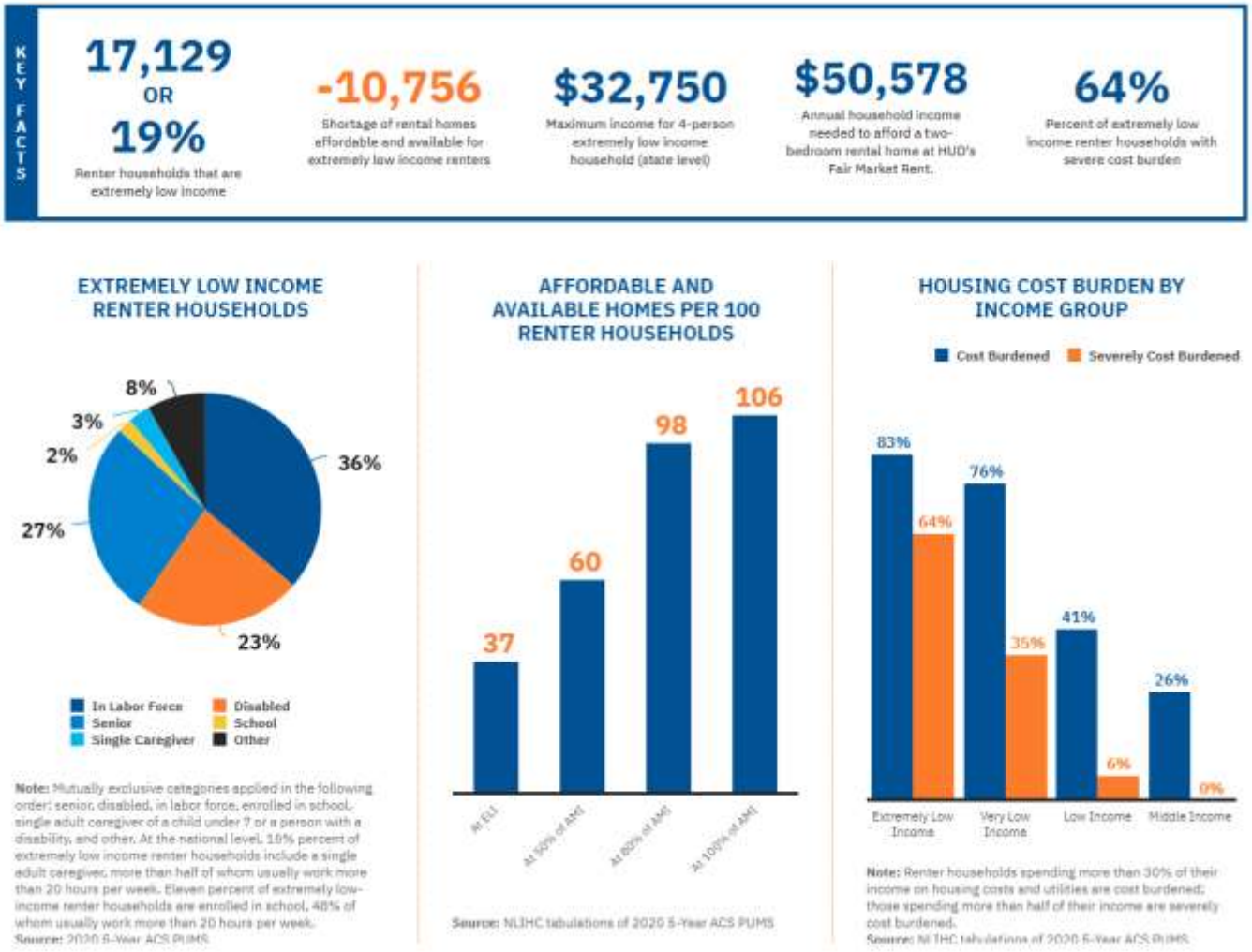


Figure 78: Key facts, Alaska housing burden [558]

According to the U.S. Department of Housing and Urban Development, affordable housing is generally defined as housing where the resident is paying no more than 30% of gross income for housing costs, including utilities. [559] The percentage of owner-occupied housing units varies significantly across the state, with a state average of 63% of individuals owning a home.[560] The county with the highest percentage of housing ownership is Wahkiakum County at 89%, and the county with the lowest housing ownership is Whitman County at 44%.[561]

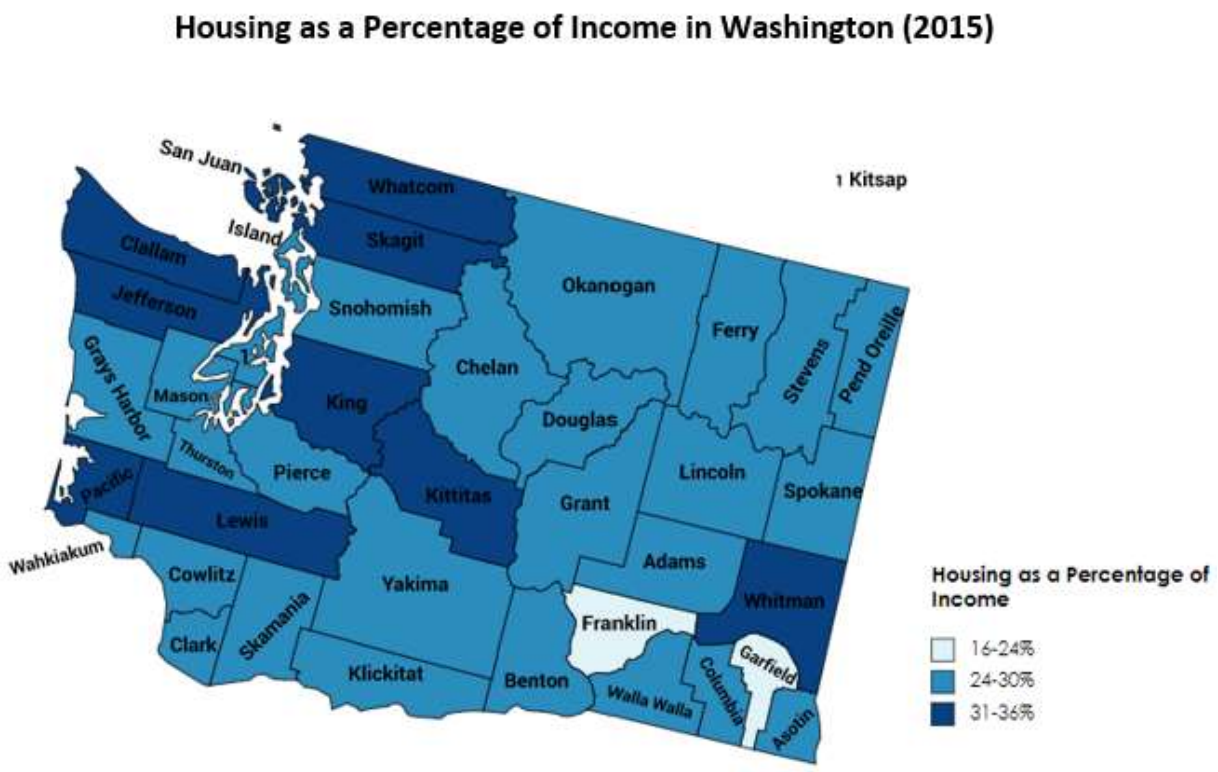


Figure 79: Housing as a Percentage of income in Washington by County[562]

In 2015, Franklin and Garfield Counties spent the least on housing on average.[563] A majority of counties in Washington (27 counties) spent 30% or less on housing, which is deemed affordable. [564] There were 10 counties, that spent above this threshold, with the most expensive county being San Juan County at 34% of income. [565] While this map represents county averages, it is important to note that there is variability within these different areas. For example, there are residents within King County who spend less than 24% of income on housing, while others spend more than 87%.[566] Spending a higher percentage of income on housing may make it challenging to prioritize other basic needs such as transportation, food, and medical care. In 2019, 29% of children in Washington lived in households with a high housing cost burden.[567]

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.[568] 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. [569]

Also, children who are homeless are more likely to have chronic diseases and malnutrition, psychosocial and developmental challenges, interruptions in education, increased rates of infectious illness, increased prevalence and severity of asthma, and higher rates of accidents and injuries. Compounding stress of homelessness before and after birth is associated with a 99% increased risk of fair or poor child health, a 59% increased risk for developmental problems, and a 42% increase in child hospitalizations.[570] In King County in 2019, the most common self-reported cause of homelessness was job loss, followed by substance use, and then eviction. Among admitted patients at Seattle Children's Hospital, universal screening for housing security is not completed in all hospital units. Enacting universal screening for housing insecurity and formalizing partnerships between Seattle Children's and shelters and organizations could be a starting point for addressing housing insecurity among local children and families. To read more about what Seattle Children's is doing on screening for and addressing social determinants of health such as housing, please read about our screening pilot to scale in the food insecurity section of this report.

Transportation Affordability

The cost of transportation is another important measure to consider when discussing the cost of living in different communities. Affordable housing is typically the center of these discussions; however, it is vital to account for the transportation costs associated with various home locations. On average, transportation is the second largest household expenditure category after housing. [571] The Center for Housing and Policy has found that the tradeoff in housing savings gained at the cost of transportation is eroding, with 77 cents being spent on transportation for every dollar spent on housing. [572]

Variability in housing and transportation costs can contribute to health disparities. Communities and neighborhoods that are walkable and have greater access to public transportation allow residents to access employment and necessities with less dependence on cars. [573] However, these walkable areas tend to have higher housing costs, which may limit accessibility to lower-income residents. [574]

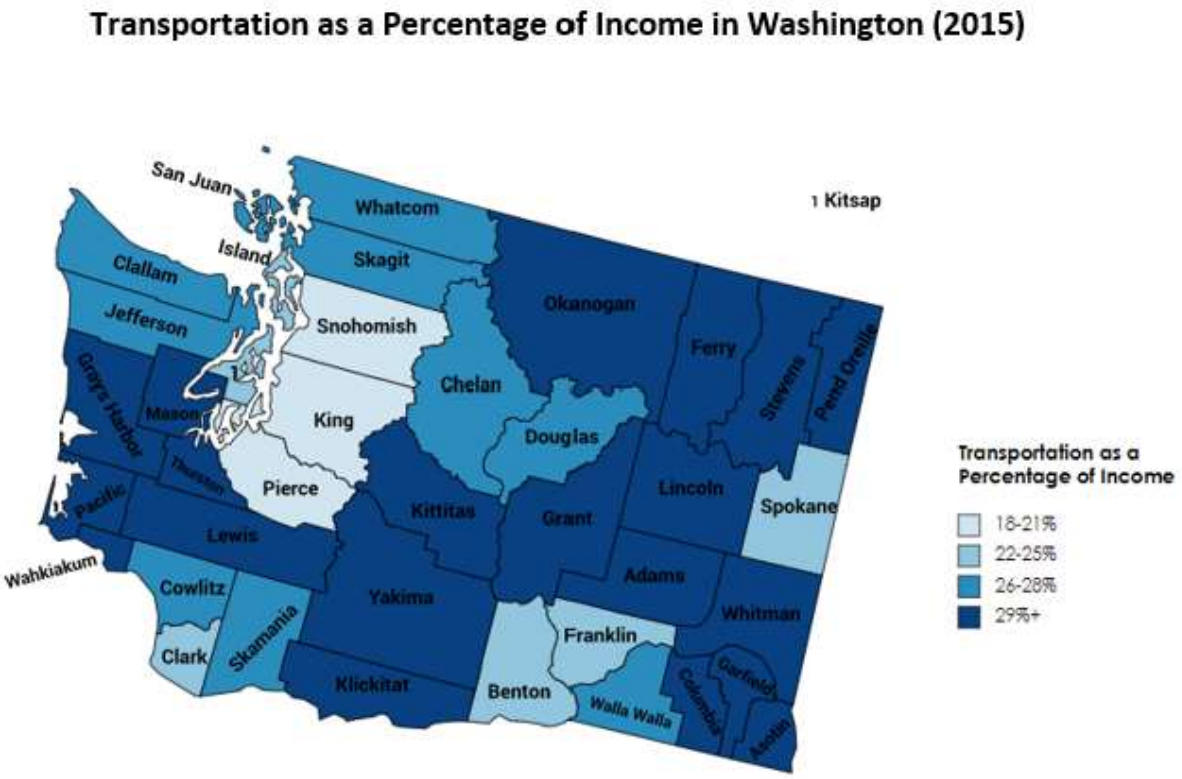


Figure 80: Transportation as a percentage of Income in Washington by County [575]

In 2015, Pierce, King, and Snohomish Counties spent the least on transportation on average. [576]These urban counties may have better access to efficient modes of transportation, such as public transportation. Rural counties in Washington spent more income on transportation on average, with many counties spending above 29% of income.[577] The most expensive county in terms of transportation was Ferry County at 36% of income, while the least expensive county was King County at 19%.[578] While this map represents county averages, it is important to note that there is variability within these different areas. For example, there are residents within King County who spend as little as 8-12% of income on transportation, while others spend 26-29%.[579]

Distance & Transportation

The vastness and remote nature of rural counties means that rural residents rely on transportation to access appropriate and well-coordinated healthcare, yet unreliable personal vehicles and limited public transit were listed as significant challenges by key informants. “Transportation is an issue – a lot of patients don’t have working cars and the public transportation system is not great, so they are very limited in terms of receiving and accessing care. So many patients miss appointments simply because they don’t have a way to get here,” shared one key informant. Key informants also discussed the added time commitment for parents to get children to the doctors: “Taking kids to medical appointments can be a half or full day event. For some parents, they don’t have the luxury of skipping a day of work because of financial repercussions and most of our clinics are not open on the weekends.” Another key informant described unique transportation-related barriers for refugees and immigrants who are new to the United States: “When they get here, they don’t have a car. Transportation is hard, and the bus is unreliable. Can you imagine trying to go to English language classes, then work, then to the grocery store, then picking up your kid from school and taking them to the doctor all via bus?” Several people noted that these access challenges associated with distance and transportation are made more acute by severe temperatures, winter snowfall, and poor road conditions that are common throughout Eastern Washington, almost all of Alaska and rural Montana and Idaho.

“Some of my patients travel from 5-6 hours away because that is truly the closest option to home. But it’s even difficult to get patients who live close by to their appointments because they face so many transportation barriers that are exacerbated by their socioeconomic status.”

Education

Education is an important modifiable social determinant of health, and key informants commonly listed it as a challenge. Length and quality of education predict employment and income, which influence living situation, access to healthcare, and ultimately, health status and life expectancy.[106] Because of this relationship, high school graduation rate is an important predictor of health. There are drastic racial/ethnic disparities in the on time high school graduation rate, especially among American Indian students who face disproportionate educational barriers and are 2-3 times less likely to graduate on time compared to white students. Lower educational attainment includes poor grades and test scores, however, health-risk behaviors such as sexual initiation, violence, and substance use are also heavily associated. Academic success among youth is an outstanding measure of overall well-being and primary predictor and determinant of health outcomes overall. Schools and academic settings play a crucial role in promoting health and safety to youth and establishing suitable lifelong healthy behaviors. Prior research has shown that school health programs can help reduce the prevalence of youth health risk behaviors, resulting to a positive effect on academic performance.[580]

High School On-Time Graduation Rate

According to the Washington Office of Superintendent of Public Instruction, 84,828 students were enrolled in Washington State high schools. “For the class of 2021, 82.5% of students graduated, 8% were continuing, and 9.5% of student’s dropout. Graduation rates are based on a cohort that is made up of all students who start 9th grade together. A student that graduates high school is more likely to earn a higher income, less likely to be incarcerated, and have greater economic mobility across generations.”[581]

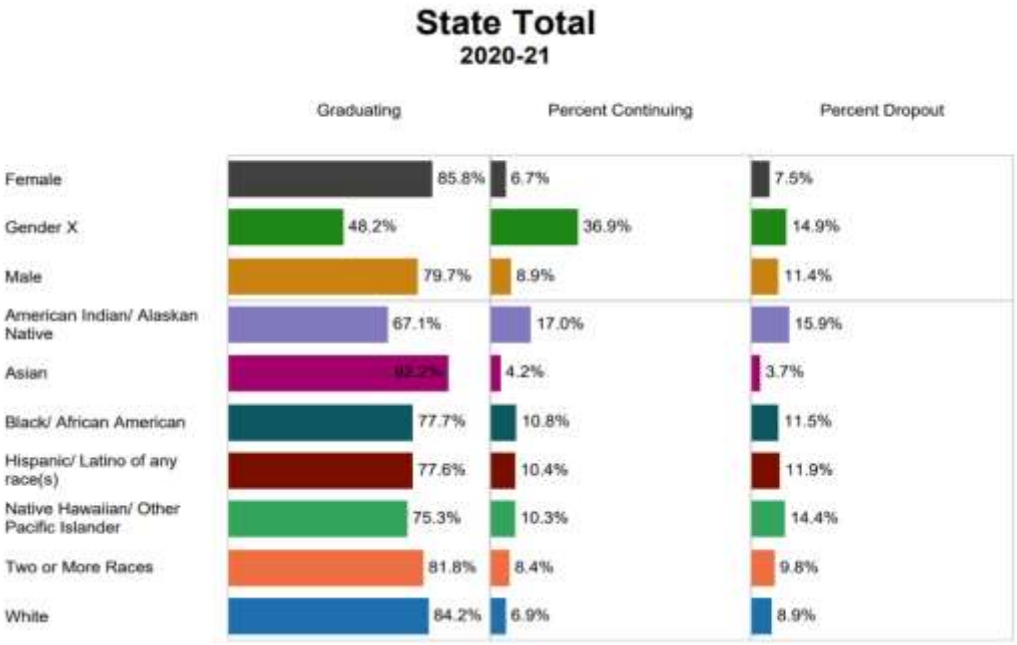


Figure 81: Washington Graduation Rates by Federal Race and Ethnicity (2020-2021) [582]

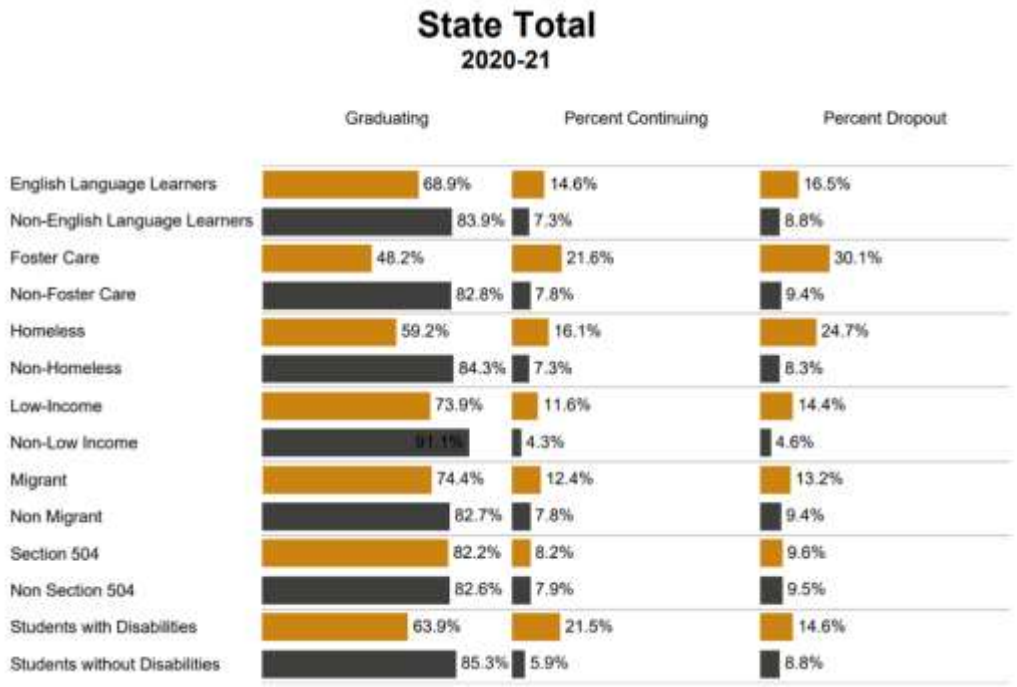


Figure 82: Washington Graduation Rates by Program and Characteristic (2020-2021) [583]

Again, from the Public Office of the Superintendent, "Washington state graduation rates for the class of 2021 were lowest for American Indian/Alaskan Native (67.1%) and Native Hawaiian/Other Pacific Islander (75.3%) students. Students who are English Language Learners, in Foster Care, Homeless and have disabilities also have shown low graduation rates. Dropout rates are inversely associated with characteristics similar to graduation rates, where Foster Care (30.1%) and Homeless (24.7%) students have the highest rates."[584] The 2020-2021 high school graduation rate in

rural Montana was 83%, slightly below the 90% rate among urban counties; these rates have remained relatively stable over the past four years.[585] The inverse was true in Idaho from 2015-2019: on average, 91% of students in rural counties completed high school on-time compared to 88% in urban counties (2020-2021 data was not available for Idaho).[586] In Alaska, public schools achieve an average graduation rate of 79% (2022), up from the 76% in 2016. [587]

Participants expressed concerns over the quality of school systems, noting that schools in under-resourced and more rural areas were not as good as those in more affluent areas. They also worried about the long-term negative consequences of school closures during the pandemic. Schooling provides essential learning and when schools were forced to close, students were deprived of critical opportunities for growth and development. The negative consequences are exacerbated for underprivileged and disadvantaged students. One key informant noted, "Some families are struggling even more now, so kids have to help out to contribute to the family income. Education has never been a huge priority and absenteeism has always been an issue – now that's gotten even worse." The *perception* of having low educational achievement can be a detrimental barrier for young people as well. For example, one social worker noted, "I have clients that are extremely intelligent, but because of some life event – like an unplanned teen pregnancy or having to help at their family businesses – they were not able to get their degrees. They now have low confidence and don't think they are smart enough to ever get their GED or go to college."

According to key informants, there are certain groups that require additional educational support but do not often get it. They described the importance of specifically addressing the needs of non-native English speakers because language-of-instruction issues negatively impact the educational opportunities for refugees and children who communicate in a language other than English. One interviewee shared, "There are a few English-as-a-second-language teachers in our county, but in most places, students don't have access to these services. Kids often get placed in classes based on age and are expected to do the same level of work as native English speakers. Navigating our school system and education in a different language is extremely difficult." According to refugee youth, language barriers can make them feel isolated, anti-social, and hopeless, which can lead to depression. Struggling with speaking and comprehension, while trying to navigate a public school system that is not set up to accommodate their needs, also makes it difficult for refugees to make friends and causes them to be a target for bullying.[588] "There is a lot of ignorance in our schools. The teachers just put all the students [who use a language other than English] at one table and they are further segregated from their peers. There is no malintent, but it still creates significant social and educational harms."

"There are a few English-as-a-second-language teachers in our county, but in most places, students don't have access to these services. Kids often get placed in classes based on age and are expected to do the same level of work as native English speakers. Navigating our school system and education in a different language is extremely difficult."

Early Childhood Education

Today, American families face two intertwined crises. The first is what Harvard economist Claudia Goldin calls "America's first female recession," with women leaving the workforce in record numbers as the nation continues to battle covid-19. The second is a lack of access to affordable, high-quality childcare, which both makes it harder for parents to work, as well as creates an achievement gap that becomes apparent as early as kindergarten. Decades of research affirm that early-childhood education programs can boost cognitive development, improve academic achievement, and spur long-term educational attainment, thus reducing the academic achievement and attainment

gaps. The National Bureau of Economic Research, the Education Commission of the States, and public health studies cited by the Centers for Disease Control and Prevention report the positive and long-term effects of early child care and prekindergarten on high school graduation rates, college attendance, and adulthood self-control and self-esteem. [589] In the face of historic setbacks to female participation in the workforce, the issues of access to affordable, high-quality childcare have never been more urgent — not only for working mothers and their families, but for our economy at large. Universal childcare and prekindergarten would alleviate these pressures while contributing to the nation's economic resilience and the likelihood of academic success for its students.

According to the US Department of Health and Human Services, "Prekindergarten education programs have the potential to improve school readiness, particularly among high-risk children. Alongside the expansion of state-funded programs, Head Start programs have greatly increased access to preschool. Head Start is a federal program that promotes school readiness for infants, toddlers, and preschool-aged children from low-income families. These programs are delivered in a variety of settings, including centers, family childcare, and the home. These programs also work to engage parents and caregivers with a focus on wellbeing. There are multiple programs that reflect the needs of specific populations within the community, including traditional Head Start, Early Head Start, which is for children under 3 years old, American Indian and Alaska Native Head Start, and Migrant and Seasonal Head Start. Despite the increase in access, many children, especially 3-year-olds, continue to be left out, exacerbating socioeconomic differences in educational achievement." [590]

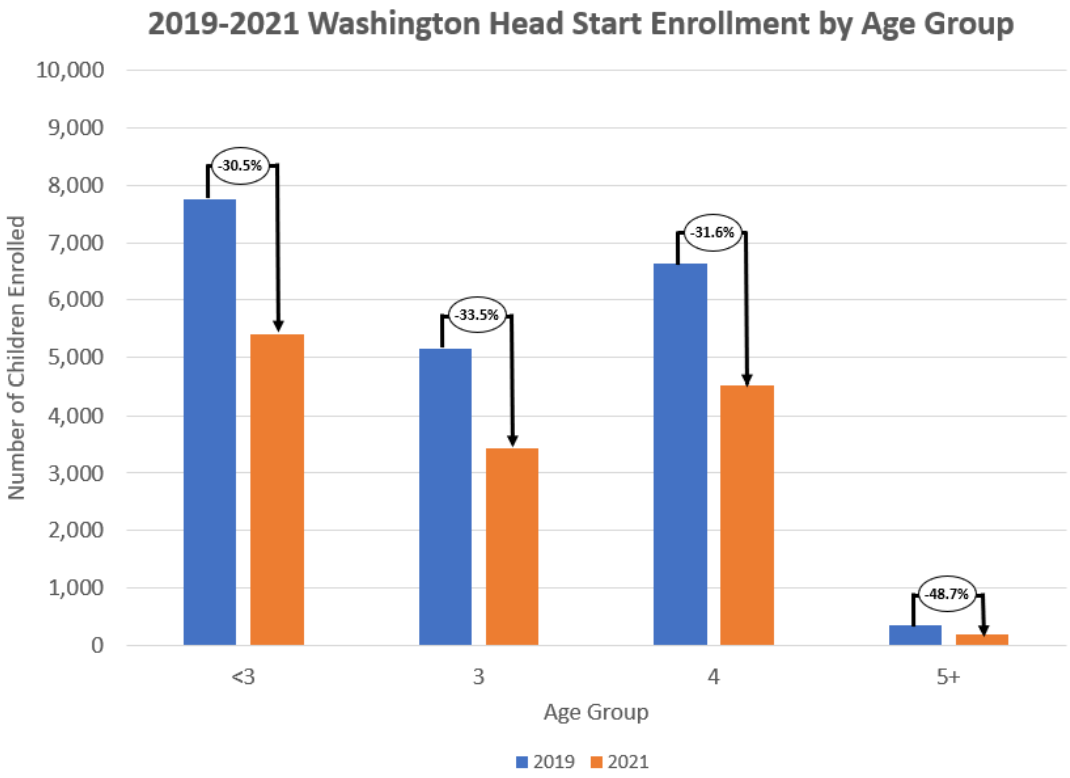


Figure 83: Washington Head Start Enrollment by Age Group (2019-2020)[591]

Head Start enrollment by age group analysis from KIDS COUNT posits "from 2019 to 2021, there has been a 32.9% decrease in the total number of children enrolled in Head Start programs in Washington State. This decrease could be attributed to the COVID-19 pandemic and stay-at-home orders that limit in person activities. While all age groups

experienced a similar percent decrease of around 30%, the 5+ age group experienced the largest percent decrease at 48.75" [592]

Income & Economic Stability

A pediatric community health assessment in 2022 in a chapter on Economic Security would be considered incomplete without an analysis of the income gap, especially that stratified by race. Economic inequality has expanded over the past years because of the COVID-19 pandemic, shutting the windows of stability and opportunity for millions of Americans. In communities of color, this growing inequality has manifested itself through structural, systemic and institutional factors that are driving health and income inequities for those who were already struggling pre-COVID. Seattle and other urban cities in WAMI tout a healthy economy and Seattle is one of the fastest growing major cities in the US. But the economic prosperity and wealth that has come from these two points has not been spread out equally. While Seattle has a rich, growing and diverse population and a culture that appears progressive, people and communities of color remain on the margins of the rising economy. When comparing Seattle's White residents to residents of color, we see massive income and wealth gaps, racially disparate unemployment rates and higher rates of cost-burdened renters. As in most major U.S. cities, inequality in urban areas in WAMI has been ingrained in the economic and social growth since their city's inceptions.[593] In a May, 2022 article in the Seattle Times, columnist Gene Balk writes, "When you combine the income of every household in Seattle, it added up to a staggering $46.3 billion in 2020, according to new census data. Of course, some households took in a much bigger share of that money than others. The most affluent 20% of Seattle households — roughly 69,000 of the city's 344,600 households — had an average income of $345,000 in 2020. The least affluent 69,000 households averaged about $18,800 — an extremely small amount in a city with one of the highest costs of living. That means the top 20% had an average household income about 18 times higher than the bottom 20%. Seattle's income gap between top and bottom income groups, while big, is far from the worst. Among the 50 most-populous U.S. cities, Seattle ranked 20th. One factor keeping Seattle's income gap in check is the city's famously high minimum wage. Seattle passed its wage law in 2014, which gradually increased the minimum wage citywide. It's now as high as $17.27 per hour for some workers — the highest in the nation. The average income for the lowest 20% of households in Seattle ($18,800) is the third-highest among the 50 largest U.S. cities. Despite a high minimum wage, Seattle still had a large wage gap creating income disparities worth mentioning here. In 2020, the median household income in Washington was $77,006 [594] while the median household income in 2020 in the United States was $67,521. [595] While the median household income in Washington was above the national median, there are racial disparities in income. From 2015 to 2019, Hispanic households averaged $55,618 per year, while Asian households averaged $110,405. [596]

Economic stability is the connection between financial resources (income, socioeconomic status, affordable cost of living) and health,[102] and it was one of the most frequent themes that emerged in conversations with key informants. The ever-increasing price of housing combined with stagnant wages makes it difficult for parents/caregivers to find a job that provides sufficient income to pay rent and afford other necessary expenses for their families. "Our community is very poor. Poverty affects almost all of my patients, which is both a cause of health problems and an impediment for providing good care." Poverty is a complex and insidious determinant of health caused by a web of social and systemic factors. In describing some of the social challenges faced by rural youth and families, one key informant said, "Socioeconomic status and housing and income and healthcare are all related. Poverty is our constant companion, and it is exacerbated by low economic vitality, housing, food insecurity, education, and high levels of trauma." Socioeconomic status is a key factor influencing quality of life, across the life span, for children, youth, and families. Lower levels of socioeconomic status are associated with higher infant mortality, mental and behavioral difficulties, stressful adolescent experiences, decreased educational success, and is a reliable predictor of child abuse and neglect. [597] Further, the persistent, cyclical nature of poverty can significantly impact health and health outcomes for generations to come. One

key informant explained, “The lifetime cycle of poverty is so difficult to break. Families are looked down upon as this is something they did to themselves but it’s not their fault. Parents begin to think ‘I am less than…’”

Montana and Idaho have lower median household income estimates compared to the United States, but fewer people in these states experience poverty compared to national averages in almost all age groups. However, when poverty rates are disaggregated by rurality, the disparities become evident. In Idaho, the nine counties with the highest poverty rates among those aged 0-17 are rural counties, while the nine counties with the lowest poverty rates in this age group are micropolitan and metropolitan areas. In Montana, the micropolitan and metropolitan counties are consistently clustered towards the top with the lowest poverty rates for children 0-17. [598] There is also a correlation between race and poverty. American Indian youth in rural Montana have an increased risk of poverty, with the four majority-AIAN counties having the first, fourth, seventh, and fourteenth highest percentage of people under 18 in poverty. [599]

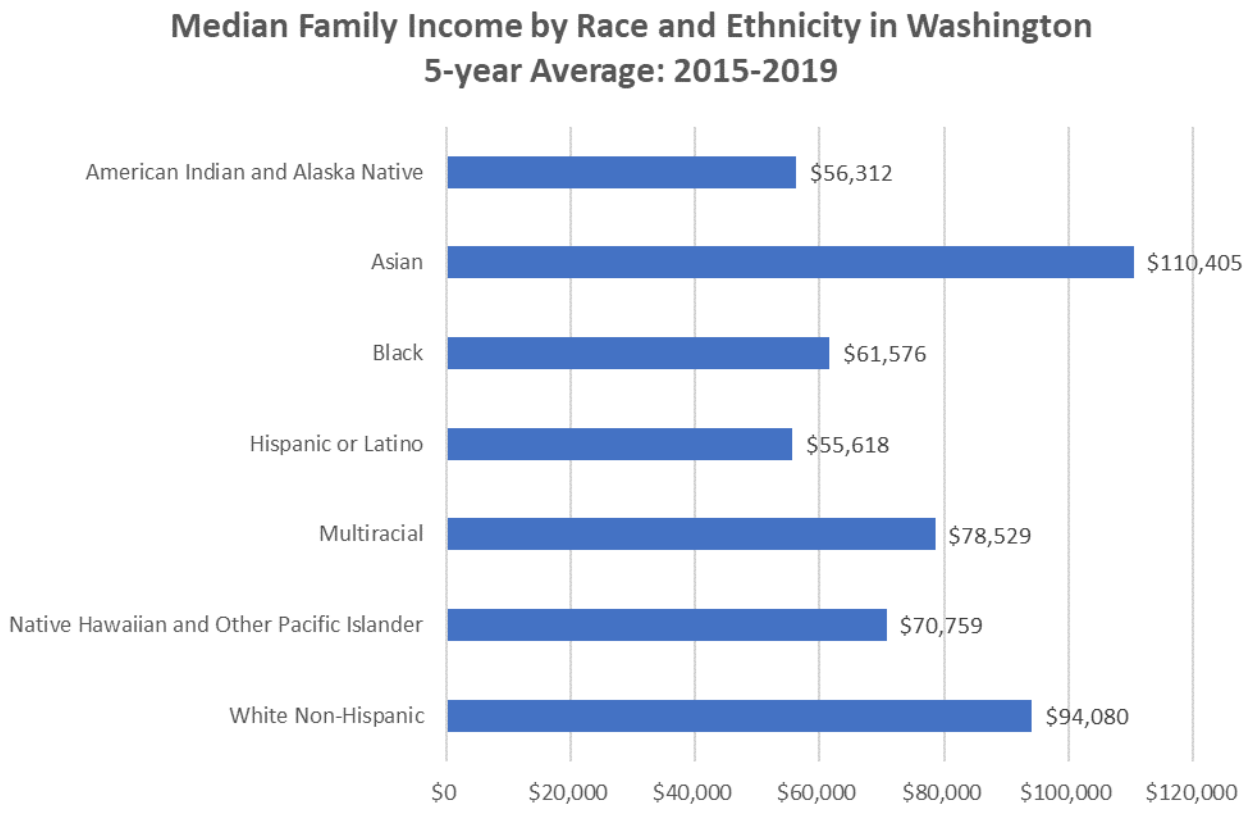


Figure 84: Washington Median Family Income by Race and Ethnicity (2015-2019) [600]

Housing & Houselessness by County

Homelessness is closely related to the decline in physical and mental health. Higher rates of health problems are present for homeless persons, which include HIV infection, alcohol and drug abuse, mental illness, tuberculosis, and other conditions. [601] Other health problems result from various factors such as barriers to care, lack of access to adequate food and protection, and limited resources and social services. [602]

Short-term trauma of homelessness can significantly impact a child’s future development. Children who experience homelessness have immediate, long-term, and considerably higher rates of emotional and behavioral health problems. Children struggle with self-esteem issues, leading them to be at risk for substance use, suicide, and other negative results. This also includes academic difficulties that include below-grade level reading, high rate of learning disabilities,

poor school attendance, and failure to advance to the next grade or graduate. Four out of five children who have experienced homelessness have been exposed to at least one severe violent event by age 12. [603]

Across the nation, there are more than 1.26 million children and youth experiencing homelessness. Students experiencing homelessness are more likely to have academic problems and more likely to drop out of school when compared to their housed peers. Homeless students have higher absentee rates, lower achievement test scores, and less likely to engage in school. [604]

School Year	Number of Students Experiencing Homelessness
2014–15	33,642
2015–16	37,661
2016–17	39,189
2017–18	40,085
2018–19	39,888
2019–20	36,996
2020–21	32,335

Figure 85: Washington Numeric Change in Pre-K – 12th Grade Students Experiencing Homelessness (2014-2021) [605]

Since 2001, there has been an increase in children and youth experiencing homelessness in Washington State. Due to the implications of COVID-19 school closures, school districts had difficulty identifying students who were experiencing homelessness during the 2020-2021 school year. This explains the significant decline of students experiencing homelessness, however, there has been a declining trend since the peak 2017-18 school year (40,085).[606]

Student Group	Number of Students Experiencing Homelessness	Total Student Population	Percent of State Population Experiencing Homelessness
All Students	32,335	1,145,848	2.8%
Gender			
Male	16,323	592,210	2.7%
Female	15,894	552,128	2.9%
Gender X	208	2,484	8.4%
Race/Ethnicity			
American Indian/ Alaskan Native	981	15,428	6.4%
Asian	667	94,381	0.7%
Black/African American	3,089	53,871	5.7%
Hispanic/Latino of any race(s)	11,581	283,550	4.1%
Native Hawaiian/Other Pacific Islander	995	14,744	6.7%
Two or More Races	3,244	100,579	3.2%
White	11,794	584,559	2.0%
Student Group			
Unaccompanied Youth	4,444	5,462	81.4%
Students with Disabilities	7,164	171,340	4.2%
English Learners	6,799	139,094	4.9%

Figure 86: Washington Student Enrollment by Student Group (2020-2021) [607]

During the 2020-21 school year, 2.8% of the total student population experienced homelessness within Washington State. Females (2.9%) and Gender X (8.4%) students experienced higher percentages of homelessness compared to Male students. American Indian/Alaskan Native (6.4%), Black/African American (5.7%), and Native Hawaiian/Other Pacific Islander (6.7%) students were the top percentages for Race/Ethnic student groups. Unaccompanied Youth (81.4%) had the highest percentages of students experiencing homelessness overall.[608]

Employment

Individuals who are unemployed experience worse health outcomes and higher mortality rates than those who are employed. [609] Unemployment can lead to increased risk of unhealthy behaviors related to alcohol and tobacco consumption, diet, and exercise, which can lead to further health issues. [610]Additionally, access to health care may be limited for those who are unemployed because employer-sponsored health insurance is the most common source of health insurance. [611]

In March of 2022, Washington had an unemployment rate of 4.3%, with the highest rate being in Ferry County at 10.6%, and the lowest rate being in King County at 2.5%. [612]These rates have improved since 2020, when the unemployment rate reached 8.4% across the state, due to the COVID-19 pandemic. [613] In 2020, the highest county unemployment rate reached 11.7% in Ferry County, with 5 other counties above 10%.[614]

The hardships of unemployment can have long-term impacts on child wellbeing and development due to reduced economic resources and elevated stress. [615]

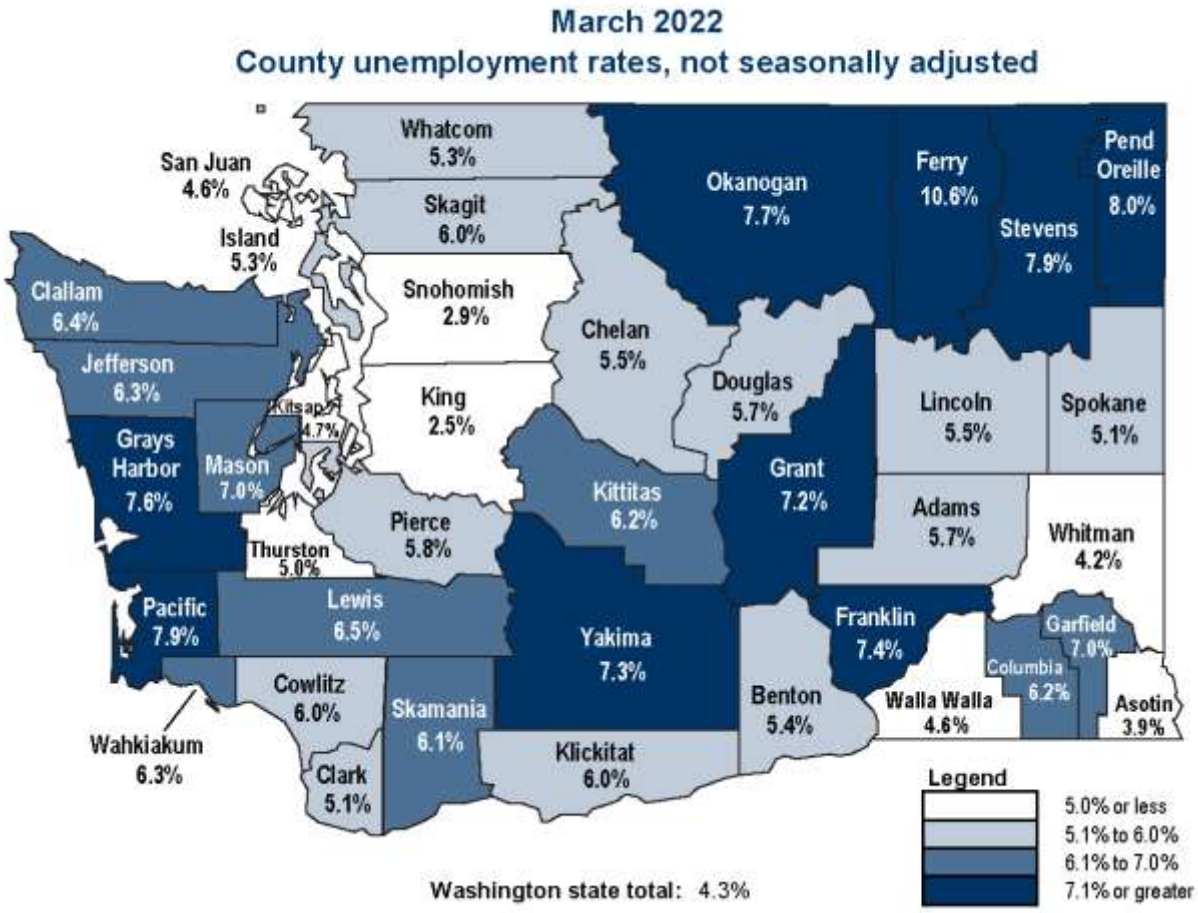


Figure 87: Washington County Unemployment Rates, Not Seasonally Adjusted (March 2022) [616]

Free and Reduced School Lunch

Food insecurity and hunger are known to impair child development and increase risk of poor health outcomes. [617] Free and reduced-price meal programs can lead to substantial reductions in childhood food insecurity, poor health, and obesity. [618] Free and reduced-price meal eligibility is based on each family's financial circumstances; however, some school districts offer free meals school-wide regardless of need.[619] This measure can help indicate levels of food insecurity and poverty in the community.

In the 2021-2022 school year, an average of 55.44% of students across the state of Washington participated in the free and reduced-price lunch program. [620] The highest participation rate was in Adams County, with 83.79% of students participating, and the lowest participation rate was in King County, with 34.23% of students participating. [621]

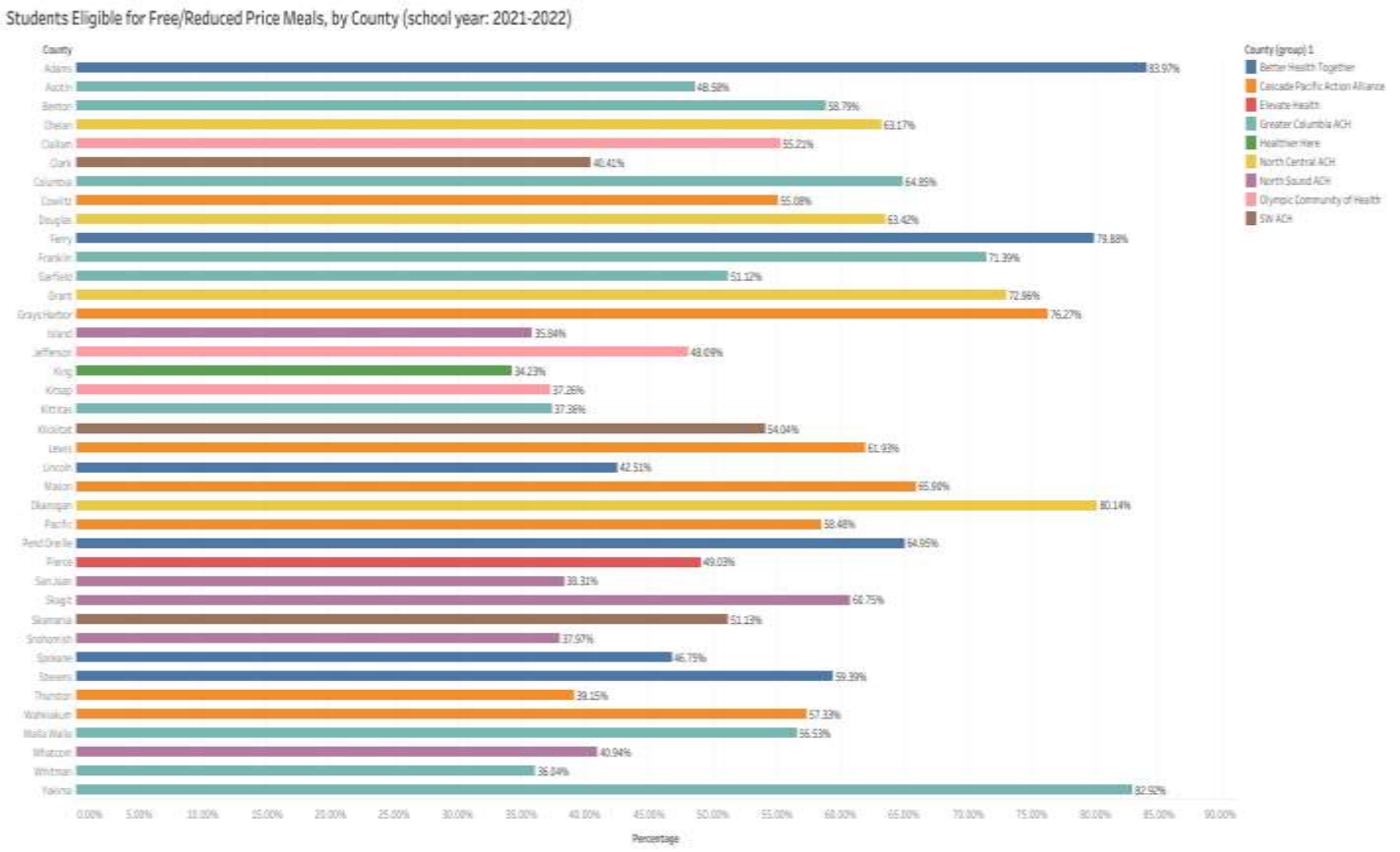


Figure 88: Washington Free and Reduced Meal Eligibility by County (2021-2022) [622]

Foster Care's Intersection with Family Economic Security

Child welfare caseworkers are the first responders to keeping our children safe, ensure their well-being, and help reunite them with their respective families. Although their work is difficult and robust, states nationwide struggle to manage their caseloads. In Washington State there is a set 18:1 target caseload ratio for social workers stemming from the settlement of Braam v. State of Washington. The Department of Children, Youth and Families (DCYF), Child & Family Welfare Services (CFWS) have an average casework size of 19.6 cases. This is above the best recommended practices, which are between 12-15 cases. Due to the high sizes of caseloads, social worker turnover has increased, slowing down the amount of time children can leave a foster care setting.[623]

Washington state has recorded 1,863 hotel stays in Fiscal Year 20 (FY20) for children and youth under age 18 who were in foster care. Of the total number recorded, 4.1% were under the age of 5, 20.5% aged 5 to 9, 32.7% aged 10 to 14, and 42.7% aged 15 to 17. Since 2017, there has been a 126% increase in hotel stays (824), according to the Washington State Office of the family and Children's Ombuds. Youth are 2.5 times more likely to face incarceration, when having experienced at least one foster care placement in a group home or institution. AI/NA are three times more likely to be placed in and out of home care, African Americans are two times more likely, including youth who are two or more mixed races. [624]

2020 Washington Foster Care Placements in Family Settings

	2020 State Foster Home (%)	2020 Private Foster Home (%)	2020 Kin Placement (%)	2020 Non-Family Setting (%)
North Sound ACH	36.23%	11.42%	47.56%	4.78%
Pierce ACH	23.87%	25.27%	46.76%	4.10%
King ACH	25.15%	17.10%	53.07%	4.69%
SW WA ACH	59.79%	4.68%	33.19%	2.34%
North Central ACH	40.05%	16.89%	41.21%	1.86%
Better Health Together ACH	42.73%	2.73%	46.78%	7.76%
Olympic ACH	41.31%	12.98%	44.22%	1.49%
Cascade ACH	47.33%	8.81%	39.57%	4.30%
Greater Columbia ACH	51.23%	4.45%	42.32%	2.00%

Figure 89: Washington Foster Care Placements in Family Settings (2020) [625]

There are three types of family settings: kinship care, state-licensed foster homes, and privately licensed foster homes. Non-family settings include shelter care and group care. State licensed Foster Homes and Kin Placements are the two highest percentages within majority of the ACH's, excluding Pierce, where Private Foster Homes are second highest. Non-family Settings are the least common with the lowest percentages, except Better Health Together and North Central. [626]

Key takeaways include:

- 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.

Community Strengths and Resources

As stated earlier, Seattle Children's does not include the word *needs* in their report because we believe the communities we serve offer more than a list of needs or challenges. They have their own unique set of assets and resources that can be harnessed to meet community needs, improve quality of life, and strengthen the community as a whole. The following themes emerged from key informant interviews and survey data.

Community Cohesion & Support

When asked about community strengths and assets, key informants often described the cohesiveness of their tight-knit communities as a substantial benefit. *Friendly, welcoming, hospitable,* and *connected* were commonly used to describe communities. Tight-knit communities promote social connection, safety, pride, and positivity, and can also contribute to positive physical and mental health outcomes. Additionally, intra-community support and empathy may provide rural

residents with resources and assistance that would otherwise be difficult to obtain in remote, low-resource communities. One participant shared, "The community is so supportive and there is a shared sense of connection among neighbors. They are always willing to help and looking to support, even when they don't have a lot of excess resources for themselves." Despite the significant growth and population changes, many participants acknowledged that their

"The community is so supportive and there is a shared sense of connection among neighbors. They are always willing to help and looking to support, even when they don't have a lot of excess resources for themselves."

communities still have "a small-state, down-home, neighborhood vibe" and found comfort in always seeing someone they knew at the grocery store, school, or anywhere in the community. Refugees and Native American families were identified as groups with especially strong community connection. A key informant who works closely with immigrants and refugees described this: "Sometimes all they have is their community and relationships. They form strong bonds and find solace connecting with people who have shared practices and beliefs during this period of transition." Another key informant shared, "Tribal families are always willing to step up and help their families and neighbors. If it's food security, family instability, whatever…once they identify an issue, they are motivated to help." At the same time, it is possible that a long history of disadvantage and social exclusion has forced them to rely more heavily on their own communities rather than the community at large. Engagement and inclusion of historically marginalized groups – refugees, BIPOC, low-income families, people who are disabled, the LGBTQIA2S+ population, and others – can provide a path for making their voices more audible and create a more equitable and diverse community.

Resilience

As described in the previous sections, rural communities face significant social, economic, environmental, and quality-of-life challenges that act as persistent barriers to living a healthy lifestyle. Even as the COVID-19 pandemic continues to test the strengths of rural children and families, rural residents persistently model resilience, determination, and resourcefulness. Resilience – or the ability to adapt to challenging life experiences – was a common theme in discussions with key informants about their communities' strengths. One key informant offered her perspective, "These kids and families have experienced so much trauma and hardship, especially in the last two years, but they continue to show up with enormous resiliency. The soul and grit of these folks is inspirational." Another participant described the resilience of refugees and immigrants: "They have been through horrific things…to be able to move to a new country, pick themselves up, start working, and overcome racism, discrimination, language barriers to support their families, it's incredible." Community resilience – or the sustained ability of a community to utilize available resources to prepare for, respond to, withstand, and recover from adverse situations [627] – was celebrated as a particular strength of the LGBTQIA+ community. In describing the community resilience required to push back on Idaho House Bill 675 blocking gender-affirming pediatric care, one key informant shared, "The LGBTQ community pulled together advocates to fight this harmful bill. When they get pushed down, they don't stay down. It is always a joy to witness their strength, and it's been an honor to work with them to prevent harmful policies like that."

Shared Value Around the Health & Well-Being of Children

Key informants consistently described their communities as family-focused and places that prioritize the health and well-being of children. As one key informant described, "Our community is very family focused. There is a shared value

around prioritizing the well-being of our kids." Parents were described as interested, engaged, and highly motivated. For example, one physician in Idaho noted, "If they need to bring their child back for another visit, they will miss work. If they don't have a car, they will get a friend. Despite all the social challenges, they truly put their kids first. This is a positive aspect of working in pediatrics." Other key informants said this community-wide championing for children's health meant hospitals and community organizations were often able to bring in substantial support for pediatric health initiatives.

Community Partnerships & Collaboration

While acknowledging that they have a way to go to ensure that all community members have equitable opportunities for health, key informants applauded the work being done by community organizations and coalitions. Whether talking about housing, substance abuse, or barriers to care, the services provided through community-level collaboration and partnership were identified as essential to promoting and improving the health of children and families. One key informant described this symbiosis: "We have a positive collaborative relationship. If one group is focusing on childhood education, we either stay out and tackle other issues or ask if they want help expanding their efforts. It's non-territorial and the community is the priority." A few key informants mentioned how inspiring it has been to see community agencies come together to support groups who have experienced extreme hardship during the pandemic. For example, one participant said, "Federal government funding did not cover what our health department needed to appropriately respond to the pandemic, so they turned to social services and those groups rose to the challenge."

Dedicated Healthcare Providers

Doctors, nurses, social workers, and other healthcare providers were consistently recognized as the cornerstone of the communities they serve. In rural towns, it is not uncommon to see "womb-to-tomb" practitioners – or those that deliver babies, do annual well-child visits, care for parents, and comfort the elderly. This continuity of care allows providers to build connections and develop relationships with patients, which is an important aspect of providing high-quality care. Despite limited primary and specialty care options, key informants said physicians do an excellent job communicating with each other and identifying additional care options for patients, even those beyond county or state lines. One key informant shared, "Rural kids and families already face incredible barriers to living a healthy life, so it is an incredible asset to have thoughtful healthcare providers who will go the extra mile to make their patients' lives just a little bit easier." Among key informants who are healthcare providers themselves, they described feeling valued and receiving great community support. Several key informants also mentioned a "small but mighty network of providers" specifically dedicated to serving the needs of the refugee community and LGBTQIA+ youth in Montana and Idaho, although much work remains to make competent care accessible to marginalized populations.

Whether talking about housing, substance abuse, or barriers to care, the services provided through community-level collaboration and partnership were identified as essential to promoting and improving the health of children and families.

Great Outdoors

From the alpine lakes of Glacier National Park to the geothermal features of Yellowstone National Park to the broad flatlands of the Great Plains, and the majestic mountains of Denali or the Olympic peninsula, WAMI is defined by its diverse terrain and beautiful landscapes. While there are countless factors that create inequitable access to the outdoors, many key informants identified the beauty and opportunities for outdoor recreation as strong assets. One key informant noted, "We exceed green space ratios and have lots of opportunity for outdoor exercise engagement." Another added, "When public indoor spaces became off-limits during COVID, I became more thankful than ever for the trails, parks, and walking paths my community has to offer."

Recent Economic Boost

Numerous key informants expressed concerns about the rapid rise in population and the corresponding impacts on housing and cost of living that put extra pressure on low- and middle-income families. But many of those informants also recognized some silver linings of the situation, including community growth, vibrancy, job opportunities, and economic momentum amid the global pandemic. A key informant shared her perspective, "A current strength of our community is the growth it is experiencing. The real estate market is going crazy, which I know is a double-edged sword. But in this small town of ours, it is exciting to see young professionals moving, new businesses opening up… there are pockets of good energy and motivation and I think that will have community-wide ripple effects." Another key informant suggested that the recent economic boost was responsible for spurring a sense of pride in the community. "We live in a beautiful area nestled in the mountains, but for so many years, everyone was leaving town to go live and work somewhere else. We were surprised when people began moving here from out-of-state, but I think it's brought excitement and a little self-esteem boost for the community."

Conclusion

From across WAMI, families, providers, and other stakeholders shared their experiences, concerns, and hopes for youth, helping the Seattle Children's Community Health and Benefit team start to understand the community priorities that has been our true north and guide for this 2022 Community Health Assessment. Although this work continues as we develop our resulting Community Health Implementation Strategies, a review of listening sessions and data to date clearly demonstrate several emerging themes. Perhaps unsurprisingly, mental and behavioral health of children and teens continues to be a central concern for families and providers, along with access to both mental healthcare and general healthcare. The COVID-19 pandemic, along with the countless stresses it created, became a central theme and source of concern for families. Economic security, especially in the setting of the pandemic, also continued to be a key area of focus. The importance of community and cultural engagement emerged in multiple listening sessions as a closely held value for families and other stakeholders alike, and the need for increased engagement was evident. Finally, and long overdue, the role of race and racism on all levels, from interpersonal to structural, clearly emerged as an area that demands focus. The effects of racism were seen in almost every theme that was touched on, from mental health and access to care to COVID-19 and economic security.

As the analysis and examples in this report have demonstrated, a wide array of factors influences a community's health, and many entities in the community share responsibility for maintaining and improving its health. If a community's resources are to be mobilized for a continuing effort to improve its own health, participants must know what values they have in common and develop a clear and shared vision of what can be achieved.

Seattle Children's 2022 Community Health Assessment has examined the myriad of factors that contribute to children's health in WAMI. We sought to move beyond health outcomes to the drivers of health. Through listening sessions, key

informant interviews and guidance from community leaders and partners, we gathered a voluminous amount of information that highlighted specific challenges but also spotlights the wonderful work being done in and alongside community. We are so proud and thankful to share this assessment with each of you.

Acknowledgements

Seattle Children's would like to thank all the individuals and organizations who graciously offered their advice, expertise, and assistance in the preparation of this Community Health Assessment. We recognize that our efforts to complete this assessment, and to address the health needs of our community, are greatly strengthened by their support and participation. We are especially grateful to all the community stakeholders who offered us their time and expertise in the form of thoughtful, insightful feedback regarding pediatric health challenges and opportunities in our community. We appreciate the perspective and best practices shared by partner organizations, including members of the King County Hospitals for a Healthier Community. Additional thanks go to our state and county health departments for maintaining the data we needed. We are particularly grateful to Public Health–Seattle & King County for generating data for our analysis and their guidance and analysis as well. We also appreciate the assistance of the many pediatricians in medical residency and master's in public health students and master's in health administration students that conducted listening sessions, stakeholder interviews and performing data analysis: our deep thanks and eternal gratitude.

In late 2020, after an illustrious 38-year career at Seattle Children's, Elizabeth (Tizzy) Bennet retired as Director of Community Health and Engagement. She has a Master's in Public Health and is a Master Certified Health Education Specialist. Tizzy has made significant contributions in pediatric injury prevention research, education and advocacy during her career at Seattle Children's. She's contributed to Washington State's national recognition for being a leader in drowning prevention by partnering with organizations throughout the State to keep families safe in and around water, researching what factors lead to child and teen drownings, and developing programs to reduce drowning risk and prevent drowning. She helped establish the Stay on Top of It campaign that significantly increased life jacket use among children. She's led water safety programming for the Vietnamese community and Everyone Swims, a policy and system change strategy to increase access to swimming and water recreation in partnership with aquatics facilities and beaches throughout King County. She's co-led the Washington State Drowning Prevention Network since its establishment in 1994. Tizzy has also led firearm tragedy prevention efforts in communities throughout the State by establishing the Protect Our Kids from Firearm Tragedies coalition and co-leading the Washington State Firearm Tragedy Prevention Network. Additionally, Tizzy has co-authored nearly 50 publications in the areas of health education and diversity, child passenger safety, drowning prevention, safe firearm storage, and hand hygiene. Tizzy has deep experience and passion for meeting the needs and building on the strengths of families and communities through comprehensive programs that combine policy, system change, direct service, education, social marketing, health behavior change and media strategies. Even in her retirement, one can find her volunteering her time in community coaching families on injury prevention practices or providing clinical instruction at the University of Washington. Tizzy is an incredible leader, colleague, and mentor in public health. She consistently exemplifies integrity, excellence, and compassion in her work, and strives for cultural humility and inclusivity. Her warm, welcoming character is infectious and her life-long passion towards keeping kids safe is evident. Tizzy leads by example and continually seeks ways to learn and grow from those around her. She has impacted countless lives and we dedicate this CHA to her in acknowledgement that our work has been shaped by her gentle guidance and thoughtful insight every step of the way. Thank you, Tizzy.

Thank you Tizzy!

Appendix A: Methods

Methods for this 2022 Seattle Children's Pediatric Community Health Assessment and the Jointly Authored 2021/2022 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

For the 2022 Pediatric Community Health Assessment the secondary and primary data were collected to complete the pediatric WAMI CHA. Secondary data were collected from a variety of local, county and state sources to present community demographics, social determinants of health, healthcare access, birth characteristics, leading causes of death, chronic disease, health behaviors, mental health, substance use and misuse, and preventive practices. The analysis of secondary data yielded a preliminary list of significant health needs, which then informed primary data collection. The following criteria were used to identify significant health needs: Primary data were obtained through surveys with community partner stakeholders, public health, and service providers, members of medically underserved, low-income, and BIPOC populations in the community, and individuals or organizations serving or representing the interests of such populations, and 6,335 surveys with community residents of WAMI. The primary data collection process was designed to validate secondary data findings, identify additional community issues, solicit information on disparities among subpopulations, ascertain community assets potentially available to address needs and discover gaps in resources.

The community stakeholders were asked to prioritize the significant health needs according to highest level of importance in the community. Among community member responses, mental and behavioral health as a top level of concern, not enough physical activity or playtime, suicide and injury prevention, COVID-19 and access to healthy affordable foods. Among community partner respondents, economic insecurity, mental and behavioral health, suicide by firearm, health care interactions regardless of race (equity), housing and homelessness, and disease and injury prevention were ranked as the top priority needs in the WAMI service area.

Figure 90: WAMI Survey of Parents, Guardians and Caregivers, n = 6,335 [628]

and weight, and violence and injury prevention. Furthermore, for the 2021/2022 CHNA report, a new section on COVID-19 was added as well as a Medicaid profile focusing on King County Medicaid demographics, top 10 causes of emergency department (ED) utilization, and high ED utilizers without a visit to a primary care provider in the last year. While hospitals and health systems reached consensus on a core set of topic areas, each hospital may also gather additional information specific to its service area. Recognizing that the CHNA is not intended to provide comprehensive data for each specialized topic, indicators continue to be selected according to the following criteria:

1. 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.
2. Ability to make valid comparisons to a baseline or benchmark.
3. 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.
4. 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.
5. 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.
6. Alignment with local and national healthcare reform efforts, including the triple aim.

For the purpose of the 2021/2022 CHNA Report, eleven (11) indicators were removed for which timely and/or actionable data are not currently available in King County. Eighteen (18) new indicators were added to the CHNA to reflect emerging or more widely accepted community health needs, such as firearm-related deaths and e-cig or vape pen use. All removal and addition of indicators was conducted in a manner consistent with the aforementioned selection criteria. 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.

It should be noted that the King County Hospitals for a Healthier Community (HHC) comprises 10 hospitals/health systems in King County and Public Health – Seattle & King County (PHSKC) with the fiscal administrative support of the Washington State Hospital Association (WSHA). This collaborative was formed in 2012 to identify the greatest needs and assets of the communities its members serve in order to develop coordinated plans to support the health and well-being of King County residents. One of the primary goals of HHC has been to collaborate on a joint community health needs assessment (CHNA) in order to avoid duplication of efforts, which, in turn, would help focus available resources on a community's most important health needs. HHC has collectively produced three CHNA reports: the 2015/2016 report, the 2018/2019 report, and this most recent 2021/2022 report. Participating Hospitals and Health Systems include:

Evergreen Health

Kaiser Permanente

MultiCare Health System

- Auburn Medical Center
- Covington Medical Center

Navos

Overlake Medical Center & Clinics

Seattle Cancer Care Alliance

Seattle Children's

Swedish Health Services

- Swedish Ballard Campus
- Swedish Cherry Hill Campus
- Swedish First Hill Campus
- Swedish Issaquah Campus

UW Medicine

- Harborview Medical Center
- Northwest Hospital & Medical Center
- UW Medical Center
- Valley Medical Center

Virginia Mason Franciscan Health

- St. Anne Hospital
- St. Elizabeth Hospital
- St. Francis Hospital
- Virginia Mason Medical Center

Limitations

While we gathered a great deal of community input from a wide range of stakeholders, limited resources made it impossible to reach all 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.

Considerations for Collecting Data in Rural Areas

Community health assessment designs and data collection methods vary from state to state depending on the organization conducting the assessment, the size of the population, and location. Although there are many different CHA toolkits and models, including the PRECEDE-PROCEED model, Community Health Assessment and Group Evaluation (CHANGE) model, and Mobilizing for Action through Planning and Partnerships (MAPP) very few specifically apply to rural areas.[629]

Epidemiological and demographic data is helpful for understanding the economic conditions and health trends in rural areas, but many of the datasets that hospitals, policymakers, and researchers rely on for understanding rural health are prone to error. The combination of small populations dispersed across large geographic landscapes makes quality data collection and reporting especially challenging in rural areas, leading rural residents to be missed or undercounted.[630] An analysis of 2010 Census data showed that 79% of "hard-to-count" counties were in rural areas. Rural areas are also

home to many groups who are considered hard-to-count populations, such as people of color, Tribal members, people with disabilities, undocumented people, people with low-income, and children. This means members of hard-to-count populations who live in rural areas are disproportionately undercounted.[631] American Indian and Alaska Natives have been undercounted in the last three censuses, and they had the highest undercount rate of any racial / ethnic group in 2010. With 84% of Montana American Indians and 63% of Idaho American Indians living in rural areas / small towns, these communities are at an increased risk of being undercounted and overlooked.[632] Undercounting, small sample sizes, and varying definitions of rurality cause secondary data to not fully represent the realities of rural living and impact research on health equity, often leading to investments and programs that do not accurately reflect the health needs of the community. Incorporating qualitative data from primary sources, via interviews and surveys for example, is a strategy to help mitigate this concern.[633]

Considerations for Remote Data Collection During the COVID-19 Pandemic

In response to social distancing measures and organization-wide travel restrictions, Seattle Children's has pivoted from in-person qualitative data collection to virtual key informant interviews and online surveying for the 2022 CHA. While remote data collection can save time, money, and resources, it has its strengths and weaknesses. For example, virtual interviews allow for in-depth, rich qualitative data gathering, but it can be difficult to build a rapport and establish trust through the phone or from behind a computer screen. Online surveys can reach a large sample in a short amount of time, but without an interviewer to clarify and probe, the data may be less reliable.[634] There is also a persistent digital divide that limits access to reliable internet and technology in rural areas, making remote data collection significantly more difficult.[635]

Remote data collection also poses potential ethical issues and recruitment barriers. The COVID-19 pandemic has had severe physical, mental, emotional, and psychosocial impacts, causing tremendous strain and stress on healthcare workers, professionals, and families alike. Consequently, it is important to consider the burden that key informants and survey respondents may face and weigh the potential risks of outreach against the potential benefits of participation.[636] Remote recruitment challenges include incorporating diverse perspectives, obtaining a sample that is representative of rural Montana and Idaho, and reaching groups that have been historically marginalized and underserved. Purposive, convenience, and snowball sampling are a few approaches that can help overcome some of the challenges of recruiting interviewees and survey participants in a virtual environment.[637] However, these strategies must be employed in a manner that is respectful, culturally appropriate, and does not perpetuate colonial research practices.

- Purposive Sampling: A subjective sampling technique in which the researcher purposefully selects participants because of who they are, their experiences, or the information they can provide. Example: Seeking key informants with experience providing gender-affirming care in Idaho or connections to Spanish-speaking communities in Montana.
- Convenience Sampling: A nonprobability sampling technique in which the researcher selects participants because they are convenient sources of data. Example: Using Seattle Children's regional network of care providers to recruit physicians who treat Montana and Idaho youth or reaching survey participants through online social networking platforms.
- Snowball Sampling: A nonprobability sampling method in which current participants help recruit future participants. It is important to draw from multiple initial pools of participants to achieve a diverse sample. Example: Asking key informants for recommendations for other key informants to interview or sharing the survey link in social media platforms and asking members to distribute it through their channels. [638]

It cannot be understated the advent of the global COVID-19 pandemic and its impact on our ability to conduct a community health assessment in ways prior to a time when strict infection prevention protocols were in place. The COVID-19 pandemic pushed the process of collecting learning data from in-person to remote in just a few weeks,

mobilizing researchers and practitioners alike to learn new systems, adapt instruments, and engage in a great deal of trial and error. At the time of publication, 2 years and 7 months after the first shutdowns, the health care sector, specifically the community health section is cautiously moving back to in-person activities with new expertise. Enrolling participants, building trust, deploying methods that engendered connectivity were all limitations in this CHA. The COVID pandemic, and resulting lack of access to participants, will mean needing to continually improve how everyone in our sector collect data remotely or cautiously use infection prevention protocols as we return to in person data collection through listening sessions and the like. The lessons learned during the move to remote data collection offer opportunities to invest in and improve how we collect data remotely, potentially opening opportunities to reach more people in difficult-to-reach parts of the region or during emergencies. While we still have a long way to go to find remote and resource-efficient methods that can adequately replace in-person interactions, this CHA endeavored to try.

Other 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.

Review of Existing Reports

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:

#	Report Name	Organization
1	City of Burien Community Assessment Survey	City of Burien
2	City of SeaTac Human Services Needs Assessment	City of SeaTac
3	Puget Sound Educational Service District — Early Learning Programs Community Assessment 2018 / Supplement to the 2018 Community Needs Assessment	Puget Sound Educational Service District
4	South King County Mobility Coalition Food Access and Transportation Needs Assessment January 2019	Hopelink, South King County Mobility Coalition
5	And So We Press On: A Community View on African American Health in Washington State (2019 Research Report)	Byrd Barr Place
6	Affordable Housing Advisory Board 2018 Affordable Housing Update	Washington State Department of Commerce
7	Affordable Housing Update: 2019 Affordable Housing Update Pursuant to RCW 43.185B.040	Washington State Department of Commerce
8	Transportation Barriers and Needs for Immigrants and Refugees: An Exploratory Needs Assessment. June 2019.	UW Evans School of Public Policy and Governance Graduate Consulting Lab for Hopelink, King County Mobility Coalition
9	King County American Indian and Alaska Native Housing Needs Assessment	Seattle Indian Services Commission
10	King County Fare Structure Needs Assessment: KCMC Access to Work and School Committee. February 2018.	King County Mobility Coalition
11	Puget Sound Food Infrastructure Exploration	Ecotrust for Sustainable Communities Funders and the Bullitt Foundation
12	State of Play: Seattle-King County — Analysis and Recommendations	Aspen Institute Project Play
13	Seattle Rental Housing Study — Final Report (June 2018)	UW Center for Studies in Demography and Ecology
14	Snoqualmie Valley A Supportive Community for All: Community Needs Assessment	A Supportive Community for All
15	Community Input Summary: Puget Sound Taxpayers Accountability Account	Puget Sound Taxpayers Accountability Account
16	Chinatown International District Framework and Implementation Plan 2018 Status Report	City of Seattle
17	Youth update 2019 — City of Kent	City of Kent
18	City of Kirkland — 2018 Survey	City of Kirkland
19	Age Friendly Seattle Action Plan	City of Seattle
20	Sammamish Health and Human Services Needs Assessment	City of Sammamish
21	Seattle–King County Aging and Disability Area Plan Update 2018–19	Aging and Disability Services
22	Seattle Goodwill CAN	Seattle Goodwill
23	Solid Ground Community Report 2018	Solid Ground
24	SESE Family Engagement Survey Data	Southeast Seattle Education Coalition
25	Healthy Food Availability and Food Bank Network Report	City of Seattle
26	City of Seattle 2019 Annual Action Plan	City of Seattle
27	Area Plan 2020–2023 Seattle King County	City of Seattle
28	Fulfilling the Commitment to our Community: Needs Assessment for Urban Disabled and Elder Natives	Urban Indian Health Institute
29	Our Bodies, Our Stories	Urban Indian Health Institute
30	White Center CDA Annual Summit Strong Voices 2018 Report	White Center CDA
31	White Center 2019 Summit	White Center CDA
32	2019 Gender Affirming Healthcare Access Report	Ingersoll Gender Center
33	Celebrating the Power of Bilingualism	OneAmerica
34	Seattle's 2018–2022 Consolidated Plan for Housing and Community Development	City of Seattle
35	Lessons Learned from Community Engagement	SOAR
36	Consumer Voice Listening Project and Community Grants Program (2018)	HealthierHere
37	Consumer Voice Listening Project and Community Grants Program (2019)	HealthierHere
38	2019 Community Health Needs Assessment	Kaiser Foundation Health Plan of Washington
39	Community Health Needs Assessment 2018	Overlake Medical Center and Clinics
40	Community Health Needs Assessment 2018 Swedish Ballard	Swedish Ballard
41	Community Health Needs Assessment 2018 Swedish Edmonds	Swedish Edmonds
42	Community Health Needs Assessment 2018 Swedish (Seattle) Cherry Hill/ First Hill	Swedish (Seattle) Cherry Hill/First Hill
43	Community Health Needs Assessment 2018 Swedish Issaquah	Swedish Issaquah
44	Community Health Needs Assessment 2018 Swedish Cancer Institute	Swedish Cancer Institute
45	SCCA 2019 Community Health Needs Assessment (CHNA)	Seattle Cancer Care Alliance
46	Seattle Children's 2019 Community Health Assessment	Seattle Children's
47	Everything Is Medicine	Community Health Board Coalition
48	Report on Gun Violence Among Youth and Young Adults	Public Health – Seattle & King County

Appendix B: Report Structure

Report Definitions and Structure

For each indicator, this report includes:

- A description of the indicator
- Overall estimate for King County or Washington State or WAMI 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 (CHI) website includes additional data for each indicator included in this report as well as many other indicators. Additional indicators that are available online have been included at the beginning of each report topic section.

When available, CHI indicators include:

- 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: 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.
- To protect confidentiality, presentation of data follows various reliability and suppression guidelines per data sharing agreements.

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).

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 a percentage 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 asked only 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).

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 four, the federal poverty guideline was $25,100 in 2018; in 2019 it was $25,750.

Neighborhood poverty levels are based on the proportion of people in a census tract in which their annual household income (as reported in the US Census Bureau's American Community Survey) falls below the federal poverty level.

- High poverty: 20% or more of the population in the neighborhood is below the federal poverty level. Using this criterion, 14.0% of the King County population lives in high-poverty neighborhoods.
- Medium poverty: 5% to 19% of the population is below the federal poverty level. Using this criterion, 62.7% of the King County population lives in medium poverty neighborhoods.
- Low poverty: fewer than 5% of the population is below the federal poverty level. Using this criterion, 23.3% of the King County population lives in low poverty neighborhoods.

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 is 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 two 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 their 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 and Alaska Native, Asian, Native Hawaiian and Other Pacific Islander, Some Other Race; (Two or more races) Hispanic or Latino origin, white alone (not Hispanic or Latino). 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 and Alaska Native, Native Hawaiian/Pacific Islander) in which a high proportion of regional residents are that race and one or more other races, the group "(race) alone or in combination" is sometimes used to include all who identify as that group.

Some surveys that we source in the document 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). However, our CHA report uses the following race/ethnicity terms

(when available): American Indian/Alaska Native (AIAN), Asian, Black, Hispanic, Multiple, Native Hawaiian/Pacific Islander (NHPI), and White.

Limitations of Race/Ethnicity Categories: When asked to identify their race/ethnicity in surveys, respondents are often offered a narrow range of options (see terms above); those broad categories are then used to make expansive race/ethnicity comparisons. The vast diversity within race/ethnicity 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 with Black Americans; Vietnamese, Korean, and East Indians in one Asian category; white Americans with eastern Europeans; or Brazilians with Mexicans — 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 are too small to allow for informative 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 three-year intervals — to smooth out the peaks and valleys of the yearly data in trend lines. For example, for events occurring from 2010 to 2020, rates may be graphed as three-year rolling averages: 2010– 2012, 2012–2014…2017–2020. Adjacent data points will contain overlapping years of data.

Rounding Standards: Rates for all data sources are rounded to one decimal point (for example, 15.4%).

Statistical Significance: Differences between subpopulation 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: Listening Session Questions & Online Survey

Listening Sessions

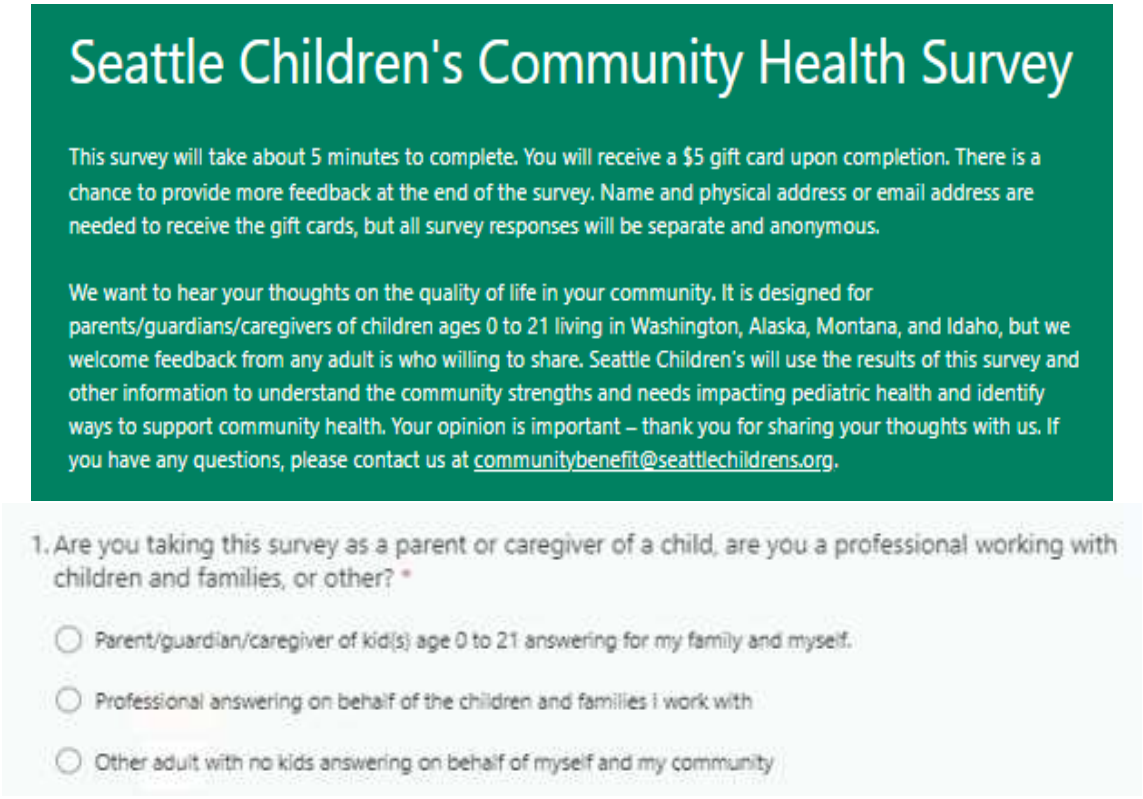
Many, if not all, of the following interview questions were used for key informant interviews and/or listening sessions with community participants either in person or virtually during the pandemic:

1. Help us understand a little more about you all. What are some things you like to do as a family?
2. When you think about your kids, what keeps you up at night or what worries might you have?
3. When you think about your kids, what do you hope for?
4. Do you feel it is easy to find information about:
    a. raising kids?
    b. health and safety information?
    c. mental or behavioral health, such as depression, anxiety, or ADHD?
    d. healthy eating or physical activity for kids and families?
        i. If it isn't "easy" per se, what resources are you looking for that you haven't been able to find?
5. 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.
6. 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 number 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?
7. 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?
8. 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.
9. 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?
10. 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?
11. 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?
12. What local resources are available to families that are hungry?
13. What would you like to see Seattle Children's do or provide here related to the health and well-being of kids?
14. Do you have anything else you'd like to share with us?

Online Survey

The following survey was deployed via electronic means in March of 2022 with 6,335 parents, guardians, caregivers, adult allies, or providers of pediatric services in Washington, Alaska, Montana and Idaho. In response to social distancing

measures and organization-wide travel restrictions, Seattle Children's has pivoted from in-person qualitative data collection to virtual key informant interviews and online surveying for the 2022 CHA. While remote data collection can save time, money, and resources, it has its strengths and weaknesses. For example, virtual interviews allow for in-depth, rich qualitative data gathering, but it can be difficult to build a rapport and establish trust through the phone or from behind a computer screen. Online surveys can reach a large sample in a short amount of time, but without an interviewer to clarify and probe, the data may be less reliable.[639] There is also a persistent digital divide that limits access to reliable internet and technology in rural areas, making remote data collection significantly more difficult.[640] The primary data collection process was designed to validate secondary data findings, identify additional community issues, solicit information on disparities among subpopulations, ascertain community assets potentially available to address needs and discover gaps in resources.



Seattle Children's Community Health Survey

This survey will take about 5 minutes to complete. You will receive a $5 gift card upon completion. There is a chance to provide more feedback at the end of the survey. Name and physical address or email address are needed to receive the gift cards, but all survey responses will be separate and anonymous.

We want to hear your thoughts on the quality of life in your community. It is designed for parents/guardians/caregivers of children ages 0 to 21 living in Washington, Alaska, Montana, and Idaho, but we welcome feedback from any adult is who willing to share. Seattle Children's will use the results of this survey and other information to understand the community strengths and needs impacting pediatric health and identify ways to support community health. Your opinion is important – thank you for sharing your thoughts with us. If you have any questions, please contact us at communitybenefit@seattlechildrens.org.

1. Are you taking this survey as a parent or caregiver of a child, are you a professional working with children and families, or other? *

- Parent/guardian/caregiver of kid(s) age 0 to 21 answering for my family and myself.
- Professional answering on behalf of the children and families I work with
- Other adult with no kids answering on behalf of myself and my community

2. Where do you spend most of your time? (Consider where you live, work, attend school, etc.) *

Please enter city and state.

Enter your answer

3. When you think about your kid(s)' health today, what are your top concerns? *

Choose up to 5

- [ ] Not enough healthy and affordable food options
- [ ] Not enough physical activity (playtime, sports, dance, walking, jogging, hiking, etc.)
- [ ] Injuries (from motor vehicle or bike crashes, poisoning, drownings, etc.)
- [ ] Crime or violence in the community
- [ ] Violence in the home
- [ ] Mental and behavioral health (anxiety, depression, eating disorder, ADHD, etc.)
- [ ] Suicidal or self-harm behaviors or thoughts (hurting oneself, feelings of not wanting to live, etc.)
- [ ] Not enough positive relationships (with peers, family, etc.)
- [ ] Substance use (alcohol, tobacco, marijuana, other drugs)
- [ ] Discrimination based on identity (race/ethnicity, gender, sexuality, immigration status, language, religion, and other identities)
- [ ] COVID-19
- [ ] Ongoing medical needs (asthma, diabetes, cancer, or other chronic conditions)
- [ ] Getting quality medical care
- [ ] Learning abilities and disabilities
- [ ] I'm not sure
- [ ] Other

4. Below is a list of community services. Please share how easy it is for you and your family to access the following in your community today. *

	Very hard to access	Hard to access	Easy to access	Very easy to access	I'm not sure
Healthy and affordable foods	○	○	○	○	○
Safe spaces to be active	○	○	○	○	○
Safety items (examples include car seats, life jackets, helmets)	○	○	○	○	○
Affordable quality housing	○	○	○	○	○
Reliable transportation	○	○	○	○	○
Job opportunities	○	○	○	○	○
Childcare	○	○	○	○	○
Affordable quality health care	○	○	○	○	○
Information about mental and behavioral health	○	○	○	○	○
Information about suicide or self-harm prevention	○	○	○	○	○
Mental and behavioral health care services	○	○	○	○	○
Immunizations (examples include COVID-19, MMR, Flu, Tdap)	○	○	○	○	○
Health information in the language that you speak	○	○	○	○	○

5. Please share your thoughts on the following statements. *

	Strongly disagree	Disagree	Agree	Strongly agree	I'm not sure
I am happy with the quality of life in my community. (Consider your sense of safety, well-being, etc.)	○	○	○	○	○
My community is a good place to raise children. (Consider education, after school programs, etc.)	○	○	○	○	○
There is someone I can turn to for day-to-day emotional support with parenting or raising children.	○	○	○	○	○

6. Systemic oppression and racism negatively affect the health and well-being of the children and families we serve. We want to make sure everyone receives the best care possible. In the last twelve months, how often have you and your family experienced... *

	Never	Sometimes	Often	Always	I'm not sure
Unkind or disrespectful interaction in your child's medical setting because of your race/ethnicity?	○	○	○	○	○
Challenges in getting medical care because of your race/ethnicity?	○	○	○	○	○
Medical services that are not as good as what other people get because of your race/ethnicity?	○	○	○	○	○

7. Where do you get health information in your community? *

Choose all that apply

- [ ] Healthcare provider (Doctor, Pediatrician, Nurse, etc.)
- [ ] Community leaders, religious leaders, elders
- [ ] Friends / family
- [ ] Support groups
- [ ] Schools / teachers
- [ ] Internet
- [ ] Newspaper, newsletters, flyers, or other publications
- [ ] Social media (Facebook, Twitter, etc.)
- [ ] Other

8. How many people live in your home (including yourself)? *

Enter your answer

9. What are the ages of people living in your home (including yourself)? *

Example: 2, 8, 43, 43, 65

Enter your answer

10. What is your gender identity? *

Choose all that apply

- [ ] Female
- [ ] Male
- [ ] Transgender
- [ ] Cisgender
- [ ] Non-Binary
- [ ] Two Spirit
- [ ] Prefer not to answer
- [ ] Other

11. How would you describe your race? *

Choose all that apply

- [ ] American Indian or Alaska Native
- [ ] Asian
- [ ] Black or African American
- [ ] Native Hawaiian or Pacific Islander
- [ ] White or Caucasian
- [ ] Prefer not to answer

12. How would you describe your ethnicity? *

- ◯ Hispanic or Latino/a/x/e
- ◯ Not Hispanic or Latino/a/x/e
- ◯ Prefer not to answer

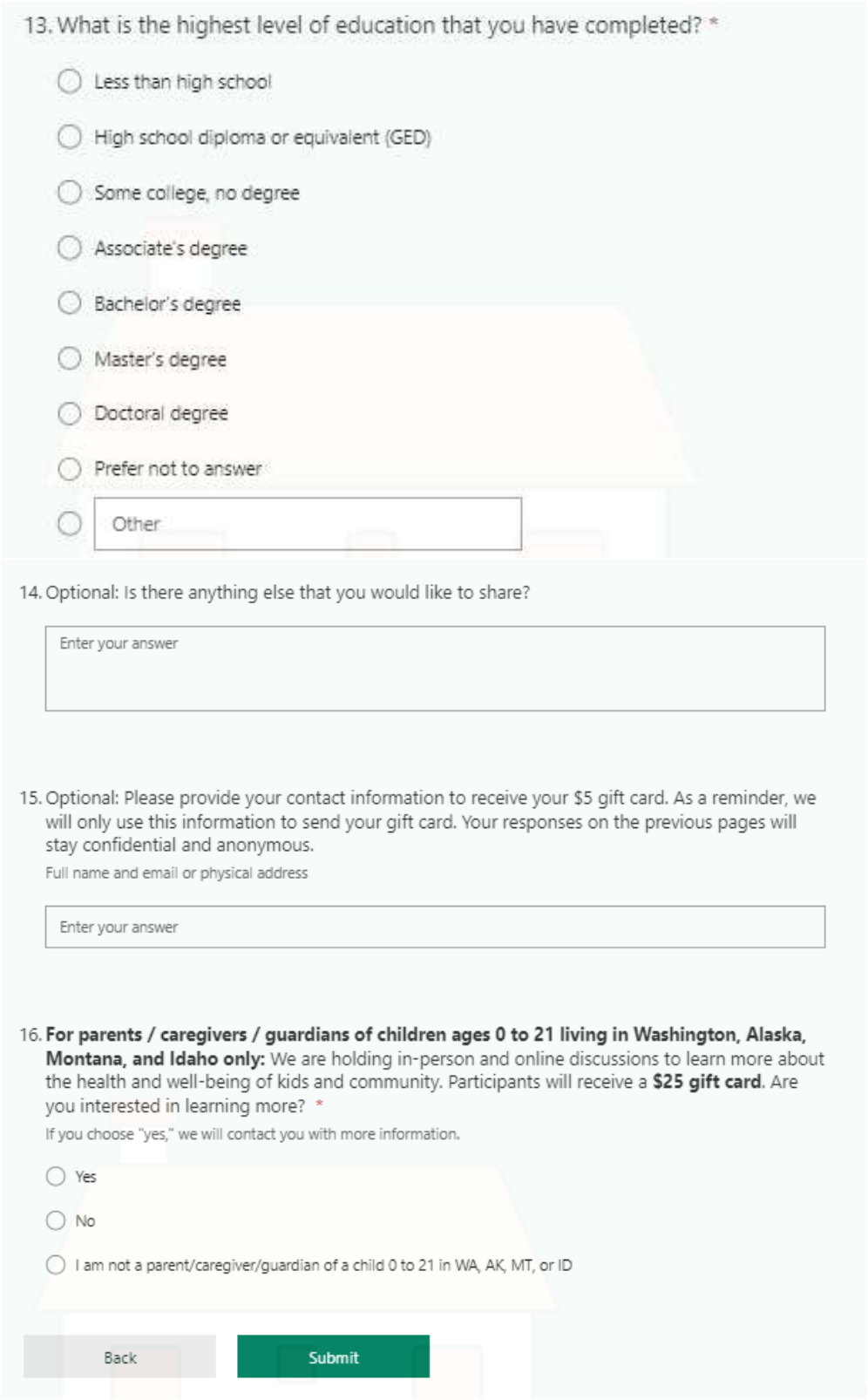


Figure 91: Online Survey conducted by Seattle Children's for 2022 CHA

Appendix D: Evaluation of our Community Health Implementation Strategies, 2019-2022

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 2019-2022 Community Health Improvement Strategies, developed in response to the most urgent health and safety needs of the children, teens and families in WAMI identified through our second Community Health Assessment in 2019. In this appendix, we summarize the results of our priority area strategies implemented over the past three years.

Summary

4 Community benefit priority areas

- 12 Strategies
  - 63 Tactics

Status Key

- Completed
- Partially completed
- Incomplete

Results

Primary Priority Area: Mental and Behavioral Health

Goal: Partner with our community to identify and implement innovative solutions for pediatric mental and behavioral health. Improve access so every child.

Strategy 1: Expand the capacity and continuum of mental and behavioral health services offered by Seattle Children's and by the community.

Key tactics	Status	Highlights / Narrative	Opportunities
Maintain the Partnership Access Line (PAL) and the Washington Mental Health Referral Services and secure ongoing and sustainable state funding for both programs.		Since its launch in April 2019, the Mental Health Referral Service has seen increased demand for support in accessing mental health care in the community. COVID-19 changed the landscape of available community providers: while it was initially easier to find care just after COVID-19 onset in early 2020, workforce shortages and increasing demand with limited capacity increases have meant that it is now increasingly challenging to locate providers for children and youth. Seattle Children's - in partnership with the state legislative Child and Youth Behavioral Health Work Group (CYBHWG) - successfully advocated increased funding for the Mental Health Referral Service, allowing them to hire more referral specialists to more adequately meet the demand.	★ Continue to seek ongoing funding – as needed – to ensure the MH Referral Service can meet the demand for community outpatient care.
Pilot a new state-funded PAL for Schools program		This state-funded pilot project was designed to provide support and consultation to two WA school districts in their work providing services for students with mental and behavioral health challenges. The project began in fall of 2019 with outreach across the state to identify interested districts. Partnerships with Sumner-Bonney Lake and	★ There is opportunity to scale-up this model to offer consultation to schools state-wide and preliminary discussions have begun to explore expansion. Based on learnings from this pilot, the new PAL for Schools' model

		Medical Lake were developed, and their school staff received: • Guidance on services and supports needed for students & accessing this care if outside of the school system • Professional development trainings in mental health topics. Our work began with weekly consultations to school teams in which we reviewed students in need to additional support and steps that could be taken. With the closure, then move to online schooling that happened in response to COVID 19, schools had less direct contact with students, so we pivoted to providing telehealth trainings for school staff in areas identified by each district. PAL psychologists provided 12 virtual professional development trainings to over 300 school staff: • Topics included anxiety, suicide prevention, staff wellness, depression, and distress tolerance. • Responses to the trainings were overwhelmingly positive, with training evaluation data showing consistently high overall quality ratings. Consultations regarding specific students resumed over as schools returned to working in person with student. Thirty-five (35) team-based consultations were provided to school staff.	could be: a given school has 1 hour per week scheduled with a psychologist in which they will review their most difficult (MTSS Tier 3) students and the psychologist would be spending a 2nd hour regarding that one school pre-reviewing provided student records and making quick post consult discussion notes.

Advocate at the state and federal level for increased Medicaid reimbursement rates for pediatric mental and behavioral health services.		Initially, a rate increase was passed in the 2020 State Legislative Session, however the pandemic onset occurred prior to the Governor's signing of the proposed budget. Thus, some items were vetoed from the budget, one of which was the Medicaid reimbursement rate increase for behavioral health. The 2020 rate increase was ultimately passed again in 2021, but was noted as insufficient given the impact of COVID-19 on capacity and workforce shortages. Seattle Children's - in partnership with the state legislative Child and Youth Behavioral Health Work Group (CYBHWG) - successfully advocated for a Medicaid reimbursement rate increase of 7% in the 2022 Washington State Legislative session.	★ While this rate increase was significant and meaningful, inflation has risen at a similar rate in this same time frame – this rate increase serves as protecting WA from falling further behind but it doesn't have the intended effect of advancing our reimbursement to truly sustainable levels – SC and CYBHWG will consider how/when to advocate for additional rate increases.
Support the legislative priorities of the state-wide Child Behavioral Health Work Group.		Seattle Children's emphatically supported the behavioral health priorities of the Child and Youth Behavioral Health Work Group (CYBHWG). In the 2020 State Legislative Session, despite COVID-19 vetos, funding was allocated to pilot Intensive Outpatient Programs (IOPs) and Partial Hospitalization Programs (PHPs) at Seattle Children's and Sacred Heart. In the 2021 State Legislative Session, WA increased funding for the IOP and PHP pilots. Also in 2021, SC supported CYBHWG's legislative priorities including: a proviso to expand youth mobile crisis services statewide and ensure existing teams can meet increased demand as well as a proviso to direct the Health Care Authority (HCA) to explore Medicaid waiver options for respite care for youth with behavioral health challenges, without adversely impacting the respite waivers for children and youth in the foster care system and for children and	★ SC will continue to partner with CYBHWG and support priority policies and provisos.

		families enrolled with the Developmental Disabilities Administration (DDA). In 2021, WA passed HB1477 to redesign the crisis system as we implement the new suicide prevention lifeline: 988. A Seattle Children's community health member serves as the CYBHWG representative to the Crisis Response Improvement Strategy (CRIS) Committee. 2022 was a historic session for child and youth behavioral health – the programs and services funded this session are almost too numerous to list in this box. Significantly, SB5736 passed unanimously, fully funding IOP and PHP under Medicaid. Additionally, SC worked with CYBHWG leadership to pass HB1890, which will enable CYBHWG to create a Strategic Plan for Prenatal-25 Behavioral Health. For a more extensive summary of 2022 legislative outcomes, see the On the Pulse Blog Post: https://pulse.seattlechildrens.org/legislative-wins-for-child-and-youth-behavioral-health-in-washington-state/	
Implement the Psychiatry and Behavioral Medicine Unit (PBMU) Community Advocacy, Resource and Engagement (CARE) Team to support patients and families as they return to community care following a PBMU Admission.		This service has been critically necessary to "bridge the gap" between inpatient care and community resources. A 2022 journal article published by the CARE Team leaders shares some results and impacts: "Between December 2019 and February 2022, the CARE Team worked with 238 patients. They carried a broad range of diagnoses including mood and anxiety disorders, psychosis, obsessive compulsive disorder, disruptive behavior disorders, intellectual/developmental disorders including autism, eating disorders, and post-traumatic stress disorder. Youth with autism spectrum disorder comprised 25% of the CARE Team population compared to 16% of the inpatient unit as a whole during this time	★ There is broad recognition among the inpatient psychiatry team at Seattle Children's that the PBMU CARE team is a necessary service. In the coming years, expansion of this service and additional capacity may be necessary.

		frame." "The mean length of service was 5.5 weeks. Caregiver satisfaction was 3.9/5 for the 85 patients who were surveyed." The study also "demonstrated statistically significant reductions in EDMH visits for mental health reasons, and a nominal reduction in psychiatric hospitalizations in the 60 days after discharge, compared to the 60 days prior. Further, the proportion of youth with any EDMH visits or hospital stays decreased significantly in the 60 days post-discharge." All quotes from Simmons et al., 2022[i]	
Pilot a Behavioral Health Crisis Care Clinic to support youth and their families in crisis in maintaining safety and stability in their community.		Seattle Children's Behavioral Health Crisis Care Clinic (BHCCC) is an innovative program that provides short-term outpatient treatment to families experiencing a suicidal crisis. Families engage in up to 4 visits as an alternative to more intensive treatment like inpatient hospitalization. In the BHCCC, patients and their parents or caregivers receive quick access to evidence-based, suicide-specific intervention to stabilize the crisis and connect them to longer-term care in the community. This program became even more critically necessary after the onset of the COVID-19 pandemic. Since opening its doors in March 2019, the CCC has served over 240 patients. In that same time, the team has received more than 800 referrals; while a number of referrals are declined due to clinical appropriateness, the most common reason for not accepting a referral was due to the capacity constraints of the CCC. Almost 300 patients were referred but couldn't be seen due to capacity	★ These services are effective and impactful, and more capacity via this model is needed both at Seattle Children's and in the community.

		limitations – this highlights the significant need for additional capacity in the CCC and the demand for this model. Case management is a critical component of the CCC's services, ensuring patients connect to community care after receiving treatment for suicidality. A majority of the patients seen in the CCC (56%) were not connected to outpatient care upon initiating services with CCC; of those patients, 82% discharged from CCC's services with connection to an outpatient provider in the community. Of the patients who entered the CCC with a provider, 39% discharged with connection to additional outpatient resources in their community. This model was so successful, Seattle Children's added an Anxiety Behavioral Crisis Clinic (ABCC) to quickly treat and stabilize patients with anxiety or disruptive behavior issues in a similar manner. The CCC team has also worked with community organizations to support in standing up additional similar programs.	
Enhance partnerships with community based organizations to enhance programs and increase capacity.		Community partnerships have long been critical in mental and behavioral health, but arguably never more critical than during and following the COVID-19 pandemic. While COVID-19 made it more challenging to provide programmatic sponsorships and be in community in-person, it enabled new opportunities to partner and collaborate. Seattle Children's Community Health team members collaborate with colleagues through multiple local and state workgroups and coalitions.	★ The clinician leading the Autism Center's collaborative work with school districts would like to scale this up as a statewide approach and collaboration.

		SCH's Autism Center faculty have established a collaborative project with 4 local school districts to increase access to diagnosis and services for youth with concerns about ASD. The AC team is supporting school staff who are completing the assessments in the school setting, the data is then reviewed by CAC clinician who works with the school team to develop a plan and prepare documentation needed to get services in place.	
Enhance learning and educational collaboration between community healthcare, mental health care providers, and Seattle Children's. Explore ways to disseminate information from SCH and share learnings as a community.		There are at least 3 programs to highlight here where Seattle Children's clinicians have shared their expertise with community providers in a learning-collaborative-type model. The Eating Disorder Treatment Network trains cohorts of community behavioral health agency therapists in how to effectively treat and manage youth with eating disorders. This is especially critical given the limited options for eating disorder care among patients ensured by Medicaid. The Autism Center – including faculty from both Seattle Children's and the University of Washington – provides two different ECHO programs: The first is an ECHO program for primary care providers or pediatricians to mentor them on how to diagnose autism spectrum disorder (ASD). https://uw-ctu.org/echo/echo-autism/ The second is an ECHO program specifically for Wraparound with Intensive Services (WISe) teams in order to support them in more effectively working with youth who have ASD and/or intellectual/developmental disability (IDD). https://uw-ctu.org/echo/echo-idd-wraparound-impact/	★ These educational collaboratives are broadly seen as effective and value-added. There is significant opportunity in the future to continue these, scale them up, and consider new types of ECHO or Treatment Network models for other cohorts of providers and for other diagnoses or behavioral presentations.

Explore strategies to increase access to services in languages other than English.		While interpretation is available for individual appointments, there was a program to pilot delivering group-based care with simultaneous interpretation. This pilot resulted in great learnings and there is intention to re-offer simultaneous interpretation in group treatments. Additionally, a new clinic providing services in Spanish opened within outpatient psychiatry: the Child and Adolescent Latino Mental Health Assessment and Treatment (CALMA) Clinic. CALMA is a mental health evaluation and treatment clinic for children and families who primarily speak Spanish. Providers are bilingual and can provide care in both Spanish and English.	★ There is a need to continue to explore strategies for delivering care in languages other than English, whether that be through direct service, through individual interpretation, or through simultaneous interpretation in group treatments.
Expand OBCC's school-based services with an emphasis on elementary schools as well as an emphasis on behavioral health.		COVID-19 inevitably had an impact on in-person school services. Currently, the models in King County allow for 2-3 days of services in school-based health centers. OBCC provides in-person care at two elementary schools. At one elementary school, OBCC providers are present 3 days per week delivering in-person behavioral health care. Recently, OBCC applied for additional grant funding to increase behavioral health provider presence by 1 day a week at the second elementary school site. This grant funding, which was approved, will include additional training for the behavioral health provider on providing group interventions, expanding access to care. For the past two school years, OBCC mental and behavioral health providers have been able to offer Incredible Years (a parent coaching program) to parents from the two elementary schools via Zoom.	

At OBCC, explore promising models in tele-health that are implementable and relevant for OBCC and the community they serve; identify strategies and partnerships in order to increase access to tele-health interventions.		This was an unusual "silver lining" of the COVID-19 pandemic: a significant majority of behavioral health appointments at OBCC were transitioned to a tele-health model at the beginning of 2020. In this 3 year period, majority of the appointments that were originally in-person were delivered via tele-health Even at the end of September 2022, most appointments are still conducted remotely. Interpretation is available for tele-health appointments in languages other than English. Strategies have been explored and implemented to obtain consent for care remotely if the patient/family was only seen via telehealth and never in-person at the clinic. One notable highlight is that given the success of the telehealth models, clinic providers were able to cover appointments for students who would normally be seen in school when the school-based provider role was temporarily not filled. Students were able to participate in telehealth with an OBCC provider from their school setting, limiting the disruption in their day and preventing care from being interrupted by a provider transition.	
At OBCC, explore ways to expand the role of workforce who can support families in navigating multiple systems including concrete needs as well as mental and behavioral health care.		The behavioral health team at OBCC currently has three types of workforce who can support families in navigating multiple systems: a behavioral health case manager, a behavioral health care coordinator, and the social work team. For the behavioral health case manager, while this was an existing role, over the past 3 years there have been a number of improvements in their workflow enabling more efficient and comprehensive support for families. The behavioral health care coordinator role was new to	★ Continue to explore workforce strategies that support patients and families as they navigate complex healthcare systems ★ Pilot the new CMHW role and build on learnings from that program.

		OBCC as of December 2021 and provides specific support and care coordination to families receiving behavioral health services. OBCC scaled up the social work team from 2.0 FTE to 7.0 FTE during this time period. The social work team is first line response to Zero Suicide Initiative, responsible for conducting more in-depth safety assessment, planning, and connecting patients to mental and behavioral health services when indicated. Additionally, Seattle Children's was the recipient of a CDC grant to embed Community Health Workers (CHWs) to support families with children awaiting mental health services – "Community Mental Health Workers" (CMHWs). Work is underway to scope this role and hire CMHWs who can support families with a variety of needs as they access mental and behavioral health care.	
Maintain and consider methods for expanding the parent peer co-led mindfulness parent skills group at OBCC.		These skills groups were made available virtually during the COVID-19 pandemic, increasing the geographic accessibility and maintaining integrity to supporting the parents/caregivers of youth with disabilities, mental health needs, or medical complexities. Additionally during COVID, these mindfulness skills groups were made more available to workforce at OBCC and internally to raise awareness of the value of mindfulness and cultivate continued interest. In the past 3 years, this program has transitioned to a model of braided-funding: partially sustainable funding through OBCC and partial grant-funding. The mindfulness facilitators actively partner with community organizations and community partners to	★ Continue to partner w/ community orgs to teach mindfulness skills groups to cohorts or audiences that community partners have gathered. ★ Try to bring the mindfulness practice/class itself to community events rather than simply focus on recruitment. This can help model the value of the class and could increase recruitment of the parent peer-led model.

		share expertise and skills groups in person with those organizations. Five parent peer instructors were certified as CHWs in 2022.	

Strategy 2: Educate and raise awareness: Educate and raise awareness of mental and behavioral health to increase child wellness, family skills, and to eliminate stigma

Key tactics	Status	Highlights / Narrative	Opportunities
Offer Youth Mental Health First Aid Classes through a partnership between King County, Chad's Legacy Project, and Seattle Children's. Explore expanding program to offer courses more frequently and increase access for adults interacting with at-risk and/or trauma exposed youth populations.		As with many other activities, Youth Mental Health First Aid (YMHFA) needed to pivot to virtual offerings in light of the onset of COVID-19. Between Oct 1, 2019 and Sept 30, 2022, Seattle Children's hosted 34 classes and had a total of 692 registrants. In late 2021, a cohort of 5 Seattle Children's workforce were trained as YMHFA instructors, enabling SC to expand and continue offerings of virtual YMHFA classes.	★ Continue to offer YMHFA classes virtually – potentially increasing the number of classes ★ Consider strategies to increase attendance and reduce attrition rate between sign-up and participation
PAL will continue to host educational conferences for primary care providers in Washington and Alaska at rotating regional locations. In Alaska, consider trialing a tele-video option for the conference.		PAL hosts 4 CME Conferences in Washington State each year and at least 1 annually in Alaska. Conferences feature expert speakers on specific pediatric psychiatric topics including: ADHD in Special Populations, Antidepressants – Warnings and Precautions, Assessing and Managing Hallucinations and Psychosis in Children and Adolescents, Depression Assessment and Treatment in Pediatric Primary Care, and more! These educational conferences are free to primary care	★ Continue to host conferences virtually and in-person to offer educational settings to primary care providers in WA and AK

		providers. Many conferences were hosted virtually after the onset of the COVID-19 pandemic; as of 2022, both in-person and continued webinars are planned.	
Conduct research on methods of mental health problem detection and treatment that are more efficient, culturally applicable, and readily disseminated.		One of the ways Seattle Children's has made mental health detection and treatment more culturally responsive is through the launch of a new Spanish-speaking mental health clinic: the Child and Adolescent Latino Mental Health Assessment and Treatment (CALMA) Clinic. CALMA is a mental health evaluation and treatment clinic for children and families who primarily speak Spanish. Providers are bilingual and can provide care in both Spanish and English.	★ Continue to expand research and clinical services tailored and responsive to cultural needs.
Expand current mental health educational resources for schools, children, families, and community, in partnership with those schools, individuals, and communities. Emphasize partnership with populations at high-risk and/or trauma exposed, including youth in foster care, LGBTQ youth, youth and families where English is not their primary language, youth of color, and indigenous youth.		The original vision for expanded mental and behavioral health educational resources and offerings was significantly impacted by the onset of the COVID-19 pandemic. While this seriously limited in-person presentations and discussions, it did enable additional virtual offerings and expanded reach. In the early phase of the pandemic, in Spring of 2020, Seattle Children's hosted a series of Facebook Live events on coping during COVID-19. These 5 events reached more than 250,000 people on Facebook as of October 2020. Also in the Spring of 2020, Seattle Children's launched a new Mental Health Resource Hub to share mental health resources and information with our community. Throughout 2021, providers contributed to blog posts,	★ As we move more into a "post-COVID" world where in-person events are allowed, there is significant opportunity to continue to expand community partnerships to raise awareness about mental health, reduce stigma, and increase access to mental wellness supports and mental health care. ★ There is also momentum to continue creating free, video-based classes with psycho-educational materials that can

		Facebook Live events, and recorded videos to share information about supporting your child's mental health and wellness as well as specific interventions parents can take to manage their child's anxiety and/or disruptive behavior disorder. In 2022, the first community classes taught by psychiatry launched via Zoom. SC offers a class on Finding Mental Health Care in Washington: A Class on Where to Start in both English and Spanish. There are plans to offer classes on early childhood interventions.	be shared widely with the community.
Partner with local media outlets and local youth initiatives to increase mental health awareness, reduce stigma, and build community resilience.		Since our last CHA/CHIS, Seattle Children's formed a multi-disciplinary mental health communications workgroup with representation from across the channels of Marketing and Communications as well as representatives from Community Health. This workgroup meets monthly to collaborate on sharing mental health information with the community including proactively reaching out to local and national media outlets to share mental health information.	★ Continue monthly meetings and plans to share mental health information widely with community. ★ Continue development and implementation of annual mental health communications plan.
As part of our ongoing partnership with Forefront and SMART Center, enhance outreach to schools to provide education and raise awareness.		Via a longstanding partnership with Public Health – Seattle & King County, we continued to provide consultation and training for care providers in the School Based Clinics throughout King County. During the last school year, we provided training and consultation to the school based advanced practice nurses and the mental health providers in 31 elementary, middle, and high schools across King County, and have added two new schools for the 2022-2023 school year. Consultation and training is provided by SCH/UW Child Psychiatry Fellows with faculty supervision and staff and faculty psychologists, who provide both group and individual support. Members of our team also	

		work with the SMART Center and we have partnered over the last year to complete a pilot project testing a brief, common elements based, intervention model, at the request of PH-SKC. SCH/UW psychologists provided the training and consultation for this project and SMART Center staff lead the evaluation efforts. We will move forward this school year with a second phase of this work. In the context of this work, our team has provided continuing education presentations for the school based teams—with presentations on assessment and management of ADHD and ASD during the 2021-2022 year, in addition to trainings on the use of common elements approaches.	

Strategy 3: Expand efforts to integrate mental and behavioral health care and wellness with physical health care and wellness.

Key tactics	Status	Highlights / Narrative	Opportunities
Continue to expand efforts to integrate mental and behavioral health care with primary care at OBCC, including building space for fully integrated care. At OBCC, continue providing integrated care in specialty care, such as in the sickle cell program, and enhance integrated care in additional specialties, such as the nutrition program.		A significant development at OBCC – which brings advancement in integrated care and *so much* more – is the opening of a second location in Othello Square. In March 2022, OBCC Othello opened it's doors offering "access to an innovative, integrated approach to care – where medical, dental, behavioral health, physical therapy and rehabilitation, nutrition services, and more are available under the same roof, at the same appointment, if needed. And, as always, the clinic's 'Quality Care with Dignity' mission means we care for each patient's whole health regardless of a family's ability to pay. The new OBCC Othello location brings these services closer to the 75% of our existing clinic families who have moved to south for more affordable housing." For more information on OBCC	★ Given the magnitude of work to open OBCC Othello, a new Center of Excellence, and a Gender Affirming Care program, the opportunities for continued work are yet to be determined. There is always continuous process improvement work to be done as new projects and programs launch, so this work may undergo iterative improvements based on patient/family, community,

		Othello, see the On the Pulse blog post. In July 2022, a new integrated Center of Excellence was created for the care of patients with Sickle Cell Disease. "As part of this Center of Excellence, a roadmap of program enhancements are in place to make progress towards improving and growing the Seattle Children's Sickle Cell Disease Program to better serve patients with SCD and their families." There was a stated goal of providing care via multi-disciplinary teams so patients can get what they need in a single visit. Read more On the Pulse blog post. OBCC also launched an integrated Gender Affirming Care clinic: the team consists of a medical provider, behavioral health, and navigator.	and workforce feedback.
Promote programs and education to support positive parenting relationships and family/caregiver wellness. Promote and continue to integrate the infant/child mental health curriculum, Promoting First Relationships® in Pediatric Primary Care (PFR-PPC), with medical residents, preceptors, and others.		In the past 3 years Seattle Children's has offered 23 parent trainings through the Positive Parenting Program, which had over 1,000 attendees. Topics in the positive parenting series included: • Mindfulness for Parents • Supporting Multi-Racial Identity in Children • Single Parenting • Building a Connected Family • Positive Parenting-An Introduction • Helping Children De-escalate • Responding to Challenging Behaviors in Toddlers • Successful Transition Back to School • Siblings and Peer Relationships • Consequences vs. Solutions • Encouragement vs. Praise In that same period, Seattle Children's led 30 Promoting	★ Continue providing parent trainings through the Positive Parenting Program that support family/caregiver wellbeing as well as child/youth wellbeing. ★ Continue to train residents and other providers in Promoting First Relationships® in Pediatric Primary Care (PFR-PPC)

		First Relationships® in Pediatric Primary Care (PFR-PPC) trainings to train 150 residents and other providers.	
Integrate mental and behavioral wellness into all appropriate community health wellness events where Seattle Children's is attending or hosting.		As with many other in-person activities, Community Health events paused in 2020 due to COVID-19. As events have resumed in 2022, Community Health has intentionally included mental health resources at events for safe firearm storage giveaways, back-to-school fairs, and more.	★ Continue to collaborate to ensure MBH information is shared at as many Community Health events as appropriate.
At OBCC, pilot and explore a program around Behavioral Dentistry to improve the behavioral health care experience of patients receiving dental care.		An innovation at OBCC – in part to respond to the need for behavioral health supports for patients receiving dental care – is the implementation of a "provider of the day' system. Each of the main service lines (medical, behavioral health, dental, etc.) all have a 'provider of the day' who is 'on call' for in-the-moment collaboration. A provider from one service can quickly consult with a provider from another service – including behavioral health. The behavioral health provider can meet the patient and family, provide resources including on developmental issues such as potty training. Specifically for the dentistry program, the behavioral health provider of the day is able to respond immediately to behavioral health needs that are discussed in dental appointment and also to support dental health behaviors. The goal of this system is prevention: providing in-the-moment response, psycho-education, resources, and care, truly meeting kids where and when they need it.	★ Continue iterative improvements in the provider of the day response system and consider continuous process improvement re: integrated behavioral and dental care

Strategy 4: Develop and support a diverse mental and behavioral health workforce at Seattle Children's and in the community that reflects the communities they serve.

Key tactics	Status	Highlights / Narrative	Opportunities
Advocate at the state level for scholarships and loan-forgiveness for students and professionals seeking mental and behavioral health careers.		Seattle Children's – as a partner of the Child and Youth Behavioral Health Work Group (CYBHWG) – successfully advocated for funds to be provided for behavioral health loan repayment program grants. Funding was provided in the 2022 Washington State Legislative Session: $1m in FY22 and $1m in FY23.	★ Continue to examine if this level of loan-forgiveness and scholarship is meeting the workforce need and explore strategies for continued workforce supports.
Support the legislative priorities of the Workforce Subcommittee of the state-wide Child Behavioral Health Work Group.		As noted above, SC partners closely with CYBHWG and emphatically supports the identified priorities. Seattle Children's Govt Affairs leader also co-chairs the CYBHWG subgroup on Workforce & Rates – identifying and supporting policies and provisos that improve child and youth behavioral health workforce. Among other priorities, this subgroup has championed Medicaid rate increases.	★ Continue supporting the priorities of the Workforce & Rates subgroup of CYBHWG; this tactic has only become even more critical given some of the significant workforce shortages exacerbated by the COVID-19 pandemic.
Identify additional ways to recruit and retain culturally and linguistically diverse mental and behavioral health workforce, with an emphasis on workforce who can provide services in languages other than English.		While not specific to mental and behavioral health, in the past 3 years Seattle Children's instituted an organization-wide requirement for leaders to participate in training regarding best practices for reducing bias in interview and candidate selection – this work is designed to increase equity in hiring. Within Seattle Children's Workforce Development and Planning Team, mental and behavioral health workforce was named as a strategic focus for this team; there have been three major areas of focus related to mental and	★ The workforce planning team continues to explore ways to cultivate awareness of mental and behavioral health careers among future talent – including youth and young adults – with a specific focus on youth with diverse racial/ethnic backgrounds and those who are under-resourced. Representation

		behavioral health workforce. The first was a landscape assessment of the current state of mental and behavioral health workforce at Seattle Children's and advancement pathways. The goal of this work was to make opportunities in mental and behavioral health careers more visible to internal SC employees as well as to future talent. The intent is to build a diverse pipeline by raising awareness and creating opportunities for exposure. Secondly, the workforce planning team supported work within psychiatry to create career advancement pathways for frontline pediatric mental health specialists as well as work to re-evaluate educational requirements for that role to increase equitable access to those career opportunities. Third, the workforce planning team has cultivated intentional community partnerships in order to create and facilitate career exposure and awareness for youth and young adults, particularly those with diverse racial and ethnic backgrounds and under-resourced youth in our region generally. During two annual Sound Careers Virtual Events in April 2021 and 2022, mental and behavioral health careers were highlighted first via a scavenger hunt activity and secondly through a multi-role panel that spoke to varying roles in the mental and behavioral health field. Another partnership is with Rainier Scholars, workforce planning team is building a core group of Seattle Children's workforce (intentionally including mental and behavioral health) who can do 1:1 informational interviews with interested students. Workforce planning team is also cultivating a Speakers	matters everywhere, and especially in the mental health field. ★ Seattle Children's overall, the division of psychiatry, and the workforce planning team continue to explore ways to recruit and retain a workforce who truly represents the communities we serve.

		Bureau so mental and behavioral health can be represented when teachers and school counselors reach out requesting career talks. In the past 3 years, multiple conversations were held with students at Chief Sealth High School. More locally within the department of Psychiatry, a hiring manager's workgroup was formed to evaluate existing hiring practices and implement anti-racist hiring practices.	

Priority Area: Suicide and Injury Prevention

Goal: Reduce preventable childhood injury and death, and help every child live the healthiest and most fulfilling life possible through equitable community and hospital-wide approaches.

Strategy 1: Increase access to and proper use of safety devices to diverse, under-resourced, and high-risk populations across the Washington, Alaska, Montana, Idaho (WAMI) Region.

Key tactics	Status	Highlights / Narrative	Opportunities
Increase safety devices (i.e., firearm lockboxes, life jackets, medication lockboxes, bike helmets and car seats) distribution to families		a) Seattle Children's Safe Firearm Storage Program distributed **1,048** lock boxes, **323** trigger locks, and **1,060** cable locks and corresponding safe firearm storage education to communities across Washington State and Missoula, Montana. Safe firearm storage devices and education were disseminated via **8** partner-led community events and programs and **4** Seattle Children's hosted events in Lynnwood, Chehalis, Seattle, and Bellingham. Additionally, we collaborated with Safe Kids Snohomish to evolve community education options by piloting a tabling model for safe firearm storage education and device distribution at **3** events in King and Snohomish counties in 2022. b) Over **450** safe firearm storage devices were distributed to patient families across **6** departments. Seattle Children's workforce members can be trained in **clinic-based safe firearm storage** education and device distribution. To enhance resources for clinic-based safe firearm storage education, we partnered with medical residents to develop Tips for Provider Messaging on Safe Firearm Storage and published it on our website in 2020. A research study was conducted to determine the impacts of providing	★ Continue to partner with communities across WAMI to: ▪ Co-host health and safety events ▪ Expand offerings for devices education and distribution in communities ▪ Assess opportunities to culturally tailor suicide and injury prevention education ★ Collaborate with Seattle Children's teams to ensure equitable access to safety devices education and resources across departments and clinics. ★ Expand opportunities to promote safe medicine storage and disposal. ★ Evaluate clinic-based safety device education and distribution program(s).

		firearm storage devices with training during clinical care with household members of children who present to a pediatric hospital with an emergent mental health complaint published in Academic Pediatrics in 2021. c) With support from Kohl's Cares and Panda Cares, Seattle Children's Health and Safety Program fit and distributed **1,932** bike helmets and **1,614** life jackets through community events and community partner programs. d) To further promote pediatric injury prevention and support patient families who receive care at Seattle Children's, more than **26** bike helmets and **46** life jackets were fitted and distributed to patients by clinical care teams.	
Foster collaboration of pediatric suicide and injury prevention initiatives across the WAMI region		a) Supported **11+** life jacket loaner stations across Washington State by providing **168** life jackets and ongoing technical assistance on how to develop and maintain life jacket loaner stations. b) Ongoing participation with **5** local and national coalitions/workgroups related to suicide and injury prevention including: Washington's Action Alliance for Suicide Prevention Workgroup, King County Youth Suicide Prevention Coalition, Safe States Anti-racism and Health Equity workgroup, Safe States Hospital Injury Prevention workgroup, Seattle Children's Trauma-Informed Care Workgroup. c) Participated in the Washington State Suicide Prevention Plan Youth Workgroup to inform plan updates.	★ Continue support of life jacket loaner station sites across Washington. ★ Nurture existing partnerships and develop new ones across the spectrum of suicide and injury prevention. ★ Identify opportunities to engage underrepresented communities to promote suicide and injury prevention. ★ Support tools for schools to prevent firearm violence in collaboration with community.

Note: *Due to the COVID-19 pandemic, we partnered with Marketing and Communications and Infection Prevention to develop a modified community event model to align with infection prevention protocol. We applied this model to events for bike helmet fittings and giveaways, life jacket fittings and giveaways, safe firearm storage education and giveaways, and car seat check events. We shared this model with 13 community groups and organizations nationally.*

Strategy 2: Expand suicide and injury prevention awareness education to families, caregivers, community organizations, schools, community pediatricians and other providers.

Key tactics	Status	Highlights / Narrative	Opportunities
Pilot a hospital-based medication storage distribution and disposal program to prevent adolescent substance (i.e., opioids, recreational and illicit drugs) misuse.		a) Partnered with Seattle Children's Innovation and clinical teams to conduct market research and user test viable options for safe medicine storage to meet family needs. b) Developed and disseminated: i. Community education on Safe Medicine Storage and Disposal to Prevent Misuse; and updated existing patient education materials to expand education on safe medicine storage and disposal. *ii.* *On the Pulse* article publication Home Safety During COVID-19: Preventing Medicine Misuse, and Alcohol and Drug Use, in response to families spending more time at home during the pandemic. iii. Video PSA on safe medicine storage and disposal. c) Provided community presentations during the 2020 and 2021 Washington Poison Center's Overdose Prevention & Harm Reduction virtual education series. d) Promoted Washington State's Safe Medication Return Program through social, parenting newsletters, provider newsletters, etc. to encourage safe medicine disposal. e) Promoted King County's Laced & Lethal Campaign through social, parenting newsletters, and provider communications to prevent youth fentanyl overdose.	★ Refine program plan for safe medicine storage and disposal with input from stakeholders. ★ Expand language options for educational materials. ★ Continue partnering with clinical teams on safe medicine storage options for patient families – especially for suicide prevention. ★ Continue to promote safe medicine storage and disposal within Seattle Children's and throughout communities (e.g., Washington Poison Center resources, Washington's Safe Medication Return Program). ★ Continue to promote youth fentanyl overdose prevention information as recommended by community.

Develop and disseminate suicide prevention and mental health promotion educational resources.		a) Public Health Seattle King County and Prevention Works in Seattle developed suicide prevention messages for radio PSAs with input from Seattle Children's (2020 listenership numbers = 81,1000). b) Annual promotion of Suicide Prevention Month including partnership with Forefront Suicide Prevention to offer LEARN Saves Lives training and educational resources to workforce and community. c) Participated in the 2021 Washington State Suicide Prevention Plan Youth Workgroup to inform state plan updates in partnership with Washington State Department of Health. d) Partnered with Crisis Connections to offer youth suicide prevention curricula to schools in Washington State, prioritizing under-resourced schools in areas with high rates of youth suicide. e) Developed 1 podcast episode on suicide prevention in partnership with C89.9 Coping 101 series. f) Ongoing promotion of Seattle Children's suicide prevention education including: i. Firearms in the Home community education distributed to more than 256,270 families (English and Spanish speaking) with children in the 3-year age group through partnership with Watch Me Grow Washington. ii. Firearm safety and suicide prevention PSA runs on local news outlets. iii. Teens, Depression and Firearms education via community events, social media, parenting newsletters, etc.	★ Continue assessment for a comprehensive approach to suicide prevention at Seattle Children's and within communities in partnership with community organizations. ★ Focus on opportunities to promote and/or develop culturally tailored educational resources for families. ★ Identify opportunities to engage underrepresented communities at risk for suicide to promote suicide prevention.
Support child passenger safety awareness and education.		a) Hosted 7+ community car seat check events in Seattle and created a new location for car seat checks in partnership with Overlake Medical Center and Clinics to support more families throughout greater King County.	★ Assess opportunities for community-facing educational materials for children with different abilities or special

		b) Washington Medical-Legal Partnership supported proposed changes by the Washington Health Care Authority for Washington Apple Health coverage of car seats and standing frames to account for needs of children and youth with special health needs. c) Seattle Children's Family Resource Center provided over 300 car seats to patient families.	needs. ★ Continue to host community car seat checks across King County and beyond. ★ Support capacity for child passenger safety prior to hospital discharge and within community.
Promote and disseminate water safety awareness and education.		a) Partnered with Injury Free Coalition for Kids to provide review and input on water safety education available online to communities nationwide. b) Educational video on How to Fit Kids for Life Jackets published on Seattle Children's website and shared via PSAs. c) Provided 9 presentations on water safety and drowning prevention to families and drowning prevention professionals in collaboration with No More Under, Bellevue Fire, ParentMap, Washington Recreation & Park Association, Washington State Parks Boating, Schools Out Washington, Mother Africa, and SPLASHForward d) Held 3 train-the-trainer sessions on life jacket fitting and safety information with Solid Ground, Mercy Housing, and Harborview Injury Prevention and Research Center staff. e) Completed publications contributing to water safety research include: i. Adolescent Water Safety Behaviors, Skills, Training and Their Association with Risk-Taking Behaviors and Risk and Protective Factors journal article in *Children*. ii. Disparities in Adolescent Reported Drowning Prevention Strategies in *Journal of Adolescent Health*, in partnership with Harborview Injury Prevention and Research Center and Washington State Department of Health.	★ Identify opportunities to engage teens in water safety messaging. ★ Partner with pediatricians to develop or promote water safety messaging to patient families. ★ Continue to partner with state and local organizations to promote water safety and drowning prevention including enhanced collaboration for National Water Safety Month, etc. ★ Continue to provide community education, consultation, and technical assistance specific to adolescent drowning prevention and life jacket use to communities as needed.

Expand reach of abusive head trauma prevention.		a) Over 1,200 people reached through abusive head trauma prevention education and positive parenting programs, including birthing hospitals across Washington State. b) Child abuse prevention campaign launched, including video PSA and flyer to support parent and caregiver mental health during the COVID-19 pandemic. c) Child abuse prevention and positive parenting promotion information and resources promoted through Seattle Children's Health and Safety Social Media campaign.	★ Continue to elevate and expand education and resources to promote positive parenting and abusive had trauma prevention to families and providers across WAMI.
Support sports injury prevention. *Note: Organized sports were reduced or eliminated, and athletic trainers were redeployed from their regular work in response to the COVID-19 pandemic*		*a) On the Pulse* article published: Returning to Sports Safely During COVID-19. b) Seattle Children's Sports Medicine teams: i. Planned and piloted a new, free virtual youth sports course*, Youth Sports: How Parents Can Support Positive Development* in partnership with the University of Washington. ii. Developed educational sports and exercise videos for Girls on the Run and Special Olympics of Washington. iii. Offered a series of virtual symposiums for athletic trainers. c) In partnership with LeagueSide over 19,000 parents and caregivers received messages on injury prevention and safe recreational play across Washington State.	★ Continue to provide coaching and education on sports safety and injury prevention within schools. ★ Expand offering of the Youth Sports course to families for free or low-cost virtually and/or in-person. ★ Promote Return to Learn guidelines.

Strategy 3: Collaborate with diverse, under-resourced, and high-risk populations to foster equity in suicide and injury prevention education.

Key tactics	Status	Highlights / Narrative	Opportunities
Evaluate youth associated suicide and injury to inform prevention and early intervention initiatives.	🟡	a) Literature reviews in progress; and key learnings shared with peers ongoing (e.g., incorporated into presentation to Washington Recreation and Park Association conference attendees).	★ Develop recommendations to enhance suicide and injury prevention programs based on evidence-based or evidence-informed efforts.
Develop better understanding of evidence-based strategies around displayed health behaviors on social media sites and consider new ways to provide prevention and intervention programs using social media.	🟢	b) Evaluation and manuscript published (*Receptiveness and Responsiveness of Using Social Media for Safe Firearm Storage Outreach a Mixed Methods Study*). c) Launched Seattle Children's Health and Safety social media campaign in partnership with Marketing and Communications and Community Health to promote injury prevention and wellness information and resources.	
Foster collaboration with Seattle Children's teams (e.g., Inclusion Networks and Patient and Family Education) and community resources to inform education and communications.	🟡	a) Partnered with Seattle Children's Inclusion Networks and Parent Advisors on suicide and injury prevention messaging, including safe firearm storage key messages and suicide prevention month messaging. b) Collaborated with the Parenting Inclusion Network to promote National Injury Prevention Day 2021.	★ Enhance collaboration with Workforce Planning, Diversity, and Inclusion on National Suicide Prevention Month and National Injury Prevention Day activities.
Integrate trauma-informed approaches into suicide and injury prevention initiatives.	🟡	a) Seattle Children's Trauma Informed Care Workgroup launched in 2021 with a mission to create a trauma-informed environment and culture at Seattle Children's for patients, their families, and workforce using anti-racism and equity as core tenets and to provide care that promotes safety and healing and resists re-traumatization.	★ Identify opportunities to incorporate trauma informed approaches into suicide and injury prevention education delivery and safety device distribution processes.
Conduct evaluation of lifejacket distribution to under resourced communities	🟡	a) Updated life jacket survey form for community education and giveaway events and implemented 2021-2022.	★ Apply findings and recommendations from surveys to better serve under resourced

			communities.
Be intentionally inclusive of inviting network (i.e., Firearm Tragedy Prevention Network, Drowning Prevention Network) speakers and attendees.		a) Tool developed to establish a baseline of meeting content variety, and to track past and future meeting presentations. b) Developed relationships with community-based organizations to inform community gun violence prevention.	★ Continue to identify and implement ways to create a more inclusive network. ★ Focus on community building with organizations across the state to promote harm reduction strategies.

Strategy 4: Support evidence-based pediatric suicide and injury prevention efforts through community partnerships.

Key tactics	Status	Highlights / Narrative	Opportunities
Maintain leadership role with WA State Firearm Tragedy Prevention Network (FTPN).		a) Co-led four Washington State Firearm Tragedy Prevention Network (FTPN) meetings with Seattle King County Public Health, Washington Chapter of the American Academy of Pediatrics, and Harborview Injury Prevention and Research Center including the first ever virtual meeting as an adaptation to the COVID-19 pandemic. i. Approximately 273 total combined meeting attendees from across Washington State. b) Developed and disseminated quarterly email communications compiler to share information and resources with the network between meetings. c) Co-crafted a network charter with the FTPN leadership committee.	★ Continue to support network meetings and communications. ★ Identify opportunities to diversify the FTPN leadership committee.

Maintain leadership role with WA State Drowning Prevention Network (DPN).		a) Revived the Washington State Drowning Prevention Network (DPN) meetings in collaboration with Washington State Department of Health, Safe Kids Washington, Public Health Seattle and King County, Washington State Parks Boating Program, Washington Recreation and Park Association and Seattle Parks and Recreation (3 meetings between May and April 2022). b) Supported development of three DPN committee working groups (life jackets, education, media and outreach) to enhance statewide collaboration and drowning prevention efforts. c) Developed and disseminated 23 email communication compilers with timely information for network members. d) Ongoing participation in Boating Injury Surveillance group through the National Association of State Boating Law Administrators (NASBLA).	★ Continue to support network meetings, working groups and communications.
Identify opportunities to engage communities via task forces, coalitions, (e.g., Safe Kids Coalitions) work groups, events, etc. annually.		a) Connection developed with Safe Kids Montana, Safe Kids Alaska, Safe Kids South King County, and St. Luke's Children's (Idaho) to share information/resource and learn from one another. b) Regular participation in partner meetings including Safer Homes Coalition, Western Pacific Injury Prevention Network, Injury Free Coalition for Kids, Washington State Department of Health Action Alliance for Suicide Prevention, and Safe States Alliance. c) Contributed to the 2021 Washington State Suicide Prevention Plan through participation in the Youth Workgroup. d) Completed 15 focus groups and interviews with caregivers in community to inform usefulness of the Water Watchers tool in partnership with Harborview Injury Prevention and Research Center and No More Under.	★ Continue to invest in new or emerging groups operating in this space.

Support hospital suicide screening initiative(s).		a) Seattle Children's Zero Suicide Initiative implemented to ambulatory clinics and regional clinics. This model has been shared with organizations including Safe States, Children's Miracle Network Hospitals, Washington Chapter of the American Academy of Pediatrics, and University of Wisconsin Health. b) Community Health partnership with clinical teams to integrate safe firearm storage education and resources into the Zero Suicide pathway. c) Partnership with Marketing and Communications, Patient Family Education and Communications, and Zero Suicide teams to develop a Caring Contacts program for suicide prevention.	★ Support clinical teams to implement Zero Suicide and connect patients who screen positive for suicide receive resources for safe discharge. ★ Advocate for safe firearm storage education and resources to be integrated into Zero Suicide as part of clinical standard work and create a sustainability plan. ★ Proceed with support for implementation of Caring Contacts program for patients post discharge.
Provide education and consult for policies that promote safer swim areas, surveillance, life jacket use, and swim lessons.		a) Completed 8 local, state, and national presentations on water safety and drowning prevention in collaboration with partner organizations. b) Supported swimming lessons scholarships availability through Seattle Parks & Recreation. c) Provided consultation to State Parks Boating regarding best practices for life jacket loaner stations.	★ Support capacity to offer consultation and technical assistance to water safety partners. ★ Continue to support child and family access to swimming lessons in collaboration with community partners. ★ Support the pipeline for lifeguard career programs (focus on teens and young adults) in partnership with community.
Promote life jacket loaner programs.		a) Completed 2020-2022 updates to life jacket loaner list and Google Map in partnership with State Parks Boating. b) Supported development of 6 signs across 2 new life jacket loaner stations in Sultan, WA, and Cle Elum, WA.	★ Continued support for new and existing life jacket loaner sites in Washington. ★ Utilize the DPN to share best practices for life jacket loaner stations in partnership with State Parks Boating.

Priority Area: Healthy Lifestyles: Healthy Eating, Safe and Active Living and Food Security

Goal: We will develop and support programs, partnerships and policies to prevent, assess and treat children that help them achieve healthy growth, focusing on addressing inequities and disparities.

Strategy 1: Expand community environmental supports for healthy eating, physical activity, and food security through community partnerships and programs.

Key tactics	Status	Highlights / Narrative	Opportunities
Increase access to healthy affordable foods and support healthy food access efforts (e.g. Fresh Bucks or SNAP Market Match) in King County.		a) **COVID-19 Response:** The impact of COVID-19 on cannot be understated relating to this strategy and progress therein. However, from 2019-2022 we deepened our partnership with the City of Seattle's Office of Sustainability and Environment, and had some of the following highlights: • Reached over 14,000 households to provide emergency grocery voucher assistance at the start of the pandemic. • Distributed 59,000 bags of fruits and vegetables from local farms to families with school aged children • Fresh Bucks vouchers distributed to 12,200 Seattle households to be redeemed at 31 participating retailers/Fresh Bucks locations valued at $47,000 in fresh fruits and vegetables in regional households annually. • Distributed 221,000 fresh produce boxed to Seattle Public School students to help meet food insecurity needs.	★ Fresh Bucks is a healthy food program that helps neighbors afford fruits and vegetables. Eligible and enrolled customers receive $40 each month to spend at participating farmers markets, independent grocers, and supermarkets using the Fresh Bucks Card or Healthy Savings app. Because the Seattle based program enrollment is currently full, opportunities for program expansion exist. ★ For SNAP Market Match, an opportunity exists with the State to expand the program beyond the current 120 participating Washington farmers markets and farm stands, shoppers who use Supplemental Nutrition Assistance Program (SNAP).

Increase healthy eating and nutrition education for the pediatric population in the region.		a) Despite 2020 temporarily closing YMCAs and the ACT program model of onsite programming, we were able to pivot and pilot of ACT! virtually *called ACT! @Home*. Instead of stopping entirely, we collaborated on a way to bring the healthy lifestyles program to families in their homes. b) Gratitude goes out to the YMCA partners for being brave and navigating this online format to reach families. Our reach certainly wasn't as robust as the time when several YMCA branches were open to in person classes however it was a start. We are likely to continue offering this as an optional format since we have learned *ACT@Home* can help those families that may not be physically going into YMCAs for the time being.	★ Opportunities for hybrid at this stage of the pandemic deserve exploration.
Identify food insecurity and improve access to healthy, affordable foods among children in our region.		a) Every family who comes to the Odessa Brown Clinic for a well-child visit completes a short questionnaire about food insecurity. Patients that screen positively are connected to food assistance programs such as SNAP, WIC or their neighborhood food bank. b) In addition, we team up with Northwest Harvest to bring a mobile food pantry to Odessa Brown twice a month and we provide families with produce prescriptions — vouchers for fruits and vegetables that are good at grocery stores and farmers markets. c) We crafted and printed online a toolkit entitled "Food Resources Patient and Family Education Toolkit" and brought it live online: The Patient & Family Education & Communication team and Food Security program collaborated on the new toolkit, which makes it easier to find food resources. Search for information on local food banks, SNAP, WIC, and more.	★ Continue to support expansion of the hospital-based food pantry program as it continues to meet demands: in Aug 2021 we welcomed 207 individuals or 58 families, who accessed the walk-up food pantry model + home deliveries. One year later in Aug 2022, we welcomed 562 individuals or 128 families. We are committed to stabilizing resources for main campus clinics + five regional clinics by end of 2023.

		d) Safeway Albertsons and Northwest Harvest (NWH) are teaming have teamed up to provide NWH agency partners Safeway grocery cards to distribute to families. e) Even and despite COVID-19, we honor all visitors to our hospital campus food pantry, 1/3 of which are our own workforce members. The food pantry is still open to walk-in visitors. Some food pantry successes: • # of deliveries to inpatient families from University District Food Bank is increasing again. • Use of delivery service is increasing. Families in King County have access to everything in the food pantry, delivered to their door. • A grant from Safeway Albertson's enabled us to distribute grocery gift cards to families. • The outpatient food security pilot is going to strategically expand over the next several months. COVID has made this urgent. After 2.5 years, our scope includes 9 out of ~35 clinics. f) Hunger Vital Sign screening will still be required and essential. Epic (our electronic health record) has made the Hunger Vital Sign accessible org-wide.	
Aim to eliminate inequities in childhood physical activity and nutrition outcomes among racial/ethnic minorities and socioeconomically disadvantaged populations through innovative behavioral interventions and policies in school and community settings.		a) Inequities deeply remain in this space and despite COVID-19 driving even more disparate outcomes in pediatrics, some highlights are: • We continued work on the CDC awarded REACH grant (Racial and Ethnic Approaches to Community Health). Through REACH, recipients such as Seattle Children's plan and carry out local, culturally appropriate programs to	★ Opportunities remain around completing the KC REACH goals to increase access to healthy foods, to engage residents in planning processes to create active living environments, and to establish effective community-clinical

		address a wide range of health issues. In King County the REACH grant has two components: The first is designed to improve health equity among African Americans/Blacks and Asian Americans, the two largest racial/ethnic populations living in South Seattle, SeaTac, and Tukwila – a contiguous area in the county where at least 20% of residents live at or below poverty level. The second component is to promote and increase access to flu and COVID-19 vaccinations for Black/African American, African-born, Asian, Hispanic, and Pacific Islander populations throughout the county with a focus on south Seattle and south King County. • With schools and community settings shuttered during the height of the COVID-19 pandemic, progress in these areas wasn't as robust.	linkages within the priority are by building on existing community strengths.

Strategy 2: Advocate for policy, system and environmental changes that increase healthy eating, nutrition education and safe and healthy recreation.

Key tactics	Status	Highlights / Narrative	Opportunities
Policy, System and Environmental changes in King County.		a) Over the last three years, we invested in our partnership with the Childhood Obesity Prevention Coalition as one of our primary PSE partners: b) PSE wins include: introduction of Healthy Drinks, Healthy Kids (SB 6455) which made great progress but didn't become law. This bill would have made designated healthy beverages the default beverage on every kids' menu instead of sugary drinks in hospitality settings. c) Washington State operating budget provided $2.5 million for fruit & vegetable incentives. Advocates were successful in helping to secure an additional $1.3 million for the Fruit and Vegetable Incentive Program this past session to fill a hole left by a missing year of federal grant	★ Explore the BUILD Health grant opportunity and REACH notice of funding opportunity in early 2023.

		funds. This investment will sustain the program through the current biennium for 35,000 SNAP shoppers without interruption. d) There are currently six statewide transportation policy goals used to guide public investments in transportation. HB 2461 and SB 6452 were introduced to add "health" as a seventh goal. HB 2461 did pass the House floor but was unable to get a vote in the Senate Transportation Committee. e) When child and adolescent vaccine rates plummeted during the pandemic, we collaborated with WCAAP partners to reach hundreds of thousands of Washington families to help kids catch up on crucial vaccines. We coached pediatric clinics across the state to achieve significant increases in adolescent vaccination rates. We are listening to and encouraging families to vaccinate against COVID- 19: especially families of color and other communities who lack access or face other barriers – providing families with reliable information and support.	
Advocate for capital improvements in the WA state budget for schools to increase health and safety.		a) We were part of prior efforts to develop and sustain the Healthy Kids, Healthy Schools grant program back in 20215. Since that time there has been more than $10 million invested in Washington schools, including helping schools purchase school kitchen and physical education equipment and water bottle filling stations. We intend to fight for another round of grant funding in the 2021 legislative session and were cheered to see that OSPI put forward this grant program as part of their decision package to the Governor which was then picked up the Governor's proposed Capital budget. b) Regarding Physical Education School Assessments: In 2017 we worked with others to successfully pass HB	★ Future opportunities are unfortunately limited due to the State's budget crisis.

		1235, which requires school districts to conduct an annual review of their physical education programs. The first round of data was captured in the 2018-19 school year but COVID wiped out the review process in the 2019-20 school year and capturing data in this current school year is clearly not a given. We know there is follow up policy work ahead here but really wanted several years of data to support that effort.	
Invest in culturally and community tailored programs (e.g. healthy eating, cooking, and nutrition) to promote food affordability as well as cooking and eating at home.		a) COVID-19 response paused all cooking demonstrations, gardening classes and health fair curriculum dissemination via outreach events. b) With initial support from a $5.8 million U.S. Department of Agriculture Food Insecurity Nutrition Incentive (FINI) Grant (2015-2020), the Washington State Department of Health and dozens of state and local partners developed and tested fruit and vegetable incentive programs with farmers markets, grocery stores, and healthcare systems. c) To continue the programs started under the FINI grant, the FVIP was established by Substitute House Bill 1587 in 2019, and the State of Washington appropriated $3.8 million for FVIP (for the 2019-2021 biennium). Continued support from state, federal, and private funding allows the FVIP to continue operating. d) In 2020, Washington State Department of Health and partners were awarded a $4.7 million U.S. Department of Agriculture Gus Schumacher Nutrition Incentives Program (GusNIP, formerly FINI) Grant (2020-2023) to support and expand SNAP Market Match and Grocery Store SNAP Incentives to reach more Washingtonians. e) During FY 20, Odessa Brown Children's Clinic served 116 families with FINI. Also, OBCC maintained their food	★ As infection prevention protocols permit, an opportunity to continue and expand cooking classes and grocery shopping on a budget classes should resume.

		bank during COVID and has served 1,800 bags of foods to community members since March, 2020.	
Implement or sustain evidence based initiatives to increase the number of safe places to play, engage in physical activity and help promote healthy growth.		a) 500 Free play kits (soccer balls, jump ropes, sidewalk chalk, frisbees and masks) that were distributed by the Healthy King County Coalition in partnership with SC via the CDC REACH grant in October of 2020 in South Seattle. b) Blog post on Dr. Pooja Tandon's work and research, along with Dr. Michelle Garrison's work and Phoung Troung, RD's work on healthy eating and active living reached over 3,000 households. c) Despite 2020 temporarily closing YMCAs and the ACT program in its model at the time, we were able to pivot and pilot an ACT! Program virtually called ACT! @ home.	★ As the Seattle Children's Research Institute resumes in person research opportunities, the evidence base for programmatic interventions will also increase. Opportunities to explore deeper partnerships with SCRI exist.
Integrate advocacy as a core component of healthy eating, safe and active living and food security initiatives.		a) See above on legislative wins around food security. b) During the legislative sessions over the past three years a few items of note: WA house bill 2660 and house bill 6091 were passed. HB 2660 (Rep. Marcus Riccelli): increases use of the Community Eligibility Provision to provide meals at no cost to all students. As a result of this bill, 7,200 more students at high need schools will be able to access nutritious school meals without worrying about how they will afford it. Operating budget included $57,000. Also, regarding HB 6091 (Sen. Judy Warnick): formalizes the Food Policy Forum, which is a public/private partnership that has been meeting for a few years to build bipartisan policy recommendations to improve the health of our food system. Budget provided funding to Dept of Agriculture and the Conservation Commission for staffing. c) Department of Transportation Active Transportation Funding (Safe Routes to School; Bike and Pedestrian; and Complete Streets projects) for much of session it was	★ With the sunset of the Childhood Obesity Prevention Coalition, we can and should seek enduring advocacy partners in this work, most notably the Health Coalition for Children and Youth (HCCY).

		unclear what the Legislature would choose to do about the impact of I-976 on the transportation budget. The final transportation budget utilized one-time transfers, adjustments, and the usage of underspent dollars due to deferred or cancelled projects to balance the budget. The budget did not make the extensive cuts that were anticipated heading into session, and still believed by many to be coming in the long-term. d) Advocacy efforts also got a $500,000 line item in the budget for "No Child Left Inside" where these one-time funds are provided for additional grans for youth-focused outdoor education and recreation program in WA State. Another budget line item included: $696,000 to Department of Children, Youth & Families Funding is provided for 1,425 youth in an out of home placement to participate in extracurricular actives such as art, sports, summer camp and clubs to ensure these youth have the same opportunities for recreational experiences as their peers.	

Priority Area: Economic Security

Goal: In partnership with our community, Seattle Children's will leverage our assets to address upstream determinants of health.

Strategy 1: Honor our role as an anchor institution through place-based work and investments locally and regionally.

Key tactics	Status	Highlights / Narrative	Opportunities
WORKFORCE: Hire local, diverse workforce from under-resourced communities in our region.		a) We set a fiscal year 2022 goal to increase employee diversity by race/ethnicity to 40%, to further reflect patient population. The Q4 FY22 goal of 40% is trending positively toward the goal, with a current result of 40%. b) Since 2017, we have increased our executive leadership diversity from 0% to 42%.	★ Ongoing work to increase employee diversity includes requiring hiring managers to attend inclusive and equitable recruitment training, redesigning the SeattleChildrens.org careers site and incorporating new diverse recruitment videos, publishing diversity analytics and highlighting Seattle Children's Inclusion Networks.
PURCHASING: Contract for services and supplies from local vendors that are small, and diverse, meaning women-owned or BIPOC owned.		a) During 2019-2022 our goal was to increase spend by 10% annually as noted above; by the end of Q3 we were 75% to goal for total diverse spend. b) We have also hired a Manager, Supplier Diversity who reports to our Chief Procurement Officer. c) Our Sourcing team has an annual goal for increasing local and diverse spending by 10% *year over year*. Our current state total diverse spend percentage is 4.3%. Initially we wanted to reach a total percentage of 10% diverse spend in WA State, which felt achievable given state demographics (Population of WA is 69.3% White, 12.4% Hispanic, 3.7% African American and 8.11% Asian).	★ In our first few years of work and learning, we realized there is slow but consistent progress and we need to revise the first projected goal to something achievable by 2025, and determine next goals at that time. That work is in progress.

CONSTRUCTION: Construct new buildings with a minimum level of diverse (small, local POC owned) contractors required with every bid.		a) Completed in 2022, the Forest B building is a 310,000-square-foot addition to Seattle Children's hospital campus. It will expand the hospital's clinical space and allow us to treat more patients to meet the growing demand for our services in the region. As Seattle Children's finished construction on Forest B, our new critical care and clinics building, we set a goal of 10% of those total construction contracts given be awarded to diverse contractors. 10% goal was met. It needs to be noted that Diverse criteria = Women/Minority*/Veteran owned businesses. Businesses in HUB economic zones. ** "Minority" is not a term we prefer here at SC as we much prefer Black, Indigenous, People of Color: the global majority. However, it is a term still used by the State of Washington and the Federal Government to classify businesses owned or operated by BIPOC individuals*	★ Opportunities remain with the idea of Forest C, the Sand Point Magnuson clinic remodel and any OBCC Othello seismic retrofit work in the years ahead.

Strategy 2: Address upstream social and environmental determinants of health.

Key tactics	Status	Highlights / Narrative	Opportunities
Develop and maintain local housing supports such as the Housing Solutions for Hope Guild, Transplant House and partnerships with Mercy Housing, Cedar Crossing and Popsicle Place Shelter.		**a)** Housing Solutions for Hope guild raised over $136,000 in August of 2022 alone- all proceeds aim to deliver safe, readily-available housing solutions for patient families in greatest need at Seattle Children's. This Funding will create longer term lodging solutions for families while under Seattle Children's care determined by stays from 1 week to 3 months. b) Founded by transplant recipients, Transplant House is a	★ As we add more clinics into the social determinants of health screening, we have an opportunity to add more housing partners into the referral network.

		grassroots nonprofit organization that provides the region's most clean, affordable and home-like residences for people awaiting or recovering from transplants. Highlights include expanding the contract that the hospital has with this service provider to house even more patient families.	
Further develop and support the Medical Legal Partnership.		a) The Medical-Legal Partnership (MLP) is a Seattle Children's program that provides pro bono attorney services for Seattle Children's and OBCC patients. Since its inception in 2013, the MLP program has only had 1.1 FTE dedicated staff support to operate this program for our Washington state based patient families. In the past year, MLP has provided legal services to 279 patients and their families, provided 255 legal consultations with health care providers at the hospital, Autism Center and OBCC, trained 593 staff through 44 legal education trainings, and achieved health policy improvements on several statewide systemic advocacy projects. Demographics of those families:74% of clients below 200% of the Federal Poverty Level, 51% of clients speak a Language other than English, 55% of clients are from communities of color and hail from many Counties outside of King County. MLP continues to provide financial benefit to Seattle Children's. b) We have successfully added in a 1.0 FTE into the program effective late 2022.	★ We continue to improve upon how we take referrals into the MLP program and innovate around health harming legal needs.
Support Odessa Brown Children's Clinic (OBCC) redevelopment.		a) Operated by Seattle Children's, OBCC opened a new facility in Seattle in March of 2021 at Othello Square, a community space that includes a charter elementary school and mixed-income housing. OBCC Othello aims to address social determinants of health that impact children by providing outpatient medical, dental and behavioral health services as well as nutrition, sports medicine, physical therapy, and occupational therapy.	★ Opportunities for community engagement, especially around the OBCC Central District campus remain.

		b) With the help of donors who contributed more than $125 million to various health initiatives, the hospital invested $52 million to build Othello OBCC. The hospital is also providing more than $37 million in operational funds and a $125 million endowment for OBCC.	
Partner with Medicaid Transportation supports and the Community Resource Team to assist families and remove barriers to accessing care.		a) While we have been able to reorganize the team that helps with Medicaid Transportation supports, we have not been able to expand that team during COVID-19. b) Staff changes have shifted resources from a Community Resources Team model to a Social Work departmental lead model and we have been able to hire 5 new FTE in the Social Services Specialist category.	★ Deeper opportunities exist within our relationship with HopeLink that we look forward to developing.
Increase Seattle Children's sustainable practices and climate action plan.		a) In the summer of 2022, Seattle Children's announced the signing of the Department of Health and Human Services' (HSS) Health Care Sector Pledge, strengthening its enduring commitment to sustainability and environmental stewardship to provide better futures for children, their families and the community. The voluntary pledge will commit us to: • Reducing our organization's emissions by 50% by 2030 and to net zero by 2050 and publicly reporting on their progress. • Completing an inventory of supply chain emissions. • Developing climate resilience plans for their facilities and communities. b) The Seattle Children's hospital campus aims to be carbon neutral by 2025 with climate work across several areas including health care delivery, supply chain and infrastructure, and education. Additionally: • The organization is a member of the Health Care Without Harm US' Health Care Climate Council	★ We're proud of these efforts but know there's so much more work to be done. ★ As an organization, Seattle Children's is steadfast in its commitment to the environment and eager to do even more to build on the foundational programs and efforts underway. ★ Federal policy changes that will help move this work to the next level include incentives for sustainability including tax credits, financial incentives for improving hospital energy efficiency and investments to strengthen public transit and grow safe cycling and walking routes.

		• Seattle Children's has removed 100% of Desflurane from our formulary • Seattle Children's expanded telemedicine options for patients to reduce carbon footprint of operations • Seattle Children's implemented an internal sustainability program that provides ongoing education to nurses, physicians, staff and leadership • The organization's Green Team began Project SPRUCE, reducing anesthetic gas impacts 6-fold and received a 2022 Husky Green Award • The transportation program gained Platinum recognition from Seattle's Department of Transportation c) Seattle Children's has been recognized by external organizations focused on measuring environmental stewardship and commitment to sustainability. This includes being awarded the Top 25 Environmental Excellence Award by Practice Greenhealth (2015-2020) and being named one of the 50 Greenest Hospitals in America by Becker Hospital Review. Additionally, Seattle Children's was the first hospital in the U.S. to receive Salmon Safe certification for its campus in northeast Seattle in 2017.	

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 2019 to 2022, we sought to make an impact in four priority areas by embarking on 12 strategies and 63 tactics. In total, we proudly made progress on all 63 tactics: 49 of which are "green" indicating complete or progressing with little to no barriers to achieve successful outcomes. The remaining 14 tactics are in "yellow" status, meaning some pivots or slowdowns have kept us from achieving proclaimed outcomes but the work is continuing in earnest.

While there is still much work to be done, we are proud of the progress we've made the past three years despite COVID-19's impact on our abilities to launch some of these efforts. To learn more about our Community Benefit work, please visit: www.seattlechildrens.org/communitybenefit.

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