







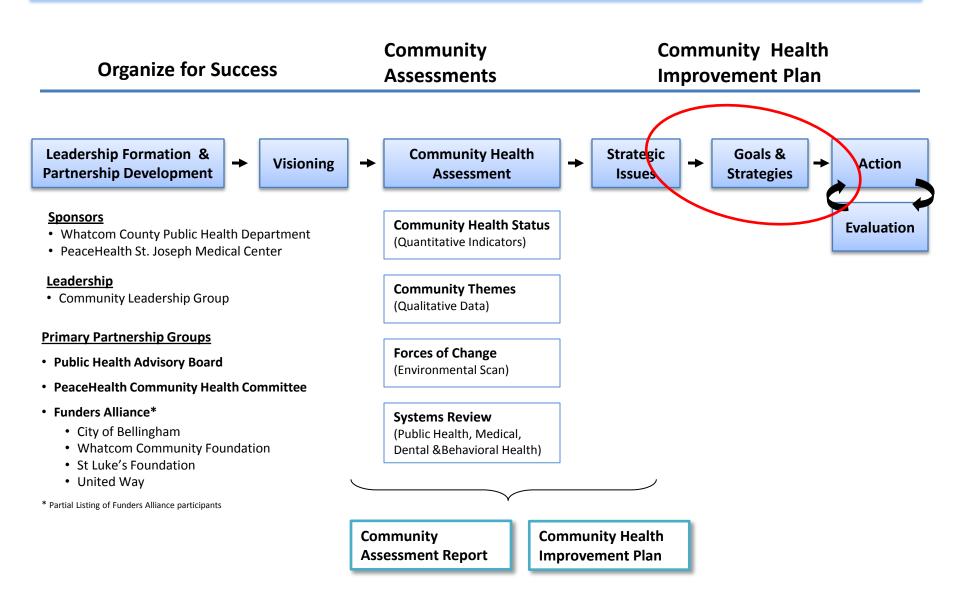
Whatcom County Community Health Improvement Plan Update

March, 2013





Mobilizing for Action through Partnerships and Planning ~ (MAPP) Process



CHIP Big Picture

Primary Goal:

 Improve health for all Whatcom County residents, especially vulnerable groups and populations with poor health outcomes

Implementation Priorities:

- Focus on substance abuse
- Community-based leadership and "voice"
- Build on current efforts to improve community health

Priorities	Assessment Findings	
Healthy Child, Youth and Family Development	 Income and education are directly related to health outcomes. Childhood adverse events have a significant impact on health and well being. Whatcom County has high rates of childhood abuse and lower rates of high school graduation. 	Sı
Healthy and Active Living in Neighborhoods and Communities	Research shows that people in more rural areas and lower income city neighborhoods have: • Less access to healthy foods • Fewer safe places to be physically active, e.g. ride a bike or walk. • More exposure to tobacco smoke and tobacco products.	Substance Abuse
Health Care for Vulnerable Populations	 Primary care capacity in Whatcom County is insufficient. There are more effective ways to provide care for high utilizing patients with complex chronic conditions. People of certain ethic groups do not feel welcomed into our health care system. 	Se

Call for Community Response

Strategic

Goals that Inspire

Strategic Priorities	Goals
Support Healthy Child, Youth and Family Development	 All families are strong, stable and supported from the start All children enter school safe, healthy and ready to learn All youth graduate from high school prepared for bright healthy futures
Promote Healthy and Active Living in Neighborhoods and Communities	 All people live in safe, healthy and affordable homes All people feel safe and connected to their neighbors and to their community All people have opportunities to adopt healthy active lifestyles in their neighborhoods or communities
Ensure Health Care for Vulnerable Populations	 All people have access to essential health care services All children, adults and seniors with complex needs receive supports that optimize outcomes All people feel welcomed into the health care system and are satisfied with their health care system experiences

Substance Abuse Key Issue

Strategic Priorities	Substance abuse
Healthy Child, Youth & Family Development	Impact on children and family wellbeing
Healthy & Active Living in Neighborhoods & Communities	Crime rates and effect on neighborhoods
Health Care for Vulnerable Populations	Treatment availability

Respect for "Voice"

Strategic Priorities	People with Interest
Healthy Child, Youth & Family Development	 Young families, particularly families with lower incomes Families who are part of non-majority racial and ethnic groups Single parents, particularly single mothers living in poverty
Healthy & Active Living in Neighborhoods & Communities	 People living in rural areas of the county Lower income Bellingham neighborhoods
Health Care for Vulnerable Populations	 People who are uninsured or under-insured, or have Medicaid coverage People with chronic health conditions requiring ongoing and intensive engagement with health care system. Non-English speaking populations; people who are part of non-majority racial and ethnic groups

Building on Current Work

Strategic Priorities	Leading Organizations and Coalitions
Healthy Child, Youth & Family Development	 Opportunity Council/Early Learning and Family Support Services United Way of Whatcom County Whatcom County Health Department Whatcom Family and Community Network Whatcom Early Learning Alliance School Districts and Higher Education (e.g, Bellingham Public Schools/WWU Woodring College of Education)
Healthy & Active Living in Neighborhoods & Communities	 Whatcom County Health Department City of Bellingham Opportunity Council/Housing Center
Health Care for Vulnerable Populations	 Whatcom Alliance for Healthcare Advancement (WAHA) PeaceHealth St. Joseph Medical Center Interfaith Community Health Center

Strategic Priority 1: Supporting Healthy Child, Youth and Family Development

Goals	Outcome Measures (Proposed)	Proposed Initiatives and Actions
All families are strong, stable and supported from the start	 ↓ % Families with young children living in poverty ↓ % Households in which children have 3 or more adverse childhood experiences (ACES) 	 Develop cohesive system of services and supports for new parents/emerging families, including targeted health and social services for at-risk families (i.e., nurse home visitation, mental health counseling, housing case management, financial literacy)
All children enter school safe, healthy and ready to learn	↑ % Children who meet kindergarten school readiness standards (all domains)	 Expand availability and access to high quality early learning opportunities and developmental supports for at-risk children
All youth graduate from high school prepared for bright healthy futures	↑% Youth who graduate from high school on-time	 Implement evidence-based approaches in schools and other settings to respond compassionately to children and youth who have experienced adverse events (ACEs) or have other challenges to success

Supporting Healthy Child, Youth and Family Development

Enhance family Optimize early childhood Improve educational Goals/ functioning and reduce development and school achievement and **Employment Focus** adverse childhood Areas readiness attainment experiences Income Better Increase family economic Increase parental support Increase parental stability and ability to meet for children's learning and educational attainment and **Opportunities** basic needs development vocational skills for Personal and Family Health Identify and address Identify and address youth Identify and address child parental mental health, mental health and substance use and behavioral and developmental issues that interpersonal violence developmental issues impact learning issues Increase positive youth Increase positive parenting Increase child connection connection to family, and healthy family to positive high quality -Improve friends, school and relationship skills early learning environments health community -Reduce disparities **Emerging families:** Young children: Youth/young adults: Life Course Pregnant mothers/new Middle and high school 0-6 years Stage parents ↓# and % of children who ↑ # and % children who ↑ # and % youth who Key ↓# and % families living

meet kindergarten

readiness standards

experience abuse/neglect

(high ACEs)

Measures

in poverty

graduate from high school

Strategic Priority 2: **Promoting Healthy & Active Living in Neighborhoods and Communities**

Goals	Outcome Measures (Proposed)	Proposed Initiatives and Actions
All people live in safe, healthy and affordable homes	↑%People who report no housing related problems (cost, inadequate facilities, homelessness)	 Advocate for ongoing development or refurbishing of affordable housing and supportive housing units within close proximity to healthy community amenities
All people feel safe and connected to their neighbors and to their community	↑% People who feel safe walking in their neighborhood ↑% People who report knowing their neighbors	 Complete GIS mapping project relating health amenities to geography Develop place-based projects to improve safety, social connections, and advance healthy living opportunities in targeted communities.
All people have opportunities to adopt healthy active lifestyles in their neighborhoods or communities	↑% People that live within ½ mile of healthy community amenities (transit, grocery store, park/play area, walking path/trail)	 Incorporate "healthy living" perspective in community design and planning including transportation, economic development, and housing plans

Strategic Priority 3: **Ensuring Health Care for Vulnerable Populations**

Goals	Outcome Measures (Proposed)	Proposed Initiatives and Actions
All people have access to essential health care services	 ↓% of people who are treated in the ED who do not have health insurance coverage ↑ %Adults with preventive dental visit in past year 	 Expand access to health insurance coverage/financial support Expand primary care, oral health and behavioral health capacity, particularly for underserved populations
All children, adults and seniors with complex health needs receive supports that optimize outcomes	 ↓ # and rate of avoidable Emergency Dept (ED) visits and hospitalizations ↑ %Children/adults with complex health needs who receive care in Medical Home 	 Develop community response to high-utilizing patients with complex needs, (e.g. "hot spotter" primary care clinics and centralized case management with access to substance specialists) Pilot new ways of integrating mental health and chemical dependency treatment with primary care
All people feel welcomed into the health care system and are satisfied with their system experiences	↑%People who report satisfaction/perception of high quality care	 Implement system-wide cultural sensitivity training and review of organizational practices





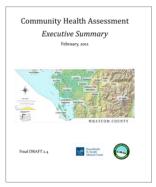


Next Steps # 1

Complete Documents, Create Community Collateral



CHA SourceDocument



CHA Executive Summary



CHIP

- CHIP User's Guide
- Presentation templates
- Web presence

Acknowledgements



ASSESSMENT & PLANNING

Project Funded by:

PeaceHealth St. Joseph Medical Center and the Whatcom County Health Department

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Sue Sharpe, St. Luke's Foundation

David Stalheim, City of Bellingham

Peter Theisen, United Way of Whatcom County

David Webster, City of Bellingham (and Opportunity Council)

Greg Winter, Opportunity Council

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CHIP Retreat Facilitation

Scott Davis, Tacoma-Pierce County Health Department

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PeaceHealth St. Joseph Medical Center Community Benefit Committee

Whatcom County Public Health Advisory Board

Whatcom Alliance for Healthcare Access (Larry Thompson, Elya Moore)

Whatcom County Health Department Staff (Gail Bodenmiller, Anne Deacon, Gail DeHoog, Joe Fuller, Melissa Morin, Nicole Willis, Judy Ziels)

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Project Support

Kathy Cunningham

IMPLEMENTATION

Sponsors and Funders to Date (3/2013)

