Community Health Improvement

Whatcom County, WA | 2012-2017

Annual Report

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Annual Report Acknowledgements

The Whatcom County Health Department's 2015 Annual Report for the *Community Health Improvement Plan,* provides a progress update for community partner organizations, community residents, and Whatcom County leadership in relation to the implementation of the 2012-2017 Whatcom County *Community Health Improvement Plan* (CHIP). This report informs stakeholders of CHIP strategy implementation, while also providing a plan to monitor and evaluate progress in the future.

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Introduction

This document is a companion to Whatcom County's *Community Health Improvement Plan* (2012-2017) and *Community Health Assessment* (2011), and is intended to share lessons learned, specific actions that are in progress and forward momentum of the community's priorities. On the following pages you will find a brief overview of the process that has led to this point in community health improvement planning for Whatcom County, and the future direction of this collaborative effort. This report contains a progress report narrative, as well as a revised *Community Health Improvement Plan (CHIP): Implementation Plan*.

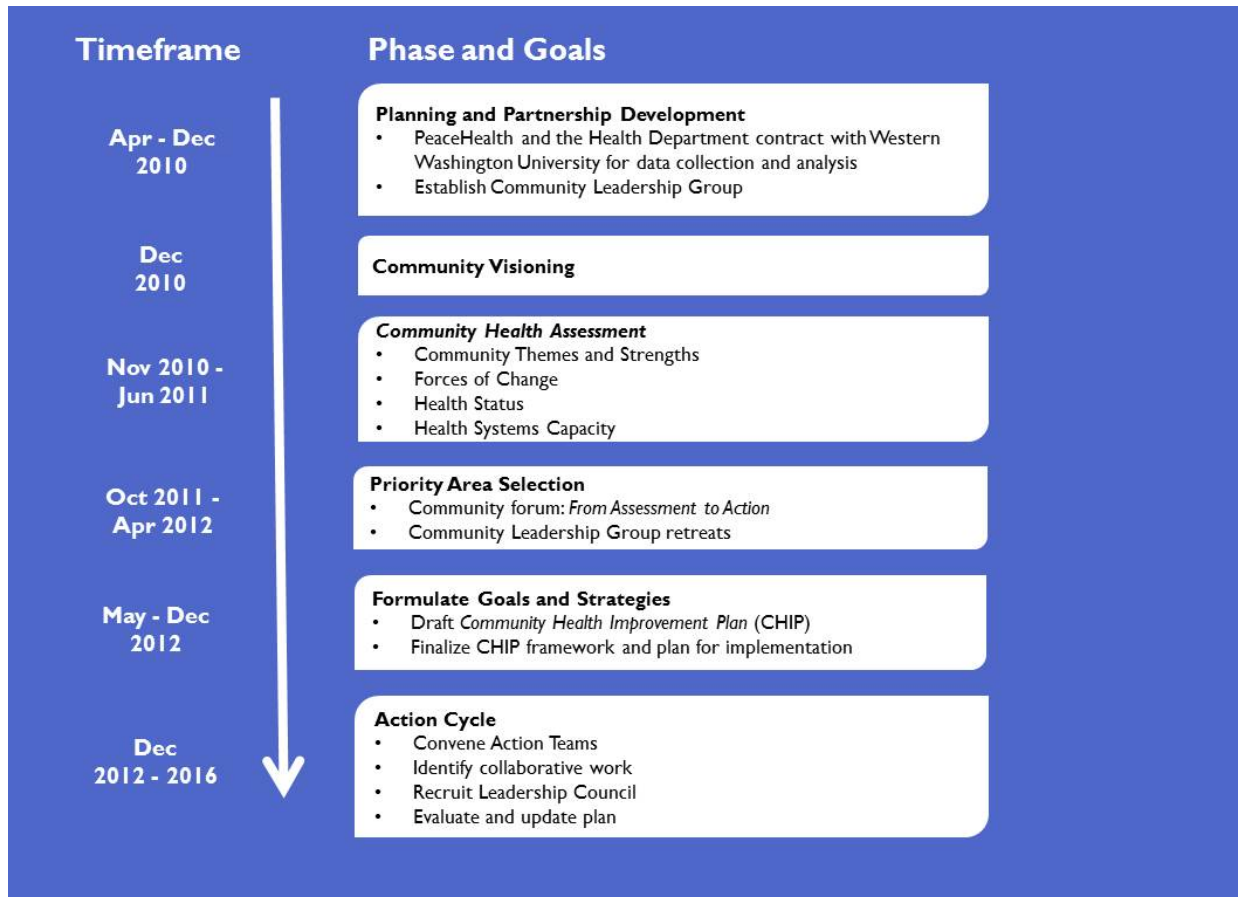
To review the complete *Community Health Assessment* or the *Community Health Improvement Plan*, visit http://www.whatcomcounty.us/health.

Background and Planning Process

Whatcom County's community health improvement planning is an ongoing, multi-year assessment and planning effort sponsored by PeaceHealth St. Joseph Medical Center and the Whatcom County Health Department (hereafter called Health Department), in collaboration with multiple community partners. The goal is to guide community leaders and residents in making decisions about where to invest time and resources to make measurable differences in the health and well-being of the community. Through this process, the Whatcom County *Community Health Assessment* (2011) and *Community Health Improvement Plan* (2012-2017) were developed.

Planning Process and Timeline

Below is a brief summary of the timeline and steps involved in Whatcom County's community health improvement planning, with more detailed information to follow.



The *Community Health Assessment* (2011)

Community Health Assessment data demonstrates that while most people living in Whatcom County are healthy, not everyone shares in this experience of good health. Low income, lack of work, limited education, geographic isolation and racial or ethnic background are factors that correlate with less opportunity for good health and higher risk for poor health. Gaps in opportunities, achievement and outcomes can and should be closed. To determine the health priorities of Whatcom County, data was paired with community input that shared stories and experiences of life in Whatcom County to give insight into the general health of the community. By pairing the data with community stories, priority areas were determined for focused effort to make a lasting impact in the community, which have been captured in the *Community Health Improvement Plan* (2012-2017).

Key Findings from the *Community Health Assessment*:

- People in Whatcom County are generally healthy
- Despite overall good health, challenges and disparities are hidden among the averages
- Poverty and adversity threaten the health, well-being and success of a significant portion of children and young families
- Mental health and substance use are particular challenges for the community
- The community is well-positioned to respond to federal health care reform, but issues of access remain for certain populations
- Whatcom County is becoming older and more ethnically diverse
- Service providers are facing major changes in client needs, resource availability and requirements for accountability
- Access to healthy food, safe, affordable housing and health-promoting living environments are increasingly recognized as contributing to good health
- Environmental protection and economic development are inextricably linked
- Communities that are disproportionately impacted by health and social issues have limited voice in community decisions, and have much to offer

Moving from Assessment to Action

In October 2011, the Community Leadership Group and core team sponsored a community forum titled *From Assessment to Action*. Visioning partners and other interested community members were invited to a presentation of *Community Health Assessment* findings. The large group then broke into smaller groups to discuss the key findings. Input from this forum provided a framework for the identification of priority areas:

1. Community voice and engagement
2. Healthy child, youth and family development
3. Healthy living in neighborhoods and communities
4. Health care access and service delivery
5. Substance abuse and mental health
6. Health data and metrics

In March and April 2012, the Community Leadership Group held two full-day retreats to discuss and select the final priority areas. After consideration of the assessment findings and community input, leadership identified four priority areas for strategic intervention as the community works to address the overarching question: *How do we improve health, reduce disparities and advance equity in Whatcom County?*

1. Build community connectedness and resilience
2. Enhance child and family well-being
3. Promote healthy active living
4. Improve health care access and service delivery

The selected priorities reflect a deliberate and, at times, difficult process of making decisions about where to focus attention for the greatest impact on improving health, reducing disparities and advancing equity in Whatcom County. In creating this plan, community leaders have recognized that in order to improve health, issues of disparities that exist in the community must be addressed.

Priority Area Development and the *Community Health Improvement Plan* (2012-2017)

After identification of the priority areas, a *Community Health Improvement Plan* was developed that captured the vision of the community and leadership, as well as utilized evidence-based programs and interventions to achieve marked improvement in each priority area. Development of the Whatcom County *Community Health Improvement Plan* generally followed the Mobilizing for Action through Partnerships and Planning (MAPP) framework, an evidence-based community health strategic planning model. The process involved multiple steps and many community participants over a period of approximately 18 months. The *Community Health Improvement Plan* is broad, but does not include every important issue that affects the community. The hope is that the community will continue efforts to address other important issues at the same time that the *Community Health Improvement Plan* provides a focus for concentrated and collective action that will improve overall health and equity.

Community Partnerships for Health Improvement

After the *Community Health Improvement Plan* was completed, infrastructure was put in place to support ongoing implementation. This involved engaging different groups in implementation. While several members of the Leadership Group continued on in their leadership capacity with the newly formed Leadership Council, several new members joined the group. Additionally, Action Teams have been formed around three of the four areas, with each group adding strategies to promote the fourth priority area of building community connectedness and resilience, as this has been determined to be so foundational to the success of the entire *Community Health Improvement Plan.*

Each Action Team has organizational sponsors who provide staff to chair the group:

- Child and Family Well-being: Opportunity Council and United Way of Whatcom County
- Healthy Active Living: Whatcom County Health Department and the Whatcom Community Foundation
- Whole Person Care (previously called Health Care): PeaceHealth, Whatcom Alliance for Health Advancement and Unity Care NW (formerly Interfaith)

Action Team members have a wide variety of experience and expertise in their team's priority area. Together, they identify key areas for alignment and collaboration within the community. Additionally, each team has a chair that convenes the group and helps it move forward, with some staffing support from the Health Department. Over the summer of 2015, the Action Team chairs began working together to gain clarity around how to work with the Leadership Council to move the priorities of the *Community Health Improvement Plan* forward, as well as find opportunities for collaboration and collective action. This work continues to evolve.

For the full roster of Leadership Council and Action Teams, visit Appendix B of this report.

Monitoring and Evaluation

Preparation

Over the course of 2015, the Health Department worked with Action Team chairs and community partners to determine both how to best monitor and track the progress of the *Community Health Improvement Plan* (2012-2017), and to finalize the *Community Health Improvement Plan (CHIP): Implementation Plan* by adding tools such as:

- Measurable objectives (the big picture changes for the community)
- Population measures with baseline and target data
- Performance measures (how the success of strategies and approaches will be measured)
- Lead community partners who will initiate the work, provide direction and monitor progress
- Demonstrated alignment with national and state priorities and evidence-based interventions to help maintain a focused approach for implementation and evaluation efforts
- Policy changes needed to accomplish health objectives

Action Team chairs and community partners assessed each goal and strategy from the *Community Health Improvement Plan* to capture the evolution and progress of goals and strategies, and determine what should continue as part of the collective work moving forward. This process has been documented in Appendix A: Strategy and Activity Progress Chart.

The chart below captures how goals have evolved as the work and approach has grown or become more defined.

Priority Area	2011 Goals	2015 Goals
Build Community Connectedness and Resilience	• Foster community voice and engagement • Cultivate a culture of compassion and understanding • Respond collectively to community substance use and mental health challenges	• Foster community voice and engagement • Cultivate a culture of compassion and understanding • Respond collectively to community substance use and mental health challenges
Enhance Child and Family Well-being	• Strengthen emerging families • Support early learning • Help youth thrive at home and school	• All families are strong, stable and supported from the start • All children enter school safe, healthy and ready to learn • All children and youth thrive at home and school
Promote Healthy Active Living	• Expand access to healthy food • Create more safe places to walk, bike, play and connect • Limit exposure to tobacco, alcohol and other harmful substances	• Enhance access to healthy foods, particularly for low-income and isolated populations • Enhance access to safe, affordable housing, particularly for low-income and isolated populations • Create more safe places to walk, bike, play and connect • Limit exposure to tobacco, alcohol and other harmful substances
Improve Health Care Access and Service Delivery	• Ensure access to essential health care services • Connect people with complex health conditions to needed supports • Enhance patients' experience of care	• All people have the medical, behavioral health and dental services they need to thrive • All care is provided in respectful and culturally appropriate ways

Evaluation Plan

Evaluating implementation efforts is an important task in sustaining Whatcom County's community health improvement, and helps community partners ensure what they are doing is working in the way they intended, and that their collective efforts are as effective and efficient as possible. The Health Department is committed to supporting community partners through monitoring and evaluation activities. The evaluation of the *Community Health Improvement Plan and Community Health Improvement Plan (CHIP): Implementation Plan* focuses on five areas:

1. **Participation**: monitor whether participants continue to represent a broad and diverse cross-section of the community and assess whether participant's engagement in CHIP-related groups and activities is a good use of their time and organizational resources
2. **Implementation**: engage Action Team members and community partners to monitor and report the progress made on the strategies and activities as specified in the *Community Health Improvement Plan (CHIP): Implementation Plan*
3. **Evidence-based interventions**: track the dissemination and use of evidence-based recommendations
4. **Population-level change**: collect, compile and compare population-level data from baseline, current and targets
5. **Revision**: utilize bi-annual progress reports and annual evaluation results to make revisions to strategies, activities and performance measures outlined in the *Community Health Improvement Plan* Implementation Plan

Whatcom County Health Department's 2016 evaluation activities include:

- April 2016 and October 2016: staff will work with Action Team chairs to develop bi-annual progress reports that include community examples of implemented strategies, including evidence-based interventions
- June – August 2016: staff will work with Action Teams and the Leadership Council to update the Strategies and Activity Progress Chart and revise the *Community Health Improvement Plan (CHIP): Implementation Plan*
- September – October 2016: staff will develop and release a 2016 Annual Report to the community. The report will include population data trend analysis from the *Community Health Assessment* (2016) to identify community-level changes
- Ongoing: staff will disseminate information related to *Community Health Improvement Plan* evaluation activities (i.e. reports and plan updates) via web and email distribution
- Bi-annually (or more frequently as requested): staff will work with Action Teams to provide progress updates to the Leadership Council

Progress Report Narrative

Several organizations and individuals throughout Whatcom County have rallied around the community priorities outlined in the *Community Health Assessment* and *Community Health Improvement Plan.* Since its release in 2012, the *Community Health Improvement Plan* has resulted in a tremendous amount of social change and community action within Whatcom County. Within this section, each priority area (Build Community Connectedness and Resilience, Enhance Child and Family Well-being, Promote Healthy Active Living and Improve Health Care Access and Service Delivery) is explained in greater detail and provides a highlight of some of the progress made in the community. In the next section, the revised *Community Health Improvement Plan (CHIP): Implementation Plan* for each priority area is provided. For an overview of the issue, key findings from the *Community Health Assessment,* and relevant community assets and existing community efforts, visit our *Community Health Improvement Plan* at http://www.whatcomcounty.us/health.

The narrative below references strategy and goal numbers that correlate to the numbering system within the revised *Community Health Improvement Plan (CHIP): Implementation Plan*.

Priority Area 1: Build Community Connectedness and Resilience

Contained within this section is work related to the infrastructure and funding of the *Community Health Improvement Plan* and its implementation, cultivating in a culture of compassion in our approach and in the wider community, and a focused effort to address the substance abuse and mental health needs in the community.

Foster community voice and engagement (goal 1.1.)

Infrastructure (strategy 1.1.1.)

2015 was a year of much change within Whatcom County's community health improvement planning. Unable to advance without dedicated resources, the decision was made to fund two staff positions: an Executive Director (hiring on-hold as of November 2015), and project support from the Health Department (hired in April 2015). The Leadership Group, who had been involved and driving *Community Health Improvement Plan* efforts to this point, decided to reform as a Leadership Council with additional members in May 2015. Meanwhile, the three Action Teams continued to meet to define themselves and their work. The Leadership Council and Action Teams look to 2016 with renewed focus, a more cohesive Leadership Council and agreement that equity is the driving force behind all the work being done.

Funding the *Community Health Improvement Plan* Priorities (strategy 1.1.1.)

In addition to in-kind organizational support provided by organizations throughout the county, the three philanthropic organizations that comprise the Whatcom Center for Philanthropy have made major, intentional shifts to the way they do business and allocate funds.

- United Way of Whatcom County expanded their support of partner organizations by opening up their Community Impact Funds to more effectively address specific local issues in a way that creates measurable change. This allowed for greater flexibility in their granting process, and established priorities for funding aligned with the *Community Health Improvement Plan.* They also set a requirement that organizations applying for funds utilize evidence-based practices connected to key community indicators. As of July of the 2015 program year, over $1,000,000 was granted to partner agencies throughout Whatcom County to fund projects that support both *Community Health Improvement Plan* priorities and United Way's three program focus areas: Education: Strong Kids, Income: Stable Families and Health: Vibrant Community.
- The Whatcom Community Foundation changed their funding criteria to align with *Community Health Improvement Plan* priorities and shared their funding process as a model for other philanthropic and community organizations.
- The Chuckanut Health Foundation went through a process of changing its vision and mission to reflect their commitment to the broader definition of community health and the social determinants of heath using the *Community Health Improvement Plan* vision as a basis. Additionally, they started a Strategic Impact Fund allowing them to set aside or prefund programs and projects aligned with *Community Health Improvement Plan* priorities. Examples of funding include grants awarded to Whatcom Taking Action's and the SEAS program ($31,000 grant in 2014 and ~$45,000 for expansion in 2016); WAHA for the substance abuse advisory committee ($30,000) and the Interfaith Family Health Center for expansion of their behavioral health services ($25,000).

Additionally, each foundation has committed significant funds to support the Leadership Council and Action Teams and has equity at the front and center of the work they're doing – on websites, promotional materials, grant applications and woven into their mission and vision.

Equity and Whatcom County

This fall, with the generous support of the Whatcom Community Foundation, a Whatcom Delegation of 33 individuals from a variety of sectors attended the 2015 Equity Summit in Los Angeles, CA. The group continues to meet to further the conversations and work around what equity looks like in Whatcom County, and is working with the Leadership Council to collaborate and align work with an equity focus (strategy 1.1.1).

Cultivate a culture of compassion (goal 1.2.)

In 2013, the Public Health Advisory Board spent time reviewing and processing research regarding the negative impact of adverse childhood experiences ("ACEs") and early trauma on population health outcomes. In recognition that the impact early trauma has on children, families and the general population is on par with, or greater than, biological or infectious diseases, the Public Health Advisory Board put forth a resolution to the Whatcom County Council, acting as the Board of Health, to adopt a "trauma sensitive" or "compassionate" approach to public health services. On October 29, 2013, the resolution was adopted and states that "the Health Board will work with Health Department staff to ensure that "compassionate approaches" are built into all public health related services and contracts including human services programs, and the Health Board will seek opportunities to increase awareness and promote the concept of a "compassionate" or "trauma sensitive" approach, and to integrate this paradigm into the broadest possible range of all public health, education and human services in our county" (Whatcom County Resolution Number: Res. 2013-038).

Respond collectively to community substance use and mental health (goal 1.3)

In late 2014, the Health Department sponsored an Addiction Forum to bring together partners to address the epidemic rise in opiate addiction within Whatcom County (strategy 1.3.1.). Their work includes improving the treatment and recovery systems as well as prevention in the community. Forum participants formed three sub-committees, each of which continues to meet to develop their plans and actions (strategy 1.3.2.):

- The Health Care sub-committee is led by the Whatcom Alliance for Health Advancement (WAHA) with financial support from the Chuckanut Health Foundation. WAHA has completed an initial report outlining some of the gaps in treatment infrastructure, especially as it impacts opiate addiction.
- The Criminal Justice sub-committee is temporarily on-hold due to a newly-formed Incarceration Prevention & Reduction Task Force.
- The Community Health sub-committee targets schools, social services and community health, and its initial focus was education and awareness. The sub-committee launched an education campaign promoting the "Good Samaritan Law" which allows someone to call 911 to report a likely drug overdose, without concern of arrest for doing so. This campaign is promoted through signs on all Whatcom Transit Authority buses, pharmacy counters and the Health Department's Syringe Services program, and wallet-sized reference cards.

The Whatcom Prevention Coalition (WPC), the Ferndale Community Coalition (FCC), and the Campus Community Coalition (CCC) convene stakeholders several times a year to respond collectively to community substance use and mental health challenges. Community coalition members collaboratively develop strategic plans and ensure all strategies are being implemented. They also work to build on existing community work, leverage community assets and avoid creating duplicate services (strategy 1.3.1.).

Conclusion

When determining the infrastructure for how to implement the *Community Health Improvement Plan*, instead of forming an Action Team for this priority area, it was decided that each Action Team should include strategies within their work to address and strengthen this priority. It has been acknowledged that this area needs further development to align and integrate the work happening in the community with the work of the Leadership Council and Action Teams. As this evolves, the Health Department will continue to report on community progress within this area, as well as work to form stronger partnerships to collaborate on the collective priorities of the *Community Health Improvement Plan*.

Priority Area 2: Enhance Child and Family Well-being

Contained within this section is some of the progress made related to ensuring all children and families in Whatcom County have the supports needed to thrive. Research clearly indicates children who grow up in strong, nurturing environments free of significant adversity (such as violence, neglect and chronic poverty), and participate in high-quality early childhood programs, have a greater chance of success in later years in school and the workplace, as well as achieving good physical and mental health throughout life.

All families are strong, stable and supported from the start (goal 2.1.)

- The evidence-based *Strengthening Families Program,* delivered by WSU Extension, is being delivered within several school districts in Whatcom County and has a targeted approach to deliver additional programming to identified, high-need communities (strategy 2.1.1.). The *Strengthening Families Program* (SFP) is a nationally and internationally recognized, parenting and family strengthening program for high-risk and general population families. This evidence-based family skills training program has been found to significantly improve parenting skills and family relationships, reduce problem behaviors, delinquency and alcohol and drug abuse in children and to improve social competencies and school performance.
- The Whatcom Nurse-Family Partnership program has recently been awarded an expansion grant. This expansion will be done in partnership with the Lummi Nation and will establish a service team with a cultural liaison in order to better meet the needs of tribal families (strategy 2.1.2.).

All children enter school safe, healthy and ready to learn (goal 2.2.)

- In 2009, as public funding for children and youth with special health care needs was decreasing, the Health Department led a community effort to figure out how to improve services for children and youth with special health care needs and their families. The result is Whatcom Taking Action, a partnership of community leaders, parents and providers of care and support services working together to build an integrated system of health care, developmental services and support services that local families can easily and efficiently access. One of the first initiatives of Whatcom Taking Action (in part, thanks to a grant from the Chuckanut Health Foundation), was the development of a single entry point for all children and their families that have concerns about their health, development or behavior called the Single Entry Access to Services (SEAS). SEAS is a centralized intake for children that connects people to services and resources with the help of a staff navigator. While SEAS serves and benefits all children with concerns ages zero to twenty-one and their families, the impact it has had on children ages zero to three is especially significant. Referrals for children ages zero to three to receive needed developmental supports through the Early Support for Infants and Toddlers program have grown more than 30% per year since SEAS has been in place in the community, giving these children the best opportunity to be supported and ready for kindergarten (strategy 2.2.2.).
- Whatcom Taking Action is working to build a system that helps identify, navigate, evaluate and serve children with neurodevelopmental and behavioral concerns called GIDES (General Interdisciplinary Developmental Evaluation System) primarily focused on kids ages prenatal to eight. In large part because of the priorities set by the *Community Health Improvement Plan,* family stress is slated to be used as a prime indicator of risk for poor child development outcomes. As of December 2015, a limited, modified pilot for children on the autism spectrum has been launched and the wait time for an autism evaluation was reduced from 9 months to 4 months. The full model for GIDES has not been implemented. In order for it to become fully operational, it needs to be embedded into a clinic with organizational support, similar to what the Opportunity Council provides for SEAS (strategy 2.2.2).
- Kaleidoscope Play & Learn groups help families prepare their young children (from birth to age 5) for success in school and life by increasing parent capabilities, reducing social isolation and improving child development. It is being effectively implemented in Whatcom County on a limited basis and ready for expansion. The Whatcom Early Learning Alliance has built momentum and capacity to assist two of the more rural and underserved communities to develop local play and learn groups. And, with an additional investment from United Way, this strategy will be implemented throughout the county in a culturally responsive way (strategy 2.2.3.).
- As Lydia Place fulfilled their mission of housing women with children, they recognized that parenting supports were a missing component. They initially started a housing case management program in collaboration with the Homeless Service Center and the Health Department, and have now expanded to include the *Parents as Teachers* evidence-based parenting support model that focuses on helping parents support the development of their child from birth through the end of the kindergarten year (strategy 2.2.3.).

All children and youth thrive at home and school (goal 2.3.)

- Several agencies and coalitions support fifteen different youth-driven prevention clubs in Whatcom County, including the Whatcom Prevention Coalition (WPC), the Ferndale Community Coalition (FCC), Bellingham/Whatcom County Commission Against Domestic Violence (BWCADV), Domestic Violence Sexual Assault Services (DVSAS), the Health Department, Planned Parenthood and several school districts. These youth groups focus on a wide range of prevention topics including substance use, suicide, mental health issues, bullying, teen dating violence, sexual assault and teen pregnancy (strategy 2.3.1.).
- In 2010, Whatcom County imposed 1/10 of one percent sales tax to fund new mental health, chemical dependency or therapeutic court services. This funding has been used to place behavioral health specialists and family resource coordinators in each of the seven school districts and provides funding for youth assessment and treatment for both substance use and mental health. In addition, the fund supports family outreach and referral to services and resources in the community (strategy 2.3.2.).
- Many school districts have had some ACEs/trauma-informed schools training, and all are at different stages of adopting improved systems to link youth to needed resources. The incorporation of a more compassionate school model has led to the expansion of resources related to how and what support for youth, families and staff looks like. An example of this within the Bellingham School District is the adoption of alternative policies to out-of-school suspension and incorporation of a restorative justice practice for youth displaying challenges with executive function related to adversity. Many schools are also addressing secondary trauma and compassion fatigue among staff by expanding internal resources and support (strategy 2.3.2.).

Conclusion

Through the community health improvement process, the work of the child and family Action Team has focused on increasing awareness of the importance of healthy early childhood development for building both healthier individuals and communities, and the role of the whole community in supporting healthy child development. Next steps include working with the other Action Teams to assess whether a child/family Collective Impact project is the best approach for creating the supports necessary for children and families to thrive.

Priority Area 3: Promote Healthy Active Living

Research demonstrates that where a person lives – the access they have to quality education, parks/trails/open space to recreate, stable housing, economic security, social relationships, health care and health behaviors – are foundational to the long-term health of a person. In fact, the earlier these pieces are in place, the lower an individual's chances are for chronic illness, and the greater the chances of overall good health and well-being. This knowledge has been a driving force in the evolution of this priority area since its inception. A lot of progress has been made as a result of individual and collective work, some of which is shared below.

Enhance access to healthy foods, particularly for low-income and isolated populations (goal 3.1.)

- In 2013, the Foothills Community Food Partnership (FCFP), a coalition comprised of the Foothills Food Bank, Whatcom Farm-to-School, Local Food Works, East Whatcom Regional Resource Center staff, Kendall Elementary School staff and the Health Department, was formed to address issues of food insecurity and poor access to healthy food in east Whatcom County. Partners organized the Foothills Food Summit in 2014, bringing together over 50 community members and agency representatives to discuss food access challenges and identify appropriate solutions for this rural community. The result is the Foothills Food Access Plan, which is currently being implemented by the FCFP and other community partners. Since the summit, a new mobile farmers market has launched in two east Whatcom County locations, school-based emergency food assistance programs have doubled their reach and over $1,000,000 has been secured to expand the East Whatcom Regional Resource Center to house a new distribution and storage facility for the Foothills Food Bank (strategy 3.1.1.).
- In 2014, the Bellingham Farmers Market piloted a Supplemental Nutrition Assistance Program (SNAP)-matching incentive program that enabled SNAP participants to double the amount of food they could purchase with their SNAP benefits at the market, up to twenty dollars. Funding for this pilot program was provided by a grant from the Sustainable Whatcom Fund of the Whatcom Community Foundation. After a successful pilot year, additional partners, including the Opportunity Council, Community Food Co-op and Sustainable Connections, received a USDA Food Insecurity Nutrition Incentives grant to expand the program to the Wednesday Farmers Market and both Community Food Co-op locations. Along with ongoing matching funds from the Whatcom Community Foundation, this partnership is helping to put over $80,000 in fresh fruits and vegetables annually into the hands of SNAP participants over three years, from 2015-2018 (strategy 3.1.1.).
- In October 2015, conversations between community members and the Bellingham Food Bank led to a new food pantry program hosted at Alderwood Elementary and made possible by funding from the Whatcom Community Foundation. It was determined that the Alderwood site would provide better food bank access for families without transportation, and more availability to families who are working during other food bank hours. The Bellingham Food Bank now uses the Alderwood Elementary gym as a pick-up site one day a week, and it is open to any family needing assistance (strategy 3.1.1.).

Enhance access to safe, affordable housing, particularly for low-income and isolated populations (goal 3.2.)

At any point in time, at least 651 people in Whatcom County are homeless. Throughout the year, hundreds more face the prospect of losing their homes due to economic reasons, family break up, mental illness, drug or alcohol abuse and domestic violence (Whatcom County Coalition to End Homelessness 2015 Annual Report).

- In 2012, Whatcom County updated the 10-Year Plan to End Homelessness, which emphasizes a "housing first" approach that prioritizes placement of the homeless directly into permanent housing and supportive services while identifying and addressing gaps in homeless prevention and supportive services (strategy 3.2.1.).
- In 2012, voters in Bellingham approved a housing levy called the Bellingham Home Fund to provide safe, affordable housing for the community's vulnerable populations. The levy will produce about $3 million per year for seven years to help low-income people get into affordable housing (strategy 3.2.1.).
- In January 2015, The Homeless Service Center launched the Homeless Outreach Team funded primarily through the City of Bellingham and the VA. The goal of the team is to develop productive, trusting relationships with the people most vulnerable to the chaos and dangers of life on the street. In the first nine months of the program, the Homeless Outreach Team made over 2,220 contacts with 300 unique persons (strategy 3.2.1.).
- The Whatcom Homeless Service Center and its partners are aggressively pursuing the addition of more units of supportive housing like the new Francis Place operated by Catholic Housing Services and Catholic Community Services. Additionally, they are working to raise awareness within the community by hosting screenings and discussions of the *Homeless in Bellingham* video series (strategy 3.2.1.).

Create more safe places to walk, bike, play and connect (goal 3.3.)

- From 2013-2015, the Health Department led processes to review the comprehensive plans for Whatcom County and the City of Bellingham in order to make policy recommendations from a public health and equity perspective. In addition to submitting specific recommendations to both planning departments, Health Department staff have created planning and health review tools, identified relevant metrics and participated in the development of the City of Bellingham's Pedestrian (2012) and Bicycle (2014) Master Plans.
- *Community Health Improvement Plan* priorities are included in Whatcom Futures: Toward a Sustainable Economy, a long-term vision for the future of Whatcom County that accommodates growth, economic development, environmental sustainability and equitable access to opportunities (strategy 3.3.1.).
- In 2013, the Kendall Columbia Valley Connectivity Plan Association (KCVCPA) began meeting to discuss the potential to develop a non-motorized, shared-use trail in the Columbia Valley between homes and area services. The zero to three was responding to feedback from a community meeting held in March 2013 where residents voiced concern about safety due to the lack of any pedestrian and bicycle facilities. With assistance from the National Park Service Rivers, Trails, and Conservation Assistance Program, the group conducted a community survey and hosted a design workshop in 2015, both of which led to the creation of a trail plan for the area. The plan describes the potential for not only a trail in the main north-south corridor, but also connections through the neighborhoods, as well as possibilities for future recreation and community gathering spaces. The KCVCPA formed a WA State non-profit in 2014, and continues to meet to implement the trail plan (strategy 3.3.1.).
- There is ongoing dialogue and increased partnership between planning and public health staff and increased recognition of the connection between planning and health for decision-makers. Evidence of this is the Healthy Planning Resolution, passed unanimously in October 2015 by the Whatcom County Board of Health. It commits Whatcom County to applying a "Healthy Planning" approach to Whatcom County's planning processes and decision-making, with consideration of a wide range of health topics. Initial recommendations of tools, processes, and opportunities to integrate a health perspective in decision-making and community planning will be presented to the Board of Health in February 2016 (strategy 3.3.1.).

Limit exposure to tobacco, alcohol and other harmful substances, especially for youth (goal 3.4.)

- Since 2011, youth prevention clubs have been developing and disseminating social norm messaging within their schools and community related to alcohol, tobacco and marijuana prevention**.** Youth groups have also participated in the Community Assessment of Neighborhood Stores Survey which helps provide education to retailers about the impact of advertisement and product placement on youth and families. The Whatcom Prevention Coalition and Ferndale Community Coalition also disseminate social norming and educational campaigns via social media monthly (strategy 3.4.1.).
- Youth prevention teams and adult advisors partnered with the Bellingham Police Department to participate in the 2012 and 2013 Kick Butts Day, which helped raise awareness of tobacco use in our parks and outdoor areas. Youth also presented to the City of Bellingham Parks Advisory Committee to advocate for smoke-free play areas (strategy 3.4.2.).
- The Whatcom Prevention Coalition and the Ferndale Community Coalition have participated in meetings convened by the Liquor and Cannabis Board and submitted letters of recommendation to the board to help guide the rule-making and policy process in relation to retail marijuana. Ferndale prevention youth have also addressed the Ferndale City Council to encourage the consideration of a local jurisdiction in relation to edible marijuana products and the availability of marijuana products to youth (strategy 3.4.1.).
- In November of 2015, the Bellingham City Council voted to ban smoking of cigarettes, cigars, pipes or vaping using an e-cigarette in city parks, trails and open spaces in order to promote health and reduce the risk of exposure to secondhand smoke (strategy 3.4.2.).

Conclusion

While the initial goals of the Action Team focused on healthy lifestyles and behaviors such as eating choices, physical activity and tobacco-free lifestyle, the group has evolved to focus on the connection between health and place, and how the neighborhoods that we live in impact our health. The Action Team's broadened scope now also includes social connectedness, community design and community engagement.

Priority Area 4: Improve Health Care Access and Service Delivery

This section details some of the innovative collaborations and approaches that have led to a tremendous amount of progress in this priority area, especially around connecting people to services and ensuring care is provided in respectful, culturally appropriate ways.

All people have the health care services and supports they need to thrive (goal 4.1.)

Insurance enrollment (strategy 4.1.1.)

Insurance enrollment became a high priority within Whatcom County with the passage of the Obamacare/Affordable Care Act. Over the past three years, Whatcom County has been among the top performing counties in the state for Medicaid and Health Exchange enrollment through efforts led by WAHA in collaboration with multiple partners serving as in-person assisters. In-person assisters helped increase the percent of adults in Whatcom County with insurance from 88.9% (2012) to 95.5% (2015).

Care Management and Support for Complex Needs (strategy 4.1.3.)

- Some very successful collaborations have led to better connections to services and coordination between organizations. WAHA's Intensive Case Management (ICM) program began in 2013 and consists of case managers working in a multi-disciplinary team across organizational boundaries to provide the appropriate level of support to complex patients. Caseloads are small and each team is comprised of a mix of disciplines, such as housing case managers, nurses, social workers or mental health professionals. The effort is led by WAHA, PeaceHealth St Joseph Medical Center and Unity Care NW and works with sectors that include Criminal Justice, Emergency Medical Services (EMS) and behavioral health to coordinate care management. This program is a shared resource, functioning both between and within organizations and building off existing resources. It does not duplicate existing efforts in the community, but rather complements these efforts by providing additional support where needed and linking together existing resources.
- The Hospital Community Connector program is a result of years of partnership and planning between PeaceHealth St. Joseph Medical Center and WAHA and embeds community health workers into hospital emergency departments and discharge processes. The Community Connector Program consists of a coordinated team that is integrated into the PeaceHealth St Joseph Medical Center Emergency Department and inpatient hospital teams. The program started in the Emergency Department (ED) and then moved into the inpatient setting and serves people who have multiple conditions and require considerable resources by coordinating linkages between the hospital and community-based services. As part of a team and before discharge (either from the emergency department or hospital), community connectors assess high-risk patients for community resource eligibility and connect them to the type and level of services they need.

All care is provided in respectful and culturally appropriate ways (goal 4.2.)

- In September 2013, WAHA, Northwest Regional Council's Area Agency on Aging, PeaceHealth, the Health Department, Nooksack and Lummi Tribal representatives and other health care and social service providers began working to reduce the disparity around high readmission rates among tribal members by focusing on patient experience of care, particularly in emergency department and discharge planning. Representatives have met regularly for the past two years and built a network and relationships to convene and have problems identified in real-time and resolved. Examples include: changing discharge plans and creating better linkages to social workers through discharge processes. Anecdotes from patients, their families, and care providers reflect improved experiences within the hospital setting (strategy 4.2.1.).
- Through 2014 and 2015, PeaceHealth St Joseph Medical Center offered a *Health Care Futures* educational series to health care leaders and clinicians to better understand trends and needs shaping the way health care is provided, and meet the needs of the communities served, specifically focusing on health disparities and improving health for diverse communities. Hospital staff used a national Cultural and Linguistic Competency Assessment tool to identify areas for growth and built a series of educational opportunities to address these areas. Future work includes expanded evidence-based cultural humility training through PeaceHealth, development of cultural liaison positions within the hospital and plans for cross-cultural sharing through arts and music (strategy 4.2.1.).

Conclusion

A coordinated effort between PeaceHealth St Joseph Medical Center and the Health Department is underway to align the community's *Community Health Assessment* (2016) and the hospital's *Community Health Needs Assessment*. Within Whatcom County, health care organizations will continue to work towards providing culturally respectful and appropriate care, and the partnerships and collaborations working to ensure all people have access to the health care services they need to thrive will continue and expand.

Community Health Improvement Plan: Implementation Plan

The following pages contain the *Community Health Improvement Plan (CHIP): Implementation Plan*, which was updated in 2015.

Glossary and Key for *Community Health Improvement Plan*: *Implementation Plan*
The following terms and definitions are useful when reviewing the *Community Health Improvement Plan (CHIP): Implementation Plan*.

Term	Definition
Priority Area	Represent the best venues to focus valuable human and financial resources to ensure conditions for a healthy population
Goal	A broad statement of what you hope to accomplish
Objectives	Describes the specific measurable end-products of an intervention
Population Measures	Quantitative information on health status, quality of life and risk factors. Each population measure will include baseline and most recent data.
Population Measure Target and Target Status	Local population targets are based on the U.S. Department of Health and Human Services' Healthy People 2020 (HP 2020) target-setting methodology and resulted in the following criteria for setting population measure targets: 1). Healthy People 2020 target, 2). Results Washington target, Office of the Washington State Governor, 3). Washington Health Alliance Community Checkup top performer rate, 4). Top US Performers, County Health Rankings, 5). 10% decrease or increase from baseline or recent Whatcom County data. Target status source per measure is available in Appendix D. Target status indicates if we have met or unmet the population measure target.
Strategy	Reflect the best thinking about what works, and include contributions of many partners
Activities	Outline the steps that will be taken to achieve each objective
Performance Measures	Indicators of progress (how community partners will know they are making a difference)
Status	In order to monitor the progress in meeting performance measures, the status of each strategy has been evaluated as: • Reprioritized: strategy changed or moved to another priority area as it was agreed that a different strategy or approach would work better • In progress: work is happening and will continue into 2016 • Complete: the measures for the strategy have been met • Future: the strategy will be addressed after January 2016
Lead Community Partners	The organization(s) who will initiate the work, provide direction and monitor progress A complete list of organizational abbreviations can be found in Appendix A.
Evidence-based strategies	A strategy or activity that is based on the best available scientific evidence, using data and information systems systematically, applying program-planning frameworks, engaging the community in decision-making, conducting sound evaluation and disseminating what is learned. Evidence-based strategies listed within the Implementation Plan are from: The Guide to Community Preventive Services, The U.S. Preventive Services Task Force, The Institute of Medicine, Cochrane Reviews.
National Prevention Strategy alignment	Indicates alignment with the National Prevention Strategy's strategic directions and priorities
State Health Improvement Plan alignment	Indicates alignment with *Washington State Health Improvement Plan* priorities
Healthy People 2020	Indicates alignment with Healthy People 2020 objectives
Policy changes needed	Indicates whether policy changes are needed to accomplish identified health objectives
Data sources	Indicates source of population measure data

Priority Area 1: Build Community Connectedness and Resilience

Goal 1.1. *Foster community voice and engagement*

Objective
By December 31, 2016, community partners in Whatcom County will foster community voice and engagement and in doing so:

Population Measure	Baseline (2010)	Recent (2014)	Target	Target Status
Increase high life expectancy from birth in all areas of Whatcom County*	NA	73.1-81.7 (2013)	81.7 in all areas	unmet
Increase the % of adults reporting good, very good, or excellent health	88%	89%	80%	met
Increase the % of 10th grade students reporting medium-high to high quality of life	54.90%	50.10%	80%	unmet

**While Whatcom County has met the target for high life expectancy, geographic disparities exist*

Strategy	Activity	Performance Measures	Status	Lead Community Partners
1.1.1. Establish infrastructure for successful implementation and sustainability of the *Community Health Improvement Plan**	Engage representatives of diverse cultural, geographic and economic communities to serve in CHIP leadership positions and working groups	• # partners identified • # partners engaged	In progress	WCF, CHF, WCHD, UW, Leadership Council and Action Teams
	Establish mechanisms to keep internal stakeholders and public well informed about status of CHIP and opportunities for involvement	• # presentations	In progress	WCHD Leadership Council
	Develop and implement CHIP evaluation plan	• Clarified processes and mechanisms to select, monitor and share data/metrics related to overall CHIP goals and each of the strategic directions	In progress	WCHD

*Evidence-based strategies	The Institute of Medicine: • Private and public purchasers, health care organizations, clinicians and patients should work together to redesign health care (1.1.1.) • Making evidence the foundation of decision-making and the measure of success (1.1.1.) • Private and public entities should convene major community benefit stakeholders, to inform them about community benefit standards and to build awareness that placing a priority on diversity and cultural competency programs is a societal expectation of all institutions that receive any form of public funding. (1.1.1.) • The committee finds that the core functions of public health agencies at all levels of government are assessment, policy development, and assurance. (1.1.1.)
Policy changes needed	NA
State Health Improvement Plan alignment	NA
National Prevention Strategy alignment	Strategic directions: • Healthy and safe community environments: 3. Strengthen state, tribal, local, and territorial public health departments to provide essential services. 4. Integrate health criteria into decision making, where appropriate, across multiple sectors. 5. Enhance cross-sector collaboration in community planning and design to promote health and safety. 7. Identify and implement strategies that are proven to work and conduct research where evidence is lacking. • Empowered people: 3. Engage and empower people and communities to plan and implement prevention policies and programs. • Elimination of health disparities: 1. Ensure a strategic focus on communities at greatest risk. 5. Standardize and collect data to better identify and address disparities.
Healthy People 2020 alignment	• Increase the number of community-based organizations providing population-based primary prevention services in the following areas: injury, violence, mental illness, tobacco use, substance abuse, unintended pregnancy, chronic disease programs, nutrition, and physical activity. • Increase the proportion of Tribal, State, and local public health agencies that provide or assure comprehensive epidemiology services to support essential public health services.
Data sources	WADOH, Center for Health Statistics, Death Certificate Data, Behavioral Risk Factor Surveillance Survey (BRFSS), Washington State Healthy Youth Survey (HYS)

Priority Area 1: Build Community Connectedness and Resilience

Goal 1.2. *Cultivate a culture of compassion and understanding*

Objective
By December 31, 2016, community partners in Whatcom County will cultivate a culture of compassion and understanding and in doing so:

Population Measure	Baseline (2010)	Recent (2014)	Target	Target Status
Increase % of 10th grade students reporting having an adult with whom they can talk to about something important	74.6%	76.4%	83%	unmet
Decrease % of adults reporting inadequate social and emotional support	16%	16%	15%	unmet

Strategy	Activity	Performance Measures	Status	Lead Community Partners
1.2.1. Identify and support training opportunities related to trauma-sensitive services for providers in health, education, social service sectors and other interested parties	Encourage development of "communities-of-practice" for service providers to learn about implementing compassionate, trauma-sensitive approaches	• # providers engaged in the process • Creation of a compassionate community model	In progress	WFCN (ACEs/Resilience Team), WCHD (Community Health, Human Services, Health Equity Team, Public Health Advisory Board)
1.2.2. Support development of organizational policy statements and processes that promote integration of compassionate, trauma-sensitive principles and practices	Develop a Compassionate Community Resolution for Whatcom County	• Adoption of a resolution by County Council (10/29/2013: resolution adopted)	Complete	WFCN (ACEs/Resilience Team), WCHD (Community Health, Human Services, Health Equity Team)

*Evidence-based strategies	The Institute of Medicine: ● The committee finds that the core functions of public health agencies at all levels of government are assessment, policy development, and assurance. (1.2.1., 1.2.2.) The Guide to Community Preventive Services: ● Violence prevention focused on children and youth: reducing psychological harm from traumatic events. (1.2.1., 1.2.2.)
Policy changes needed	Strategy 1.2.2.
State Health Improvement Plan alignment	NA
National Prevention Strategy alignment	Strategic directions: • Healthy and safe community environments: 2. Promote positive social interactions and support healthy decision making. 4. Integrate health criteria into decision making, where appropriate, across multiple sectors. Priorities: • Mental and emotional well-being: 2. Facilitate social connectedness and community engagement across the lifespan
Healthy People 2020 alignment	• Increase the number of community-based organizations providing population-based primary prevention services in the following areas: injury, violence, mental illness, tobacco use, substance abuse, unintended pregnancy, chronic disease programs, nutrition, and physical activity.
Data sources	Washington State Healthy Youth Survey (HYS), Behavioral Risk Factor Surveillance Survey (BRFSS)

Priority Area 1: Build Community Connectedness and Resilience

Goal 1.3. *Respond collectively to community substance use and mental health challenges*

Objective
By December 31, 2016, community partners in Whatcom County will respond collectively to community substance use and mental health challenges and in doing so:

Population Measure	Baseline (2010)	Recent (2014)	Target	Target Status
Decrease drug or alcohol death rate (per 100,000)	12	9.7	11.3	met
Decrease suicide death rate (per 100,000)	11.6	14.1	10.2	unmet
Decrease hospital admissions for drug overdose (per 100,000)	46.3	39.48	35.5	unmet
Decrease % of 10th grade students reporting depressive feelings	28.6%	31.4%	25%	unmet
Increase % of 10th grade students having an adult to turn to when depressed	48.1%	51.6%	57%	unmet
Decrease % of adults with frequent mental stress	NA	8%	7%	unmet

Strategy	Activity	Performance Measures	Status	Lead Community Partners
1.3.1. Convene community partners to develop a common agenda and path forward	Bring together community partners across substance abuse and mental health sectors to attend a day-long substance abuse forum	• # attendees at the forum (2014: 91 community leaders attended the forum) • # partners committed to future work (2015: ~40 community partners are participating in sub-committees)	Complete	WFCN, WCHD, WWU, public schools, CADV
1.3.2. Support implementation of strategies identified by community partners	Build work groups with partners from the substance abuse forum to develop work plans for future work	• # of community-driven initiatives that address substance use and/or mental health issues	In progress	WFCN, WCHD, WWU, public schools, CADV

*Evidence-based strategies	The Institute of Medicine: ● Private and public purchasers, health care organizations, clinicians, and patients should work together to redesign health care. (1.3.1., 1.3.2.) ● Making evidence the foundation of decision making and the measure of success. (1.3.1., 1.3.2.) ● Private and public entities should convene major community benefit stakeholders to inform them about community benefit standards and to build awareness that placing a priority on diversity and cultural competency programs is a societal expectation of all institutions that receive any form of public funding. (1.3.1., 1.3.2.) The U.S. Preventive Services Task Force: ● Recommends screening and behavioral counseling interventions to reduce alcohol misuse by adults, including pregnant women, in primary care settings. (1.3.2.)
Policy changes needed	NA
State Health Improvement Plan alignment	NA
National Prevention Strategy alignment	Strategic directions: • Healthy and safe community environments: 7. Identify and implement strategies that are proven to work and conduct research where evidence is lacking. • Empowered people: 3. Engage and empower people and communities to plan and implement prevention policies and programs. Priorities: • Preventing drug abuse and excessive alcohol use: 1. Support state, tribal, local, and territorial implementation and enforcement of alcohol control policies. 2. Create environments that empower young people not to drink or use other drugs. 3. Identify alcohol and other drug abuse disorders early and provide brief intervention, referral and treatment. 4. Reduce inappropriate access to and use of prescription drugs.
Healthy People 2020 alignment	• Increase the number of community-based organizations providing population-based primary prevention services in the following areas: injury, violence, mental illness, tobacco use, substance abuse, unintended pregnancy, chronic disease programs, nutrition, and physical activity. • Increase the proportion of adolescents never using substances. • Increase the proportion of adolescents who disapprove of substance abuse. • Increase the proportion of adolescents who perceive great risk associated with substance abuse. • Reduce past-month use of illicit substances. • Increase the number of admissions to substance abuse treatment for injection drug use. • Increase the proportion of persons who need alcohol and/or illicit drug treatment and received specialty treatment for abuse or dependence in the past year. • Reduce the past-year nonmedical use of prescription drugs.
Data sources	WA Dept. of Health, Center for Health Statistics, Washington State Healthy Youth Survey (HYS), Behavioral Risk Factor Surveillance Survey (BRFSS)

Priority Area 2: Enhance Child and Family Well-being

Goal 2.1. *All families are strong, stable and supported from the start*

Objective
By December 31 2016, community partners in Whatcom County will ensure families are strong, stable and supported from the start and in doing so:

Population Measure	Baseline (2010)	Recent (2014)	Target	Target Status
Decrease % children ages 0-5 living below 200% Federal Poverty Level	16%	19% (2013)	12%	unmet
Decrease point-in-time count of families with at least one child (under 18) experiencing homelessness	101 (2008)	92 (2015)	83	unmet
Decrease child abuse and/or neglect founded allegations rate (per 100,000)	37.7	42.1	4.1	unmet
Decrease child injury and accident hospitalization rate (per 100,000)	3.3	4	2.97	unmet
Decrease % of uninsured children ages 0-17	7.9% (2011)	7.8% (2013)	0%	unmet
Increase % of children ages 3-6 who had one or more well-child visits with a primary care provider	NA	60%	66%	unmet

Strategy	Activity	Performance Measures	Status	Community Partners
2.1.1. Maintain and expand early learning and parenting supports for families with very young children (prenatal to age three)	Expand existing evidence-based programming to meet the population needs by identifying additional supports needed for families with very young children	• # of families enrolled in Nurse/Family Partnership • # of children enrolled in Early Head Start • # of participants in *Parents as Teachers* at Lydia Place	In progress	WCHD, OC: ELFS, WELA, school districts
2.1.2. Develop models of intensive support for families facing substance abuse, mental health diagnoses, and/or domestic abuse	Expand family-oriented mental health and substance use treatment options	• TBD	Future	TBD
	Explore home-visiting or site-based model of intensive parenting support for families with complex needs	• TBD	Future	TBD
	Embed social workers in pediatric and OB/GYN provider offices	• TBD	Future	TBD
2.1.3. Address the unmet needs of young families by providing necessary services and supports	Improve available transportation to family appointments; develop play and learn groups in diverse geographic locations and different languages; ensure access to food and housing for families	• TBD	Future	TBD

*Evidence-based strategies	The Institute of Medicine: ● Making evidence the foundation of decision making and the measure of success. (2.1.1.) ● All health care organizations, professional groups, and private and public purchasers should pursue six major aims; specifically, health care should be safe, effective, patient-centered, timely, efficient, and equitable. (2.1.2) ● Private and public purchasers, health care organizations, clinicians, and patients should work together to redesign health care processes. (2.1.2.) The Guide to Community Preventive Services: ● Early childhood development programs: Comprehensive, center-based programs for children of low-income families. (2.1.1., 2.1.3.) ● Adolescent health: Person-to-person interventions to improve caregivers' parenting skills. (2.1.2., 2.1.3.)
Policy changes needed	NA
State Health Improvement Plan alignment	Priority 1: Invest in the health and well-being of our youngest children and families
National Prevention Strategy alignment	Strategic directions: • Healthy and safe community environments: 7. Identify and implement strategies that are proven to work and conduct research where evidence is lacking. • Clinical and community preventive services: 6. Enhance coordination and integration of clinical, behavioral, and complementary health strategies. Priorities: • Mental and emotional well-being: 1. Promote positive early childhood development, including positive parenting and violence-free homes. 3. Provide individuals and families with the support necessary to maintain positive mental well-being. 4. Promote early identification of mental health needs and access to quality services.
Healthy People 2020 alignment	• Increase the proportion of parents who use positive parenting and communicate with their doctors or other health care professionals about positive parenting. • Increase the proportion of children with disabilities, birth through age 2 years, who receive early intervention services in home or community-based settings.
Data sources	American Community Survey (ACS), County Health Rankings (CHR), Whatcom Homeless Service Center (WHSC), Washington State Department of Social & Health Services (DSHS) Small Area Health Insurance Estimates (SAHIE), American Community Survey (ACS), Community Commons (CC), Community Checkup-Washington Health Alliance (WHA)

Priority Area 2: Enhance Child and Family Well-being

Goal 2.2. ***All children enter school safe, healthy and ready to learn***

Objective
By December 31, 2016, community partners in Whatcom County will ensure children enter school safe, healthy and ready to learn and in doing so:

Population Measure	Baseline (2010)	Recent (2014)	Target	Target Status
Increase % of children who demonstrate readiness skills for kindergarten in all areas	56.9% (2013)	53.9% (2015)	45%	met
Increase % of children who demonstrate readiness skills for kindergarten in social-emotional areas	81.5% (2013)	80.5% (2015)	TBD	met
Increase % of infants and toddlers with developmental delays who increase their rate of growth in social-emotional skills	NA	65.10%	67%	unmet

Strategy	Activity	Performance Measures	Status	Lead Community Partners
2.2.1. Expand early childhood and early learning support infrastructure	Explore developing a children's council	• TBD	Future	Action Teams and Leadership Council
	Advocate for the development of a Collective Impact model, a community-wide effort to support children and families	• TBD	Future	Action Teams and Leadership Council
	Connect existing groups working to support children and families	• # and diversity of community members/organizations involved	Future	TBD
2.2.2. Increase developmental and behavioral supports for young children	Develop and disseminate information about the importance of early identification and intervention for developmental and behavioral health issues to parents, caregivers, teachers and health care providers	• # families enrolled in home visitation/parenting support programs • # new parents screened/referred/linked for mental health and substance use concerns	In progress	WhatcomTA, WAHA, WELA, OC
	Support medical, early learning and social service provider training to improve use of developmental screening methods	• # trainings • # of people trained	In progress	WhatcomTA, WAHA, WELA, OC
	Implement local developmental-behavioral evaluation system for young children	• # of referrals • Wait time • # new parents screened/referred/linked for mental health and substance use concerns	In progress	WhatcomTA: GIDES, PHSJMC
2.2.3. Allocate resources to develop, maintain and expand early learning programs that meet high quality standards, including evidence-based social-emotional curriculum for vulnerable children	Expand existing high-quality early learning programs such as Head Start, ECEAP, Promise K and rated childcare programs	• Enrollment numbers for each program • # of additional programs	In progress	OC, WELA, school districts
	Increase connections between health care providers and early learning programs	• TBD	Future	TBD
	Develop mechanisms to identify and connect children to early learning programs	• TBD	Future	OC, WELA, school districts
2.2.4. Monitor the proportion of children entering kindergarten with preschool experience	Identify children who demonstrate developmental characteristics of entering kindergarteners	• # and % of children enrolled in preschool/pre-K prior to kindergarten	In progress	OC, WELA, school districts

Goal 2.2. continued on next page

Priority Area 2: Enhance Child and Family Well-being

Goal 2.2. *All children enter school safe, healthy and ready to learn*

Continued from previous page

*Evidence-based strategies	The Institute of Medicine: ● States and communities should develop networked systems to apply resources to the promotion of mental health and prevention of mental, emotional, and behavioral disorders among their young people. These systems should involve individuals, families, schools, justice systems, health care systems, and relevant community-based programs. Such approaches should build on available evidence-based programs and involve local evaluators to assess the implementation process of individual programs or policies and to measure community-wide outcomes. (2.2.1., 2.2.2., 2.2.3., 2.2.4.) ● Making evidence the foundation of decision making and the measure of success. (2.2.1., 2.2.3., 2.2.4.) ● All health care organizations, professional groups, and private and public purchasers should pursue six major aims; specifically, health care should be safe, effective, patient-centered, timely, efficient, and equitable. (2.2.1., 2.2.2., 2.2.3.) ● Private and public purchasers, health care organizations, clinicians, and patients should work together to redesign health care processes. (2.2.1., 2.2.2., 2.2.3.) ● Clinicians and patients, and the health care organizations that support care delivery, adopt a new set of principles to guide the redesign of care processes. (2.2.2., 2.2.3.) The Guide to Community Preventive Services: ● Early childhood development programs: Comprehensive, center-based programs for children of low-income families. (2.2.1., 2.2.2., 2.2.4.) ● Violence prevention focused on children and youth: Early childhood home visitation. (2.2.2.) ● Violence prevention focused on children and youth: Reducing psychological harm from traumatic events. (2.2.2.)
Policy changes needed	Strategies: 2.2.1., 2.2.3.
State Health Improvement Plan alignment	Priority 1: Invest in the health and well-being of our youngest children and families
National Prevention Strategy alignment	Strategic directions: • Healthy and safe community environments: 7. Identify and implement strategies that are proven to work and conduct research where evidence is lacking. 8. Maintain a skilled, cross-trained, and diverse prevention workforce. • Clinical and community preventive services: 4. Support implementation of community-based preventive services and enhance linkages with clinical care. • Empowered people: 3. Engage and empower people and communities to plan and implement prevention policies and programs. Priorities: • Mental and emotional well-being: 1. Promote positive early childhood development, including positive parenting and violence-free homes. 2. Facilitate social connectedness and community engagement across the lifespan. 3. Provide individuals and families with the support necessary to maintain positive mental well-being.
Healthy People 2020 alignment	• Increase the proportion of parents who use positive parenting and communicate with their doctors or other health care professionals about positive parenting. • Increase the proportion of children with disabilities, birth through age 2 years, who receive early intervention services in home or community-based settings. • Increase the number of community-based organizations providing population-based primary prevention services in the following areas: injury, violence, mental illness, tobacco use, substance abuse, unintended pregnancy, chronic disease programs, nutrition, and physical activity.
Data sources	Washington State Office of Superintendent of Public Instruction (OSPI), Washington State Department of Early Learning's (DEL) Early Support for Infants and Toddlers (ESIT)

Priority Area 2: Enhance Child and Family Well-being

Goal 2.3. *All children and youth thrive at home and school*

Objective
By December 31, 2016, community partners in Whatcom County will ensure children and youth thrive at home and school and in doing so:

Population Measure	Baseline (2010)	Recent (2014)	Target	Target Status
Increase on-time graduation rate	79%	79.5%	82%	unmet
Increase % of 10th grade students reporting medium-high to high quality of life	54.90%	50.10%	79.8%	unmet
Increase % of 10th grade students reporting having an adult with whom they can talk to about something important	74.60%	76.40%	83%	unmet

Strategy	Activity	Performance Measures	Status	Lead Community Partners
2.3.1. Engage parents, teachers and other important adults in providing positive support for youth social-emotional and developmental needs	Expand availability of targeted, evidence-based, positive family development programs for at-risk youth and families	• # of families enrolled in family development programs	In progress	WSU extension, WCHD, school districts
	Engage community members, including tribal and Hispanic community partners and families, in identifying and developing culturally appropriate strategies to support healthy youth development	• # and diversity of community members involved • % of youth making grade level progress	In progress	WPC, FCC, CCC, WFCN, WCHD, school districts
	Support school prevention clubs and other youth-led community health initiatives	• # of youth who participate in school prevention clubs • # of youth-led community health initiatives	In progress	FCC, WPC, BWCADV, DVSAS, WCHD, MBPP, several school districts
	Maintain and expand evidence-based youth mentoring programs for vulnerable youth	• # of trained mentors • # of youth connected to mentors	In progress	CISWC, school districts
2.3.2. Increase access of individual support for children with social-emotional and learning needs	Develop improved systems within schools and other settings to identify and link youth with social-emotional needs and learning differences to needed resources	• # of resources to support youth with executive function challenges (i.e., planning, organization, self-control) related to adversity or neuro-developmental conditions	In progress	WCHD, WPC, school districts
	Expand resources to support youth with executive function challenges	• # ACES/trauma-informed school trainings	In progress	WCHD, WPC, school districts

*Evidence-based strategies	The Institute of Medicine: • Making evidence the foundation of decision making and the measure of success. (2.3.1., 2.3.2.) • States and communities should develop networked systems to apply resources to the promotion of mental health and prevention of mental, emotional, and behavioral disorders among their young people. These systems should involve individuals, families, schools, justice systems, health care systems, and relevant community-based programs. Such approaches should build on available evidence-based programs and involve local evaluators to assess the implementation process of individual programs or policies and to measure community-wide outcomes. (2.3.1.) The Guide to Community Preventive Services: • Violence prevention focused on children and youth: Reducing psychological harm from traumatic events. (2.3.1., 2.3.2.) • Youth violence prevention: School-based programs to reduce violence. (2.3.1., 2.3.2.) • Adolescent health: Person-to-person interventions to improve caregivers' parenting skills. (2.3.1., 2.3.2.)
Policy changes needed	No
State Health Improvement Plan alignment	No
National Prevention Strategy alignment	Strategic directions: • Healthy and safe community environments: 7. Identify and implement strategies that are proven to work and conduct research where evidence is lacking. • Empowered people: 2. Promote positive social interactions and support healthy decision making. 3. Engage and empower people and communities to plan and implement prevention policies and programs. Priorities: • Injury and violence free living: 6. Provide individuals and families with the knowledge, skills, and tools to make safe choices that prevent violence and injuries. • Mental and emotional well-being: 3. Provide individuals and families with the support necessary to maintain positive mental well-being.
Healthy People 2020 alignment	• Increase the number of community-based organizations providing population-based primary prevention services in the following areas: injury, violence, mental illness, tobacco use, substance abuse, unintended pregnancy, chronic disease programs, nutrition, and physical activity. • Increase the proportion of the Nation's elementary, middle, and high schools that have official school policies and engage in practices that promote a healthy and safe physical school environment. • Increase the proportion of adolescents who are connected to a parent or other positive adult caregiver.
Data sources	Washington State Office of Superintendent of Public Instruction (OSPI), Washington State Healthy Youth Survey (HYS)

Priority Area 3: Promote Healthy Active Living

Goal 3.1. *Enhance access to healthy foods, particularly for low-income and isolated populations*

Objective
By December 31, 2016, community partners in Whatcom County will improve access to healthy foods, particularly for low-income and isolated populations and in doing so:

Population Measure	Baseline (2010)	Recent (2014)	Target	Target Status
Decrease % of population that experienced food insecurity in the last year	14.8% (2012)	14.8% (2013)	6%	unmet
Decrease % of 10th grade students reporting having experienced food insecurity in the last year	14.8%	13.0%	6%	unmet
Increase % of 10th grade students reporting eating five or more fruits and vegetables per day.	26.7%	24.5%	27%	unmet
Decrease % adults that self-report a Body Mass Index (BMI) greater than 30.0 (obese)	23%	25%	25%	met
Decrease % of 10th grade students who are in the top 5% for body mass index (obese)	10.7%	12.4%	16%	met

Strategy	Activity	Performance Measures	Status	Lead Community Partners
3.1.1. Support development of community-based healthy food access solutions	Support community groups in targeted areas (ex. East Whatcom County) in identifying innovative approaches to increase healthy food access	• # of mobile food retail • # of farmer's markets	In progress	WF2S partners: WCF, WCHD, NABC, WFN, AF
	Improve programs to support healthy food options for low-income populations or people using food assistance	• # of SNAP households participating in Fresh Bucks	In progress	BFB, WCF, FL, COA, FFB
3.1.2. Improve the quality of food served in schools to meet high nutritional standards	Support development of community-based healthy food access solution(s) in schools including school wellness policies that meet current recommendations, such as USDA requirements	• # of school districts adopting updated school wellness policies • Wellness Director position developed and funded by January 2016	In progress	WF2S partners: WCF, WCHD, school districts
3.1.3. Expand enrollment in the WIC program	Develop and implement a community outreach plan to bring more eligible families into local WIC programs	• # families enrolled in WIC • # grocery stores and farmer's markets with promotion materials	In progress	WCHD, SM, Nooksack Nation, Lummi Nation

Goal 3.1. continued on next page

Priority Area 3: Promote Healthy Active Living

Goal 3.1. *Enhance access to healthy foods, particularly for low-income and isolated populations*

Continued from previous page

*Evidence-based strategies	The Institute of Medicine: ● Making evidence the foundation of decision making and the measure of success. (3.1.1., 3.1.2., 3.1.3.) ● Schools should provide a consistent environment that is conducive to healthful eating behaviors and regular physical activity. (3.1.2.) ● Local governments, public health agencies, schools, and community organizations should collaboratively develop and promote programs that encourage healthful eating behaviors and regular physical activity, particularly for populations at high risk of childhood obesity. Community coalitions should be formed to facilitate and promote cross-cutting programs and community-wide efforts. (3.1.1., 3.1.2.)
Policy changes needed	Strategy 3.1.2.
State Health Improvement Plan alignment	Priority 1: Invest in the health and well-being of our youngest children and families
National Prevention Strategy alignment	Strategic directions: • Healthy and safe community environments: 7. Identify and implement strategies that are proven to work and conduct research where evidence is lacking. • Empowered people: 1. Provide people with tools and information to make healthy choices. 2. Promote positive social interactions and support healthy decision making. 3. Engage and empower people and communities to plan and implement prevention policies and programs. 4. Improve education and employment opportunities. • Elimination of health disparities: 1. Ensure a strategic focus on communities at greatest risk. Priorities: • Healthy eating: 1. Increase access to healthy and affordable foods in communities. 2. Implement organizational and programmatic nutrition standards and policies. 5. Support policies and programs that promote breastfeeding.
Healthy People 2020 alignment	• Increase the proportion of elementary, middle, and senior high schools that provide school health education to promote personal health and wellness in the following areas: hand washing or hand hygiene; oral health; growth and development; sun safety and skin cancer prevention; benefits of rest and sleep; ways to prevent vision and hearing loss; and the importance of health screenings and checkups. • Eliminate very low food security among children. • Reduce household food insecurity and in doing so, reduce hunger. • Increase the number of community-based organizations (including local health departments, tribal health services, nongovernmental organizations, and State agencies) providing population-based primary prevention services in the following areas: injury, violence, mental illness, tobacco use, substance abuse, unintended pregnancy, chronic disease programs, nutrition, and physical activity. • Increase the proportion of Americans who have access to a food retail outlet that sells a variety of foods that are encouraged by the Dietary Guidelines for Americans. (Developmental) • Increase the contribution of fruits to the diets of the population aged 2 years and older. • Increase the variety and contribution of vegetables to the diets of the population aged 2 years and older. • Increase the proportion of infants who are breastfed.
Data sources	Feeding America, Community Commons (CC), Washington State Healthy Youth Survey (HYS), Behavioral Risk Factor Surveillance Survey (BRFSS), County Health Rankings (CHR)

Priority Area 3: Promote Healthy Active Living

Goal 3.2. *Enhance access to safe, affordable housing, particularly for low-income and isolated populations*

Objective
By December 31, 2016, community partners in Whatcom County will improve access to safe, affordable housing, particularly for low-income and isolated populations and in doing so:

Population Measure	Baseline (2010)	Recent (2014)	Target	Target Status
Decrease % of cost burdened households	40% (2012)	39.2% (2013)	35%	unmet
Decrease % of housing units with one or more substandard conditions	NA	39.2% (2013)	9%	unmet
Decrease point-in-time count of individuals experiencing homelessness	851 (2008)	651 (2015)	586	unmet
Decrease point-in-time count of families with at least one child (under 18) experiencing homelessness	101 (2008)	92 (2015)	83	unmet
Increase % of previously homeless, in stable housing for 12 months	70%	69%	75.9%	unmet

Strategy	Activity	Performance Measures	Status	Lead Community Partners
3.2.1. Increase the percent of families connected to stable housing and other basic needs	Prioritize needs of families in community housing-related plans and policies	• Updated the Whatcom Ten Year Plan to End Homelessness (2012: plan updated) • Allocation of HOME funds for housing development (2013: fund allocation began)	Complete	Lead: WHSC Partners: Homeless Coalition, OC, Lydia Place, UCNW, WCHD
	Implement and evaluate housing pilot project to link young families with housing case management	• Launch of *Parents as Teachers* at Lydia Place • Collaboration between Whatcom Homeless Housing Center and Whatcom County Health Department	In progress	Lead: WHSC Partners: Homeless Coalition, OC, Lydia Place, UCNW, WCHD

*Evidence-based strategies	The Institute of Medicine: • Clinicians and patients, and the health care organizations that support care delivery, adopt a new set of principles to guide the redesign of care processes. (3.2.1.) The U.S. Preventive Services Task Force: • Integrating evidence-based clinical and community strategies to improve health. (3.2.1.)
Policy changes needed	Strategy 3.2.1.
State Health Improvement Plan alignment	Priority 2: Support development of healthy neighborhoods and communities.
National Prevention Strategy alignment	Strategic directions: • Healthy and safe community environments: 2. Design and promote affordable, accessible, safe, and healthy housing. 5. Enhance cross-sector collaboration in community planning and design to promote health and safety. • Clinical and community preventive services: 4. Support implementation of community-based preventive services and enhance linkages with clinical care. • Elimination of health disparities: 1. Ensure a strategic focus on communities at greatest risk.
Healthy People 2020 alignment	• Reduce the proportion of occupied housing units that have moderate or severe physical problems. • Increase the number of community-based organizations providing population-based primary prevention services in the following areas: injury, violence, mental illness, tobacco use, substance abuse, unintended pregnancy, chronic disease programs, nutrition, and physical activity.
Data sources	American Community Survey (ACS), County Health Rankings (CC), Whatcom Homeless Service Center (WHSC)

Priority Area 3: Promote Healthy Active Living

Goal 3.3. *Create more safe places to walk, bike, play and connect*

Objective
By December 31, 2016. community partners in Whatcom County will support creating more safe places to walk, bike, play and connect and in doing so:

Population Measure	Baseline (2010)	Recent (2014)	Target	Target Status
Increase % population with adequate access to locations for physical activity	NA	76%	85.0%	unmet
Decrease % of adults reporting inadequate social and emotional support	16%	16%	17.0%	unmet
Increase % of 10th grade students being physically active for > 60 mins, 5+ days/week	50.40%	51%	56.1%	unmet
Decrease violent crime rate (per 100,000)	228	196	64.0	unmet

Strategy	Activity	Performance Measures	Status	Lead Community Partners
3.3.1. Highlight, promote and support existing and emerging healthy neighborhood/healthy community initiatives by encouraging community involvement in the design and building of gathering spaces (e.g. park facilities, community centers)	Integrate community health perspective into comprehensive plans and other community plans	• # of comprehensive plans with integrated community health perspective	In progress	WCHD, COB and County Planning Departments, NEC, WF
	Support development of new bus routes and/or transit stops in outlying areas (or other innovative approaches) to addressing transportation challenges	• # of new routes/stops • # of public input meetings/forums	In progress	NTTD, WTA
	Provide technical assistance and support to community groups working on development of local walking and biking facilities (e.g. Birch Bay, East County-Deming/Kendall)	• # of community groups participating in facility planning projects	In progress	COG, WSDOT, WCHD, County Planning, KCVCPA, BPAC, BBBPRD
	Facilitate procurement of grant funds and other resources for communities interested in building or refurbishing gathering spaces in targeted areas	• TBD	Future	TBD
	Raise public and policy-maker awareness about the links between place, health and equity	• # policy makers engaged • # presentations to Whatcom County Council (Board of Health)	In progress	Lead: WCHD Partner: Public Health Advisory Board

Goal 3.3. continued on next page

Priority Area 3: Promote Healthy Active Living

Goal 3.3. *Create more safe places to walk, bike, play and connect*

Continued from previous page

*Evidence-based strategies	The Institute of Medicine: ● The committee finds that the core functions of public health agencies at all levels of government are assessment, policy development, and assurance. (3.3.1.) ● Private and public entities should convene major community benefit stakeholders, to inform them about community benefit standards and to build awareness that placing a priority on diversity and cultural competency programs is a societal expectation of all institutions that receive any form of public funding. (3.3.1.) ● Those responsible for modifications or additions to the built environment should facilitate access to, enhance the attractiveness of, and ensure the safety and security of places where people can be physically active. (3.3.1.) The Guide to Community Preventive Services: ● Environmental and policy approaches to increase physical activity: Community-scale urban design land use policies. (3.3.1.) ● Environmental and policy approaches to increase physical activity: Street-scale urban design land use policies. (3.3.1.) ● Environmental and policy approaches to increase physical activity: Creation of or enhanced access to places for physical activity combined with informational outreach activities. (3.3.1.) Cochrane Reviews: ● Interventions for increasing pedestrian and cyclist visibility for the prevention of death and injuries. (3.3.1.)
Policy changes needed	Strategy 3.3.1.
State Health Improvement Plan alignment	Priority 2: Support development of healthy neighborhoods and communities.
National Prevention Strategy alignment	Strategic directions: • Healthy and safe community environments: 3. Strengthen state, tribal, local, and territorial public health departments to provide essential services. 4. Integrate health criteria into decision making, where appropriate, across multiple sectors. 5. Enhance cross-sector collaboration in community planning and design to promote health and safety. • Empowered people: 3. Engage and empower people and communities to plan and implement prevention policies and programs. • Elimination of health disparities: 1. Ensure a strategic focus on communities at greatest risk. 3. Increase the capacity of the prevention workforce to identify and address disparities. 4. Support research to identify effective strategies to eliminate health disparities. Priorities: • Active living: 1. Encourage community design and development that supports physical activity. 3. Facilitate access to safe, accessible, and affordable places for physical activity. • Injury and violence free living: 3. Support community and streetscape design that promotes safety and prevents injuries. • Mental and emotional well-being: 2. Facilitate social connectedness and community engagement across the lifespan.
Healthy People 2020 alignment	• Increase the number of community-based organizations providing population-based primary prevention services in the following areas: injury, violence, mental illness, tobacco use, substance abuse, unintended pregnancy, chronic disease programs, nutrition, and physical activity. • Increase legislative policies for the built environment that enhance access to and availability of physical activity opportunities. (Developmental)
Data sources	ArcGIS, County Health Rankings (CHR), Behavioral Risk Factor Surveillance Survey (BRFSS), County Health Rankings (CHR) Washington State Healthy Youth Survey (HYS), Uniform Crime Reporting (UCR), Federal Bureau of Investigation (FBI), County Health Rankings (CHR)

Priority Area 3: Promote Healthy Active Living

Goal 3.4. *Limit exposure to tobacco, alcohol and other harmful substances, especially for youth*

Objective	Population Measure	Baseline (2010)	Recent (2014)	Target	Target Status
By December 31, 2016, community partners in Whatcom County will limit exposure to tobacco, alcohol and other harmful substances, especially for youth, and in doing so:	Decrease % of 10th grade students reporting that they perceive the availability of marijuana as not hard to access	73%	70.50%	63.5%	unmet
	Increase % of 10th grade students reporting that they perceived great risk associated with smoking marijuana regularly	45.8%	36.1%	36.7%	unmet
	Decrease % of 10th grade students reporting alcohol use in the last 30 days	32.3%	18.1%	19.0%	met
	Decrease % of 10th grade students reporting cigarette use in the last 30 days	13.8%	8.7%	16.0%	met
	Decrease % of 10th grade students reporting marijuana use in the last 30 days	22.5%	16.4%	18.0%	met
	Decrease % of 10th grade students reporting indoor secondhand smoke exposure	34.4%	26.4%	23.8%	unmet

Strategy	Activity	Performance Measures	Status	Lead Community Partners
3.4.1. Explore and adopt marijuana retail policies that consider the impacts of marketing and availability of marijuana on youth and provide safeguards to protect youth from the harms of early initiation	Engage youth in developing educational campaign(s) for retailers and community related to alcohol, tobacco and marijuana marketing	• # of retailers adopting voluntary product marketing and placement standards • # of youth-developed educational campaigns	In progress	Youth Prevention Clubs, WPC, FCC
3.4.2. Engage youth and other community members in advocating for healthy parks and outdoor spaces	Develop smoke-free park/play-area policies for city and county parks	• # of community parks, play areas, and other outdoor venues that are smoke-free (2015: Bellingham complete, Whatcom County in progress)	In progress	Youth Prevention Clubs, WPC, FCC, BPD, Squalicum High School
3.4.3. Increase the % of multi-unit housing facilities, particularly low-income/affordable housing units that are smoke-free	Develop and provide guidance and other resources for owners of multi-unit housing facilities on steps to adopt, implement and enforce smoke-free housing policies	• # of smoke-free policies adopted	In progress	WCHD Prevention Coalition

*Evidence-based strategies	The Institute of Medicine: • Alcohol companies, advertising companies, and commercial media should refrain from marketing practices that have substantial underage appeal and should take reasonable precautions in the time, place, and manner of placement and promotion to reduce youthful exposure to other alcohol advertising and marketing activity. (3.4.1.) The Guide to Community Preventive Services: • Reducing Exposure to Environmental Tobacco Smoke: Smoking Bans and Restrictions. (3.4.2., 3.4.3.) • Restricting Minors' Access to Tobacco Products: Community Mobilization with Additional Interventions. (3.4.1.) • Reducing Tobacco Use Initiation: Mass Media Campaigns When Combined with Other Interventions. (3.4.1.)
Policy changes needed	Strategies: 3.4.1., 3.4.2., 3.4.3.
State Health Improvement Plan alignment	No
National Prevention Strategy alignment	Strategic directions: • Empowered people: 2. Promote positive social interactions and support healthy decision making. 3. Engage and empower people and communities to plan and implement prevention policies and programs. Priorities: • Tobacco free living: 1. Support comprehensive tobacco free and other evidence-based tobacco control policies. 2. Support full implementation of the 2009 Family Smoking Prevention and Tobacco Control Act (Tobacco Control Act). 4. Use media to educate and encourage people to live tobacco free. • Preventing drug abuse and excessive alcohol use: 1. Support state, tribal, local, and territorial implementation and enforcement of alcohol control policies. 2. Create environments that empower young people not to drink or use other drugs.
Healthy People 2020 alignment	• Reduce the proportion of nonsmokers exposed to secondhand smoke. • Reduce tobacco use by adolescents. • Reduce the initiation of tobacco use among children, adolescents, and young adults. • Reduce the proportion of adolescents and young adults grades 6 through 12 who are exposed to tobacco advertising and promotion. • Increase the proportion of adolescents never using substances. • Increase the proportion of adolescents who disapprove of substance abuse. • Increase the proportion of adolescents who perceive great risk associated with substance abuse. • Reduce past-month use of illicit substances
Data sources	Washington State Healthy Youth Survey (HYS)

Priority Area 4: Improve Health Care Access and Service Delivery

Goal 4.1. ***All people have the health care services and supports they need to thrive***

Objective
By December 31, 2016, community partners in Whatcom County will ensure people have the health care services and supports needed to thrive, particularly health insurance, and in doing so:

Population Measure	Baseline (2010)	Recent (2014)	Target	Target Status
Decrease % of uninsured children ages 0-17	7.9% (2011)	7.8% (2013)	0%	unmet
Decrease % of uninsured adults	12.11% (2012)	4.55% (2015)	0%	unmet
Decrease % of uninsured adults ages 65+	1.2% (2011)	1.2% (2013)	0%	unmet
Decrease % of adults lacking a consistent source of primary care	19.6%	20.6% (2012)	16.1%	unmet
Increase number of primary care providers	97:1	1,215:1 (2012)	1,045:1	met

Strategy	Activity	Performance Measures	Status	Lead Community Partners
4.1.1. Expand and maintain health insurance enrollment, particularly for lower- income people	Develop and implement regional "in-person assister" network to identify and connect uninsured people with Medicaid and subsidized commercial coverage options	• # new enrollments in Medicaid and qualified health plans (QHP) (subsidized and unsubsidized) on a quarterly basis • % of reenrollments stratified by QHP/Medicaid	In progress	WAHA, UCNW, SM, MBPP, OC, PHSJMC, PHS

*Evidence-based strategies	The Institute of Medicine: • Private and public purchasers, health care organizations, clinicians, and patients should work together to redesign health care processes. (4.1.1.) • That purchasers, regulators, health professions, educational institutions, and the Department of Health and Human Services create an environment that fosters and rewards improvement by (1) creating an infrastructure to support evidence-based practice, (2) facilitating the use of information technology, (3) aligning payment incentives, and (4) preparing the workforce to better serve patients in a world of expanding knowledge and rapid change. (4.1.1.) The U.S. Preventive Services Task Force: • To continue the improvement in the health of the people in the United States, we need to use the complete array of effective prevention tools at our disposal, increase their effectiveness and utilization by connecting them where possible, and systematically apply them at all levels of influence on behavior. (4.1.1.)
Policy changes needed	NA
State Health Improvement Plan alignment	No alignment
National Prevention Strategy alignment	Strategic directions: • Clinical and community preventive services: 5. Reduce barriers to accessing Clinical and community preventive services, especially among populations at greatest risk. 6. Enhance coordination and integration of clinical, behavioral, and complementary health strategies. • Elimination of health disparities: 2. Reduce disparities in access to quality health care. 4. Support research to identify effective strategies to eliminate health disparities.
Healthy People 2020 alignment	• Increase the proportion of persons with a usual primary care provider. • Increase the proportion of persons who have a specific source of ongoing care. • Reduce the proportion of individuals who are unable to obtain or delay in obtaining necessary medical care, dental care, or prescription medicines.
Data sources	Small Area Health Insurance Estimates (SAHIE), American Community Survey (ACS), Community Commons (CC), Whatcom Alliance for Health Advancement (WAHA), Washington State Office of Financial Management (OFM), Behavioral Risk Factor Surveillance Survey (BRFSS), County Health Rankings (CHR)

Priority Area 4: Improve Health Care Access and Service Delivery

Goal 4.1. *All people have the health care services and supports they need to thrive*

Objective
By December 31, 2016, community partners in Whatcom County will ensure people have the health care services and supports needed to thrive, particularly dental services, and in doing so:

Population Measure	Baseline (2010)	Recent (2014)	Target	Target Status
Increase % of adults age 21 and up with Medicaid who receive dental care	27.6%	14.0%	30.4%	unmet
Increase % of children age 5 and younger with Medicaid who receive dental care	47.3%	46.8%	52.0%	unmet
Decrease % of children with dental cavities	61%	NA	49.0%	unmet
Increase number of dentist	NA	1,495:1	1,377:1	unmet
Increase % of 10th grade students who report visiting dentist in last 2 years	86.4%	86.5% (2012)	49.0%	met
Decrease % of adults without dental exam in past 12 month	NA	29.30%	51.0%	met
Decrease % of emergency room visits for dental problems	NA	2%	1.8%	unmet

Strategy	Activity	Performance Measures	Status	Lead Community Partners
4.1.2. Expand dental care capacity for lower income adults, pregnant women, people with diabetes and children	Develop focused programs to connect high-risk populations (i.e. pregnant women, young children on Medicaid, people with diabetes) to dental care	• % of children (0–5) on Medicaid with a dental visit in the past 12 months	In progress	Lead: WAHA and UCNW Partners: SM, WOHC, MBDDS, WADSF, PHSJMC
	Expand dental facilities to meet growing needs for adults	• # of new dental chairs added (capital facilities) • # new dentists • # dental providers who bill Medicaid	In progress	Lead: WAHA and UCNW Partners: SM, WOHC, MBDDS, WADSF, PHSJMC

*Evidence-based strategies	The Institute of Medicine: • All health care organizations, professional groups, and private and public purchasers should pursue six major aims; specifically, health care should be safe, effective, patient-centered, timely, efficient, and equitable. (4.1.2.) • Private and public purchasers, health care organizations, clinicians, and patients should work together to redesign health care processes. (4.1.2.) • That purchasers, regulators, health professions, educational institutions, and the Department of Health and Human Services create an environment that fosters and rewards improvement by (1) creating an infrastructure to support evidence-based practice, (2) facilitating the use of information technology, (3) aligning payment incentives, and (4) preparing the workforce to better serve patients in a world of expanding knowledge and rapid change. (4.1.2.) The U.S. Preventive Services Task Force: • To continue the improvement in the health of the people in the United States, we need to use the complete array of effective prevention tools at our disposal, increase their effectiveness and utilization by connecting them where possible, and systematically apply them at all levels of influence on behavior. (4.1.2.)
Policy changes needed	NA
State Health Improvement Plan alignment	No
National Prevention Strategy alignment	Strategic directions: • Clinical and community preventive services: 5. Reduce barriers to accessing Clinical and community preventive services, especially among populations at greatest risk. 6. Enhance coordination and integration of clinical, behavioral, and complementary health strategies. • Elimination of health disparities: 2. Reduce disparities in access to quality health care. 4. Support research to identify effective strategies to eliminate health disparities.
Healthy People 2020 alignment	• Increase the proportion of persons with a usual primary care provider. • Increase the proportion of persons who have a specific source of ongoing care. • Reduce the proportion of individuals who are unable to obtain or delay in obtaining necessary medical care, dental care, or prescription medicines.
Data sources	Washington State Health Care Authority (HCA), Washington State Smile Survey, County Health Rankings (CHR) Washington State Healthy Youth Survey (HYS), Behavioral Risk Factor Surveillance Survey (BRFSS), Community Commons (CC), Whatcom Alliance for Health Advancement (WAHA)

Priority Area 4: Improve Health Care Access and Service Delivery

Goal 4.1. *All people have the health care services and supports they need to thrive*

Objective
By December 31, 2016, community partners in Whatcom County will ensure people have the health care services and supports needed to thrive, particularly potentially avoidable care, and in doing so:

Population Measure	Baseline (2010)	Recent (2014)	Target	Target Status
Decrease % of potentially avoidable emergency room visits	NA	10%	9.0%	unmet
Decrease % acute inpatient stays that were followed by 30-day readmission for all causes	NA	4%	9.5%	met
Decrease number of preventable hospital stays ambulatory-care sensitive conditions per 1,000 Medicare enrollees	46/1,000	42/1,000	46	met

Strategy	Activity	Performance Measures	Status	Lead Community Partners
4.1.3. Develop care coordination and intensive case management for individuals with complex health needs	Develop cross-organizational intensive case management protocols for patients with complex needs	• # of intensive case management protocols • # and % of ER visits and hospital admissions for chronic health conditions (diabetes, hypertension, cardiovascular disease, and asthma)	In progress	Lead: WAHA and PHSJMC Partners: NWRC, UCNW, SM, PHMG, CW, LWRT, CCS, WHSC, BCPA, BPD, WCJ
	Develop Community Connector role in the Emergency Department that is linked with Community Health Centers, mental health services and the WAHA Intensive Case Management program	• Community Connector established in PeaceHealth Emergency Department (1/2015: first Community Connector embedded in PeaceHealth)	Complete	Lead: WAHA and PHSJMC Partners: NWRC, UCNW, SM, PHMG, CW, LWRT, CCS, WHSC, BCPA, BPD, WCJ
	Support the further development of the WAHA-sponsored Care Transitions Coaching program including expanding Care Transition services to anybody who would benefit, irrespective of payer.	• # of patients participating in Care Transitions (2013-15: WAHA employed an evidence-based Care Transitions Intervention for up to 120 patients per month for a 2.5 year period)	Complete	Lead: WAHA and PHSJMC Partners: NWRC, UCNW, SM, PHMG, CW, LWRT, CCS, WHSC, BCPA, BPD, WCJ

*Evidence-based strategies	The Institute of Medicine: ● All health care organizations, professional groups, and private and public purchasers should pursue six major aims; specifically, health care should be safe, effective, patient-centered, timely, efficient, and equitable. (4.1.3.) ● Private and public purchasers, health care organizations, clinicians, and patients should work together to redesign health care processes. (4.1.3.) ● That purchasers, regulators, health professions, educational institutions, and the Department of Health and Human Services create an environment that fosters and rewards improvement by (1) creating an infrastructure to support evidence-based practice, (2) facilitating the use of information technology, (3) aligning payment incentives, and (4) preparing the workforce to better serve patients in a world of expanding knowledge and rapid change. (4.1.3.) The U.S. Preventive Services Task Force: ● To continue the improvement in the health of the people in the United States, we need to use the complete array of effective prevention tools at our disposal, increase their effectiveness and utilization by connecting them where possible, and systematically apply them at all levels of influence on behavior. (4.1.3.)
Policy changes needed	Strategy 4.1.3.
State Health Improvement Plan alignment	Priority 3: Broaden health care to promote health outside the medical system
National Prevention Strategy alignment	Strategic directions: • Clinical and community preventive services: 5. Reduce barriers to accessing Clinical and community preventive services, especially among populations at greatest risk. 6. Enhance coordination and integration of clinical, behavioral, and complementary health strategies. • Elimination of health disparities: 2. Reduce disparities in access to quality health care. 4. Support research to identify effective strategies to eliminate health disparities.
Healthy People 2020 alignment	• Increase the proportion of persons with a usual primary care provider. • Increase the proportion of persons who have a specific source of ongoing care. • Reduce the proportion of individuals who are unable to obtain or delay in obtaining necessary medical care, dental care, or prescription medicines.
Data sources	Community Checkup-Washington Health Alliance (WHA, County Health Rankings (CHR)

Priority Area 4: Improve Health Care Access and Service Delivery

Goal 4.1. *All people have the health care services and supports they need to thrive*

Objective
By December 31, 2016, community partners in Whatcom County will ensure people have the health care services and supports needed to thrive, particularly mental health treatment, and in doing so:

Population Measure	Baseline (2010)	Recent (2014)	Target	Target Status
Increase number of mental health care providers	NA	276:1	386:1	met
Decrease % of adults with frequent mental stress	NA	8%	7.2%	unmet
Decrease % of 10th grade students reporting suicidal intent/plan	12.5%	15.0%	7.5%	unmet
Decrease % 10th grade students reporting contemplation of suicide	17.4%	18.8%	7.5%	unmet
Decrease point-in-time count of homeless adults reporting mental health disability	37% (2013)	39% (2015)	41.0%	unmet

Strategy	Activity	Performance Measures	Status	Lead Community Partners
4.1.4. Increase treatment services for children and adults with behavioral health conditions, i.e. substance abuse and/or mental health issues	Develop multi-disciplinary developmental evaluation system for children	• # of complex clients enrolled in community care coordination programs	In progress	WhatcomTA: GIDES, PHSJMC
	PeaceHealth, in collaboration with Community Health Centers, to provide incentives to recruit more psychiatrists and behavioral interventionists	• # of practitioners recruited	In progress	PHSJMC
	Develop video conferencing, i.e. tele-psychiatry opportunities	• TBD	Future	TBD
	Pilot new ways of integrating mental health and chemical dependency treatment with primary care for specific populations	• # primary care providers piloting new integrated services	In progress	WAHA
	Pilot Intensive Case Management teams that are closely aligned with primary care medical homes and oriented toward serving the needs of special populations (i.e. people who are mentally ill or homeless and children with special health care needs)	• # Intensive Case Management teams (2014: first team established)	Complete	WAHA, PHSJMC, NWRC, UCNW, SM, PHMG, CW, LWRT, CCS, WHSC, BCPA, BCPO, WCJ
	Evaluate Intensive Case Management pilots and develop an expansion plan and financing model in collaboration with key providers, payers and social service agencies	• Completed expansion plan and financing model (2015: expansion and financing plan complete)	Complete	WAHA, PHSJMC, NWRC, UCNW, SM, PHMG, CW, LWRT, CCS, WHSC, BCPA, BCPO, WCJ
	Expand care transition services to anybody who would benefit, irrespective of payer	• Updated protocol for expanding care transition services (2015: protocol updated)	Complete	WAHA

Strategy 4.1.4. continued on next page

Priority Area 4: Improve Health Care Access and Service Delivery

Goal 4.1. *All people have the health care services and supports they need to thrive*

Continued from previous page

*Evidence-based strategies	The Institute of Medicine: ● Making evidence the foundation of decision making and the measure of success. (4.1.4.) ● All health care organizations, professional groups, and private and public purchasers should pursue six major aims; specifically, health care should be safe, effective, patient-centered, timely, efficient, and equitable. (4.1.4.) ● That purchasers, regulators, health professions, educational institutions, and the Department of Health and Human Services create an environment that fosters and rewards improvement by (1) creating an infrastructure to support evidence-based practice, (2) facilitating the use of information technology, (3) aligning payment incentives, and (4) preparing the workforce to better serve patients in a world of expanding knowledge and rapid change. (4.1.4.) ● Private and public purchasers, health care organizations, clinicians, and patients should work together to redesign health care processes. (4.1.4.) The Guide to Community Preventive Services: ● Collaborative care for the management of depressive disorders. (4.1.4.) The U.S. Preventive Services Task Force: ● Recommends screening and behavioral counseling interventions to reduce alcohol misuse by adults, including pregnant women, in primary care settings. (4.1.4.) ● To continue the improvement in the health of the people in the United States, we need to use the complete array of effective prevention tools at our disposal, increase their effectiveness and utilization by connecting them where possible, and systematically apply them at all levels of influence on behavior. (4.1.4.) ● Recommends screening of adolescents (12 – 18 years of age) for management of depressive disorders when systems are in place to ensure accurate diagnosis, psychotherapy (e.g., cognitive-behavioral, interpersonal), and follow-up. (4.1.4.)
Policy changes needed	Strategy 4.1.4.
State Health Improvement Plan alignment	Priority 1: Invest in the health and well-being of our youngest children and families , Priority 3: Broaden health care to promote health outside the medical system
National Prevention Strategy alignment	Strategic directions: • Healthy and safe community environments: 7. Identify and implement strategies that are proven to work and conduct research where evidence is lacking. • Clinical and community preventive services: 2. Use payment and reimbursement mechanisms to encourage delivery of clinical preventive services. 3. Expand use of interoperable health information technology. 4. Support implementation of community-based preventive services and enhance linkages with clinical care. 5. Reduce barriers to accessing Clinical and community preventive services, especially among populations at greatest risk. 6. Enhance coordination and integration of clinical, behavioral, and complementary health strategies. Priorities: • Mental and emotional well-being: 4. Promote early identification of mental health needs and access to quality services. • Preventing drug abuse and excessive alcohol use: 3. Identify alcohol and other drug abuse disorders early and provide brief intervention, referral and treatment. 4. Reduce inappropriate access to and use of prescription drugs.
Healthy People 2020 alignment	• Increase the proportion of persons who have a specific source of ongoing care. • Reduce the proportion of individuals who are unable to obtain or delay in obtaining necessary medical care, dental care, or prescription medicines. • Increase the proportion of persons who need alcohol and/or illicit drug treatment and received specialty treatment for abuse or dependence in the past year. • Increase depression screening by primary care providers. • Increase the proportion of homeless adults with mental health problems who receive mental health services. • Increase the number of community-based organizations (including local health departments, tribal health services, nongovernmental organizations, and State agencies) providing population-based primary prevention services in the following areas: injury, violence, mental illness, tobacco use, substance abuse, unintended pregnancy, chronic disease programs, nutrition, physical activity.
Data sources	County Health Rankings (CHR), Behavioral Risk Factor Surveillance Survey (BRFSS), Community Checkup-Washington Health Alliance (WHA), Washington State Healthy Youth Survey (HYS), Whatcom Homeless Service Center (WHSC)

Priority Area 4: Improve Health Care Access and Service Delivery

Goal 4.2. *All care is provided in respectful and culturally appropriate ways*

Objective
By December 31, 2016, community partners in Whatcom County will ensure people have the health care services and supports needed to thrive, particularly for Native American and Hispanic patients, and in doing so:

Population Measure	Baseline (2010)	Recent (2014)	Target	Target Status
Decrease % of uninsured Native American/Alaska Native population	24.2%	22.5% (2012)	0%	unmet
Decrease % of uninsured Hispanic population	24.5%	26.33% (2012)	0%	unmet
Increase % of patients who gave hospital an overall rating of 9 or 10 on a scale from 0 (lowest) to 10 (highest)	NA	69%	95.0%	unmet

Strategy	Activity	Performance Measures	Status	Lead Community Partners
4.2.1. Increase cultural competency of system caregivers and enhance the experience of care for Native American and Hispanic populations	Support efforts to ensure successful care transitions from the hospital for tribal members	• # of hospital readmissions by age, race/ethnicity, income, insurance status and place of residence • % of patients who report high levels of satisfaction with hospital care by age, race/ethnicity, income, insurance status and place of residence	In progress	WAHA, UCNW, PHSJMC
	Conduct cultural competency training programs throughout PeaceHealth St Joseph Medical Center and PeaceHealth Medical Group, incorporate into ongoing caregiver competency updates, include cultural competency for all new employees	• # participants in cultural competency training for healthcare workers	In progress	PHSJMC
	Conduct organizational cultural competency policy and practice assessment using national tools	• % of patients who report high levels of satisfaction with hospital care (by age, race/ethnicity, income, insurance status and place of residence) • % of patients who report that they were treated with respect and compassion when receiving health care services	In progress	PHSJMC
	Create a safe table for open and ongoing conversation between representatives of various health care and social service provides and the Nooksack and Lummi Tribal Health Centers	• # of participants in Tribal Health and Experience of Care group (9/2013: Tribal Health and Experience of Care group established and has 28 members as of 1/2016)	Complete	PHSJMC

Strategy 4.2.1. continued on next page

Priority Area 4: Improve Health Care Access and Service Delivery

Goal 4.2. ***All care is provided in respectful and culturally appropriate ways***

Continued from previous page

*Evidence-based strategies	The Institute of Medicine: ● Clinicians and patients, and the health care organizations that support care delivery, adopt a new set of principles to guide the redesign of care processes. (4.2.1.) ● All health care organizations, professional groups, and private and public purchasers should pursue six major aims; specifically, health care should be safe, effective, patient-centered, timely, efficient, and equitable. (4.2.1.) ● Private and public purchasers, health care organizations, clinicians, and patients should work together to redesign health care processes. (4.2.1.) ● Health professions educational institutions governing bodies should develop institutional objectives consistent with community benefit principles that support the goal of increasing health-care workforce diversity including, but not limited to efforts to ease financial and nonfinancial obstacles to underrepresented minority participation, increase involvement of diverse local stakeholders in key decision-making processes, and undertake initiatives that are responsive to local, regional, and societal imperatives. (4.2.1.) ● Private and public (e.g., Federal, state, and local governments) entities should convene major community benefit stakeholders (e.g., community advocates, academic institutions, health-care providers), to inform them about community benefit standards and to build awareness that placing a priority on diversity and cultural competency programs is a societal expectation of all institutions that receive any form of public funding. (4.2.1.) ● Health professions educational institutions should be encouraged to affiliate with community-based health-care facilities in order to attract and train a more diverse and culturally competent workforce and to increase access to health care. (4.2.1.) ● Health professions education accreditation bodies should develop explicit policies articulating the value and importance of providing culturally competent health care and the role it sees for racial and ethnic diversity among health professionals in achieving this goal. (4.2.1.) The U.S. Preventive Services Task Force: ● To continue the improvement in the health of the people in the United States, we need to use the complete array of effective prevention tools at our disposal, increase their effectiveness and utilization by connecting them where possible, and systematically apply them at all levels of influence on behavior. (4.2.1.) ● Integrating evidence-based clinical and community strategies to improve health. (4.2.1.)
Policy changes needed	Strategy 4.2.1.
State Health Improvement Plan alignment	Priority 3: Broaden health care to promote health outside the medical system
National Prevention Strategy alignment	Strategic directions: • Healthy and safe community environments: 4. Integrate health criteria into decision making, where appropriate, across multiple sectors. 8. Maintain a skilled, cross-trained, and diverse prevention workforce. • Clinical and community preventive services: 4. Support implementation of community-based preventive services and enhance linkages with clinical care. 5. Reduce barriers to accessing clinical and community preventive services, especially among populations at greatest risk. • Empowered people: 1. Provide people with tools and information to make healthy choices. 2. Promote positive social interactions and support healthy decision making. 3. Engage and empower people and communities to plan and implement prevention policies and programs. • Elimination of health disparities: 1. Ensure a strategic focus on communities at greatest risk. 2. Reduce disparities in access to quality health care. 3. Increase the capacity of the prevention workforce to identify and address disparities. 4. Support research to identify effective strategies to eliminate health disparities. 5. Standardize and collect data to better identify and address disparities.
Healthy People 2020	• Increase the proportion of persons with a usual primary care provider. • Increase the proportion of persons who have a specific source of ongoing care. • Reduce the proportion of individuals who are unable to obtain or delay in obtaining necessary medical care, dental care, or prescription medicines.
Data sources	Small Area Health Insurance Estimates (SAHIE), American Community Survey (ACS), Community Commons (CC), Community Checkup-Washington Health Alliance (WHA)

Conclusion

As the third year of the *Community Health Improvement Plan* concludes, the 2015 Annual Report provides a look at achievements, successes and barriers associated with the implementation of this plan. This report was informed by the revision process to the *Community Health Improvement Plan (CHIP): Implementation Plan* for the *Community Health Improvement Plan* (2012-2017) based on data collected over the course of 2015, and will be used to further refine strategies and activities over the next year. The good work in the community will continue and future work includes:

- Integrating and aligning community efforts that are currently working in each of our priority areas. For example, collaborate with the prevention work happening in the community through the Whatcom Prevention Coalition, Western Washington University, public schools and the Health Department.
- As equity is the lens through which all work related to community health improvement should be viewed, the *Community Health Assessment (*2016*)* will analyze *Community Health Improvement Plan* population measures by age, education, gender, race/ethnicity and income. These categories are markers for social, cultural, economic and political factors that influence health, and are essential when identifying health disparities and developing strategies for addressing social and economic inequities. Racial and ethnic categories are social and historical concepts with little – if any – biological meaning. By presenting health data by race and ethnicity, especially data on individual risk behavior, it is possible to reinforce negative stereotypes and stigmatize communities of color so it is essential to proceed with respect and cultural humility.
- Implement community participatory strategies in order to develop culturally appropriate responses for all our community members.
- PeaceHealth St Joseph Medical Center and the Health Department will begin to prepare for and design the next round of community health assessment and improvement planning (2016), and work with the Leadership Council and Action Teams to align current work and processes.
- In 2016, the *Community Health Improvement Plan* evaluation design will include a comprehensive outcome evaluation and will be informed by Whatcom County's *Community Health Assessment* (2016).
- The Leadership Council will determine their role in community engagement and leadership with an advocacy and policy focus in order to advance equity in Whatcom County, as well as support the work of the Action Teams.
- Action Teams will focus on collaborative opportunities within each priority area and decide upon the feasibility and scope of a Collective Impact project.
- The Leadership Council, Action Teams and Equity Summit 2015 delegation members will consider whether Whatcom County should identify equity measures to watch to evaluate progress toward equity in Whatcom County.
- Encouraging Action Teams to utilize evidence-based recommendations for each priority area. As part of evaluation activities, the Health Department will track the dissemination and use of evidence-based recommendations throughout the *Community Health Improvement Plan* implementation.
- The Whatcom County Health Department will continue to work with community partners to monitor and evaluate the progress of the *Community Health Improvement Plan (2012-2017)* and share findings with the community annually.

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Appendix A: Strategy and Activity Progress Chart

This chart captures the evolution and progress of the strategies identified in the *Community Health Improvement Plan* (2012-2017), and can be understood using the following information:

1. **Timeline of Strategies**
   - 2011: included as a priority, goal or strategy in the original *Community Health Improvement Plan*
   - 2013: included in the draft Implementation Plan used as a basis for forming Action Teams
   - 2015: a current priority, goal or strategy being worked on within the community

2. **Each CHIP strategy has been rated using the following four criteria:**
   - Is the strategy feasible to implement?
   - Are resources available in the community for strategy development and implementation?
   - Could the strategy be completed within the community in remaining years of the current CHIP?
   - Is progress being made toward implementation of a given strategy?

3. **The status of each CHIP strategy has been evaluated as:**
   - **Reprioritized**: strategy changed or moved to another priority area as it was agreed that a different strategy or approach would work better
   - **In progress**: work is happening and will continue into 2016
   - **Complete**: the measures for the strategy have been met
   - **Future**: the strategy will be addressed after January 2016

4. **Color code for chart:** Strategies shaded in gold have moved forward and are captured in greater detail within our *Community Health Improvement Plan (CHIP): Implementation Plan*. Strategies in white have been reprioritized and will not continue in their current form.

5. **Organizational abbreviations:** Many dedicated and talented individuals and organizations have contributed to work that advances the *Community Health Improvement Plan* priorities. In the interest of space in the grid below, we've abbreviated many organizational names. Abbreviations are not necessarily recognized as the organization's official abbreviation. We've tried to be as accurate as possible and thank you in advance for your understanding. This list is not exhaustive of all who have participated in *Community Health Improvement Plan* work, but is meant to identify the lead or partners working on a particular strategy.

- Acme Farms: AF
- Agriculture Business Center: ABC
- Bellingham Community Paramedic: BCPA
- Bellingham Food Bank: BFB
- Bellingham Police Department: BPD
- Bellingham Public Schools: BPS
- Bellingham/Whatcom County Commission Against Domestic Violence: BWCADV Blaine Birch Bay Parks & Recreation District 2: BBBPRD2
- Campus Community Coalition: CCC
- Catholic Community Services: CCS
- Chuckanut Health Foundation (formerly St Luke's): CHF
- City of Bellingham: COB
- Commission Against Domestic Violence: CADV
- Community Health Centers: CHC
- Community In Schools of Whatcom County, : CISWC
- Compass Whatcom: CW
- Council on Aging: COA
- Domestic Violence Sexual Assault Services: DVSAS
- Early Head Start (w/in OC): EHS
- Early Learning and Family Services (w/in OC): ELFS
- Ferndale Community Coalition: FCC
- Food Lifeline: FL
- Foothills Food Bank: FFB
- Kendall/Columbia Valley Connectivity Plan Association: KCVCPA
- Lake Whatcom Residential Treatment: LWRT
- Mt Baker District Dental Society: MBDDS
- Mt Baker Planned Parenthood: MBPP
- Nooksack Tribal Transportation Department: NTTD
- NW Agriculture Business Center: NABC
- Northwest Economic Council: NEC
- Opportunity Council: OC
- PeaceHealth St Joseph Medical Center: PHSJMC
- Pioneer Human Services: PHS
- Sea Mar Community Health Centers: SM
- United Way of Whatcom County: UW
- Unity Care NW (formerly Interfaith): UCNW
- WA Dental Service Foundation: WADSF
- Western Washington University WWU:
- Whatcom Alliance for Health Advancement: WAHA
- Whatcom Community Foundation: WCF
- Whatcom County Bicycle/Pedestrian Advisory Committee: BPAC
- Whatcom County Health Department: WCHD
- Whatcom County Jail: WCJ
- Whatcom Family Community Network: WFCN
- Whatcom Farm to School: WF2S
- Whatcom Food Network: WFN
- Whatcom Futures: WF
- Whatcom Homeless Service Center (w/in OC): WHSC
- Whatcom Oral Health Coalition: WOHC
- Whatcom Prevention Coalition: WPC
- Whatcom Taking Action: WhatcomTA
- Whatcom Transit Authority: WTA

Priority 1: Build Community Connectedness and Resilience

PRIORITY AREA	GOALS	STRATEGIES	2011	2013	2015	Feasible Y/N	Resources Y/N	Community Y/N	Progress Y/N	Status
Build Community Connected-ness and Resilience	Foster community voice and engagement	Reach out to representatives of diverse cultural, geographic and economic communities to serve in CHIP leadership positions and working groups.	X	X	X	Y	Y	Y	Y	In progress
		Establish infrastructure for successful implementation and sustainability of *Community Health Improvement Plan.*		X	X	Y	Y	Y	Y	In progress
	Cultivate a culture of compassion and understanding	Engage policymakers in dialogue about these issues.	X	X	X					Reprioritized
		Disseminate information to multiple audiences through a variety of media channels.	X	X						Reprioritized
		Support community conversations about these issues.	X	X						Reprioritized
		Identify and support training opportunities related to trauma-sensitive services for providers in health, education social service sectors and other interested parties (employers, communities of faith).	X	X	X	Y	Y	Y	Y	In progress
		Encourage development of "communities-of-practice" for service providers to learn about implementing compassionate, trauma-sensitive approaches.	X	X	X	Y	Y	Y	Y	Complete
		Support development of organizational policy statements and processes that promote integration of compassionate, trauma-sensitive principles and practices.	X	X	X	Y	Y	Y	Y	In progress
		Develop mechanisms to recognize organizations that take steps to adopt compassionate approaches and share successes with the community.	X							Reprioritized
		Support evaluation studies to monitor outcomes related to changes in practices across multiple sectors.	X							Reprioritized
	Respond collectively to community substance use and mental health challenges	Convene whole system to develop a common agenda and path forward.	X	X	X	Y	Y	Y	Y	In progress
		Identify ways to build on community strengths and assets, using tools such as appreciative inquiry.	X	X						Reprioritized
		Incorporate substance use and mental health objectives throughout CHIP.	X							Reprioritized
		Support implementation of strategies identified by the whole system.	X	X	X	Y	Y	Y	Y	In progress

Priority 2: Enhance Child and Family Well-being

PRIORITY AREA	GOALS	STRATEGIES	2011	2013	2015	Feasible Y/N	Resources Y/N	Community Y/N	Progress Y/N	Status
Enhance Child and Family Well-being	All families are strong, stable and supported from the start	2011: Implement and maintain evidence-based parenting support/home visitation programs for low-income pregnant/parenting mothers and fathers 2015: Maintain and expand early learning and parenting supports for families with very young children (prenatal to age three)	X	X	X	Y	Y	Y	Y	In progress
		Expand existing evidence-based programming to meet the population needs by identifying additional supports needed for families with very young children.			X	Y	Y	Y	N	Future
		Prioritize needs of emerging families in community housing-related plans and policies.	X	X	X					Reprioritized
		Implement and evaluate housing pilot project to link young families with housing case management	X	X						Reprioritized
		Develop and implement a community outreach plan to bring more eligible families into local WIC programs.	X	X	X					Reprioritized
		Advocate for community and workplace policies that support new families.	X							Reprioritized
		Develop models of intensive support for families facing substance abuse, mental health diagnoses, and/or domestic abuse.			X	Y	N	N	N	Future
		2011: Explore mechanisms to better identify and link new parents to mental health and substance use interventions. 2015: Expand family-oriented mental health and substance use treatment options.	X	X	X	Y	N	N	N	Future
		Explore home-visiting or site-based models of intensive parenting support for families with complex needs.			X	Y	N	N	N	Future
		Embed social workers in pediatric and OB/GYN provider offices.			X	Y	N	N	N	Future
		Address the unmet needs of young families by providing necessary services and supports.			X	Y	N	N	N	Future
		Improve available transportation to family appointments; develop play and learn groups in diverse geographic locations and different languages; ensure access to food and housing for families.			X	Y	N	N	N	Future
	All children enter school safe, healthy and ready to learn	Develop a multi-facetted community-based initiative aimed at increasing awareness of current brain research and enhancing the capacity of adults to provide the support children need for healthy development.	X							Reprioritized
		Expand early childhood and early learning support infrastructure.			X	Y	N	N	N	Future
		Advocate for the development of a collective impact model, a community-wide effort to support children and families.			X	Y	N	N	N	Future
		Explore developing a children's council, tying together existing groups working to support children and families.			X	Y	Y	N	N	Future
		Develop and disseminate information about the importance of early identification and intervention for developmental and behavioral health issues to parents, caregivers, teachers and health care providers.	X	X	X	Y	Y	Y	Y	In progress
		Connect existing groups working to support children and families.			X	Y	Y	N	N	Future
		Support medical, early learning and social service provider training to improve use of developmental screening methods.	X			Y	Y	Y	Y	In progress

Priority 2: Enhance Child and Family Well-being continued

PRIORITY AREA	GOALS	STRATEGIES	2011	2013	2015	Feasible Y/N	Resources Y/N	Community Y/N	Progress Y/N	Status
Enhance Child and Family Well-being	All children enter school safe, healthy and ready to learn	2011: Build on community efforts to improve system capacity for evaluation and management of child developmental and behavioral health needs. 2015: Increase developmental and behavioral supports for young children.	X	X	X	Y	N	N	Y	In progress
		Implement local developmental-behavioral evaluation system for young children.			X	Y	N	N	Y	In progress
		Develop multi-disciplinary developmental evaluation system for children.	X	X	X	Y	N	N	Y	In progress
		Allocate resources to develop, maintain and expand early learning programs that meet high quality standards, including evidence-based social-emotional curriculum for vulnerable children.	X	X	X	Y	Y	Y	Y	In progress
		Develop mechanisms to identify and connect children to early learning programs.	X		X	Y	Y	Y	Y	Future
		Monitor the proportion of children entering kindergarten with preschool experience to identify and close gaps.	X		X	Y	Y	Y	Y	In progress
		Expand existing high quality early learning programs.	X	X	X	Y	Y	Y	Y	In progress
		Increase connections between health care providers and early learning programs.	X	X	X	Y	Y	Y	Y	In progress
	All children and youth thrive at home and school	Expand availability of targeted, evidence-based, positive family development programs for at-risk youth and families.	X	X	X	Y	Y	Y	Y	In progress
		Engage community members, including tribal and Hispanic community partners and families, in identifying and developing appropriate strategies to support healthy youth development.	X	X	X	Y	Y	Y	Y	In progress
		Develop improved systems within schools and other settings to identify and link youth with social-emotional needs and learning differences to needed resources.	X	X	X	Y	Y	Y	Y	In progress
		Expand resources to support youth with executive function challenges.	X	X	X	Y	Y	Y	Y	In progress
		Maintain and expand evidence-based youth mentoring programs.	X	X	X	Y	Y	Y	Y	In progress
		Support school prevention clubs and other youth-led community health initiatives.	X	X	X	Y	Y	Y	Y	In progress

Priority 3: Promote Healthy Active Living

PRIORITY AREA	GOALS	STRATEGIES	2011	2013	2015	Feasible Y/N	Resources Y/N	Community Y/N	Progress Y/N	Status
Promote Healthy Active Living	Enhance access to healthy foods, particularly for low-income and isolated populations	Integrate community health perspective into comprehensive plans and community plans.	X	X	X	Y	Y	Y	Y	In progress
		Improve programs to support healthy food options for low-income populations or people using food assistance.	X	X	X	Y	Y	Y	Y	Complete
		Support school districts in the development of updated school wellness policies that meet current recommendations, including USDA requirements.	X	X	X	Y	Y	Y	Y	In progress
		Support development of community-based healthy food access solution(s) in schools.	X	X	X	Y	Y	Y	Y	In progress
		Develop and implement a community outreach plan to bring more eligible families into local WIC programs.	X	X	X	Y	Y	Y	Y	In progress

Priority 3: Promote Healthy Active Living continued

PRIORITY AREA	GOALS	STRATEGIES	2011	2013	2015	Feasible Y/N	Resources Y/N	Community Y/N	Progress Y/N	Status
Promote Healthy Active Living	Enhance access to safe, affordable housing, particularly for low-income and isolated populations	Advocate for safe, affordable housing as a foundation for healthy living.	X	X	X	Y	Y	Y	Y	In progress
		Prioritize needs of emerging families in community housing-related plans and policies.	X	X		Y	Y	Y	Y	Complete
		Implement and evaluate housing pilot project to link young families with housing case management.	X	X	X	Y	Y	Y	Y	In progress
	Create more safe places to walk, bike, play and connect	Integrate community health perspective into Comprehensive Plans and other community plans.	X	X	X	Y	Y	Y	Y	In progress
		Support development of new bus routes and/or transit stops in outlying areas (or other innovative approaches) to address transportation challenges.	X	X		Y	Y	Y	Y	In progress
		Provide technical assistance and support to community groups working to develop local walking and biking facilities.	X	X		Y	Y	Y	Y	In progress
		Highlight, promote and support existing and emerging healthy neighborhood/ healthy community initiatives.	X	X	X	Y	N	N	Y	In progress
		Support community-based place-making projects, using inclusive community engagement approaches.	X	X	X	Y	N	Y	Y	In progress
		Facilitate procurement of grant funds and other resources for communities interested in building or refurbishing gathering spaces in targeted areas.	X	X	X	Y	Y	Y	Y	Future
		Raise public and policy-maker awareness about the links between place, health and equity.	X	X	X	Y	Y	Y	Y	In progress
	Limit exposure to tobacco, alcohol and other harmful substances, especially for youth	Engage youth in developing educational campaign(s) for retailers and community related to alcohol, tobacco and marijuana marketing.	X	X		Y	Y	Y	Y	In progress
		Explore and adopt marijuana retail policies that consider the impacts on youth of marketing and availability of marijuana and provide safeguards to protect from early initiation.	X			Y	Y	Y	Y	In progress
		Engage youth and other community members in advocating for healthy parks and outdoor spaces.	X	X		Y	Y	Y	Y	Complete
		Develop and provide guidance and other resources for owners of multi-unit housing facilities on steps to adopt, implement and enforce smoke-free housing policies.	X	X	X	Y	Y	Y	Y	In progress
		Provide resources to residents of multi-unit housing facilities to advocate for smoke-free housing policies	X	X						Reprioritized

Priority 4: Improve Health Care Access and Service Delivery

PRIORITY AREA	GOALS	STRATEGIES	2011	2013	2015	Feasible Y/N	Resources Y/N	Community Y/N	Progress Y/N	Status
Improve Health Care Access and Service Delivery	All people have the health care services and supports they need to thrive	Expand and maintain health insurance enrollment, particularly for lower-income people.	X	X	X	Y	Y	Y	Y	In progress

Priority 4: Improve Health Care Access and Service Delivery continued

PRIORITY AREA	GOALS	STRATEGIES	2011	2013	2015	Feasible Y/N	Resources Y/N	Community Y/N	Progress Y/N	Status
Improve Health Care Access and Service Delivery	All people have the health care services and supports they need to thrive	Develop and implement regional In-Person Assister network to identify and connect uninsured people with Medicaid and subsidized commercial coverage options.	X	X	X	Y	Y	Y	Y	In progress
		Develop collaborative recruitment efforts that include incentives to attract additional primary care physicians and mid-level providers to the county who will serve Medicaid/Medicare patients and outlying geographic areas.	X	X	X	N	N	N	N	Reprioritized
		2011: Implement focused programs to connect high-risk populations to dental care (i.e. pregnant women, young children on Medicaid, people with diabetes). 2015: Develop focused programs to connect high-risk populations (i.e. pregnant women, young children on Medicaid, people with diabetes) to dental care.	X	X	X	Y	Y	N	Y	In progress
		2011: Build or expand dental facilities to meet growing needs. 2015: Expand dental facilities to meet growing needs for adults.	X	X	X	Y	Y	Y	Y	In progress
		2011: Develop coordinated system of care for people with complex behavioral and medical conditions. 2015: Develop care coordination and intensive case management for individuals with complex health needs.	X	X	X	Y	Y	Y	Y	In progress
		Develop cross-organizational intensive case management protocols for patients with complex needs.		X	X	Y	Y	Y	Y	In progress
		Pilot Intensive Case Management teams that are closely aligned with primary care medical homes and oriented toward serving the needs of special populations (i.e. people who are mentally ill or homeless and children with special health care needs).		X	X	Y	Y	Y	Y	Complete
		Evaluate Intensive Case Management pilots and develop an expansion plan and financing model in collaboration with key providers, payers and social service agencies.		X	X	Y	Y	Y	Y	Complete
		Develop multi-disciplinary developmental evaluation system for children.	X	X	X	N	N	N	N	Reprioritized
		Develop video conferencing, (i.e. tele-psychiatry opportunities).			X	Y	Y	N	N	Future
		2011: Provide incentives to recruit more psychiatrists and behavioral interventionists for children and adults. 2015: PeaceHealth in collaboration with Community Health Centers to provide incentives to recruit more psychiatrists and behavioral interventionists.	X	X	X	Y	Y	Y	Y	In progress
		Pilot new ways of integrating mental health and chemical dependency treatment with primary care for specific populations.	X	X	X	Y	Y	N	Y	In progress
		Increase treatment services for children and adults with behavioral health conditions (i.e. substance abuse and/or mental health issues).		X	X	Y	N	N	N	In progress

Priority 4: Improve Health Care Access and Service Delivery continued

PRIORITY AREA	GOALS	STRATEGIES	2011	2013	2015	Feasible Y/N	Resources Y/N	Community Y/N	Progress Y/N	Status
Improve Health Care Access and Service Delivery	All people have the health care services and supports they need to thrive	Develop Community Connector role in the Emergency Department that is linked with Community Health Centers, mental health services and the WAHA Intensive Case Management program.			X	Y	Y	Y	Y	Complete
		PeaceHealth to lead planning an *Urgent Care* alternative to the Emergency Department with behavioral health capacity and strong linkages to Community Health Centers.			X					Reprioritized
		Support the further development of the WAHA-sponsored Care Transitions Coaching program.	X	X	X	Y	Y	Y	Y	Complete
		Support efforts to ensure successful care transitions from the hospital for tribal members.	X	X	X	Y	Y	Y	Y	In progress
		2011, 2013: Expand Care Transition services to other payer groups (in addition to Medicare). 2015: Expand Care Transition services to anybody who would benefit, irrespective of payer.	X	X	X	Y	Y	Y	Y	Complete
	All care is provided in respectful and culturally appropriate ways	Support ongoing efforts to centralize minimum set of data required for health care system information and referral.	X	X	X	Y	N	N	Y	In progress
		Maintain and expand Single Entry Access to Services (SEAS) phone line for Children & Youth with Special Health Care needs (CYSHCN).	X	X		Y	N	N	Y	In progress
		Train and deploy Community Connectors, embedded in health homes of Intensive Case Management teams, to assist those who need the extra help.		X		Y	Y	Y	Y	In progress
		2011: Develop and implement programs focused on increasing "health literacy". 2013: Develop and implement programs focused on increasing health literacy and patient activation.	X	X	X	Y	Y	N	Y	In progress
		2011: Encourage quality improvement efforts within health care settings focused on patient-provider communication and provider-provider communication. 2015: Conduct cultural competency training programs throughout PeaceHealth St Joseph Medical Center and PeaceHealth Medical Group, incorporate into ongoing caregiver competency updates, include cultural competency for all new employees.	X	X	X	Y	Y	Y	Y	In progress
		Increase cultural competency of system caregivers and enhance the experience of care for Native American and Hispanic populations.	X	X	X	Y	Y	Y	Y	In progress
		Conduct organizational cultural competency policy and practice assessment using national tools.	X	X	X	Y	N	N	Y	In progress
		Create a safe table for open and ongoing conversation between representatives of various health care and social service provides and the Nooksack and Lummi Tribal Health Centers.	X	X	X	Y	Y	Y	Y	Complete

Appendix B: Leadership Council and Action Team Members

	Name	Organization	Organization Role
Health Care / Whole Person Care	Chris Phillips	PeaceHealth St. Joseph Medical Center	Director of Community Affairs
	Elya Moore	Whatcom Alliance for Health Advancement	Chief Innovation Officer
	Sue Sharpe	Chuckanut Health Foundation	Executive Director
	Anne Deacon	Whatcom County Health Department	Human Services Manager
	Lara Welker	Whatcom Alliance for Health Advancement	Program Manager
	Melody Coleman	Northwest Regional Council	ADR/FCSP Supervisor
	Rachel Lucy	PeaceHealth St Joseph Medical Center	Director of Learning and Education
	Jessica Rock	Whatcom Alliance for Health Advancement	In Person Assister Manager
	Greg Winter	Whatcom Homeless Service Center	Executive Director
	Lynnette Treen	Whatcom Alliance for Health Advancement	Director of Care Management
	Des Skubi	Interfaith Community Health Center	Executive Director
	Gib Clarke	Interfaith Community Health Center	Director of Development
	Name	Organization	Organization Role
Child and Family	David Webster	Opportunity Council	Director of Early Learning and Family Support Services
	Peter Theisen	United Way	President
	Jessica Sankey	Whatcom Early Learning Alliance	Coordinator
	Bonnie Hayward	Lummi Early Learning Programs: Early Head Start	Program Director
	Byron Mannering	Brigid Collins	Executive Director
	Judy Ziels	Whatcom County Health Department	Public Health Nurse Supervisor
	Kaye Marshall	Mt Baker School District	Early Childhood Coordinator
	Christine Perkins	Whatcom County Library System	Executive Director
	Laurie Alexander	Whatcom County Children's Administration	Area Administrator
	Trish Hart	Mt. Baker School District	School Board President
	Kristi Dominguez	Bellingham Public Schools	Director of Teaching & Learning, Early Childhood
	Name	Organization	Organization Role
Healthy Living / Healthy Places	Mauri Ingram	Whatcom Community Foundation	Executive Director
	Melissa Morin	Whatcom County Health Department	Community Health Specialist
	Pamela Jons	Whatcom Community Foundation	Director of Advancement & Programs
	Geof Morgan	Whatcom Family and Community Network	Executive Director
	Greg Winter	Whatcom Homeless Service Center	Executive Director
	Lisa Pool	City of Bellingham	Planner
	Liz Mogford	Western Washington University	Sociology Professor
	Tim Costello	Western Washington University	Director of Center for Service Learning
	Travis Tennessen	Western Washington University	Assistant Director Center for Service Learning
	Name	Organization	Organization Role
Leadership Council	David Webster	Opportunity Council	Director of Early Learning and Family Support Services
	Francisco Rios	WWU: Woodring College of Education	Dean
	Regina Delahunt	Whatcom County Health Department	Director
	Sue Sharpe	Chuckanut Health Foundation	Executive Director
	Charlie Burleigh	Mt Baker School District	Superintendent
	Chris Phillips	PeaceHealth St. Joseph Medical Center	Director of Community Affairs
	Darrell Hillaire	N/A	Community Stakeholder
	Elya Moore	Whatcom Alliance for Health Advancement	Chief Innovation Officer
	Greg Baker	Bellingham Public Schools	Superintendent
	Mauri Ingram	Whatcom Community Foundation	President and CEO
	Peter Theisen	United Way of Whatcom County	President and CEO
	Rosalinda Guillen	Community to Community (C2C)	Executive Director
	Amy Rydel	Whatcom County Health Department	Community Health Specialist Lead

Appendix C: *Community Health Assessment* (2011) and *Community Health Improvement Plan* (2012-2017) Acknowledgements

PeaceHealth St. Joseph Medical Center and Whatcom County Health Department gratefully acknowledge the time and dedication of the many people and organizations that participated in the *Community Health Assessment* and Improvement Planning process. This project would not have been possible without community involvement.

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Community Leadership Group	Greg Baker, EdD*, Bellingham Public Schools Laurie Brockmann, MSW, MPH, Consultant Gib Clarke, MPH, Interfaith Community Health Center Regina Delahunt*, Whatcom County Health Department Susan Given-Seymour, Northwest Indian College Rosalinda Guillen, Comunidad a Comunidad (Community to Community Development) Mauri Ingram*, Whatcom Community Foundation (WCF) Pamela Jons, Whatcom Community Foundation Michael Massanari, MD, Western Washington University, Critical Junctures Institute Liz Mogford, PhD, MPH, Western Washington University Francisco Rios, PhD*, Western Washington University 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*, Whatcom Homeless Service Center Judy Ziels, RN, MPH, Whatcom County Health Department **Designates Core Group*
Special Advisors	PeaceHealth St. Joseph Medical Center Community Health Committee St. Luke's Foundation Board Scott Davis, CHIP Retreat Facilitator, Tacoma-Pierce County Health Department United Way of Whatcom County Board and partners Whatcom Alliance for Health Advancement (Larry Thompson, Elya Moore) Whatcom Community Foundation Board and staff Whatcom County Board of Health (County Council) Whatcom County Health Department staff (Gail Bodenmiller, Anne Deacon, Gail DeHoog, Joe Fuller, Melissa Morin, Nicole Willis, Judy Ziels) Whatcom County Public Health Advisory Board
Project Support	Colleen Kuehl, Whatcom County Health Department Kathy Cunningham, Whatcom County Health Department Rachel Myers, Whatcom Community Foundation

Appendix D: Population Measure Chart

PRIORITY	OBJECTIVE	POPULATION MEASURE	BASELINE	BASELINE YEAR	RECENT	RECENT YEAR	2016 TARGET	TARGET SOURCE	TARGET STATUS	DATA SOURCE
Build Community Connectedness and Resilience	By December 31, 2016, community partners in Whatcom County will foster community voice and engagement and in doing so:	Increase high life expectancy from birth in all areas of Whatcom County	NA	NA	73.1-81.7	2013	81.7 in all census tracts	Center for Health Statistics, Washington State Department of Health	unmet	WADOH, Center for Health Statistics, Death Certificate Data
		Increase % of adults reporting good very good, or excellent health	88%	2010	89%	2014	79.8%	Healthy People 2020 target, U.S. Department of Health and Human Services	met	Behavioral Risk Factor Surveillance Survey (BRFSS)
		Increase % of 10th grade students reporting medium-high to high quality of life	54.9%	2010	50.1%	2014	79.8%	Healthy People 2020 target, U.S. Department of Health and Human Services	unmet	Washington State Healthy Youth Survey (HYS)
	By December 31, 2016, community partners in Whatcom County will cultivate a culture of compassion and understanding and in doing so:	Increase % of 10th grade students reporting having an adult with whom they can talk to about something important	74.6%	2010	76.4%	2014	83.2%	Healthy People 2020 target, U.S. Department of Health and Human Services	unmet	Washington State Healthy Youth Survey (HYS)
		Decrease % of adults reporting inadequate social and emotional support	16%	2010	16%	2014	15.0%	Healthy People 2020 target, U.S. Department of Health and Human Services	unmet	Behavioral Risk Factor Surveillance Survey (BRFSS)
	By December 31, 2016, community partners in Whatcom County will respond collectively to community substance use and mental health challenges and in doing so:	Decrease drug or alcohol death rate (per 100,000)	12	2010	9.7	2014	11.3	Healthy People 2020 target, U.S. Department of Health and Human Services	met	WA Dept. of Health, Center for Health Statistics
		Decrease suicide death rate (per 100,000)	11.6	2010	14.1	2014	10.2	Healthy People 2020 target, U.S. Department of Health and Human Services	unmet	WA Dept. of Health, Center for Health Statistics
		Decrease hospital admissions for drug overdose (per 100,000)	46.3	2010	39.48	2014	35.5	10% decrease from recent Whatcom County data	unmet	WA Dept. of Health, Center for Health Statistics
		Decrease % of 10th grade students reporting depressive feelings	28.6%	2010	31.4%	2014	25.7%	10% decrease from baseline Whatcom County data	unmet	Washington State Healthy Youth Survey (HYS)
		Increase % of 10th grade students having an adult to turn to when depressed	48.1%	2010	51.6%	2014	56.7%	10% increase from recent Whatcom County data	unmet	Washington State Healthy Youth Survey (HYS)
		Decrease % of adults with frequent mental stress	NA	2010	8%	2014	7.2%	10% decrease from recent Whatcom County data	unmet	Behavioral Risk Factor Surveillance Survey (BRFSS)
Enhance Child and Family Well-being	By December 31 2016, community partners Whatcom County will ensure families are strong, stable and supported from the start and in doing so:	Decrease % children ages 0-5 living below 200% Federal Poverty Level	16%	2010	19%	2013	12.0%	Top US Performers, County Health Rankings	unmet	American Community Survey (ACS), County Health Rankings (CHR)
		Decrease point-in-time count of families with at least one child (under 18) experiencing homelessness	101	2008	92	2015	83	10% decrease from recent Whatcom County data	unmet	Whatcom Homeless Service Center (WHSC)
		Decrease child abuse and/or neglect founded allegations rate (per 1,000)	37.7	2010	42.1	2014	4.1	2015 Target, Results Washington, Office of the Governor	unmet	Washington State Department of Social & Health Services (DSHS)

PRIORITY	OBJECTIVE	POPULATION MEASURE	BASELINE	BASELINE YEAR	RECENT	RECENT YEAR	2016 TARGET	TARGET SOURCE	TARGET STATUS	DATA SOURCE
		Decrease child injury and accident hospitalization rate (per 100,000)	3.3/ 1,000	2010	4/ 1,000	2014	2.97	10% decrease from baseline Whatcom County data	unmet	Washington State Department of Social & Health Services (DSHS)
		Decrease % of uninsured children ages 0-17	7.90%	2011	7.80%	2013	0.0%	Healthy People 2020 target, U.S. Department of Health and Human Services	unmet	Small Area Health Insurance Estimates (SAHIE), American Community Survey (ACS), Community Commons (CC)
		Increase % of children ages 3-6 who had one or more well-child visits with a primary care provider	NA	NA	60%	2014	66.0%	Increase 10% from recent Whatcom County data	unmet	Community Checkup-Washington Health Alliance (WHA)
	By December 31, 2016, community partners in Whatcom County will ensure children enter school safe, healthy and ready to learn and in doing so:	Increase % of children who demonstrate readiness skills for kindergarten in all areas	56.9%	2013-2014	53.9%	2015-2016	44.8%	2016 Target, Results Washington, Office of the Governor	met	Washington State Office of Superintendent of Public Instruction (OSPI)
		Increase % of children who demonstrate readiness skills for kindergarten in social-emotional areas	81.5%	2013-2014	80.4%	2015-2017	NA	NA	met	Washington State Office of Superintendent of Public Instruction (OSPI)
		Increase % of infants and toddlers with developmental delays who increase their rate of growth in social-emotional skills	NA	NA	65.1%	2013-2014	67.3%	2019 Target, Results Washington, Office of the Governor	unmet	Washington State Department of Early Learning's (DEL) Early Support for Infants and Toddlers (ESIT)
	By December 31, 2016, community partners in Whatcom County will ensure children and youth thrive at home and school and in doing so:	Increase on-time graduation rate	79%	2010-2011	79.5%	2013-2014	82.4%	Healthy People 2020 target, U.S. Department of Health and Human Services	unmet	Washington State Office of Superintendent of Public Instruction (OSPI)
		Increase % of 10th grade students reporting medium high to high quality of life	54.9%	2010	50.1%	2014	79.8%	Healthy People 2020 target, U.S. Department of Health and Human Services	unmet	Washington State Healthy Youth Survey (HYS)
		Increase % of 10th grade students reporting having an adult with whom they can talk to about something important	74.6%	2010	76.4%	2014	83.2%	Healthy People 2020 target, U.S. Department of Health and Human Services	unmet	Washington State Healthy Youth Survey (HYS)
Promote Healthy Active Living	By December 31, 2016, community partners in Whatcom County will improve access to healthy foods, particularly for low-income and isolated populations and in doing so:	Decrease % of population that experienced food insecurity in the last year	14.8%	2012	15%	2013	6.0%	Healthy People 2020 target, U.S. Department of Health and Human Services	unmet	Feeding America, Community Commons (CC)
		Decrease % of 10th grade students reporting having experienced food insecurity in the last year	14.8%	2010	13%	2014	6.0%	Healthy People 2020 target, U.S. Department of Health and Human Services	unmet	Washington State Healthy Youth Survey (HYS)
		Increase % of 10th grade students reporting eating five or more fruits and vegetables per day.	26.7%	2010	24.5%	2014	27.0%	10% increase from recent Whatcom County data	unmet	Washington State Healthy Youth Survey (HYS)

PRIORITY	OBJECTIVE	POPULATION MEASURE	BASELINE	BASELINE YEAR	RECENT	RECENT YEAR	2016 TARGET	TARGET SOURCE	TARGET STATUS	DATA SOURCE
		Decrease % adults that self-report a Body Mass Index (BMI) greater than 30.0 (obese)	23%	2010	25%	2014	25.0%	Top US Performers, County Health Rankings	met	Behavioral Risk Factor Surveillance Survey (BRFSS), County Health Rankings (CHR)
		Decrease % of 10th grade students who are in the top 5% for body mass index (obese)	10.7%	2010	12.4%	2014	16%	Healthy People 2020 target, U.S. Department of Health and Human Services	met	Washington State Healthy Youth Survey (HYS)
	By December 31, 2016, community partners in Whatcom County will improve access to safe, affordable housing, particularly for low-income and isolated populations and in doing so:	Decrease % of cost burdened households	40%	2012	39.2%	2013	35.3%	10% decrease from recent Whatcom County data	unmet	American Community Survey (ACS), County Health Rankings (CC)
		Decrease % of housing units with one or more substandard conditions	NA	NA	39.15 %	2013	9.0%	Top US Performers, County Health Rankings	unmet	American Community Survey (ACS), County Health Rankings (CC)
		Decrease point-in-time count of individuals experiencing homelessness	851	2008	651	2015	586	10% decrease from recent Whatcom County data	unmet	Whatcom Homeless Service Center (WHSC)
		Decrease point-in-time count of families with at least one child (under 18) experiencing homelessness	101	2008	92	2015	83	10% decrease from recent Whatcom County data	unmet	Whatcom Homeless Service Center (WHSC)
		Increase % of previously homeless, in stable housing for 12 months	70%	2010	69%	2014	75.9%	10% increase from recent Whatcom County data	unmet	Whatcom Homeless Service Center (WHSC)
	By December 31, 2016. community partners in Whatcom County will support creating more safe places to walk, bike, play, and connect and in doing so:	Increase % population with adequate access to locations for physical activity	NA	2010	76%	2014	85.0%	Top US Performers, County Health Rankings	unmet	ArcGIS, County Health Rankings (CHR)
		Decrease % of adults reporting inadequate social and emotional support	16%	2010	16%	2014	17.0%	Top US Performers, County Health Rankings	unmet	Behavioral Risk Factor Surveillance Survey (BRFSS), County Health Rankings (CHR)
		Increase % of 10th grade students being physically active for > 60 mins, 5+days/week	50.4%	2010	51%	2014	56.1%	10% increase from recent Whatcom County data	unmet	Washington State Healthy Youth Survey (HYS)
		Decrease violent crime rate (per 100,000)	228	2010	196	2014	64.0	Top US Performers, County Health Rankings	unmet	Uniform Crime Reporting (UCR), Federal Bureau of Investigation (FBI), County Health Rankings (CHR)
	By December 31, 2016, community partners in Whatcom County will limit exposure to tobacco, alcohol, and other harmful substances, especially for youth, and in	Decrease % of 10th grade students reporting that they perceive the availability of marijuana as not hard to access	73%	2010	70.5%	2014	63.5%	10% decrease from recent Whatcom County data	unmet	Washington State Healthy Youth Survey (HYS)
		Increase % of 10th grade students reporting that they perceived great risk associated with smoking marijuana regularly	45.8%	2010	36.1%	2014	36.7%	Healthy People 2020 target, U.S. Department of Health and Human Services	unmet	Washington State Healthy Youth Survey (HYS)

PRIORITY	OBJECTIVE	POPULATION MEASURE	BASELINE	BASELINE YEAR	RECENT	RECENT YEAR	2016 TARGET	TARGET SOURCE	TARGET STATUS	DATA SOURCE
	doing so:	Decrease % of 10th grade students reporting alcohol use in the last 30 days.	32.3%	2010	18.1%	2014	19.0%	2017 Target, Results Washington, Office of the Governor	met	Washington State Healthy Youth Survey (HYS)
		Decrease % of 10th grade students reporting cigarette use in the last 30 days	13.8%	2010	8.7%	2014	16.0%	2018 Target, Results Washington, Office of the Governor	met	Washington State Healthy Youth Survey (HYS)
		Decrease % of10th grade students reporting marijuana use in the last 30 days	22.5%	2010	16.4%	2014	18.0%	2019 Target, Results Washington, Office of the Governor	met	Washington State Healthy Youth Survey (HYS)
		Decrease % of10th grade students reporting indoor secondhand smoke exposure	34.4%	2010	26.4%	2014	23.8%	10% decrease from recent Whatcom County data	unmet	Washington State Healthy Youth Survey (HYS)
Improve Health Care Access and Service Delivery	By December 31, 2016, community partners in Whatcom County will ensure people have the health care services and supports needed to thrive, particularly health insurance, and in doing so:	Decrease % of uninsured children ages 0-17	7.9%	2011	7.8%	2013	0%	Healthy People 2020 target, U.S. Department of Health and Human Services	unmet	Small Area Health Insurance Estimates (SAHIE), American Community Survey (ACS), Community Commons (CC)
		Decrease % of uninsured adults	12.1%	2012	4.55%	2015	0%	Healthy People 2020 target, U.S. Department of Health and Human Services	unmet	Whatcom Alliance for Health Advancement (WAHA), Washington State Office of Financial Management (OFM)
		Decrease % of uninsured adults ages 65+	1.2%	2011	1.2%	2013	0%	Healthy People 2020 target, U.S. Department of Health and Human Services	unmet	Small Area Health Insurance Estimates (SAHIE), American Community Survey (ACS), Community Commons (CC)
		Decrease % of adults lacking a consistent source of primary care	19.6%	2010	20.6%	2012	16.1%	Healthy People 2020 target, U.S. Department of Health and Human Services	unmet	Behavioral Risk Factor Surveillance Survey (BRFSS)
		Increase number of primary care providers	97:1	2010	1,215: l	2012	1,045: l	Top US Performers, County Health Rankings	met	County Health Rankings (CHR)
	By December 31, 2016, community partners in Whatcom County will ensure people have the health care services and supports needed to thrive, particularly dental services, and in doing so:	Increase % of adults age 21 and up with Medicaid who receive dental care	27.6%	2010	14.0%	2014	30.4%	10% increase from baseline Whatcom County data	unmet	Washington State Health Care Authority (HCA)
		Increase % of children age 5 and younger with Medicaid who receive dental care	47.3%	2010	46.8%	2014	52.0%	10% increase from baseline Whatcom County data	unmet	Washington State Health Care Authority (HCA)
		Decrease % of children with dental cavities	61%	2010	NA	2014	49.0%	Healthy People 2020 target, U.S. Department of Health and Human Services	unmet	Washington State Smile Survey
		Increase number of dentist	NA	2010	1,495: l	2012	1,377: l	Top US Performers, County Health Rankings	unmet	County Health Rankings (CHR)
		Increase % of 10th grade students who report visiting dentist in last 2 years	86.4%	2010	86.5%	2012	49.0%	Healthy People 2020 target, U.S. Department of Health and Human Services	met	Washington State Healthy Youth Survey (HYS)
		Decrease % of adults without dental exam in past 12 month	NA	2010	29.30 %	2014	51.0%	Healthy People 2020 target, U.S. Department of Health and Human Services	met	Behavioral Risk Factor Surveillance Survey (BRFSS), Community Commons (CC)

PRIORITY	OBJECTIVE	POPULATION MEASURE	BASELINE	BASELINE YEAR	RECENT	RECENT YEAR	2016 TARGET	TARGET SOURCE	TARGET STATUS	DATA SOURCE
	By December 31, 2016, community partners in Whatcom County will ensure people have the health care services and supports needed to thrive, particularly potentially avoidable care, and in doing so:	Decrease % of emergency room visits for dental problems	NA	NA	2%	2014	1.8%	10% decrease from recent Whatcom County data	unmet	Whatcom Alliance for Health Advancement (WAHA)
		Decrease % of potentially avoidable emergency room visits	NA	NA	10%	2014	9.0%	Healthy People 2020 target, U.S. Department of Health and Human Services	unmet	Community Checkup-Washington Health Alliance (WHA)
		Decrease % acute inpatient stays that were followed by 30-day readmission for all causes	NA	NA	4%	2014	9.5%	Expected Rate, Washington Health Alliance (WHA) Community Checkup	met	Community Checkup-Washington Health Alliance (WHA)
		Decrease number of preventable hospital stays ambulatory-care sensitive conditions per 1,000 Medicare enrollees	46/ 1,000	2010	42/ 1,000	2014	46	Top US Performers, County Health Rankings	met	County Health Rankings (CHR)
	By December 31, 2016, community partners in Whatcom County will ensure people have the health care services and supports needed to thrive, particularly mental health treatment, and in doing so:	Increase number of mental health care providers	NA	NA	276:1	2012	386:1	Top US Performers, County Health Rankings	met	County Health Rankings (CHR)
		Decrease % of adults with frequent mental stress	NA	2010	8%	2014	7.2%	10% decrease from recent Whatcom County data	unmet	Behavioral Risk Factor Surveillance Survey (BRFSS), Community Checkup-Washington Health Alliance (WHA)
		Decrease % of 10th grade students reporting suicidal intent/plan	12.5%	2010	15%	2014	7.5%	Healthy People 2020 target, U.S. Department of Health and Human Services	unmet	Washington State Healthy Youth Survey (HYS)
		Decrease % 10th grade students reporting contemplation of suicide	17.4%	2010	18.8%	2014	7.5%	Healthy People 2020 target, U.S. Department of Health and Human Services	unmet	Washington State Healthy Youth Survey (HYS)
		Decrease point-in-time count of homeless adults reporting mental health disability			33%	2014	41.0%	Healthy People 2020 target, U.S. Department of Health and Human Services	unmet	Whatcom Homeless Service Center (WHSC)
	By December 31, 2016, community partners in Whatcom County will ensure people have the health care services and supports needed to thrive, particularly for Native American and Hispanic patients, and in doing so:	Decrease % of uninsured Native American/Alaska Native population	24.2%	2008-2010	22.5%	2010-2012	0%	Healthy People 2020 target, U.S. Department of Health and Human Services	unmet	Small Area Health Insurance Estimates (SAHIE), American Community Survey (ACS), Community Commons (CC)
		Decrease % of uninsured Hispanic population	24.5%	2008-2010	26.3%	2010-2012	0%	Healthy People 2020 target, U.S. Department of Health and Human Services	unmet	Small Area Health Insurance Estimates (SAHIE), American Community Survey (ACS), Community Commons (CC)
		Increase % of patients who gave hospital an overall rating of 9 or 10 on a scale from 0 (lowest) to 10 (highest)	69%	2012	NA	NA	95.0%	Washington Health Alliance (WHA) Community Checkup top performer rate	unmet	Community Checkup-Washington Health Alliance (WHA)