2012–2016

Community Health Improvement Plan

WHATCOM COUNTY

Update
September
2013






WHATCOM COUNTY
WASHINGTON
PUBLIC HEALTH


PeaceHealth
St. Joseph
Medical Center

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.

Funding for the project provided by:
PeaceHealth St. Joseph Medical Center, Whatcom County Health Department, St. Luke's Foundation, and Whatcom Community Foundation.

CHIP Staff Leads
Chris Phillips*, Director, Community Affairs, PeaceHealth St. Joseph Medical Center
Astrid Newell, MD*, Manager, Community Health Division, Whatcom County Health Department

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*

CHIP Retreat Facilitation
Scott Davis, Tacoma-Pierce County Health Department

Special Advisors
PeaceHealth St. Joseph Medical Center Community Health Committee
St. Luke's Foundation Board
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
WCHD-Colleen Kuehl, Kathy Cunningham
WCF-Rachel Myers
Cover art: Mahria Sooter

Plan Organization & Terminology

Contents

Acknowledgements 3

Plan Organization & Terminology 4

Executive Summary 5

Introduction 7

Overview of Planning Process 8

Shared Vision & Values for Community Health 12

Priorities for Community Health Improvement 13

STRATEGIC DIRECTION 1: BUILD COMMUNITY CONNECTEDNESS AND RESILIENCE 15

STRATEGIC DIRECTION 2: ENHANCE CHILD AND FAMILY WELL-BEING 22

STRATEGIC DIRECTION 3: PROMOTE HEALTHY ACTIVE LIVING 30

STRATEGIC DIRECTION 4: IMPROVE HEALTH CARE ACCESS AND SERVICE DELIVERY 37

Plan Implementation 44

Terminology

- Equity: The state, quality, or ideal of being just, impartial, and fair.
- Disparities: Differences in health or social status between population groups.
- Vision: A statement of our preferred future (*what we dream for our community*).
- Strategic Direction: A course of action that ultimately leads to achievement of vision and goals (*where we are heading*).
- Priorities: Issues identified as needing and deserving focused attention (*what is important*).
- Goals: Aspirational statements of the overall results we are seeking (*what is possible*).
- Objectives: Specific things that we want to accomplish (*what we want to do*).
- Strategies: Actions and policies designed to achieve our goals and objectives (*how we will do our work*).
- Measures: Indicators of our progress (*how we will know that we are making a difference*).
- TBD: To be developed.

Executive Summary

The Whatcom County Community Health Improvement Plan is the result of a multi-step, multi-year assessment and planning process sponsored by PeaceHealth St. Joseph Medical Center and Whatcom County Health Department in collaboration with multiple community partners. In addition to meeting health care reform and public health regulatory requirements, the purpose of the plan is to provide a framework 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.

The plan does not include all the important health issues facing the community, but rather focuses on closing gaps in opportunities and outcomes for vulnerable groups. By concentrating on these issues, we can create a healthier community that benefits everyone.

Community Health Assessment

The Whatcom County Community Health Assessment (*CHA, 2011)* serves as a foundation for the plan. Review of quantitative and qualitative data revealed the following findings:

Community Health Status:

- 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 our children and young families.
- Mental health and substance use are particular challenges for our community.
- Our community is well positioned to respond to federal health care reform, but basic issues of access remain for certain populations.

Community Themes and Forces of Change:

- Whatcom County is becoming older and more ethnically diverse.
- Service providers are facing major changes in client needs, resource availability, and requirements for accountability.
- Food and nutrition are seen as key focus areas for the community.
- Housing and the built-environment 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.

Strategic Directions and Priorities

From the assessment process, community leaders identified the following strategic directions to improve health, reduce disparities, and advance equity in the community:

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***

Whatcom County
Community Health Improvement Plan
2012-2016

Infrastructure

- Leadership
- Facilitation/Staff Support
- Communication
- Data and Evaluation
- Partners and Resources

Overarching Goals

- Improve Health
- Reduce Disparities
- Advance Equity

Strategic Directions and Priorities

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*

Enhance Child and Family Well-Being

- *Strengthen emerging families*
- *Support early learning*
- *Help 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*

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*

Introduction

The Whatcom County Community Health Improvement Plan is a result of many months of work involving numerous community partners. In addition to meeting **health care regulatory**[1] and **public health accreditation**[2] requirements, the plan reflects a sincere desire to move toward a healthier community where everyone has the opportunities they need to be healthy and thrive. Data and community input from the **Community Health Assessment**[3] phase of this project serve as the foundation for the plan.

The purpose of the plan is to provide a **framework** that will guide community leaders and residents in making decisions about where to invest time and resources in order to make **measurable differences** in the health and well-being of the community. The plan is also meant to facilitate **alignment** of efforts within the community to have greater **collective impact**.[4]

The plan is broad, but does not include every important issue that affects our community. For example, the plan does not have a major focus on specific health issues of seniors, or of concerns with water quality or other issues that impact the natural environment. The hope is that our community will continue efforts to address these important issues at the same time that we hone in on a few areas for concentrated attention. The selected strategic directions, priorities, and objectives reflect a deliberate and, at times, difficult process of prioritization and decisions about where to focus attention for the greatest impact on improving health, reducing disparities, and advancing equity.

In creating this plan, community leaders have recognized that in order to improve health we must tackle issues of **disparities** that exist in our community. Community health assessment data demonstrate 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 minority 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.

"A healthier community benefits everyone."

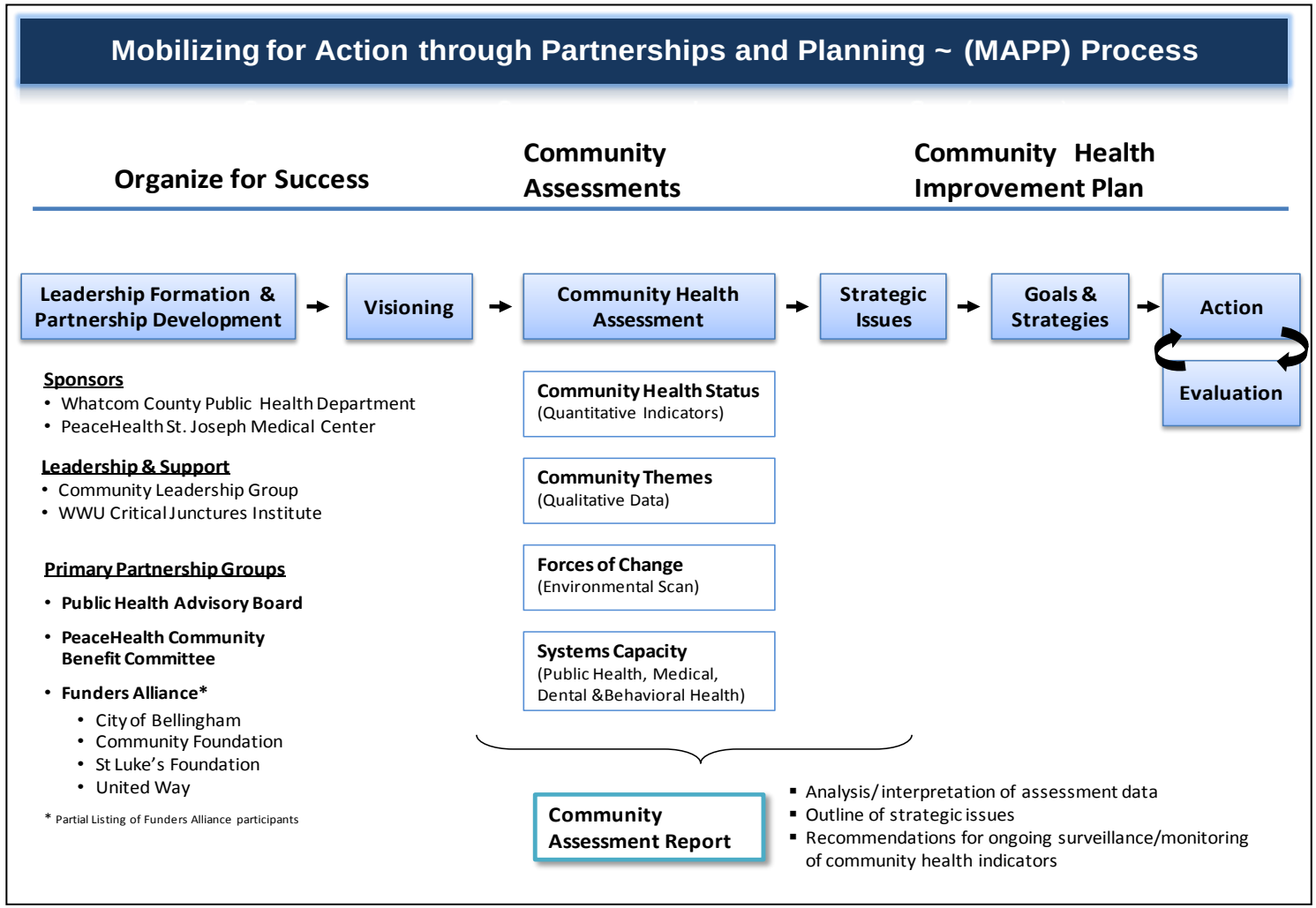
WORDS OF WISDOM

- *Every community is filled with leaders.*
- *Whatever the problem, community itself has the answers.*
- *We don't have to wait for anyone. We have many resources with which to make things better now.*
- *We need a clear sense of direction AND we need to know the elegant, minimum next step.*
- *We proceed one step at a time, making the path by walking it.*
- *Local work evolves to create transformative social change when connected to similar work around the world.*

From *Bob Stilger, Healthy and Resilient Communities: Living the Future Now (http://resilientcommunities.org)*

Overview of Planning Process

Development of the Whatcom County Community Health Improvement Plan (CHIP) (2012–2016) generally followed the **Mobilizing for Action through Partnerships and Planning**[5] (*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. Ongoing community conversations over the past year have resulted in modifications and revisions for 2013.



Steps included:

- **Leadership Formation and Partnership Development**
  - Create public-private partnership between Whatcom County Health Department and PeaceHealth St. Joseph Medical Center.
  - Contract with Western Washington University (Critical Junctures Institute) for technical assistance and data collection/analysis. (*Summer 2010)*
  - Establish Community Leadership Group. (*October 2010)*

- **Visioning**
  - Convene nearly 50 partners and interested community members to create vision for community health. (*December 2010)*

- **Assessments**
  - *Community Health Status Assessment*
    - Compile and review *MAPP* core indicators plus additional indicators of interest. Review Robert Wood Johnson Foundation County Health Rankings. Intentionally focus on social and economic factors that impact health. (*November 2010–March 2011*)
  - *Community Themes and Strengths Assessment*
    - Review reports and findings from a variety of recent assessment activities in the community.
    - Convene Themes and Strengths Forum. Include presentations by groups and entities involved in community initiatives and assessments. (*March 2011)*
    - Conduct key informant interviews and focus groups.
    - Participate in community meetings/events.
  - *Forces of Change Assessment*
    - Brainstorm and discuss factors, trends, and events that impact or potentially impact community health at Community Leadership Group meeting. (*April 2011)*
  - *Health Systems Capacity Assessment*
    - Review public health capacity/standards indicators.
    - Review health care capacity/quality indicators.

- **Sharing Assessment Findings and Identifying Strategic Issues**
  - Convene community forum: *From Assessment to Action.* (*October 2011*)
  - Create Community Health Assessment *Executive Summary* document and share with multiple community groups. (*December 2011–ongoing*)

- Convene two Community Leadership Group full-day retreats to identify strategic issues and focus areas for community health improvement planning. (*March–April 2012*)

❖ **Community Health Improvement Plan Development and Implementation**

- Draft plan based on strategic issues. (*May–June 2012*)
- Convene two half-day Community Leadership Group Meetings to refine plan and select intervention strategies and action steps. (*May–August 2012*)
- Finalize initial plan framework and prepare for implementation. (*September–December 2012)*
- Secure leadership commitment, convene action groups, identify initiatives, develop communication strategies, and update plan. *(December 2012–September 2013)*

Shared Vision & Values for Community Health

Vision*

We are Whatcom County, a people and a place, culturally and geographically diverse, united in our vision of a healthy and vibrant future where:

- **Every child** grows in a safe and nurturing environment.
- **Every person** has access to comprehensive and integrated health services and social supports across the lifespan and spectrum of needs.
- **Every population** shares in the abundance of opportunities for healthy active living, outstanding education, satisfying employment, and meaningful community participation.
- **We all** flourish through our connections and commitment to each other and to the air, land, and waters that surround and sustain us**.**

To accomplish our vision we will act with these guiding values:

- **Collaborate** to connect and maintain health and social support systems that are accessible, efficient, accountable, and culturally relevant.
- **Strive** for equity, fairness, and justice in all that we do.
- **Work** with one another with integrity, humility, compassion, and respect.
- **Invest** effectively to improve our community with careful planning and evaluation.
- **Build** on community assets and strengths.
- **Honor** diversity and inclusiveness, fostering a sense of place and belonging for everyone.
- **Risk** being innovative, action-oriented, and resourceful.
- **Address** past and present issues that divide us with openness and a spirit of healing.
- **Promote** shared leadership and collective responsibility for the health of our community.
- **Preserve**, protect, and replenish our wealth of shared natural and social resources for future generations.

**Developed through a community visioning process, December 2010.*

Priorities for Community Health Improvement

<u>Strategic Directions and Priorities</u>:
What we will focus on

In order to **improve health, reduce disparities, and advance equity**, we will focus work on the following strategic directions and priorities:

1. **Build Community Connectedness and Resilience**
   - *1.1. Foster community voice and engagement*
   - *1.2. Cultivate a culture of compassion and understanding*
   - *1.3. Respond collectively to community substance use and mental health challenges*

2. **Enhance Child and Family Well-being**
   - *2.1. Strengthen emerging families*
   - *2.2. Support early learning*
   - *2.3. Help youth thrive at home and school*

3. **Promote Healthy Active Living**
   - *3.1. Expand access to and promotion of healthy food*
   - *3.2. Create more safe places to walk, bike, play, and connect*
   - *3.3. Limit exposure to tobacco, alcohol, and other harmful substances, especially for youth*

4. **Improve Health Care Access and Service Delivery**
   - *4.1. Expand insurance coverage and access to primary care and dental care*
   - *4.2. Connect people will complex health conditions to needed supports*
   - *4.3. Enhance patients' experience of care*

<u>Overarching Goals</u>

- **Improve health**
- **Reduce disparities**
- **Advance equity**

<u>Strategies</u>: *How we will do the work*

We will use the following recommended strategies to make and demonstrate positive impact:

- **Community outreach and engagement** *(COM)*
- **Targeted programs and projects for vulnerable populations** *(PRO)*
- **Strategic policy, systems, and environmental changes** *(PSE)*
- **Effective use of data and metrics to facilitate change and accountability for results** *(DAT)*

Alignment with State and National Priorities

Whatcom County's Community Health Improvement Plan strategic directions, priorities, goals, objectives, and measures are closely aligned with state and national health improvement plans and priorities.

State plans and priorities

- Results Washington *(Washington State Governor Jay Inslee, 2013)*[6]
- Washington State Agenda for Change *(Washington State Public Health Improvement Partnership, 2012)*[7]
- Healthy Communities: A Tribal Maternal-Infant Strategic Plan *(American Indian Health Commission for Washington State, 2010)*[8]
- Washington State Early Learning Plan *(WA Dept of Early Learning, 2010)*[9]

National plans and priorities

- Healthy People 2020[10]
- Robert Wood Johnson County Health Rankings[11]
- National Prevention Strategy (2011)[12]
- Beyond Health Care: New Directions for a Healthier America. Recommendations from the Robert Wood Johnson Foundation Commission to Build a Healthier America (2009) [13]
- Patient Protection and Affordable Care Act (2010)[14]
- United Way of America: Advancing the Common Good[15]

STRATEGIC DIRECTION 1: BUILD COMMUNITY CONNECTEDNESS AND RESILIENCE

Overview of Issue

The overall **well-being** of a community is dependent on many factors, including **the physical and social environment** of the community. **Community culture**[16] plays a significant role in the development and maintenance of conditions that either **help people thrive** or reinforce disparities. Creating a healthy community culture involves fostering **positive social connections** and ensuring that community members have opportunities for **meaningful input, involvement, and influence** on conditions that impact their lives and their families' lives.

Of all the issues impacting community well-being, **substance abuse and mental illness** are two of the most pressing and in need of community response. Substance abuse and mental illness are both **causes and consequences** of health and social problems and disparities in our community. Communities, such as tribal communities, with **long histories of trauma** and **discrimination** on a population level, often experience disproportionately higher rates of substance use, mental illness, and associated difficulties. Whatcom County data demonstrate this is true for our **local tribes**. Those who **experience adversity as children**, including growing up in households with substance abuse or mental health issues, are more likely to have challenges with substance use and mental health issues in their own lives. **Adverse Childhood Experiences** (ACEs)[17] are strongly correlated with substance use behaviors and mental health status. These issues, **when unaddressed**, play major roles in **disrupting social cohesion** and **sense of community**. The complexity of these issues calls for a "**whole system/whole community response**" that builds on the strengths of the community and generates **hope for the future**. Recognizing the connections between psychological trauma and health issues can help our community to respond in new and better ways, using **compassionate, trauma-informed approaches**[18] [19] that promote healing, help break intergenerational cycles of despair, and build more resilient and connected people.

Synopsis of Assessment Findings

- Whatcom County is **growing** and becoming more **diverse**. The total population increased 21% from 2000 to 2010 (from 166,814 to 201,140) (*U.S. Census, 2010*). The County population is primarily white, but racial and ethnic minorities, particularly people of **Hispanic origin**, make up an increasingly larger proportion of the population (currently 8% of total population). Two **federally recognized tribes** (Lummi Nation and Nooksack Tribe) live within the County, making up about 3% of the population.

- The **unique geography** of the county **promotes isolation** of some population groups. **Pockets of poverty** are scattered throughout the county, and include areas within cities (e.g., Bellingham and Ferndale), tribal reservations, and in more rural areas (e.g., Birch Bay/Blaine, East County). **Travel distance and transportation barriers** in rural and outlying areas increase challenges with developing and maintaining positive social connections and community involvement.

- In general, people in Whatcom County feel a sense of **connection and belonging** and are appreciative of the **beautiful natural environment** and the **sense of community.** But this is not true for everyone.

- Common sentiments shared by members of **marginalized groups** (racial/ethnic minorities, immigrants, migrant workers, and others) include fear and mistrust of large institutional systems such as health care and government, and feelings of **stigmatization and disrespect**. Past experiences with the majority culture as well as current challenges (e.g., issues related to immigration) contribute to **fear and isolation**. At the same time, individuals within these groups have **valuable insights** into community challenges and demonstrate a desire and willingness to identify and participate in solutions that build on their respective **communities' strengths**.

- Review of County Health Rankings data shows that Whatcom County has **higher proportions** of people experiencing **poor mental health status** and **drinking excessively** than comparable counties.[20] Healthy Youth Survey data show that more than **1 in 4 youth** experience **serious depression symptoms** and approximately **1 in 6** youth **contemplate suicide** (*HYS, 2010, 2012*).

- Multiple indicators from a variety of sources point to **increased use of illicit substances**, particularly **heroin** in the past several years. The number and rate of **drug-affected infants** born at PeaceHealth St. Joseph Medical Center (PHSJMC) tripled between 2006 and 2010. The rate of accepted referrals for **victims of child abuse and neglect** remains consistently higher than the state (and significantly higher in certain areas of the county and for certain groups) largely due to parental substance use. The number of **syringe exchange clients** at Whatcom County Health Department (WCHD) has risen exponentially (and clients are noticeably younger) in the last five years. County **Hepatitis C** rates have also risen to **epidemic proportions** in relation to IV drug use. **American Indians** are **disproportionately impacted** by mental health and substance use concerns.

Community Assets

Efforts to build community connectedness and resilience in Whatcom County will benefit from strengthening existing collaborations of community partners and building on current efforts, including work that has grown from conversations related to the CHIP.

Existing community collaborations and partnerships:

- ***Whatcom Family and Community Network —***A network of health, education, and social service professionals and community members that serves as the local "community public health and safety network." Supports community-building efforts, partners

with Lummi Nation and Nooksack Tribe, engages Hispanic families, and promotes healthy youth and family activities in targeted neighborhoods and schools. Facilitates ACEs Prevention Network and Whatcom Prevention Coalition.

- ***ACES Prevention Network***—a network of community members and professionals engaged in collaborative learning in order to reduce and mitigate adverse childhood experiences and build community resilience.

- ***Whatcom Prevention Coalition (WPC)—***a coalition of community partners including school professionals, youth, and families working to promote healthy youth development and prevent substance use and other problem behaviors.

Current work to build on:

- The Community Leadership Group for the CHA and CHIP identified the **need to have diverse voices and representation** at the leadership table, and to hear the perspectives of community members from diverse backgrounds through **focus groups** and **community forums**. Despite positive movement in this direction, the Leadership Group recognizes that more effort is needed in this area, particularly in **building stronger connections** with Tribal partners and other groups, meeting people where they are in the community, and facilitating **community-driven** (as opposed to agency-driven) health improvement processes.

- Whatcom County partners have taken **steps to address substance use** and **mental health issues** including: passage of the **Mental Health Sales Tax** (1/10th of 1 percent) that funds prevention and treatment services, establishing the **Behavioral Health Access Program** that provides access to services for those who do not have other means of payment, expanded **medication-supported** (Suboxone®) opiate withdrawal programs, **on-site substance use counselor** in the Needle Exchange Program to link clients to treatment, and **targeted prevention and intervention** efforts in local schools that have higher mental health and substance use risks.

- The Nooksack Tribe received a large federal Substance Abuse and Mental Health Administration grant and is working to address **youth substance use** issues and help tribal youth stay in school.

- The Whatcom County Public Health Advisory Board has recently developed a Board of Health resolution promoting adoption of a "**compassionate approach" to public health related services** (2013). Ongoing conversations relate to the public health role in supporting the integration of compassionate, trauma-sensitive principles and practices in organizations across multiple sectors (e.g., education, health, and business).

- ACEs Prevention Network and Whatcom Family and Community Network have launched an **evaluation project** to look at "what is working" to reduce ACEs and build resiliency in the community. The project is funded by the state ACEs Public Private Initiative (APPI), including the Bill & Melinda Gates Foundation, Empire Health Foundations, and others. Partners are using an "**Appreciative Inquiry**" model and sharing this innovative approach with others across the state.

Priority 1.1. Foster community voice and engagement

Our goal: "All people have opportunities to actively participate in community life without fear or stigmatization."

Objectives	Proposed Strategies
1.1.1. Increase diversity of CHIP leadership team and work groups	• Reach out to representatives of diverse cultural, geographic, and economic communities to serve in CHIP leadership positions and working groups. *COM* • Discern and address barriers to participation. *COM*
1.1.2. Increase community engagement in CHIP implementation	• Support participatory neighborhood or community-based initiatives through neighborhood groups, communities of faith, businesses, and professional associations. *COM* • Use innovative engagement techniques, such as human-centered design approaches. *COM* • Collect and monitor community involvement indicators for all CHIP initiatives. *DAT*

Measures	
Process Indicators	• # and diversity of community members serving in CHIP leadership roles • # and diversity of community members involved in community health improvement efforts
Outcome Indicators	• TBD
Data Development	• Identify mechanisms to measure engagement and sense of belonging on a broad community level

Priority 1.2. Cultivate a culture of compassion and understanding

Our goal: "All people are treated compassionately and with respect."

Objectives	Proposed Strategies
1.2.1. Increase policymaker and community awareness about the impacts of psychological trauma on long-term health and well being	• Engage policymakers in dialogue about these issues. *COM* • Disseminate information to multiple audiences through a variety of media channels. *COM* • Support community conversations about these issues. *COM*
1.2.2. Increase provider knowledge, skills, and capacity to deliver services that are sensitive to the impacts of adversity and trauma.	• Identify and support training opportunities related to trauma-sensitive services for providers in health, education, and social service sectors and other interested parties (employers, communities of faith). *PRO* • Encourage development of "communities-of-practice" for service providers to learn about implementing compassionate, trauma-sensitive approaches. *PSE*
1.2.3. Increase organizational commitment to compassionate, trauma-sensitive principles and practices	• Support development of organizational policy statements and processes that promote integration of compassionate, trauma-sensitive principles and practices. *PSE* • Develop mechanisms to recognize organizations that take steps to adopt compassionate approaches and share successes with the community. *PSE* • Support evaluation studies to monitor outcomes related to changes in practices across multiple sectors. *DAT*

Measures	
Process Indicators	• # and % of community members and policymakers who participate in educational presentations about trauma and resiliency • # and % of service providers across multiple sectors who have received training in trauma-sensitive principles and practices • # and % of community organizations that adopt formal policies supporting compassionate, trauma-sensitive services
Outcome Indicators	• TBD
Data Development	• Identify mechanisms to measure staff and customer/client/patient/student outcomes associated with changes in approach

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

Our goal: "All people have the support they need to address substance use and mental health challenges."

Objectives	Proposed Strategies
1.3.1. Increase collaborative community planning to address substance use and mental health issues	• Convene "whole system" to develop a common agenda and path forward. *COM* • Identify ways to build on community strengths and assets, using tools such as Appreciative Inquiry[21]. COM
1.3.2. Increase community action related to substance use and/or mental health issues	• Incorporate substance use and mental health objectives throughout CHIP. *PSE* • Support implementation of strategies identified by the "whole system." *PSE*

Measures	
Process Indicators	• # of community members and sectors working together to address substance use and mental health challenges • # of community-driven initiatives that address substance use and/or mental health issues
Outcome Indicators	• % of adults reporting poor mental health status *(Source: BRFSS)* • % of youth reporting contemplation of suicide in past year *(Source: HYS)* • % of youth and adults reporting excessive drinking *(Sources: HYS, BRFSS)* • % of youth who have used illicit substances in past 30 days *(Source: HYS)*
Data Development	• Identify and monitor positive mental health ("happiness") indicators

STRATEGIC DIRECTION 2: ENHANCE CHILD AND FAMILY WELL-BEING

Overview of Issue

The importance of protecting the **health, well-being, and future of children** and youth emerged as a consistent theme throughout the Community Health Assessment process. Mounting evidence shows that health and social **disparities begin early in life**, and that interventions and support for vulnerable families during pregnancy and the first years of life have the remarkable potential to change the trajectory of children's lives forever. Children and youth who have experienced **adversity** due to poverty or family dysfunction are at higher risk of **learning and other challenges** that manifest as behavioral problems, poor performance in school, unhealthy peer relationships, depression and substance use issues, obesity, and other health issues. **Caring adults** and **safe environments** can mitigate these impacts and help children and youth move past adversity to achieve better health and success in school and life.

Synopsis of Assessment Findings

- The recent economic downturn and changes in social service systems and supports have been particularly challenging for young families. In Whatcom County, **nearly one third of all families with young children** less than age five **live at or below the federal poverty level** (*ACS, 2009*). **Hispanic, American Indian, and single-mother** households are **disproportionately** affected. **Unstable and unsafe housing situations** (due to issues such as high housing costs, homelessness, crowding, inadequate facilities, household or neighborhood substance abuse, and domestic violence) are consistently identified by young families as **major stressors** *(Focus groups/client input).* Despite economic needs, many families may not be accessing available services and supports. Approximately **40%** of low-income Whatcom County **women and children** who are eligible to participate in Women, Infants, and Children (WIC) nutrition education and supplemental food program are not enrolled (*WIC, 2013*).

- The **birth of a child**, while a joyful time for many families, **can be overwhelming** for new parents who are burdened with economic concerns, relationship problems, chemical dependency, mental illness, or a seriously ill infant. In these circumstances, **parental stress** may be so high that children are at risk of maltreatment or neglect. Rates of accepted referrals for child abuse and neglect are consistently higher in Whatcom County than in comparable counties and the state. In 2011, **nearly 2,000 children** (ages 0–18) were accepted by Child Protective Services as valid child abuse and neglect referrals *(DSHS, 2011).* It is likely that some children do not come to the attention of authorities, but suffer in silence.

- **Parental substance abuse** is a major risk factor for child maltreatment and is associated with significant developmental impacts for children born to drug-addicted mothers. In 2008, **17.4 % of pregnant women** in Whatcom County on DSHS/Medicaid required treatment for substance abuse compared with 12.6% for the state (*DSHS, 2010*). **Maternal depression** is associated with difficulties in **mother-infant bonding** and attachment—important for healthy child development. Maternal depression during and after pregnancy is commonly reported, though the actual incidence is unknown.

- Learning and education are key to long-term social and economic well-being, and linked closely with health outcomes. Success in school can be affected by **individual child factors** (such as the presence of a developmental condition like autism, Attention Deficit Hyperactivity Disorder (ADHD), or history of fetal drug exposure), by **social factors** (such as poverty and family problems), and by the **capacity of adults and the community** (such as teachers and the school system) to support children. In 2012, **approximately half** of the children assessed on entry into kindergarten in three districts in Whatcom County **did not meet** one or more **measure of school readiness**: social-emotional, physical, cognitive, literacy, language, or math (*WAKids, 2013*). In 2012, only **73.9% of Whatcom County youth graduated from high school on time**. Approximately **60% of American Indian** (61.3%) and **Hispanic** (59.7%) youth graduated on time (*OSPI, 2013*).

- Recognizing and **responding to developmental and behavioral challenges as early as possible** gives children the best chance of success, and may reduce the need for special educational and support services. In Whatcom County, **system fragmentation** and **limited resources to evaluate and support child behavioral health issues** are identified as key issues that impact children, families, schools, and pediatric health care providers locally *(Whatcom Taking Action).*

- Measures of youth quality of life give a picture of the overall well-being of children and youth in the community. In 2012, approximately **50% of youth** reported **high or medium high quality of life** while the other half reported low or medium low quality of life. The measure included questions about getting along with parents or guardians, looking forward to the future, feeling good about self, satisfaction with the way life is now, and feeling alone (*HYS, 2012*).

Community Assets

Efforts to enhance the health and well-being of children, youth, and families in Whatcom County can benefit from strengthening existing collaborations of community partners and building on current work, including initiatives and programs that arose from community conversations during the development of the CHIP.

Existing community collaborations and partnerships:

- ***First Steps Coalition***—A network of health and social service providers that provide maternity support services and related services to low-income families during pregnancy and post-partum period. Facilitated by Whatcom County Health Department.

- ***Whatcom Early Learning Alliance (WELA)***—An alliance of early learning professionals and partners working to promote early child development and school readiness. Facilitated by Opportunity Council (Early Learning and Family Services).

- ***Whatcom Prevention Coalition (WPC)—***A coalition of community partners including school professionals, youth, and families working to promote healthy youth development and prevent substance use and other problem behaviors. Facilitated by Whatcom Family and Community Network.

- ***ACES Prevention Network***—A network of community members and professionals working to reduce and mitigate adverse childhood experiences and build community resilience. Facilitated by Whatcom Family and Community Network.

- ***Whatcom Taking Action for Children and Youth with Special Health Care Needs (Whatcom Taking Action)—***A collaboration of community partners and families working to improve the system of services and supports for children, youth, and families impacted by special health and developmental needs.

Current work to build on:

- In November 2012, Whatcom County Health Department implemented a local **Nurse-Family Partnership program**, an evidence-based nurse home visitation program for **low-income first-time mothers and their babies.** As of September 2013, the program is nearly at full capacity with 45 families enrolled. A bilingual Spanish-speaking nurse was hired to reach out to Hispanic families.

- In 2012, Bellingham Public Schools and Western Washington University (Woodring College of Education) initiated a ***Collective Impact Partnership*** to **reduce educational achievement gaps** in the Bellingham school district area.

- United Way of Whatcom County recently funded an **early literacy pilot project** in a higher risk catchment area of the **Ferndale School District** in support of early learning. The pilot project has been a success and is now expanding.

- During the past three years, administration and staff at **Shuksan Middle School**, a diverse middle school in Bellingham Public Schools have implemented multiple strategies to create a **healthier school environment** for children and families, including specific outreach for Hispanic families.

- During the 2012–2013 school year, school district administration and staff in the **Mount Baker School District** began exploration of the **impact of Adverse Childhood Experiences** on families in the district where a large proportion of children qualify for Free-and-Reduced Lunch. Priorities were identified for 2013.

Priority 2.1. Strengthen emerging families

Our goal: "All families are strong, stable, and supported from the start."

Objectives	Proposed Strategies
2.1.1: Increase the % of parents and caregivers who consistently provide safe, nurturing care for their infants and young children	• Implement and maintain evidence-based parenting support/home visitation programs for low-income pregnant/parenting mothers and fathers (e.g., Nurse Family Partnership, Early Head Start). *PRO* • Engage community members, including tribal and Hispanic community partners and families, in identifying parental support needs and developing new approaches. *COM*
2.1.2: Increase the % of emerging families connected to stable housing and other basic needs	• Prioritize needs of emerging families in community housing-related plans and policies (e.g., updating the *Whatcom Ten Year Plan to End Homelessness*, allocation of *HOME* funds for housing development). *PSE* • Implement and evaluate housing pilot project to link young families with housing case management (i.e., Whatcom Homeless Housing Center/Whatcom County Health Department collaboration). *PRO* • Develop and implement a community outreach plan to bring more eligible families into local WIC programs (e.g., Whatcom County Health Department, SeaMar, Nooksack, and Lummi). *PRO* • Advocate for community and workplace policies (e.g., paid parental leave, child care support) that support new families. *PSE*
2.1.3: Increase the % of new parents (pregnant and parenting mothers, new fathers) that receive needed mental health and/or substance use intervention	• Expand family-oriented mental health and substance use treatment options. *PRO* • Explore mechanisms to better identify and link new parents to mental health and substance use intervention (e.g., screening and linkage systems during pregnancy and at discharge from hospital birth center). *PSE*

Measures	
Process Indicators	• # and diversity of community members/organizations involved • # families linked to housing supports • # new parents screened/referred/linked for mental health and substance use concerns • # families enrolled in home visitation/parenting support programs • # and % of low income women and children that are eligible for WIC who are actively participating in local WIC programs • # new family-friendly policies/practices adopted
Outcome Indicators	• % of families with young children living at/or below poverty line (by race, ethnicity, and single parent status) (*Source: ACS*) • Rate and # of drug affected newborns (by race, ethnicity, and income) (*Source: PHSJMC*) • Rate and # of accepted referrals for child abuse and neglect (by race, ethnicity, and income) (*Source: DSHS*)
Data Development	• Establish and monitor Child Well-being Index including family/parenting indicators • Identify positive parenting/caregiving indicators

Our goal: "All children enter school safe, healthy, and ready to learn."

Priority 2.2. Support early learning

Objectives	Proposed Strategies
2.2.1. Increase the % of parents, caregivers, and early care/education providers who consistently provide positive support for young children's developmental needs	• 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. *PSE*
2.2.2. Increase the % of young children who receive early identification and intervention for developmental and behavioral health concerns	• 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. *COM* • Support provider training to improve use of developmental screening methods. *PSE* • Build on community efforts to improve system capacity for evaluation and management of child developmental and behavioral health needs (e.g., Whatcom Taking Action for Children and Youth with Special Health Care Needs). *PSE/COM*
2.2.3. Increase the % of young children connected to high quality preschool experience prior to kindergarten	• Allocate resources to develop, maintain, and expand early learning programs that meet high quality standards, including evidence-based social-emotional curriculum for vulnerable children (e.g., Head Start/Early Childhood Education and Assistance Program). *PRO* • Develop mechanisms to identify and connect children to early learning programs. *PSE* • Monitor the proportion of children entering kindergarten with preschool experience to identify and close gaps. *DAT*

Measures	
Process Indicators	• # and diversity of community members involved • # of parents and caregivers receiving training/information about child development • # and % of children screened for developmental and behavioral health issues by age 24 months • # and % of children enrolled in preschool/pre-K prior to kindergarten
Outcome Indicators	• % of children who demonstrate developmental characteristics of entering kindergarteners in all six domains (social, emotional, physical, language, cognitive, literacy, and math) (*by school district, race/ethnicity, family income) (Source: OSPI/WaKIDS)*
Data Development	• Determine method to identify and monitor # and % of children diagnosed with serious behavioral or developmental disorders requiring specialized intervention

Priority 2.3. Help youth thrive at home and school

Our goal: "All youth graduate from high school prepared for bright healthy futures."

Objectives	Proposed Strategies
2.3.1. Increase the % of parents, teachers, and other important adults who consistently provide 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 (e.g., Strengthening Families Program©). *PRO* • Engage community members, including tribal and Hispanic community partners and families, in identifying and developing culturally appropriate strategies to support healthy youth development. *COM*
2.3.2. Increase the % of children and youth who receive individualized support for 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. *PSE* • Expand resources to support youth with executive function challenges (i.e., planning, organization, self-control) related to adversity or neuro-developmental conditions. *PRO*
2.3.3. Increase the % of youth connected to positive adult mentors and healthy youth activities	• Maintain and expand evidence-based youth mentoring programs for vulnerable youth (e.g., Communities in Schools, Compass to Campus). *PRO* • Support school prevention clubs and other youth-led community health initiatives. *COM*

Measures	
Process Indicators	• # and diversity of community members involved • # of trained mentors • # of youth connected to mentor
Outcome Indicators	• % of youth that report high quality of life (*Source: HYS*) • % of youth who report positive connection to school and community (*Source: HYS*) • % of youth making grade level progress (*Sources: OSPI and school districts*) • % of youth who graduate from high school on time (*Source: OSPI*)
Data Development	• Identify positive youth indicators to include in "Child Well-being Index"

STRATEGIC DIRECTION 3: PROMOTE HEALTHY ACTIVE LIVING

Overview of Issue

"Living healthy" depends on numerous factors including an individual's physical attributes, personal knowledge and motivation, social supports, and the **environment** in which he or she lives, learns, works, and plays. Research shows that people who live in safe, stable housing in neighborhoods or communities with greater **access to healthy foods**, **safe places to be physically active**, reduced **exposure to environmental toxins** such as tobacco smoke, and more **positive social connections** have lower rates of obesity, smoking, and other health conditions than those who do not have these opportunities.

Synopsis of Assessment Findings

- Overall, Whatcom County has **lower rates of health conditions** such as obesity and diabetes associated with lifestyle issues than comparable counties. Despite this positive finding, rates of overweight and obesity are growing. Specific sub-populations **including low income and racial/ethnic minority groups** are **disproportionately impacted**. Tobacco use also continues to be an issue, particularly for low-income adults: 36% for adults with annual income <$20,000 vs. 18% for all adults (*BRFSS, 2007*).

- Community Health Assessment data revealed that some areas of Whatcom County, particularly outlying and **unincorporated areas** of the county, have **higher risks of obesity and tobacco use** (e.g., obesity is more prevalent in North county areas, smoking is more prevalent in East county areas). Racial/ethnic minority and lower income populations are also more likely to be impacted by these health issues and live in areas with fewer opportunities for healthy active living.

- There is **great variation** in Whatcom County between geographic areas in terms of potential **"walkability" or "bikeability"—**the ability to live reasonably well without a car. Bellingham is rated as a "Walker's Paradise," Ferndale is considered "very walkable," Lynden is "somewhat walkable," and all other areas were "car-dependent" (*ACHIEVE, 2011*).

- In a survey of City of Bellingham residents, 57% reported feeling safe walking alone at night in their neighborhoods (*COB, 2011*). In a **community prioritization process** conducted through the Whatcom ACHIEVE initiative, enhancing **community safety and perceived safety** (traffic and crime) was identified as the **top priority for improving physical activity** among children and families (*ACHIEVE, 2010*).

- According to *County Health Rankings* (*2013*), **6% of low-income people** in Whatcom County **do not live near a grocery store** (national goal is 0%). Maps developed during

the *Whatcom County Community Food Assessment (2011)* project demonstrate significant "**food deserts**" in unincorporated areas of the county. Rural residents (living in unincorporated Whatcom County—approximately 44% of County residents) are most likely to have convenience stores, rather than grocery stores as the closest place to buy food.

- Whatcom County has a **higher number of retail alcohol and tobacco licenses** that are active during the year compared with other similar counties and the state (*RPP, 2010*). In 2009, there were 2.21 active alcohol licenses per 1,000 Whatcom County population compared to 1.70 in similar counties and 1.99 in the state. In 2009, there were 1.08 tobacco retail and vending licenses compared to 0.88 for similar counties and 1.00 in the state. In 2012, 25% of Whatcom County retail stores (6 of 24) that had **random tobacco compliance** visits sold cigarettes to minors (*DOH, 2012*).

- Despite **state laws** limiting tobacco use in businesses and worksites, a significant number of people including children are **exposed to second-hand smoke** in home and community environments:
  - An estimated 29% of Whatcom households with children under age 18 have at **least one smoker in the home** (*BRFSS, 2007*).
  - The PeaceHealth St. Joseph Medical Center campus and all public school (K–12) campuses are **smoke-free.** However other large campuses (Western Washington University, Whatcom Community College, and County government) are not. There are **no designated smoke-free parks or play areas** in the County.

Community Assets

Efforts to promote healthy active living in Whatcom County can benefit from strengthening existing collaborations of community partners and building on current work, particularly work associated with ACHIEVE and Community Transformation Grant funding.

Existing community collaborations and partnerships:

- ***ACHIEVE partners—***A network of community partners that came together to create the *Community Action Plan for Healthy & Active Living in Whatcom County* in 2009–2010. The network meets periodically to review progress and identify opportunities to move the plan forward.

- ***Whatcom County Food Network[22]—***A network of organizations, agencies, and institutions playing a key role in strengthening the local and regional food system.

- ***Birch Bay Waterfront Group/Healthy Communities Assessment Team—***A group of community members from Birch Bay working to create a healthy waterfront area, including a safe pedestrian facility and park.

- ***East Whatcom Coalition for Safe and Healthy Communities—***A group of community members who are working to promote traffic safety improvements and other improvements in East Whatcom County.

- ***Let's Move Blaine Coalition—***A coalition of community partners working to increase youth physical activity and reduce childhood obesity in the Blaine area.

Current work to build on:

- Over the past several years, Whatcom County has begun to focus on **changing policies, systems, and environments** (PSE) to promote healthy active living, reduce risk of chronic disease, and reduce disparities. In 2009–2010, a *Community Action Plan for Healthy Active Living* was created through the ACHIEVE project, a federally funded collaborative community planning process. The plan emphasizes PSE strategies related to **nutrition, physical activity, and tobacco**. Since then, the county has received funds through the federal *Community Transformation Grant* (CTG) to implement components of the Community Action Plan in **targeted areas of the county** with higher risk of health conditions such as obesity and smoking.

- Recent work includes planning for a waterfront **pedestrian facility** in Birch Bay; traffic safety improvements, trail development, and **food access improvements** in East County (Deming/Kendall); bicycle/pedestrian planning in the City of Bellingham; and **prioritizing affordable housing development near healthy amenities** (or development of the amenities near existing affordable housing).

- Early work has also begun on changing community design standards to **promote more walking, biking, and other forms of physical activity** and incorporating access to healthy community amenities in comprehensive community plans.

- With support from Whatcom Prevention Coalition, youth are working on **smoke-free parks/play area policies** with Bellingham Parks and Recreation, and conducting a Community Assessment of Neighborhood Stores (CANS) to assess current **tobacco and alcohol marketing** and provide recommendations to retailers to reduce impact on youth.

- Bellingham/Whatcom Housing Authority has expressed interest in creating healthier environments for residents of public **multi-unit housing complexes** by implementing **smoke-free policies**.

Priority 3.1. Expand access to and promotion of healthy food

Our goal: "All people have access to safe, healthy food in their neighborhoods and communities."

Objectives	Proposed Strategies
3.1.1. Increase the % of low-income and geographically-isolated households that have access to a grocery store (or other affordable healthy food outlet) within close proximity to home	• Incorporate recommendations regarding grocery store development and siting in community plans and policies (e.g., City and County comprehensive plans, affordable housing plans). *PSE* • Support community groups in targeted areas in identifying innovative approaches to increase healthy food access (e.g., mobile food retail, farmer's markets). *COM/PSE*
3.1.2. Increase the % of food served in schools and other institutions that meets high nutritional standards	• Support school districts in the development of updated school wellness policies that meet current recommendations, including USDA requirements. *PSE* • Maintain and expand farm-to-institution programs in schools and other settings to promote healthy local food. *PSE*

Measures	
Process Indicators	• # and diversity of community members involved • # of school districts adopting updated school wellness policies
Outcome Indicators	• % of low-income households with access to a grocery store within ½ mile of residence (urban) and 10 miles (rural) *(Source: County Health Rankings)*
Data Development	• Develop "Healthy Community Index," including food access measures • Expand use of GIS/mapping technology to share data • Develop measures for healthy food in schools and other institutions

Priority 3.2. Create more safe places to walk, bike, play, and connect

Our goal: "All people have opportunities to adopt healthy active lifestyles in their neighborhoods and communities."

Objectives	Proposed Strategies
3.2.1. Increase the % of low-income and geographically-isolated households that have access to a park, play area, or trail within close proximity to home	• Incorporate recommendations regarding park/trail development and siting in community plans and policies (e.g., City and County comprehensive plans, bike/pedestrian plans, affordable housing plans). *PSE*
3.2.2. Increase the % of low-income households that have access to reliable transit that connects to key community destinations	• Incorporate recommendations regarding transit access and siting in community plans and policies (e.g., City and County comprehensive plans, transportation plans, affordable housing plans). *PSE* • Support development of new bus routes and/or transit stops in outlying areas (or other innovative approaches to addressing transportation challenges). *PRO*
3.2.3. Increase the % of urban growth areas and small cities with safe walking and biking facilities	• Support targeted traffic safety improvement projects in urban growth areas. *PRO* • 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). *COM/PSE* • Incorporate recommendations regarding walking and biking facilities in community plans and policies (e.g., City and County Comprehensive Plan, transportation plans, affordable housing plans). *PSE*
3.2.4. Increase the % of communities that have safe, community-designed spaces for social gatherings and community events	• Encourage community involvement in the design and building of gathering spaces (e.g., park facilities, community centers). *COM* • Facilitate procurement of grant funds and other resources for communities interested in building or refurbishing gathering spaces in targeted areas. *PRO*

Measures	
Process Indicators	• # and diversity of community members involved
Outcome Indicators	• % of households that have access to a park, play area, or trail within ½ mile (urban) or 10 miles (rural) • % of people who feel safe walking or biking in their neighborhood • % of households that spend greater than 45% of income on housing plus transportation
Data Development	• Develop and monitor "Healthy Community Index" including access to healthy community amenities

Priority 3.3. Limit exposure to tobacco, alcohol, and other harmful substances, especially for youth

Our goal: "All people are protected from the harmful effects of tobacco and other substances where they live, learn, work, and play."

Objectives	Proposed Strategies
3.3.1. Increase the % of retailers who adopt "youth-friendly" marketing and product placement strategies to limit youth exposure	• Engage youth in developing educational campaign(s) for retailers and community related to alcohol, tobacco, and marijuana marketing. *COM* • 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. *PSE*
3.3.2. Increase the % of community parks, play areas, and other outdoor venues that are smoke-free	• Engage youth and other community members in advocating for healthy parks and outdoor spaces. *COM* • Support smoke-free park/play-area policies for city and county parks. *PSE* • Support smoke-free/tobacco-free policies for worksite and college campuses. *PSE*
3.3.3. 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. *PRO* • Provide resources to residents of multi-unit housing facilities to advocate for smoke-free housing policies. *COM*

Measures	
Process Indicators	• # and diversity of community members, including youth, involved • # of smoke-free policies adopted • # of retailers adopting voluntary product marketing and placement standards
Outcome Indicators	• % of children who are exposed to second-hand smoke in homes *(Source: HYS)* • % of youth that report that tobacco, alcohol, and marijuana are easy to get *(Source: HYS)*
Data Development	• TBD

STRATEGIC DIRECTION 4: IMPROVE HEALTH CARE ACCESS AND SERVICE DELIVERY

Overview of Issue

Whatcom County is generally **well-served by health care providers** and facilities including primary care providers, medical specialists, dental and behavioral health providers, alternative care providers, and a community hospital. The more critical issue for community health is **access** to those health services. Barriers to care include **lack of or inadequate health insurance**, **mal-distribution of primary care providers**, and the limited number of current **providers accepting new patients**. Barriers are particularly acute for residents who lack or have limited public-funded insurance, who live in rural communities, who are poor and less educated, or who feel **stigmatized** due to cultural issues such as race/ethnicity, sexual orientation, or history of mental illness or addiction. Access to **dental care** is particularly acute for the underinsured and for those with limited resources. Improvements in the **quality and coordination of services**, especially for those with chronic health conditions and **patient experience/perceptions of care** were also identified as community health priorities.

Synopsis of Assessment Findings

- Whatcom County is designated a **Health Professional Shortage Area** as defined by the federal government, and selected census tracts are also designated Medical Under-Served Areas. These designations are based on a shortage of primary care providers, particularly in rural communities and in communities where poverty and homeless rates are highest. Structural needs in the delivery system also include selected subspecialty providers and dental providers.

- **Unmet health care needs** have been **growing** in recent years. In 2007, **16% of adults** indicated they needed health care in the past year but were **unable to see a doctor** due to cost, compared with 8% in 1996 and 9% in 2002 (*BRFSS 2007*). Populations that were most likely to have unmet needs included those who had no health care coverage (48%), those who earn less than $20,000 per year (32%), respondents who report their health status as *fair/poor* (28%), 18–29 years olds (23%), those with a high school education or less (22%), and those that were unemployed (20%).

- In 2010, an estimated 11–16% of adults in Whatcom County did not have health insurance (*CHAT, 2009, WA-OFM, 2011*). In 2007, 37% of adults did not have dental insurance. The number of **uninsured visits** to Interfaith Community Health Center **grew significantly** from 4,790 in 2008 to 7,453 in 2010 (I*nterfaith CHC data*).

- Thirty-one percent of Whatcom County **residents rely on public insurance** (Medicare or Medicaid/Basic Health). Patients with Medicare or Medicaid insurance find it

increasingly difficult to locate providers who provide care for new patients. Only 44% of providers accepting Medicare and 41% of providers accepting Medicaid will see new patients (*DOH, 2010*).

- **Teenage mothers** indicated **barriers to receiving prenatal care** included physicians not accepting new patients on Medicaid (and "coupons"), lack of external support in obtaining referrals to physicians, transportation (especially rural residents), and fear of informing their family about the pregnancy (*Focus group*).

- Members of the **Hispanic/Latino community** indicated barriers to accessing care included l**anguage barriers**, disrespectful providers and staff, **inadequate or poor quality treatment**, impossibly long waiting lists for dental care, and significant bureaucratic or paperwork barriers to accessing care made more complicated by immigration status or lack of documentation (*Focus group*). Tribal community members identify perceived lack of confidentiality and lack of cultural understanding as barriers to care. Low-income adults identified **dental care as the most needed but least available service** (*Whatcom Prosperity Project, 2011*).

- Based on national performance reporting requirements, the quality of health services provided in Whatcom County is variable. There is a striking disparity between the **quality of the processes** of care that are **on par with best practices** in the nation (e.g., pre-operative antibiotic usage–98th percentile and implementation of congestive heart failure protocol-99th percentile) and **people's perception of that care that ranks below average** for the nation and below that of other community hospitals in the region. Only 59% of PHSJMC patients assigned the hospital a score of 9–10 on a quality rating scale of 1–10. This ranks at the 19th percentile for the nation (*CMS-Hospital Compare*).

- Over **9,000 ER visits per year** are for **behavioral health issues** (mental illness or substance use related health need) *(PHSJMC, 2011).* Many of these are **potentially avoidable** if behavioral health issues are better managed in the community setting. ER visits in general are **disproportionately greater for Medicaid patients** (27–29% of all visits with only 17% of the county population insured under Medicaid) than other payer sources, suggesting that increasing access to coordinated health services for Medicaid clients and clients with behavioral health issues could potentially reduce avoidable ER visits.

- In the state of Washington, **visits for substance abuse** in federally qualified community health centers have **increased 27.8%** from 2007 to 2009 *(HRSA, 2009).* In 2008, only 36% of the 4,460 adult DSHS clients in Whatcom County with an alcohol or drug problem received alcohol or drug treatment (DSHS, *2011).* In the same year, 48% of the 982 youth DSHS clients with an alcohol or drug problem received treatment.

Community Assets

Existing community collaborations and partnerships:

- ***Whatcom Alliance for Health Advancement (WAHA)*** (formerly "*Whatcom Alliance for Healthcare Access*")[23]—A non-profit organization that connects people to health care and facilitates transformation of the current system into one that improves health, reduces cost, and improves the experience of care. The WAHA board of directors represents a wide diversity of partners from local health care, public health, and community members.

- ***Whatcom County Oral Health Coalition[24]—***A coalition of dental and mental health professionals, public health, social service providers, and other community partners working to promote oral health and improve access to dental care for children and adults in Whatcom County. Current efforts focused on linking pregnant women and young children to dental care, as well as exploring options for adult dental care access.

- ***Whatcom Taking Action for Children and Youth with Special Health Care Needs (Whatcom Taking Action)[25]—***A collaboration of community partners and families working to improve the system of services and supports for children, youth, and families impacted by special health and developmental needs.

Current work to build on:

- Over the past 10 years, Whatcom County has dedicated **significant resources to addressing issues of health care access and quality**, specifically through the work of WAHA. WAHA is leading the way to facilitate **local implementation of the Affordable Care Act**, including work to develop an **Accountable Care Organization** and serving in a multi-county leadership role to implement "in-person assister" services to get **uninsured people linked to health insurance** through the state Health Insurance Exchange. WAHA is also working on targeted projects to reduce hospital readmissions (Project IMPACT) and develop intensive case management supports for complex patients, among numerous other health care initiatives including dental and behavioral health care access efforts.

- With support from the Whatcom Community Foundation, Whatcom Taking Action for Children and Youth with Special Health Care Needs developed and implemented a **Single Entry Access to Services (SEAS) phone line** at the Opportunity Council that helps families connect to needed services. Teams are now working to develop **General Interdisciplinary Developmental Evaluation Services (GIDES)** to better support children with developmental needs.

Priority 4.1. Expand insurance coverage and access to primary care and dental care

Our goal: "All people have access to essential health care services."

Objectives	Proposed Strategies
4.1.1. Increase the % of people with health insurance coverage	• Develop and implement ACA "In-Person Assister" network to identify and connect uninsured county residents with Medicaid and subsidized commercial coverage options. *PRO*
4.1.2. Increase the % of low-income individuals and people living in rural areas of the county who have a primary care provider	• Develop collaborative recruitment efforts that include incentives and other approaches to attract additional primary care physicians and mid-level providers to the county who will serve Medicaid/Medicare patients and outlying geographic areas. *PSE*
4.1.3. Increase the % of low-income individuals and high-risk populations that receive regular preventive and restorative dental care	• Implement focused programs/projects to connect high-risk populations to dental care (i.e., pregnant women, young children on Medicaid, people with diabetes). *PRO* • Build or expand dental facilities to meet growing needs. *PSE*

Measures	
Process Indicators	• # and diversity of community members engaged • # of adults newly enrolled in health insurance plan • # of primary care providers recruited • # of new dental chairs added (capital facilities)
Outcome Indicators	• % of adults with unmet health needs due to cost *(Source: BRFSS)* • # and % of ER visits by uninsured patients (*Source: PHSJMC)* • % of primary care providers to population (HPSA ratio) *(Source: US Dept of Health and Human Services, HRSA)* • % of adults with usual source of health care *(Source: BRFSS)* • % of children with untreated dental decay *(Source: Smile Survey)* • % of children (0–5) on Medicaid with a dental visit in the past 12 months *(Source: Medicaid)* • % of adults with a dental visit in past 12 months (by income) *(Source: BRFSS)*
Data Development	• Consider additional data sources as some data are not updated regularly

Priority 4.2. Connect people with complex health conditions to needed supports

Our goal: "All children, adults, and seniors with complex needs receive supports that optimize outcomes."

Objectives	Proposed Strategies
4.2.1. Increase the % of children and adults with behavioral health conditions (e.g., substance use and mental health concerns) who receive needed treatment by appropriate specialists	• Develop multi-disciplinary developmental evaluation system for children. *PSE* • Provide incentives to recruit more psychiatrists and behavioral interventionists for children and adults. *PSE* • Pilot new ways of integrating mental health and chemical dependency treatment with primary care for specific populations. *PRO*
4.2.2. Increase the % of people with chronic, complex health conditions, who receive intensive case management that is well integrated with primary care medical homes	• Establish a local registry of patients with high intensity needs. *PSE* • Develop cross-organizational intensive case management protocols for patients with complex needs. *PSE* • Pilot ICM teams that are closely aligned with primary care medical homes and oriented toward serving the needs of special populations (people who are mentally ill or homeless, and children with special health care needs). *PRO* • Evaluate ICM pilots and develop an expansion plan and financing model in collaboration with key providers, payers, and social service agencies. *PSE*
4.2.3. Increase the % of people who successfully transition from hospital to home (or extended care setting) after a hospital admission	• Support the further development of the WAHA-sponsored Care Transitions Coaching program. PRO • Support efforts to ensure successful care transitions from the hospital for Tribal members. PRO • Expand Care Transition services to other payer groups (in addition to Medicare). PRO

Measures	
Process Indicators	• # and diversity of community members engaged • # and % of medical provider practices meeting Affordable Care Act "Patient-Centered Medical Home" criteria
Outcome Indicators	• # and % of patients who are readmitted to the hospital within 30 days after discharge (by race, ethnicity, insurance status, and primary care practice) *(Source: PHSJMC)* • # and % of ER visits and hospital admissions for chronic behavioral health conditions *(Source: PHSJMC)* • # and % of ER visits and hospital admissions for chronic health conditions (diabetes, hypertension, cardiovascular disease, and asthma) *(Source: PHSJMC)*

Data Development	• Identify mechanisms to measure
	  ○ % of children and adults with developmental and behavioral health conditions with unmet health care needs
	  ○ # of children and adults with complex health needs linked to medical home

Priority 4.3. Enhance patients' experience of care

Our goal: "All people feel welcomed into the health care system and are satisfied with their health care experiences."

Objectives	Proposed Strategies
4.3.1. Increase the % of people who can easily find the information and resources they need to make health care decisions	• Support ongoing efforts to centralize health care system information and referral (e.g., WAHA access services counselors). *PSE* • Maintain and expand Single Entry Access to Services phone line for Children & Youth with Special Health Care needs (CYSHCN) (e.g. Whatcom Taking Action/Opportunity Council). *PSE*
4.3.2. Increase the % of people who feel they communicate well with their health care providers (and their health care providers communicate well with each other)	• Develop and implement programs focused on increasing "health literacy." *PRO* • Encourage quality improvement efforts within health care settings focused on patient-provider communication and provider-provider communication. *PSE* • Support enhancements in electronic health information exchange. *PSE*
4.3.3. Increase the % of people who feel their cultural, spiritual, and religious beliefs and traditions are respected and valued within the health care system	• Conduct organizational cultural competency policy and practice assessment using national tools. *PSE* • Explore feasibility of embedding tribal and Hispanic community resource liaisons at hospital to provide advocacy and assist with care transition. *COM/PRO*

Measures	
Process Indicators	• # and diversity of community members involved
Outcome Indicators	• % of people who report that the local health care system is easy to navigate • % 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
Data Development	• TBD

Plan Implementation

Completion of the Whatcom County Community Health Improvement Plan document is an exciting milestone in the community health improvement planning process. The document provides a framework for action as well as a launching point for ongoing community conversation about what is important for the health and well being of our community.

Implementation of the CHIP has already begun. Steps have been taken to establish a formal leadership structure, expand partnerships, align organizational priorities, identify resources, raise community and policymaker awareness, and launch new projects and programs. Despite this progress, realizing the potential of the CHIP requires clarity about actions and accountability for results. A separate "Implementation Plan" that outlines next steps and a small number of initiatives related to Strategic Directions and Priorities is being developed as a companion document to the CHIP. The "Implementation Plan" document will include tasks, timelines, milestones, partners, resources, and constraints connected to each initiative.

Further development of infrastructure is critical to the ongoing success of the CHIP, and will be included within the "Implementation Plan." Clarifying roles of various partners and assuring adequate capacity to support collective work are necessary steps. Infrastructure issues to consider include:

- Leadership and Decision-Making
- Facilitation and Staffing Support
- Communication
- Data and Evaluation
- Partnership and Resource Development
- Initiative Development, Staffing, and Coordination

Throughout the planning process, community leaders have demonstrated both personal and organizational commitment to this work. Incredible tenacity, a willingness to grapple with tough issues, and a desire to move forward together provide the foundation for catalyzing positive community change.

Final Words

Thank you for your interest in reviewing this plan. While the plan attempts to provide a road map for next steps in the community health improvement process in Whatcom County, there will inevitably be unexpected bumps and turns in the road. Maintaining the strong partnerships that have been nurtured through this planning phase and building new partnerships will be key to staying on track and achieving the results that we desire.

We will be healthier together…

For more information about the CHA or CHIP, please contact:

Astrid Newell, Whatcom County Health Department
anewell@whatcomcounty.us

Chris Phillips, PeaceHealth St. Joseph Medical Center
cphillips@peacehealth.org

[1] **Health care regulatory requirements:** Federal health care reform (Patient Protection and Affordable Care Act of 2010) requires tax exempt hospitals to conduct periodic community health assessments and develop implementation strategies in partnership with local public health. More info available at http://www.naccho.org/topics/infrastructure/mapp/chahealthreform.cfm and http://www.kff.org/healthreform/upload/8061.pdf

[2] **Public health accreditation**: The national Public Health Accreditation Board requires that local public health agencies complete a community health assessment and community health improvement plan as a pre-requisite for accreditation. More info available at http://www.phaboard.org

[3] **Community health assessment**: A complete version of the Whatcom County Community Health Assessment Report of Findings (2012) and Executive Summary (2012) can be found at www.whatcomcounty.us/health

[4] **Collective impact**: http://www.ssireview.org/articles/entry/collective_impact

[5] **Mobilizing for Action Through Partnerships and Planning**: More info available at http://www.naccho.org/topics/infrastructure/mapp/

[6] **Results Washington**: WA State Governor's Office, 2013. Strategic framework for Washington State includes goals for World Class Education; Prosperous Economy; Sustainable Energy and a Clean Environment; Healthy and Safe Communities; Efficient, Effective and Accountable Government. www.results.wa.gov

[7] **Washington State Agenda for Change**: Public Health Improvement Partnership, 2012. Public health guidance document developed collaboratively with WA State Dept of Health and representatives of local health jurisdictions. Prioritizes preventing communicable disease and other health threats, fostering healthy communities and environments, and public health partnering with the health care system. http://www.doh.wa.gov/Portals/1/Documents/1200/A4C-APsummary.pdf

[8] **Healthy Communities: A Tribal Maternal-Infant Strategic Plan** (American Indian Health Commission for Washington State, 2010): http://www.doh.wa.gov/Portals/1/Documents/1200/phsd-AIHCPlan.pdf

[9] **Washington State Early Learning Plan** (WA Dept of Early Learning, 2010): http://www.del.wa.gov/publications/elac-qris/docs/ELP_Exec.pdf

[10] **Healthy People 2020**: http://www.healthypeople.gov/2020/default.aspx

[11] **County Health Rankings**, Robert Wood Johnson Foundation. http://www.countyhealthrankings.org/

[12] **National Prevention Strategy** (June 2011): http://www.surgeongeneral.gov/initiatives/prevention/strategy/report.pdf

[13] **Beyond Health Care: New Directions for a Healthier America.** Recommendations from the Robert Wood Johnson Foundation Commission to Build a Healthier America (2009) http://www.commissiononhealth.org/PDF/779d4330-8328-4a21-b7a3-deb751dafaab/Beyond%20Health%20Care%20-%20New%20Directions%20to%20a%20Healthier%20America.pdf

[14] **Affordable Care Act** (U.S. Department of Health and Human Services, 2010): Federal health care reform legislation. http://www.hhs.gov/opa/affordable-care-act/index.html

[15] **United Way of America: Advancing the Common Good**. http://www.unitedway.org. National United Way agenda focuses on 1) Education-Helping Children and Youth Achieve Their Potential, 2) Income-Promoting Financial Stability and Independence, and 3) Health-Improving People's Health.

[16] **Community culture**: a set of core beliefs, values, practices, principles, norms, or behaviors that are held by a group of people who have common interests and a willingness to work together to achieve them. Definition from *The Role of Community Culture in Efforts to Create Healthier, Safer, and More Equitable Places: A Community Health Practitioner Workbook* (Prevention Institute, 2013): http://www.preventioninstitute.org/component/jlibrary/article/id-338/127.html

[17] **Adverse Childhood Experiences (ACEs)**: Certain experiences are major risk factors for the leading causes of illness and death as well as poor quality of life in the United States. Progress in preventing and recovering from the nation's worst health and social problems is likely to benefit from understanding that many of these problems arise as a consequence of adverse childhood experiences. http://www.cdc.gov/ace/

[18] **Trauma-Informed Care**: Trauma-informed care is an approach to engaging people with histories of trauma that recognizes the presence of trauma symptoms and acknowledges the role that trauma has played in their lives. http://www.samhsa.gov/nctic/

[19] **Compassionate Schools**: The Heart of Learning and Teaching: *Compassion, Resiliency, and Academic Success.* A framework for working with students whose learning has been adversely impacted by trauma in their lives. http://www.k12.wa.us/compassionateschools/

[20] **County Health Rankings** (*Robert Wood Johnson Foundation and University of Wisconsin Population Health Institute, 2013*). http://www.countyhealthrankings.org/app/#/washington/2013/whatcom/county/outcomes/overall/snapshot/by-rank

[21]**Appreciative Inquiry** (AI): a theory and practice of change that involves asking questions that strengthen a system's capacity to achieve positive potential. http://appreciativeinquiry.case.edu/intro/whatisai.cfm

[22] **Whatcom Food Network**: http://whatcom.wsu.edu/ag/foodnetwork/aboutus.html

[23] **Whatcom Alliance for Health Advancement** (WAHA) –formerly "*Whatcom Allliance for Healthcare Access*". A non-profit organization that connects people to health care and facilitates transformation of the current system into one that improves health, reduces cost and improves the experience of care.http://www.whatcomalliance.org

[24] **Whatcom County Oral Health Coalition**: http://happyteeth.org/

[25] **Whatcom Taking Action for Children and Youth with Special Health Care Needs** (Taking Action): http://www.co.whatcom.wa.us/health/children/taking_action2.jsp