CASCADE PACIFIC ACTION ALLIANCE
IMPROVING COMMUNITY HEALTH & SAFETY

# REGIONAL HEALTH IMPROVEMENT PLAN (RHIP)

## PRIORITY AREAS:

- ECONOMIC AND EDUCATIONAL OPPORTUNITIES
- HEALTH INTEGRATION AND CARE COORDINATION
- IMPROVE CHRONIC DISEASE PREVENTION AND MANAGEMENT
- PREVENTION AND MITIGATION OF ADVERSE CHILDHOOD EXPERIENCES
- PROVIDER ACCESS / CAPACITY

## POTENTIAL STRATEGIES & PROJECTS

### Provider Capacity

1. Develop capacity for community-based programs to educate and train allied health professionals.
2. Develop a peer-to-peer health worker workforce (e.g., define CHW for the region and participate on the statewide task force now discussing this issue).
3. Development of 7-county tele-medicine network for greater specialty access.
4. Develop an ARNP residency program in the region.
5. Develop and implement a joint, regional recruitment plan of providers with the goal of increasing provider capacity through individually developed plans put together by county.
6. Train primary care providers on asking youth and young adults about family planning and on inserting/implanting long-acting reversible contraception to increase access to birth control and reduce unintended pregnancy rates.

### Care Coordination/Pilot Project

***Inventory & Assessment***

7. Survey region to determine who is coordinating care now, and where that is happening.
8. Gather evidence-based practices (contact Wymer/UW/SAMSHA; learn from current health homes; use a cost-benefit analysis.)

## POTENTIAL STRATEGIES & PROJECTS

9. Hold focused learning sessions on current CHW projects within the region and state.
10. Develop a quality improvement agreement across multiple agencies following individual care – ultimately ending w/CQI being incorporated in coordinated care.
11. Develop integrated care assessments across multiple life domains (e.g., housing, domestic violence, social determinants of health, etc.).
12. Develop an electronic record that follows clients by having multiple agencies collaborating on the creation of a single assessment.

### Community-based Care Coordination:

13. Identify and develop specific care coordination projects utilizing multi-disciplinary teams (e.g. CHWs whose experience positions them to engage populations traditional healthcare workforces struggle to reach, once trained they could support addressing the root causes of high utilization.) (Note: this could be in a variety of settings neighborhood, health home, long-term care, early learning, home visiting, etc.)
14. Improve access to chronic disease self-management programs regionally.
15. Use the MCO Health Home community-based care coordination program to engage eligible people into community-based care coordination and improve collaboration between providers and social services.
16. Operationalize integrated school-based health centers in high schools and community/technical colleges to provide youth and young adults direct access to physical and behavioral health services.

**Housing**

17. Partner with developers to build affordable, quality housing for people in need.

**Criminal Justice**

18. Develop and expand jail and fine alternatives as well as stronger transitions of care between criminal justice and health care (public and private).

### Education

19. Collaborate and partner with Chambers of Commerce, trade associations, and Workforce Development Council members to identify healthcare and other workforce gaps, and increase and co-create educational opportunities and training.
20. Create and implement a public messaging campaign to emphasize college and post-secondary education for all students, and opportunities for careers in the allied health sector in this region.

## POTENTIAL STRATEGIES & PROJECTS

21. Develop a core curriculum pathway to deliver health, social-emotional wellness (click WEBLINK for several research reports), comprehensive health education K-12, and health insurance literacy to high school students.
22. Support implementation of "Education Advocates" (mentors) for high-risk incoming middle/junior high school students, and "Graduation Coaches" for high risk incoming high school students, using Check and Connect (an evidence-based practice to foster school completion – click WEBLINK)
23. Expand screening of children and youth for behavioral health needs, and provide access to school-based and community-based intervention/treatment services for those identified in need (the behavioral health pilot).
24. Expand school-based and community-based opportunities for highly engaging, contextualized learning (food gardens, maker spaces/studio-schools, worksite learning, service learning.)
25. Expand school-based multi-tiered systems of support for children and youth to include school-based and community-based social/behavioral supports (click WEBLINK for Communities in Schools Evaluation Summary.)
26. Support school climate improvement efforts in regional schools (click WEBLINK for background/research.)
27. Recruit organizations and support them in offering youth mentoring and scholarship programs like the PeaceHealth St. John Medical Center Youth Mentoring Program.

### Economic Development

28. Collaborate with regional workforce development councils to build a sector partnership that will connect youth to local businesses (e.g., Thurston County's Business to Youth Connect program).
29. Develop a summary of applicable trade skills needed in the community to enhance education curriculum.
30. Support individuals in obtaining and maintaining employment and livable income.

### Thoughtful Community Growth

31. Design and build healthy and safe neighborhoods (e.g., bike lanes; walking trails; quality, safety, & location of housing).
32. Build a sustainable local food system improving access to healthy food (e.g. food banks, community gardens, food policy).

### Adverse Childhood Experiences (ACEs)

33. Use CPAA shared learning sessions to learn about successful applications of ACEs information, prevention models, resilience programs or strategies that should expand by CPAA activities.
34. Increase access across the CPAA region to Nurse Family Partnership and/or other evidence-based home visiting programs that build knowledge and skills for mothers with young children and can stop the intergenerational transition of ACEs.

## POTENTIAL STRATEGIES & PROJECTS

35. Expand the Kinship Program regionally.
36. Coordinate with the N.E.A.R. Speakers Bureau to generate requests for presentations and workshops across the CPAA region that disseminate current scientific information with fidelity regarding Neurobiology, Epigenetics, Adverse Childhood Experiences, and Resilience.
37. Train school staff members to be Collaborative Learning for Education Achievements and Resilience (CLEAR - weblink) consultants for the implementation of the Attachment, Self-Regulation, and Competency (ARC - weblink) promising practice.

## TRANSFORMATION AREAS:

- HEALTH CARE WORKFORCE
  Assessing, increasing, and supporting greater health care workforce capacity is a cross-cutting issue across the region.

- CHANGES ACROSS SYSTEMS OF CARE
  Identify and design innovative and promising practices to implement and evaluate efforts to ensure an individual with complex needs receives effective and efficient care across all areas. Care Coordination: Health Homes, Long-term Care, Peer-based.

- SOCIAL DETERMINANTS CHANGE
  Work across sectors to tackle social determinant issues that have been proven to influence individual health status (i.e., housing, economic**,** education, criminal justice, ACES).

- TRAUMA INFORMED COMMUNITY
  Create a trauma-informed community across the region by embedding an ACEs lens in policies and practices across public/private organizations.