

2014 KITSAP COUNTY COMMUNITY HEALTH IMPROVEMENT PLAN

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BACKGROUND

WHAT IS KITSAP COMMUNITY HEALTH PRIORITIES

Kitsap Community Health Priorities (KCHP) is a collaborative, community-driven process to improve health and well-being in Kitsap County. The process involves broad participation of diverse sectors of the community in setting community health and well-being priorities, taking action on those priorities, and monitoring progress. KCHP began in December 2010 and is intended to be a cyclical, dynamic, and long-term process.

GOALS

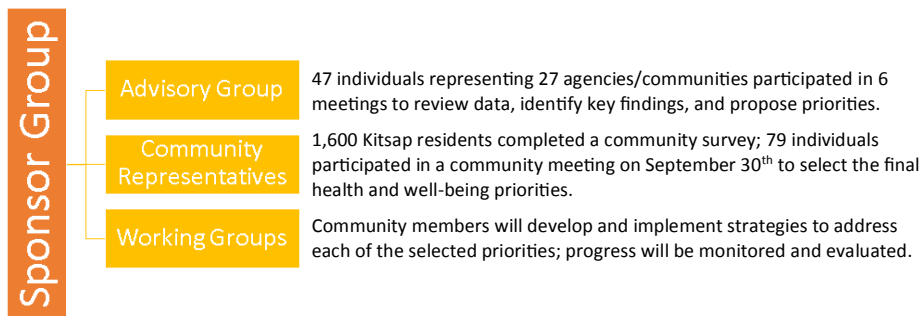
- ◆ Improve health and well-being status and opportunities for all.
- ◆ Improve collaboration and planning among community agencies.
- ◆ Increase public awareness of and engagement around improving health and well-being.
- ◆ Increase access to and use of data.

TIMELINE



PARTICIPANTS

KCHP is led by a Sponsor Group comprised of three founding members: Kitsap Public Health District, Harrison Medical Center, and United Way. Two additional members joined in 2014: Kitsap Community Foundation and Kitsap County Human Services Department. The Sponsor Group defines and monitors the KCHP process and provides financial support. Participation in KCHP is open to any county residents and individuals working within the county. The distribution list includes over 250 individuals, many of whom serve as primary contact for community organizations/agencies. Levels for participation for the 2014 KCHP process were as follows:

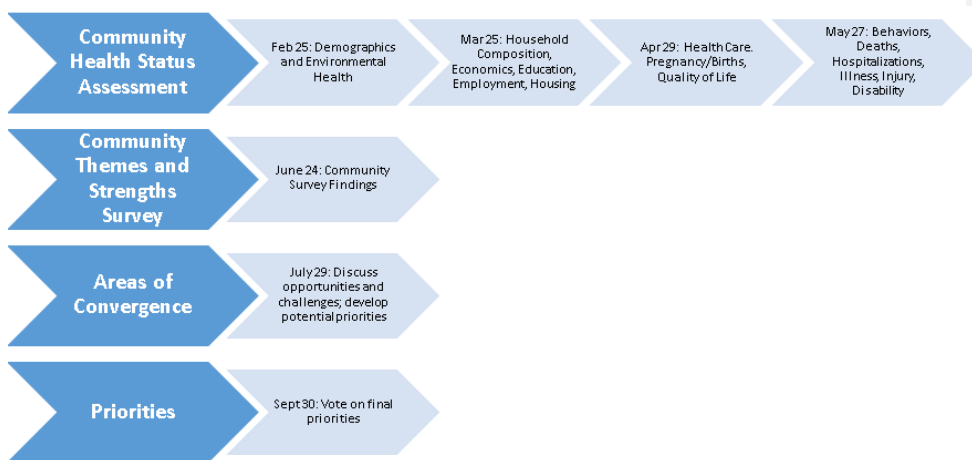


DATA REVIEW AND PRIORITIZATION PROCESS

The 2014 KCHP data review process was based on a modification of the National Association of County and City Health Officials (NACCHO) Mobilizing for Action through Planning and Partnerships (MAPP)

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model.¹ The KCHP process included review of findings from a Community Health Status Assessment and Community Themes and Strengths Survey and input on forces of change and the community capacity in the public health, health care, and social services systems. Kitsap Public Health District Epidemiologists presented assessment findings to the KCHP Advisory Group in a large group format which was followed by discussions in small groups to identify key findings, forces of change, system capacity, and missing data. Key findings were summarized into “Areas of Convergence” from which Advisory Group members identified potential priorities. Final priorities were selected by Community Representatives from the list of potential priorities.



COMMUNITY HEALTH STATUS ASSESSMENT

The Community Health Status Assessment (CHSA) included over 260 indicators of health and well-being. Indicators were derived from standard quantitative public health data sources. Rates or percentages were presented for Kitsap County with a trend over time and comparison to Washington State. When possible, Kitsap rates or percentages were presented for sub-groups: sub-county areas, age groups, gender, race/ethnicity, income level, education level, among others. The CHSA was compiled by Epidemiologists at the Kitsap Public Health District and presented in topical modules to the Advisory Group at 4 meetings.

COMMUNITY THEMES AND STRENGTHS SURVEY

The Community Themes and Strengths Survey (Survey) included 31 questions and a participant demographics section. The survey was a convenience sample obtained through wide dissemination of

¹ <http://www.naccho.org/topics/infrastructure/mapp/>

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both electronic and paper surveys. In total, 1,897 surveys were completed of which, 1,600 were used for analysis based on participant reported Kitsap County zip code. Questions were designed to collect information beyond the CHSA indicators and include qualitative input. Epidemiologists at the Kitsap Public Health District administered and analyzed the survey and presented findings to the Advisory Group.

INPUT ON FORCES OF CHANGE AND COMMUNITY CAPACITY

The Advisory Group identified and provided input on key issues including differences by sub-groups, missing data or other information that would be important to know, community capacity to address the issue, opportunities/factors/events/barriers in the community that may affect the issue.

AREAS OF CONVERGENCE AND POTENTIAL PRIORITIES

Fourteen “Areas of Convergence” resulted from the overlap in key findings identified by Advisory Group small groups at each data review meeting. Each Area of Convergence included relevant data from the CHSA and Survey. To establish the list of potential priorities, the Advisory Group reviewed the Areas of Convergence and then each individual wrote down their top 10 priority issues on sticky notes which they placed on a topic-specific poster. On each poster and between posters, sticky-notes with similar issues were consolidated. Advisory Group members were given 5 sticky dots to vote on the consolidated issues – they could place all dots on one issue or divide them up. Using this method, 6 potential priorities were identified.

FINAL PRIORITIES

For each of the six potential priorities, data, disparities and impact were presented to Community Representatives by the Kitsap Public Health District Epidemiologist. Following an Advisory Group led small group discussion of the process and findings, Community Representatives were given 3 sticky dots to vote on the final priorities – they could place all dots on one issue or divide them up. Using this method, 4 final community health and well-being priorities were selected.

AREAS OF CONVERGENCE (14)	POTENTIAL PRIORITIES (6)	FINAL PRIORITIES (4)
Adverse Childhood Experiences	Adverse Childhood Experiences	Adverse Childhood Experiences (ACEs): Prevent ACEs and reduce the negative impact of ACEs
Aging Population		
Bremerton (as an outlier)		
Education		
Food Access/Insecurity*		
Housing/Homelessness	Affordable Housing	Affordable Housing: Increase affordable housing and make homelessness a one-time brief event
Living Wage Jobs, Workforce Education/Training	Living Wage Jobs	
Mental Health/Emotional Well-Being/Stress	Mental Health	Mental Health: Ensure mental health care is accessible, available, and timely for all
Overweight/Obesity/Chronic Disease	Obesity	Prevent/Reduce Obesity: Make it easy for all residents to be physically active and ensure all residents have healthier food options
Parenting		
Physical Activity/Active Living*		
Prenatal Care		
Substance Use	Youth substance use/abuse	
Transportation		

*Integrated into obesity potential and final priority

PRIORITIES

ADDRESSING HEALTH AND WELL-BEING PRIORITIES

Working groups comprised of community representatives will work on strategies to address the priorities. Progress will be monitored and evaluated from objectives that are specific, measurable, attainable, relevant, and time-bound (SMART). Annual work plans for the four priorities are detailed on the pages that follow.

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ADVERSE CHILDHOOD EXPERIENCES (ACEs): Prevent ACEs and reduce the negative impact of ACEs.

Health Indicator: Increase the percentage of Kitsap residents with 0, 1, or 2 ACEs

Health Indicator: The percentage of Kitsap residents with 0 ACEs (Source: Adult self-report, Behavioral Risk Factor Surveillance System)	Baseline	Year1	Year2	Year3	Year4	Year5
	34% (2011)	n/a	n/a	n/a		

Responsible Parties: KPHD, Kitsap Community Foundation, United Way, Suquamish Tribe, Kitsap County Human Services, and Olympic Educational Services District

Objective	Strategies	Measurement	Target Date	Year 1 (2015)	Target Date	Year 2 (2016)	Target Date	Year 3 (2017)	EBP	Policy Change
Prevent ACEs & Promote resiliencies to mitigate the effects of ACEs	Establish key elements of CI approach	Backbone agency structure established by 6/30/15	6/30/15	Funders Committee comprised of KPHD, Kitsap Community Foundation, United Way and Suquamish Tribe established December 2014; Project Director for CI Hired April 2015	N/A	N/A	N/A	N/A		
		At least 5 sectors represented in steering committee for CI by 7/15/15 Establish frequency of Steering committee meetings	7/15/15	Steering committee established, participating sectors include OESD, Kitsap County Human Services, Olympic College, Emmanuel Apostolic Church, KPHD, Kitsap Community	N/A	N/A	N/A	N/A		

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				Foundation; monthly meetings held beginning 7/16/15						
		Establish common agenda and goals	8/15/15	Common agenda <i>identified as:</i> <i>Improve the overall health & well-being of Kitsap & its residents, through the reduction of ACEs and building of resilience.</i>	N/A	N/A	N/A	N/A		
		Establish key measurements	6/15/16	N/A	N/A	Shared measures identified. By 2025: A 10% decrease in the proportion of Kitsap County Residents reporting 3 or more ACEs A 20% increase in the percentage of adults in	N/A			

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						Kitsap County who report they feel socially and emotionally supported A 20% increase in the % of children in Kitsap County who report they have someone to turn to when feeling sad or hopeless about the future A 10% increase in the % of children in Kitsap County who report they live in a home with good family management A 50% increase in post-secondary completion for Kitsap & Mason students, through a focus on reducing gaps in equity and opportunity for minority and special education students and young adults				
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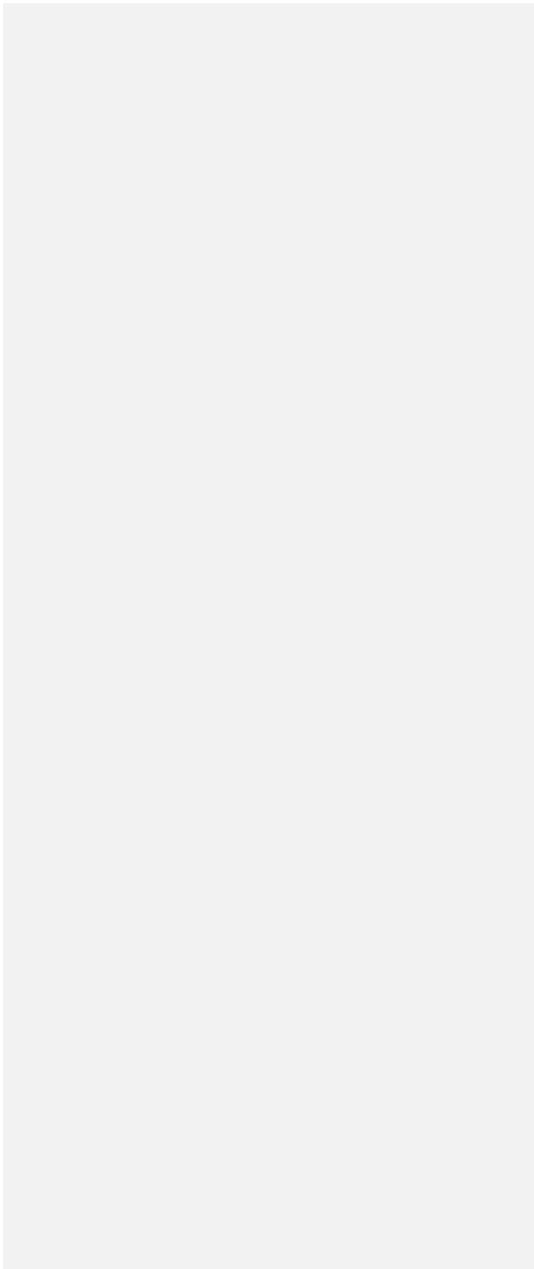
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	Educating diverse sectors in the NEAR sciences	At least 15 agencies from diverse sectors trained in NEAR sciences by 12/15/15 Extend Collaborative Leadership Academy for additional 6 months to allow for at least 20 agencies to engage in increased application of NEAR concepts in organizational structures by 9/30/16	12/15/15	Established Collaborative Learning Academy, which trained 25 local non-profits from diverse sectors in NEAR	9/30/16	23 organizations continued involvement in Collaborative Learning Academy to allow more time for integration of NEAR into agency culture and policies	N/A			
	Integrate NEAR into agency policies and systems	At least 3 sectors modify existing or implement new policies by 9/30/16	N/A	N/A	9/30/16 12/31/16	The Healthy Eating Active Living Coalition formally adopted a NEAR lens to their work and is developing a strategic plan to specifically identify strategies and activities where HEAL and NEAR overlap.	12/31/17	As of June 2017, Housing Kitsap is exploring how to make changes to their eviction policy and procedures to be more trauma-		X

Commented [KE1]: Revision to work plan determined February 2016

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						Georgia's House, a homeless shelter in Kitsap County, has begun training staff and volunteers in the NEAR research as fundamental to informing their client engagement.		informed. Specifically, the agency is shifting their case conference with potential eviction clients to earlier in the process to ensure clients have more time to problem-solve.		
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~~MENTAL BEHAVIORAL~~ HEALTH: Ensure ~~mental behavioral~~ health care is accessible, available, and timely for all.

Commented [KS2]: Change from "mental" to 'behavioral' approved by KCHP partners at KCHP Summit 10/2015.

Responsible Parties: KPHD, KMHS, Kitsap County Human Services, Kitsap Community Resources

Health Indicator:	Baseline (2014 CHA)	Year1 2015	Year2 2016	Year3 2017	Year4 2018	Year5
Mental health provider shortage areas (http://hpsafind.hrsa.gov/HPSASearch)	Entire county		Entire county (6/10/16)	Entire county		
Adults report mental distress (14 or more days of poor mental health during the past 30 days) (BRFSS)	14% (2011-12)	13% (2013)	15% (2014)	11% (2015)		
Alcohol or drug related deaths (DSHS Risk Profile)	11.5 per 1,000 (2012 not in CHA)	10.9 per 1,000 (2013)	12.8 per 1,000 (2014)	13.0 per 1,000 (2015)		

Health Indicator:

Objective	Strategies	Measurement	Target Date	Year 1 2015	Target Date	Year 2 2016	Target Date	Year 3 2017	EBP	Policy Change
Strengthen local initiatives that promote mental health care	Identify opportunities with Kitsap Human Services and Kitsap Mental Health to promote behavioral health integration and efforts	Convene KHS and KMHS to identify opportunities by 3/15/15	3/15/15	Sector leaders prioritized educating community about pending BH integration and 1/10 th of 1% funding opportunities to expand BH interventions across the lifespan	N/A	N/A	N/A	N/A		
	Conduct at least 1 community event annually at which	Presentation to broad group of stakeholders on	12/31/15	100 community members participated in	12/31/16	Partner meeting with the Olympic Community of	12/31/17	Partner meeting with the Olympic		

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	information on BH integration will be provided	behavioral health integration changes as part of health care reform		annual KCHP Summit on 10/26/15, at which KC RSN presented on proposed behavioral health integration for M/Caid population & timeline		Health on June 14, 2016 focused on lessons learned from Southwest WA Early Adopter Region bidirectional integration; 115 community members participated		Community of Health held on January 30, 2017 and focused on the require Medicaid Waiver demonstration project on bidirectional integration; 100 community members participated		
	Solicit feedback from KCHP participants on whether objective should expand from “mental health care” focus to “behavioral health care focus” by 12/31/15	Health priority voted to be changed to <i>Ensure behavioral health care is accessible, available and timely for all</i>	12/31/15	10/26/15	N/A	N/A	N/A	N/A	N/A	N/A
	Explore opportunities to leverage cross-over of behavioral health priority with other priorities to maximize impact with limited	Discuss with behavioral health partners, KCHP Sponsor Group, and Housing working group	N/A	12/30/15 discussion with Housing Working Group – concept approved to pursue projects that service homeless/housing unstable persons	3/1/16	2/8/16 discussed with sponsor group; concept approved of pursuing joint ACEs and Housing projects which help address	3/1/17	Medical respite care identified as significant gap in service for persons being discharged from hospital setting into		

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	resources by 3/1/16	opportunities for cross-leverage		with behavioral health issues		behavioral health objectives		homelessness but who require some level of medical support to recover		
Identify new funding opportunities for combined housing/behavioral health programs	Develop program concept for combined housing/behavioral health project that would benefit most vulnerable members of community by 1/31/16	Submit Medicaid Transformation Project and competitive application to 1/10 th of 1% funding opportunity to provide intensive care coordination to persons with behavioral health issues in need of housing and other social services; and access to medical, chemical dependency and mental health care	N/A	N/A	1/31/16	Submission to Health Care Authority for Medicaid Waiver on 1/14/16	N/A	N/A	N/A	N/A
					3/15/16	Submitted 1/10th of 1% Crisis Response Team ("Kitsap Connect") proposal to Kitsap County for intensive care coordination services to chronically homeless, mentally ill, chemically dependent population on 3/11/16				

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						<u>July 1, 2016 – June 30, 2017.</u>				
<u>Launch Kitsap Connect – integrated behavioral health/affordable housing/homeless reduction program</u>	<u>Finalize subcontract, hire staff, develop referring processes with partner organization, develop MOUs, intake forms, care plan forms, data tracking tools</u>	<u>Staff hired, project design established</u>	<u>N/A</u>	<u>N/A</u>	<u>9/1/16</u>	<u>Program Coordinator, public health nurses, Housing Outreach/Stabilization Coordinator, and mental health professional hired; intake and care plan forms developed; Nightingale Notes selected as electronic medical record;</u>				
	<u>Team receives referrals from partner agencies; care coordination conferences established; outreach, crisis response, care coordination activities begin; baseline data collected for individual participants</u>	<u>Individual baseline data established per care plans</u>	<u>N/A</u>	<u>N/A</u>	<u>12/31/16</u>	<u>Referrals of high utilizers made to Kitsap Connect by partner agencies; staff conducted baseline assessment for each eligible referral using the Vulnerability Assessment Tool; additional baseline data on health, ED usage, housing, etc</u>				

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						collected and input into EMR				
	Ongoing outreach, crisis response and care coordination activities; individual-level data behavioral and satisfaction outcomes tracked and recorded;	50 highly vulnerable, costly clients with intensive crisis response and care coordination services				By June 2016, 26 clients participated in Kitsap Connect and received intensive care coordination and referral services. 79% of these had complex/chronic medical needs, 58% had chemical dependency & mental illness;	12/31/17			
		50% of enrolled clients remain engaged in the program and make progress on their tailored care plan					12/31/17			
		75% of clients report moderate to high level of satisfaction with program as measured by a patient satisfaction survey					12/31/17			
		75% of clients decrease use of costly services					12/31/17			

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		compared to their baseline and according to their care plan.								
		Reduce calls by 30% from baseline. Of inappropriate or high emergency department utilizers, reduce Ed admits by 15% from baseline					12/31/17			
	Advisory Committee established and meets 2-4 times.	Advisory Committee meets 2-4 times per year.				Advisory committee established and met May 2017	12/31/17			
	Partnership survey administered; data analyzed	90% of agencies participating in care conference and the Advisory Committee will report improved collaboration via a systems assessment survey					12/31/17			

AFFORDABLE HOUSING: Increase affordable housing and make homelessness a one-time brief event.

Responsible Parties: KPHD, KMHS, Kitsap County Human Services, Kitsap Community Resources, Harrison Medical Center.

Health Indicator:	Baseline	Year1	Year2	Year3	Year4	Year5
Households spending more than 30% of income on housing (Source: American Community Survey)	2014 CHA 39% (2012)	2015 35% (2013)	2016 34% (2014)	2017 31% (2015)		
Rate of individuals receiving services from Kitsap homeless programs (rate per 1,000 Kitsap County residents) (Source: Housing Management Information System)	31 per 1,000 (2013)	19 per 1,000 (2014)	18 per 1,000 (2015)	17 per 1,000 (2016)		

Objective	Strategies	Measurement	Target Date	Year 1	Target Date	Year 2	Target Date	Year 3	EBP	Policy Change
Identify opportunities to increase affordable housing opportunities in Kitsap County	Convene housing sector leaders to collectively identify and prioritize affordable housing gaps and potential solutions	Convene at least 5 housing sector leaders by 3/1/15 Establish priorities by 6/30/15	3/1/15	Housing Kitsap, Bremerton Housing Authority, Housing Solutions, Benedict House, Kitsap Mental Health and Kitsap County Housing met to identify affordable housing gaps and assets on 4/20/15 & 5/18/15 Priority opportunities identified as: Improving housing placement options for youth aging out of foster care, inmates being released from	N/A	N/A		N/A		

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				prison, and chronically ill hospitalized persons Top priority identified as: need for medical respite care for persons discharged from hospital into homelessness					
	Establish baseline assessment of top priority opportunity	Convene Hospital Case Manager and housing sector leaders to gather information data on hospital discharge in to homelessness by 9/1/15 Develop baseline data by 3/1/16 9/30/16	9/1/15	Meeting convened on 7/27/15	9/30/16				
	Identify potential solutions to housing placement of persons discharged from hospital	Visit respite care medical models in King County as potential solution by 12/31/15 3/31/16	N/A	N/A	3/31/16	Visit to Jefferson Terrace and Union Gospel Mission respite programs conducted on by team of 7 people from working group (2 KPHD, 1 KMHS, 1 Housing Kitsap, 1 BHA, 1 Housing Solutions Center, 1 KC Homelessness and			

Commented [KE3]: Modified d/t unanticipated emerging priority for working group around high utilizers

						Housing Program) on 3/25/16				
	Identify funding opportunities for top housing priorities by 6/30/16	Discuss funding potential with KCHP Sponsor Group (Harrison Medical Center, United Way, and Kitsap Community Foundation)	N/A	N/A	2/8/16	Discussed funding opportunities with KCHP Sponsor Group – Jeanelle Rasmussen agreed to meet with David Schultz of HMC to follow up for potential hospital support of project				
	Identify site and clinical partners for pilot medical respite program	1-2 sites identified; 1-2 clinical partners identified	N/A	N/A	N/A	N/A	6/30/17	Benedict House identified as potential pilot site; Housing Kitsap proposal to develop new site for 5-bed medical respite facility; Peninsula Community Resources and Harrison Health Partners identified as potential clinical partners		

PREVENT/REDUCE OBESITY: Make it easy for all residents to be physically active and ensure all residents have healthier food options.

Responsible Parties: KPHD, Harrison Medical Center, Schools

Health Indicator:	Baseline 2014CHA	Year1 2015	Year2 2016	Year3 2017	Year4	Year5
Youth (grade 8) report engaging in 1 or more hours of physical activity five or more days per week (Source: Healthy Youth Survey)	62% (2012)	64% (2014)	n/a	58% (2016)		
Adults report engaging in 1 or more hours of physical activity on average each day per week (Source: BRFSS)	n/a	38% (2013)	n/a	41% (2015)		
Youth (grade 8) report eating 5 or more fruits/vegetables daily (Source: Healthy Youth Survey)	74.29% (2012)	76.24% (2014)	n/a	22% (2016)		

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Commented [KS4]: Incorrect % was reported, changed to be the % eating 5+ to match indicator wording.

Objective	Strategies	Measurement	Target Date	Year 1 (2015)	Target Date	Year 2 (2016)	Target Date	Year 3 (2017)	EBP	Policy Change
Promote Healthy Eating/Active Living (HEAL) among low-income children	Partner with Harrison Medical Center and local elementary schools to implement a HEAL project utilizing pedometers	# steps taken (pre/post-test)	June 1, 2015 6/1/15	Implemented a HEAL pedometer program at 3 Naval Elementary School classrooms for 67 kids. Students tracked steps on average 3.5 weeks (5 week program). Total steps for students: week 1: 6377; week 2: 6011; week 3: 6436; week 4: 5722; week 5: 5920. Students increased fruit/vegetable intake 2.6 to 3.2 average servings. More students reported limiting to 2 hours or less of daily screen time.	N/A	N/A	N/A			

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				Students reported drinking fewer sugar-sweetened beverages per day (0.9 to 0.7).						
	Expand HEAL pedometer program to addition low-income schools	# schools introduced to program	12/31/15	<p>Implemented a HEAL pedometer program at <u>2</u> South Colby Elementary School <u>classrooms</u> for 51 kids.</p> <p>Students tracked steps on average 5.2 weeks (6 week program). Total steps for students: week 1: 5879; week 2: 6390; week 3: 6174; week 4: 5130; week 5: 6310; week 6: 4338.</p> <p>Students increased fruit/vegetable intake 2.6 to 2.9 average servings. More students reported limiting to 2 hours or less of daily screen time.</p> <p>Students reported drinking fewer sugar-sweetened beverages per day (1.1 to 0.8)</p>	June 2016	Implement a HEAL pedometer program at West Hills Elementary Schools.				
	Develop a HEAL resource guide for early childcare settings	Completion of guide; number of trainings conducted with early learning educators/care takers	N/A	N/A	Dec 12/31/16 6	Resource guide completed; trained a total of three agencies (OESD, KCR, Suquamish Tribe Early Learning Center) with over 100 teachers and staff combined covering all of the Head Start.				

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						Early Headstart classrooms in Kitsap. All of the agencies implement the guide; partner agencies meet together quarterly to discuss best practices and new ideas				
	Use NEAR research to inform HEAL coalition strategies	Formal affiliation established between HEAL Coalition and Kitsap Strong	N/A	N/A	N/A	N/A	6/30/17	HEAL Coalition subcontracted by Kitsap Strong to develop HEAL strategies that are trauma-informed and founded on NEAR science principles		

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