

Pacific County Health and Human Services
**Community Health Improvement
Plan**

2023-2024



Public Health & Human Services

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Executive Summary

This Community Health Improvement Plan (CHIP) is an update and revision of the plan that was developed in 2019. Previously, Pacific County developed a CHIP that was scheduled to begin early 2020. However, due to the emergency needs of the COVID-19 pandemic at the same time, the CHIP was ultimately put on hold.

This current CHIP contains input from 100 individuals in face-to-face meetings and electronic surveying through a Community Health Assessment (CHA). The Health and Human Services Advisory Board and its subcommittees are responsible for setting the priorities and presenting to the Pacific County Board of Health for their approval and adoption. Priorities for action in the coming years, 2023 to 2024, will include:

Behavioral Health

- Improve the ratio of Pacific County mental health providers to residents from 1:240 to 1:230
- Improve Designated Crisis Responder (DCR) response times by 50%

Dental

- Improve the ratio of Pacific County dental providers to residents from 1:2870 to 1:2200

Developmental Disabilities

- Implement Developmental Disabilities (DD) Transition programs in Pacific County Schools
- Increase opportunities for community connections and support programs for individuals and families with developmental disabilities.

Health Care

- Decrease the number of individuals who are part of underserved populations reporting delayed medical care due to cost by 5%.

Health Equity

- Increase the number of applications to state and federal programs from qualifying individuals in underserved populations.

Housing

- Quickly identify and engage people experiencing homelessness
- Prioritizing those experiencing homelessness and/or greatest need
- Improve the efficiency and effectiveness of our homeless crisis response system
- Assess the impact of local plans on households becoming housed and the number of those left unsheltered
- Address racial disparities among individuals facing homelessness
- Increase housing stock to provide for those in the homeless crisis response system
- Improve financial and supportive services to increase housing placements

Introduction

PCHHS's adopted their latest CHIP in 2020. The following were included as goals in the 2020 plan:

- ❖ Improve access to physical, behavioral, and dental health care services
- ❖ Improved housing opportunities
- ❖ Improved transportation options

The previous 2020 CHIP included these priority actions:

1. Establishment of at least one school-based health center
2. Recruitment of 2 additional primary care providers at both Ocean Beach Hospital and Willapa Harbor Hospital
3. Exploration of telehealth options among hospitals and Federally Qualified Health Centers
4. Recruit and retain at least two additional dentists to be an ABCD providers; 1 for North county and 1 for South county
5. Coordinated Entry (CE) workgroup development to address gaps between state and federal CE services and data collection to prioritize individuals with greatest need
6. Decrease barriers for "Dial-A-Ride" services and improve support for individuals without access to public transportation

Development Process

In early 2019, the Cascade Pacific Action Alliance (CPAA) developed funding and support for each Member County to create Local Forums. Each county hosts a local forum, which identifies local health priorities, adopts shared regional priorities, and implements local action.. Key stakeholders from the local community forums communicate the local work and preferences to the regional level at meetings of both the CPAA Council and the Support Team. In Pacific County, the Health Subcommittee of the Health and Human Services Advisory Board was slated to act as the local forum. However, due to the emergency response needs of the COVID-19 pandemic, efforts for a new CHIP beginning in 2020 were postponed.

Shifting from pandemic emergency response to a new normal was a necessary step to continue improving health outcomes in Pacific County. The efforts for developing the CHA were spearheaded by Epidemiologist, Connor Montgomery, with support from PCHHS staff and direct input from director Katie Lindstrom. An electronic CHA survey was developed and distributed to collect information on priorities. Results of survey responses were summarized and presented to all subcommittees to select main priorities for the upcoming CHIP. In addition, considerations for other Pacific County health entities priorities were included in the presentation.. An Action Plan was developed in accordance with each PCHHS Subcommittee. The various subcommittees created goals and activities and selected measures of success for the main priorities. Each Subcommittee or individual was assigned responsibility to track each goal. Finally, the CHIP was presented to the Health & Human Services Advisory Board for adoption.

The complete CHIP was presented to the Pacific County Board of County Commissioners / Board of Health for final approval and adoption. Other agencies, including hospital and community clinic boards were informed and invited to approve and adopt this Community Health Action Plan. Below are other entities' CHIPs; in an effort to increase collaboration, we have scheduled our next CHIP plan to be revised in collaboration with those below in 2024.

Other Pacific County Community Health Plans

| Agency | Priority #1 | Priority #2 | Priority #3 |
|----------------------------|--|---------------------------------|-----------------------------------|
| Ocean Beach Hospital | Access to primary care, care coordination, and chronic disease | Access to specialty care | Mental health and substance abuse |
| Willapa Harbor Hospital | Access to primary care | Access to specialty care | Transportation |
| Valley View Medical (2019) | Access to primary care | Access to behavioral healthcare | Access to specialty care |

Action Plan

BEHAVIORAL HEALTH

Problem #1: Too many people report that they are not receiving the behavioral healthcare they need

| Goal: By December 2024, improve the ratio of Pacific County mental health providers to residents from 1:240 to 1:230 (Source: RWJ) | | | | |
|---|---|----------|---|--|
| Strategy 1: Reduce stigma associated with behavioral health issues and treatment | | | | |
| Activity | Who's responsible? | When? | Measures of success | |
| Provide trainings to providers, law enforcement, elected officials, schools, and community members to reduce stigma | BH Subcommittee, Abigail Bentley, Community Conversations | Q2 2023 | Surveys show improved attitudes among at least 50% of participants. At least 25 residents participate | |
| Update BH treatment options in Pacific County Resource guide. Distribute to the public (paper copies, website, social media, targeted outreach) | Emily Singarath, WBH, ESD 113, CIHS provide updated info | Biannual | Twice in a calendar year, BH resource guide is updated and distributed | |
| Promote/provide education opportunities for providers (i.e. Mental Health First Aid, ACES 101, Trauma Informed Care, Motivational Interviewing) | State Initiatives, MCO, HCA, PCVU, Dave Cundiff, Maryanne Murray, WHH (Chelsea), Dr. Krager, Carole | Biannual | Twice in a calendar year, trainings are provided or shared | |
| Providing cultural humility trainings within Pacific County for the various communities | Community Conversations, PCVU, PCIS, and Opioid Summit Group | Biannual | Twice in a calendar year, trainings are provided | |
| Strategy 2: Increase telehealth capabilities and accessibility for behavioral health care | | | | |
| Target common community gathering areas for telehealth options (schools, library, etc.) | Wellspring and BH Subcommittee | Ongoing | Explore partnerships with regional libraries, schools, and other community hubs | |
| Facilitate opportunities for telehealth trainings (cross-agency) and best practices for rural communities and specific populations | HCA, SAMHSA, BH Subcommittee, Health Officers | Biannual | Twice in a calendar year, BH resource guide is updated with current telehealth trainings and resources for distribution | |
| Provide application assistance to federal free phone, WIFI, and hardware programs. Provide education at COC mtgs for case managers re. programs | Outreach, PCIS, CCAP, PCHHS, PPR, FRCs, other case managers | Ongoing | Education for providers at COC meetings, 2 events/year for federal phone and WIFI program application assistance | |
| Support local expansion of internet services in areas currently without service | Jessica Verboomen, elected officials, HHSAB advocate for improved services | Ongoing | Provide education regarding internet/fiber expansion legislation to HHSAB and elected officials | |

| Strategy 3: Increase behavioral health staff retention and recruitment | | | | |
|---|---|---------|---|--|
| Activity | Who's responsible? | When? | Measures of success | |
| Provide professional development and mentorship to current staff to increase internal promotion of BH staff | BH Subcommittee, Local Providers, Outside Agency Supervisors | Q2 2024 | Provide support for local agency recruitment policy and procedures | |
| Facilitate improved social supports and network within the community (Interagency peer networking) | BH committee, Community Hubs (Library, local business), Providers | Ongoing | Advocate for basic social support meetings in community hubs | |
| Advocate for increased financial incentives for MH providers to work in rural areas | HHSAB, Elected officials | Ongoing | Advocacy occurs through HHSAB | |
| Ensure local providers use financial incentives/loan repayment programs and salary transparency in provider recruitment efforts | Abigail Bentley, WBH, CIHS, ESD 113 use materials in recruitments | Ongoing | Financial incentive information used in 100% of all recruitments | |
| Support expansion of workforce housing for behavioral health professionals | Darian Johnson, Economic Development Council, WBH, CIHS, ESD 113 | Ongoing | Establish one dedicated housing option for BH providers each year | |
| Strategy 4: Increase behavioral health services for those involved in the criminal justice system | | | | |
| Provide education to attorneys, court staff & drug court panel members to increase understanding of BH system benefits to those involved in the criminal justice system | Jessica Verboomen, Kelsey Staats, WBH, CIHS | Ongoing | At least one training per calendar year | |
| Provide therapeutic court programs including: Felony Drug Court, Mental Health Diversion, Family Therapeutic Court | Jessica Verboomen, Kelsey Staats, Superior Court, Prosecutor, TX Agencies | Ongoing | Expansion of therapeutic courts to adapt to new legislation and law changes, as necessary | |
| Provide mental health & SUD assessments, TX, & reentry planning/aftercare for individuals who are involved in the Criminal Justice system. | Dawn Wright, Jessica Verboomen, PCSO, TX Agencies | Ongoing | Increase the ratio of eligible participants and the number of participants engaged | |
| Strategy 5: Provide school based behavioral healthcare to students in K-12 schools | | | | |
| Implement SUD prevention/intervention/treatment services at NGRVSD, OBSD, SBSD, WVSD, and RSD | PC Schools, ESD-113 | Ongoing | Implementation of services for at least two school districts | |
| Implement family resource and student assistance programs at NGRVSD, OBSD, SBSD, WVSD, and RSD | PC Schools, ESD-113 | Ongoing | Implementation of services for at least two school districts | |
| Partner with local behavioral health agencies and schools to ensure school based mental health services are available in each district. | BH Subcommittee, Local Providers, Community Hubs (Library, school) | Ongoing | Establish consistent and cohesive school based mental health services for at least two school districts | |

Problem #2: The mental health crisis system is not meeting the needs of citizens, healthcare, or law enforcement

| Goal: By December 2024, decrease DCR response times by 50% (Currently 314 min avg.) | | | | |
|--|---|--------------|--|--|
| Strategy 1: Improve communication and collaboration between crisis response partners (DCR, Mobile Crisis, Emergency Departments, and Law enforcement) | | | | |
| Activity | Who's responsible? | When? | Measures of success | |
| Convene monthly crisis partner meetings to identify gaps in service and develop plans to address concerns. | Abigail Bentley, Jessica Verboom, Crisis Partners, PCVU | Monthly | Meetings occur monthly. Partners report increased understanding of crisis system protocols | |
| Provide education on how to access the Pacific County crisis line, functions of various partners (DCR vs Mobile Crisis) to law enforcement, hospital staff, and community. | Abigail Bentley, Jessica Verboom, BH Subcommittee | Ongoing | Provider education happens quarterly, updated resource guide annually, community education via social media 2x month | |
| Advocate for locally based crisis responders (currently regional) | BH Subcommittee, HHSAB, BOCC | Ongoing | At least one report of progress per calendar year to both HHSAB & BOCC | |
| Strategy 2: Improve quality and coordination of care between crisis, inpatient, and outpatient mental health care. | | | | |
| Streamline process for referral systems (crisis to inpatient/outpatient, inpatient to community). | BH Subcommittee, Coordination of Care (CoC) | Annual | Reviewing and utilizing CoC information to identify gaps in referrals to reduce redundancy annually | |
| Improved information sharing with changes in legislature and funding | BH Subcommittee, Jessica Verboom, Verboom | Annual | Increasing HHSAB and Commissioner awareness about pertinent changes in PC community | |
| General education and outreach for clients' and their Apple Health insurance options | State Initiatives, MCO, HCA, PCVU | Biannual | Twice in a calendar year, trainings are provided | |

DENTAL CARE

Problem #1: There is a lack of access to baby, child, and adult dental care

| Goal: By December 2024, improve the ratio of Pacific County dental providers to residents from 1:2870 to 1:2200 (Source: RWJ) | | | | |
|---|--|-----------|--|--|
| Strategy 1: Implement preventative care opportunities across Pacific County | | | | |
| Activity | Who's responsible? | When? | Measures of success | |
| Partner with organizations (i.e. dental schools,, military), that provide visiting dental providers to set up temporary clinics | Emily Singharath, Dr. Grant Abernathy | Ongoing | Establish at least one partnership to facilitate temporary clinics | |
| School based fluoride cleaning, screening, & sealant programs | Health Subcommittee | Biannual | Schedule at least one school-based dental clinic for 2025 | |
| Facilitate SmileMobile visits per year for underserved populations (PCC, Schools, PCIS, Shoalwater) | Health Subcommittee, Emily Singharath, Dr. Abernathy | Ongoing | Schedule mobile clinics (Totals: 2 visits in 2023 and 3 visits in 2024) | |
| Strategy 2: Increase number of dental providers in Pacific County | | | | |
| Educate dental providers regarding loan relief for rural communities to assist with recruitment of new providers | Dr. Abernathy, Emily, Health Subcommittee | Annual | Development of resources materials and distribution to providers | |
| Explore recruitment options from Washington Health Corps | Dr. Grant Abernathy, Emily Singharath | Ongoing | Recruitment presentation to Health Subcommittee | |
| Increase number of dental providers who accept medicaid as part of Access to Baby and Child Dentistry (ABCD) | Emily Singharath | Quarterly | Outreach to providers quarterly, one additional provider by 12/24 | |
| Strategy 3: Increase community knowledge of best practice dental care and local resources | | | | |
| Create and distribute education/awareness resource guide(s) of best practices for child dentistry for families. | Emily Singharath, Health Subcommittee | Annual | Develop child dentistry resource guide, distribute to 50 WIC families per year | |
| Create and share dental education posts to social media | Emily Singharath | Monthly | 2 posts per month | |
| Gather and distribute oral health supplies at semi-annual intervals. Will be distributed with education materials | Health Subcommittee | Biannual | Collection and distribution of supplies every 6 months | |
| Provide dental care information, toothbrushes/floss, at community health fairs and community connect events | Emily Singharath | Ongoing | Distribution of collected supplies and information at each event | |
| Establish teledentistry for remote screening options | Emily Singharath, Dr.Abernathy, Health Subcommittee | Ongoing | Create teledentistry options with at least two providers | |

DEVELOPMENTAL DISABILITIES

Problem #1: Individuals and families lack supports as they navigate transitions throughout the lifespan

| Goal: By December 2024, implement transition programs in at least three Pacific County schools. At least 6 are knowledgeable of DD transitional guidelines. | | | |
|--|---|---------------------------|---|
| Strategy 1: Education for DD individuals and their families/caregivers about programs/resources available to them following the school transition to adulthood | | | |
| Activity | Who's responsible? | When? | Measures of success |
| Development of transitional guidelines for Pacific County school districts | Princess Klus and DD Subcommittee | Start of 2023 school year | Development and distribution of transition guide |
| Development of specific resource/planning guide for Pacific County individuals and family units | Princess Klus and DD Subcommittee | Start of 2024 school year | Development and distribution of resource guide |
| Host resource support/education for school district special education departments | CYSHCN & Special Ed Directors of School Districts | Annual | Create 2 opportunities per school year for resource support |
| Strategy 2: Improve communication and decrease resource gaps between transitional periods | | | |
| Establishing a full county roster of families with DD transitional needs | DDA, PC Schools, PCHHS | Annual | Creation of roster for PC residents |
| Host education opportunities for individual family units and training sessions for current stakeholders to give generalized guidance | PC Schools, DD Subcommittee | Q2 2024 | Biannual of education opportunities and training sessions |
| Explore future DVR and PC partnership opportunities | PCVU, SMART, WBH, PAVE, DDA, CCAP, DDC, FRC | Q4 2024 | Define incentives, pay scales, and other financial details |
| Strategy 3: Increase community connections & support for and between families and individuals with developmental disabilities | | | |
| Hire DD coordinator to support individuals and families with developmental disabilities | DD Subcommittee, PCHHS, Jessica Verboomen | Q2 2023 | Position funded by Q2 and supported as 1.0 FTE thereafter |
| Develop and implement monthly community integrated social/recreational program for individuals and their families | DDA, PCHHS, CCAP | Ongoing | Attendance of at least 2 individuals and/or family units at events. |
| Expand community inclusion to all individuals who are eligible and and who indicate an interest in the service | DD Subcommittee, CCAP | Ongoing | A minimum of 1 individual will enroll in Community Inclusion by the of Q4 |

HEALTH CARE

Problem #1: Too many individuals from historically underserved populations report delaying medical care due to cost and/or access

Goal: By December 2024, decrease the percentage of individuals who are part of underserved populations reporting delayed medical care due to cost by 5% (Baseline: Hispanic 19%, Native American 17%, Pacific Islander 14%, Multi race 15%)
Source: 2016-2020 BRFSS

| Strategy 1: Increase Medicaid enrollments among historically underserved populations. | | | | |
|--|---|----------|--|--|
| Activity | Who's responsible? | When? | Measures of success | |
| Support staff training at "by and for" organizations to develop additional "in-person assisters" for direct outreach enrollment services | Health Subcommittee, Shoalwater Clinic, PCIS, PPR, PCVU | Ongoing | Development of at least 1 additional "in-person assister" at each organization | |
| Provide regular "in-person assister" trainings and support for outreach workers and case managers at social service agencies and medical clinics | Shoalwater Clinic, PCIS, PPR, PCVU | Biannual | Staff training occurs biannually | |
| Conduct targeted outreach to underserved populations and provide Medicaid application assistance | Shoalwater Clinic, PCIS, PPR, PCVU | Ongoing | Hosting 1-2 events per year dedicated to Medicaid registration | |
| Increase enrollments in Family Planning Only medicaid for confidential teens and others not eligible for medicaid | PCHHS SRHP Staff | Ongoing | 2 PCHHS staff trained in enrollment process by Dec 2023, individuals enrolled as needed thereafter | |
| Strategy 2: Establish at least one "School-Based Health Center" (SBHC) by 2024. | | | | |
| Assess need, resources, and readiness among 6 local school districts. | Health Subcommittee, HHSAB | Q3 2023 | Engagement with school districts to gauge need and interest | |
| Identify and partner with one district, healthcare provider, and behavioral healthcare provider | Health Subcommittee, HHSAB | Q4 2023 | Identification of school district that would like to host a SBHC | |
| Apply for grants and develop a funding plan to support a SBHC in at least one district. | Health Subcommittee, HHSAB | Ongoing | Application of at least one grant to support SBHC development | |

| | | | | |
|---|---|--------------|---|--|
| Goal: By December 2024, increase identification, screening, and referrals to treatment for populations at high-risk for communicable diseases (CD) (Baseline: Appointment only currently.) | | | | |
| Strategy 1: Improve communicable disease data quality, gathering, and reporting. | | | | |
| Activity | Who's responsible? | When? | Measures of success | |
| Provide in person education and written materials to providers regarding required CD reporting and process (medical for all CD and EMS for Opioid & Suicide) | PHN, Communications Staff, Dr Krager, Abigail Bentley | Quarterly | All providers (2 hospitals and 2 clinics) provided education annually | |
| Improve data accessibility for PCHHS assessment staff | Connor Montgomery, PHNs, Lori Ashley | Ongoing | PCHHS assessment staff has access to all relevant health care provider data related to CD | |
| Ensure all relevant PCHHS staff are trained and regularly completing required reporting in WDRS, PHIMs and other state systems | Lori Ashley | Annual | All PHNs, LPNs receive annual training. Review for compliance annually | |
| Strategy 2: Provide increased opportunities for testing/screening clinics to populations at high risk for Hep C (IV drug users and individuals over age 45). | | | | |
| Partner with Behavioral Health & Housing partners to conduct outreach and advertise clinics for high risk populations | Darian Johnson, Jessica Verboommen, Lori Ashley | Ongoing | Establish partnerships with local Behavioral Health & Housing entities (at least 2 organizations) | |
| Establish partnerships with surrounding counties to coordinate screening and reporting based on need | Dr. Krager, Connor Montgomery, Abigail Bentley | Ongoing | Creation of reporting network between SW Washington Counties under the supervision of Dr. Krager | |
| Establish and provide weekly walk in screening clinics and referrals as needed | Lori Ashley, PHNs, Emily Singharath | Quarterly | Organize and advertise Hep C screening clinics with options for North and South county residents | |

HEALTH EQUITY

Problem #1: Certain populations in Pacific County are disproportionately underserved by key government programs (Medicaid, DSHS, and Veterans benefits)

| Goal: <i>By December 2024, increase the number of applications from individuals in underserved populations in Pacific County</i> | | | |
|--|--|--------------|--|
| Strategy 1: Improve the tracking, quality, and use of demographic data to encourage data driven decisions, enhance evaluation of services, and inform resource distribution & targeted outreach | | | |
| Activity | Who's responsible? | When? | Measures of success |
| Review current program and service utilization where demographics are available, and identify where they are not available. | Connor Montgomery, PC Subcommittees, HHSAB | Ongoing | Collection of data and understanding of where gaps reside |
| Create a comprehensive list of current utilization and gaps to track progress | Connor Montgomery | Ongoing | Development of system for tracking progress across Pacific County |
| Maintain tracking progress through annual reporting | Connor Montgomery, PC Subcommittee Managers | Annual | Annual review completed and presented to BOCC |
| Strategy 2: Increase Medicaid/Apple Health and DSHS program applications for historically underserved populations (American Indian/Native Alaskan by 5%, Hispanic by 5%) | | | |
| Provide Medicaid & DSHS application assistance to individuals and at community events targeting underserved populations. | Health Subcommittee, Shoalwater, PCVU, PCIS, PCHS, Valleyview, WBH | Biannual | Two outreach events per year, support 2 additional provider to implement application assistance services |
| Provide training for additional "in person assister staff and DSHS navigators for staff at "by and for" organizations and other providers | DSHS, SeaMar, PCHHS, PCVU, PCIS, Providers | Biannual | Two additional in person assisters established each calendar year |
| Strategy 3: Increase services, support, and applications for assistance for Veterans in Pacific County | | | |
| Fund VSO position to provide services for Veterans | BH Committee, PCHHS, Jessica Verboom | Q1 2023 | Position is funded at .50FTE through end of 2024, and 1.0 FTE thereafter |
| Creation of individual and/or event outreach opportunities | Subcommittees, FRCs, PCIS, PCVU, PPR, etc. | Ongoing | Exploration of outreach opportunities within each Subcommittee's area |
| Developing sustainability plan for outreach efforts with partners PCIS (Hispanic/Latinx) PCVU (indigenous/LGBTQIAS+), PPR (low income/homeless) | PC Subcommittees | Ongoing | Revising and reviewing strategies from initial outreach events from 2023-2024 with Pacific County partners |

HOUSING (5-Year Plan, Updated 11/2022)

Objective #1: Quickly identify and engage people experiencing homelessness under the state definition, and all unaccompanied youth under any federal definition, through outreach and coordination between every system that encounters people experiencing homelessness.

Milestone for Objective #1: HMIS Enrollments in CE increase by 10% by 2024

| Strategy 1: Expand partnerships and coordination to ensure efficient identification and referral of individuals and families experiencing homelessness. | | | | | | | |
|---|--|---------------------------|---|----------------------------------|-------------------------------|------------------------------|----------------------------|
| Activity | Who's responsible? | By When? | Measures of success | Quarter 1 January- March 2023 | Quarter 2 April- June 2023 | Quarter 3 July- Sept 2023 | Quarter 4 Oct- Dec 2023 |
| Continue the Coordination of Care meetings to case conference shared clients with other providers | COC Group | Ongoing, monthly | COC meetings are held monthly through 2023 | | | | |
| Universal ROI implemented into Coordinate Entry system | PCHHS | February 2023 | Universal ROI is added as a field in HMIS client profiles | | | | |
| Increase capacity of the delivery system and coordinated entry by creating multiple access doors to include at least 2 new access doors | The Joint Grays Harbor and Pacific County Coordinated Entry (CE) workgroup | February 2023 | Add PCHHS and CSN to the general CE system to allow them to provide CE assessments for clients | | | | |
| Strategy 2: Ensure Compliance with Coordinated Entry Guidelines | | | | | | | |
| Activity | Who's responsible? | By When? | Measures of success | Quarter 1 January- March 2023 | Quarter 2 April- June 2023 | Quarter 3 July- Sept 2023 | Quarter 4 Oct- Dec 2023 |
| Continue the Joint Grays Harbor and Pacific County Coordinated Entry (CE) workgroup to address current issues related to coordinated entry, and ensure that the Coordinated Entry system complies with state and federal coordinated entry data collection requirements | PCHHS, CSN, CCAP, GHCHHS, and DV Center | Ongoing | The Joint Grays Harbor and Pacific County Coordinated Entry (CE) Workgroup meetings held monthly through 2023 | | | | |
| Implement updated CE guidelines that incorporate Commerce's CE updates adopted in Oct. 2021 | The Joint Grays Harbor and Pacific County Coordinated Entry (CE) workgroup | January 2023 | Fully updated CE guidelines adopted by CE system | | | | |
| Improve HMIS Data Quality (quarterly review of data quality; all county contract documents to require data entry compliance) | All housing providers that utilize HMIS, Housing Subcommittee | Ongoing review, quarterly | Analyze Data Quality dashboard published by DOC quarterly at Homeless Housing Subcommittee meetings and maintain a 25% or less data error rate | | | | |
| Strategy 3: Diversify interventions available for those experiencing homelessness | | | | | | | |
| Activity | Who's responsible? | By When? | Measures of success | Quarter 1 January- March 2023 | Quarter 2 April- June 2023 | Quarter 3 July- Sept 2023 | Quarter 4 Oct- Dec 2023 |
| Search for and if available, try to apply for more funding sources that allow for diversion, street outreach, and emergency shelter/housing resources | Homeless Housing Subcommittee | March 2023 | Create inventory of available local, state, and federal funding available for diversion, street outreach, and emergency shelter/housing resources | | | | |
| Continue funding for YHDP programs to engage youth and unaccompanied minors experiencing homelessness in order to get a better understanding of youth homelessness in Pacific County | PCHHS | October 2023 | Execute YHDP RRR and SSD contracts for FY 2023 - 2024 | | | | |
| Assist in implementation of the new Apple Health and Homes program in Pacific County | Homeless Housing Subcommittee | February 2023 | Invite Commerce representatives to share out at Homeless Housing Subcommittee meeting | | | | |
| Strategy 4: Create liaison positions at key public institutions: jails, schools, etc. | | | | | | | |
| Activity | Who's responsible? | By When? | Measures of success | Quarter 1 January- March 2023 | Quarter 2 April- June 2023 | Quarter 3 July- Sept 2023 | Quarter 4 Oct- Dec 2023 |
| Continue to support Family Resource Coordinators in local schools to help identify homeless youth and families | BH Subcommittee, Local School Districts, ESD 113 | Ongoing | Maintain funding for Family Resource Coordinators in (FRC) at least 4 schools within Pacific County. | | | | |
| Continue to support Jail Reentry Liaison to help identify homeless individuals involved in the jail system | BH Subcommittee & Sheriff's office | Ongoing | Maintain funding for Jail Reentry Liaison employed by PCHHS | | | | |
| Explore opportunities to add a liaison for homeless individuals involved in BH services | BH Subcommittee & Homeless Housing Subcommittee | Aug. 2023 | Make recommendations to BH Subcommittee meeting of funding available to support a BH Liaison position | | | | |

Objective #2: Prioritize housing for people with the greatest need.

Milestone for Objective #2: Pacific County's homeless system prioritization is at least 45% by Nov. 2023 *taken from Commerce County Report Card report

| Strategy 1: Ensure prioritization for housing programs are effective to serving those with greatest need | | | | | | |
|--|--|------------------|--|----------------------------------|-------------------------------|------------------------------|
| Activity | Who's responsible? | by When? | Measures of success | Quarter 1 January- March 2023 | Quarter 2 April- June 2023 | Quarter 3 July- Sept 2023 |
| Local Policies and Procedures for prioritization are annually updated | Homeless Housing Subcommittee and the Joint Grays Harbor and Pacific County Coordinated Entry (CE) workgroup | January 2023 | Update is submitted & prioritization tools edited to reflect policies | | | |
| Continue a Youth Centered Coordinated Entry system (13- 18 years of age) to help prioritize youth into the limited programs available. | The Joint Grays Harbor and Pacific County Coordinated Entry (CE) workgroup | Ongoing | All CE access points are utilizing the YVA Prioritization Tool | | | |
| Create and maintain a By Name List to ensure individuals with highest need are being placed into open program slots | The Joint Grays Harbor and Pacific County Coordinated Entry (CE) workgroup | Ongoing, monthly | All CE access points are working in a shared priority pool (By Name List) and list is assessed for next available program placements | | | |
| Strategy 2: Implement more opportunities for Permanent Supportive Housing to serve those with highest need | | | | | | |
| Activity | Who's responsible? | by When? | Measures of success | Quarter 1 January- March 2023 | Quarter 2 April- June 2023 | Quarter 3 July- Sept 2023 |
| Continue funding for PSH projects within Pacific County | POCHS | Oct 2023 | Execute HUD PSH contracts for FY 2023 - 2024 | | | |
| Support the development of new units for the use of Apple Health and Homes participants | Commerce | May 2023 | Commerce releases applications for capital funding for Apple Health and Homes | | | |
| Improve relationships with EMS, hospitals, BH providers, etc. to increase referrals to PSH program | POCHS & COC group | Ongoing | Have one representative from EMS, hospitals, and a BH provider attend the monthly COC meetings | | | |

Objective #3: Operate an effective and efficient homeless crisis response system that swiftly moves people into stable permanent housing

Milestone for Objective #3. Decrease length of time homelessness from 303 days to 250 days by 2024 *taken from Commerce County Report Card report

| Strategy 1: Improve the local street outreach to increase connection to CE | | | | | | |
|---|--|-----------------------------------|--|----------------------------------|-------------------------------|------------------------------|
| Activity | Who's responsible? | by When? | Measures of success | Quarter 1 January- March 2023 | Quarter 2 April- June 2023 | Quarter 3 July- Sept 2023 |
| Coordinate annual Project Community Connect event to provide resources and outreach to individuals experiencing poverty | PPR, PCHHS | January 2023, annually thereafter | Annual event, serves at least 100 individuals & expanding to having similar event in North County | | | Quarter 4 Oct- Dec 2023 |
| Create avenues for CE assessments to be completed with individuals while outreach is done in the field | Outreach partners & the Joint Grays Harbor and Pacific County Coordinated Entry (CE) workgroup | January 2023 | Include CE access while completed the 2023 PIT county event | | | |
| Strategy 2: Ensure case managers are using best practices when working with clients | | | | | | |
| Activity | Who's responsible? | by When? | Measures of success | Quarter 1 January- March 2023 | Quarter 2 April- June 2023 | Quarter 3 July- Sept 2023 |
| Ensure case managers/care coordinators are creating robust housing stability plans and actively working with individuals towards the goals. | Housing Providers | Ongoing review, annually | At least 25% of individuals show improvement on the Self-sufficiency matrix | | | Quarter 4 Oct- Dec 2023 |
| Provide community-wide training for housing providers and social service partners (motivational interviewing, mental health first aid (MHFA), harm reduction, etc.). | PCHHS | December 2023 | Offer MHFA at least twice per year to service providers. Offer ACEs training at least once per year to service providers. Offer Youth Mental Health First Aid at least once per year to service providers. | | | |
| Provide training to direct service providers on best practices in homeless housing services including diversion / problem-solving conversations, street outreach, professional boundaries, etc. | Housing Providers | Ongoing review, annually | Compliance to contract training requirements are met in annual reviews | | | |

Objective #4: Assess the impact of the fully implemented local plan on the number of households housed and the number of households left unsheltered, assuming existing resources and state policies

Milestone for Objective #4 - A 15% reduction in number of households unsheltered reported in the DSHS supplemental PIT count by 2025

| Strategy 1: Fully analyze homelessness within Pacific County | | | | | | |
|---|---------------------------------------|----------------------------|--|----------------------------------|-------------------------------|------------------------------|
| Activity | Who's responsible? | by When? | Measures of success | Quarter 1 January- March 2023 | Quarter 2 April- June 2023 | Quarter 3 July- Sept 2023 |
| Conduct Housing Needs assessment and evaluate Pacific County housing continuum of care programs and services. Develop a quality improvement plan and update the 5 year plan if indicated. | PIC EDIC & Liveable Cities | June 2023 | Completed and published Housing Needs Assessment by Liveable Cities | | | |
| Collect data on leading factors to homelessness within Pacific County | Housing and Homelessness Subcommittee | July 2023 | Reach out to Commence to get assistance from their homelessness prevention team to help with Pacific County analysis | | | |
| Strategy 2: Ensure goals are being met within the local plan | | | | | | |
| Activity | Who's responsible? | by When? | Measures of success | Quarter 1 January- March 2023 | Quarter 2 April- June 2023 | Quarter 3 July- Sept 2023 |
| Complete quarterly updates to activities outlined in the local plan | Homeless Housing Subcommittee | On-going review, quarterly | Update submitted in local plan | | | |

Objective #5: Address racial disparities among people experiencing homelessness

Milestone for Objective #5- By November 2023, Pacific County's HMIS data will show a 5% increase in Native American/Alaskan Native being served who are experiencing homelessness and housing insecurity

| Strategy 1: Evaluate data to ensure equity within the homeless response system | | | | | | Quarter 1 January- March 2023 | Quarter 2 April- June 2023 | Quarter 3 July- Sept 2023 | Quarter 4 Oct- Dec 2023 |
|---|--|----------------------------|---|--|--|----------------------------------|-------------------------------|------------------------------|----------------------------|
| Activity | Who's responsible? | by When? | Measures of success | | | | | | |
| Use racial equity tools provided by Commerce to evaluate the current homeless housing response system and work to eliminate gender and racial disparities within the system. Make adjustments to service delivery as indicated. | Homeless Housing Subcommittee & Equity Subcommittee | On-going review, quarterly | Analyze Racial Equity Dashboard published by Commerce quarterly at Homeless Housing Subcommittee meetings | | | | | | |
| Use CE HMIS data to evaluate if population accessing the system reflect the proportion of individuals experiencing homelessness/housing instability | Homeless Housing Subcommittee & Equity Subcommittee | On-going review, quarterly | Analyze CE HMIS demographic report and local rates for homelessness and housing insecurity measures quarterly at Homeless Housing Subcommittee meetings | | | | | | |
| Strategy 2: Develop a plan to minimize racial disparities (especially for our Native American/Alaskan Native population) | | | | | | Quarter 1 January- March 2023 | Quarter 2 April- June 2023 | Quarter 3 July- Sept 2023 | Quarter 4 Oct- Dec 2023 |
| Activity | Who's responsible? | by When? | Measures of success | | | | | | |
| Engage with Shoalwater Bay & Chinook tribes to ensure connection/support/engagement relative to the Indigenous homeless population | Equity Subcommittee | January 2023 | Have meeting with Shoalwater Bay and Chinook tribal leadership to learn about member's needs and tribal services | | | | | | |
| Research and engage with other tribal leadership of the most prominent tribes making up our Indigenous population in Pacific County to ensure connection/support/engagement relative to the Indigenous homeless population | Equity Subcommittee | February 2023 | Have meeting with other tribal leadership representing our local Indigenous population to learn about member's needs and tribal services | | | | | | |
| Reach out to the tribal HCA liaisons to engage in conversation around helping tribal members access resources | Equity Subcommittee | March 2023 | Have meeting with HCA liaison | | | | | | |
| Connect with facilities that serve tribal members | Equity Subcommittee | April 2023 | Have meeting with Northwest Indian Health Treatment Facility and the Quinault Wellness Center | | | | | | |
| Strategy 3: Ensure the homeless response system is accessible for all races | | | | | | Quarter 1 January- March 2023 | Quarter 2 April- June 2023 | Quarter 3 July- Sept 2023 | Quarter 4 Oct- Dec 2023 |
| Activity | Who's responsible? | by When? | Measures of success | | | | | | |
| Contract directly with and prioritize funding By and For organizations; provide long term grantees with the flexibility to allow for culturally appropriate responses | PCHHS, BOCC, & Housing Partners | Dec 2023 | Contractual relationship established or expanded with at least one By and For organization | | | | | | |
| Create Equity Subcommittee focused on addressing racial disparities in the homeless service system | Health and Human Services Advisory Board | January 2023 | Establish group and hold bimonthly meetings | | | | | | |
| Assess outcomes of implementing the CE Language Access Plan | The Joint Grays Harbor and Pacific County Coordinated Entry (CE) workgroup | May 2023 | Disperse surveys to receive feedback from clients and partner agencies regarding how accessible CE is for specific racial groups | | | | | | |

Objective # 6: Increase Housing stock available to provide housing to individuals involved in the homeless crisis response system in Pacific County

Milestone for Objective #6- By December 31st, 2023, 21 units for individuals at 30% AMI or lower were added

| Strategy 1: Review all surplus property and consider developing a plan regarding redistribution of surplus property for purchase and/or rehab into affordable housing units | | | | | | |
|---|----------------------------------|---|---|---------------------------------|------------------------------|-----------------------------|
| Activity | Who's responsible? | By When? | Measures of Success | Quarter 1 January-March 2023 | Quarter 2 April-June 2023 | Quarter 3 July-Sept 2023 |
| Units County surplus property for affordable housing project | BOCC & PCHHS | March 2023 | Complete surveys needed on at least one County-owned piece of property being considered for the affordable housing project | | | Quarter 4 Oct-Dec 2023 |
| Create surplus property inventory that includes underserved homes & vacant land | PO EDC & Livable Cities | January 2023 | List of top five candidate properties identified for potential development and/or rehab | | | |
| Create a plan for next steps for identified properties once property inventory is completed | Housing Workgroup | March 2023 | Published plan reported out to Housing Workgroup and Homeless Housing Subcommittee | | | |
| Strategy 2: Maximize all local, state, and federal funding options for capital housing projects | | | | | | |
| Activity | Who's responsible? | By When? | Measures of Success | Quarter 1 January-March 2023 | Quarter 2 April-June 2023 | Quarter 3 July-Sept 2023 |
| Advocate for county to implement 2.1% funding for affordable housing development | BOCC, HHCB | May 2023 | Hold one BOCC Workshop educating the board on the available 0.1% | | | Quarter 4 Oct-Dec 2023 |
| Create inventory of available local, state, and federal funding for developers to use for affordable housing capital projects | Homeless Housing Subcommittee | March 2023 | Published list of available funding posted on PCHHS's & Pacific County website | | | |
| Explore the use of .05 funding to go towards capital housing projects | POCC & BOCC | April 2023 | At least one new housing project is submitted for BOCCs review by Spring 2023 for next disbursement of US awards | | | |
| Advocate for county to implement a 22% increase in real estate excise tax to support for affordable housing initiatives | BOCC | May 2023 | Encourage HHCB to include this as a recommendation to the BOCC | | | |
| Strategy 3: Explore all avenues for changes in Comprehensive Plan to accommodate and plan for affordable housing options | | | | | | |
| Activity | Who's responsible? | By When? | Measures of Success | Quarter 1 January-March 2023 | Quarter 2 April-June 2023 | Quarter 3 July-Sept 2023 |
| Educate our municipal planning commissions of RCW 35.70A | Housing Workgroup | March 2023 | Hold the first education meeting on RCW 35.70A.000 with our municipality | | | Quarter 4 Oct-Dec 2023 |
| Implement the recommendations of "Livable Cities" ordinance review | Housing Workgroup | June 2023 | Hold education meeting with municipalities and county to hear the outcomes of the Livable Cities ordinance and permitting review | | | |
| Encourage more flexibility in zoning for more housing options (ADU, duplex, triplex, etc) | Housing Workgroup | June 2023 | Hold education meeting with municipalities and county to hear the outcomes of the Livable Cities ordinance and permitting review | | | |
| Research safe parking/camping options for homeless individuals | Homeless Housing Subcommittee | Sept. 2023 | Create safe parking ad hoc to research best practices and possible solutions to share out to Homeless Housing Subcommittee | | | |
| Strategy 4: Increase landlord and developer interest in affordable units | | | | | | |
| Activity | Who's responsible? | By When? | Measures of Success | Quarter 1 January-March 2023 | Quarter 2 April-June 2023 | Quarter 3 July-Sept 2023 |
| Advocate for increased funding for developers and fewer regulations in zoning and permitting process | PO EDC & Livable Cities | June 2023 | Hold education meeting with municipalities and county to hear the outcomes of the Livable Cities ordinance and permitting review | | | Quarter 4 Oct-Dec 2023 |
| Create incentives for developers and homeowners by reducing regulations and fees through law interest loans? | Housing Workgroup | Aug 2023 | Hold education meeting with municipalities and county to provide some ideas of ways developers and landlords can be incentivized through code changes | | | |
| Provide educational information events to provide education on state housing programs, tenant incentives, home preservation loans, and mitigation programs | CCAP Landlord Liaison | 1 event by June 2023 1 event by Dec 2023 | At least 10 landlords attended the landlord engagement meetings | | | |
| Strategy 5: Preserve/Maintain existing housing units for affordable housing | | | | | | |
| Activity | Who's responsible? | By When? | Measures of Success | Quarter 1 January-March 2023 | Quarter 2 April-June 2023 | Quarter 3 July-Sept 2023 |
| Support JPCA in the acquisition of units for the use of preserving them for affordable housing | Housing Subcommittee | On-going | Continue to provide JPCA predevelopment funding to acquire units at risk of losing affordability | | | Quarter 4 Oct-Dec 2023 |
| Assist households in applying for weatherization grants | CCAP, Outreach Partners | On-going | Households receive weatherization grants (increase by 10%) | | | |
| Assist households with assessing loans and grants for home repair | ABC and remaining Together PCHHS | Meeting mid-July Jan 2023, application assistance provided on-going | 1 ABC and Together Together develop systems to assist with applications 21 households receive USDA home repair grants. | | | |

Objective #7: Improve Financial and Supportive Services / Increase Housing Placements

Milestone for Objective #7 - Exits to permanent housing will be 80% and returns to homelessness will be 5% for Pacific County by 2024 *taken from Commerce County Report Card report

| Strategy 1: Improve local community - based organizations' capacity | | | | | Quarter 1 January- March 2023 | Quarter 2 April- June 2023 | Quarter 3 July- Sept 2023 | Quarter 4 Oct- Dec 2023 |
|--|---|---|--|--|----------------------------------|-------------------------------|------------------------------|----------------------------|
| Activity | Who's responsible? | by When? | Measures of success | | | | | |
| Provide organizational development training for community - based organizations | Homeless Housing Subcommittee | Oct. 2023 | Facilitate first training hosted by a TA provider | | | | | |
| Encourage a streamlined process for stakeholders to apply for local funding | Health and Human Services Advisory Board & BOCC | May 2023 | Implementation of RFP process for all local funds available to community - based organizations | | | | | |
| Explore options for creating a collaborative process to help agencies build capacity | Housing Subcommittee | July 2023 | Present examples to Housing Subcommittee members about TA assistance when applying for funding | | | | | |
| Strategy 2: Encourage stability after housing placements | | | | | Quarter 1 January- March 2023 | Quarter 2 April- June 2023 | Quarter 3 July- Sept 2023 | Quarter 4 Oct- Dec 2023 |
| Activity | Who's responsible? | by When? | Measures of success | | | | | |
| Host landlord and tenant education events | NUP, HOSWWA, & CCAP Landlord Liaison | 1 event by June 2023, 1 event by Dec 2023 | At least 10 landlords and 10 tenants attending the landlord and tenant education sessions | | | | | |
| Attempt to reduce returns to homelessness by seeking support from partner agencies to ensure supportive services continue after placement into housing | Housing providers, Housing Committee | Dec 2023 | An additional partner agency becomes a Pathways provider | | | | | |
| Increase referrals to employment services for clients in housing programs | Housing providers & outreach partners | Mar 2023 | Increase employment service new enrollments by 10% in first quarter | | | | | |
| Support development of sober living (Oxford houses) and expansion of other housing resources available to individuals with behavioral health diagnosis | Housing Subcommittee | Apr 2023 | Reach out to the current women's Oxford house coordinators to see if they are willing to expand for a men's Oxford housing | | | | | |
| Strategy 3: Increase early intervention to prevent housing instability | | | | | Quarter 1 January- March 2023 | Quarter 2 April- June 2023 | Quarter 3 July- Sept 2023 | Quarter 4 Oct- Dec 2023 |
| Activity | Who's responsible? | by When? | Measures of success | | | | | |
| Utilize HB 1277 funding to provide eviction prevention funding | Pacific County | 2024 | An executed contract with Commerce | | | | | |
| Promote eviction prevention legal aid and Dispute Resolution Services | NUP & DRC | Aug 2023 | Create and execute an outreach plan to educate community on available services | | | | | |
| Create a diversion program to help reduce risk of homelessness | CCAP | Feb. 2023 | Create policies and procedures for CE diversion program | | | | | |

Sustainability

This CHIP's priorities will aim to address these immediate concerns, while also building the long-term sustainability to continue improving community health and well-being for Pacific County. Effective, community health improvement plans are dynamic. While goals, objectives, and priorities are meant to be long-term, strategies may need to be adjusted. Strategies may need revision based on a completed objective, an emerging health issue, a change in responsibilities, or a change in resources and assets.

PCHHS will monitor CHIP activities. Reports of progress will be made to the Board of County Commissioners/Board of Health, the Health & Human Services Advisory Board, PCHHS Subcommittees and Pacific County providers and community members. All identified tasks and timelines, will be monitored and assessed for progress, and adjustments made when indicated to ensure that the plan remains relevant. Changes will be developed in collaboration with partners and stakeholders involved in the planning process.

Along with necessary changes to strategies and activities, Pacific County will be exploring partnerships with other healthcare providers and entities to continue making a more comprehensive CHIP moving forward. Our hope is that through combined efforts between aforementioned groups, like Willapa Harbor Hospital and Ocean Beach Hospital, we can create a more impactful CHIP with less duplicated work and more directed focus within each entity's area of expertise and scope of practice.

We can look forward to improved health of the residents of Pacific County, and increased collaboration among the various agencies and individuals will help achieve this vision.

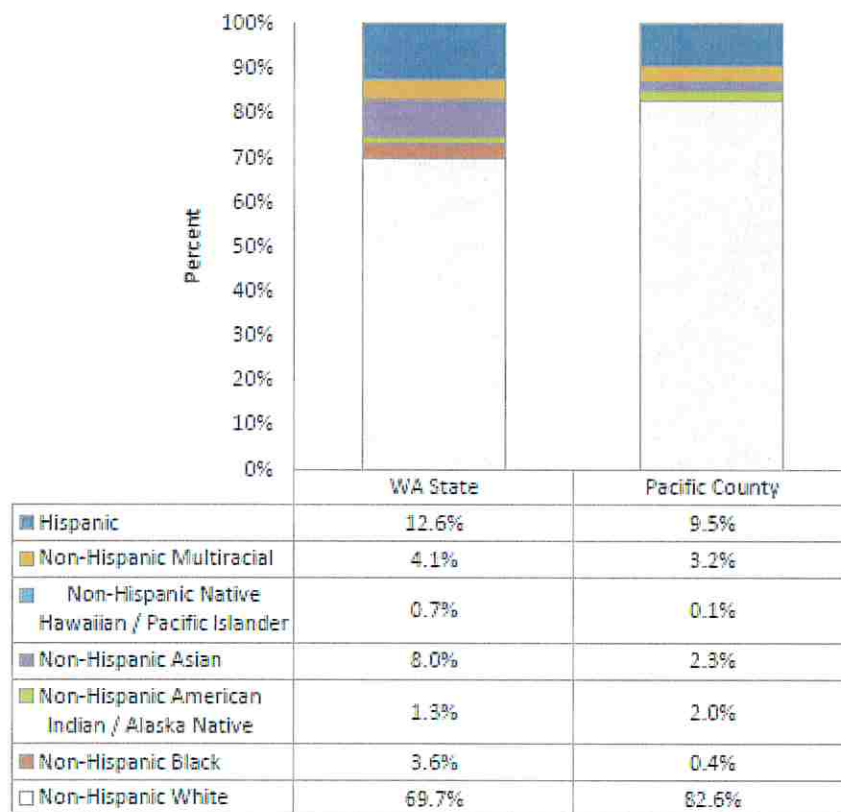
Appendix A: Community Profile

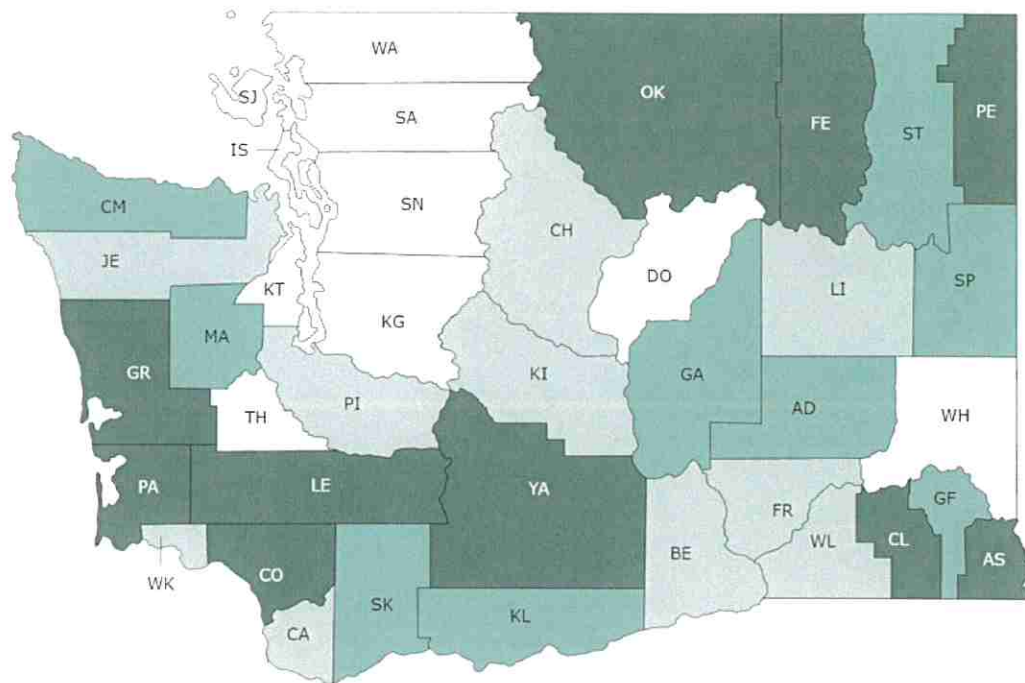
Pacific County Population: 21,183 = less than 1% of state

Age Distribution

- Washington State: 15% are age 65+; 23% are age < 18
- Pacific County: 29% are age 65+; 17% are age < 18

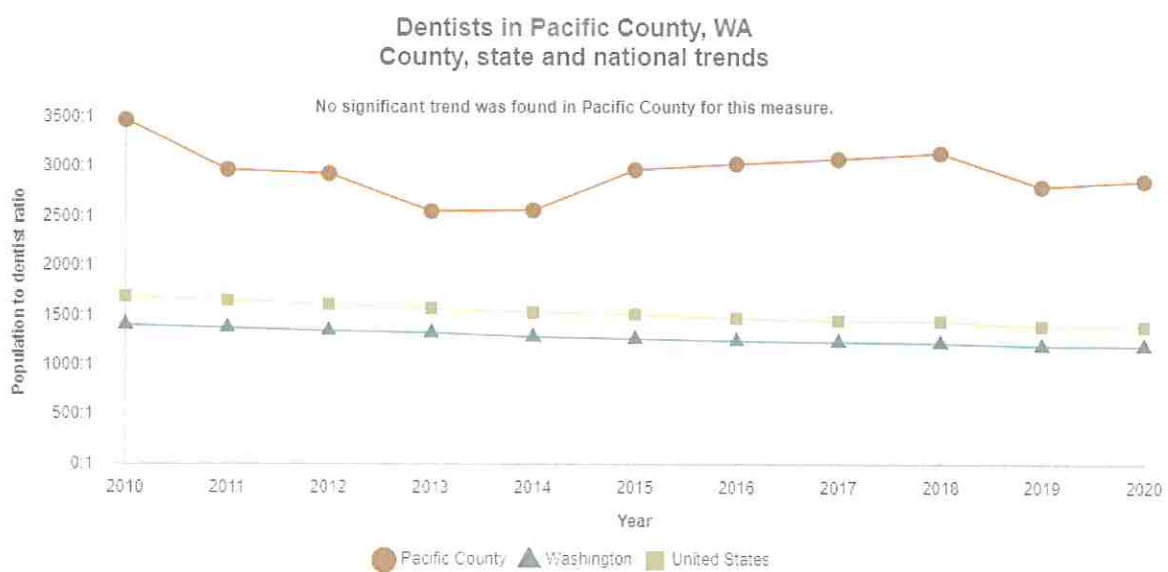
Population by Race / Ethnicity





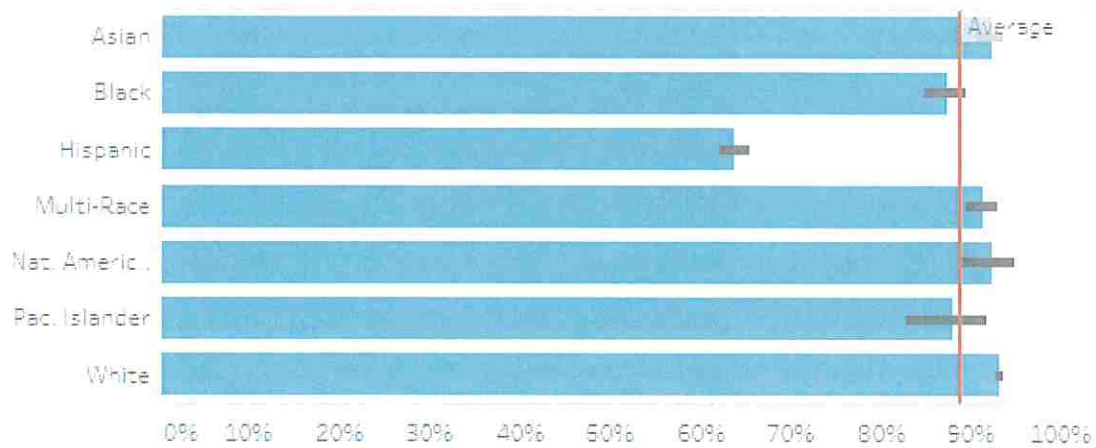
Health Outcome Ranks 1 to 10 11 to 20 21 to 29 30 to 39

Source: RWJF, 2022



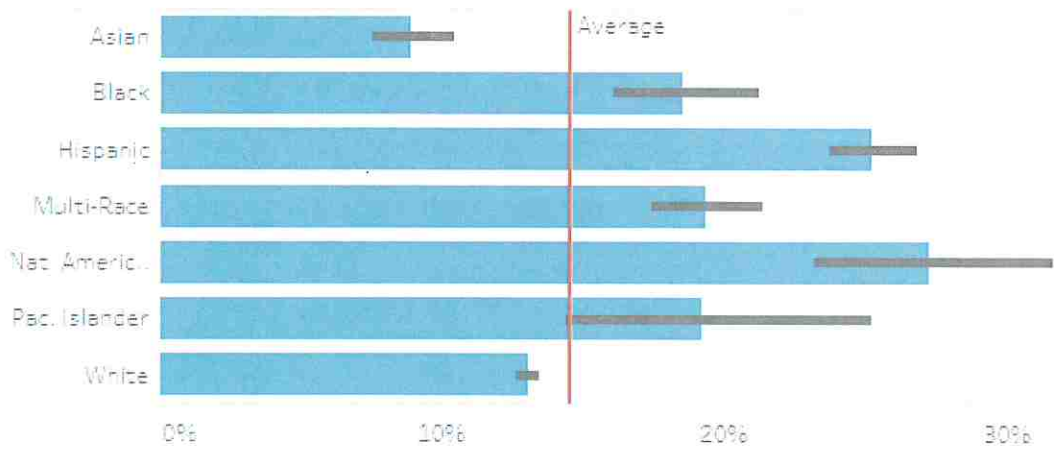
Source: RWJF, 2022

Has Health Insurance (18-64) by Race, 2016-2020



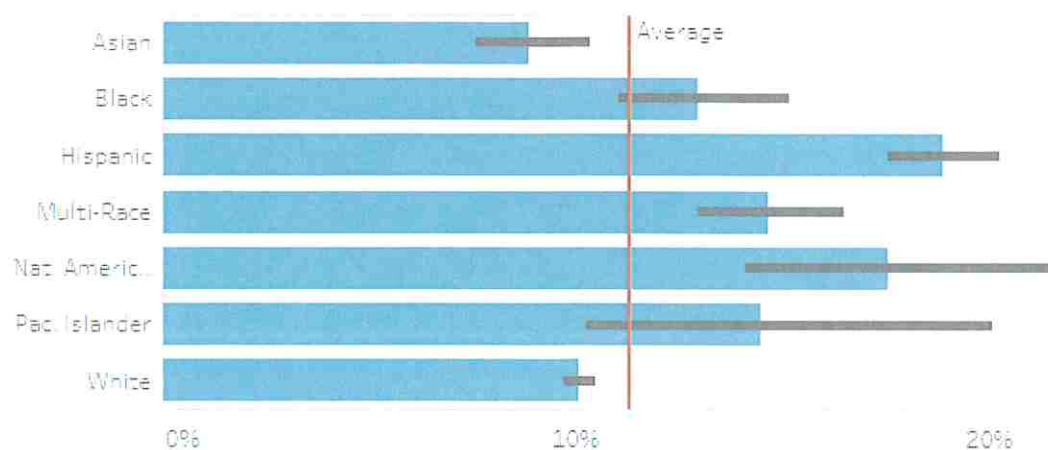
Source: BRFSS, 2022

Physical Health Not Good by Race, 2016-2020



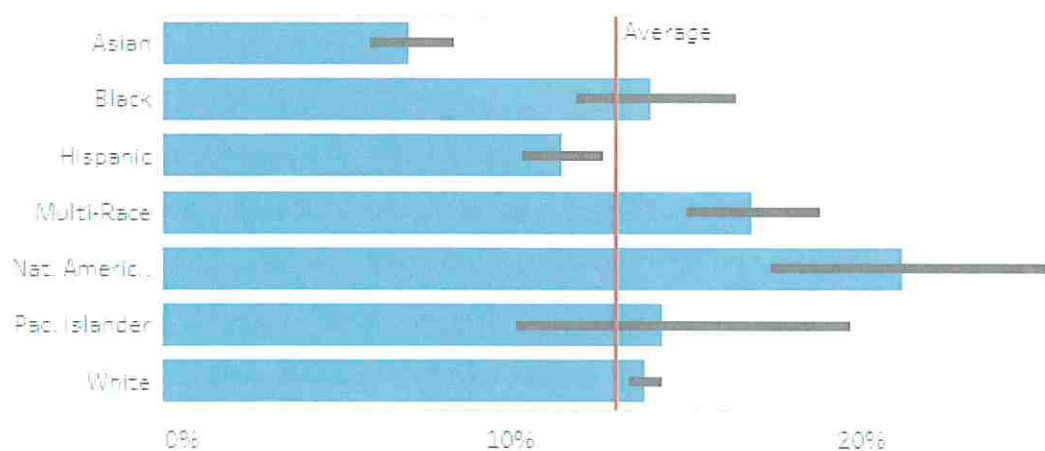
Source: BRFSS, 2022

Delayed Medical Care Due to Cost by Race, 2016-2020



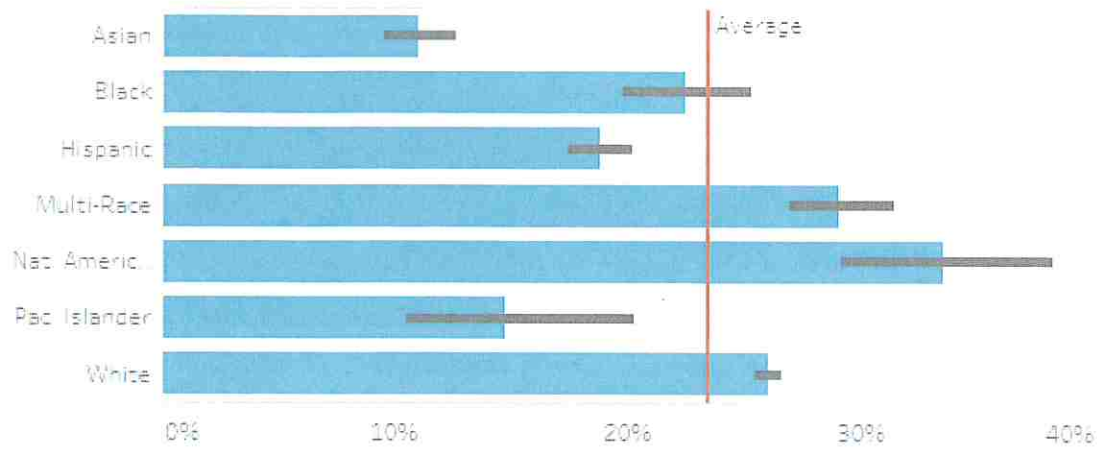
Source: BRFSS, 2022

14+ Days of Poor Mental Health in Past 30 by Race, 2016-2020



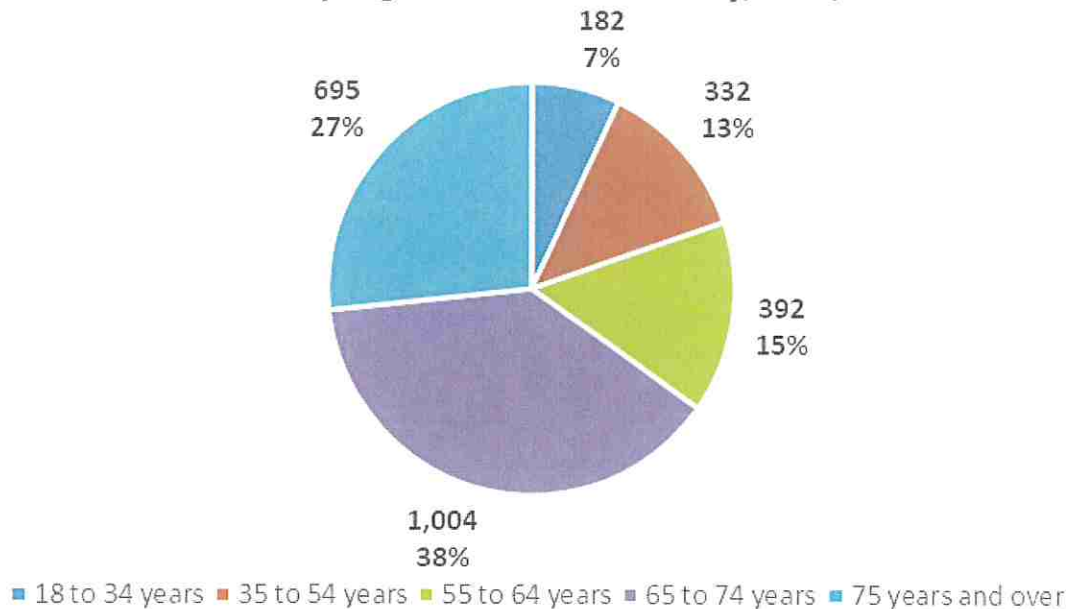
Source: BRFSS, 2022

Diagnosed with Depression by Race, 2016-2020

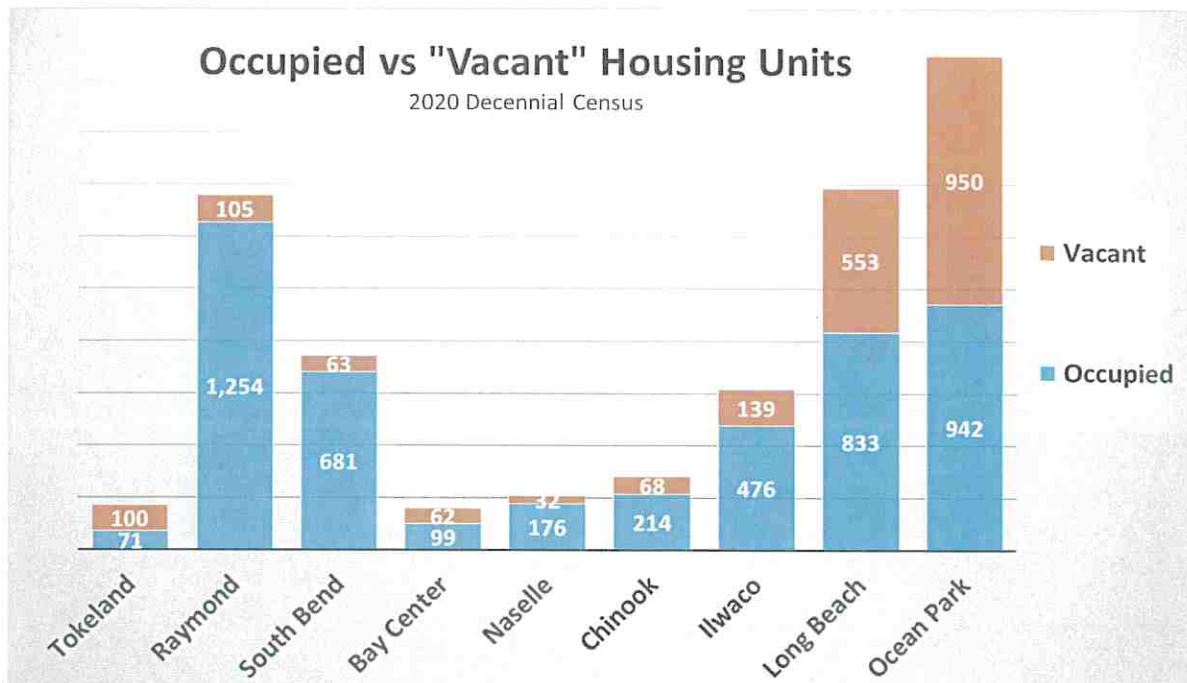


Source: BRFSS, 2022

Veterans By Age in Pacific County, WA, 2021



Source: US Census Bureau, 2022



Source: US Census Bureau, 2022

| Pacific County Homeless Estimates Compared to HMIS Clients, 2022 | | | |
|--|---|-------------------------|------------|
| Race/Ethnicity | Percent of Homeless and Unstably Housed | Percent of HMIS Clients | Difference |
| American Indian, Alaska Native, or Indigenous | 12% | 1% | +10% |
| Asian or Asian American | 3% | 1% | +3% |
| Black, African American, or African | 2% | 1% | +1% |
| Hispanic/Latin(a)(o)(x) (Any race) | 11% | 11% | 0% |
| Native Hawaiian or Pacific Islander | 1% | 0% | +1% |
| Unknown | 1% | 9% | -8% |
| White Non Hispanic/Non-Latin(a)(o)(x) | 75% | 78% | -3% |

Source: Homeless Management Information System, 2022

Appendix B: Community Health Assessment

In order to submit this form, you should open it with Adobe Acrobat Reader.

Pacific County Community Health Assessment

The goal of this survey is to gather feedback on Pacific County public health, health care delivery, and current community health needs. Survey responses are anonymous. At the conclusion of this review, we will produce and share a community health improvement plan. This survey will take about 10-15 minutes to complete. If you have questions, please contact Connor Montgomery: cmontgomery@co.pacific.wa.us

Please select your age group

- ☐ 10-19 years
- ☐ 20-29 years
- ☐ 30-39 years
- ☐ 40-49 years
- ☐ 50-59 years
- ☐ 60-69 years
- ☐ 70+ years

Gender

Specify Other Gender

Race

Specify Other Race

Ethnicity

Marital Status

Highest Education Level Earned

Number of Individuals in Household

Annual Household Income

Please answer in USD only. No "\$" or other currency denotation required.

Please confirm your Pacific County Zip Code

Community Health

This section will ask questions regarding what you believe to be the most important factors in each of the following categories. Answers are limited to 3 per section, so please consider your answers critically and provide additional details in the space provided below.

In the following list, what do YOU think are the three most important factors for a "Healthy Community"? (Factors which most improve the quality of life in a community)

- | | |
|--|--|
| <input type="checkbox"/> Good place to raise children | <input type="checkbox"/> Low crime / safe neighborhoods |
| <input type="checkbox"/> Low level of child abuse | <input type="checkbox"/> Good schools |
| <input type="checkbox"/> Access to health care (e.g., family doctor) | <input type="checkbox"/> Parks & recreation |
| <input type="checkbox"/> Clean environment | <input type="checkbox"/> Affordable housing |
| <input type="checkbox"/> Arts and cultural events | <input type="checkbox"/> Excellent race/ethnic relations |
| <input type="checkbox"/> Good jobs & healthy economy | <input type="checkbox"/> Strong family life |
| <input type="checkbox"/> Healthy behaviors & lifestyle | <input type="checkbox"/> Low adult death and disease rates |
| <input type="checkbox"/> Low infant deaths | <input type="checkbox"/> Religious or spiritual values |
| <input type="checkbox"/> Emergency preparedness | <input type="checkbox"/> <div></div> |

Please share additional comments regarding "HEALTHY COMMUNITY FACTORS" below:

In the following list, what do YOU think are the three most important "health problems" in our community? (Those problems which have the greatest impact on overall community health)

- | | |
|---|--|
| <input type="checkbox"/> Aging problems (e.g. arthritis, hearing/vision loss, etc.) | <input type="checkbox"/> Cancers |
| <input type="checkbox"/> Child abuse / neglect | <input type="checkbox"/> Dental problems |

- | | |
|--|---|
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Domestic Violence |
| <input type="checkbox"/> Firearm-related injuries | <input type="checkbox"/> Heart disease and stroke |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> HIV / AIDS |
| <input type="checkbox"/> Homicide | <input type="checkbox"/> Infant death |
| <input type="checkbox"/> Infectious disease (e.g. hepatitis, TB, COVID-19, etc.) | <input type="checkbox"/> Mental health problems |
| <input type="checkbox"/> <input type="text"/> injuries | <input type="checkbox"/> Rape / sexual assault |
| <input type="checkbox"/> Respiratory / lung disease | <input type="checkbox"/> Sexually Transmitted Diseases (STDs) |

Please share additional comments regarding "HEALTH PROBLEMS" below:

In the following list, what do YOU think are the three most important "risky behaviors" in our community? (Those behaviors which have the greatest impact on overall community health)

- | | |
|--|--|
| <input type="checkbox"/> Alcohol abuse | <input type="checkbox"/> Being overweight |
| <input type="checkbox"/> Dropping out of school | <input type="checkbox"/> Drug abuse |
| <input type="checkbox"/> Lack of exercise | <input type="checkbox"/> Lack of maternity care |
| <input type="checkbox"/> Poor eating habits | <input type="checkbox"/> Not getting "shots" to prevent disease |
| <input type="checkbox"/> Racism | <input type="checkbox"/> Tobacco use |
| <input type="checkbox"/> Not using birth control | <input type="checkbox"/> Not using seat belts / child safety seats |
| <input type="checkbox"/> Unsafe sex | <input type="checkbox"/> Unsecured firearms |
| <input type="checkbox"/> <input type="text"/> | |

Please share additional comments regarding "RISKY BEHAVIORS" below:

Dental

Pacific County is currently engaging in learning more about Access to Baby and Child Dentistry (ABCD)

efforts to improve future access and quality of care from providers. Please answer the following prompts to the best of your experience/knowledge.

Please rate the statements below for baby and child dentistry

| | Not Satisfied | Somewhat Satisfied | Satisfied | Very Satisfied | Unsure/Not Applicable |
|---------------------------------------|---------------|--------------------|-----------|----------------|-----------------------|
| Accessibility to Dental Care Services | | | | | |
| Clarity of costs | | | | | |
| Quality of services received | | | | | |

Obesity

Based on findings from Behavioral Risk Factor Surveillance System (BRFSS) data over the previous 5 years, Pacific County is currently engaging in learning more about...

Please rate the statements below for...

| | Not Satisfied | Somewhat Satisfied | Satisfied | Very Satisfied | Unsure/Not Applicable |
|--|---------------|--------------------|-----------|----------------|-----------------------|
| Accessibility of healthy grocery options | | | | | |
| Costs of healthy grocery options | | | | | |
| Quality of grocery food options | | | | | |

Quality of Life

Read through the prompts below and select your level of satisfaction with each. If you're unsure about any answer you may skip that prompt and move onto the next one.

| | Strongly Disagree | Disagree | Neither agree nor disagree | Agree | Strongly Agree | Not Applicable/Unsure |
|--|-------------------|----------|----------------------------|-------|----------------|-----------------------|
| I am satisfied with the quality of life in our community. | | | | | | |
| I am satisfied with the health care system in our community. | | | | | | |

This community is a good place to raise children.

This community is a good place to grow old.

There is economic opportunity in this community.

This community is a safe place to live.

There are networks of support for individuals and families during times of stress and need.

All individuals and groups have the opportunity to contribute to and participate in the community's quality of life.

All residents perceive that they can make the community a better place to live. (Individually and collectively)

There are a broad variety of health services in the community.

There is a sufficient number of health and social services in the community.

Levels of mutual trust and respect are increasing among community partners.

There is an active sense of civic responsibility, engagement, and pride in shared accomplishments.

Please share additional comments regarding "QUALITY OF LIFE" below:

Please share additional comments regarding "OBESITY" below:

Conclusion

Leisure Physical Activity

Based on findings from Behavioral Risk Factor Surveillance System (BRFSS) data over the previous 5 years, Pacific County is currently engaging in learning more about...

Please rate the statements below for...

| | Not Satisfied | Somewhat Satisfied | Satisfied | Very Satisfied | Unsure/Not Applicable |
|--|------------------|-----------------------|-----------|-------------------|--------------------------|
| Accessibility to nearby outdoor walking paths | | | | | |
| Feelings of security/comfort while utilizing spaces | | | | | |
| Quality of spaces/parks provided | | | | | |

Please list the greatest strengths of Pacific County's Public Health when addressing community health improvement in recent years.

Please list Pacific County Public Health's biggest areas for community health improvement moving forward.

Please select if you would like any of the following:

- ☐ A copy of the Community Health Improvement Plan (CHIP)
- ☐ A follow-up interview about responses recorded today via email
- ☐ A follow-up interview about responses recorded today via phone call

Email

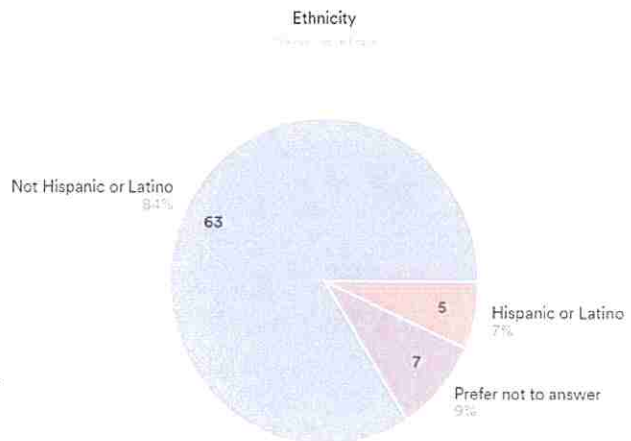
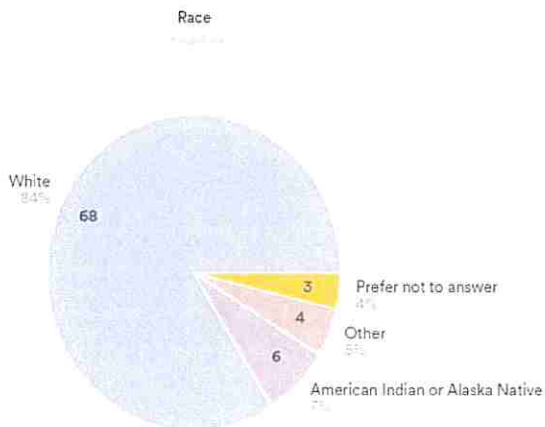
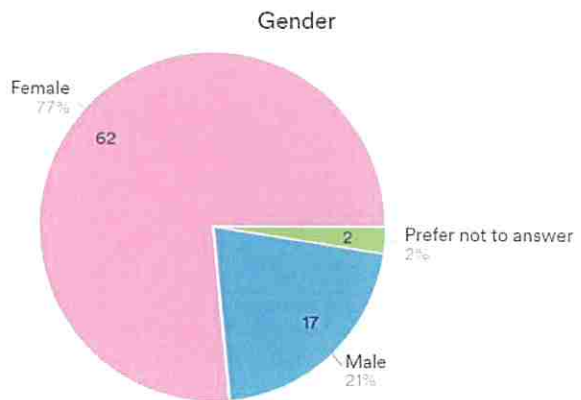
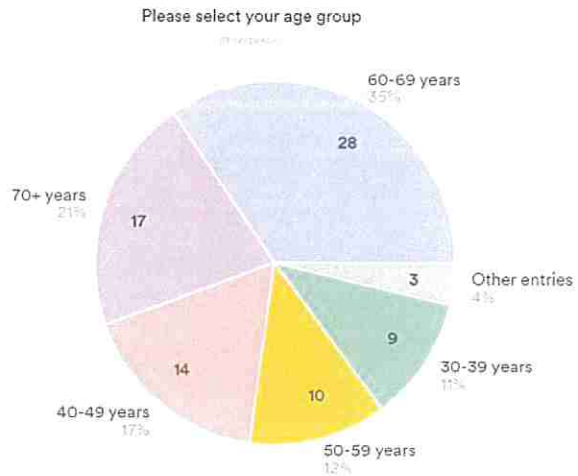
example@example.com

Phone Number

Please enter a valid phone number.

Appendix C: Community Health Assessment Results

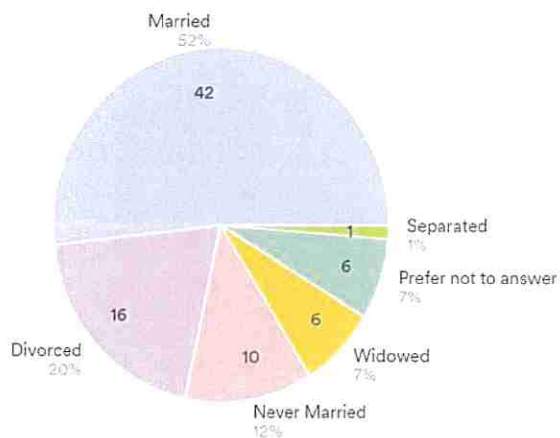
CHA Results: Demographics



CHA Results: Demographics

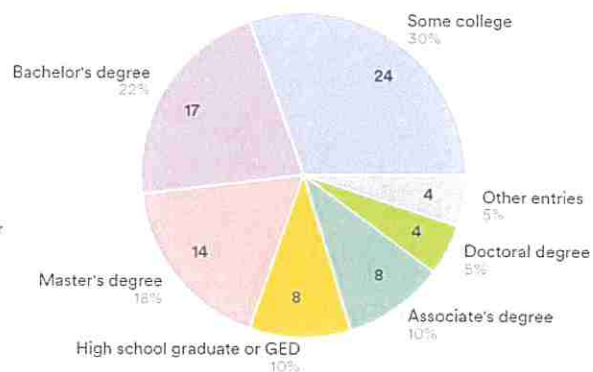
Marital Status

(25 Responses: 100%)



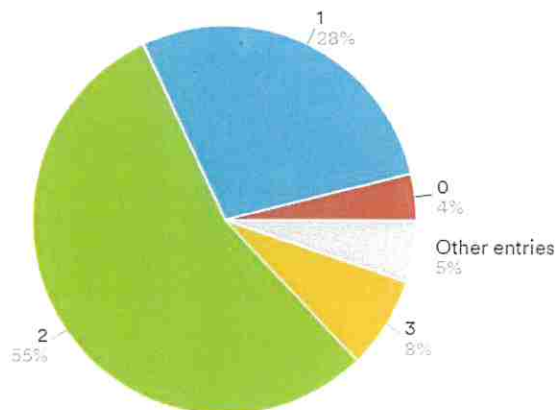
Highest Education Level Earned

(24 Responses: 100%)



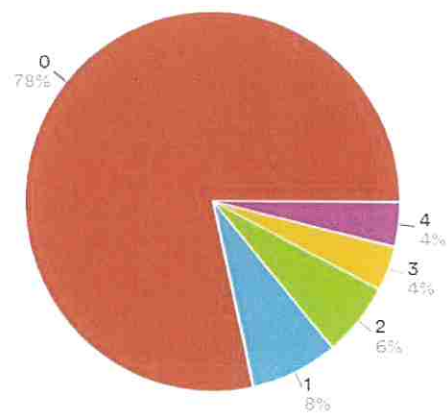
Number of Individuals Over 18 Years Old in Household

(25 Responses: 100%)



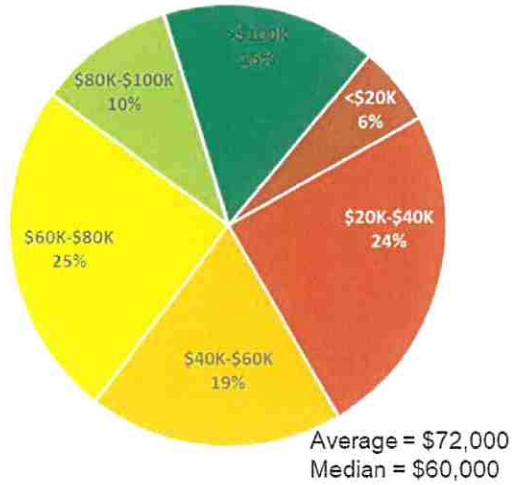
Number of Individuals Under 18 Years Old in Household

(24 Responses: 100%)

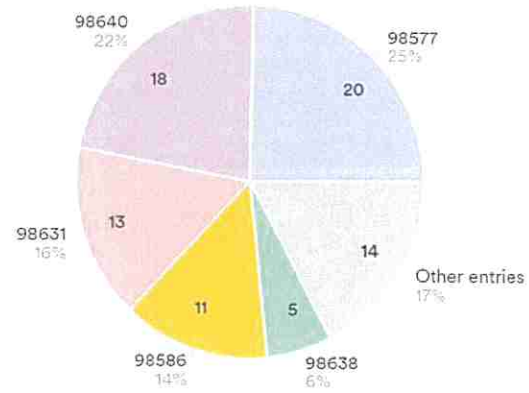


CHA Results: Demographics

Annual Household Income by Income Category



Please confirm your Pacific County Zip Code



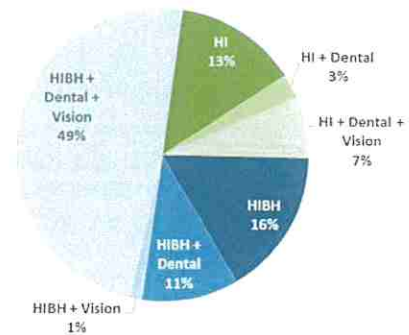
I currently have the following insurance coverages (select all that apply):

Health insurance with behavioral healthcare

34%

167

Breakdown of Insurance Coverages

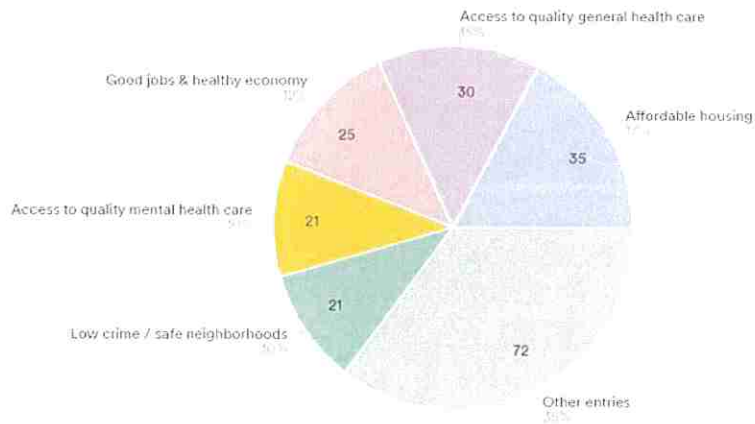


| Data | Response | % |
|--|----------|-----|
| Health insurance with behavioral healthcare | 57 | 34% |
| Dental insurance | 51 | 31% |
| Vision insurance | 42 | 25% |
| Health insurance without behavioral healthcare | 17 | 10% |

Health Priorities - Healthy Community

In the following list, what do YOU think are the three most important factors for a "Healthy Community"? (These factors have the most positive impact on the quality of life in a community)

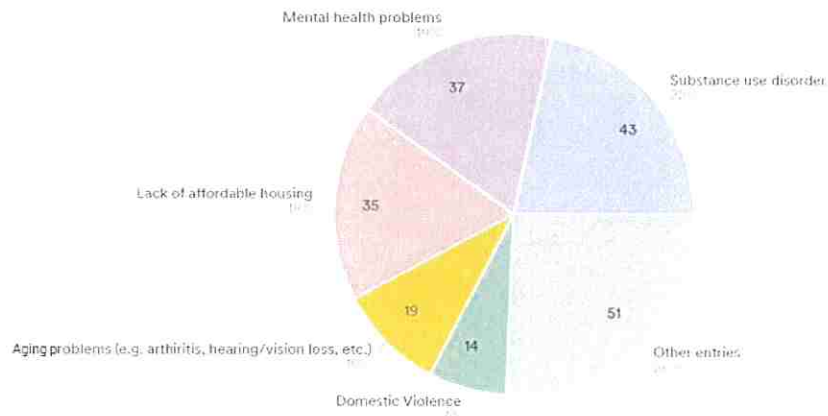
2018-2019



Health Priorities - Health Problems

What do YOU think are the three most important "health problems" in our community? (These problems have the greatest negative impact on overall community health)

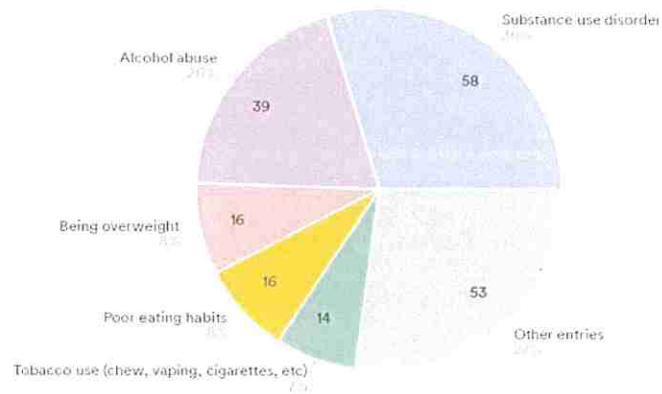
2018-2019



Health Priorities - Risky Behaviors

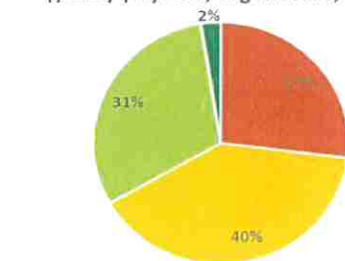
What do YOU think are the three most significant "risky behaviors" in our community? (These behaviors have the greatest negative impact on overall community health)

City of Lowell 2021



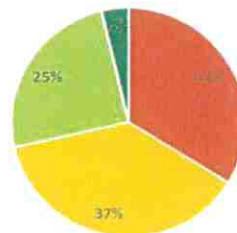
Access and Quality of Healthcare: Physical Care

Accessibility to physical healthcare services
(yearly physical, urgent care, etc.)



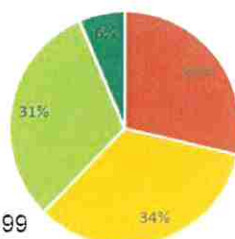
Mean score = 2.09
Closest to:
"Somewhat Satisfied"

Affordability of physical healthcare



Mean score = 2.16
Closest to:
"Somewhat Satisfied"

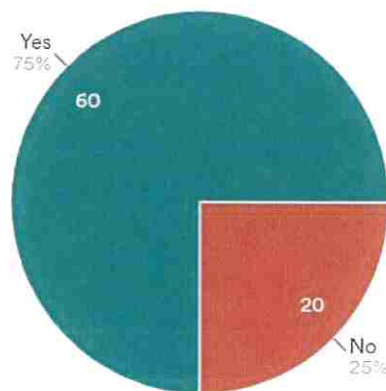
Quality of services received for general
healthcare



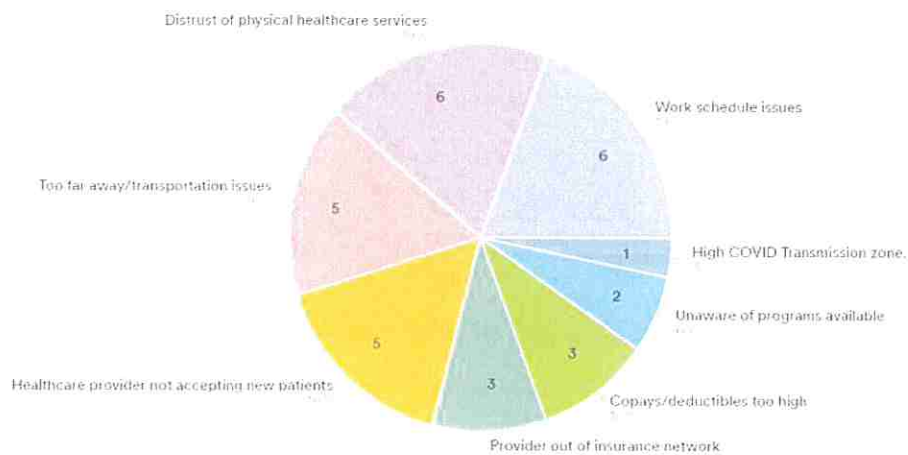
Mean score = 1.99
Closest to:
"Somewhat Satisfied"

■ Not Satisfied ■ Somewhat Satisfied ■ Satisfied ■ Very Satisfied

In the past 12 months, did you complete a routine, physical healthcare visit?

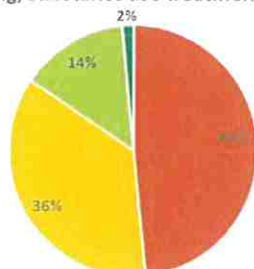


If no, why not?



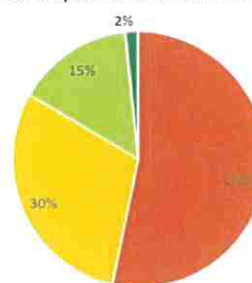
Access and Quality of Healthcare: Behavioral Care

Accessibility to behavioral healthcare services
(counseling, substance use treatment, etc.)



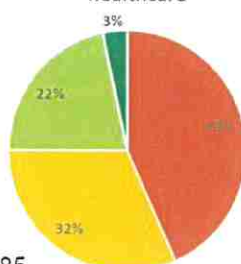
Mean score = 1.69
Closest to:
"Somewhat Satisfied"

Affordability of behavioral healthcare



Mean score = 1.65
Closest to:
"Somewhat Satisfied"

Quality of services received for behavioral healthcare

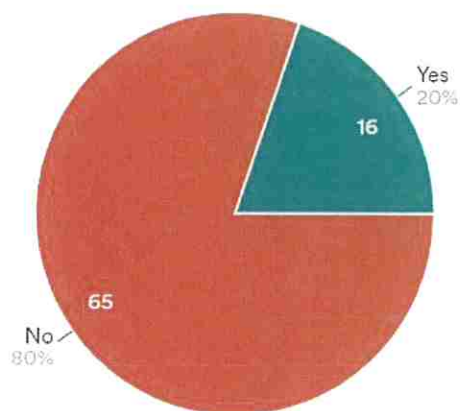


Mean score = 1.85
Closest to:
"Somewhat Satisfied"

■ Not Satisfied ■ Somewhat Satisfied ■ Satisfied ■ Very Satisfied

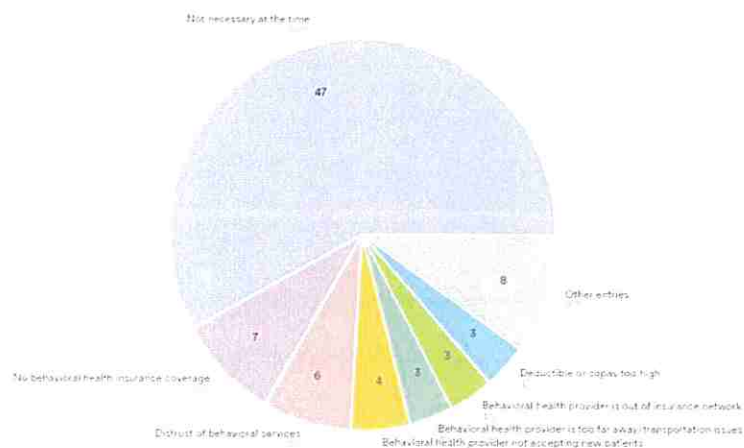
In the past 12 months, did you access behavioral healthcare for any reason?

281 responses



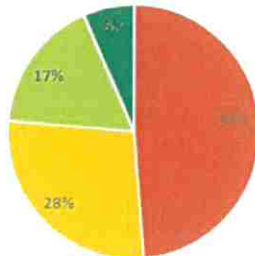
If no, why not?

281 responses: 281 responses



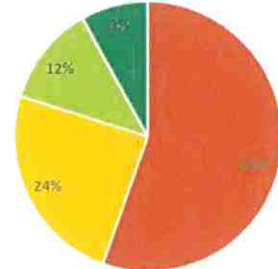
Access and Quality of Healthcare: Dental Care

Accessibility to dental services (cleanings, extractions/surgery, etc.)



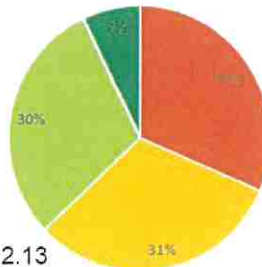
Mean score = 1.82
Closest to:
"Somewhat Satisfied"

Affordability of dental services



Mean score = 1.73
Closest to:
"Somewhat Satisfied"

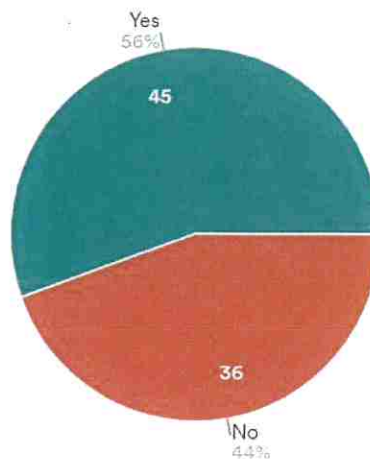
Quality of services received for dental care



Mean score = 2.13
Closest to:
"Somewhat Satisfied"

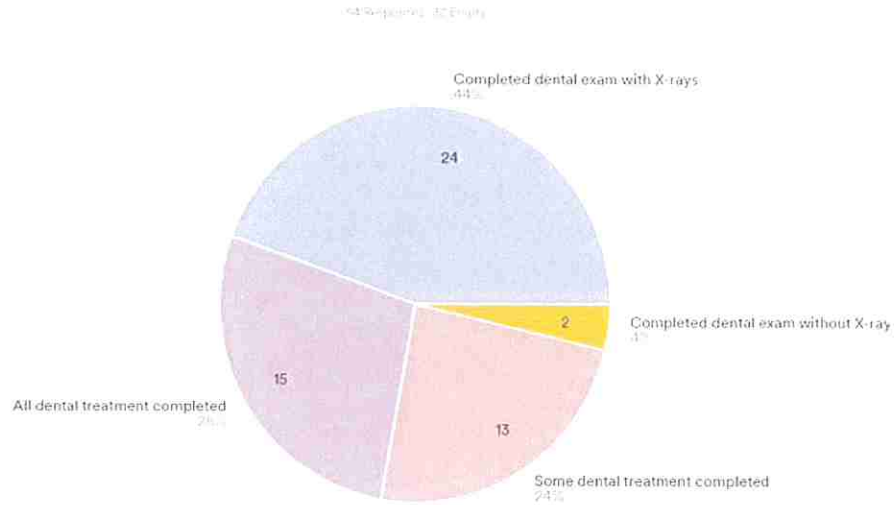
Not Satisfied Somewhat Satisfied Satisfied Very Satisfied

In the past 6 months, did you complete a dental visit?

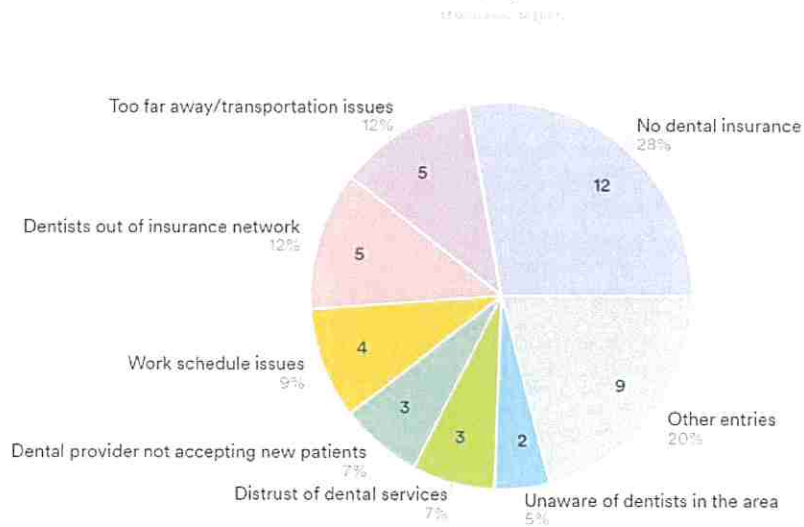


Access and Quality of Healthcare: Dental Care

If yes, what were the outcomes?



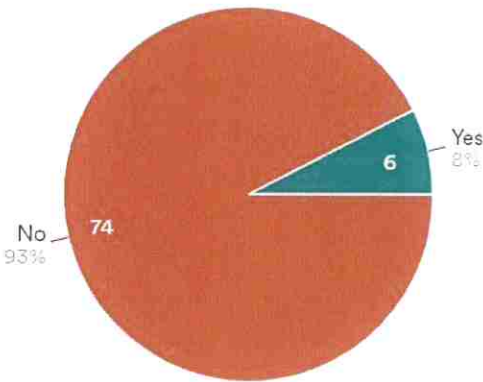
If no, why not?



Access and Quality of Healthcare: Child Dental Care

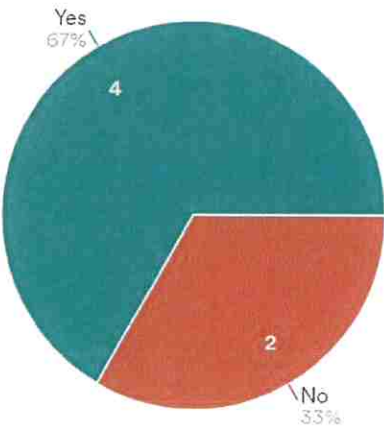
Are you a parent or guardian of a child 0-5 years old OR a developmentally disabled child 0-12 years old?

6 Responses: 100%



In the past 6 months, did they complete a dental visit?

6 Responses: 100%



Please rate the statements below related to child dentistry in Pacific county:

6 Responses: 100%

Mean score = 2.40
Closest to:
"Somewhat Satisfied"

Mean score = 2.25
Closest to:
"Somewhat Satisfied"

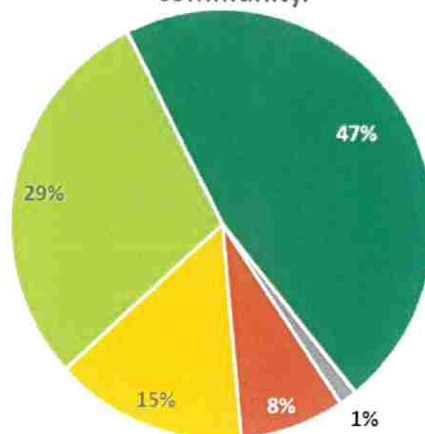
Mean score = 3.00
Closest to: "Satisfied"



Quality of Life

I am satisfied with the quality of life in our community.

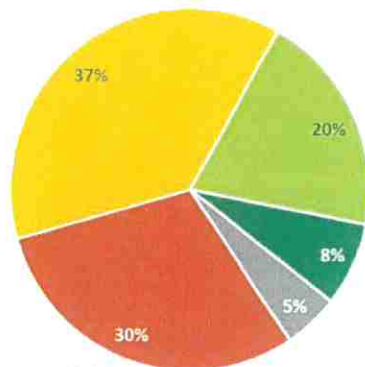
Mean score = 3.30
Closest to: "Agree"



Strongly Disagree Disagree Agree Strongly Agree Unsure/Not Applicable

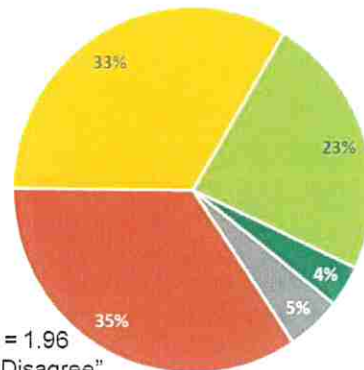
Quality of Life: Healthcare Services

There are a broad variety of health services in the community.



Mean score = 2.09
Closest to: "Disagree"

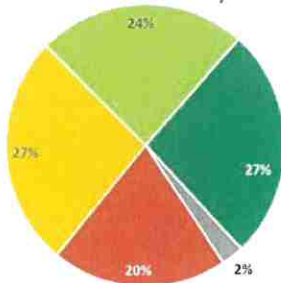
There is a sufficient number of health and social services in the community.



Mean score = 1.96
Closest to: "Disagree"

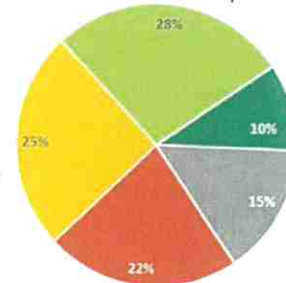
Strongly Disagree Disagree Agree Strongly Agree Unsure/Not Applicable

I am satisfied with the general health care services in our community.



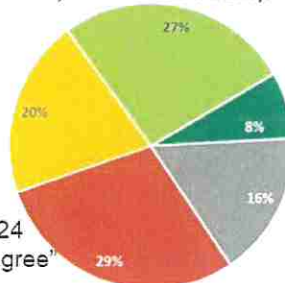
Mean score = 2.65
Closest to: "Agree"

I am satisfied with the mental health care services in our community.



Mean score = 2.33
Closest to: "Disagree"

I am satisfied with the substance use treatment system in our community.



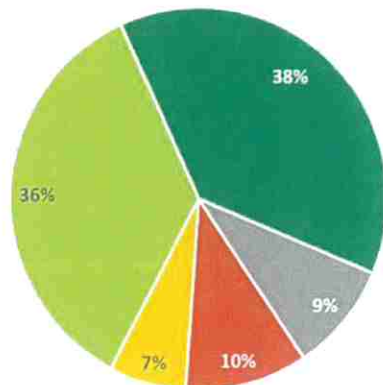
Mean score = 2.24
Closest to: "Disagree"

Strongly Disagree Disagree Agree Strongly Agree Unsure/Not Applicable

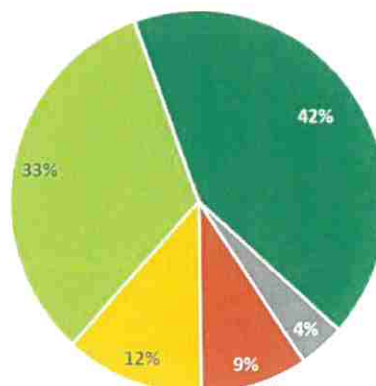
Quality of Life: Community Life

This community is a good place to raise children.

This community is a good place to grow old.



Mean score = 3.24
Closest to: "Agree"

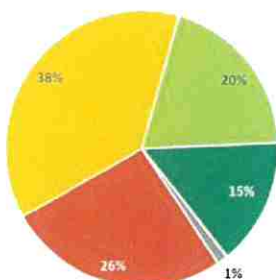


Mean score = 3.26
Closest to: "Agree"

Strongly Disagree Disagree Agree Strongly Agree Unsure/Not Applicable

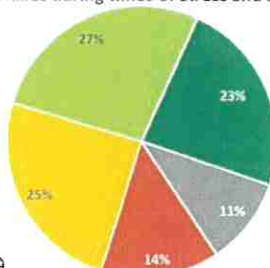
There is economic opportunity in this community.

There is affordable housing in this community.

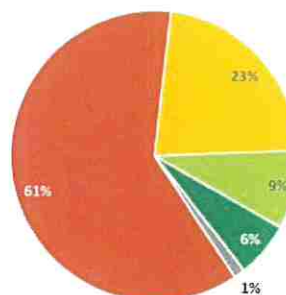


Mean score = 2.28
Closest to: "Disagree"

There are networks of support for individuals and families during times of stress and need.



Mean score = 2.79
Closest to: "Agree"

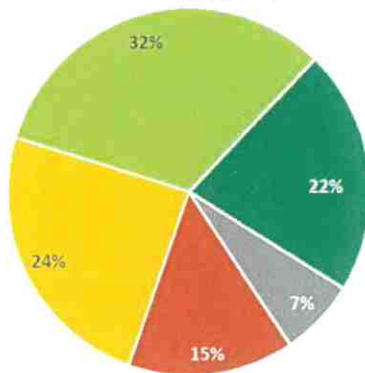


Mean score = 1.64
Closest to: "Disagree"

Strongly Disagree Disagree Agree Strongly Agree Unsure/Not Applicable

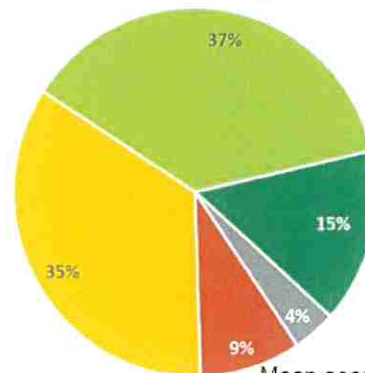
Quality of Life: Community Life

All individuals and groups have the opportunity to contribute to and participate in the community's quality of life.



Mean score = 2.87
Closest to: "Agree"

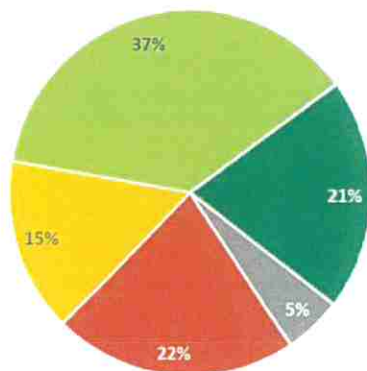
All residents perceive that they can make the community a better place to live. (Individually and collectively)



Mean score = 2.71
Closest to: "Agree"

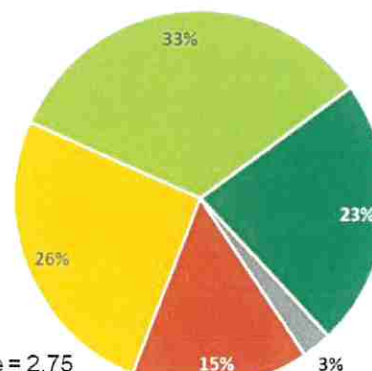
Strongly Disagree Disagree Agree Strongly Agree Unsure/Not Applicable

Levels of mutual trust and respect are increasing among community partners.



Mean score = 2.69
Closest to: "Agree"

There is an active sense of civic responsibility, engagement, and pride in shared accomplishments.



Mean score = 2.75
Closest to: "Agree"

Strongly Disagree Disagree Agree Strongly Agree Unsure/Not Applicable