Live Well
Washington County

2014 Community Health Improvement Plan for Washington County

A Strategic Plan for our Community's Health







December 2014

Letter from the Division Manager

Dear Community Partner:

I am pleased to present Live Well Washington County, our 2014 community health improvement plan (CHIP). At Washington County Public Health, we are working to improve and protect the health of the county's 550,990 residents across the lifespan. This plan is the result of a formal community health assessment and planning effort that reflects more than four years of collaborative work.

In coordination with regional and local agency partners and community stakeholders, we established a shared vision, conducted a comprehensive community health assessment, and developed an assets-based planning document. Using a modified version of the Mobilizing for Action through Planning and Partnerships framework as our guide, we conducted four interdependent assessments that, when combined, provide a comprehensive snapshot of the specific health needs and opportunities in our community. The results of these assessments not only produced viable data, but more importantly created a mechanism to envision and plan a healthier tomorrow for our communities. Our CHIP is the result of the hard work following our Community Health Needs Assessment.

To develop our CHIP, community members worked together to address identified health issues as well as identify conditions needed to support and improve health. By engaging our community members, asking their opinions, learning about unmet needs and evaluating our resources, it became clear that our communities are committed to improving health and safety for everyone. No single organization has the resource, expertise and ability to improve community health, but together we can achieve our vision through working collectively on common goals and strategies.

The contributions and commitment from our community partners provided the basis for our community health improvement planning, and this process has strengthened our internal and external partnerships. I would like to thank all of those organizations and individuals listed on the next page as partners for their contributions of time, information, creative ideas and ongoing commitment to help implement the identified strategies and objectives. Strong, effective partnerships are necessary for our community to create the conditions that will lead to improving the health and well-being of Washington County residents and the health of our community. As we look to the future we will continue to measure our progress in this collective impact approach and work toward a healthier thriving community for all.

Thank you for your dedication and support in this process.

Tricia Mortell

Tricia Mortell,
Washington County Public Health Division Manager

Acknowledgements

Document prepared by:
Erin Mowlds, MPH

Other Authors and Contributors
Rebecca Collet, MA, JD
Amanda Garcia-Snell, MPH
Tricia Mortell, RD, MPH
Kimberly Repp, PhD, MPH
Rose Sherwood, MPH
Nicole Shearer

Live Well Washington County Leadership Team
Linda Nilsen-Solares, Project Access NOW
Maureen Quinn, OSU Extension Service
Joe Reisman, LifeWorks NW
Erin Mowlds, Washington County Public Health

Public Health Advisory Council
Larry Boxman – Public safety representative
Laura Byerly – Licensed practicing physician
Tom Engle – Consumer of public health services
Tiffany Fieken – School representative
Rosa Foronda - Person representing underserved/ minority communities
Jonathan Gietzen – Licensed health care professional
Boone Kizer – Nonprofit organization representative
Lou Ogden – Elected official
Rachel Parker-Sharpsteen – Youth organization representative
Eunice Rech – Hospital representative
Dick Stenson – Consumer of public health services
Barbara Vybiralova – Regulated service industry representative

Live Well Washington County Partner Organizations
Adelante Mujeres
Adventures Without Limits
Beaverton Full Gospel Church
Beaverton School District
Bicycle Transportation Alliance
Boys and Girls Club
Center for Intercultural Organizing
Community Action
DHS Aging and People with Disabilities
DHS Child Welfare
FamilyCare
Harkin's House
Health Share of Oregon
Kaiser Permanente
Legacy Health
LifeWorks NW
Lines for Life
Luke Dorf Inc.
Morrison Child & Family Services
National Association of Mental Illness
Neighborhood Health Center
Northwest Regional Education Service District
OHSU
Oregon Community Health Workers Association
Oregon Family Support Network
Oregon Latino Health Coalition
Oregon Oral Health Coalition
OSU Extension Service
Portland DBT Institute
Portland Veterans Association Medical Center
Project Access NOW
Providence Health & Services
Sequoia Mental Health Services
Sherwood School District
SW Community Health Center
Tualatin Hills Parks and Recreation
Tuality General Psychiatry
Tuality Health Alliance
Tuality Healthcare
Virginia Garcia Memorial Health Center
Washington County Addictions
Washington County Crisis Team
Washington County Administrative Office
Washington County Developmental Disabilities
Washington County Disability, Aging and Veteran Services
Washington County Housing Services
Washington County Juvenile Department
Washington County Land Use and Transportation
Washington County Medical Examiner
Washington County Mental Health
Washington County Public Health
Washington County Sheriff's Office
Western Psychological
Westside Transport Alliance
Willamette Valley Senior Behavioral Health
Women's Healthcare Associates

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I. Executive Summary

Many factors affect the health of individuals and communities. These factors are referred to as the l determinants of health and include income and social status, education, environmental conditions, social support networks, and access to healthcare services. The complexity of these determinants makes it essential to work collaboratively with many partners to address the unique needs of the community. Live Well Washington County was formed to foster these strong multisector partnerships to improve health for all who live, work, learn and play in Washington County.

This 2014 community health improvement plan is a community-driven, strategic and measurable work plan. It defines how community partners across sectors will come together to address priority health issues identified by a comprehensive assessment of local data. More than 60 diverse Washington County community partner organizations identified three priority areas for the Live Well Washington County process: (1) improve access to integrated health care, (2) prevent chronic disease, and (3) prevent suicide.

Each of the three priority areas has a multisector community collaborative working to implement strategies to meet the objectives they identified. The process addresses the social and environmental determinants of health by engaging partners from across the community in order to tap in to expertise, knowledge and resources. The plan is developed using evidence- based best practices and a collective impact approach.

The Access to Integrated Care Committee includes partners from hospitals, health care systems, federally qualified health care centers, safety net clinics, behavioral health service providers, public health and behavioral health leadership, emergency medical services, and culturally-specific community-based organizations. Representatives from each of these groups joined Live Well Washington County to align their local assessments and planning documents and develop a collaborative approach to address common priorities. The committee developed goals focused on improving access and integration of physical, behavioral and oral health for residents of Washington County. The focus of the work plan is on improving access to integrated care for newly insured and the remaining uninsured residents in Washington County, improving coordination across the health care system, and improving system navigation for people living in Washington County.

The Chronic Disease Prevention Committee is comprised of more than 20 partners from across the county focused on improving access to healthy food and opportunities for physical activity, reducing tobacco use, and improving programs for people living with chronic disease. The committee used local data, best practices, local planning documents and an inventory of current programs and policies to develop collaborative objectives. The work plan includes strategies to expand and support current programs and policies; increase engagement from vulnerable populations in planning and policy decisions; support health in all policies across partner organizations; and improve workforce diversity to support culturally-specific chronic disease prevention efforts.

The Suicide Prevention Council identified objectives and strategies, based on the 2012 National Strategy for Suicide Prevention, with the goal of preventing suicide in Washington County. The vision of the council is "zero is possible" in alignment with the national Zero Suicide approach. The Council is made up of more than 40 partners including behavioral health service providers, community-based organizations, law enforcement, medical examiners, emergency medical services, private practice mental health providers, public health and faith leaders. The work plan priorities are to integrate and coordinate suicide prevention activities across multiple sectors and settings; promote responsible media reporting; reduce access to lethal means; promote suicide prevention as a core component of health care services; and evaluate the impact and effectiveness of suicide prevention interventions and systems.

The three committees are using the collective impact approach to ensure mutually reinforcing strategies, a common agenda and measurement system, regular ongoing communication, and strong backbone support to improve the success of the initiatives. The common foundational goals of Live Well Washington County to reduce health disparities and improve health equity, strengthen the focus on prevention and build community partnerships and collaboration through collective impact.

In addition to tracking progress on specific objectives and strategies throughout the Live Well Washington County work plans (Appendix A), the following long-term measures and infrastructure goals will be tracked (Appendix B):

Priority Health Issue	Targeted Health Improvement Tracking 2014-2018
Chronic Disease	Decrease percent of population with low or no healthy food access (track by race/ethnicity)
	Increase percent of adults with adequate fruit and vegetable consumption
	Increase percent of adults who engage in regular physical activity
Suicide	Decrease age-adjusted suicide rate
	Decrease suicide count by year
	Track suicide rates by vulnerable population
Access to Health Care	Increase percent of population with a regular doctor
	Increase primary care physician per 100,000 population
	Increase adults with some type of health insurance
Foundational Goals	**Live Well Infrastructure Tracking**
Health Equity	Align with recommendations from local and regional equity plans
	Incorporate a healthy equity lens through all CHIP work plans
Prevention	Develop a strategic framework for prevention in Washington County—with ongoing focus on equity and cultural responsiveness
Partnership and Collaboration	Track number of organizations participating in the CHIP
	Grant dollars awarded to support CHIP objectives
	Score on the Collective Impact Maturity Model (Appendix C)

II. Washington County Demographics

Washington County, located west of Portland, Oregon, is one of three counties making up the Portland metropolitan area. The county spans 724 square miles and is the second most populous county in Oregon. Approximately 30,000 residents live in designated rural areas.

The birth rate in Washington County has historically been one of the highest in the state. In 2013, the birth rate was 13 births per 100,000 population, which is significantly higher than the state average of 11.5 births per 100,000 population. Washington County also has the lowest death rate in Oregon, with only 5.8 deaths per 100,000 population in 2013. The high birth rate and low death rate contribute to the population growth of the county. The population of Washington County has grown by approximately 3.4% per year since 1990, reaching nearly 555,000 residents in 2013, which is a higher rate of growth compared with both Oregon and the U.S.

Washington County is the second most diverse county in Oregon, with 23% of residents reporting a race other than white. Between 2000 and 2010, Washington County experienced a 67% increase in the Hispanic population, which is higher than the state and national average increase. Approximately 17% of Washington County residents are foreign born, with approximately 36% of these reporting white race, 35% reporting Asian race and 41% reporting Hispanic ethnicity independent of race. Close to 11% of Washington County residents are not U.S. citizens, and of these 42% speak a language other than English at home.

Washington County has a significantly lower number of families living below poverty level (8%) than the U.S. county average (11%). However, the burden of poverty does not fall equally among races and ethnicities. American Indians or Alaska Natives make up approximately 27% of families living below poverty, as do 24% of those reporting Hispanic ethnicity, independent of race. Although Washington County has one of the lowest high school dropout rates (1.3% in 2011) and highest high school graduation rates (80%), there are considerable disparities along racial and ethnic groupings. Approximately 4% of non-Hispanic white residents over the age of 25 do not have a high school diploma, whereas 41% of Hispanic residents report having no high school diploma.

III. Determining Health Priority Areas

A summary of the Healthy Columbia Willamette Collaborative Community Health Needs Assessment*

In 2010, local health care and public health leaders began to discuss the upcoming need for several community health assessments and health improvement plans within our region in response to the Affordable Care Act and Public Health Accreditation. They recognized that the most efficient and effective approach would be to create a work group responsible for conducting a region-wide community health assessment for Clackamas, Multnomah, Washington counties (Oregon) and Clark County (Washington).(10%) and the nation (13%).

Membership

With start-up assistance from the Oregon Association of Hospitals and Health Systems, the Healthy Columbia Willamette Collaborative was developed. It is a large public-private collaborative comprised of fourteen hospitals, four local public health departments and two coordinated care organizations in the four-county region. Members include: Adventist Medical Center, Clackamas County Health Division, Clark County Public Health Department, FamilyCare, Health Share of Oregon, Kaiser Sunnyside Hospital, Legacy Emanuel Medical Center, Legacy Good Samaritan Medical Center, Legacy Meridian Park Medical Center, Legacy Mount Hood Medical Center, Legacy Salmon Creek Medical Center, Multnomah County Health Department, Oregon Health & Science University, PeaceHealth Southwest Medical Center, Providence Milwaukie Hospital, Providence Portland Medical Center, Providence St. Vincent Medical Center, Providence Willamette Falls Medical Center, Tuality Healthcare/Tuality Community Hospital and Washington County Public Health. Multnomah County Health Department applied for and was given the contract to be the legal entity and neutral convener for the first three-year cycle. Year one started in June 2012.

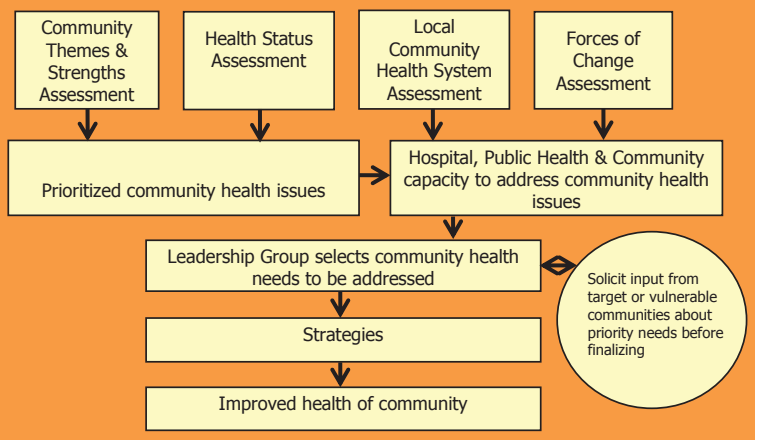
Vision

Align efforts of hospitals, coordinated care organizations, public health and the residents of the communities they serve to develop an accessible, real-time assessment of community health across the four-county region.

It will eliminate duplicative efforts, lead to prioritization of community health needs, enable joint efforts for implementing and tracking improvement activities, and improve the health of the community.

Assessment Model

The Healthy Columbia Willamette Collaborative is using a modified version the Mobilizing for Action through Planning and Partnerships (MAPP) assessment model (see image below). The MAPP model uses health data and community input to identify the most important community health issues.



Five phases of this assessment model were completed between August 2012 and April 2013:

The Community Themes and Strengths Assessment (Fall 2012)

This first assessment involved reviewing 62 community engagement projects that had been conducted in the four-county region since 2009. Findings from the 62 projects were analyzed for themes about how community members described the most important health issues affecting themselves, their families and the community.

The Health Status Assessment (Fall 2012)

The second assessment was conducted by epidemiologists from the four county health departments with representatives from two hospital systems acting in an advisory capacity.

This workgroup systematically analyzed quantitative population health-related behavior and outcome data to identify important health issues affecting each of the four counties as well as the four-county region. More than 120 health indicators (mortality, morbidity and health behaviors) were studied.

The analysis used the following criteria for prioritization:

- disparity by race/ethnicity,
- disparity by gender,
- a worsening trend,
- a worse rate at the county level compared to the state,
- a high proportion of the population affected,
- and a severe health consequence.

The Local Community Health System Assessment & Forces of Change Assessment (Winter 2013)

The third and fourth assessments were combined and involved interviewing and surveying 126 stakeholders. This assessment was designed to solicit stakeholder feedback on the health issues resulting from the first two assessments listed above. Stakeholders were asked to add and prioritize health issues they thought should be on the list, as well as describe their organizations' capacity to address these health issues.

Community Listening Sessions (Spring 2013)

The next phase is not a formal MAPP component, but was added to ensure the findings from the four assessments resonated with the local community. Fourteen community listening sessions were held with uninsured and/or low-income community members living in Clackamas, Clark, Multnomah and Washington counties. In all, 202 individuals participated. During these meetings, community members were asked whether they agreed with the issues that were identified through the four assessments. Participants were also asked to add to the list the health issues that they thought were missing. Next, participants voted for what they thought were the most important issues from the expanded list. The findings of this assessment resulted in the following

Findings from First Five Phases

After all of the four assessments and community listening sessions were completed, the findings from all combined point to the following "health focus areas" as the most important health issues affecting the four county community (in alphabetical order):

- Access to affordable health care
- Cancer
- Chronic Disease (related to physical activity and healthy eating)
- Culturally-competent services and data collection
- Injury (falls and accidental poisoning/overdose)
- Mental health
- Oral health
- Sexual health (Chlamydia)
- Substance abuse

Healthy Columbia Willamette Selection Process

Recognizing that nine focus areas would be too many to address in a way that could affect the improvement of indicators over a few-year time period. The Collaborative developed selection criteria to further prioritize health issues from the list above. The health focus area will be/have

- identified by at least two of the three community engagement activities (i.e., Community Themes & Strengths Assessment, Local Community Health System & Forces of Change Assessment and/or the community listening sessions);
- identified as a health issue (with indicators) through the Health Status Assessment OR if data are not currently available;
- one of the top five most expensive in the metropolitan statistical areas in western U.S. OR if data are not currently available; and
- been shown to improve as a result of at least one type of intervention (evidence-based practices).

Health Focus Areas Identified after Selection Criteria Applied

Those health focus areas that meet these criteria for the region include (in alphabetical order):

- Access to affordable health care
- Chronic disease (related to physical activity and healthy eating)
- Mental health
- Substance abuse

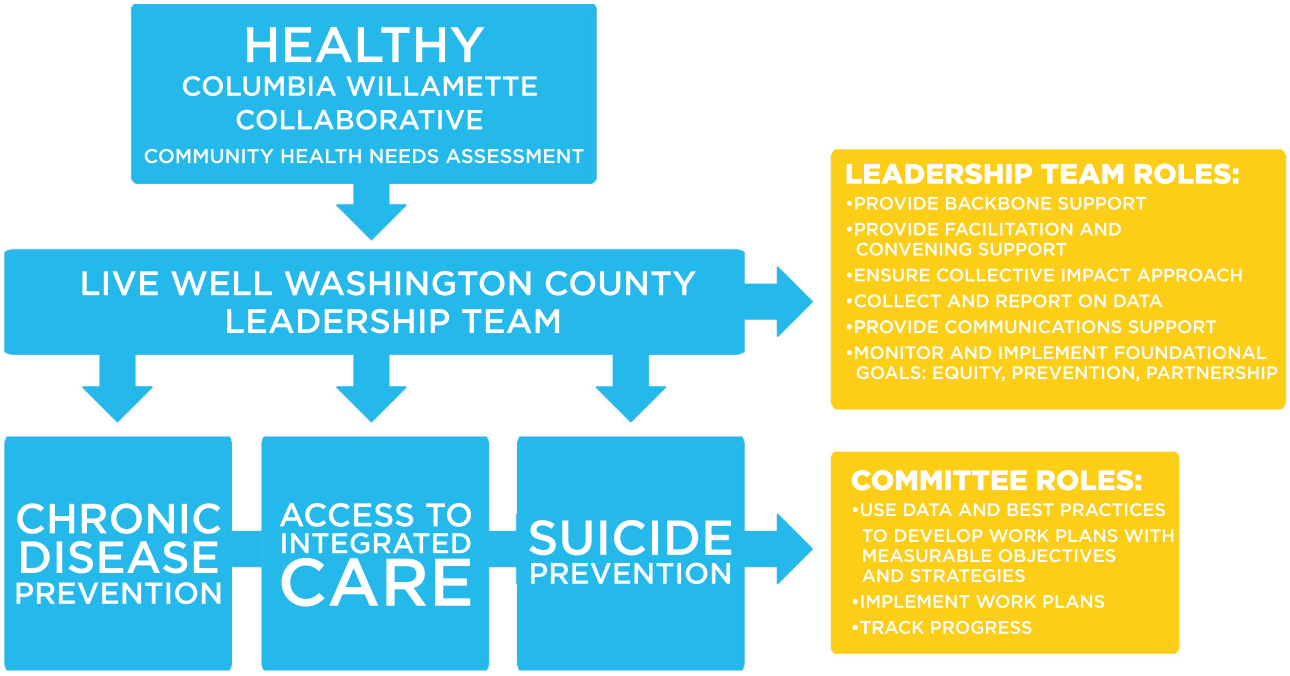
*This section was prepared by:

Christine Sorvari, MS
Healthy Columbia Willamette
C/O Multnomah County Health Department
503-988-8692
christine.e.sorvari@multco.us

IV. The Community Health Improvement Planning Process

Live Well Washington County is led by a leadership team of four community partners with expertise in the health priority areas and includes three multisector committees implementing strategies to address each of those areas.

Live Well Washington County Structure:



The Live Well Washington County process included the following steps:

Preparation and Planning

In 2012, Washington County Public Health and regional partners initiated a community health assessment effort, using the adapted MAPP process, through the Healthy Columbia Willamette Collaborative described in section III. In Washington County, a community-based leadership team was formed to review the findings from this process and to determine the priorities for Live Well Washington County, which include improving access to health care, preventing chronic disease and preventing suicide. The CHIP leadership team participated in the 2014 National Leadership Academy for the Public's Health, a year- long program designed to build community leadership teams to create and implement successful community-driven health improvement plans. The team led efforts to foster multisector participation, develop policy and environmental approaches, utilize collective impact, improve the focus on equity, implement meaningful data collection, and build individual and team leadership skills to support long-term collaborative success. The leadership team also provided oversight of the plan and coordination of outreach, communications and measurement.

Community Involvement

For each of the three priority areas, a multisectoral community collaborative was formed to lead development and implementation of strategies to address each of the three priority areas. Those committees are: (1) the Access to Integrated Health Care Committee; (2) the Chronic Disease Prevention Committee; and (3) the Suicide Prevention Council. The committees are comprised of more than 60 partners from across key sectors and utilize the collective impact approach. This approach aligns with the vision of the CHIP to be "a strategic plan for the community's health." The approach increases impact by aligning goals, strategies and measurement, maintaining backbone support and ensuring regular communication.

Development of the Plan

The committees identified objectives, strategies and detailed work plan. They used numerous sources and tools to identify strategic approaches to address the three priority areas. Those include local data; evidence-based and best practice approaches; local, state and national recommendations; and other local agencies' work plans. In addition to the specific priority areas, the committees also identified three foundational goals to integrate across Live Well Washington County. Those are reducing health disparities and improving health equity; strengthening the focus on prevention; and improving community partnership and collaboration.

Each committee conducted a variation of the following steps to identify objectives and strategies:

- Review of the Healthy Columbia Willamette Collaborative Community Health Needs Assessment and local data, including the following:
  - Local demographics
  - Community health data
  - Issues prioritized by the assessment process
- Review of national recommendations to determine framework for planning
- Review of current work and strategies (among participants and other partners)
- Use of crosswalk tools (see Appendix D) to identify potential objectives and strategies based on the following:
  - Evidence-based and best practices
  - Identified gap areas
  - Other aligned plans
  - Potential opportunities for collaboration
- Review of potential strategies with the following discussion topics:
  - Is your agency involved in this work?
  - Do you want to advocate for the committee to vote for this strategy?
  - Do you think it would be ideal for collaborative work?
- Voting on years 1-2 and long-term strategies based on the following criteria
  - Alignment with other local planning documents
  - Alignment with national, state and local recommendations
  - Alignment with capacity and your agencies work
  - Supported by data and best practices
  - Potential opportunities to collaborate

The intent of the planning process is to develop a CHIP that complements and aligns with other local, state and national planning efforts including the following: Creciendo Juntos Key Goals, National Prevention Strategy (2011), National Strategy for Suicide Prevention (2012), Oregon Health Authority Behavioral Health Strategic Plan (2015-2018), Oregon Health Equity Alliance Five Year Health Equity Plan (2012-2017), Oregon's Healthy Future: A Plan for Empowering Communities (2013), Washington County 2020 Transportation Plan, Washington County Early Learning Community Hub planning, Washington County Food Systems Plan (2013), Washington County Public Health Strategic Plan (2014 update) and coordinated care organization and local hospital community health improvement plans.

Implementation

Live Well Washington County is a measurable work plan for community partners to use in their own agencies to support aligned strategies. Multisector community partners will use the plan to set priorities, coordinate activities and target resources. This document will be a five-year guide as Washington County partners strive to improve community health in the three priority areas. The Live Well Washington County is a living document — the plan will continue to grow and evolve as all committees continue to meet and refine the work.

Measurement and Tracking

The Live Well Washington County leadership team will provide support with data collection and reporting in order to track progress toward meeting all committee objectives. The measurement system includes three levels of tracking: (1) long-term targeted health improvement indicators (Appendix B); (2) indicators to show progress on the chosen objectives (Included in work plans in section VII and in Appendix A); and (3) methods to track progress on the individual strategies (included in Appendix A).

Washington County Public Health and other backbone support organizations will ensure ongoing measurement and tracking of the Live Well objectives. In addition, the Washington County Public Health Advisory Council (members appointed by the Board of County Commissioners) will provide ongoing monitoring of the overall progress. An online dashboard system will be used to visually track progress on the objectives and strategies. These indicators will be reviewed with the committees in order to ensure progress, celebrate successes and identify opportunities for improvement.

The Collective Impact Approach:

Collective impact initiatives are long-term commitments by key multisector partners to address issues and reach common goals. Research has supported five key conditions that lead to successful collective impact initiatives that produce powerful results: a common agenda, shared measurement systems, mutually reinforcing activities, continuous communication and backbone support organizations. Live Well Washington County's process incorporated these five conditions in the following ways:

A Common Agenda

Collective impact requires partners to have a common understanding of the problem and a joint approach to solving it through agreed upon actions. The Live Well Washington County CHIP committees used local community health assessment data, research on evidence-based best practices and national and state recommendations to develop common goals and objectives. The committees identified common objectives based on the following criteria: (1) supported by local data and best practice approaches; (2) aligned with current agency goals and work plans; (3) aligned with current capacity to support work on the objective; (4) and opportunities to collaborate among CHIP partner organizations.

Shared Measurement Systems

In order to support progress and ensure common goals, it is necessary that partners agree on how to track and measure progress and success. For each of the three committees, there are long term and short term performance measures identified that will continue to evolve with the work plan (See Appendix A and B). The performance indicators will ensure increased accountability and enable partners to see the shared progress across the priority areas. The three committees, the backbone support organizations, and the Washington County Public Health Advisory Council all have a role in tracking and monitoring CHIP progress.

Mutually Reinforcing Activities

Each partner involved in the multisector CHIP committees brings unique expertise, experience and resources to the table. Increasing collective impact requires identifying the most effective way these roles and particular capabilities can fit together to support the chosen goals and objectives. The work plans identified by each CHIP committee include unique roles for each partner.

Continuous Communication

In order to support a common agenda, shared measurement and mutually reinforcing activities, it is essential that there is regular communication across partner organizations. It is important to develop a structured way for all involved partners to communicate about progress on the initiative in order to increase accountability and reduce duplication. Live Well Washington County developed structured meetings with regular meeting times and structured agendas.

In addition, the Live Well Washington County newsletter was developed as a method to share new research and articles related to CHIP objectives for the three committees and for partners to share information about current programs and upcoming events.

Backbone Support

To ensure a sustainable and successful process, it is crucial to have a backbone support organization to manage collaborative partnerships. In addition, a backbone support organization is necessary to provide the infrastructure and capacity to plan, manage and support the initiative through ongoing facilitation, technology and communications support, data collection and reporting, and handling of logistical and administrative details. This is especially important in order to maintain continued focus on the other four components of collective impact. Washington County Public Health, in partnership with the Live Well Washington County leadership team, is providing the backbone support that will help ensure progress toward the chosen goals.

V. Implementation and Tracking

Foundational Goal #1:

Health Equity

Social determinants of health are the economic and social conditions that influence a person's opportunity to be healthy. Health begins long before a person needs medical care. It begins in families, neighborhoods, schools and jobs and is connected to a person's income, education, age, race, or ethnicity. Vulnerable populations often experience health disparities, which mean they have poorer health outcomes than other segments of the population. Outcomes such as disparities in mortality and morbidity are often avoidable and associated with social disadvantages that create barriers to opportunities.

Addressing these disparities is a necessary step to have a positive and lasting impact on the community's health. Striving to realize health equity in Washington County will be achieved by incorporating equity into each of the priorities outlined in Live Well Washington County.

Statement of Need

Washington County is the second most diverse county in Oregon, with 23% of residents reporting a race other than white. The county has a higher percentage of Asians (9%) compared with Oregon (5%) and persons reporting Hispanic ethnicity (16%) in comparison to the Oregon average (12%). Between 2000 to 2010, there was a larger increase across every racial group compared with the state of Oregon. The Hispanic population in Washington County increased by a greater amount (67%) than the state average (64%) and the national average (43%).

Approximately 90,000 residents of Washington County are foreign-born, which includes anyone who was not a US citizen or national at birth. Washington County has a much higher percentage of the population that is foreign-born (17%) than the state (10%) and the nation (13%). 66% of the foreign-born population speaks a language other than English at home. Of those who speak a language other than English at home, 17% are living below the poverty level, versus 8% of those who speak only English at home (ACS 2008-12).

Washington County has a lower percentage of individuals (27%) living in households with an income below 200% of the Federal Poverty Level compared with Oregon (35%) and the national average (34%). However, the burden of poverty does not fall equally among races and ethnicities. American Indians or Alaska Natives make up approximately 27% of families living below poverty level, as do 24% of those reporting Hispanic ethnicity, independent of race. This indicator is relevant because poverty creates barriers to access to health services, healthy food and other necessities that contribute to poor health status (Community Commons).

Incorporating equity into the CHIP

Health equity is an essential component to Live Well Washington County. As evident from the preceding data, Washington County's population is diverse and attention must be paid to strategies that address the social determinants of health. Priority areas for the CHIP were selected based on a robust community health assessment. This assessment included analysis of quantitative population health-related behavior and outcome data to identify important health issues based on factors such as disparity by race/ethnicity and by gender. Additionally, qualitative data was gathered through stakeholder interviews and community listening sessions. These were designed for culturally identified residents to ensure the findings of the quantitative assessment resonated with the community. Utilizing this comprehensive assessment to determine the priorities for Washington County's CHIP helps ensure that the strategies selected reflect the health needs of those most vulnerable to negative health outcomes.

The priorities identified through the community health needs assessment were used to form the three CHIP committees. All CHIP committees include broad representation from traditional and nontraditional community partners, representing some of Washington County's most vulnerable residents. CHIP committees utilized best practices and existing equity plans and recommendations to inform objective and strategy development. These included Oregon Health Equity Alliance 5-Year Plan and The Oregon State of Equity Report. Many of the objectives selected for the first year and into the future align closely with these other plans.

In order to ensure an ongoing commitment to health equity throughout the implementation of the Live Well Washington County, the CHIP leadership team and all three committees will implement the following goals:

FOUNDATIONAL GOAL: Health Equity

GOAL: Integrate strategies that support improved health equity across the Live Well Washington County health priority areas

EQUITY OBJECTIVE #1

Align CHIP objectives and strategies with statewide and regional equity work plans and recommendations.

STRATEGY

1.1 Include "aligned with other plans and recommendations" as criteria for selection of CHIP objectives and strategies.

1.2 Review the Oregon Health Equity Alliance 5 year Plan with all committees

OUTCOME INDICATORS

- Alignment of CHIP objectives and strategies with equity work by OHEA, and other strategic plans focused on health equity

EQUITY OBJECTIVE#2

Develop and implement evaluation criteria to assess equity alignment among all CHIP committees.

STRATEGIES

2.1 Align CHIP data collection practices with equity plans to ensure common measurement system.

2.2 Utilize Equity and Empowerment Lens tool in all CHIP committees to evaluate objectives for appropriateness.

2.3 CHIP partners participate in data collection training to improve accuracy and effectiveness of collection methods.

OUTCOME INDICATORS

- Evaluation criteria developed
- Evaluation criteria used to identify opportunities for improvement
- Equity and Empowerment Lens used by three CHIP committees
- Percent of Live Well partners participating in data collection training

Health Equity continued

EQUITY OBJECTIVE #3

Provide regular updates to equity coalitions and to advocacy and service organizations on CHIP progress to ensure accountability.

STRATEGIES	OUTCOME INDICATORS
3.1 Participate in community meetings and provide CHIP updates as appropriate.	• Bi-annual updates to OHEA coalition • Annual updates to other equity partners • Published CHIP and updates in various languages
3.2 Publish CHIP and updates in a variety of formats to ensure accessibility for all community partners and residents.	

EQUITY OBJECTIVE #4

Ensure broad participation by non-traditional partners in all CHIP committees.

STRATEGIES	OUTCOME INDICATORS
4.1 Provide invitations to Oregon Health Equity Alliance members and other identified partners to all CHIP committee meetings.	• Representatives from identified key sectors based on equity mapping participate in CHIP • OHEA members included on CHIP email distribution lists
4.2 Recruit CHIP partners through a variety of avenues to ensure multisector representation.	

Foundational Goal #2:

Prevention

Prevention cultivates environments for overall health and well-being. It is dynamic and ongoing and designed to reduce risk factors and promote protective factors that support the development of healthy, safe and nurturing communities. All aspects of prevention are connected and should be interwoven to achieve population-level change and systems transformation. Prevention policies and programs reduce physical and behavioral health care costs and improve overall productivity and quality of life. Collective impact is key to successfully integrating prevention efforts.

By focusing on the promotion of physical, behavioral and social health while also advocating for the prevention of disease and illness, Live Well Washington County partners can create healthier environments. These include homes and families, workplaces, schools and communities where people have the opportunity to live long and productive lives. Better health and well-being positively impacts our communities and our economy. For example, with better physical and behavioral health, children are more prepared to enter school, are in school more days and are better equipped to learn; adults are more productive and present at work; and seniors maintain their independence.

Statement of Need:

Washington County is the home for 36,894 children ages zero through five(1), 29,980 (54.8%) of which are at risk of not being ready for kindergarten. Children who experience one or more of the following are defined as at risk: 1) children of color, 2) children with disabilities, 3) English-language learners, 4) low-income children (family incomes at or below 185% of Federal Poverty Level), 5) homeless and migrant children, and 6) abused and trauma-affected children.

Among the 136,795 children under eighteen in Washington County, 15,254 (11.2%) are Asian and 34,603 (25.3%) are Hispanic, which are Washington County's two largest minority populations. Overall Washington County has 16.1% Hispanic residents and 9.3% Asian residents. (2)

10.9% of Washington County's residents live in poverty (below the poverty level). 14.2% of children under 18 and 21.6% of Hispanic residents in Washington County live in poverty. However, 26.9% of all Washington County residents have incomes at or below 185% of poverty.

1. U.S. Census Bureau; American Community Survey, 2013 American Community Survey 1-Year Estimates, using American FactFinder; <http://factfinder2.census.gov>; (19 December 2014).
2. Source: 1) NCHS Population Estimates: National Center for Health Statistics (NCHS), Estimates of the resident population of the United States by year, county, age, bridged race, Hispanic origin, and sex (Vintage 2012). 2) Census Bureau Population Estimates: U. S. Census Bureau, Population Division, Annual Estimates of the Resident Population by Age, Sex, Race, and Hispanic Origin for Counties (Vintage 2012).

Community partners have identified the need for cross-sector partnerships and to create a culture of innovation that emphasizes upstream prevention. By sharing accountability for the common values and goals, partners can better address equity, share funding and leverage limited resources.

Incorporating prevention in to the CHIP

A focus on prevention throughout Live Well Washington County will help improve the health, quality of life and prosperity of residents. Community partners have identified three distinct ways in which this can be accomplished. These include expansion and incorporation of prevention efforts into CHIP strategies throughout a broad range of community sectors; participation of CHIP committee members with specific expertise in prevention and upstream intervention; and alignment with existing prevention-based reports and planning documents, such as the Washington County Early Learning Community Hub and the Creciendo Juntos Key Goals.

In order to ensure an ongoing commitment to prevention throughout the implementation of Live Well Washington County, the Live Well leadership team and the committees will implement the following goals:

FOUNDATIONAL GOAL: Prevention

GOAL: Integrate strategies that support prevention across the Live Well Washington County health priority areas

PREVENTION OBJECTIVE #1

Develop a strategic framework for prevention in Washington County — with ongoing focus on sustainability, equity and cultural responsiveness.

STRATEGY	OUTCOME INDICATORS
1.1 Develop a needs assessment and inventory of prevention services throughout the county; assess current level of capacity and readiness.	• Completed needs assessment; developed inventory of prevention services • Strategic prevention framework implemented and incorporated in to Live Well Washington County work plan.
1.2 Conduct a strategic planning process to identify comprehensive inventory of services, needs, strengths, and program/service gaps in the prevention system.	
1.3 Incorporate strategic plan objectives in to Live Well Washington County plan.	

PREVENTION OBJECTIVE #2

Incorporate strategies in to the CHIP to promote equity and physical and social wellness, through the reduction of inequality and poverty and mitigation of Adverse Childhood Experiences (ACEs).

STRATEGY	OUTCOME INDICATORS
2.1 Apply the Equity and Empowerment Lens for reducing disparities and disproportionate risks to programs, policies, practices, goals, strategies and services implemented through the CHIP work plan.	• Ongoing application of equity and empowerment lens • Percent of CHIP partners involved in ACES planning
2.2 Prioritize family-centered and trauma-informed planning and family engagement to achieve positive outcomes through intergenerational reduction of ACEs, inequality and poverty.	

Prevention continued

PREVENTION OBJECTIVE #3

Develop and support policies, procedures and practices in local systems that are trauma-informed, family-centric, culturally responsive, and build equity and resiliency among the workforce, families, individuals and children.

STRATEGY	OUTCOME INDICATORS
3.1 Develop tools to support policy, procedures and practices that are aligned with the prevention framework.	• Number of new policies implemented as result of CHIP objectives • Tools developed to inform policy development and practices that are informed by the prevention framework • CHIP performance measures are aligned with prevention goals
3.2 Develop a system of shared measurement and accountability for prevention.	

PREVENTION OBJECTIVE #4

Develop funding and support implementation of cost-effective, evidence-based prevention programs and environmental strategies, particularly upstream prevention with a focus on prenatal and early childhood life stages.

STRATEGY	OUTCOME INDICATORS
4.1 Develop a sustainable funding plan for an aligned and coordinated prevention system, which includes evidence-based environmental strategies, as well as targeted programming emphasizing the promotion of equity and mitigation of risk in key prevention focus areas.	• Track dollars devoted to prevention strategies • Funding plan developed • Strategies aligned with the Washington County Early Learning Community Hub
4.2 Develop mechanisms for opportunities to share and leverage funding.	

Foundational Goal #3:

Partnership and Collaboration

Effectively addressing complex health issues requires dedication and partnership from a broad range of organizations and agencies. Representatives from multiple sectors need to be involved in planning and implementation processes to effect change at the policy, systems and environmental level. Each organization plays a unique role in supporting the community's health. By taking a collective impact approach, efforts will be better aligned to have the greatest impact on addressing health issues. Collective impact requires commitment from partners to work together differently and shift towards a focus of collaborative work to achieve common goals.

Statement of Need:

While Washington County has a long history of strong community partnerships and collaborations, there is still a need for better alignment of goals and integration of efforts. Traditionally, partners have integrated within sectors but struggled to develop and maintain cross-sector collaborations. Even among the most effective collaborations, gaps still exist. Without a broad range of perspectives to inform planning and implementation of various community-based processes, the results may not be the best fit for the entire community.

Incorporating prevention in to the CHIP

The Live Well Washington County leadership team and partner organizations have made it a priority to build the health improvement plan on a foundation of cross-sector collaboration. This will create effective, lasting change and make the greatest impact on the community's health. The leadership team identified stakeholders from multiple sectors to represent the diverse perspectives and voices in the community. As the committees developed shared goals and objectives, current work was identified and the committees incorporated strategies to expand and build on current projects. This approach will help ensure better use of limited resources, reduce duplication of efforts and identify opportunities for aligned goals and strategies.

The Live Well Washington County leadership team is in the process of developing a formal outreach plan based on identified gaps in order to ensure that all groups from the community are represented in the plan. Washington County Public Health and the Live Well Washington County leadership team are committed to continuing to track and improve the collective impact approach through the three CHIP committees. The Collective Impact Maturity Model tool (Appendix C) will be used to track progress on key goals related to partnership and collaboration.

FOUNDATIONAL GOAL: Partnership & Collaboration

GOAL: Develop and implement the CHIP process to strengthen and support partnership and collaboration across Washington County

PARTNERSHIP AND COLLABORATION OBJECTIVE #1

Implement a collaborative effort to identify short and long term goals and develop a strategic work plan that aligns with current work by partners and health priorities identified in the regional Community Health Needs Assessment (CHNA).

STRATEGY	OUTCOME INDICATORS
1.1 Review priority health issues and outcomes from the CHNA and identify current work by partners that could support issues.	• Regional CHNA findings reviewed by each committee • Work plan including goals, objectives, strategies, tasks, performance indicators and target dates developed by each committee • Work plans updated every six months
1.2 Develop potential objectives and strategies through collaborative committee meetings and meetings with partners absent from meetings.	
1.3 Committee partners vote on strategies to align work plan with current efforts, local data, and evidence-based best practice recommendations.	
1.4 Meet regularly to track progress on implementation.	

PARTNERSHIP & COLLABORATION OBJECTIVE #2

Increase CHIP involvement by identified key sectors and ensure there is representation from key stakeholders in the community.

STRATEGY	OUTCOME INDICATORS
2.1 Identify key stakeholders based on a community asset mapping process.	• Percent of key identified sectors represented on the three committees • Percent of new organizations that participate in CHIP as a result of outreach efforts • Outreach efforts tracked and updated every 6 months
2.2 Develop and implement outreach plan.	
2.3 Track progress on outreach efforts.	

Partnership & Collaboration continued

PARTNERSHIP & COLLABORATION OBJECTIVE #3

Develop and implement a CHIP communication and messaging plan to improve outreach efforts.

STRATEGY
3.1 Identify needed components (newsletter, website, one pagers)
3.2 Survey CHIP partners to identify the most helpful tools.
3.4 Develop communication tools including a simple presentation and one page.
3.4 Identify and seek resources for needed communication tools.

OUTCOME INDICATORS

- Communication and messaging plan developed
- Outreach tools developed
- Resources identified to support CHIP website or other needed outreach tools

PARTNERSHIP & COLLABORATION OBJECTIVE #4

CHIP leadership team provides infrastructure and backbone support to the CHIP process to support multisector participation.

STRATEGY
4.1 Develop materials to facilitate collaboration in decision making and planning efforts.
4.2 Track strategic work plan progress through measurement system based on adapted Community Balanced Scorecard.
4.3 Provide support for coordinating logistics, convening partners, facilitating meetings, and tracking progress

OUTCOME INDICATORS

- Committee meetings held at least quarterly
- Leadership team meeting held at least bi-monthly
- CHIP work plan updated every 6 months
- Washington County Public Health Advisory Council tracking progress on CHIP objectives

Priority #1:

Access to Integrated Health Care

Access to healthcare is a critical aspect of preventive health medicine. Due to national policy changes, millions of Americans are gaining access to insurance coverage. However, insurance coverage is only a starting point for meaningful preventive and primary care services. Health insurance coverage does not guarantee availability of culturally appropriate care, sufficient providers or affordable health care services.

Access to healthcare emerged as a priority health issue in Washington County because the data show Washington County has lower levels of adults with health insurance, low non-physician primary care provider rate and a low level of mental health providers. In 2013, 81% of adults had some type of health insurance, which is slightly lower than the national county average of 82%. Within health insurance coverage, there are disparities with only 49% of Hispanic/Latino residents reporting health insurance, compared to the Asian population with 91% health insurance coverage. The non-physician primary care provider rate in Washington County is lower than the national county average of 47.2 providers per 100,000 population, with only 46 providers per 100,000 population. The ratio of mental health providers per population is also of concern. Washington County has a ratio of one mental health provider per 632 population in comparison with the state average of 1:410. This was the top health issue reported by the community. In addition to the data suggesting an issue with access to care, 88% of interviewed community stakeholders reported access to care as a priority.

Assets and Resources to Support Access to Care

- Strong partnerships and collaborations between health care partners
- Coordinated donated care model
- Premium assistance project
- Patient care navigators
- Coordinated Care Organizations addressing access issues for Medicaid population
- Federally Qualified Health Centers (FQHCs)
- School-Based Health Centers (SBHCs)
- Hospital and FQHC partnerships to connect uninsured to care
- Walk-in clinic for uninsured
- Free care clinics to uninsured in faith based settings

About the Access to Integrated Care Committee and the Planning Process

The Access to Integrated Care Committee is committed to improving access to affordable and culturally appropriate services across the community. With a rapidly changing health care environment, it is more important than ever for partners to collaborate to identify the most effective systems approach.

The Washington County Access to Integrated Care Committee is comprised of key partners from across the health care system. This committee is an expansion of a past committee that did not include behavioral and oral health partners. The addition of these partners and other community groups was essential to building a collective impact framework

Prior to the first meeting, the backbone support partners conducted phone interviews to identify individual interests of each of the organizations participating in the process. In addition, the backbone support partners used local data and local planning documents, including community health improvement plans developed by local hospitals and coordinated care organizations, to develop potential objectives and strategies that align with participants' goals.

The committee reviewed access to care data and discussed the goals and structure of the committee. This was used to inform the committee in reviewing, revising and finalizing the objectives. The committee then used a crosswalk tool (see Appendix D) to review potential strategy ideas and discuss them based on alignment with their capacity, existing work in the county and identified gap areas. The committee voted based on the set criteria described in section VI.

The following tables describe the objectives and strategies identified by the committee. See Appendix A for a more detailed work plan. This work plan is a living document and the strategies outlined in this section and Appendix A will change and evolve over the five year time period. Appendix A is updated every six months.

PRIORITY 1: Access to Integrated Care

GOAL: Improve access to quality, affordable, culturally-responsive health care for residents of Washington County

ACCESS TO INTEGRATED CARE OBJECTIVE #1

Assure health insurance coverage to residents of Washington County.

SHORT TERM STRATEGY

1.1 Integrate SBHCs into alternative payment methodology (support regional strategies).

1.2 Ensure all health insurers reimburse for services provided at SBHCs.

LONG TERM STRATEGY

1.3 Support expansion of coverage for undocumented youth (DREAM Act Youth).

OUTCOME INDICATORS

- Alternative Payment Model for SBHCs identified and adopted
- Percent of health insurers who reimburse for SBHC services
- Legislation passed to expand coverage to undocumented youth

ALIGNMENT

- Oregon Latino Health Coalition's Health Care for All Children 2015 Legislative Campaign
- Washington County Early Learning Community Hub
- Regional Alternative Payment Innovation Project

RECOMMENDED POLICY CHANGES

- Legislation to support expanded coverage to DREAM Act youth

Access to Integrated Care continued

ACCESS TO INTEGRATED CARE OBJECTIVE #2

Increase capacity, connection to and utilization of a health home for newly insured and remaining uninsured in Washington County.

SHORT TERM STRATEGY

2.1 Develop inventory of current strategies to expand access including identification of barriers to accessing care.

2.2 Identify and implement strategies to address barriers identified by the inventory including patient navigation, increasing resources and workforce.

LONG TERM STRATEGY

2.3 Improve workforce diversity through support of community health workers (CHWs).

OUTCOME INDICATORS

- Inventory of current strategies developed and maintained (updated every six months)
- Monitor access to care: number of new clients served, demographics of clients served, data on pilots to reduce cost to uninsured patients, percent of population with a regular doctor, primary care physicians per 100,000 population

ALIGNMENT

- Oregon Health Equity Alliance (formerly HOPE Coalition) Five Year Health Equity Plan 2012-2017
- Washington County Clinic Transition Stakeholder Subcommittee
- Health Share of Oregon Community Health Improvement Plan, 2014

RECOMMENDED POLICY CHANGES

- TBD

Access to Integrated Care continued

ACCESS TO INTEGRATED CARE OBJECTIVE #3

Improve capacity and utilization of behavioral health services (including prevention and early intervention) for underserved populations and eliminate avoidable health gaps and health disparities in Washington County's behavioral health care system.

SHORT TERM STRATEGY

3.1 Improve access to culturally competent and appropriate behavioral health services based on study from the Oregon Healthy Future's advisory group (Strategy #3 in Oregon Healthy Futures).

LONG TERM STRATEGY

3.2 Support strategies to improve capacity and utilization for behavioral health services for youth, including undocumented youth.

OUTCOME INDICATORS

- Plan for improving culturally competent and language appropriate behavioral health services developed
- Number of SBHCs with behavioral health services available 5 days/ week

ALIGNMENT

- Oregon Health Equity Alliance (formerly HOPE Coalition) Five Year Health Equity Plan 2012-2017
- Health Share Community Health Improvement Plan, 2014
- Oregon's Healthy Future: A Plan for Empowering Communities, 2013
- Oregon Health Authority Behavioral Health Strategic Plan, 2015-2018

RECOMMENDED POLICY CHANGES

- TBD

Access to Integrated Care continued

ACCESS TO INTEGRATED CARE OBJECTIVE #4

Improve capacity and utilization of affordable, preventive and integrated oral health services for underserved populations in Washington County.

STRATEGY

4.1 Expand access to integrated oral health services through federally qualified health centers and community clinics.

LONG TERM STRATEGY

4.2 Expand integrated oral health services in all Washington County SBHCs.

OUTCOME INDICATORS

- Number of SBHCs, FQHCs and community clinics that comprehensively integrate oral health care into their activities

ALIGNMENT

- Strategic Plan for Oral Health in Oregon, 2014-2020
- Oregon's Healthy Future: A Plan for Empowering Communities, 2013
- Health Share Community Health Improvement Plan

RECOMMENDED POLICY CHANGES

- TBD

Access to Integrated Care continued

GOAL: Develop meaningful cross-sector system coordination

ACCESS TO CARE OBJECTIVE #5

Support coordination of mutually reinforcing activities between service providers.

SHORT TERM STRATEGY

5.1 Develop a model to increase access and utilization of medical homes for at risk children and families through coordination with Washington County's Early Learning Community Hub.

5.2 Develop a strategy for preventive and behavioral health services through the promotion and integration of evidence based strategies.

LONG TERM STRATEGY

5.3 Develop an aligned strategy for addressing high utilizers including preventive strategies, aligned use of high utilizer lists and EDIE data and strategies that take advantage of emergency medical services access, assessment, and clinic capabilities for preventive, gate keeping and out-of-hospital care and services.

OUTCOME INDICATORS

- Medical home model developed in alignment with Washington County's Early Learning Community Hub partners
- Strategy developed for integrated preventive and behavioral health services (includes family wellness, developmental screenings, well child and well adolescent checks)
- Track readmission rates and post hospital follow-up (based on CCO data)

ALIGNMENT

- Oregon Health Authority Behavioral Health Strategic Plan, 2015-2018
- Washington County Early Learning Community Hub reports and planning
- Coordinate Care Organization (CCO) priorities and metrics

RECOMMENDED POLICY CHANGES

- TBD

Priority #2:

Chronic Disease Prevention

Nationally, 75% of healthcare dollars go to the treatment of chronic disease. The two leading causes of death in Washington County are cancer and heart disease, comprising 44% of deaths in the county. Chronic disease is also a major cause of premature death around the world. Changing health behavior can dramatically influence the presence of chronic diseases.

In the most recent community health needs assessment, chronic disease emerged as a top health issue due to several factors. Washington County has high death rates due to heart disease, CVD/stroke, prostate cancer and Alzheimer's disease. Within these disease categories there were usually significant disparities related to race/ethnicity and gender (as applicable). In addition, the 10-year death rate trend is worsening, and there is a higher death rate in Washington County compared with the Oregon average. Washington County experiences a higher female breast cancer incidence, low adult fruit and vegetable consumption, low levels of adult regular physical activity and higher levels of low-income preschool obesity. The data support chronic disease as a serious health issue in the county, with 64% of interviewed community stakeholders listing chronic disease as a top health issue.

The priority health behaviors in Washington County that affect chronic disease are low adult fruit and vegetable consumption and low levels of adult regular physical activity. Approximately 25% of adults reported eating the recommended five or more servings of fruit and vegetables per day and 54% of adults met the recommended level of physical activity.

Assets and Resources to support Chronic Disease Prevention

- Integrated academic partners
- Engaged active transportation partners, including advocacy groups and Safe Routes to School programs
- Strong agricultural community that supports capacity building and educational partnerships
- Diverse and active network of early learning advocate and service providers
- Cross-sector chronic disease self management programs
- Widespread faith community and interfaith collaborations that promote wellness
- Involved and informed citizens focused on livable communities
- Progressive parks and recreation districts and departments
- Broad network of traditional health workers engaged in chronic disease prevention efforts
- Collaborative multisector partnerships focused on food security and nutrition education
- School districts committed to staff and student wellness
- Hospital community benefit program support
- Coordinated Care Organization involvement
- Dedicated breastfeeding support and advocacy
- Culturally specific organizations that promote equity
- Advocacy and engagement across the life course
- Committed municipal leaders and land use planners interested in healthy communities

About the Chronic Disease Prevention Committee and the Planning Process

The committee was formed in 2012 as part of a Healthy Communities Grant to support development of community-based chronic disease prevention strategies. They continued to meet after the grant funding ended to implement those identified strategies. They were formally reconvened in early 2014 to become the chronic disease prevention CHIP committee as part of Live Well Washington County.

This committee began by increasing familiarity with the collective impact approach, the proposal for the Live Well Washington County structure and the local data related to chronic disease. The committee then spent time developing an inventory of their individual organization's current work related to chronic disease prevention and identifying gaps in programming and policy across the county. The committee used crosswalk tools (see Appendix D) to identify alignment between local data, evidence-based best practices, and an inventory of current work to brainstorm goals and objectives for the committee's focus.

Once that process was complete, the committee voted on strategies based on specific criteria. (1) supported by local data; (2) best practice approaches; (2) aligned with current agency goals and work plans; (3) current capacity to support work on the objective; (4) and potential opportunities to collaborate among CHIP partner organizations.

The following tables describe the objectives and strategies identified by the committee. See Appendix A for a more detailed work plan. This work plan is a living document and the strategies outlined in this section and Appendix A will change and evolve over the five year time period. Appendix A is updated every six months.

PRIORITY 2: Access Chronic Disease Prevention

GOAL: Increase access to healthy and affordable food, opportunities for physical activity, tobacco free environments and chronic disease self-management programs for all residents of Washington County

CHRONIC DISEASE PREVENTION OBJECTIVE #1

Increase access to and awareness of affordable, healthy food and physical activity opportunities through educational programs and resources.

SHORT TERM STRATEGY

1.1 Expand existing educational and incentive programs for low income families.

LONG TERM STRATEGY

1.2 Increase healthy food options available at food banks, school cafeterias and after school programs.

OUTCOME INDICATORS

- Map of existing programs developed
- Number of new participants in selected education programs
- Number of new participants in Farm 2 School program

ALIGNMENT

- National Prevention Strategy, 2011
- Washington County Public Health Strategic Plan, 2012-2016 (2014 Update)
- Washington County Food Systems Plan, 2013

RECOMMENDED POLICY CHANGES

- TBD

Chronic Disease Prevention continued

CHRONIC DISEASE PREVENTION OBJECTIVE #2

Identify opportunities to incorporate health into community design processes and policies to support (1) access to healthy and affordable food, (2) opportunities for physical activity and (3) access to tobacco-free environments.

SHORT TERM STRATEGY

2.1 Support and advance the implementation and adoption of healthy community policies being pursued by committee partners.

LONG TERM STRATEGY

2.2 Increase awareness and use of the Health in All Policies approach to ensure policies, plans and programs implemented by committee partners have neutral or beneficial impacts on the determinants of health.

OUTCOME INDICATORS

- Number of committee partners participating on Technical Advisory Committees (TACs)
- Number of joint use agreements and MOUs between partner organizations
- Number of partners participating in Health in All Policies training
- Number of partners adopting the Health in All Policies approach

ALIGNMENT

- Washington County 2020 Transportation Plan
- Washington County Public Health Strategic Plan, 2012-2016 (2014 Update)

RECOMMENDED POLICY CHANGES

- MOUs in place between partners to consider health in planning and policy decisions
- Health in All Policies approach in place at all participating organizations

Chronic Disease Prevention continued

CHRONIC DISEASE PREVENTION OBJECTIVE #3

Support the understanding and development of a "culture of health" with local business partners.

SHORT TERM STRATEGY

3.1 Increase number of employers who adopt and implement worksite wellness policies and programs.

LONG TERM STRATEGY

3.2 Increase community infrastructure for farming as a viable career and exciting opportunity.

OUTCOME INDICATORS

- "CDC Worksite Health Scorecard Score" or score on the "Total Your Health Values Survey"
- Number of new participants in farming education programs
- Development of plan for improving future farming opportunities

ALIGNMENT

- Oregon's Healthy Future: A Plan for Empowering Communities, 2013
- National Prevention Strategy, 2011
- Washington County Food Systems Plan, 2013
- Washington County Public Health Strategic Plan 2012-2016 (2014 Update)

RECOMMENDED POLICY CHANGES

- Adoption of worksite wellness policies by committee partner organizations
- Adoption of worksite wellness policies among all businesses in Washington County

Chronic Disease Prevention continued

CHRONIC DISEASE PREVENTION OBJECTIVE #4

Develop and maintain infrastructure to support implementation of committee objectives.

SHORT TERM STRATEGIES

4.1 Support and increase use of community health workers to improve workforce diversity and cultural competency in Washington County.

4.2 Maintain and expand Live Well Washington County infrastructure elements related to communications, capacity and evaluation.

LONG TERM STRATEGY

4.3 Identify funding opportunities to support CHIP objectives.

OUTCOME INDICATORS

- Infrastructure components in place supporting community health activities including (1) communications and media campaign; (2) ongoing multi-sectoral committee; (3) performance measurement and evaluation; (4) plan for actively seeking funding
- Number of community health workers in Washington County
- Number of partners who have incorporated CHIP strategies into their agency's work plan

ALIGNMENT

- Health Share of Oregon Community Health Improvement Plan, 2014
- Washington County Public Health Strategic Plan, 2012-2016 (2014 Update)

RECOMMENDED POLICY CHANGES

- TBD

Chronic Disease Prevention continued

CHRONIC DISEASE PREVENTION OBJECTIVE #5

Increase community engagement and participation in chronic disease prevention efforts among vulnerable populations.

SHORT TERM STRATEGY

5.1 Increase youth engagement and participation through a youth health council.

LONG TERM STRATEGY

5.2 Outreach with vulnerable populations to participate in land use and transportation community engagement opportunities.

5.3 Develop bike and pedestrian advisory committees in every city to advocate for better bike, pedestrian and transit connections.

OUTCOME INDICATORS

- Youth Council developed and meeting regularly
- Youth Council work plan including strategies that support engagement and policy changes
- Outreach plan developed (including specific populations)
- Bike and pedestrian advisory committee developed and sustained in every city

ALIGNMENT

- Washington County Public Health Strategic Plan, 2012-2016 (2014 Update)
- Washington County 2020 Transportation Plan

RECOMMENDED POLICY CHANGES

- TBD

Chronic Disease Prevention continued

CHRONIC DISEASE PREVENTION OBJECTIVE #6

Improve collaboration to increase programmatic supports for people experiencing chronic disease.

SHORT TERM STRATEGY

6.1 Promote chronic disease self-management (CDSM) programs among clients of committee partners.

LONG TERM STRATEGY

6.2 Collaborate with community partners to ensure that people at risk for negative health outcomes from chronic conditions have opportunities to learn about increase consumption of healthy fresh affordable foods.

OUTCOME INDICATORS

- Inventory of existing CDSM programs developed
- Inventory of existing CDSM programs shared across partner organizations
- Network of CDSM providers developed
- Number participating in selected CDSM programs

ALIGNMENT

- Washington County Food Systems Plan, 2013
- Washington County Public Health Strategic Plan, 2012-2016 (2014 Update)

RECOMMENDED POLICY CHANGES

- TBD

Priority #3:

Suicide Prevention

Suicide has a devastating effect on individuals, communities and families, but suicide can be prevented. There are many risk and protective factors associated with suicide that can be targeted through evidence-based prevention. Out of more than 50 health issues evaluated for Washington County in the community health needs assessment, death due to suicide was the highest ranked health issue based on the data. This health issue was selected as a top priority because there are significant disparities along racial, ethnic and gender lines for suicide rates. Additionally, 81% of interviewed community stakeholders mentioned mental health as a top health issue for the region, and there is a known connection between mental health issues and suicide.

Oregon has the 13th highest suicide rate in the country, and it is the leading cause of death for youth ages 10-24 and veterans under the age of 45. Veterans are overrepresented in suicide deaths in Oregon. They comprise 8% of the population and 22% of suicide deaths.

Washington County has an average of 65 suicides per year, and the number has been increasing yearly from 2010. The age-adjusted suicide rate was approximately 14 deaths per 100,000 population for 2010, which is higher than the national average of approximately 13 deaths per 100,000 population in the same year. The population with the highest suicide rate in Washington County is non-Hispanic white males with a rate of 25 deaths per 100,000 population for years 2008-2012. When further broken down by age, non-Hispanic white males age 65 years and older have a suicide rate of 38 deaths per 100,000 population. Medical examiner data suggest that Vietnam era veterans are disproportionally affected by suicide in Washington County. They comprise a larger portion than expected of suicides in the 65+ year age range. The male veteran suicide rate in the county was 42 deaths per 100,000 population in 2012, which is the highest suicide rate in the county.

Assets and Resources to Support Suicide Prevention

- Suicide Fatality Review Committee
- Dedicated funding to support Suicide Prevention Council objectives
- Strong partnerships between County Public Health and Mental Health divisions
- Epidemiological support and integration
- Engaged Emergency Medical Services and medical examiners
- Committed faith-based community
- Involvement from law enforcement
- Volunteer trainers
- Supported evidence-based prevention strategies
- Active local government leaders
- Broad network of mental health providers

About the Suicide Prevention Council and the Planning Process

The Washington County Suicide Prevention Council is a collaborative committee comprised of a variety of partners including educators, first responders, government organizations, law enforcement, members of the faith community, mental health providers, national associations, survivors of suicide loss and other concerned citizens. It was developed in 2013 to address suicide prevention in a coordinated and countywide effort but lacked structure and strategic direction. Since that time, Washington County Mental Health and Public Health divisions have partnered to co-facilitate the council as one of the three Live Well Washington County committees. This partnership has resulted in a very active and engaged group of passionate community partners. In addition, the Suicide Fatality Review Committee was formed to conduct research to better inform suicide prevention and intervention practices in Washington County.

The council used community health assessment data and the 2012 National Strategy for Suicide Prevention to develop objectives and strategies in each of the four national strategic directions. Participants reviewed national recommendations and voted for priorities based on current capacity, alignment with local assessment data and potential opportunities to build on existing work.

The following tables describe the objectives and strategies identified by the committee. See Appendix A for a more detailed work plan. This work plan is a living document and the strategies outlined in this section and Appendix A will change and evolve over the five year time period. Appendix A is updated every six months.

PRIORITY 3: Suicide Prevention

GOAL: Promote responsible media reporting of suicide, accurate portrayals of suicide and mental illnesses in the entertainment industry, and the safety of online content related to suicide

SUICIDE PREVENTION OBJECTIVE #1

Implement plan to encourage and recognize news organizations that develop and implement policies and practices and follow recommendations addressing the safe and responsible reporting of suicide and other related behaviors.

STRATEGIES

1.1 Evaluate current reporting to identify issues and recommendations.

1.2 Educate local media about recommended best practices.

1.3 Utilize agency websites and social media sites to disseminate suicide prevention messaging materials.

OUTCOME INDICATORS

- Number of local media outlets recognized for utilizing responsible reporting criteria
- Number of organizations on the Suicide Prevention Council sharing information via the Live Well Washington County newsletter, social media sites and agency websites

ALIGNMENT

- 2012 National Strategy for Suicide Prevention: GOALS AND OBJECTIVES FOR ACTION, A report of the U.S. Surgeon General and of the National Action Alliance for Suicide Prevention
- 2014 Washington County Public Health Strategic Plan

RECOMMENDED POLICY CHANGES

- Local news organizations adopt safe reporting policies
- Academic institutions adopt guidance on how to address consistent and safe messaging on suicide and related behaviors in their curricula

Suicide Prevention continued

GOAL: Integrate and coordinate suicide prevention activities across multiple sectors and settings

SUICIDE PREVENTION OBJECTIVE #2

- Integrate suicide prevention into the values, culture, leadership, and work of a broad range of organizations and programs with a role to support suicide prevention activities.
- Establish effective, sustainable, and collaborative suicide prevention programming at the local level.

STRATEGY

2.1 Continue to expand collective impact approach (mutually reinforcing activities throughout the Suicide Prevention Council).

2.2 Support existing prevention strategies (including ACES, Good Behavior Game).

OUTCOME INDICATORS

- Sustainability of the work (resources or grant funding amount coming in connected to council work)

ALIGNMENT

- 2012 National Strategy for Suicide Prevention: GOALS AND OBJECTIVES FOR ACTION, A report of the U.S. Surgeon General and of the National Action Alliance for Suicide Prevention
- Washington County Public Health Strategic Plan, 2012-2016 (2014 Update)

RECOMMENDED POLICY CHANGES

- Legislation to support required suicide fatality review committee
- Other policies TBD based on recommendations from the suicide fatality review committee

Suicide Prevention continued

GOAL: Promote efforts to reduce access to lethal means of suicide among individuals with identified suicide risk

SUICIDE PREVENTION OBJECTIVE #3

- Identify and implement methods to encourage providers who interact with individuals at risk for suicide to routinely assess for access to lethal means.
- Identify an ongoing plan for sustaining this objective.

STRATEGY

3.1 Promote the CALM (Counseling on Access to Lethal Means) free online training course in our community.

3.2 Develop comprehensive training series recommendation (including CALM).

OUTCOME INDICATORS

- CALM training hits in Washington County zip codes
- Number of providers reached through strategies identified by the council
- Implementation of long-term plan

ALIGNMENT

- 2012 National Strategy for Suicide Prevention: GOALS AND OBJECTIVES FOR ACTION, A report of the U.S. Surgeon General and of the National Action Alliance for Suicide Prevention
- 2012-2016 Washington County Public Health Strategic Plan (2014 Update)

RECOMMENDED POLICY CHANGES

- Health care system partners adopt CALM training as part of required training series

Suicide Prevention continued

GOAL: Develop, implement and monitor effective programs that promote wellness and prevent suicide and related behaviors

SUICIDE PREVENTION OBJECTIVE #4

Strengthen the coordination, implementation and evaluation of comprehensive local suicide prevention programming.

STRATEGY

4.1 Increase QPR training capacity and participation throughout the county.

4.2 Improve communication and coordination within the system about available resources.

OUTCOME INDICATORS

- Number participating in local QPR training

ALIGNMENT

- 2012 National Strategy for Suicide Prevention: GOALS AND OBJECTIVES FOR ACTION, A report of the U.S. Surgeon General and of the National Action Alliance for Suicide Prevention

RECOMMENDED POLICY CHANGES

- *Placeholder for recommended policy changes from the Suicide Prevention Council*
- Recommended adoption of a Suicide Prevention Strategic Plan

Suicide Prevention continued

GOAL: Promote suicide prevention as a core component of health care services

SUICIDE PREVENTION OBJECTIVE #5

- Promote the adoption of "Zero Suicides" as an aspirational goal by health care and community support systems that provide services and support to defined patient populations.
- Develop and implement protocols for delivering services for individuals with suicide risk in the most collaborative, responsive and least restrictive settings.

STRATEGY

5.1 Identify a primary care provider champion to join and partner with the Suicide Prevention Council.

5.2 Build capacity for AMSR (Assessing and Managing Suicide Risk) training in Washington County.

5.3 Partner with health care system partners to support suicide prevention strategies.

5.4 Promote adopting of the Zero Suicide approach by one hospital system.

OUTCOME INDICATORS

- Adoption of the Zero Suicide approach by hospital or health care system in Washington County
- Suicide rate within pilot health system compared to other health system partners
- Percent of hospitals adopting recommended screening protocol series in Washington County

ALIGNMENT

- 2012 National Strategy for Suicide Prevention: GOALS AND OBJECTIVES FOR ACTION, A report of the U.S. Surgeon General and of the National Action Alliance for Suicide Prevention
- 2012-2016 Washington County Public Health Strategic Plan (2014 Update)

RECOMMENDED POLICY CHANGES

- Adoption of the Zero Suicide approach by all Washington County hospital and health care systems

Suicide Prevention continued

GOAL: Evaluate the impact and effectiveness of suicide prevention interventions and systems and synthesize and disseminate findings

SUICIDE PREVENTION OBJECTIVE #6

- Evaluate the effectiveness of suicide prevention interventions.
- Assess, synthesize and disseminate the evidence in support of suicide prevention interventions.

STRATEGY

6.1 Ongoing implementation of Suicide Fatality Review.

6.2 Ongoing monitoring and tracking of suicide data as a component of the CHIP measurement system.

6.3 *Placeholder for recommended strategies from the suicide fatality review committee*.

OUTCOME INDICATORS

- Develop system recommendations based on the review of [TBD # of suicides] by the Suicide Fatality Review Committee
- Adoption and/ or implementation of recommended policy, systems or environmental changes based on recommendations from the Suicide Fatality Review Committee
- % of CHIP Suicide Prevention outcome indicators

ALIGNMENT

- 2012 National Strategy for Suicide Prevention: GOALS AND OBJECTIVES FOR ACTION, A report of the U.S. Surgeon General and of the National Action Alliance for Suicide Prevention
- 2012-2016 Washington County Strategic Plan (2014 Update)

RECOMMENDED POLICY CHANGES

- TBD based on recommended policy changes from the Suicide Fatality Review Committee

VI. Sources

Demographics

American FactFinder, United States Census Bureau

American Community Survey, United States Census Bureau

Community Commons, Community Health Needs Assessment Report for Washington County

Oregon Public Health Assessment Tool (OPHAT), Office of the State Epidemiologist, Public

Health Division, Oregon Health Authority

Healthy Columbia Willamette Community Dashboard for Washington County

Healthy Columbia Willamette Collaborative

Healthy Columbia Willamette Collaborative reports: http://www.healthycolumbiawillamette.org/index.php?module=htmlpages&func=display&pid=5005

Collective Impact

Stanford Social Innovation Review research on Collective Impact

Collective Impact Maturity Model for Community Health Improvement, Insightformation, Inc. March 2013

Vulnerable populations

American FactFinder, United States Census Bureau

American Community Survey, United States Census Bureau

Community Commons, Community Health Needs Assessment Report for Washington County

Access to healthy food: http://www.ipa.udel.edu/publications/HealthPolicyIssueBrief3.pdf

Healthy Columbia Willamette Community Dashboard for Washington County

National leading causes of death: http://www.cdc.gov/nchs/data/nvsr/nvsr61/nvsr61_06.pdf

Oregon Department of Education

Access to care

County Health Rankings & Roadmaps, Washington County

Community Commons, Community Health Needs Assessment Report for Washington County

Healthy Columbia Willamette Community Dashboard for Washington County

Health Resources and Services Administration

Oregon Behavioral Risk Factor Surveillance System (BRFSS)

Chronic disease

CD Summary, July 17, 2012; 61 (15).

Oregon Public Health Assessment Tool

National Vital Statistics Report, 61 (6), October 2012.

Healthy Columbia Willamette Community Dashboard for Washington County

Community Commons, Community Health Needs Assessment Report for Washington County

US Department of Agriculture Food Atlas

Suicide

Oregon Public Health Assessment Tool (OPHAT)

Shen X, Millet L. Suicides among veterans in Oregon, 2014. Oregon Health Authority, Portland, Oregon.

Shen X, Millet L. Suicide in Oregon: Trends and Risk Factors. 2012 Report. Oregon

VII. Appendices

Includes:

A. Live Well Washington County Ongoing Work Plans (updated and time-stamped every 6 months)

B. Long Term Measures and Infrastructure Tracking

C. Collective Impact Maturity Model for Community Health Improvement

D. Example crosswalk tool (used by Live Well Washington County committees)

Chronic Disease Prevention							
GOAL 1:	Increase access to healthy and affordable food, opportunities for physical activity, tobacco free environments and chronic disease self-management programs for all residents of Washington County.						
Objective 1	Increase access to and awareness of affordable, healthy food and physical activity opportunities through educational programs and resources.						
Years	**Strategies**	**Outcome Indicators**	**Tasks**	**By Who?**	**By When?**	**Current/ baseline**	**Updates**
2014-2016	1.1 Expand existing educational and incentive programs for low income families.	By December 2015, develop a community map of existing programs developed (for sharing and planning purposes); By December 2016, increase number of people in selected education and incentive programs by # TBD (baseline established by 4/2015).	Develop map of existing educational and incentive programs to identify gaps and distribute to partners	Work Group # 1: WCPH, Boys and Girls Club, Adventures Without Limits, Virginia Garcia, Tualatin Hills Parks and Recreation	Jul, 2015	TBD (using map and inventory process at 1/2015 and 4/2015 meetings)	
			Share information about current programs via Live Well newsletter	Washington County Public Health staff	Ongoing (monthly on first Tuesdays)		
			Engage school districts in the CHIP process	Work Group #1: WCPH, Boys and Girls Club, Adventures Without Limits, Virginia Garcia, Tualatin Hills Parks and Recreation	Jul, 2015		
2016-2018	1.2 Increase healthy food options available at food banks, school cafeterias and after school programs.	By December 2018, increase the percent of schools participating in Farm 2 School program by # TBD.	TBD	TBD (work group members will be identified in 2015)	TBD	TBD	

Chronic Disease Prevention							
GOAL 1:	Increase access to healthy and affordable food, opportunities for physical activity, tobacco free environments and chronic disease self-management programs for all residents of Washington County.						
Objective 2	Identify opportunities to incorporate health into community design processes and policies to support (1) access to healthy and affordable food, (2) opportunities for physical activity and (3) access to tobacco-free environments.						
Years	**Strategies**	**Outcome Indicators**	**Tasks**	**Responsible Party**	**By When?**	**Current/ baseline**	**Updates**
2014-2016	2.1 Support and advance the implementation and adoption of healthy community policies being pursued by committee partners.	By December, 2015, 25% of committee partners participating on Technical Advisory Committees (TACs); other indicators TBD	Partners share upcoming policy plans	All committe	Apr, 2015	Currently 10% participate on TACs (as of 12/2014)	
			Compile list of content area experts for policy technical assistance	Work Group #2: WC Housing, BTA, DAVS, LUT, WCHHS	Jul, 2015		
			Compile best practice policy templates for use by partners		Dec,2015		
			Invite partners to participate on advisory committees	All committee	Ongoing		
2016-2018	2.2 Increase awareness and use of the Health in All Policies approach to ensure policies, plans and programs implemented by committee partners have neutral or beneficial impacts on the determinants of health.	By December 2018, increase the number of joint use agreements and MOUs between partner organizations by # TBD; By December 2017, 75% of committee partners participate in Health in All Policies training; Track the number of partners adopting the Health in All Policies approach.	TBD	TBD (work group members will be identified in 2015)	TBD	TBD	

Chronic Disease Prevention							
GOAL 1:	Increase access to healthy and affordable food, opportunities for physical activity, tobacco free environments and chronic disease self-management programs for all residents of Washington County.						
Objective 3	Support the understanding and development of a "culture of health" with local business partners.						
Years	**Strategies**	**Outcome Indicators**	**Tasks**	**Responsible Party**	**By When?**	**Current/ baseline**	**Updates**
2014-2016	3.1 Increase number of employers who adopt and implement worksite wellness policies and programs.	By December 2016, increase the percent of identified employers adopt and implement worksite wellness policies and programs from 25% to 50%; Track the "CDC Worksite Health Scorecard Score" or score on the "Total Your Health Values Survey" (baseline established by 7/2015)	Increase engagement with business community to participate on the committee	Workgroup #3: WTA, BTA, WCPH, Virginia Garcia	Ongoing	25% employers have WW program in place (assessment conducted 10/2012)	
			Develop worksite wellness policy toolkit for businesses		Dec, 2016		
			Host a WW event for business partners	Workgroup #3: WTA, BTA, WCPH, Virginia Garcia	Dec, 2016		
2016-2018	3.2 Increase community infrastructure for farming as a viable career and exciting opportunity.	By December 2017, increase number of new participants in farming education programs by 2 School Districts; By December 2007, develop plan for improving future farming opportunities	TBD	TBD (work group members will be identified in 2015)	TBD	3 SDs currently participate	

Chronic Disease Prevention							
GOAL 1:	Increase access to healthy and affordable food, opportunities for physical activity, tobacco free environments and chronic disease self-management programs for all residents of Washington County.						
Objective 4	Develop and maintain infrastructure to support implementation of committee objectives.						
Years	**Strategies**	**Outcome Indicators**	**Tasks**	**Responsible Party**	**By When?**	**Current/ baseline**	**Updates**
2014-2016	4.1 Support and increase use of community health workers to improve workforce diversity and cultural competency in Washington County.	By December 2016, increase the number of community health workers in Washington County by # TBD (baseline established 1/27/2015)	Identify current CHW programs and capacity	Work Group #4: Health Share, Providence, Adventures Without Limits, WCPH	Apr, 2015	TBD (January 27, 2015 meeting)	
			Develop educational materials and a common message about role of CHWs		Dec, 2015		
			Align with current CHW programs		Ongoing		
			Identify outreach plan and targeted providers		Dec, 2015		
2014-2018	4.2 Maintain and expand Live Well Washington County infrastructure elements related to communications, capacity and evaluation.	By December 2016, all infrastructure components in place: (1) communications and media campaign; (2) multisectoral committee; (3) performance measurement and evaluation; (4) plan for actively seeking funding; By December 2018, 50% of participants have incorporated CHIP strategies into their agency's work plan	Live well Washington County leadership team develops timeline	Live Well Leadership team; WCPH	Dec, 2015	Communications materials in process, Newsletter developed (started 10/14), Multi-sector committee in place, process to identify grant funding opportunities in place	12/14 10% participants included CHIP in work plans
			WCPH PIO and community partners develop a communications plan	Live Well Leadership team; WCPH, WCHHS PIO	Jul, 2015		
			TBD	TBD	TBD		
2014-2018	4.3 Identify funding opportunities to support CHIP objectives.	Ongoing tracking of grant proposals and applications aligned with CHIP objectives	TBD	Live Well Leadership Team; WCPH	TBD	Current applications in process	

Chronic Disease Prevention							
GOAL 1:	Increase access to healthy and affordable food, opportunities for physical activity, tobacco free environments and chronic disease self-management programs for all residents of Washington County.						
Objective 5	Increase community engagement and participation in chronic disease prevention efforts among populations at risk for negative health outcomes.						
Years	**Strategies**	**Outcome Indicators**	**Tasks**	**Responsible Party**	**By When?**	**Current/ baseline**	**Updates**
2014-2016	5.1 Increase youth engagement and participation through a youth health council.	By December 2014, develop a youth health council; By December 2015, youth council work plan will include strategies that support engagement and policy changes	Assess youth participation needs	Work Group #5: Boys and Girls Club, OSU Extension Service, Virginia Garcia, WCPH	Apr, 2015	No Youth Council in place at beginning of project period (2014)	As of Dec, 2014 Youth Council formed and started meeting
			Align existing youth councils in Washington County		Jul, 2015		
			Include youth councils in training opportunities and CHIP process		Ongoing		
2016-2018	5.2 Outreach with vulnerable populations to participate in land use and transportation community engagement	By December 2016, develop an outreach plan (including specific populations); ongoing implementation	TBD	TBD (work group members will be identified in 2015)	TBD	TBD	
2016-2018	5.3 Develop bike and pedestrian advisory committees in every city to advocate for better bike, pedestrian and transit connections.	By December 2018, develop bike and pedestrian advisory committees in every city	TBD	TBD (work group members will be identified in 2015)	TBD	2 bike and pedestrian advisory councils as of 12/14	

Chronic Disease Prevention							
GOAL 1:	Increase access to healthy and affordable food, opportunities for physical activity, tobacco free environments and chronic disease self-management programs for all residents of Washington County.						
Objective 6	Improve collaboration to increase programmatic supports for people experiencing chronic disease.						
Years	**Strategies**	**Outcome Indicators**	**Tasks**	**Responsible Party**	**By When?**	**Current/ baseline**	**Quarterly Update**
2014-2016	6.1 Promote chronic disease selfmanagement (CDSM) programs among clients of committee partners.	By July 2015, develop an inventory of existing CDSM programs; By December 2015, share the inventory across partner organizations; By December 2015, develop a network of CDSM providers; By December 2016, increase the number participating in selected CDSM programs to # TBD	Update and expand CDSM web pages for county and committee partners to better include resources Compile list of CDSM programs	Work Group #6: DAVS, WTA, Housing, LUT, WCPH	Ongoing Dec, 2016	Establsihing baseline; No network of providers or inventory of current programming, limited coordination	
2016-2018	6.2 Collaborate with community partners to ensure that people at risk for negative health outcomes from chronic conditions have opportunities to learn about increasing consumption of healthy fresh affordable foods.	TBD	TBD	TBD (work group members will be identified in 2015)	TBD	TBD	

Suicide Prevention							
GOAL 1:	Promote responsible media reporting of suicide, accurate portrayals of suicide and mental illnesses in the entertainment industry, and the safety of online content related to suicide						
Objective 1	Implement plan to encourage and recognize news organizations that develop and implement policies and practices and follow recommendations addressing the safe and responsible reporting of suicide and other related behaviors.						
Years	**Strategies**	**Outcome Indicators**	**Tasks**	**Responsible Party**	**By When?**	**Current/ baseline**	**Quarterly Update**
2014-2016	1.1 Evaluate current reporting to identify issues and recommendations.	By December 2014, evaluate current reporting to identify issues and recommendations.	Review and conduct evaluation of current reporting	WCHHS PIO	Dec, 2014	Evaluation/ scan being conducted	
2014-2016	1.2 Educate local media about recommended best practices.	TBD: Number of local media outlets recognized for utilizing responsible reporting criteria and other materials	Compile and develop media training and talking points	WC Mental Health, WC PIO, Beaverton Full Gospel Church	Dec, 2015	TBD	
2016-2018	1.3 Utilize agency websites and social media sites to disseminate suicide prevention messaging materials.	TBD: Number of organizations on the Suicide Prevention Council sharing information via the Live Well Washington County newsletter, social media sites and agency websites	Post materials to sites	WCHHS PIO; SPC members	Ongoing	TBD	
			Track hits/downloads	WCPH	TBD	TBD	

Suicide Prevention							
Goal 2	Integrate and coordinate suicide prevention activities across multiple sectors and settings						
Objective 2	Integrate suicide prevention into the values, culture, leadership, and work of a broad range of organizations and programs with a role to support suicide prevention activities.; Establish effective, sustainable, and collaborative suicide prevention programming at the local level.						
Years	**Strategies**	**Outcome Indicators**	**Tasks**	**Responsible Party**	**By When?**	**Current/ baseline**	**Quarterly Update**
2014-2018	2.1 Continue to expand collective impact approach and mutually reinforcing activities throughout the Council.	TBD; Resources or grant funding amount coming in connected to council work	Apply for Garrett Lee Smith Youth Suicide Prevention grant	Live Well leadership team	Septemeber 2014	TBD	Received grant dollars ($120,000 per year for 5 year Suicide Prevention Coordinator to implement objectives)
			TBD		TBD		
2014-2018	2.2 Support existing prevention strategies (including ACES, Good Behavior Game).	By December 2015, increase the number of community organizations involved in ACES work by # TBD; By December 2016, 4 identified school districts implementing GBG	ACES survey to community partners	WCPH ACES program	Dec, 2015	49/71 respondants have targets related to the 10 ACES categories	71 responses to ACES Survey as of 1/2015
			Implement GBG Grant with 4 identified school districts	WC Early Learning Community Hub	Dec, 2017	Currenlty 0 schools implementing (12/2014)	
			Conduct Triple P trauma-informed training	LifeWorks NW	Dec, 2015	No Triple P training avaiable	

Suicide Prevention							
Goal 3	Promote efforts to reduce access to lethal means of suicide among individuals with identified suicide risk.						
Objective 3	Identify and implement methods to encourage providers who interact with individuals at risk for suicide to routinely assess for access to lethal means; Identify an ongoing plan for sustaining this objective.						
Years	**Strategies**	**Outcome Indicators**	**Tasks**	**Responsible Party**	**By When?**	**Current/ baseline**	**Quarterly Update**
2014-2016	3.1 Promote the CALM (Counseling on Access to Lethal Means) free online training course in our community.	Objective TBD; CALM training hits in Washington County zip codes	Develop and implement CALM training promotion plan	All SPC members	Dec, 2015	TBD #s submitted February 2015	CALM Promotion Plan developed
			Agencies discuss how to incorporate CALM into required trainings				
			Use social media to promote the CALM online training				
2016-2018	3.2 Develop and share comprehensive training series recommendation (including CALM).	Number of outside partners receive one pagers and related materials; Track number of participants in recommended trainings	Develop one pagers: (1) series of available recommended trainings; (2) CALM flyer with community resource links	WCHHS PIO	Dec, 2014	2014 Training numbers: ASIST Trainings: 5 trainings , 139 people ; Adult MHFA: 2 Trainings, 40 people total; Youth MHFA: 1 training; 18 people	
			Distribute one pagers	All SPC members	Ongoing		

Suicide Prevention							
Goal 4	Develop, implement and monitor effective programs that promote wellness and prevent suicide and related behaviors						
Objectives 4	Strengthen the coordination, implementation and evaluation of comprehensive local suicide prevention programming.						
Years	**Strategies**	**Outcome Indicators**	**Tasks**	**Responsible Party**	**By When?**	**Current/ baseline**	**Quarterly Update**
2014-2016	4.1 Increase QPR training capacity and participation throughout the county.	By December, 2014 increase the number of QPR trainers to 10; Increase # participating in local QPR training to 250 (from 180)	Implement train the trainers model	WC Mental Health	Ongoing	QPR Trainings (2014): 10 Trainings, 180 people	
			Host QPR training	SPC	11-Feb-15		
2016-2018	4.2 Improve communication and coordination within the system about available resources.	TBD	TBD	New Suicide Prevention Coordinator, Live Well leadership team, WC PIO	Ongoing	TBD	

Suicide Prevention							
Goal 5	Promote suicide prevention as a core component of health care services						
Objective 5	Promote the adoption of "Zero Suicides" as an aspirational goal by health care and community support systems that provide services and support to defined patient populations; Develop and implement protocols for delivering services for individuals with suicide risk in the most collaborative, responsive and least restrictive settings.						
Years	**Strategies**	**Outcome Indicators**	**Tasks**	**Responsible Party**	**By When?**	**Current/ baseline**	**Quarterly Update**
2014	5.1 Identify a primary care provider champion to join and partner with the Suicide Prevention Council.	By December 2014, one Primary Care Provider regularly participates as a member of the Council	Reach out to Washington County Health Officer and primary care provider partners	Northwest Regional ESD Washington County Public Health Division	Dec, 2014	No PCP involved (summer, 2014)	PCP partcipating regularly (12/2014)
			Connect with the Access to Care CHIP Committee		Dec, 2014 and ongoing		
2014-2015	5.2 Build capacity for "suicide care" training in Washington County.	By Dec, 2015, have ongoing best practice suicide care training available in Washington County; Number of agencies providing the Suicide Care training	Review and evaluate possible trainings	Sherwood School District Washington County Mental Health	Summer, 2014	No "suicide care" training fo clinicians avaiable in the county	Hosting AMSR (Assessing and Managing Suicide Risk) training 2/27/2015
			Identify one training to recommend/ support		Oct, 2014		
			Host first training in Washington County		By March, 2015		

Suicide Prevention							
2015-2018	5.3.Partner with health care system partners to support suicide prevention strategies.	Objective TBD: Percent of hospitals adopting recommended screening protocol series in Washington County	Develop a subcommittee to identify opportunities for working with health care system partners	New Suisice Prevention Coordinator, Northwest Regional ESD, Veterans Administration, Washington County Public Health, Washington County Mental Health	By Oct, 2014	TBD	Subcommittee formed and meeting
			Partner with the Access to Care CHIP committee to promote recommended screening tools		By Jul, 2015		
2015-2018	5.4 Promote adopting of the Zero Suicide approach by one hospital system.	By December, 2017, adoption of the Zero Suicide approach by one hospital or health care system in Washington County; Track suicide rate within pilot health system compared to other health system partners	Host summit with focus on Zero Suicide approach and aimed at hospitals and health care systems (with Sero Suicide speaker David Covington)	Summit Planning Committee: WCPH, WCMH, LifeWorks NW, New suicide Prevention Coordinator, WCHHS PIO	March, 2015	Currently, no Washington Coutny health system has impleemnted the Zero Suicide approach	Summit planning in process.

Suicide Prevention							
Goal 6	Evaluate the impact and effectiveness of suicide prevention interventions and systems and synthesize and disseminate findings						
Objective 6	(1) Evaluate the effectiveness of suicide prevention interventions; (2) Assess, synthesize and disseminate the evidence in support of suicide prevention interventions.						
Years	**Strategies**	**Outcome Indicators**	**Tasks**	**Responsible Party**	**By When?**	**Current/ baseline**	**Quarterly Update**
2014-2018	6.1 Ongoing implementation of Suicide Fatality Review	Develop annual recommendations based on the review of [TBD # of suicides] by the Suicide Fatality Review Committee; Adoption and/ or implementation of recommended policy, systems or environmental changes based on the recommendations	Develop one year report for the SFR Committee; meet with leadership to review	Suicide Fatality Review Committee, Washington County Epidemiology Team	Report by Ongoing	TBD	Report in progress (as of 1/2015)
			Submit HIA proposals for SFR	WCPH	TBD	TBD	
			SFR continues to meet and conduct reciews	SFR committee	Ongoing quarterly	Meeting regualrly	
2014-2018	6.2 Ongoing monitoring and tracking of suicide data as a component of the CHIP measurement system.	% of CHIP Suicide Prevention outcome indicators with updated data	Live Well leadership team monitors and tracks suicide prevention objectives	Live Well leadership team	Ongoing	TBD	

Access to Integrated Care							
GOAL 1:	Improve access to quality, affordable, culturally-responsive health care for residents of Washington County						
Objective 1	Assure health insurance coverage to residents of Washington County.						
Years	**Strategies**	**Outcome Indicators**	**Tasks**	**Responsible Party**	**By When?**	**Current/ baseline**	**Updates**
2014-2016	1.1 Integrate SBHCs into alternative payment methodology (support regional strategies).	By December 2016, Alternative Payment Model for SBHCs identified and adopted by SBHCs	Workplan specifics TBD (Januray- April 2015 Meetings)	WC Early Leaning Community Hub, WCPH, Regional Alternative Payment grant group, WCPH SBHC advisory group	Dec, 2016	AP pilots at FQHCs, no SBHCs (as of 12/2014)	
2014-2016	1.2 Ensure all health insurers reimburse for services provided at SBHCs.	By December, 2016, 100% of health insurers reimburse for SBHC services	TBD	WC Early Leaning Community Hub, WCPH, Regional Alternative Payment grant group, WCPH SBHC advisory group	Dec, 2016	Currently all but one health insurer reimburses for SBHC services	
2014-2018	1.3 Support expansion of coverage for undocumented youth (DREAM Act Youth).	Legislation passed to expand "Oregon Healthy Kids" coverage to undocumented youth	TBD	All committee; Oregon Latino Health Coalition	Dec, 2018	Bill in process for 2015 legislative session	

Access to Integrated Care							
Goal 1	Improve access to quality, affordable, culturally-responsive health care for residents of Washington County						
Objective 2	Increase capacity, connection to and utilization of a health home for newly insured and remaining uninsured in Washington County.						
Year	**Strategies**	**Outcome Indicators**	**Tasks**	**Responsible Party**	**By When**	**Current/ baseline**	**Quarterly Update**
2014-2016	2.1 Develop inventory of current strategies to expand access including identification of barriers to accessing care.	By July 2015, develop an inventory of current strategies (updated every six months); Track access to care indicators	Workplan specifics TBD (Januray- April 2015 Meetings)	WCPH and WCMH partners, Project Access NOW, Oregon Oral Health Coaltion	TBD	TBD	
2015-2018	2.2 Identify and implement strategies to address barriers identified by the inventory including patient navigation, increasing resources and workforce.	TBD	TBD	WCPH and WCMH partners, Project Access NOW, Oregon Oral Health Coaltion	TBD	TBD	
2015-2018	2.3 Improve workforce diversity through support of community health workers (CHWs).	TBD	TBD	Health Share of Oregon, Legacy, Providence, WCPH	TBD	TBD	

Access to Integrated Care							
Goal 1	Improve access to quality, affordable, culturally-responsive health care for residents of Washington County						
Objective 3	Improve capacity and utilization of behavioral health services (including prevention and early intervention) for underserved populations and eliminate avoidable health gaps and health disparities in Washington County's behavioral health care system.						
Year	**Strategies**	**Outcome Indicators**	**Tasks**	**Responsible Party**	**By When**	**Current/ baseline**	**Quarterly Update**
2014-2016	3.1 Improve access to culturally competent and appropriate behavioral health services based on study from the Oregon Healthy Future's advisory group (Strategy #3 in Oregon Healthy Futures).	By July 2015, plan for improving culturally competent and language appropriate behavioral health services developed; Additional TBD based on Oregon Healthy Futures and Oregon Behavioral Health Plan	Workplan specifics TBD (Januray- April 2015 Meetings))	TBD	TBD	TBD	
2016-2018	3.2 Support strategies to improve capacity and utilization for behavioral health services for youth, including undocumented youth.	Objective TBD: Increase # TBD of SBHCs with behavioral health services available 5 days/ week	TBD	SBHC Advisory Group, WCMH, WCPH, WC Early Learning Community Hub, LifeWorks NW, other mental health providers	TBD	TBD	

Access to Integrated Care							
Goal 1	Improve access to quality, affordable, culturally-responsive health care for residents of Washington County						
Objective 4	Improve capacity and utilization of affordable, preventive and integrated oral health services for underserved populations in Washington County.						
Year	**Strategies**	**Outcome Indicators**	**Tasks**	**Responsible Party**	**By When**	**Current/ baseline**	**Quarterly Update**
2014-2016	4.1 Expand access to integrated oral health services through federally qualified health centers and community clinics.	By December 2016, x% of FQHCs and community clinics comprehensively integrate oral health care into their activities	Workplan specifics TBD (Januray- April 2015 Meetings)	Oregon Oral Health Coalition, Virginia Garcia, Neighborhood Health Center, Project Access NOW	TBD	TBD	
2016-2018	4.2 Expand integrated oral health services in all Washington County SBHCs.	By December 2016, x% of SBHCs comprehensively integrate oral health care into their activities	TBD	WCPH, Oregon Oral Health Coalition, SBHC Advisory Group, Project Access NOW	TBD	TBD	

Access to Integrated Care							
GOAL 2:	Develop meaningful cross-sector system coordination						
Objective 5	Support coordination of mutually reinforcing activities between service providers.						
Year	**Strategies**	**Outcome Indicators**	**Tasks**	**Responsible Party**	**By When?**	**Current/ baseline**	**Quarterly Update**
2014-2016	5.1 Develop a model to increase access and utilization of medical homes for at risk children and families through coordination with Washington County's Early Learning Community Hub.	Medical home model developed in alignment with Washington County's Early Learning Community Hub partners	Workplan specifics TBD (Januray- April 2015 Meetings)	WC Early Learning Community Hub, FQHCs, SBHC Advisory Group, WCPH	TBD	TBD	
2014-2016	5.2 Develop a strategy for preventive and behavioral health services through the promotion and integration of evidence based strategies.	Strategy developed for integrated preventive and behavioral health services (includes family wellness, developmental screenings, well child and well adolescent checks)	TBD	WC Early Learning Community Hub, LifeWorks NW, FQHCs, WCPH	TBD	TBD	
2016-2018	5.3 Develop an aligned strategy for addressing high utilizers including preventive strategies, aligned use of high utilizer lists and EDIE data and strategies that take advantage of emergency medical services access, assessment, and clinic capabilities for preventive, gate keeping and out-ofhospital care and services.	Track readmission rates and post hospital follow-up (based on CCO data); other tasks TBD	TBD	Health Share of Oregon, FamilyCare, WC EMS, Providence, WCMH, WCPH, Project Access NOW, LifeWorks NW	TBD	TBD	

Priority Health Issue	Targeted Health Improvement Tracking 2014-2018
Chronic Disease	Decrease percent of population with low or no healthy food access (track by race/ethnicity)
	Increase percent of adults with adequate fruit and vegetable consumption
	Increase percent of adults who engage in regular physical activity
Suicide	Decrease age adjusted suicide rate
	Decrease suicide count by year
	Track suicide rates by vulnerable population
Access to Health Care	Increase percent of population with a regular doctor
	Increase primary care physician per 100,000 population
	Increase ratio of mental health providers per population
	Increase adults with some type of health insurance
Live Well Washington County	**Live Well Infrastructure Tracking**
Health Equity	Align with recommendations from local and regional equity plans
	Incorporate a healthy equity lens through all Live Well work plans
Prevention	Develop a Strategic Prevention Framework for Prevention in Washington County—with ongoing focus on equity and cultural responsiveness
Partnership and Collaboration	Number of organizations participating in Live Well Washington County
	Grant dollars awarded to support Live Well Washington County objectives

Collective Impact Maturity Model for Community Health Improvement

Bill Barberg, President, Insightformation, Inc. March 2013

For decades, communities have struggled with implementing plans to achieve health improvement goals. Research published in the Stanford Social Innovation Review has identified five conditions of achieving "Collective Impact." This assessment identifies different levels of accomplishment for each of those conditions. Identifying where your community is in each of these vital areas is an ideal way to being the process of moving to a higher level of practices and results. Rate your organization/community on a scale of 1.0 to 4.0 on the following scale for each of the five conditions:

COMMON AGENDA: Developing and Managing a Shared Strategy for Change

1. **Starting Point:**
   - Organizations are each following their own agendas without shared priorities goals or strategies.
   - Efforts are fragmented, duplicated, and there is inconsistent use of language and concepts.
2. **Making Some Progress**
   - Working together on a Community Health Needs Assessment leads to agreement on priority health issues.
   - Community organizations come together to set goals, but there is still poor alignment and collaboration on the strategies to achieve the goals.
   - Individual organizations independently develop plans or logic models to justify their actions and get funding.
3. **Better Approaches:**
   - Organizations work together to identify the underlying causes and key strategies for addressing priority issues
   - Organizations seek to find and share proven and promising practices to improve efficiency and effectiveness.
   - Strategy Maps are collaboratively developed for each of the priority issues
4. **Best of Promising Practices:**
   - A "zoomable" Strategy Map framework helps align the efforts of many community partners around the jointly-developed strategy maps.
   - All Objectives have clear "From-To Gaps" and may identify barriers and/or Key Success Factors (KSFs).
   - Strategy Maps development is integrated with Quality Improvement practices and techniques.
   - Funders and cross-sector teams actively collaborate on strategy refinement and implementation.
   - The strategy is managed by a cross-section of community leaders using state-of-the-art techniques and tools.

SHARED MEASUREMENT: Deploying a Shared System of Strategic Measurement

1. **Starting Point:**
   - Measurement chaos. There is a lot of duplicated work developing measures and collecting data, and most organizations use different, inconsistent measure definitions.
   - The measurement that is being done produces limited value. Most measures are health status measures or highly-aggregated community statistics that do little to help manage strategy implementation.
2. **Making Some Progress**
   - High-level Outcome measures are tracked, and there is agreement to work toward specific goals (SMART Goals).
   - Individual programs are measured with operational measures like inputs, outputs, efficiency and effectiveness.

- Program measures are used primarily for evaluation at the end of a program.
- Data is increasingly used for decisions, and discussions look at how to move the measures.

3. Better Approaches:

- Balanced Scorecard concepts and practices (such as clarifying objectives, measures, targets and initiatives) are used for organizations to measure their strategy (both drivers and outcomes).
- There is improved standardization in how measures are defined and used among different groups, along with increased data sharing.
- There are common reports that include measures for a variety of organizations as well as agreed-upon community indicators.
- Measures are used as a catalyst to improve performance at each stage of strategy development and execution.

4. Best of Promising Practices:

- The Community Balanced Scorecard" (CBSC) approach is used to measure multiple aspects of the strategy.
- Strategy management software makes strategy measurement easy and efficient. Presentation-ready formats minimize the time spent re-entering and re-packaging information for different audiences.
- Leading and Lagging indicators are used to continually improve alignment, resource allocation and strategy execution. Multiple funders monitor initiatives, strategic drivers, and project progress with a shared system.
- Data is efficiently shared, minimizing redundant data collection, and community organizations work to improve the quality of the data for the measures they are sharing.
- Operational systems allow information on individuals to be appropriately shared among organizations and efficiently aggregated for community-level measures.

MUTUALLY-REINFORCING ACTIVITIES: Working as a Team to Do More with Less

1. Starting Point:

- Projects are launched (and managed) by different organizations and are not part of a coordinated community strategy.
- Most organizations are not even aware of what other organizations are planning to do in similar areas.
- Many organizations work on similar things and duplicate work in many ways.
- Organizations striving to do similar things compete for resources rather than seeking ways to share their efforts to do more with less.

2. Making Some Progress

- Projects are tied to priority health issues, but with little emphasis on teamwork to improve effectiveness.
- Funders may encourage collaboration (in theory), but still use competitive ways of granting resources.
- Some progress is made in linking funding to project implementation to increases accountability.
- There are discussions of how to reinforce each other's activities to achieve better Collective Impact.

3. Better Approaches:

- Multiple organizations align their efforts around shared Strategy Maps to so their unique strengths can be best used to accomplish specific objectives that together advance an overall strategy..
- Collaborative work on strategic objectives expands awareness of who is working on what, and increases sharing of ideas, practices, data, and tools that reduces the "re-inventing the wheel" on projects that are launched.
- Gaps are identified, and organizations that may fill those gaps are invited to collaborate to improve overall community effectiveness.
- An organized framework of community work enhances efforts to seek and win large grants.

4. **Best of Promising Practices:**

- Organizing Initiatives/Projects and programs around a "Zoomable" strategy map framework allows information on a large number of projects to be efficiently monitored and reported on.
- The shift from organization-centric planning to community strategy-centric planning brings groups together to determine how they can best combine their efforts to stretch scarce resources.
- Funders shift from rewarding projects based on individual success to rewarding collaboration and sharing.
- Projects are consistently woven together to create lasting, sustainable outcomes, optimizing community assets.
- Multiple organizations work with individuals based on coordinated care plans and shared information.

CONTINUOUS COMMUNICATION: Staying Informed, Learning, and Efficiently Collaborating

1. **Starting Point:**

- Very little communication among the many organizations working to improve health.
- Promising practices, materials, insights, data and expertise are rarely shared to help other organizations be more successful in achieving health improvement goals (due to both inward-focused mindsets and lack of good tools).
- People wanting information on community health issues need to seek it out from a variety of different sources.

2. **Making Some Progress**

- Community-wide meetings occur, but on-going information exchange is still rare and not in very useful formats.
- Cross-organization task teams are established, but they are not very effective, nor are they equipped with efficient tools to support efficient and effective collaboration.
- A variety of Websites have information that is shared, but it tends to be either overwhelming or fragmented so the use and value is limited.
- Attempts are made to use on-line tools, but those efforts are not based on best practices.

3. **Better Approaches:**

- Regular meetings and reports keep a wide range of stakeholders informed—and keep work from slipping.
- Action Teams work to learn from each other and from peers around the country to improve performance.
- There is reasonably good communication among the members—but it is time-intensive for staff and relies on E-mail, documents, PowerPoint, Excel and phone calls.
- Information is communicated to a variety of audiences in various ways—Website, reports, etc.

4. **Best of Promising Practices:**

- On-line tools with interactive, presentation-ready formats greatly reduce the time required to keep everyone informed.
- 24x7 access to centralized information optimized for different audiences keeps strategy execution top-of-mind and at people's fingertips.
- A well-designed set of wikis support rapid access to the information people need to act effectively—measures, project status, intentions and plans are available for those who care about them.
- Many partners and individuals efficiently update centralized information to accelerate progress.
- People across the community can access the most current information (maintained in one place) on a variety of Websites.
- Care providers (clinical and social) have up-to-date information on patients, even across multiple organizations

BACKBONE SUPPORT: Helping to Coordinate, Align, and Managed Successful Collective Impact

1. **Starting Point:**
    - No formal backbone organization exists.
    - Efforts to collaborate are difficult because there is no structure or leadership to help communicate, coordinate and align efforts.
    - There is little appreciation for the value of backbone support.

2. **Making Some Progress**
    - A "backbone organization" exists to serve as a mutual convener and help facilitate collaboration.
    - The backbone organization uses a people-based approach and basic technologies (documents, PowerPoint, Excel and E-mail) approach to support communication and collaboration.
    - Progress is slow because so much depends on a backbone organization that has insufficient staff and resources.

3. **Better Approaches:**
    - The backbone organization is reasonably well funded and has dedicated staff.
    - The community partners work together with the backbone organization to attempt to achieve all the conditions of Collective Impact.
    - The backbone support helps with community progress, but the constrained capacity of the backbone organization limits the scope of issues and organizations that can be involved.
    - The backbone staff may struggle with information overload, but they work hard to accomplish coordination and communication (using the limited tools that they have available).

4. **Best of Promising Practices:**
    - A backbone organization has staff along with the appropriate "digital backbone" infrastructure to allow the dedicated staff to be much more efficient and successful.
    - The on-line information management tools do much of the heavy lifting for communication, monitoring, and alignment.
    - The backbone organization is much more sustainable, because it can support more issues with fewer staff because it has the appropriate tools—which cost less than staff and scale more easily.
    - Community Partners are able to take on more of the workload (reducing the burden on the backbone organization) because they can leverage the 'digital backbone" technologies.
    - A blend of person-based, strategic and operational tools allows flexible and efficient collaboration at many different levels: strategic, operational, and relational.
    - Organizations across the community see great value in how the backbone organization and on-line infrastructure saves them time and money—so they are willing to keep funding the backbone function.

For more information on improving on this Collective Impact Maturity Model, please contact Bill Barberg.

Bill.barberg@insightformation.com 763-331-8361

Appendix D: Example Crosswalk Tool

Objective 1: Increase access to and awareness of affordable, healthy food and physical activity opportunities through educational programs and resources		
Strategies	**Best practice/ promising practices and recommendations**	**Alignment with other local, state, and national plans**
1.1 Expand existing programs including nutrition, cooking and gardening classes, CSAs, and incentive programs i.e. Rx Play, Fruit and Veggie Rx	Social support interventions in community settings (1)	National Prevention Strategy
1.2 Increase healthy food options available at food banks, school cafeterias, and after school programs; maximize the amount of local food served in K-12 schools by increasing the number of schools participating in Farm to School programs	Providing healthy foods in existing establishments, supporting local farm-to-table efforts Increase availability of affordable healthier food and beverage choices in public service venues; improve availability of mechanisms for purchasing foods from farms (2)	National Prevention Strategy; Oregon State Health Improvement Plan; Washington County Food Systems Plan
1.3 Increase opportunities for local food processing, distribution, marketing, and sales	Provide incentives for the production, distribution, and procurement of foods from local farms (2)	Washington County Food Systems Plan
1.4 Increase farmers markets that accept WIC	Incentives for retailers and consumers can increase consumption of and availability of healthy food by participants; Program's and farmers markets allowing SNAP recipients to use part of their benefits to buy fresh produce with EBT cards increases purchase of these foods (3)	National Prevention Strategy
1.5 Develop and maintain an inventory of school, community and other types of gardens in Washington County		Washington County Food Systems Plan
1.6 Implement a comprehensive awareness and outreach campaign focused on what it means to be healthy and how to achieve it. Campaign will include promotion of existing resources and programs	Community-wide campaigns; health communication campaigns that include mass media and health-related product distribution (1)	Washington County Food Systems Plan
1.7 Improve outdoor recreation use through increased signage for existing trails and outdoor public recreation areas, and through a coordinated web based and app recreation maps – possible strategy: connect to Intertwine.org	Creation of enhanced access to places for physical activity combined with informational outreach activities; creating physical activity opportunities for residents through facilitating community trail development and promoting its use among youth and adults Improve access to outdoor recreational facilities (1)	
1.8 Increase participation in safe routes to school and partner	Enhance infrastructure supporting bicycling; Enhance	Aligned with the Washington

Appendix D: Example Crosswalk Tool

	infrastructure supporting walking (2)	County Transportation Plan (objective 8.6)
1.9 Develop and implement plan to collaborate with Community Health Workers to support CHART objectives	Integrate community health workers (CHWs) into community-based efforts to prevent chronic disease—demonstrated value and impact of CHWs in preventing and managing a variety of chronic diseases (4)	Alignment with Health Share of Oregon Community Health Improvement Plan
Objective 2: Identify opportunities to incorporate health into community design processes and policies to support (1) access to healthy and affordable food, (2) opportunities for physical activity, and (3) access to tobacco free environments		
Strategies	**Best practice/ promising practices and recommendations**	**Alignment with other local, state, and national plans**
2.1 Promote policies through increased engagement and participation; improve participation on CHART member participation on County and city planning advisory committees	Creation of or enhanced access to places for physical activity combined with informational outreach activities**;** community scale urban design and land use policies; street scale urban design and land-use policies (1) Improve access to outdoor recreational facilities; enhance infrastructure supporting bicycling; enhance infrastructure supporting walking (2)	
2.2 Support and promote "access for all" park initiative – THPRD		
2.3 Proactively seek opportunities to conduct HIAs of county plans and policies		
2.4 Advocate for better bike, pedestrian and transit connections		Washington County Transportation Plan (objectives 13.0, 14.0, and 15.0)
2.5 Update community development code to strengthen requirements for active transportation facilities		
2.6 Update the road design guidelines to provide for the implementation of more bicycle and pedestrian friendly transportation projects		
2.7 Update the parking code (utilizing the TGM grant)		
2.8 Assess potential policies to determine policies to prioritize and support (year 1); Jan. 2015-Dec. 2018 begin planning and implementation for policy recommendations	Community scale urban design and land use policies; street scale urban design and land-use policies (1) Zone for mixed-use development (2)	
2.9 Conduct a pilot project for neighborhood bikeways plan	Enhance infrastructure supporting bicycling (2)	
2.10 Implement Healthy retail program (including healthy	Increase access to healthy and affordable foods in communities;	Oregon State Health

vending)	implement organizational nutrition standards and policies (5) Provide incentives to food retailers to locate in and/or offer healthier food and beverage choices in underserved areas (2)	Improvement Plan (Healthy Vending Policies); OHEA 5 year plan
2.11 Increase trail connectivity	Creation of or enhanced access to places for physical activity combined with informational outreach activities (facilitating community trail development and promoting its use among youth and adults)* Enhance infrastructure supporting walking (2)	
Objective 3: Support the understanding and development of a "culture of health" with local business partners		
Strategies	**Best practice/ promising practices and recommendations**	**Alignment with other local, state, and national plans**
3.1 Increase number of employers who adopt and implement worksite wellness policies	Assessment of Health Risks with feedback plus health education; worksite programs to control overweight and obesity; point of decision prompts to encourage use of stairs; smoke-free policies (1) Implement organizational nutrition standards and policies (5) Increase availability of affordable healthier food and beverage choices in public service venues (2)	Oregon State Health Improvement Plan; National Prevention Strategy; Washington County Food Systems Plan
3.2 CHART partners adopt worksite wellness policies; Internal sharing of resources between CHART; develop and distribute worksite wellness kits for CHART partners		
3.3 Improve workforce diversity in Washington County to increase cultural competency		OHEA 5 year Plan; state equity plans
3.4 Ban/limit sale of tobacco in health related businesses (pharmacies, etc.)		
3.5 Utilize economic incentives to increase healthy food options in proximity to schools		
3.6 Work with businesses to incentivize more bike parking	Enhance infrastructure supporting bicycling (2)	

3.7 Increase community infrastructure for farming as a viable career and exciting opportunity		
Objective 4: Develop infrastructure to support implementation of CHART objectives		
Strategies	**Best practice/ promising practices and recommendations**	**Alignment with other local, state, and national plans**
4.1 Identify funding opportunities to support CHIP objectives		Washington County Transportation Plan
4.2 Community health information website	Community-wide campaigns; Health communication campaigns that include mass media and health-related product distribution (2)	
4.3 Marketing and outreach of CHIP: presentations, networking and branding strategy		
4.4 Education and outreach to sector and agency leaders on health topics and existing programs and resources		
4.5 Partner with Community Health Workers (CHWs) to be the bridge between specific subpopulations and strategy development	Integrate community health workers (CHWs) into community-based efforts to prevent chronic disease—demonstrated value and impact of CHWs in preventing and managing a variety of chronic diseases (4)	Health Share of Oregon Community Health Improvement Plan
Objective 5: Increase community engagement and participation in chronic disease prevention efforts among vulnerable populations		
Strategies	**Best practice/ promising practices and recommendations**	**Alignment with other local, state, and national plans**
5.1 Increase youth engagement and participation through a youth health council	Participate in community coalitions or partnerships to address obesity (2)	
5.2 Develop a farmer training and mentoring program		
5.3 Outreach with vulnerable populations to participate in land use and transportation community engagement opportunities; Outreach to MUH and neighborhood associations	Participate in community coalitions or partnerships to address obesity (2)	
5.4 Develop bike and pedestrian advisory committees in every city	Enhance infrastructure supporting bicycling; enhance infrastructure supporting walking; participate in community coalitions or partnerships to address obesity (2)	

Appendix D: Example Crosswalk Tool

Objective 6: Improve collaboration to increase programmatic supports for people experiencing chronic disease		
Strategies	**Best practice/ promising practices and recommendations**	**Alignment with other local, state, and national plans**
6.1 Coordinated outreach to providers to raise awareness of chronic disease self management programs and identify champions	Combined diet and physical activity promotion programs to prevent Type 2 diabetes among people at increased risk; Case Management Interventions to Improve glycemic control; Disease management programs; self-management education in community gathering places (1)	
6.2 CHART partners promote chronic disease self management programs among clients		
6.3 Collaborate with community partners to ensure that people at risk for negative health outcomes from chronic conditions have opportunities to learn about increasing consumption of healthy fresh affordable foods through chronic disease self management programs		Washington County Food Systems Plan

(1) Guide to Community Preventive Services (The Community Guide) (CDC)
(2) Recommended Community Strategies and Measurements to Prevent Obesity in the United States: Implementation and Measurement Guide (CDC, 2009)
(3) Robert Wood Johnson Foundation Research (Salud America!) (2013)
(4) Addressing Chronic Disease through Community Health Workers: A Policy and Systems Level Approach (CDC, 2014)
(5) National Prevention Strategy recommendation

Plans Included:
Oregon Health Improvement Plan
National Prevention Strategy
Washington County Food Systems Plan
Washington County Transportation Plan
Health Share of Oregon Community Health Improvement Plan
Community Commons Reports