Olympic Community of Health
Individual Needs Action Collaborative
August 24th, 2022; 1:00-2:30 pm
See calendar invite for meeting location and zoom link

UPDATED COVID Protocol: *To best protect and honor everyone's safety, county and venue-specific safety precautions are followed at all OCH events. At this event the following safety precautions will be followed:*

- *In alignment with venue protocols, masks will be optional.*
- *OCH encourages participants to take additional safety precautions as they aid in personal comfort.*
- ***Please note OCH is no longer requiring proof of vaccination for in-person attendance***

Purpose

The purpose of the individual needs action collaborative is to create a 4-year action plan (2023-2026) with organizational, Tribal, community, and regional actions to advance this focus area including: a regional result, indicators, target population, and both near- and long-term actions. At the end of 2022, the four action collaboratives will come together to present to the OCH Board of Directors on progress and plans for the upcoming year.

Meeting objectives

1. Review inputs and work to date
2. Prioritize actions

Agenda

Item		Topic	Lead	Purpose	Attachments
1	1:00-1:15pm	Welcome & Introductions	Celeste	Welcome, connecting	1. June 8 meeting summary
2	1:15-1:25pm	Grounding in process	Celeste	Grounding in journey to date, what's happening today, and next steps	
3	1:25-1:45pm	Summary	Celeste & Ayesha	What's missing from the actions	2. DRAFT summary
4	1:45-2:25pm	Prioritizing actions	Celeste & Ayesha	Refine and prioritize actions considering, what's missing, what benefits from a collective regional response, impact, and ease	3. Situational Overview
5	2:25-2:30pm	Next steps	Celeste		Olympic Action Collaboratives 2022 Meeting Schedule

Olympic Community of Health
Meeting Summary
Individual Needs Action Collaborative

Date: 6/8/2022	**Time:** 1-2:30	**Location:** Zoom
Attended: Kate Weller, Lucritia Stansbury, Nicolina Miller, Dawna Bryant, Maria Mungarro, Minnie Whalen, Kaela Moontree, Sandra Allen, Susan Buell, Marlaina Simmons, Reba Harris **Staff and Contractors:** Celeste Schoenthaler, Drew Gilliland		
Purpose The purpose of the access to care action collaborative is to create a 4-year action plan (2023-2026) with organizational, Tribal, community, and regional actions to advance the focus area including: a desired regional result, indicators, target population, and both near- and long-term actions. At the end of 2022, the four action collaboratives will come together to present to the OCH Board of Directors on progress and plans for the upcoming year.		
Topic	**Discussion/Outcome**	**Action/Next Steps**
Welcome, introductions, housekeeping	• Group introductions	N/A
Indicator themes	• Celeste reviewed the work from the last meeting. Staff created categories for the indicators that were derived in April and the group was asked to consider what is missing, what resonates, and what benefits from a collective regional response. • The group added notes to a google doc that staff will further compile.	Staff will flesh out the indicators and will bring a simplified version back to the group.
Moving to actions	• Celeste moved the group on to start to think about actions and target populations to achieve the result. • Participants were asked to individually come up with 3-5 bold ideas and populations to focus on.	Staff will compile the ideas and bring something back to the group to further flesh out.
Next steps	• July 13 meeting is canceled so staff can organize and synthesize all of the information that we've gleaned to date. • Next meeting is August 24 at OCH HQ in Port Hadlock.	Don't forget to block travel time.

Olympic Community of Health

Individual Needs are met timely, easily, and compassionately Action Collaborative

Result statement - Each Olympic region community member feels seen, heard, and connected, and has the resources they need to be healthy.

Possible indicators *(will be selected based on prioritized actions)* –

- Client/patient reported ease of access to services
- Community knowledge of services
- Stigma
    - SUD
    - Mental health
- Well-being
    - Percent mental health
    - Percent SUD
    - Percent experiencing isolation
    - Youth suicide rates
    - Thriving elders
    - Uplifted community
- Collaboration/communication across partners

Note: Access specific indicators are included in the access to care scope

Possible populations of emphasis –

The population of emphasis includes the Olympic region general population. Specific action items may include further refinement and detail of specific populations of emphasis which may include:

- Unhoused
- Elderly/aging
- Isolated
- Youth
- Foster care
- SUD
- Those with high ACEs
- Medicaid and underinsured

Possible actions *(for prioritization)* –

Care coordination	• Create a centralized, regional, accurate, easy to access resource directory • Create a centralized, regional, bi-directional communication and referral system (community-information exchange) that ensures continuity of care and that client needs are met • Create resource for transportation assistance in an easily accessed location by community (food banks, etc.) with a published calendar • Expand and coordinate grassroots care coordination efforts (Clallam Care Connect, REAL team, etc.) for high need/risk/utilizers • Establish intentional workflow/structure for regional care coordination (care coordination air traffic control, hub) that meets client needs and community context • Establish regional standardized SDOH screening
Culturally competent workforce	• Promote a resilient workforce to strengthen collaboration • Increase regional professional development opportunities through culturally competent trainings, events, etc. • Increase access to community-based coordinators that work with one client throughout their journey of care (community-health workers, care coordinators, promotoras, navigators, etc.)
Community engagement	• Expand access to resilience building youth programs • Maximize and expand grassroots community outreach programs (wellness kits, etc.) • Partner and community accessible convenings to share local resources • Host community-based health fairs with volunteer providers offering education & answering questions • Create a presentation that can be used by anyone to address stigma

Notes: 1) SUD specific actions, including stigma, are included in the Together, Recovery is Possible. 2) Housing specific indicators are included in the Everyone Housed scope of work. 3) Access specific actions are included in the Access to Care scope of work.

Resources needed to facilitate success as we pursue possible action items -

- Leveraging existing expertise
- Continued collaboration across regional partners
- Continue to recruit new voices and faces to the action collaborative and other spaces to inform this work, including those with lived experience, those most impacted, and representation across all local communities. Consider new partnerships that will support the work including health-serving partners, faith-based communities, etc.
- Pursue applicable funding to support new, innovative ideas
- Use community-tailored approach (targeted universalism)

Olympic COMMUNITY of HEALTH

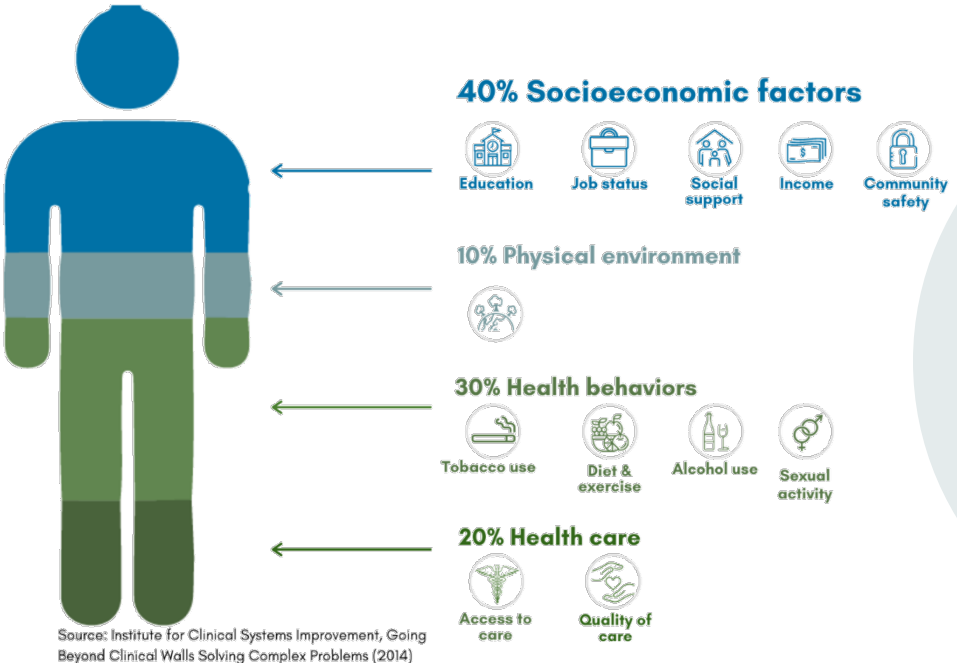
Individual needs are met timely, easily, and compassionately

Situational overview

Olympic Community of Health (OCH) believes that all people deserve to live with dignity. This includes a coordinated system of care that is tailored and compassionate to individual needs, putting the patient at the center. With a vision of healthy people, thriving communities, OCH has prioritized addressing individual needs as one of four focus areas beginning in 2022.

OCH can support and maximize local efforts to address the determinants of health by coordinating partner activities, identifying gaps, and expanding innovative and equitable solutions. OCH aims to enhance communication and collaboration across partners to achieve a healthier, more equitable three-county region.

Background



Source: Institute for Clinical Systems Improvement, Going Beyond Clinical Walls Solving Complex Problems (2014)

Ensuring that care is not only available but also easy to understand and navigate is necessary for individuals to achieve their thrive and reach their full potential. Care delivered in a culturally sensitive and appropriate way support equity advancements and the health of the overall population. A more streamlined, positive experience for the individual will result in better health outcomes and reduced costs in the long-term. This focus will preserve emergency resources and provide approachable pathways for quality health care.

Clallam

Clallam County is mostly rural and surrounds parts of the Olympic National Park, impacting travel and other barriers to care. Clallam County has an older population (30% age 65 and over) and is the home of three sovereign Tribal nations (Jamestown S'Klallam, Lower Elwha Klallam, and Makah). Unemployment rates are higher than state averages (6.8% Clallam, 4.8% WA, 2017) as are food insecurity rates among youth (15.4% Clallam, 12.1% WA, 2018).

Jefferson

Jefferson County has the oldest population (38% age 65 and over) in the state. A mostly rural county surrounded by much of the Olympic National Park with the majority of the population residing in Port Townsend. Severe affordable housing shortfalls and limited access to childcare are common challenges

among residents. Jefferson County has the highest rates of mental health among youth at 47.2% (as measured by the percent of students who reported feeling sad or hopeless every day for two weeks or more in row in the past 12 months, *Healthy Youth Survey, 2018*).

Kitsap

Kitsap County is home to a mix of suburban and rural communities. The county has a large military and veteran presence. The population has steadily increased as travel to and from Seattle & King County has become more convenient by multiple ferry options, which has consequences for the resources of local communities such as infrastructure, housing, social services, access to care, and more.

Examples of Current efforts

Organization	County	Program/Project Description
Kitsap Strong and Clallam Resiliency Project	Clallam, Kitsap	**Community-based interventions** to support well-being and prevent behavioral health problems are evident in the work of Kitsap Strong and the Clallam Resiliency Project. These non-profits provide education on N.E.A.R. Science (Neuroscience, Epigenetics, Adverse Childhood Experiences, and Resilience) and trauma-informed practices for health care providers, schools, faith-based organizations, and other community groups.
Quileute Tribe	Clallam	During COVID-19, the Quileute Tribe delivers community **wellness kits** to households on the reservation. Each delivery contains different activities and resources and often contains items rooted in Quileute tradition such as coloring pages, essential oils, fry bread ingredients and recipes, carved feathers, canoe pins, and dream catchers.
Clallam Care Connection (3C)	Clallam	North Olympic Healthcare Network, Port Angeles Fire Department, Peninsula Behavioral Health, and ReDiscovery collaborate on **community-based care coordination** to improve the health of individuals with complex, chronic conditions. The group aims to deliver a seamless experience of care that is person-centered, cost-effective, addresses determinants of health, resulting in improved health and wellness. During the initial pilot, 3C saw a 90% decline in 911 calls among eight community members who graduated from the program and a cost savings of over $100,000 by preventing 67 emergency calls and medic unit rollout.
Jefferson Healthcare	Jefferson	Jefferson Healthcare's **Health Equity Committee** works to provide culturally relevant and sensitive training for staff.
Peninsula Community Health Services	Kitsap	PCHS's **community health workers** are innovatively partnering with local organizations including the county jail, local emergency department, Salvation Army, and WorkSource to better understand and provide for community needs.
Port Angeles Fire Department	Clallam	The Port Angeles Fire Department launched a **Community Paramedic** program. Initial results show a 50% decrease in emergency room visits among clients.
Olympic Community of Health	Clallam, Jefferson, Kitsap	OCH completed an environmental scan, literature review, and survey of local partners to look at how **adverse social conditions across the region are impacting health** and explore opportunities for region-wide collaborative interventions. Findings were shared at regional convenings in 2020 and are available on the OCH website.

Major gaps

- Resources and services for **those without English as a second language or limited English proficiency** individuals is limited.
- There are limited resources for the **LGBTQ+ community**. There is a need for additional education for health and service providers on appropriate terminology, tailoring care, and **trauma-informed** practices.
- **Stigma** can be a barrier for those seeking behavioral health services, both mental health and substance use disorder. It can also be a barrier to reaching out to friends or employers for help as stigma contributes to alienation from others who do not understand the disease or how to help.
- Effective **linkages between community and clinical providers** are limited due to communication barriers and ongoing changes to resources resulting in fragmented referral systems and less support for patient needs.
- To support and address equity, there is a need for more **culturally sensitive practices and policies** that consider historical trauma, racism, and bias.
- Communication barriers and competing priorities and approaches lead to **fragmented coordination** among clinical, community, and public health services.

Example activities

- Support evaluation and expansion of community paramedicine and navigator programs across the region.
- Provide opportunities for health care providers, teachers, and community members to participate in culturally relevant, equity-based, and trauma-informed care trainings.
- Implement, support, and evaluate a region-wide health information exchange platform with closed-loop referral and bi-directional communication in alignment with key privacy laws, HIPAA and 42 CFR Part 2.
- Expand cross-sector, community-based, patient-centered care coordination solutions that improve patient experience as well as reduce unnecessary health care costs.
- Implement screening on the determinants of health at the point of care with workflows that support appropriate referral, care coordination, and follow-up.
- Empower health care consumers to become active participants in their own health and health care, for example by implementing an *Own Your Health* campaign (WA Health Alliance).