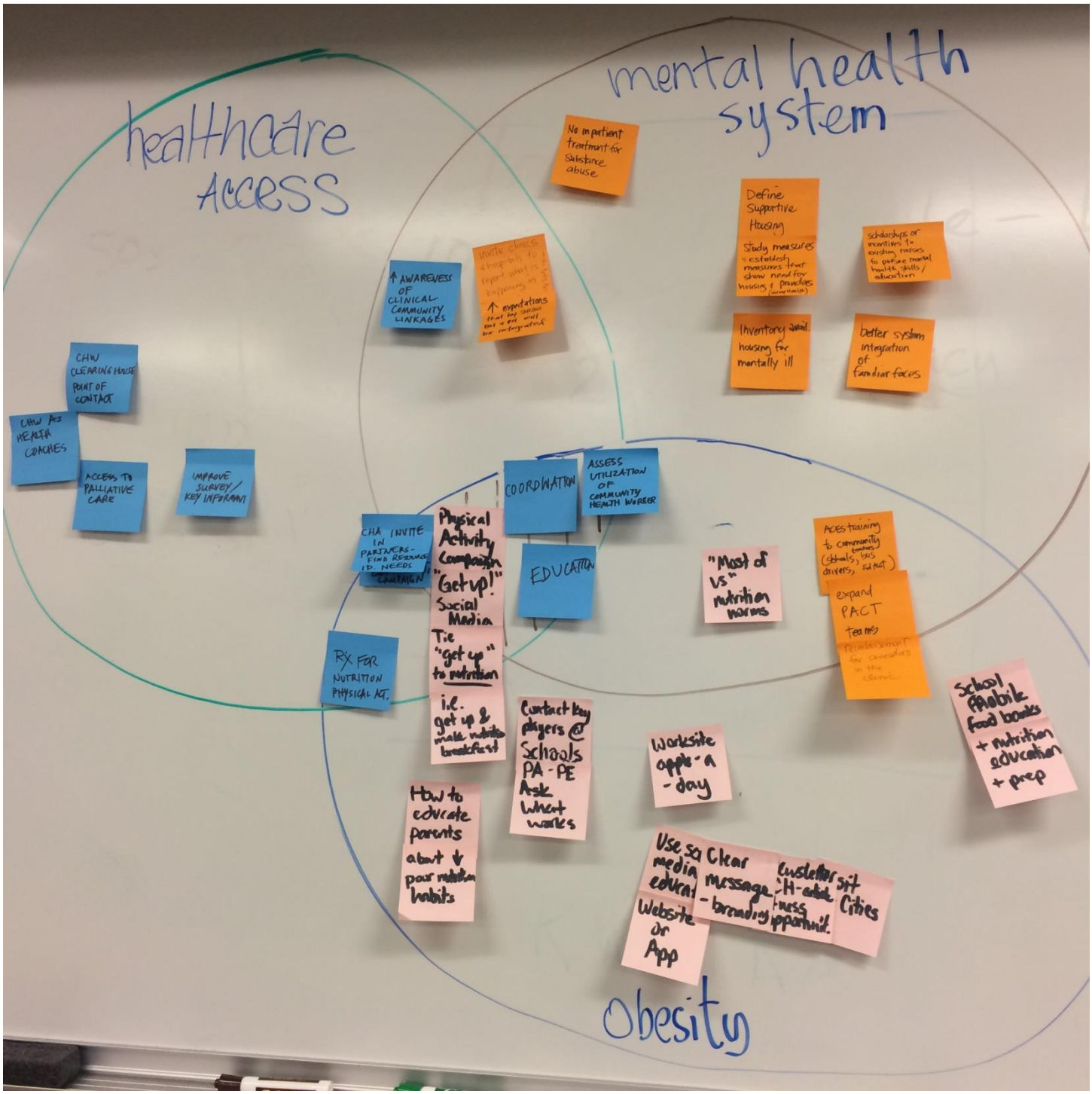


Updated!

Community Health Improvement Plan

For the People of Benton and Franklin Counties

2013-2020

Table of Contents

Vision

Benton and Franklin Counties are vibrant communities in which all individuals, regardless of their circumstances, experience good health.

May 2017

We've come a long way, but the journey's not over.

In 2016, the Benton-Franklin Community Health Alliance (hereafter "Alliance") updated the 2012 Community Health Needs Assessment (CHNA). Community members confirmed that the focus still needs to be on the original two strategic issues in the 2013 - 2017 Community Health Improvement Plan (CHIP):

- Improve access to health care
- Reduce Obesity

But that we also need to prioritize a third strategic issue:

- Improve the Mental/Behavioral Health System

What have we learned so far? It is possible to become overwhelmed at the sheer magnitude of the opportunity. The Alliance searched for the "sweet spot" that would allow us to focus attention on initiatives that impact all three of these important strategic issues.

This CHIP update recognizes both where we are and where we would like to be in terms of overall community health. We have made progress in the last three years, but there are still people in our community who struggle to achieve health.

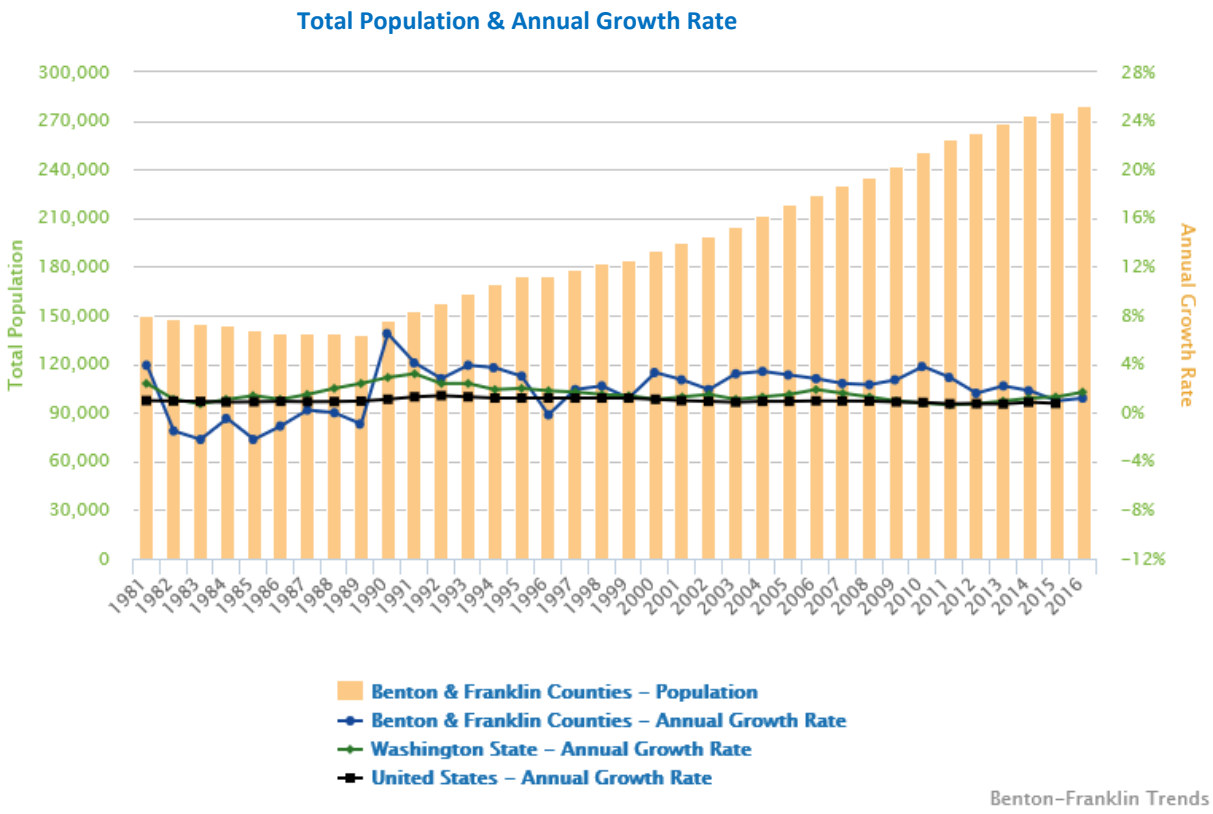
What you can do. More than you might imagine. Take small steps that can make a big difference in your life like choosing the stairs instead of the elevator. Then, consider volunteering at a community garden or starting a worksite wellness program to help meet the needs of neighbors and coworkers. Finally, help us advocate for legislation or policy changes to improve access to mental health services or to make it easier to walk through the community so we can continue to meet the needs for the next generation.

On behalf of the dozens of volunteers and organizations that make up the Alliance, thank you. Your support and participation matter.

Sincerely,

Amy D. Person, MD
Chair, Benton-Franklin Community Health Alliance
Health Officer, Benton-Franklin Health District

About Benton and Franklin Counties



The bi-county population reached 279,170 in 2016, with Benton County at 190,500 and Franklin County adding another 88,670. One in three Franklin County residents is under age 18, compared with one in four in Benton County.

In 2015, just over 51 percent of Franklin County residents and 21 percent of Benton County residents identified as Hispanic. Black, Asian, Native American and those of two or more races were about 7 percent of the total bi-county population.

In Benton County, one in five people reported that English is not spoken at home. Nearly half of Franklin County residents reported not speaking English at home.

EDUCATION	Benton	Franklin
High School Graduate or GED only (2015)	26%	27.7%
Some college or Associate's Degree (2015)	35.1%	29.6%
Baccalaureate Degree (2015)	19.1%	11.8%
Graduate Degree (2015)	10.5%	6.9%
Students receiving free and reduced price school lunches (2016 school year)	49.4%	70%

ECONOMIC VITALITY	Benton	Franklin
Labor Force 16 years and older (2016)	94,363	40,101
Unemployment rate (2016)	6.7%	7.6%
Residential Building Permits per 1000 residents (2015)	4.5	4.5
Median Household income (2015)	$62,484	$59,664
Percent below poverty level (2015)	15.3%	15.8%

Source: http://www.bentonfranklintrends.org

Community Health Needs Assessment

The 2016 Community Health Needs Assessment (CHNA) contains a point-in-time snapshot of the community's health. The CHNA used National Association of City and County Health Official's Mobilizing for Action through Planning and Partnerships model and incorporated data, forces of change and community perceptions to help identify key problems and assets in the community.

Participants confirmed that the 2016 CHNA should retain the two strategic issues from the 2012 CHNA. A third strategic issue was added to address growing concerns around mental health issues:

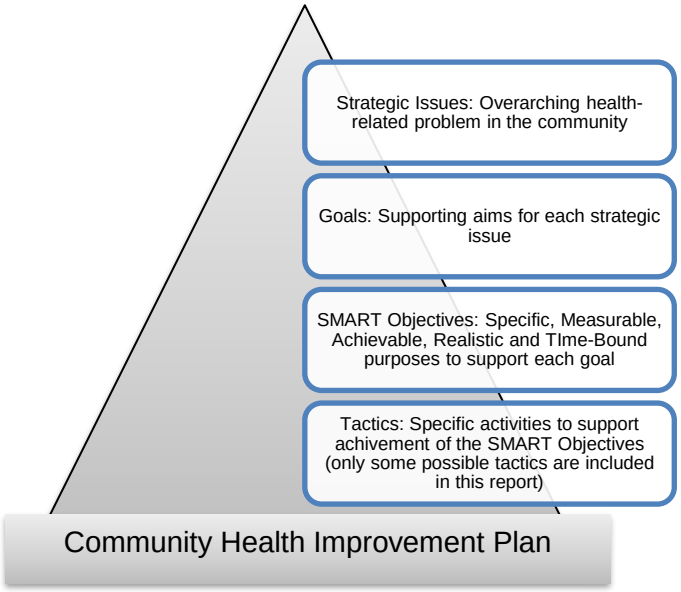
- Improve access to health care
- Reduce obesity
- Improve the mental/behavioral health system *(new)*

The Alliance also chose to focus on these three areas through the lens of health equity to help ensure that everyone in the community has the tools needed to achieve health. Finding ways to maintain the healthy changes will also build sustainability of this important work.

The following pages illustrate what has been accomplished in the past couple of years and serve as a guide over the next few years as partners work together with the Alliance to achieve better access to health care, improved mental/behavioral health system, and reduced obesity in our community.

CHIP Structure:

The elements of the implementation plan are listed below. The top of the pyramid contains the overarching strategic issues at the community level. These issues are supported by the goals and the objectives help us to measure our success over time. The foundation of the pyramid represents the activities and work of the Alliance and our community partners. For the CHIP Update, we have included the strategic issues, goals, and objectives, and indicated progress on original objectives, as well as new objectives to continue the work.



Three subcommittees of the Alliance (BFCHA), the Health Access Team, Healthy Lifestyles Committee and Behavioral Health Committee are helping to direct work on the CHIP strategic issues. Each of the subcommittees is in the process of identifying their priorities and developing their specific work plans in order to achieve their goals for the upcoming year. The CHIP highlights tactics and activities that are evidence-based or best practices. The specific activities and timeframes will be determined by the subcommittees.

Update: CHIP 2013-2020

Improve Access to Health Care

The BFCHA Health Access Team focuses on implementing the health care access objectives. The committee currently meets on the first Friday of the month. Contact Kirk Williamson: kfw@bfcha.org.

***NEW* LONG-TERM OUTCOMES**

- People receive integrated (Physical, Mental, Oral health) holistic care.
- The community culture supports innovative and adaptive models of care that improve health outcomes.
- Physical, dental, mental health care and palliative care are integrated.
- Avoidable emergency department utilization is reduced.

ACCESS GOAL 1: RESOURCES WILL BE IDENTIFIED TO REDUCE THE BARRIERS AND COSTS OF HEALTH CARE		
AC SMART OBJECTIVES:	**COMPLETED:**	**NOTES:**
AC 1.1: Create and implement a Provider and Office Manager Advisory Panel (POMAP), comprised of 5 to 10 practices, to understand local barriers to health care by December 2014. Baseline: POMAP does not yet exist Source: BFCHA Health Access Team (HAT), 2012	✓	Providers completed six surveys between August 2014 and May 2016. Topics were access to care for newly insured populations, coordination of specialty care, technology, mental health, oral health, and end of life care.
AC 1.2a: Increase the number of Community Health Workers (CHW) from 1 to 20 in the community by September 2015. Baseline: 1 CHW Source: Washington State Department of Health CHW Training Program, 2012	✓	As of December 31, 2015, 100 people had completed Community Health Worker training in Benton and Franklin counties (Source: Department of Health).
AC 1.2b New: Increase the number of employment opportunities for Community Health Workers. Baseline: TBD Source: 2017		No existing baseline. Tactics include survey of currently trained CHWs to identify needs.
AC 1.3: Enroll 2,400 uninsured citizens onto health care coverage through the Washington Health Benefit Exchange (WHBE) using In-Person Assisters (IPA by December 7, 2014. Baseline: 0 enrolled through WA HBE Source: Community Action Connections, 2012	✓	As of March 9, 2015, 20,421 people had been enrolled in expanded Medicaid and 4270 in Qualified Health Plans in Benton and Franklin counties (WA Health Benefit Exchange).
AC 1.4: Implement an evidence-based health curriculum in one local elementary or middle school by November 2015. Baseline: unknown Source: BFCHA, 2012	✓	Already implemented by School Districts.

ACCESS GOAL 2: THE COMMUNITY WILL EXPERIENCE COORDINATED HEALTH CARE		
AC SMART OBJECTIVES:	**COMPLETED:**	**NOTES:**
AC 2.1a Increase the number of points of distribution for the "Good Health Begins with Me" rack card from 6 to 50 outlets by September 2015. Baseline: 6 outlets of distribution Source: BFCHA Health Access Team, 2013	✓	The rack card has been distributed to more than 50 locations.
AC 2.1b New: Provide the RACK Card in at least 2 additional languages by December 2019. Baseline: 2 languages; English & Spanish Source: BFCHA Health Access Team, 2016		Continue work to reduce health literacy barriers and to reduce health disparities due to language barriers.
AC 2.2 Conduct at least 2 community presentations that increase awareness about emerging health models by December 2014. Baseline: zero presentations Source: BFCHA Health Access Team, 2013	✓	More than 2 community presentations occurred. Topics included health homes, Federally Qualified Health Centers (FQHCs).
AC 2.3 Increase the number of organizations distributing the book "What to do When My Child Gets Sick" from 4 to 10 by December 2015. Baseline: 4 outlets of distribution Source: BFCHA Health Access Team, 2013	✓	The book has been distributed to more than 10 locations.
AC 2.4 Maintain a 50% reduction of ED utilization by 800 patients enrolled in the Consistent Care Program through December 2017. Baseline:400 Patients Source: Consistent Care Program, July 2013	✓	945 patients have achieved a 53% reduction in ER visits over 360 days
AC 2.5 New: Implement evidence-based initiatives to continue trend in reducing 30-day hospital readmissions from 37.2 per 1,000 to 30 per 1,000 by December 31, 2020 (30 day readmission rate among Medicare beneficiaries per 1,000). Baseline: 38.8 per 1,000 (2014), 37.2 per 1,000 (2017) Source: Qualis Health, 2017		Possible tactics: community based paramedics, Greater Columbia ACH Readmissions Avoidance Project.
AC 2.6 Increase the number of opportunities for dentist-provider and for dentist-community interactions from zero to three by December 2016. Baseline: 0 Source: BFCHA Oral Health Committee, 2012	✓	BFCHA has presented the Eastern Washington Medical-Dental Summit annually for the past 4 years to promote shared learning opportunities among medical and dental providers. The inaugural year also included a public screening of "Say Ahh", a documentary on oral health filmed in the Tri-Cities. Planning is underway for Summit V in spring 2018.

Conduct six community-based mental health first aid training classes by 2017. Baseline: 0 First Aid Training classes Source: Behavioral Health Committee, 2013		Moved to mental health section
Produce and distribute a mental health resource brochure to at least 36 locations (hospitals, libraries, agencies, urgent cares, TCCC, TCCH) throughout Benton and Franklin Counties by 2015. Baseline: 0 Mental Health Resource Brochures Source: BFCHA Behavioral Health Committee,		Moved to mental health section

ACCESS GOAL 3: THE HEALTH CARE DELIVERY SYSTEM WILL HAVE THE CAPACITY TO MEET THE NEEDS OF THE COMMUNITY		
AC SMART OBJECTIVES:	**COMPLETED:**	**NOTES:**
AC 3.1 Support at least one statewide health policy that expands access to health services by December 2015. Baseline: A few health policies have been supported by BFCHA in the past, but this is the first time an intentional goal has been set. Source: BFCHA, 2013	✓	SB 5779: Mental Health and Primary Care integration passed and signed into law. (Supported by Behavioral Health Committee members, 11/16/2016). Alliance also worked with Tri-Cities Regional Chamber of Commerce Government Affairs Committee on policy to support another medical school in eastern WA. WSU's medical school inaugural class begins Fall 2017.
AC 3.2 Increase the number of dentists providing free dental services to the uninsured from 5 to 10 by December 2015. Baseline: 5 Dentists Source: BFCHA Oral Health Coalition, 2013		Grace Clinic is the only one providing free oral health services. Tri-Cities Community Health and Columbia Basin Health Association both have a sliding fee discount.
AC 3.3 New: Increase community utilization of palliative and hospice care by December 31 2020. Baseline: TBD Source: BFCHA Patient Safety/Transitions Committee, 2017		Possible tactics: increase awareness about palliative and hospice care by community members and health care providers.

Reduce Rates of Obesity and Diabetes

The BFCHA Healthy Lifestyles Committee focuses on implementing the nutrition and physical activity objectives. The committee currently meets on the third Wednesday of the month. Contact Kirk Williamson: kfw@bfcha.org.

***NEW* LONG-TERM OUTCOMES**

- Reduce obesity among 3-5 year old children by December 2025. (Baseline source: Early Childhood Education and Assistance Program/Head Start)
- Reduce the percent of 10th grade students who are obese from 13.6% to 10% by December 2025. (Baseline source: 2016 HYS)
- Reduce percent of adults who are obese from 32% to 22% by December 2025. (Baseline source: 2012 Benton-Franklin Trends Dashboard & CHR-BRFSS) *(30.2% in 2013)*
- Reduce diabetes among the Hispanic population from 8% to 5% by December 2027. (Baseline source: Washington State Department of Health)
- Reduce diabetes among the adult population from 9% to 6% by December 2030. (Baseline source: 2010 BRFSS, Benton-Franklin Trends Dashboard) *(8.5% in 2013)*

REDUCE OBESITY GOAL 1: COMMUNITY MEMBERS WILL BE MORE PHYSICALLY ACTIVE		
OB SMART OBJECTIVES:	**COMPLETED:**	**NOTES:**
OB 1.1 Increase the number of businesses and individuals participating in the Tri-City Regional Chamber of Commerce (TCRCC) "Good Health is Good Business" campaign by 100% by August 2015. Baseline: 5 Business, 432 Individuals Source: 2012 Tri-Cities Chamber of Commerce Good Health is Good Business Program	✓	Well established in its 7th year, the Good Health is Good Business program consists of two eight week challenge periods, one in the spring and one in the fall.
OB 1.2 Increase the number of elementary schools in Benton & Franklin Counties that implement Safe Routes to School (SRTS) programs from 0 to 5 by September 2019. Baseline: 0 Elementary Schools implement SRTS programs Source: SRTS website (Washington Dept. of Transportation), 2012		WSU nursing students worked with 3 schools to identify safe routes, but implementation of the program has been delayed by school renovations and construction and a lack of resources.
OB 1.3a Increase the prevalence of adults aged 18 and older who report they obtain the recommended level of weekly physical activity (moderate PA 30 minutes/day 5x/week, or vigorous physical activity 20 minutes a day 3 times a week) to 60% by December 2017. Baseline: 53.6% Benton and 51.0% Franklin Source: Washington DOH Local Public Health Indicators-BRFSS 2005-2010.	✓	2012: 64% of adults obtaining recommended physical activity (Washington: 69%)

OB 1.3b New: Increase the percent of adults aged 18 and older who report they obtain the recommended level of weekly physical activity (moderate physical activity 30 minutes/day 5 times per week, or vigorous activity for 20 minutes a day 3 times a week) from 64% to 70% by December 2020. Baseline: 64% of adults obtaining recommended physical activity Source: Washington DOH Local Public Health Indicators-2012 BRFSS		The Alliance will continue to expand the community goals for adult physical activity in order to reduce rates of obesity.
OB 1.4a Decrease the percent of middle school students who do not meet the physical activity recommendations from an average of 45% to 43% or better by December 2017. Baseline: 46% of 6th graders and 45.5% of 8th grade students not obtaining 60 minutes of physical activity for 5 to 7 days per week. Source: 2010 Healthy Youth Survey (askhys.net)	✓	**2016:** **6th grade:** 42.4% obtained 60 minutes of physical activity less than 5 days per week. **8th grade:** 38.5% obtained 60 minutes of physical activity less than 5 days per week.
OB 1.4b New: Increase the percent of 10th grade students who report that they meet the physical activity recommendations (physically active for at least 60 minutes per day in the last 5, 6 or 7 days per week) from 57.6% to 58.6% or better by December 2020. Baseline: 57.6% of 10th grade students obtaining 60 minutes of physical activity for 5 to 7 days per week. Source: 2016 Healthy Youth Survey (askhys.net: Benton and Franklin Counties combined report)		The Alliance will continue to expand the community goals to increase child and adolescent physical activity in order to reduce rates of obesity.
OB 1.5 Increase "Bicycle Friendly Community" designation from 0 to 1 by December 2015. Baseline: 0 Bicycle Friendly Community designations Source: 3-Rivers Bicycle Coalition, 2013		The cities of Pasco and Richland expressed support for the concept, but declined to apply for official designation.
OB 1.6a Increase the rate of access to recreational facilities from 8 per 100,000 to 11 per 100,000 by December 2017.* Baseline: 8 per 100,000, the Washington state rate is11 per 100,000 Source: County Health Rankings, 2012		The measure has changed to "access to exercise opportunities" which includes parks, trails, etc. (not just fitness gyms). See OB 1.6b
OB 1.6b New: Increase access to exercise opportunities by 5% in both counties by December 31, 2020. Baseline: 82% Benton, 55% in Franklin (WA: 88%) Source: County Health Rankings, 2016		New measure better reflects Alliance goal to reduce health disparities as it includes exercise opportunities that are free or low cost. Possible tactics: community-wide campaign to promote physical activity, "Prescribe a Park", or "Prescription to Play" accessible opportunities.

OB 1.7 New: Increase the number of cities adopting Complete Streets policies for new commercial and residential development from 2 to 5 by December, 2019. Baseline: 2 cities have adopted complete streets policies (Pasco resolution, West Richland ordinance) Source: City Council meeting minutes, 2016		Possible tactics: educational opportunities for city planners and local government officials, capitalize on WA state funding opportunities that support Complete Streets.

REDUCE OBESITY GOAL 2: ADULTS WILL MAKE MORE NUTRITIOUS FOOD CHOICES		
OB SMART OBJECTIVES:	**COMPLETED:**	**NOTES:**
OB 2.1 Increase the percentage of people in our community, who eat five or more servings per day of fruits and vegetables from 22% to 40% by December, 2017. Baseline: 22% of the population eat five or more servings of fruits and vegetables/day Source: Washington Department of Health LPHI (BRFSS) 2009		Method of measurement by the BRFSS survey has changed.
OB 2.2 Increase access to healthy foods by 2% by December 2017. Baseline: 12% Franklin, 4% Benton, 5% Washington (% low income and do not live within a certain distance to a grocery store) Source: County Health Rankings, 2012		Measure by CHR has changed to food environment index (new objective OB 2.4)
OB 2.3 Increase nutritious options served by restaurants and fast food establishments by 20% by December 2017. Baseline: Currently not measured at community level Source: BFCHA Healthy Lifestyles Committee, 2013		Not currently measurable, this objective is now included as a tactic under OB 2.4.
OB 2.4 New: Improve the Food Environment Index from 7.5 to 8 by June 2020. Baseline: 7.5 factors that contribute to a healthy food environment Source: 2017 CHR (2012-2013 USDA)		Possible tactics: improve nutritious food options available through institutions
OB 2.5 New: Increase number of food gardens for use by groups of low-income and at-risk populations from 40 to 60 by December 31, 2020. Baseline:40 Community/Food Gardens Source: WSU Master Gardeners Program, 2017		Ongoing work lead by WSU Master Gardeners in the Food Gardening Program. Possible tactics; building new and expanding existing gardens to improve access to fresh vegetables, fruits and herbs.

REDUCE OBESITY GOAL 3: PROMOTE BREASTFEEDING AND IMPROVE CHILD NUTRITION		
OB SMART OBJECTIVES:	**COMPLETED:**	**NOTES:**
OB 3.1 Increase the percent of women who breastfeed for at least 6 months from a combined county average of 38.3% to 60.6% (HP2020 Target) by 2017. Baseline: 38.8% of mothers still breastfeeding when babies are 6 months old. Source: WIC (average of overall rates from both BFHD and TCCH), 2012, 2016		2016 update: 40.9% of babies in WIC in Benton and Franklin Counties are breastfed until age 6 months or older.
OB 3.2 Increase the number of providers (BFHD WIC, Head Start, and Early Head Start) and professionals (Physicians, Dieticians) who complete nutrition training from 5% to 20% by 2017. Baseline: 5**%** completed nutrition training Source: BFHD WIC, 2012		Planned education for practitioners did not occur.
OB 3.3 Increase the number of school districts who participate in a school nutrition incentive program from 20% to 80% by 2017. (at least one school building per district) Baseline: 20% of the School Districts participate in a school nutrition incentive program Source: BFCHA Healthy Lifestyles Committee estimation, 2013	✓	Implemented by most of the school districts
OB 3.4 New: Reduce the 2nd day breastfeeding supplementation rate from 42.9% to <25% by December 31, 2020. Baseline: 42.9% newborns receiving formula supplementation Source: WA DOH, BFHD WIC Breastfeeding Program (USDA goal is <25%), 2016		Possible tactics include breastfeeding training for hospital staff, survey providers on knowledge and attitudes, and survey mothers.
OB 3.5 New: Support implementation of the 5-2-1-0* wellness campaign in at least 3 schools by December 31, 2020. Baseline: TBD Source: Greater Columbia Accountable Community of Health, 2017		This objective aligns with regional work by Greater Columbia ACH to prevent chronic disease.

*Daily: 5 or more fruits and veggies; 2 hours or less screen time; 1 hour of physical activity; 0 sugary drinks

(New) Improve the Mental/Behavioral Health System

The BFCHA Behavioral Health Committee focuses on implementing the mental health objectives. The committee currently meets on the first Wednesday of each month. Contact Kirk Williamson: kfw@bfcha.org.

This section is new to the CHIP; therefore, some tactics from the BFCHA Behavioral Health Committee have been included to provide context.

LONG-TERM OUTCOMES

- All providers integrate behavioral/mental & physical health services by 2020.
- Everyone has access to mental health/behavioral health services and awareness of available resources in the community.

New **MENTAL HEALTH GOAL 1: CREATE MORE AWARENESS ABOUT WHOLE PERSON HEALTH (INCLUDING BEHAVIORAL/MENTAL HEALTH)**
SMART OBJECTIVE: MH 1.1 Conduct six community-based behavioral health first aid training classes by 2017. Baseline: 2 trainings (Mental Health First Aid) Source: BFCHA Behavioral Health Committee, 2013
Tactics:
• Encourage and promote community education in recognizing and responding to people with behavioral health needs. • Survey first-responders to determine interest or need for Mental Health First Aid training.
SMART OBJECTIVE: MH 1.2 Increase access to mental health/behavioral health services and awareness of available resources (support groups, trainings, classes, brochures) in the community by 2020. Baseline: TBD Source: Behavioral Health Committee, 2017
Tactics:
• Encourage and promote four community events each year which battle stigma of mental illness and increase awareness of whole person health. • Produce and distribute a mental health information brochure.

New MENTAL HEALTH GOAL 2: WORK TO ELIMINATE GAPS IN THE SYSTEM

SMART OBJECTIVE:

MH 2.1 Increase the number of mental health providers (therapists, counselors, peer supports) in the community (clinics, schools, hospitals) by 20% by December 31, 2022.

Baseline: TBD
Source: BFCHA Behavioral Health Committee, 2017

Tactics:

- Advocacy to increase training opportunities and reduce barriers, e.g. loan repayment.
- Collaboration with school guidance counselors and health system recruiters.

SMART OBJECTIVE:

MH 2.2 Increase the number of providers integrating behavioral/mental & physical health services by 20% by December 31, 2020.

Baseline: TBD
Source: BFCHA Behavioral Health Committee, 2017

Tactics:

- Advocate for, monitor and support completion of a gap analysis for MH/BH services with Benton and Franklin County Commissioners.
- Evaluate proposals and provide supporting testimony and data for commissioners to move forward with comprehensive mental health system for Benton and Franklin Counties.
- Assist in developing a meaningful “dashboard” report for Commissioners and the community to monitor effectiveness of mental health referral system.
- Encourage community discussion.
- Host workshops to bring mental and physical health providers together.

New MENTAL HEALTH GOAL 3: IMPROVE INTEGRATION AND COORDINATION OF SERVICES

SMART OBJECTIVE:

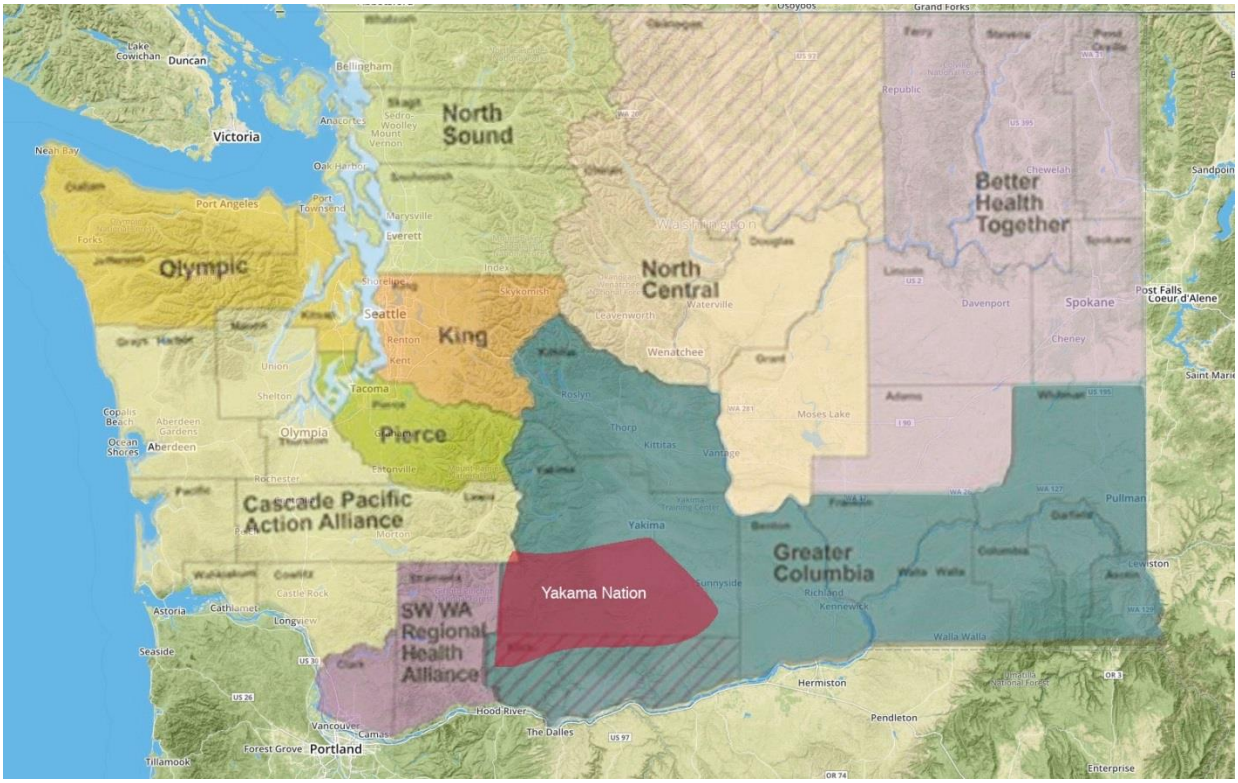
MH 3.1 Increase the number of appropriate housing units (including "Housing First" units) available for people who are chronically homeless along with support services and case management by December 31, 2020. (Note: Housing First refers to a HUD model).

Baseline: TBD
Source: BFCHA Behavioral Health Committee, 2017

Tactics:

- Supportive housing has been identified as a priority need in the Medicaid Transformation Demonstration Project, so the Alliance will defer identifying specific tactics in order to better align with the efforts of the Greater Columbia Accountable Community of Health.

Alignment with Local, Regional, State, and National Work



The Benton-Franklin Community Health Alliance was formed more than 20 years ago with the original purpose of bringing the community together to provide local care for cancer patients under the joint ownership of three local hospitals. Today the Alliance engages over 50 partnering agencies community wide to work towards improving health outcomes and access to health care.

Over the years, the Alliance and its community of volunteers have addressed a variety of community health issues, including chronic disease prevention, patient safety, pain management, tobacco prevention, improving mental/behavioral health services, and access to medical and oral health care.

The Community Health Improvement Plan not only brings local partners and agencies together to address health issues. It also aligns with state and national health priorities: Centers for Disease Control and Prevention winnable battles, Healthy People 2020, and the Washington State Health Improvement Plan (SHIP).

Washington state was recently divided into nine Accountable Communities of Health (ACHs) (see map above) that bring together leaders in the community and across the state with a common interest in improving health and health equity. Their goal is to better align local resources and activities to improve whole person health and wellness.

In 2017, the Washington State Health Care Authority received approval of its Medicaid Transformation Project from the Centers for Medicare and Medicaid Services (CMS). $1.125 billion is available across the state for well-focused community-based projects to improve health and transform health care delivery in our communities. The funding will support demonstration

projects, coordinated by the ACHs. Benton and Franklin counties are part of the Greater Columbia Accountable Community of Health (GCACH).

The Alliance is positioned to work closely with the regional 9-county GCACH (shaded in turquoise in the map above) as it selects transformation projects to be implemented in our local communities. Strategic issues addressed in our Community Health Improvement Plan (CHIP) reflect priorities identified across the GCACH region. This updated CHIP and the ongoing implementation activities of the Alliance and its subcommittees will continue to look for opportunities for alignment and collaboration with the Greater Columbia ACH's planning and priorities for improving the health of communities across the region.

Collective Impact

We gratefully acknowledge the many contributors to this important work through planning and implementation.

Organizations

Aging and Long Term Care
American Diabetes Association
Aurelia Press
Benton County
Benton-Franklin Head Start
Benton-Franklin Health District (BFHD)
Benton-Franklin Community Health Alliance (BFCHA)
Benton-Franklin Dental Society
Benton-Franklin County Medical Society
Boys and Girls Club
Catholic Family & Child Services
Chaplaincy Healthcare
Columbia Basin College
Community Action Connections
Community Health Plan of Washington
Community members/concerned citizens
Consistent Care Program of Southeastern Washington
Department of Social and Health Services
Domestic Violence Services of Benton and Franklin Counties
Educational Service District 123
Employment Security Department (Work Source)
Group Health/Kaiser Permanente Washington
Kadlec Regional Medical Center
Lourdes Counseling Center
Lourdes Health Network
Mental Health Ombuds, Inc.
Pacific Northwest National Laboratory (PNNL)
Pasco Discovery Coalition/Prosser Community Involvement and Action Coalition
Pasco Ephesus Seventh-Day Adventist Church
Pasco High School
Pasco Latino Lutheran Ministry
Petersen Hastings
PMH Medical Center, Prosser
Promotor a de Salud
Richland Seventh-Day Adventist Church
Therapy Solutions
Tri-Cities Cancer Center
Tri-Cities Community Health
Tri-Cities Diabetes Coalition
Tri-City Regional Chamber of Commerce
Tri-Cities Visitor and Convention Bureau
Trios Health
United Way/Community Solutions
Washington State University/Tri-Cities
Washington State University Extension Master Gardeners
World Relief

Acronyms

BMI: Body Mass Index

BRFSS: Behavioral Risk Factor Surveillance Survey

CHIP: Community Health Improvement Plan

CHNA: Community Health Needs Assessment

CHW: Community Health Worker

ED: Emergency Department

HYS: Health Youth Survey

IPA: In-Person Assister

MAPP: Mobilizing for Action through Planning and Partnerships

NACCHO: National Association of City and County Health Officials

POMAP: Provider and Office Manager Advisory Panel

WHBE: Washington Health Benefit Exchange

WIC: Women, Infants, and Children Program that promotes mother and child nutrition and breastfeeding

Definitions

Body Mass Index (BMI): BMI is a number calculated from a person's weight and height. BMI is not a perfect measure of body composition but can be used to screen for overweight or obesity.

BM BMI for adults and teens can be calculated by clicking here: http://www.cdc.gov/healthyweight/assessing/bmi/index.html			
Underweight	Normal weight	Overweight	Obese
< 18.5	18.5 – 24.9	25.0 – 29.9	≥ 30.0

Community Health Needs Assessment (CHNA): A community health needs assessment (CHNA/CHA) measures the health of a community at a given point in time. This can include data trends, public perceptions, capacities, and forces of change (funding, support, etc.) that may affect ability to address health issues.

Community Health Improvement Plan (CHIP): A Community Health Improvement Plan is a long-term, systematic effort to improve health outcomes in a community. The plan outlines actions that key partners plan to take based on the results of Community Health Needs Assessments.

Coordinated Care: Integrated care or coordinated care is the systematic coordination of general (physical, mental, dental) and behavioral health care.

Health: a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity (World Health Organization).

Health Equity: Attainment of the highest level of health for all people (Healthy People 2020).

Health Literacy: The degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions. (Institute of Medicine: A Prescription to End Confusion).

Medical Home: Medical homes provide continuous, comprehensive, whole person primary care. Personal physicians and their teams work with patients to address preventive, acute, and chronic health care needs. Medical homes offer enhanced access, practice evidence-based medicine, measure performance, and strive to improve care quality. (Definition from County Health Rankings and Roadmaps: http://www.countyhealthrankings.org/policies/medical%E2%80%90homes).

Mental Health: emotional, behavioral, and social maturity or normalcy; the absence of a mental or behavioral disorder, a state of psychological wellbeing in which one has achieved a satisfactory integration of one's institutional drives acceptable to both oneself and one's social wellness and life balance.

SMART Objective: Specific, Measurable, Achievable, Realistic, Time-bound components under each goal

Social determinants of health: The circumstances, in which people are born, grow up, live, work and age and the system put in place to deal with illness. These circumstances are in turn shaped by a wider set of forces: economics, social policies and politics (World Health Organization).

Strategic Issue: overarching health related concept identified as priority areas for improvement

Note: *More detailed information regarding the CHNA, this plan and process can be found on the Benton-Franklin Community Health Alliance website at www.bfcha.org.*