Lake Chelan Health
2023-2025 Community Health Needs Assessment Implementation Plan

Lake Chelan Health's 2023-2025 CHNA, coupled with the specific strategies identified within this Implementation Plan, are integral to our commitment to partner with the community to realize a healthy and more equitable Lake Chelan Valley. The CHNA, adopted on December 20, 2022, contains a thorough evaluation of the factors impacting the length and quality of life of residents of the Valley, including health behaviors, social and economic factors, clinical care, and physical environment.

The CHNA process was designed to assure that the community voice and its input into defined priorities was incorporated. The specific community engagement process and the results of that process were described in detail in the Community Engagement Section of the CHNA. Further, the Board has high interest in achieving an equitable environment for our patients, workforce, and community, and as such, is committed to integrating health equity throughout the implementation of strategies. This includes incorporating best practices for: attracting and retaining a diverse workforce; continued development of foundational health equity programs focused on staff training; providing effective language access services; delivering affirming care; and measuring and disseminating a health-equity dashboard that tracks the ability to close screening and care gaps.

Selected Priorities

After thoughtful consideration of the data and community input, and after considering the extent and magnitude of the community's needs, Lake Chelan Health (LCH) identified the following four priority areas of focus for the period of 2023-2025.

- **Access to care,** with a particular focus on primary and preventive care.
- **Behavioral health services and supports,** particularly for our youth.
- **Recruitment and retention of a quality workforce,** including a focus on affordable housing.
- **Support for our seniors to safely age in place.**

These four priorities will inform LCH's Strategic Planning and are the focus of this Implementation Plan. We are confident that the selected implementation strategies will move the needle on each priority and that LCH will be able to demonstrate quantifiable improvements over time.

Importantly, and as noted in in our CHNA, our community is richly diverse and some of our neighbors face significant health inequities. LCH will integrate into each priority and strategy purposeful investments in health equity, including awareness and training of leadership and workforce, and leveraging of community partnerships to reduce identified inequities.

Implementation Strategies

A. Priority: Access to Care, with a particular focus on primary and preventive care.

The goal is to provide equitable access to primary and preventive care in order to prevent or delay disease, to detect health problems early, and to provide education in support of good health-related behaviors and decisions. Strategies are detailed in the table below.

Strategy	Anticipated Impacts	Resources/ Community Partners
Increase walk-in clinic hours.	▪ Improve accessibility to primary and preventive services. ▪ Increase in after-hours and weekend clinic visits.	▪ LCH Primary Care and Express Clinic Providers and Staff ▪ LCH Community Health Workers (CHWs) ▪ LCH Community Paramedicine Program ▪ Columbia Valley Community Health Center (CVCH) ▪ Lake Chelan Valley School Districts ▪ Chelan Lions Club ▪ Cashmere Kiwanis Club ▪ Chelan Senior Center ▪ Catholic Charities ▪ Knights of Columbus ▪ Chelan Rotary ▪ Chelan-Douglas Health District ▪ Lake Chelan Health and Wellness Foundation
Partner with the community to provide education on healthy lifestyle choices to reduce both the risk of injury and disease progression.	▪ Increase in resident participation in community and school events focused on health and wellness. ▪ Increase in residents reporting regular exercise and healthy food choices.	
Partner with Lake Chelan Valley school districts to provide health education, including childhood injury prevention, drug and alcohol prevention, and CPR/First Aid training.	▪ Increase in percentage of children, youth, and families participating in health education. ▪ Increase in number of participants in CPR/First Aid training. ▪ Reduction in childhood injuries treated in the ED, walk-in clinic, and primary care.	
Close care gaps through provision of annual reminders for preventive annual screenings/vaccinations and of community-based screening/ vaccination programs, with a special focus on reducing inequities.	▪ Increase in compliance with annual screening recommendations. ▪ Increase the percentage of all residents, especially those from traditionally underserved groups, receiving preventive screening and recommended vaccinations.	
Provide community programming in support of heart health, obesity reduction, and chronic disease prevention.	▪ Reduce hospitalizations and ED visits related to preventable chronic conditions. ▪ Reduce burden associated with preventable diseases.	
Provide Cultural Competency and Health Equity training to providers and staff.	▪ Increase the number of providers and staff receiving training. ▪ Reduce barriers to care faced by underserved populations.	

B. Priority: Behavioral Health Services and Supports, particularly for youth.

LCH is focused on fully integrating behavioral health services into primary care. LCH also acknowledges the need to improve access and warm handoffs to the full range of services for diagnosis, treatment, and management of mental health and substance use disorder services.

Strategy	Anticipated Impacts	Resources/Community Partners
Integrate behavioral health services into primary care, including increased coordination between primary care providers, CHWs, EMS, and behavioral health providers.	▪ Increase in awareness of and access to behavioral health services. ▪ Reduce emergency room encounters associated with untreated behavioral health needs.	▪ LCH Primary Care Providers ▪ LCH ER Providers and Staff ▪ LCH CHWs ▪ LCH Community Paramedicine Program and EMS ▪ Partnership Access Line ▪ Perinatal Psychiatry Consultation Line ▪ UW Adult Psychiatry Consultation Line ▪ Rippl-TelePsych ▪ Chelan Crisis Line ▪ 988 Suicide and Crisis Lifeline ▪ Crisis to Text (741741) ▪ Parkside Crisis Line ▪ Chelan Valley Hope ▪ Lake Chelan Foodbank ▪ TLC for Seniors ▪ Chelan Valley Community Nurses ▪ Action Health Partners ▪ Chelan Senior Center ▪ Catholic Charities ▪ Knights of Columbus ▪ Chelan Rotary ▪ Chelan Lions Club ▪ Law Enforcement ▪ Hope Squad ▪ Thrive Chelan ▪ Only 7 Seconds ▪ School Districts ▪ Lake Chelan Medclub ▪ Lake Chelan Health and Wellness Foundation
Provide Tele-Behavioral Health Training to primary care providers.	▪ Increase in referrals to and visits provided by Tele-Behavioral Health.	
Utilize dedicated and trained CHW FTEs to conduct behavioral health screenings of all ER and clinic patients and to refer patients to appropriate resources.	▪ 100% of primary care and ER patients receive behavioral health screenings.	
Train CHWs in the clinics on interventions and resources specific to behavioral health and social determinants of health for children and youth, including a specific focus on cultural competency and awareness.	▪ Increase in referrals to behavioral health and wrap-around services to influence social determinants of health. ▪ 100% of LCH CHWs trained in social determinants of health, health inequities, and cultural competency/awareness. ▪ Decrease in inequities related to behavioral health outcomes and social determinants of health.	
Utilize LCH's community paramedicine program to identify and connect individuals in their homes to behavioral health services and community resources.	▪ Increase in individuals receiving behavioral health services and referrals to community resources.	
Increase access to crisis behavioral health services by training and certifying EMS staff in adult and pediatric mental health first aid and motivational interviewing, with a focus on cultural competency and awareness.	▪ Increase in individuals receiving crisis screening and referrals for appropriate behavioral health services. ▪ Reduction in being seen/boarded in the ED.	
Continue to partner with Lake Chelan Valley school districts and community organizations to conduct events and operate programs designed to reduce stigma, improve youth mental health, and prevent suicide.	▪ Increase the number of events and the number of participants in mental health programming. ▪ Decrease the percentage of residents reporting poor mental health. ▪ Reduce the rate of suicide ideation, attempts, and suicides among youth.	

C. Priority: Recruitment and retention of a quality workforce, including a focus on affordable housing.

In order to assure access to the range of health prevention, diagnosis, and treatment services needed in the community, the Lake Chelan Valley needs to grow, recruit, and retain a quality workforce, including physicians, advanced practice providers, nurses, CHWs, paramedics, EMTs, and ancillary and technical staff.

Strategies	Anticipated Impacts	Resources/Community Partners
Evaluate specific workforce needs and recruit new providers and staff that reflect the demographics of the community.	▪ Increase in number of provider/staff position openings developed/posted. ▪ Increase in number of providers and staff recruited/hired, with a special focus on bilingual providers/staff. ▪ Additional retention opportunities identified/implemented. ▪ Increase in collaboration with community housing agencies and private foundations. ▪ Reduce turnover of providers and staff. ▪ Increase in local access to care. ▪ Reduce unnecessary ED visits and hospitalizations.	▪ Lake Chelan Health Paratransit Dept. ▪ LCH Community Paramedicine and EMS ▪ Link Transit ▪ Chelan Valley Hope ▪ School Districts ▪ Chamber of Commerce ▪ Wenatchee Valley College ▪ Local Running Start Program ▪ Chelan Valley Housing Trust ▪ Habitat for Humanity ▪ Lake Chelan Health and Wellness Foundation
Work with community partners to implement programs to retain existing providers, including advocating for affordable housing, more family-wage jobs, and better transportation and childcare options.		
Partner with the local school districts and community partners to raise awareness and provide training opportunities to engage youth in potential healthcare careers after graduation.		
Partner with Wenatchee Valley College to provide high school students EMT training through the Running Start program.	▪ Increase number of EMTs in the Lake Chelan Valley, with a specific focus on increasing the number of bilingual EMTs.	

D. Priority: Support for seniors to safely age in place.

LCH intends to support the provision of education, support services, and resources to allow seniors to live in the place of their choice for as long as possible.

Strategy	Anticipated Impacts	Resources/Community Partners
Keep people safe and healthy at home by providing regular in-home safety inspections, physical and behavioral health screening tests, risk review, etc.	▪ Increase in transition/diversion services. ▪ Decrease in avoidable ED visits/hospitalizations. ▪ Decrease in unscheduled hospital readmissions within 30-days	▪ LCH Community Paramedicine Program ▪ EMS Staff ▪ LCH Discharge Planners ▪ LCH CHWs ▪ LCH Primary Care and Specialty Care Providers ▪ Lake Chelan Long-Term Care and Home-Based Service Partners ▪ Chelan Rotary ▪ Chelan Valley Hope ▪ Chelan-Douglas Health District ▪ LCH Physical Therapy ▪ EMS Paratransit ▪ Lake Chelan Health and Wellness Foundation
Provide screening and care navigation for dementia patients through the Community Paramedicine program.	▪ Increase the number of patients in ER, clinic, and hospital screened for dementia. ▪ Increase in patients navigated to resources.	
Collaborate with community partners to provide memory care support groups for family caregivers for people with dementia.	▪ Increase in number of people attending support group meetings. ▪ Increase in number of support group meetings provided.	
Provide transitional care management (TCM) services for all LCH patients aged 65+ being discharged.	▪ 100% of patients 65+ discharged from hospital receive TCM services. ▪ Reduction in unscheduled hospital readmissions within 30-days.	
Continue to partner with the community to address social determinants of health that will impact the ability of seniors to remain at home, including transportation, assistance with daily activities, home repairs, and addressing food insecurity.	▪ Increase in percentage of people assessed at ER, clinics, and/or hospital for wraparound/support service needs. ▪ Increase in number of referrals to community resources.	
Partner with the local senior centers to support/implement the Stay Active and Independent for Life (SAIL) evidence-based fall prevention program	▪ Decrease in number of fall-related calls to 911. ▪ Increase in number of people attending healthy living and fall-prevention classes. ▪ Increase in number and type of classes offered.	