HCHN Governance Council
Strategic Planning Part 3, 2019-2020

Public Health
Seattle & King County

Overview: Completion of Strategic Planning

- ✓ Review what needs to be accomplished over next 12 months (*Slide 3*)
- ✓ Review purpose of strategic plan (*Slide 4)*
- ✓ Revisit vision setting –where we want to be in 12 months (*Slide 5)*
- ✓ Finalize content of strategic priority list (Slide 6)
- ✓ Identify racial equity actions (*Slide 7*)
- ✓ Revisit needs assessment recommendations (*Slide 10 & 13)*

HCHN Governance Council – Key Milestones, July 2019- July 2020

Mar.-Apr. 2019

1. Began strategic planning
2. Reviewed previous needs assessment and priorities

July – Sept. 2019

3. Orient new members & review membership needs
4. Complete OSV requirements
5. **Finalize strategic plan & determine plan format**
6. Approve the selection of the new Project Director
7. Receive quarterly briefing on program performance
8. Review and approve 2020 budget (Aug. 7th meeting)

Oct. – Dec. 2019

9. Prepare for & hold officer elections
10. Receive quarterly performance briefing

Jan. – Mar. 2020

11. Review/adopt policies on scope & availability of services/locations/hours (annual eval. at retreat)
12. Review/revise HCHN program overall planning priorities (annual assess. at retreat)
13. Review/approve annual HCHN federal grant renewal application and Scope of Project (SAC & RFQ/P)

Apr. –June 2020 TBD, includes RFQ/P participation

Acronyms: **SAC** = Service Area Competition for 330h funding
RFQ/P =Request for Qualifications or Proposals for contractors

Uses of Strategic Planning Document

Updated Strategic Planning Document, along with the Community Needs Assessment

- **Informs our next grant 330h app.**
  Service Area Competition (SAC)
  What &where we propose
- **Informs our selection of contractors**
  Selection of 330h Partners (RFP/Q)
  Who we partner with
- **Informs Resource Development**
  Other grants & partnerships
- **Informs Advocacy Efforts**
  Governance Council Actions

Governance Council Vision Setting

1. What would a successful council look like in 12 months?

2. What would be a rewarding or fulfilling experience for each member?

3. How would the group be functioning?

4. What has it accomplished?

- Leverage skills around the table to maximize impact
- Have strategic understanding of gaps and leverage & our own voice so fewer people are on the street
- Function as educational ambassadors and conduit to people who want to be more engaged
- Address gaps and barriers to care
- Less people in social circle dying on the streets due to unmanaged health conditions
- All the work centers on the individuals served, maximize collaboration & coordination to make impact
- Keep people safe
- Increase services, decrease barriers, and more on-the-street coordination of programs and agencies

Started in March Strategic Planning Session

Governance Council Strategic Priority Lists – Finalize at July GC Meeting

2018	2019 Start from Strategic Planning
1) Service Expansion and Resource Development Considerations **1a) HRSA New Access Point and other grant opportunities**: • use most recent community data • focus on where other services/partnerships are already • should be an outreach component **1b) Expanding access to respite**	1) Help lead efforts to assure patients can meet basic physiological needs. This **includes restroom access and facilities to rest and recover** from illness based on acuity of need. - Specifically the idea to transition from overnight shelters to offering 24-hour shelters with enhanced services to support recovery from low-acuity illness. - Need for **continual access to hygiene services and indoor spaces**, safe shelters 2. Need to adequately **train staff in racial equity, trauma informed care, and harm reduction.** 3. Critical need to **assist people with activities of daily living (ADLs),** specifically a need for places similar to skilled nursing facilities that serve people who are cognitively or mobility impaired 4. Need for **patient navigators** to assist people to get to appointments 5. Help lead efforts to care for both an **aging homeless population** and **assure access to prenatal care**, family planning, and early intervention services. 5a. **expanded the population of interest to include youth/teens migrating to homelessness** 6. **Insufficient transportation** to get to pharmacies, urgent care, and other services 7. Helpful to **get a better sense of the scope of the problem**, how is it changing, and who is impacted from a regional perspective to better understand gaps and opportunities 8. **Need to prioritize housing as health**
2) Coordination of planning, communication and data sharing strategies (A) community-driven planning, (B) data collection and analysis and (C) community communications/ information sharing. Work in these three areas that is led by All Home, One Table, the City of Seattle, King County Department of Community and Human Services' Housing and Behavioral Health divisions, and HCHN often overlaps in its mission and areas of focus.	
3) Advocacy The Planning Council continues to find that are many aspects of the County's ongoing homeless crisis that cry out for potential input and advocacy from a community planning and oversight body that is focused primarily on the health needs of people living homeless, with focus on: **3a) Insufficient access to hygiene facilities** **3b) Need for greater community awareness of the medical, mental health, and substance use treatment access barriers faced by people experiencing homelessness**. **3c) Cuts to federal insurance navigator program.** **3d) Western State Hospital access problems.**	

Brainstorm Start- Strategies on Leading with Racial Equity

2019 Start from GC Strategic Planning

1. Composition of GC should reflect communities served, including LGBTQ+, the aging population, and American Indian/Alaska Native representation
2. Learn more about disparities related to aging through the system, from teens to adults.
3. Governance Council trainings –examples could include Undoing Institutionalized Racism (People's Institute)
4. Understand contract requirements
5. Continue work with Bernardo Ruiz

Next Steps:

- Racial Equity: identify 2 action items the GC will take over the next 12 months

Review of Previous HCHN Needs Assessments – Reference Only

Overview of HCHN Previous Community Needs Assessments*

	2016-2017	2012-2013	2007-2008
Stated Goal	Continually improve services to better address: 1) current health care needs; 2) factors associated with access & utilization; & 3) health disparities and differential needs.	Use data to inform service delivery model and focus for next 5 years	Inform 2010-2014 federal app.
Methods	• Listening sessions • Interviews/Surveys • Secondary data review	Individual interviews with chronic health risk assessment tool through convenience sampling	Individual Interviews, on-line survey & focus groups
Participants	• Homeless individuals = 101 • Providers = 43	Homeless individuals= 987 focus on day centers	• Homeless individuals= 128 8 conducted in Spanish • Providers =238
Locations	1. Safer Parking Program, Kirkland 2. The Sophia Way, Bellevue 3. St. Martin De Porres, Seattle 4. Downtown Dental Clinic 5. YWCA, Renton 6. Federal Way Day Center 7. North Seattle Public Health Center	1. Lazarus Day Center 2. Chief Seattle Club 3. Compass Housing Alliance – Adult Service Center 4. DESC – Connections and Main Shelter 5. Immanuel Lutheran Hygiene & Day Center 6. Mobile Medical Van and Site partners 7. Matt Talbot Center 8. Recovery Café 9. Union Gospel Mission 10. YWCA – Angeline's Bellevue & Seattle	1. Bible Fellowship Free Lunch, Centennial Building, Kent 2. Chief Seattle Club 3. Department of Corrections 4. Family and Adult Service Center 5. Friday Feast 6. Grace Community Church, Auburn 7. Hammond House 8. Needle Exchange 9. Operation Nightwatch 10. Urban Rest Stop

* HRSA requirement focuses on review of UDS data and population health sources (e.g. % uninsured) to better understand the goals stated in the 2016-2017 assessment. They don't dictate any other methods or requirements.

Recommendations from HCHN Community Needs Assessments

2016-2017	2012-2013	2007-2008
1. Build capacity to help patients and providers **manage disease, pain, and medication.** **2.** Assure patients can **meet basic physiological needs.** This includes **restroom access** and **additional types of respite.** **3.** Increase the number of patients who have access to **low barrier behavioral health services.** 4. HCHN consumers and former **consumers must be more involved in planning and evaluation.** **5. Support providers through training** and workforce development strategies. **6.** Sustain existing **partnerships** and cultivate new ones in **South, East, and North King County.** This includes **focus on mobility and language access** barriers. **7.** Implement strategies to measure our progress towards reducing documented **racial and ethnic health disparities.** **8.** Enhance our **partnerships with housing providers.** **9.** Help lead efforts to care for both an **aging homeless population** and **assure access to prenatal care, family planning,** and early intervention services.	**1.** Collaborations between Public Health, homeless service providers, and funders should align to **help homeless individuals manage chronic disease** **2.** Conduct further data analysis to examine chronic disease management and **learn about specific supports homeless individuals may need** (interventions) **3. Inform community stakeholders about high chronic disease prevalence** among the homeless adult day center population to better integrate health promotion	**1. Build trust between the system and homeless individuals and develop policies to reflect that trust** (increase provider training, simplify intakes, access to care, access to mental health, reduce turn over) **2. Improve system coordination** (Referral confirmations, cooperation among social service networks, tracking through health care system, collocate services) **3. Improve access to information about health care services that are available to people experiencing homelessness** **4. Increase outreach and access to services for people in need of health services** (transportation, outreach workers) **5. Increase access to entitlements/benefits for people who need them** (health coverage for undocumented people, Sliding scale for those making <30%n median income is still prohibitive) **6. Increase the capacity of the health care system to help stabilize those with health problems** (wait time, bed coverage, increase satellite clinics, workforce development, more respite and treatment beds, create clear maps & resource guides)

Common Key Words: Consumers

Common Key Words: Providers

Concrete Action Items: What We've Already Heard Folks Want& Need Done

Topic	Description
1. Peer Resource Guides	• Most common -Diabetes and Hypertension – how to realistically manage • Where to find resources (peer version of 211 guide) • Tips and suggestions for newly homeless • Tips and suggestions for navigating complex systems (e.g. mental health, housing)
2. Peer Support Groups	• Informal groups for currently or formerly homeless folks • Interest/Hobby specific groups – especially for aging and people who are isolated • Home/peer visits – accompany to appointments • Incorporate with meals • Consistent and regular meeting times
3. Opportunities to learn new skills & get involved in community	• Computers/new technology • Public Speaking or interview practice • Trades • Volunteer opportunities (participate in giving back to community) • Build resume and connections *Any of the above that can also provide stipends, employment leads, and tangible goods (e.g. clothes for interviews, phones, computers, certificate and training fees)
4. Opportunities to impact system change	• Ways to tell their story and experiences (podcasts, videos, written testimonies) • Directly train and educate providers (speakers bureaus or above) • Anti-stigma campaigns (organizing efforts that combine above) • Get connected to other groups but have a buddy/peer mentoring component