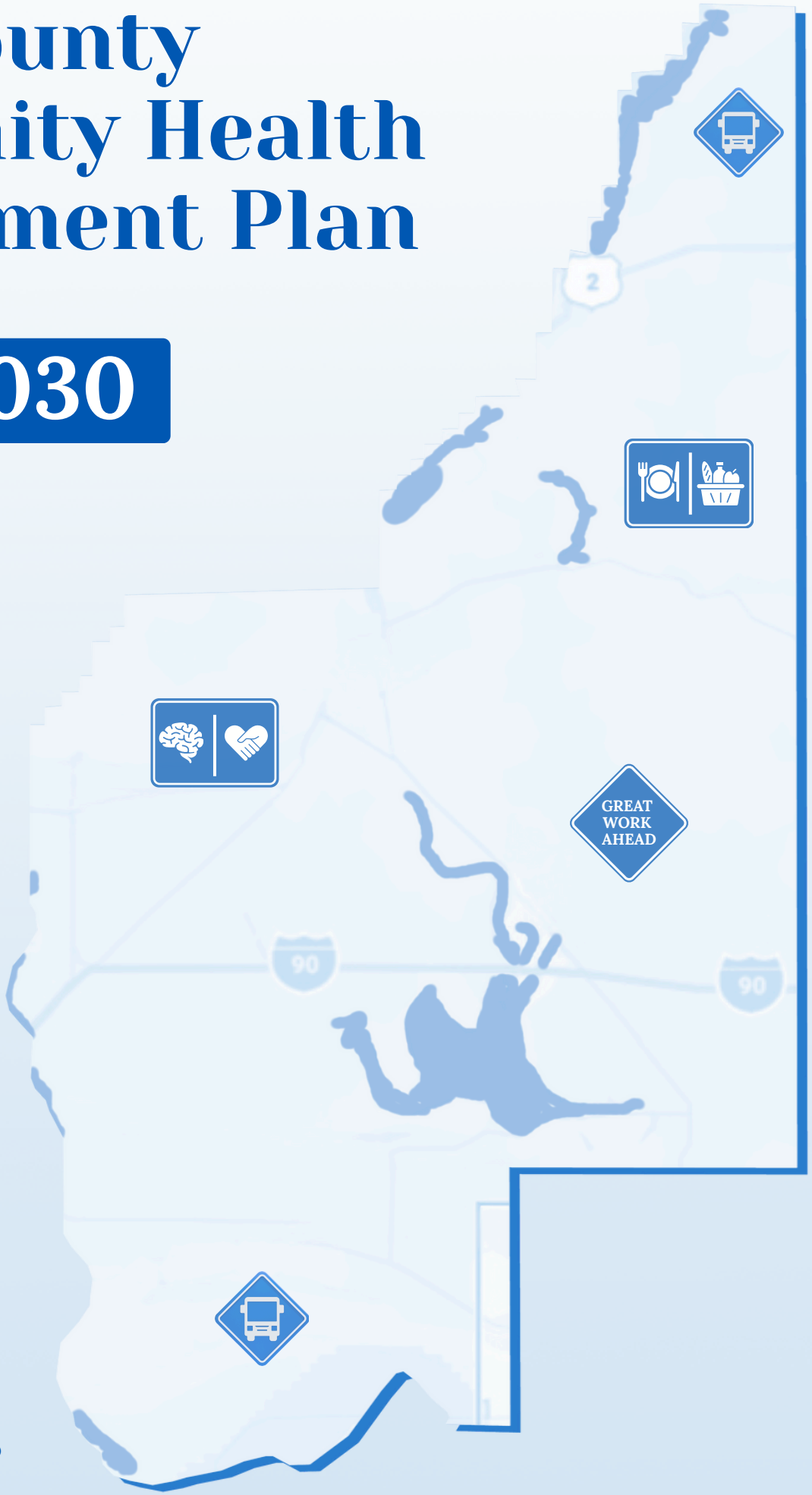
Grant County Community Health Improvement Plan

2025 - 2030



This plan is intended to be a living document—one that grows and adapts alongside our community

For our community.

Published December 2025

Board of Health Adoption

Grant County Health District (GCHD) was honored to work with a supportive and engaged Board of Health throughout the planning and adoption of the Community Health Improvement Plan (CHIP). The Board provided essential oversight and governance during each phase of the process, and in November 2025 officially approved the CHIP for publication.

GCHD extends a sincere thank you to the governing Board that served during the adoption of this plan. Thanks to their support, GCHD is proud to share this document with our community as we work together to build a safer and healthier Grant County.

The approving Board included the following members:

Tom Harris, Quincy City Council Member
2025 BOH Chair
Quincy, WA.
Seat # 3- City/Town Elected Official

Matthew Paluch
2025 BOH Vice Chair
Moses Lake, WA.
Seat #7 - Community Stakeholder

Kevin Burgess, Grant County Commissioner
Moses Lake, WA.
Seat # 1 - Grant County Commissioner

Cindy Carter, Grant County Commissioner
Royal City, WA.
Seat # 2 - Grant County Commissioner

Deanna Martinez, Moses Lake City Council
Moses Lake, WA.
Seat # 4 - City/Town Elected Official

Sheila Berschauer
Ephrata, WA.
Seat # 5 - Healthcare

Dr. Alison Ball
Colville Tribes
Seat # 8 - Tribal Representative

Judy Madewell
Moses Lake, WA.
Alternate for Seats # 3 and # 4 - City/Town Elected Official

Megan Diamond
Ephrata, WA.
Alternate Seat # 6 - Consumer of Public Health

Misty Aguilar
Moses Lake, WA.
Alternate Seat # 7 - Community Stakeholder

Grant County Coalition For Health Improvement Adoption

GCHD is grateful for the strong partnership with the Grant County Coalition for Health Improvement (CHI) throughout the development of the CHIP. The CHI played an essential role in bringing community voices into the process, helping connect partners, elevate local priorities, and strengthen engagement across the county.

Their ongoing collaboration ensured that the CHIP reflects the needs, experiences, and aspirations of the communities we serve.

GCHD extends heartfelt appreciation to the CHI members who contributed their time, insight, and commitment to this plan. With their continued leadership, the Coalition has adopted these shared priorities and remains dedicated to advancing them through unified partnerships and collective action.

Together, we are building a strong, collaborative network with diverse representation to address the social conditions that influence the well-being of Grant County residents. Guided by a vision of empowering communities to drive positive change, the CHI remains a vital partner in creating a healthier, more equitable future for Grant County.

grant county coalition

FOR HEALTH IMPROVEMENT

Acknowledgements

Agency Support

A heartfelt thank you to the dedicated GCHD team members who generously gave their time and energy to support the **Community Health Improvement Plan (CHIP)** process.

Agency support included staff primarily in GCHD's Public Health Infrastructure division and Healthy Communities and Families division. These staff acted as note takers, logistical support, draft writers, facilitators and presenters. GCHD had additional support from the Grant County Coalition for Health Improvement (CHI), who helped connect GCHD staff with community organizations and leaders for the CHIP subcommittees and facilitated our transportation subcommittee.

Community Support

The CHIP was made possible thanks to the invaluable time, space, and support contributed by organizations listed below among so many others. Their commitment was essential to the success of GCHD's community listening sessions and workgroup meetings.

Full Participant List

- City of Ephrata
- Clarvida
- Columbia Basin Hospital
- Department of Social and Health Services
- Grant & Adams County Developmental Disabilities
- Grant County Coalition for Health Improvement
- Grant County Commissioners Office
- Grant County Health District
- Grant County Suicide Prevention Taskforce
- Grant Transit Authority
- Mattawa Area Food Bank
- Mattawa Clinic
- Mattawa Community Medical Clinic
- Molina Healthcare
- Moses Lake Community Coalition
- Northwest Harvest
- People for People
- Quincy School District
- Rural Resources Community Action
- Samaritan Healthcare
- Special Mobility Services
- Unidos Nueva Alianza Foundation
- Washington Department of Transportation

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GRANT COUNTY HEALTH DISTRICT

November 2025

Dear Fellow Community Members,

Welcome to the 2025–2030 Grant County **Community Health Improvement Plan (CHIP)**.

This CHIP is intended to be a living document, one that grows and adapts alongside our community. It reflects the voices, ideas, and concerns of residents across Grant County, and was shaped through listening sessions, collaborative discussions, and local data review throughout 2024 and 2025.

Together, community members, organizations, schools, healthcare providers, and local leaders identified three shared priorities for action:

01 **Food Security**
02 **Transportation Access**
03 **Behavioral Health**

These priorities do not stand alone; they are connected to broader factors such as economic stability, chronic disease, housing, and equitable access to care. Addressing them requires acknowledging the systems and conditions that shape health and committing to solutions that are fair, sustainable, and grounded in community experiences.

The CHIP is not a finished product, it is a framework for community action. It is designed to guide decisions, strengthen partnerships, and track progress while leaving space for adaptation as new challenges and opportunities arise. Just as health is not static, neither is this plan.

We are committed to transparency and accountability, sharing progress along the way and inviting ongoing input to ensure that our efforts reflect community needs. Your voice, your ideas, and your participation will continue to shape how this work moves forward.

Thank you for being part of this process and for contributing to a healthier, more connected, and more equitable Grant County.

Sincerely,

Theresa Adkinson

Administrator, Grant County Health District

Intro & Background

Purpose of a CHA & CHIP

The goal of a **Community Health Assessment (CHA)** is to help a community understand how healthy it is. A CHA identifies the health problems and strengths present in a community. Data typically explores demographics, housing, employment, access to care, diseases, and environmental health.

The findings from the CHA then guide the **Community Health Improvement Plan (CHIP)**. The CHIP builds on the top health issues from the CHA and shares how our community can work together with local resources and partners to improve health for everyone.

Method: From CHA to CHIP

Framework

GCHD used the **MAPP 2.0 (Mobilizing for Action through Planning and Partnerships)** framework to guide the process from CHA to CHIP.

MAPP 2.0 is a national framework that helps communities identify priority health issues and create strategies for improvement. By emphasizing equity, community voices, partnerships, and evidence, MAPP 2.0 guided a process that was inclusive, data-driven, and collaborative, reflecting the true needs and strengths of Grant County.

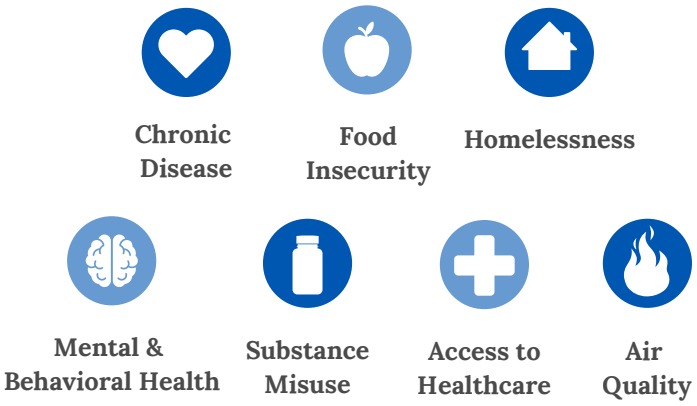
Reviewing the CHA

When deciding which health issues from the CHA should move forward as priorities in the CHIP, GCHD used an evidence-based review of external data. **Staff looked at patterns in hospitalization and death records, overall health trends, and results from state and local surveys to understand where Grant County faces the greatest challenges**. GCHD staff also compared our local outcomes to statewide and national data to see where the largest gaps or concerns existed.

Staff then used data triangulation to connect what was found in the external data with what was heard directly from the community. This meant aligning what residents said in focus groups and listening sessions with what they selected as top concerns in the community survey. By comparing these perspectives, it was clear where **measurable trends matched lived experience** and where gaps or new insights emerged.

This process helped confirm which issues were both supported by data and strongly felt by residents, ensuring that our CHIP priorities reflect both evidence and community voice.

From this combined analysis, the following top health issues emerged for consideration in the CHIP:



Intro & Background

Method: From CHA to CHIP

Pilot Round

Before launching community sessions, GCHD facilitated a pilot listening session during a staff meeting. Staff were divided into small groups and each assigned a priority area to discuss using facilitator-led questions. This pilot helped us test the questions, format, timing, and logistics before engaging the public.

Community Engagement

Next, **GCHD held eight community listening sessions (**six in-person and two virtual) to ensure diverse perspectives were included. One virtual session was held outside traditional work hours to expand access.

Before each session, staff inquired about language needs. One session was conducted primarily in Spanish, and participants were provided translated materials in top languages. Food and snacks were also offered.

Feedback was gathered in three ways: qualitative notes from each table, sticker voting at the end of session, and an optional follow-up survey where participants could also share suggestions for improvement. This approach supported broad representation and continuous quality improvement.

Priority Refinement

To identify the final health priorities, GCHD first returned to the external data from the CHA and supplemented it with more current sources.

For an issue to be considered, it needed to show evidence of at least one of three qualities:

- **Higher rates than the state average**
- **Significant upward trends**
- **Clear health disparities within the community**

Next, the list was narrowed down by layering in community input from listening sessions. Staff asked:

- **How important does the community feel this issue is?**
- **How capable does the community feel addressing it?**

Through this, three priorities emerged. Transportation was slightly unique as it did not appear in the CHA as an obvious issue, but instead surfaced in every listening session, often unprompted. **Community members connected transportation challenges to nearly every other concern, from food access to behavioral health care, reflecting the unique realities of living in a largely rural county.** Because the CHIP process is meant to follow community leadership, staff felt strongly that transportation must be included as a priority.

The priorities selected make sense within the context of the CHIP if they: *fall within the role of public health, are feasible to address within a 3-to-5 year timeframe and are a root cause.* The final priorities were:

- **Food Security**
- **Behavioral Health**
- **Transportation**

These are not the only health issues Grant County faces, but they are issues we can realistically drive change through this plan.

What is a CHIP?

What is a CHIP?

A CHIP is a long-term, strategic plan created with and for the community. It serves as a **roadmap for improving health and well-being**, highlighting the issues that matter most, and the shared actions necessary to address them.

The CHIP has several key phases:

- **The report:** a written plan that explains the community's health priorities and the goals, strategies, and objectives for each priority area
- **The monitoring and evaluation plan:** a framework for tracking progress and holding ourselves accountable
- **Implementation:** the actions taken by partners and organizations to address the priorities
- **Annual follow-ups and adaptation:** regular updates to measure progress, share results, and adjust strategies

Assess
Identify health issues, needs, & assets

Prioritize
Determine what is most pressing

Plan
Develop goals, objectives, & action steps

Implement
Execute plan through programs, policies, & initiatives

Evaluate
Measure outcomes, collect feedback, & update plan

How should a CHIP be used?

The CHIP is designed to be a shared guide for improving health in Grant County. It is meant to be referenced, adapted, and put into action by many different groups.

Community organizations can use it to align their programs with broader county-wide goals and find opportunities to partner.

Healthcare providers and hospitals can use it to identify areas where community health needs overlap with their own services.

Schools and youth programs can use it to connect health priorities with education, student well-being, and family support.

Local government and decision-makers can use it to inform policies, funding decisions, and planning that affect community health.

Residents can use it to stay informed, hold institutions accountable, and contribute to their voices and ideas.

Above all, the CHIP is a living document. As conditions change and new challenges or opportunities arise, it should be revisited and updated.

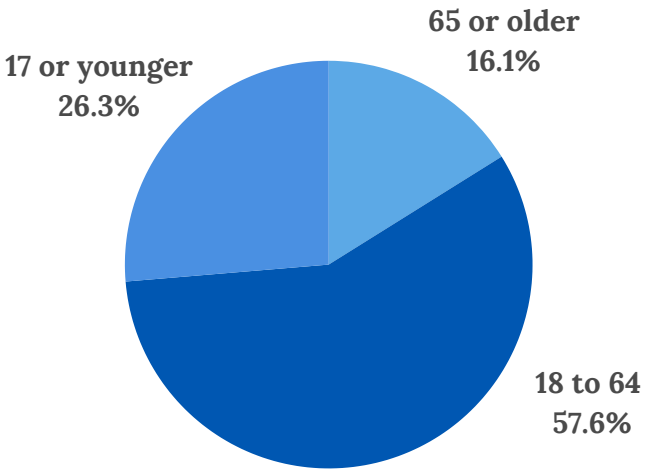

CHIP Subcommittee

COMMUNITY PROFILE

Understanding who we are as a community is central to public health planning. The demographics of Grant County give context for the priorities in our Community Health Improvement Plan (CHIP).

The key data points here are not a full picture, but they help tell the story of a young, diverse, agricultural community. This identity brings strengths in resilience, culture, and hard work, while also highlighting barriers such as isolation, cultural differences, and health risks tied to environment and access. Together, these factors shape how we move forward to improve health and well-being.

Age of Residents



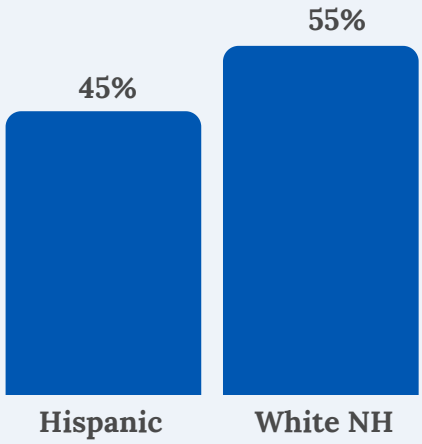
Employment of Residents

Grant County's two largest employment sectors are educational services, healthcare and social assistance, and agriculture. **Grant County ranks #1 in Washington state for market value of agricultural products sold with 1,014,389 acres of farmland.**

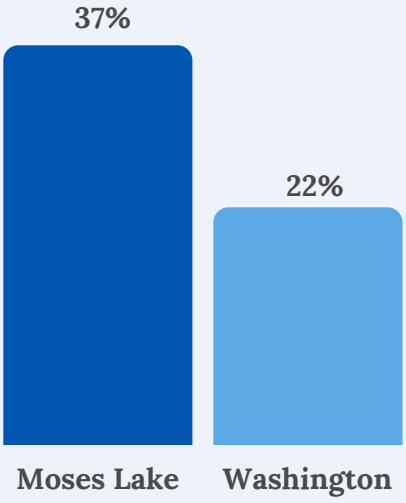
Population of Residents

In 2024, Grant County's population was 103,716, with an **annual growth rate of about 2%**. Most of Grant County residents live *outside* of Moses Lake.

Race & Ethnicity



Non-English Speakers at Home



Food Security

What is currently happening?

Grant County is rich in agriculture, ranking first in Washington for the value of agricultural products in 2022. Yet many community members still face challenges in accessing enough nutritious food for themselves and their families.

Many residents do not have reliable transportation. This leads to difficulties accessing grocery stores, food pantries and other food sources. This is compounded by the limited fresh produce and other healthy foods in rural areas, with many residents complaining about the lack of food quality in the more accessible and local markets. **This limited food accessibility affects an individual's health, daily function, and overall quality of life. This is especially true for vulnerable populations such as older adults, pregnant or breastfeeding individuals and children.**

Improving access to nutritious food is important for building a more resilient county and improving community health. Some potential strategies for reducing food insecurity include:

- Improving the robustness of our local food system by improving coordination and infrastructure
- Increasing access to nutritious foods for specific vulnerable populations
- Supporting local, sustainable food production and procurement

By formulating a plan of action with the community input and data from the CHA, using evidenced based strategies and aligning with regional efforts that are already working, **we can strengthen and help to provide a better food environment and healthier place for all in Grant County.**

Food distribution event in Mattawa

Why was this selected as a priority?

Food security was selected because it is directly correlated with health, well-being and economic stability of the community. Several residents voiced that **although there are resources available, they are created with the assumption people have personal transportation** and have little focus on those who are homebound or for kids when school is out.

The CHA also highlighted that for those able to access available resources, the options are often inexpensive but nutritionally poor. **Members from the community have expressed while the food is affordable, they do not adequately support health or meet nutritional needs.**

Food Security

Why is this important in public health?

Access to adequate, nutritious food is a fundamental part of good overall health. Children, older adults, people who are pregnant or breastfeeding, and low-income families are most at risk of the negative health impacts of food insecurity. Food insecurity may impact factors such as:

- Child development
- School performance
- Mental Health
- Chronic Diseases
- Healthcare Costs

Within the context of public health, ensuring everyone has healthy food supports better health outcomes, better educational attainment, and a happier, more resilient community.

What is the plan to improve?

On the next page, objectives 1 and 3 have a joint emphasis on improving how the local food system works. **This includes creating stronger connections between local food producers, distributors and consumers by supporting community gardens, food reclamation and food education programs.**

Furthermore, by conducting a *food system assessment* to identify gaps, assets, and opportunities we can establish a Grant County Food Council. This council will maintain representation from all towns, community members, growers, nonprofits and schools and will help reduce gaps in access and outcomes regarding this issue.

Objective 2 strives to ensure that people who are at higher risk of food insecurity, such as low-income families, older adults and individuals facing transportation or economic barriers, have adequate access to sufficient nutritious food. Grant County is striving to take action on this matter by **increasing the availability and affordability of healthy foods, and promoting access to nutrition resources for everyone within the community.** Through this plan, we will build the bridge to reduce food insecurity.

Food Security

GOAL

End hunger and food insecurity for all community members

OBJECTIVE 1: Build a coordinated food system infrastructure

ACTIVITY 1.1 Establish a Grant County Food Council with representation from all towns, community members, growers, nonprofits, and schools

(*This council will include nonprofits, community-based organizations, libraries, clinics, farmers/growers, food distributors, managed care organizations, dieticians/nutritionists*)

ACTIVITY 1.2 Join or collaborate with the NCW Food Council to align regional efforts

ACTIVITY 1.3 Conduct a food system assessment to identify gaps, assets, and opportunities

OBJECTIVE 2: Improve food access for vulnerable populations

ACTIVITY 2.1 Connect care coordinators with Grant County residents to ensure widespread screening for program eligibility

ACTIVITY 2.2 Increase community knowledge of mobile access point schedules through outreach to community centers, schools, libraries, churches, etc.

ACTIVITY 2.3 Partner with Grant County Transit and local schools to provide transportation to food resources, especially during summer, with special consideration to homebound individuals

OBJECTIVE 3: Strengthen local food procurement and sustainability

ACTIVITY 3.1 Include growers in food council activities

ACTIVITY 3.2 Support community gardens, food reclamation, and food education programs

Transportation & Access to Vital Services

What is currently happening?

Grant County is a rural community defined by its strong sense of connection and resilience. Residents take pride in supporting one another through the many health and well-being resources, programs, and services that already exist. Yet for many residents, especially those without reliable personal transportation, **access to these opportunities depends on whether they can reach them.**

Transportation is about more than getting from place to place, it is **central to accessing healthcare, reducing isolation, maintaining employment, attending school, buying food, and staying connected to community life.** Limited options mean that not everyone has equal opportunity to benefit from the resources Grant County has to offer, which can widen existing health disparities.

Improving access to safe, reliable, and inclusive public transportation can help close these gaps. It would allow more residents to participate fully in community life, take advantage of existing resources, and strengthen the health and resilience of the county as a whole.

Why was this selected as a priority?

Transportation and access to vital services was chosen as a priority because it consistently emerged as a critical issue in both the CHA and in each community listening session for the CHIP. Residents across the county voiced concerns about the lack of reliable transportation, which makes it harder to get to medical appointments, hold steady jobs, attend school, buy food, and stay connected to community life. This challenge is especially significant for older adults, low-income families, and those living in the more rural parts of Grant County.

Data confirmed these concerns. **Large portions of the county have little to no access to public transportation,** creating clear disparities in who can reach essential services. In addition, residents highlighted barriers such as limited multilingual resources and a lack of awareness about existing transit options. Combined, these issues show how transportation is deeply tied to health, equity, and opportunity in our community.

Transportation surfaced in every listening session, often unprompted. From food access to behavioral healthcare, community members connected transportation challenges to nearly every other concern.

Transportation & Access to Vital Services

Why is this important in public health?

Access to reliable transportation is much more than getting from point A to B, it plays a direct role in health. **Research shows that millions of people in the U.S. delay or skip medical care because they lack reliable transit or a vehicle.** In rural areas, this is even more critical due to longer travel times, fewer transit options, and greater distance to health services. This means chronic conditions often go unchecked and life expectancy can decline.

We know some Grant County populations without vehicle access, such as older adults, people living in remote rural areas, and immigrant communities, are already more likely to face these risks. By improving transportation, we can build on the county's strengths, strong community ties, existing resources, and willingness to come together. **Reliable, inclusive transit can help ensure everyone can reach medical care, get fresh food, stay connected socially, and use the services already in our county.**

What is the plan to improve?

Objective 1 focuses on identifying and **addressing the barriers that prevent residents from using transportation services effectively**. This includes analyzing how different populations, such as people with disabilities, residents who speak languages other than English, rural workers, school-aged children, and older adults experience transportation challenges.

Objectives 2 and 3 aim to **improve public understanding and usage of transportation services.** This involves sharing information in clear, accessible formats and using culturally appropriate outreach strategies to engage diverse community members. Addressing language barriers and improving communication will be essential to increasing participation and ensuring that public transportation in Grant County is safe, reliable, and inclusive to all.

Transportation & Access to Vital Services

GOAL

All Grant County residents—regardless of income, location, language, ability, or health status—have safe, reliable, and inclusive access to public transportation options

OBJECTIVE 1: Conduct a transportation access case study to understand barriers and identify strategies for equitable service improvements

ACTIVITY 1.1 Facilitate focus groups with priority population, i.e. people with disabilities, residents who speak languages other than English, rural workers, school-aged children, and older adults, to gather personal experiences and input

ACTIVITY 1.2 Develop and distribute a multilingual public transportation survey (digital and print) in various locations across the county

ACTIVITY 1.3 Publish a case study report including resident perspectives, common challenges, and community-informed recommendations

OBJECTIVE 2: Increase public awareness and usage of transportation services through inclusive outreach and education

ACTIVITY 2.1 Develop a multilingual, culturally appropriate outreach campaign highlighting available transit services, how to use them, and how to access medical transportation

ACTIVITY 2.2 Create a series of short, accessible "how-to" videos and flyers for digital and in-person distribution

ACTIVITY 2.3 Partner with schools, clinics, senior centers, and social service agencies to distribute materials and incorporate transportation education into existing programs

OBJECTIVE 3: Expand and modernize the geographic coverage and service availability of public transportation routes in Grant County to improve access and inclusion for rural and underserved residents

ACTIVITY 3.1 Establish a coordinated effort with Grant County transit providers to identify transportation deserts and plan for route expansion

Next Page: Activity 3.1.1, 3.1.2., 3.1.3., 3.2, & 3.3

Transportation & Access to Vital Services

ACTIVITY 3.1 *Continued*

- **Activity 3.1.1** Convene quarterly meetings with public transit providers in Grant County to assess current gaps and share data
- **Activity 3.1.2** Use meeting outcomes to identify underserved areas and propose expanded service plans
- **Activity 3.1.3** Develop a draft expansion plan with input from both providers and community members

ACTIVITY 3.2 Identify and advocate for funding opportunities (state/federal grants) to support expanded service

ACTIVITY 3.3 Pilot and evaluate a community-informed transportation solution that increases access to health and social services

- **Activity 3.3.1** Use findings from the study to co-design a pilot (flexible route van, shuttle service, inter-county connection) with transportation providers and community partners
- **Activity 3.3.2** Secure funding and/or a sponsor for the pilot program
- **Activity 3.3.3** Launch the pilot in a rural or underserved area with a focus on access to healthcare appointments and essential services
- **Activity 3.3.4** Track and evaluate the pilot's effectiveness through user feedback, ridership data, and equity impact metrics

Behavioral Health

What is currently happening?

Grant County is a growing and resourceful community with a strong foundation for creating positive changes in mental health and substance use support. As the community continues to grow, there are meaningful opportunities to build on existing efforts by enhancing coordination among providers, strengthening prevention initiatives (especially those that begin early in life), and continuing to challenge persistent stigma around behavioral health. Community members and organizations are already taking important steps toward improving access to inclusive, stigma-free, and coordinated behavioral health services. **By expanding these efforts, Grant County can reduce health disparities and create more pathways to recovery, well-being, and long-term stability for all residents.**

Improving behavioral health access is a key driver for community well-being. Advancing this goal involves **increasing collaboration across care systems, promoting open and informed conversations about mental health and substance use, and expanding the use of evidence-based prevention strategies particularly for youth.** Through strategic planning efforts like the CHIP, the path forward is clear: a shared commitment to ensuring that all residents of Grant County have access to the behavioral health resources and support they need to thrive.

Why was this selected as a priority?

The topic of behavioral health was selected because it affects every aspect of a person's life. Mental well-being, physical health, relationships, employment, education, and overall quality of life. **When mental health and substance use needs are not met, the community could experience high rates of unemployment, homelessness, chronic illness, and emergency service misuse.** Many residents are seeing and experiencing this already and would like to manage the situation effectively.

The CHA showed a lack of culturally appropriate awareness around behavioral health and a lack of a unified promotion across all service providers for outreach and engagement. Many community members who speak a language other than English expressed difficulty accessing information, feeling excluded from resources, and experiencing barriers to be able to gain full engagement with available services. The CHA also showed that intervention strategies need to begin with our schools and youth programs. Increasing prevention strategies for youth to build healthy coping skills reduces their risk of substance use and mental health challenges in the future and sets them up for long-term success.

Behavioral Health

Why is this important in public health?

Accessible, coordinated, and stigma-free support for mental health and substance use disorders ensures people can get the care that they need without barriers. **In Grant County, limited support for mental health and substance use disorder is closely linked to many factors that determine health and well-being.** When support is in place and stigma is reduced, individuals are more likely to seek help early, reducing crises, hospitalization and long-term health problems.

Without such support, disparities grow, emergency systems become strained, and the community faces greater social and economic challenges. **From a public health standpoint, increasing behavioral health access improves overall health, reduces healthcare costs, and supports a thriving and resilient community.**

What is the plan to improve?

Objectives 1 and 3 concentrate on updated prevention and early intervention by using collaboration and coordination efforts with providers and surrounding organizations to help support these vulnerable populations. By building a stronger system of support to improve mental health, reduce substance use and create long-term positive outcomes for the community, the concern can be resolved.

Objective 2 works toward **enhancing awareness and education around behavioral health while promoting understanding and empathy**. Addressing and changing community perceptions to create a more supportive environment for people facing mental health and substance misuse will be critical. This can lead to more accessible, coordinated, and stigma-free support for people with mental health and substance use disorders.

Behavioral Health

GOAL

There is accessible, coordinated, and stigma-free support for mental health and substance use disorders for all Grant County residents

OBJECTIVE 1: Increase collaboration and communication among care providers and organizations to better support individuals with mental health and substance use needs

ACTIVITY 1.1 Create a comprehensive *system of care* map (recovery map) for mental health and substance misuse in Grant County to identify existing resources, gaps, and opportunities for improved coordination and service delivery

ACTIVITY 1.2 Coordinate monthly behavioral health, primary care, housing, and social services meetings

ACTIVITY 1.3 Increase awareness, access, and utilization of recovery-focused housing options for individuals with substance use disorders by enhancing support of Oxford Housing

OBJECTIVE 2: Reduce stigma related to mental health and substance use by promoting awareness, increasing education, and fostering more compassionate, informed attitudes throughout the community

ACTIVITY 2.1 Co-create a culturally appropriate awareness campaign in collaboration with community partners, ensuring unified promotion across all service providers to enhance outreach and engagement (*At a minimum languages should include Spanish, English, Russian and Ukrainian*)

ACTIVITY 2.2 Partner with local organizations to host "Community Conversations" focused on mental health and substance use to foster dialogue, reduce stigma, and connect residents with resources

OBJECTIVE 3: Increase the implementation of evidence-based prevention strategies for youth to promote healthy development, reduce risk factors, and prevent substance use and mental health challenges

ACTIVITY 3.1 Partner with schools to implement and support evidence-based prevention and intervention programs that promote student mental health and well-being

ACTIVITY 3.2 Provide increased support to community coalitions through resources, technical assistance, and collaboration to strengthen local efforts in addressing mental health and substance misuse

Monitoring & Evaluation

Keeping track of progress and accountability through a monitoring and evaluation (M&E) plan is vital to the success of the CHIP, as this helps track progress and assess if the strategies are *actually* improving the community's health. Further evaluation of these strategies identifies which approaches are working and what needs to be adapted to remain relevant and effective.

The M&E plan starts with *SMARTIE* goals:

(S)pecific
(M)easurable
(A)chievable
(R)elevant
(T)ime bound
(I)nclusive
(E)quitable

These goals guide and monitor progress and assess whether the plan meets its intended objectives. **We will use a combination of methods such as focus groups, surveys, interviews and health outcome assessments**.

Foundational data will be collected as a baseline to measure progress towards each part of the CHIP and enable accurate measurement of progress over time; consistent check-ins will then allow for continuous improvement and allow strategies to evolve in real time. Finally, an annual evaluation report will allow community members and partners to stay involved.

APPENDIX

The attachments below are included as part of the appendix

CHIP Post Listening Session Survey

Thank you for attending our CHIP facilitation process and helping your community by engaging and providing valuable feedback in our community health improvement process!

*For a **Spanish** version of the survey, please use the drop down in the upper right corner of the survey (above the survey title) with the globe symbol!*

* Required

1. Which listening session are you reporting on? *

- ◯ Grand Coulee
- ◯ Mattawa
- ◯ Moses Lake
- ◯ Quincy
- ◯ Royal City
- ◯ Ephrata

2. How engaged did you feel during the listening session?

- ◯ Not engaged at all
- ◯ Somewhat engaged
- ◯ Moderately engaged
- ◯ Extremely engaged

3. What parts of the community listening session went well?

4. What improvements, if any, would you suggest for future listening sessions to make them more effective?

5. How did you hear about the listening session?

- [ ] Facebook
- [ ] Instagram
- [ ] Newspaper
- [ ] Flyer
- [ ] Other

6. Please rank the following community health issues based on the community's capacity to address them, with the top of the list being the issue the community is most capable of addressing and the bottom of the list being the least capable. *

- Mental Health/Behavorial Health
- Substance Use
- Chronic disease
- Homelessness
- Food insecurity
- Healthcare access/preventative healthcare
- Physical Activity

7. Please rank the following community health issues based on how likely it is that addressing them would lead to measurable and sustainable change within the next 1 to 5 years, with the top of the list being the most likely to achieve change and the bottom of the list being the least likely. *

- Mental Health/Behavorial Health
- Substance Use
- Chronic disease
- Homelessness
- Food insecurity
- Healthcare access/preventative healthcare
- Physical Activity

8. What language do you *most often* speak at home?

- ◯ English
- ◯ Spanish
- ◯ Russian
- ◯ Ukrainian
- ◯ Other

9. Which race and/or ethnicity do you identify with? (Check all that apply)

- [ ] Hispanic or Latino/a/x
- [ ] White
- [ ] Black or African American
- [ ] Native American or Alaskan Native
- [ ] Native Hawaiian or other Pacific Islander
- [ ] Asian
- [ ] Other

10. Which best describes your gender? (select all that apply)

- [ ] Woman
- [ ] Man
- [ ] Non-binary
- [ ] Transgender
- [ ] Prefer not to say
- [ ] Other

11. Would you like to be apart of future community health improvement work?
If so, please provide your preferred email for contact in the future.

Summary Report: Community Listening Sessions

This report incorporates the frequency of mentions for key concerns across all six community listening sessions (Grand Coulee, Quincy, Moses Lake, and Mattawa, Ephrata and Royal City) and provides tables of evidence for common themes. It also identifies 3 interconnected priorities for a Community Health Improvement Plan (CHIP), as well as lists possible organizations to partner with or actions to pursue. Finally, it provides next steps for the next two listening sessions and further steps using aspects of the MAPP 2.0 process to identify priority stakeholders and develop an action plan.

Key Themes and Frequency of Mentions

Key Concern	Number of Listening Sessions Mentions
Mental Health	6
Substance Use Disorder (SUD)	5
Food Insecurity	5
Affordable Housing	6
Transportation	4
Economic Stability	4
Youth Engagement	4
Health care access	3
Air Quality	2
Community safety/public safety	2

Summary of Findings by Frequency:

- **Mental Health Services** (6 mentions): Mental health services were identified as a significant gap across all communities, with concerns about long wait times, insufficient in-patient treatment, and lack of affordable resources. Ephrata and Royal City emphasized the stigma and limited access to mental health support for low-income and high-risk individuals.
- **Food Insecurity** (5 mentions): Food insecurity remains a major concern in communities like Quincy, Grand Coulee, Mattawa, Ephrata, and Royal City. Transportation barriers and lack of access to healthy, affordable foods were repeatedly highlighted.
- **Substance Use Disorder** (5 mentions): Substance use, particularly youth substance use, was raised in Quincy, Moses Lake, Mattawa, Ephrata, and Royal City. Royal City emphasized a need for more prevention programs targeting youth.
- **Affordable Housing** (4 mentions): Housing affordability and availability were highlighted as barriers in Grand Coulee, Moses Lake, Mattawa, and Ephrata, with many participants mentioning homelessness as a growing issue.
- **Transportation** (6 mentions): Transportation issues were raised in Grand Coulee, Mattawa, and now Ephrata and Royal City. This barrier affects access to healthcare, food, and employment.

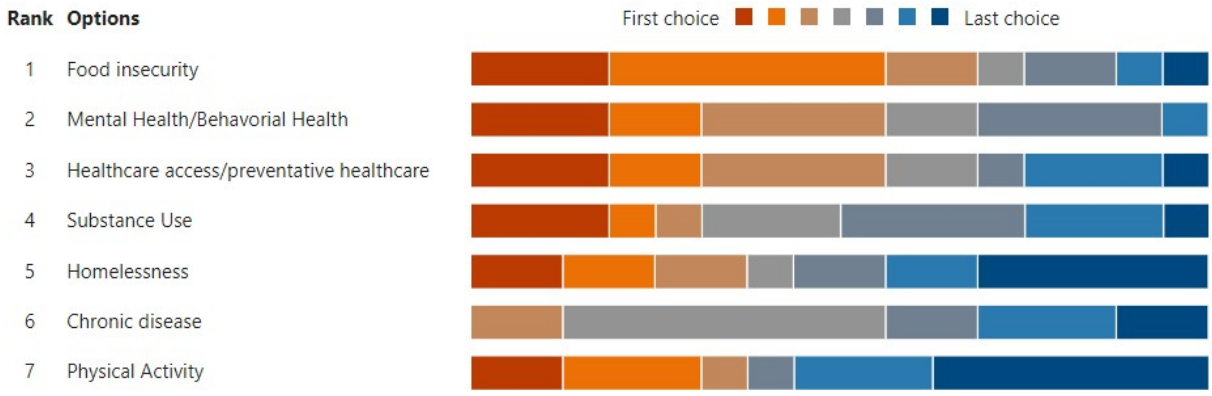
- **Community Safety** (1 mention): Concerns around gang activity and lack of law enforcement were specific to Royal City, impacting perceptions of community safety and stability.
- **Health Care Access** (3 mentions): Ephrata, Royal City and Moses Lake all cited a need for improved access to primary and specialty healthcare, with long wait times and limited availability as key barriers.

Table: Key Community Concerns and Assets

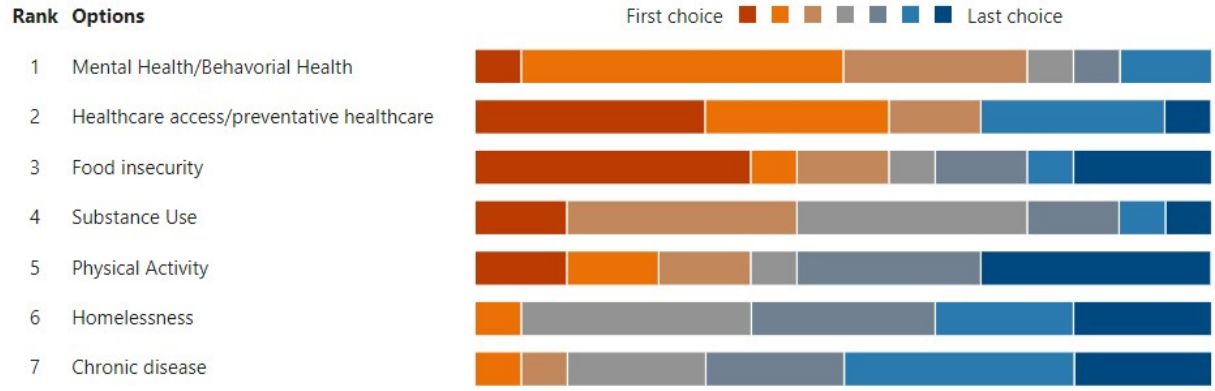
Community	Key Concerns	Key Assets/Organizations
Grand Coulee	Transportation, mental health services, food access	Coulee Medical Center, Colville Tribe, Moose Lodge
Quincy	Substance use, air quality, food insecurity, childcare	Quincy Community Health, Youth clubs, Quincy Partnership for Youth
Moses Lake	Mental health, affordable housing, air quality	Moses Lake Community Health Center, Hope Source, New Hope
Mattawa	Geographic isolation, youth engagement, health access	Mattawa Community Clinic, CBHA, School District
Ephrata	Mental health, substance use, food insecurity	Renew Grant Behavioral Health, Confluence Health Clinic, His Helping Hand, Local Schools, Settler's Natural Market
Royal City	Youth substance use, healthcare access, community safety	Royal City Community Clinic, Youth Substance Use Prevention Coalition, Local Churches, Library

Post CHIP Survey Results

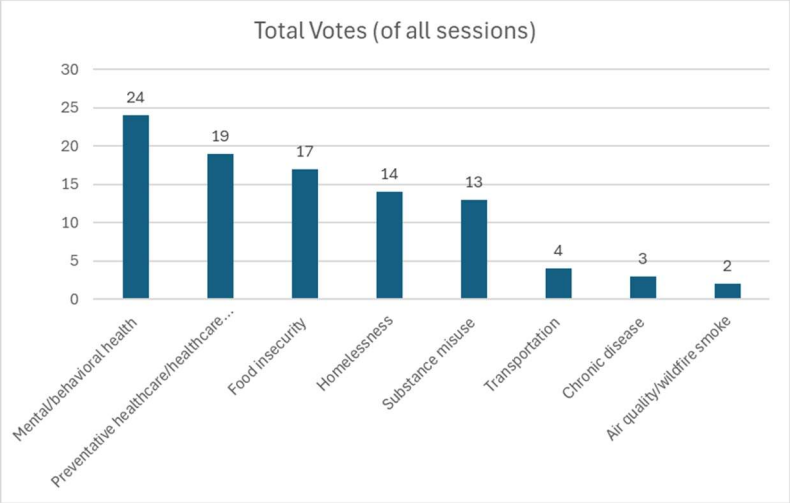
"Please rank the following community health issues based on the community's capacity to address them, with the top of the list being ***the issue the community is most capable of addressing*** *and the bottom of the list being the least capable."*



*"Please rank the following community health issues based on how likely it is that addressing them would lead to **measurable and sustainable change** within the next 1 to 5 years, with the top of the list being the most likely to achieve change and the bottom of the list being the least likely."*



These results indicate that the community believes **mental health, healthcare access, food insecurity and substance use disorder** are the most likely to have measurable and sustainable change and the most likely for the community to take part in this change.



This graph illustrates the total number of votes each public health priority received across all six sessions, as determined by participants using sticky dots for voting.

Priorities for the Community Health Improvement Plan (CHIP)

Based on the evidence and the common themes discussed during the listening sessions, the following priorities emerged as areas where targeted action can create impactful and interconnected solutions for community health:

Priority 1: Expand Mental Health Services and Support Networks

Why it's a priority: Mental health was consistently identified as a significant gap in services across all communities. Concerns include long wait times, insufficient in-patient treatment, and stigma associated with seeking help.

Possible actions to take:

- Partner with local health centers like Coulee Medical Center, Moses Lake Community Health Center, Renew Grant Behavioral Health, and Royal City Community Clinic to expand mental health services, including telehealth options and in-patient care.
- Collaborate with schools (e.g., Ephrata and Royal City School Districts, Quincy Partnership for Youth) to provide mental health education and support services for youth.
- Leverage community-based organizations like the Moose Lodge, His Helping Hand, and local churches to create safe spaces for mental health outreach and support.

Priority 2: Address Food Insecurity and Improve Access to Healthy Foods

Why it's a priority: Food insecurity is a pressing issue in many communities, particularly for low-income residents in Mattawa, Ephrata, and Royal City. Transportation and economic barriers exacerbate this issue.

Possible actions to take:

- Engage local food banks and organizations such as the Quincy Food Bank, Hope Source, and Settler's Natural Market to extend service hours and improve access to healthy, locally grown foods.
- Increase collaboration between health organizations and local agricultural groups to support community gardens, farmers markets, and educational programs on nutrition.
- Work with local transportation services to improve food distribution and access, particularly in rural areas like Grand Coulee, Ephrata, and Royal City.

Priority 3: Improve Transportation Infrastructure

Why it's a priority: A lack of access to and affordable transportation barriers were repeatedly mentioned as limiting access to healthcare, employment, and essential services, especially in rural areas.

Possible actions to take:

- Collaborate with transportation authorities to improve public transportation routes, focusing on connecting rural areas to healthcare and food resources.

- Foster partnerships with organizations like faith-based organizations, and local libraries to offer interim transportation solutions (e.g., ridesharing or community shuttles).

Post CHIP Facilitation Survey

Dec 4, 2025

Please finish this by the end of the day on Friday, May 3rd. This survey is meant to be your opinion, not the opinion of your facilitation table group or division. Your results will remain anonymous. It should only take 5-10 minutes. Thanks in advance!

* Required

1. What division are you in? *

- ◯ Public Health Infrastructure
- ◯ Healthy Communities and Families
- ◯ Environmental Health
- ◯ Investigations and Response
- ◯ Finance
- ◯ Other

2. What priorities did you choose by yourself? *

- ☐ Substance Misuse
- ☐ Mental Health/Suicide
- ☐ Chronic Disease
- ☐ Preventative Healthcare
- ☐ Air Quality/Wildfire Smoke
- ☐ Food Insecurity
- ☐ Physical Activity
- ☐ Homelessness
- ☐ STI's Prevention and Treatment
- ☐ Traffic Safety
- ☐ Foodborne/Waterborne Diseases
- ☐ Other

3. Are there any of these priorities you feel particularly strongly about and think should absolutely NOT be left out of our CHIP? If so, briefly explain why.

4. Given these priorities, which community organizations or individuals do you think should be involved in the creation of our CHIP? List any that you can think of, and contact information if you have it.

5. Is there any way we could improve the facilitation process? Were there any aspects that felt unhelpful or unnecessary? Was there any part that was confusing to you? *

6. Do you have any further suggestions for the CHIP process or comments on the facilitation today? Or any additional thoughts that weren't covered by the rest of the survey questions?

CHIP Subcommittee Meeting Agendas

June 2025 Meeting

- Reviewing and refining **Mission, Vision, and Value (MVV)** statements.
- Discussing and editing **ground rules/expectations** (draft provided).
- Beginning **Goal Brainstorming – Question 1:**
  "Reflecting on the orienting information and issue profile, what outcomes do we hope to achieve related to this priority?"
- Participants complete the rest of the goal brainstorming questions via shared document before the next meeting.

July 2025 Meeting

- Finalize goal-setting using completed brainstorming documents
- Begin structured **CHIP strategy brainstorming** using the **three types of strategy approaches**:
  - **Start from scratch** – generate new ideas that meet the community's unique needs.
  - **Plan-Do-Study-Act (PDSA) / CQI-style** – build on ideas to improve existing efforts.
  - **Evidence-based or best practice** – adapt strategies already proven to work.
- A few **example strategies for each category** will be provided to help spark discussion.
- Subcommittees will engage in a **breakout partner share** to brainstorm and refine early strategy ideas.
- A **shared working document** will be created for each subcommittee to:
  - Add emerging strategy ideas.
  - Brainstorm local programs or efforts that align.
  - Document evidence-based options for further exploration.

August 2025 Meeting

In-person retreat-style meetings for each subcommittee (1 per priority area):

- Deep-dive into strategy development.
- Identify shared measures and indicators.
- Possibly include a "field trip" or site visit relevant to the issue.
- Build energy and momentum through collaborative working sessions.

September 2025 Meeting

- Develop Objectives

    - Refine strategies and align with shared goals.
    - Begin continuous improvement action planning (CQI planning cycles).
- Steering committee compiles materials and drafts CHIP framework.

<u>October 2025 Meeting</u>

- Refinement meeting to review, make edits, discuss

Goal Development Worksheet

GOAL BRAINSTORM

Repeat this worksheet for all priority issues.

Orienting Information

Provide the following information to orient the group on the mission, vision, and value statements.

PRIORITY ISSUE	
MISSION STATEMENT	
VISION STATEMENT	
VALUES STATEMENT	

Brainstorm

Collectively think through and discuss the following questions to form your goal(s):

Reflecting on the orienting information and issue profile, what outcomes do we hope to achieve related to the priority issue?

For example: People with historically low food access can access nutritious produce easily; everyone has transportation to care; residents are aware of the mental health services located in the county and regionally.

What national- or state-level goals relate to this priority issue?

Reference resources like County Health Rankings, Healthy People, or your state's health plan.

Based on your review of the vision and priority issue, what are some potential goals for this priority issue?

What are the current barriers to achieving these potential goals?

Consider barriers in the following categories: community, policy/legal, technical, financial, other.

What measurements can we use to track progress on the priority issue?

What resources are available to address the issue, if any?

How can the goal include the voices and priorities of historically marginalized people?

How might potential goals have unintentionally different impact along lines of race, gender, class, ability, access, or power? How can the goal lessen this?[46]

Develop Goal(s)

Combine the information from the brainstorm to form a clear goal statement. You may develop more than one goal to address the priority issue.

[46] Massachusetts Department of Elementary and Secondary Education. *Creating SMARTIE goals.* Educator Evaluation Implementation Resources 2021-2022. Retrieved April 17, 2023, from www.doe.mass.edu/edeval/implementation/smartie-goals.docx