Attachment C
Community Health/Alternative Response Program

Mission

At the heart of our Community Health and Wellness Program is a commitment to promoting the physical, mental, and overall wellbeing of individuals residing in our communities. By supporting connections to resources that provide wraparound services to clients in need, we strive to break down barriers and provide accessibility to long-term resolution.

Vision

A thriving Community Health and Wellness Program aimed at providing resources that empower individuals of all ages and backgrounds to make positive lifestyle choices, build strong supportive social connections, and achieve positive outcomes of independence. This is achieved by fostering a culture of wellness and promoting community-wide health equity where everyone can live, work, and play to their fullest potential.

Values

A commitment to upholding the following values will promote a healthy, thriving, inclusive, equitable, and empowering community:

1. **Health and Wellness**: Prioritize our community members' physical, mental, and emotional wellbeing and work towards creating a culture of healthy living.

2. **Compassion and Empathy***:* Approach our work with empathy and compassion, recognizing the unique needs and challenges of everyone in our community.

3. **Collaboration and Partnership:** Building strong partnerships with individuals, organizations, and community groups to achieve our shared goals of promoting health and wellness.

4. **Equity and Inclusion:** Committed to creating an equitable and inclusive community where everyone can access resources and opportunities to achieve their full potential.

5. **Innovation and Continuous Improvement:** Strive for continuous improvement through innovation and learning to provide the highest quality services to our community.

6. **Respect and Dignity:** Treat all community members with respect, dignity, and sensitivity, and value the diversity of perspectives and experiences that enrich our community.

Goals

A range of services is offered, including preventive care, chronic disease management, behavioral health services, housing insecurity, homelessness outreach, etc., to address the unique needs of our community members. A stronger, more resilient community is supported by providing a holistic, comprehensive, and compassionate approach that addresses not only physical and mental health but also its residents' social and emotional wellbeing.

1. **Improving the overall health and wellbeing of the community:** Implementing programs and initiatives that focus on preventing and managing chronic diseases, promoting healthy lifestyle habits, and reducing risk factors related to housing insecurity.

   Objectives

   1. Create Community Care Coordinator positions to address low-level calls and promote healthy lifestyles
   2. Partner/promote a centralized location for walk-up ITA's and people with thoughts of suicide, medical respite, hygiene and beds for other needs, substance use treatments, etc.
   3. Support cultural community-based organizations to promote well-being
   4. Provide NARCAN dispensaries in the community
   5. Combat opioid epidemic
      1. Partnering with external organizations for chemical dependency, mental health professional services, and case management
      2. Continue Northeast King County Mobile Integrated Health pilot leave at home Narcan program supporting patients and their families with recourse connections.

2. **Increasing access to healthcare and social services:** Improve access to healthcare services for underserved populations (vulnerable populations), such as low-income families, seniors, and people with disabilities.

   Objectives

   1. Provide resource navigation and referral
   2. Partner with external health care and social service agencies and organizations to provide better service to the Redmond community
   3. Integrate and leverage partnerships to increase access to services
   4. Share data and communication between agencies
   5. Create shared records management system for better coordination of care
   6. Reduce the follow-up calls the co-responder mental health professional (Co-R MHP) currently handles that could be addressed by the community care coordinators
   7. Reduce suicide, suicide attempts and overdose incidents
   8. Community Care Coordinators dispatched to screened calls for service or at the request of first responders already on scene.

3. **Enhancing community engagement and participation:** Encourage community members' involvement in health-related activities and increase awareness of health issues in the community.

   Objectives
   1. Develop public education campaigns, workshops, and training in partnership with THRIVE (addiction and overdose, mental health suicide, teen suicide, gun access to teens and gun safety programs for the home)
   2. Support cultural community-based organizations to promote well-being
   3. Increase awareness about domestic violence support and programs
   4. Promoting medical literacy through multilingual, senior assistance, and understanding of appropriate care planning and goal setting for each client to support thriving independence.
   5. Enrolling all first responders in understanding Mobile Integrated Community Health and the importance of connection to services
   6. Health and safety presentations at the City of Redmond Senior Center and community events throughout Northeast King County
   7. Increase community outreach, including:
      1. Grow health screenings into schools and health fairs
      2. Conduct surveys from community and clients of mobile integrated health to confirm services are meeting the needs of the community and identify areas of improvement.

4. **Address social determinants of health:** Address root causes of socioeconomic conditions related to health, poverty, unemployment, housing inequity or insecurity, etc., that can have a significant impact on successful outcomes of independence.

   Objectives
   1. Keep people in their homes
      1. Reduce evictions
      2. Reduce displacement
      3. Support homeownership opportunities
   2. Maintain low numbers of unsheltered homelessness and car camping
      1. Adequate shelter, housing and safe vehicles spaces
   3. Continue and improve community court outcomes
   4. Continue and improve access to community court resource center
   5. Identify a community court liaison
   6. Partner with school district to promote youth wellbeing and belonging
   7. Support access to youth and senior centers
   8. Support access to public transportation
   9. Support City of Redmond’s welcoming city principles and increase equitable outcomes
   10. Monthly blood pressure checks at the Senior and Community Center in Redmond
   11. Conduct home safety inspections

5. **Monitoring and evaluating program effectiveness:** Regularly monitor and evaluate program effectiveness in achieving its objectives to help program leaders identify areas for improvement and make necessary adjustments to ensure the program meets the community's needs.

Objectives

1. Share quarterly reporting to City Council
2. Reduce 911 calls for service
3. Regularly scheduled THRIVE meetings, including MHP, MIH, Outreach, and Community Care Coordinators
4. Determine outcomes of direct services provided such as, transportation, telehealth appointments, access to housing and shelters, energy and financial assistance, behavioral health and chemical dependency services, food insecurity, PT/OT, home health, crisis resources and long-term case management
6. Number of client visits and direct hours spent working with members of the community, including:
    1. Tracking number of home/site visits
    2. Track time spent working with the client and accessing resources
    3. Track resolved client cases
7. Track 911 calls six months before community health enrollment and 6 months after community health enrollment
8. Track community, Mobile Integrated Health Team and line first responders training hours
9. Long term care 911 call review, partnership with facilities and KCEMS to look for trends and solutions