2013 Community Health Needs Assessment and Implementation Strategy

MultiCare Auburn Medical Center

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Executive Summary

Community Health Needs Assessment (CHNA) and Implementation Strategy

MultiCare Health System is a not-for-profit, community-based integrated health system with five hospitals, 10,600 employees and more than 130 Specialty, Primary and Urgent Care Clinics throughout Pierce, King, Thurston and Kitsap counties. MultiCare is one of the largest health care systems in the South Puget Sound region. Our heritage dates back to the founding of Tacoma's first hospital in 1882.

Priority Health Needs

In 2012, MultiCare contracted with the Tacoma-Pierce County Health Department to conduct a comprehensive Community Health Needs Assessment, using quantitative analysis and qualitative interviews with a representative cross-section of community leaders and area residents. The assessment process concluded in the spring of 2013, and in the resulting report, the Health Department developed the following list of priority health needs:

- Prevention and Treatment of Chronic Diseases
- Tobacco Prevention and Cessation
- Obesity
- Mental Health
- Cultural Diversity (health inequities and communication)
- Special Populations (low-income and aging)
- Access to Care

Three-Year Focus

MultiCare convened internal stakeholder meetings to review the assessment and to select the health care needs we will focus on system-wide in the next three-year period:

- Chronic Disease
- Obesity – Adult and Childhood
- Tobacco Use
- Behavioral (Mental and Chemical Dependency) Health
- Cultural Diversity

Executive Summary

Community Health Needs Assessment (CHNA) and Implementation Strategy

Each of MultiCare's five hospitals developed its own implementation strategy and created internal implementation teams. This Community Health Needs and Assessment Implementation Strategy is focused on MultiCare Auburn Medical Center in Auburn and describes how the hospital will address the identified health care needs by:

- Continuing and strengthening existing programs and services
- Exploring implemention of new strategies
- Collaborating with community organizations to implement evidence-based strategies across the service area

In addition, this report will outline existing programs and services offered by MultiCare and other community organizations that are addressing the other identified health care needs we chose not to focus on for this time period.

The strategies and activities outlined here, in partnership with key community collaborators, will require sustained, coordinated approaches to achieve lasting improvements in the health of our community. This implementation strategy is a roadmap that will likely be revised and enhanced as we continue to address the pressing health issues facing our community.

MultiCare Auburn Medical Center
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2013 Community Health Needs Assessment (CHNA) and Implementation Strategy

Introduction

Caring for our communities

MultiCare Health System is a not-for-profit, community-based integrated health system of hospitals, clinics, services and providers, with more than 10,000 employees in numerous locations in Pierce, King, Kitsap and Thurston counties in Washington. As one of the largest health care systems in the South Puget Sound region, we are dedicated to improving the health of the people we serve.

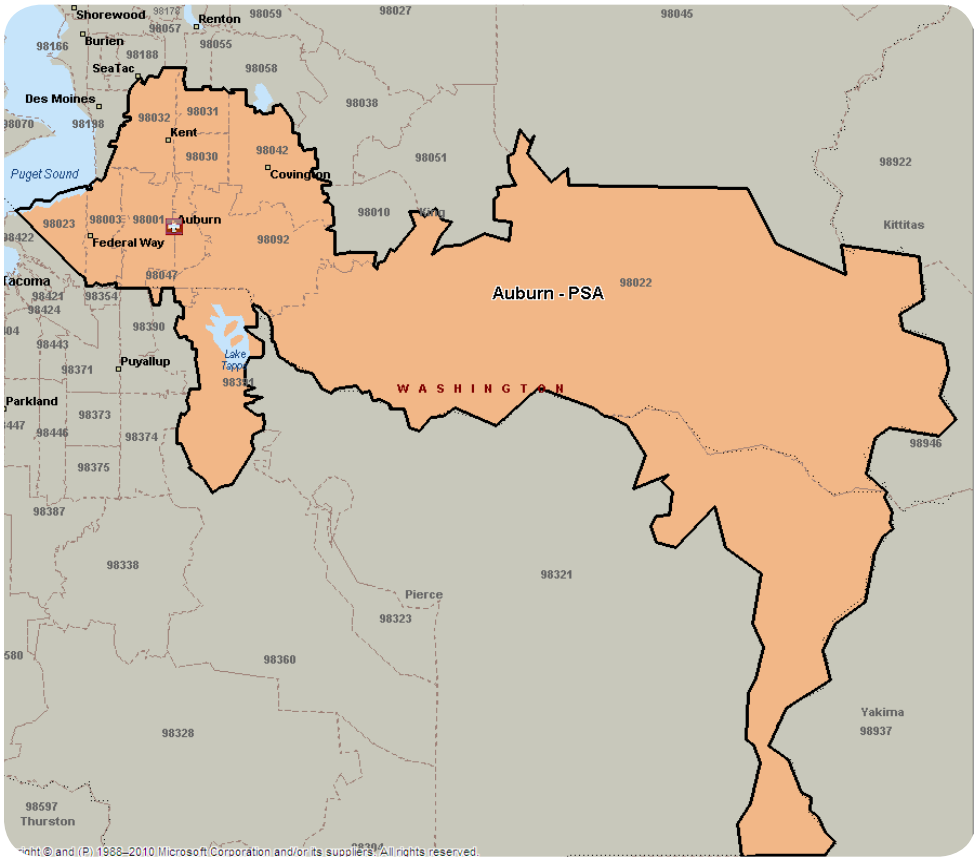
MultiCare facilities include:

- MultiCare Tacoma General Hospital (437 licensed beds)
- MultiCare Good Samaritan Hospital (286 licensed beds)
- MultiCare Allenmore Hospital (130 licensed beds)
- **MultiCare Auburn Medical Center (195 licensed beds)**
- MultiCare Mary Bridge Children's Hospital (82 licensed beds)
- MultiCare Clinics, Urgent Care Centers, MultiCare Express Clinics, Mary Bridge Subspecialty Clinics
- MultiCare ▪ Good Samaritan Home Health & Hospice
- MultiCare Good Samaritan Behavioral Health
- MultiCare Ambulatory Surgery Centers
- Laboratories Northwest

Meeting Community Needs

MultiCare Auburn Medical Center

MultiCare Auburn Medical Center Service Area



MultiCare Auburn Medical Center is a 195-bed Medical Center located in Auburn, Washington, with its primary service area (representing 75% of inpatients served) shown in the figure above. Over 415,000 people live in the Auburn primary service area.

CHNA Methodology

Background and Process

MultiCare Health System and Franciscan Health System contracted with the Tacoma-Pierce County Health Department to conduct a comprehensive Community Health Needs Assessment (CHNA). The process included quantitative analysis and qualitative interviews with community leaders and residents representing many sectors and population groups, including low-income residents and others affected by health disparities. The assessment process began in the fall of 2012 and concluded in the spring of 2013.

(Please see Appendix 1 for the complete Community Health Needs Assessment, as prepared by the Tacoma-Pierce County Health Department.)

Criteria for Prioritizing Health Needs

In the CHNA, the Health Department developed the list of priority health needs by using these four criteria:

1. *Is this health concern getting worse over time?*
2. *Is this health concern significantly worse in the service area than in the comparison area?*
3. *Are relatively large numbers of people affected by this health concern?*
4. *Was this health concern repeatedly voiced in community meetings and focus groups?*

Health care issues that met at least two of these criteria were deemed a priority by the Health Department. The resulting list of priority needs was a starting point for discussion, rather than a definitive short list requiring action.

Priority Health Needs Identified by the Health Department

The Tacoma-Pierce County Health Department identified the following priority health needs for residents within the MultiCare Auburn Medical Center service area:

- Prevention and Treatment of Chronic Diseases
- Tobacco Prevention and Cessation
- Obesity
- Mental Health
- Cultural Diversity (health inequities and communication)
- Special Populations (low-income and aging)
- Access to Care

MultiCare's Process for Selecting Health Care Priorities

MultiCare convened internal stakeholder meetings to review the assessment and to select the health care needs we will focus on system-wide. This internal stakeholder group included physician, nurse, and clinic/outpatient leaders from each of our five hospitals. The group chose the following issues to focus on system-wide in the next three-year period:

- Chronic Disease
- Obesity – adult and childhood
- Tobacco Use
- Behavioral (Mental and Chemical Dependency) Health
- Cultural Diversity (health inequities and communication)

System leaders then worked to create a resource inventory of existing programs and services offered by MultiCare that address these four identified needs. In addition, we met with Franciscan Health System, the Tacoma-Pierce County Health Department and other community organizations to explore possible community-wide solutions to some of the identified health care needs. After mapping existing internal and external resources, each MultiCare hospital developed its own implementation strategy and created internal implementation teams.

MultiCare Auburn Medical Center Implementation Strategy

MultiCare Auburn Medical Center's implementation strategy, outlined on the following pages, describes how the hospital will address the identified health care needs by:

- Continuing and strengthening existing programs and services
- Exploring implementing new strategies
- Collaborating with community organizations to implement evidence-based strategies across the service area

MULTICARE AUBURN MEDICAL CENTER **PRIORITIES**

CHRONIC DISEASE

- Decrease the percentage of adults who have type 2 diabetes
- Promote chronic disease self-management
- Promote prevention activities in the community

OBESITY

Increase the percentage of adults and youth who are at a healthy weight

TOBACCO USE

Increase the percentage of adults who are tobacco-free

BEHAVIORAL HEALTH

Reduce depression and anxiety rates

CULTURAL DIVERSITY

Improve how patients' cultural, language, and spiritual needs are addressed during health care delivery

HOSPITAL **STRATEGIES**

1. Promote awareness of diabetes and cardiac education services

2. Expand population-based prevention

3. Increase referrals to diabetes services and programs

4. Improve diabetes control through diabetes care management and preventive practices, such as self-care training

1. Promote community awareness and understanding of the READY, SET, GO! 5210 (RSG 5210) program and message

2. Increase collaboration with community partners on programs and policies to improve the health of our community

3. Surveillance of BMI data among patients

4. Promote weight management programs and services

5. Seek grants

6. Increase knowledge and best practice education of the benefits of breastfeeding

7. Increase access to healthy food in the workplace

8. Promote physical activity among MultiCare employees and their families

1. Promote awareness of and access to tobacco cessation resources and support programs

2. Promote insurance covered pharmacotherapy and/or free or low-cost cessation programs for hospital employees

3. Continue to support our tobacco-free workplace policy for all hospitals and clinics

4. Promote a smoke-free workplace for hospital employees and local businesses

1. Improve access to behavioral (mental and chemical dependency) health services by moving to an open access model of care

2. Increase integration of behavioral (mental and chemical dependency) health into chronic disease prevention and health promotion efforts

3. Focus on high-risk and high-utilizers of health care services

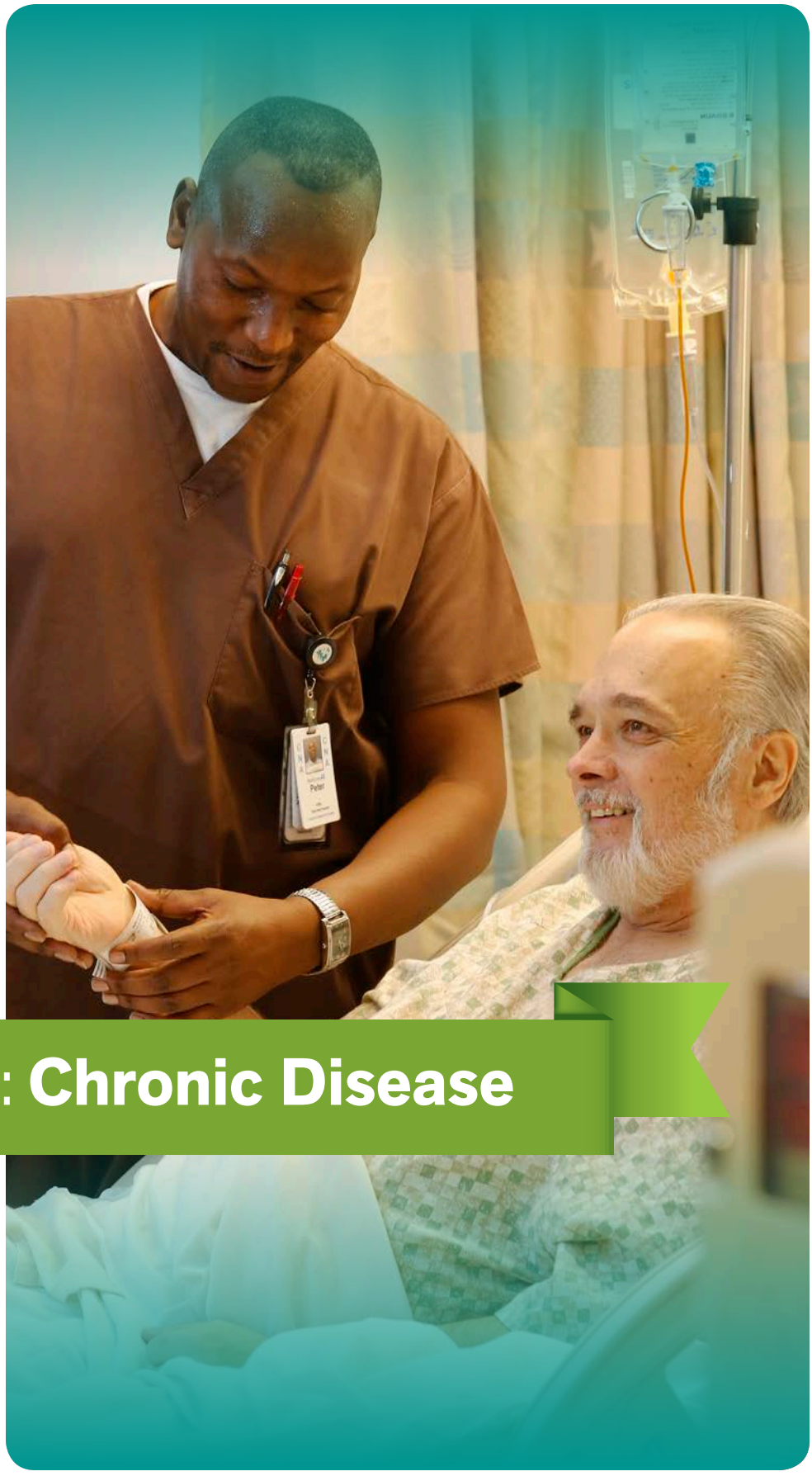
4. Explore ways to integrate chemical dependency treatment into the medical care setting

1. Promote cultural diversity and health inequity awareness among MultiCare staff

2. Increase access to interpreter/communication services

3. Offer blood pressure and type 2 diabetes risk assessments and health education at community events with a focus on underserved populations

4. Provide sports physicals to underserved youth



Focus 1: **Chronic Disease**

Focus 1: Chronic Disease

Type 2 Diabetes

Type 2 diabetes is a chronic health condition resulting from abnormally high levels of glucose (sugar) in the blood. It is a major cause of heart disease and stroke. People with diabetes who also have high blood pressure and high cholesterol levels are at an increased risk for heart disease and stroke. Diabetes is expected to grow in prevalence, and the rise in the incidence of type 2 diabetes is associated with increases in obesity, decreases in physical activity and the aging of our population. According to the CHNA, 8.5 percent of adults in the hospital's service area report being diagnosed with diabetes and 2.8 percent of adults in the same area have pre-diabetes.

Our priority is to decrease the percentage of adults who have type 2 diabetes, in addition to promoting chronic disease self-management and prevention activities in the community.

Our priority is to decrease the percentage of adults who have type 2 diabetes, in addition to promoting chronic disease self-management and prevention activities in the community through the following strategies and activities:

- **Promote awareness of diabetes and cardiac education services.**
  - Increase diabetes and cardiac education information internally and externally.
- **Expand population-based prevention.**
  - Expand blood pressure and other screenings to low-income, underserved and diverse communities through Diabetes and Cardiac Care Community Outreach and Community Outreach Liaison programs.
- **Increase referrals to diabetes services and programs.**
  - Create Smart Phrases in Epic, MultiCare's electronic health record system, to refer patients to diabetes programs and services.
- **Improve diabetes control through diabetes care management and preventive practices, such as self-care training.**
  - Develop focused disease management programs that provide care coordination and in-home monitoring to prevent development of comorbidities and complications of diabetes.
  - Provide education on self-care skills for those with diabetes.
  - Promote and refer to the YMCA Diabetes Prevention Program.

Internal Resources for Type 2 Diabetes

MultiCare Auburn Medical Center currently offers many diabetes programs and resources. They include, but are not limited to:

- **Chronic Disease Self-Management Program** for chronic disease control, home monitoring and self-care skills.
- **Integrated Diabetes Services** offers early intervention for those with pre-diabetes and medical care, support and education for people with diabetes.
- **Weight Loss and Wellness** is a specialized therapeutic lifestyle change program that targets the underlying causes of chronic disease by improving diet, activity and stress management.
- **Community Outreach Services** provides underserved communities with free blood pressure and glucose screenings.

Community Resources for Type 2 Diabetes

In addition to MultiCare programs and services, there are other community organizations and partnerships that are working on this issue. Some examples include:

- **YMCA Diabetes Prevention Program** is a 16-week program designed to decrease the risk of diabetes through promoting healthy weight management, increasing activity and improving nutrition in a friendly group environment.
- **Diabetes Association of King County** is a volunteer agency dedicated to improving the well-being of individuals with diabetes and their families, as well as preventing type 2 diabetes.
- **South Sound Diabetes Summit** is a partnership with Novo Nordisk and other community organizations that offers a free community diabetes education event with screenings.

Focus 2: **Obesity**

Focus 2: Obesity

As the CHNA indicates, obesity rates in adults and youth are alarming. Approximately 20 percent of adults are obese in King County. Within the Auburn service area, 30.2 percent of adults and 9.3 percent of eighth graders are obese. Obesity is linked to many chronic diseases, including diabetes, heart disease, stroke, cancer, osteoarthritis, asthma and sleep apnea. Poor nutrition and lack of physical activity contribute to the obesity rates in our community.

Our priority is to increase the percentage of adults and youth who are at a healthy weight.

Obesity is related to a variety of factors, including behavioral, environmental and genetic factors. We know that the most effective long-term strategy will involve community collaborations, improved policies and community initiatives to help improve the health of individuals in our community.

Our priority is to increase the percentage of adults and youth who are at a healthy weight through the following strategies and activities:

- **Promote community awareness and understanding of the Ready, Set, Go! 5210 (RSG 5210) program and message.**
  - Distribute RSG 5210 materials and other nutrition information/ resources within the community.
  - Increase the number of professionals, community champions and student ambassadors trained in RSG 5210 message and tools.
  - Expand the RSG 5210 Steering Committee to include additional community partners.
  - Increase the number of provider offices that are RSG 5210 “friendly” (e.g., have RSG 5210 messaging present in waiting rooms).
  - Partner with physicians to educate patients/family on RSG 5210, promote RSG 5210 messaging and refer patients to weight management services.
  - Collaborate with the Auburn Valley YMCA, as well as with other health systems, schools and organizations to promote the RSG 5210 message.

- **Increase collaboration with community partners on programs and policies to improve the health of our community.**
  - Partner with community organizations, businesses and government entities to offer RSG 5210 and/or other wellness activities.
  - Collaborate with King County Hospitals for a Healthier Community to support community efforts to address chronic health conditions.
- **Surveillance of BMI data among patients.**
  - Create a BMI database for adult and pediatric patients to capture internal BMI data and obesity rates.
- **Promote weight management programs and services.**
  - Create Smart Phrases in Epic to promote the RSG 5210 message and referral to weight management services.
- **Seek grants.**
  - Apply for grant funding to support healthy eating and physical activity (e.g., Supplemental Nutrition Assistance Program Education (SNAP-Ed) grants for schools and Women, Infants and Children (WIC).
- **Increase knowledge and best practice education of the benefits of breastfeeding.**
  - Provide education and training to providers and staff on how to support patients who choose to breastfeed.
  - Provide breastfeeding education to new mothers before discharge home.
  - Increase awareness and messaging around ensuring women breastfeed beyond two months.
- **Increase access to healthy food in the workplace.**
  - Promote wellness programming to hospital employees.
  - Partner with farmers markets and develop produce delivery programs.
  - Partner with local restaurants to promote healthy foods.
  - Promote healthy food choices using RSG 5210 marketing in vending machines and cafeterias.
  - Continue to offer healthier options in MultiCare cafeterias (e.g., expand whole, fresh, local menu).
- **Promote physical activity among MultiCare Auburn Medical Center employees and their families.**
  - Promote RSG 5210 to employees and families through the MultiCare Healthy@Work employee wellness program.
  - Promote community fitness and running events with employees and their families.
  - Promote the Million Minute Mission (MMM) School and Corporate Challenge to employees.

Internal Resources

MultiCare offers several services for children, adults and families related to nutrition and physical activity programming, weight management, nutrition counseling and healthy lifestyle. These include, but are not limited to:

- **Ready, Set, Go! 5210** is a community-based initiative in Pierce County to promote healthy lifestyle choices for children, youth and families.
- **Center for Healthy Living Nutrition Services** offers health, wellness and exercise programs.
- **Nutrition Counseling Service** dietitians provide outpatient nutritional counseling in South King County.
- **Healthy@Work Corporate Wellness Services** offer low-cost health education and prevention programs and screenings directly at the workplace.
- **Supplemental Nutrition Assistance Program Education** (SNAP-Ed) provides nutrition education to schools and to WIC clients.

Community Resources

In addition to MultiCare programs and services, there are other community organizations and partnerships that are working on this issue. Some examples include:

- **Healthy King County.org** is an online community for the Healthy King County Coalition, which works to reduce health inequities, ensure healthy and affordable food, provide access to physical activity and decrease smoking and other tobacco use.
- **Childhood Obesity Prevention Coalition** (COPC) is a statewide partnership that is tackling childhood obesity by working at the levels of policy and systems.

Focus 3: **Tobacco Use**

Focus 3: Tobacco Use

According to the CHNA, tobacco use in the Auburn service area is high compared to the rest of King County. In King County, 10 percent of adults report they currently smoke, compared to 16.5 percent of adults in the Auburn service area. Tobacco use can lead to tobacco/nicotine dependence and serious health problems. Secondhand smoke exposure causes disease in nonsmoking adults and children, including respiratory illness, heart disease and cancer. Children are especially vulnerable. Exposure to cigarette smoke can cause asthma and increase the risk of sudden infant death syndrome (SIDS), acute respiratory infections and ear problems. Tobacco cessation can significantly reduce the risk of contracting smoking-related diseases and has immediate health benefits.

Our priority is to increase the percentage of adults who are tobacco-free.

Our priority is to increase the percentage of adults who are tobacco-free through the following strategies and activities:

- **Promote awareness of and access to tobacco cessation resources and support programs.**
  - Increase provider referrals to tobacco cessation programs.
  - Provide "Brief Tobacco Intervention and Motivational Interviewing" training for providers.
  - Provide tobacco cessation materials and resources to provider offices and clinics.
  - Continue to use Smart Phrases in Epic to refer to tobacco cessation services.
- **Promote insurance covered pharmacotherapy and/or free or low-cost cessation programs.**
- **Continue to support the MultiCare tobacco-free policy for all hospitals and clinics.**
- **Promote a smoke-free workplace for hospital employees and local businesses.**
  - Offer smoking cessation counseling through our Healthy@Work Employee Wellness Program to hospital employees and their spouses/partners.
  - Offer tobacco cessation programs and services to local businesses through the Healthy@Work Corporate Wellness Program.

Internal Resources

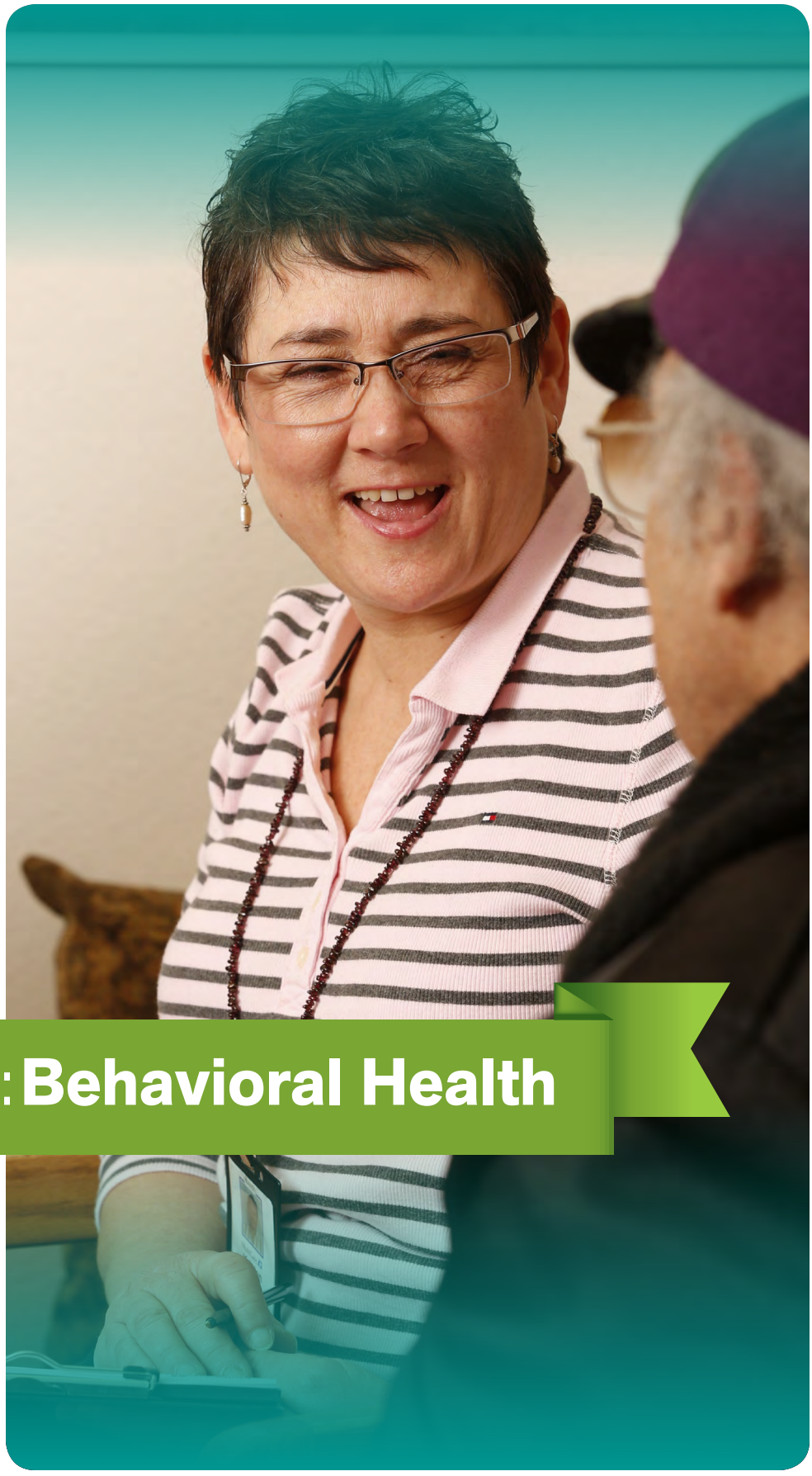
MultiCare offers several services for adults who are ready to quit using tobacco, both for their health and to limit the impact tobacco use has on children (in terms of exposure to secondhand smoke and modeling behavior). They include:

- **QuitSmart** tobacco cessation web-based program and phone support.
- **Tobacco use physician electronic visits** (e-visits) for patients via MyChart, MultiCare's secure online patient portal.
- **Tobacco-free workplace** smoking policy to reduce exposure and access to tobacco on all MultiCare Health System properties.
- **Healthy@Work Employee Wellness** QuitSmart 8-week program with free pharmacotherapy for employees.

Community Resources

In addition to MultiCare programs and services, other community organizations and partnerships are working on this issue. Some examples include:

- **Tobacco-Free Alliance of Pierce County** (TAP) is dedicated to improving the health of Pierce County residents by reducing tobacco use. Members include non-profit organizations, schools, businesses, health care organizations and public agencies. The Alliance's mission is to create community collaborations and networks empowered to promote the prevention of youth tobacco use, tobacco cessation and protection from secondhand smoke.
- **Tobacco Prevention Network** (TPN) works to provide a non-smoking environment throughout the public housing system by assisting housing authorities and landlords who administer Section 8 vouchers with implementing no-smoking policies.
- **Washington State Tobacco QuitLine** (1-800-QUIT-NOW) is a free service to help Washington State residents quit using tobacco. The QuitLine supports both immediate and long-term needs. Health coaches assist tobacco users with overcoming common barriers, such as stress, cravings, irritability and weight gain. The QuitLine is available in both English and Spanish with translation and TTY services.



Focus 4: **Behavioral Health**

Focus 4: Behavioral Health

Mental illnesses, such as depression or anxiety, affect an individual's ability to engage in healthy lifestyle practices. Adults, children and youth with untreated mental illness have poorer health, educational, social and economic outcomes.

Individuals with chronic mental illness are less likely than the general population to seek medical care in traditional medical health care settings.

Our priority is to reduce depression and anxiety rates.

Our priority is to reduce depression and anxiety rates through the following strategies and activities:

- **Improve access to behavioral (mental and chemical dependency) health services by moving to an open access model of care.**
  - Reduce average wait time for services.
  - Treat, refer and encourage self-management of mental and other health issues.
  - Use mobile health van to increase enrollment of behavioral health clients into integrated medical health and behavioral health care.
  - Integrate behavioral health and medical care/treatment.
- **Increase integration of behavior (mental and chemical dependency) health into chronic disease prevention and health promotion efforts.**
  - Embed behavioral health providers in medical care settings.
- **Focus on high-risk and high-utilizers of health care services.**
  - Expand intensive outreach and engagement of high utilizers of emergency departments utilizing behavioral health specialists.
- **Explore ways to integrate chemical dependency treatment into the medical care setting.**
  - Coordinate medical treatment and behavioral health treatment for opiate addictions.

Internal Resources

MultiCare offers comprehensive behavioral health and community services to support individuals and families in reaching their full potential. MultiCare has increased the availability of high-quality behavioral health services available throughout the area. Programs include:

- **Puyallup Valley Institute** (PVI), a division of MultiCare Good Samaritan Behavioral Health, provides counseling and psycho-therapeutic services for adults, children and families.
- **Adult Services** provides care for adults with severe and long-term mental illness.
- **Older Adult Services** include counseling services for those who are experiencing chronic or acute signs or symptoms of depression, anxiety, bi-polar disorder, schizophrenia or other lifelong or late-life disorders.
- **Program of Assertive Community Treatment** (PACT) is an evidence-based service-delivery model that provides comprehensive, locally based treatment to people with serious and persistent mental illnesses who have not been able to benefit from traditional clinic-based services.
- **Asian Counseling Services** (ACS) is a behavioral health clinic primarily serving the Asian/Pacific Island immigrant communities.
- **Behavioral Health High Emergency Departments Utilization Program** works with the top utilizers of MultiCare emergency departments to provide treatment in a more functional way by assigning a behavioral health specialist to coordinate care and provide enhanced care management services.
- **Mobile Integrated Health Care** provides primary care services to adults with severe and long-term mental illness.
- **Gero-Psychiatric Inpatient Services** is a 38-bed geriatric psychiatric inpatient unit at MultiCare Auburn Medical Center.

Community Resources

In addition to MultiCare programs and services, other community organizations and partnerships are working on this issue. Some examples include:

- **Catholic Community Services** has 12 family centers across Western Washington to provide an array of services, including counseling, case management, information and referral, chemical dependency services, mental health services and family support services to children, adults and families.
- **Valley Cities Mental Health Services** provides mental health services to people of all ages, delivering compassionate care through comprehensive outpatient clinics located in Auburn, Federal Way, Kent and Renton.
- **King County YMCA Family Services and Mental Health** provides home and office-based mental health counseling, with specialization in helping youth and families involved in the child welfare system.
- **Muckleshoot Indian Tribe Behavioral Health Program** provides comprehensive mental health services, state certified chemical dependency treatment, adult recovery housing and prevention services to Tribal community members, families and other Native Americans living on and near the Muckleshoot Indian Reservation.

Focus 5: **Cultural Diversity**

Focus 5: Cultural Diversity

Each year, the United States population becomes more diverse, in terms of race, ethnicity, religion, socioeconomic status, sexual orientation, etc. The MultiCare service area is no exception. According to the CHNA, residents and community leaders feel that greater attention to cultural diversity in the delivery of health care services is needed. In order to provide quality health care and to ensure health equity, health care systems must consider the unique cultural and communication needs of each individual patient and their families. Addressing these needs can minimize barriers that some patients experience when seeking medical services and has potential to increase both access to health care and patient satisfaction.

Our priority is to improve how patients' cultural, language, and spiritual needs are addressed during health care delivery.

Our priority is to improve how patients' cultural, language, and spiritual needs are addressed during health care delivery.

Our priority is to improve how patients' cultural, language, and spiritual needs are addressed during health care delivery through the following strategies and activities:

- **Promote cultural diversity and health equity awareness among MultiCare staff.**
  - Offer cultural sensitivity and health equity in-person and on-line trainings to staff, particularly health care providers and frontline staff.
  - Develop internal cultural diversity council.
- **Increase access to interpreter/communication services.**
  - Explore utilizing in-house interpreters.
  - Explore offering language conversion setting on main website.
  - Ensure health education materials are available in multiple languages.
  - Continue to offer telecommunications devices for hearing-impaired patients.

We are continuing to provide outreach services to ethnic minority and low-income communities through the following strategies and activities:

- Offer blood pressure and type 2 diabetes risk assessments and health education at community events with a focus on underserved populations.
- Provide sports physicals to underserved youth.

Internal Resources

MultiCare offers the following resources that addresses health inequities:

- **MultiCare's full-time Community Outreach Liaison** provides outreach and direct services, such as health screenings, to underserved communities, including African American, Latino/Hispanic, and Asian/Pacific Islander communities, and low-income populations.
- **MultiCare Tacoma Family Medicine and East Pierce Family Medicine** provides formal and informal cultural sensitivity education to resident physicians.

Community Resources

In addition to MultiCare programs and services, other community organizations and partnerships are working on this issue. Some examples include:

- **Korean Women's Association (KWA)** provides multicultural social services to meet basic human needs through education, socialization, advocacy and support.
- **The Seattle Urban League** provides social services to the African American community and other ethnic minorities and low-income individuals. They are devoted to raising awareness of health equity issues and providing opportunities for diverse collaboration.

Anticipated Outcomes and Evaluation

Better health for our whole community

As we continue to review and revise our implementation strategy, outcomes will be further developed and refined. Outcomes we anticipate from our activities focused on chronic disease, obesity, tobacco use, behavioral (mental and chemical dependency), and cultural diversity include:

- Increase in the number of patients who attend diabetes education classes
- Increase in the number of participants in the Million Minute Mission (MMM) school and corporate challenge
- Increase in the number of Brief Tobacco Interventions
- Increase in the number of referrals for behavioral health treatment

We plan to evaluate our impact through community surveys, internal data collection and other quantitative and qualitative methods.

Other Identified Needs

Meeting the needs of our patients and families

The overall goal of the Community Health Needs Assessment (CHNA) is to improve the health of our community. Certainly there are many pressing health issues that merit attention. Given the complexity of community needs and the finite resources available to address them, we selected important priority needs to focus on in the next three years of implementation.

In addition, there were three needs identified in the CHNA that are not specifically addressed in this implementation strategy:

- Special Populations (low-income and aging)
- Access to Care (lack of primary care, coordination of care and affordable care options)

We recognize that these needs are important to the health of our community. There are many existing programs and services offered by MultiCare and other community organizations that are addressing these needs.

Examples of these programs follow.

Special Populations

MultiCare provides many programs and services focused on special populations, including low-income individuals and families. These programs include:

- **Women, Infants and Children** (WIC) is a supplemental nutrition program for low-income pregnant and breastfeeding women, or women with infants and children under age five. WIC provides nutritious foods and other benefits free of charge to eligible families. Services offered at the 11 MultiCare WIC sites include nutritional and breastfeeding support, health education and referrals to medical and dental providers and other community resources.
- **The MultiCare Mary Bridge Mobile Immunization Clinic** provides free immunizations for children with no insurance or ability to pay for these services. In 2012, MultiCare provided 12,198 free immunizations.
- **Celebrate Seniority** is a MultiCare program that supports elder individuals through healthy activities and community connections. Celebrate Seniority volunteers enjoy contributing to their local community while developing strong friendships with other seniors.
- **Older Adult Services** is a MultiCare program that provides a variety of programs and services to adults aged 60 and older, who are experiencing emotional problems, behavioral disturbance and/or difficulty coping with age-related changes.
- **Eldercare** services at MultiCare are offered to older adults and their family caregivers who face the daily challenges associated with caring for a loved one with dementia. Services are designed to help reduce caregiver stress, increase knowledge about the dementia process, teach skills to care for the challenging behaviors and improve health and well-being for the family.
- **HEROS** (Helping Elders through Referral and Outreach Services) provides services to adults aged 60 and older who may be isolated, lack family support, be resistant to help or may not know how to find help to keep them safe and healthy.
- **The Good Samaritan Family Support Center** provides family-based advocacy, health and education services. Family service programs include parenting education, nutrition services, family support services, immunization services and referrals to low-income individuals and families.
- **Wise and Well Senior Dinners** are held occasionally throughout the year at the MultiCare Auburn Medical Center cafeteria. Seniors are provided with a free meal while they listen to a health presentation.

Access to Care

Providing access to affordable, high-quality health care is important for our community. As a not-for-profit community organization, MultiCare offers several programs to increase access to care, improve care coordination and provide affordable care for the uninsured and underinsured. These programs include:

- **Tacoma Family Medicine** (TFM) and **East Pierce Family Medicine** provide high quality, family medicine education for medical residents, who in turn provide comprehensive primary care for low-income and underserved patients.
- MultiCare provides **Charity Care**, or free medical care for individuals in families with incomes at 200 percent of the Federal poverty level (FPL) or below, which is $47,100 for a family of four. For persons between 200 percent and 500 percent of FPL, there is a sliding scale offered to help offset the cost of care. MultiCare provides charity care, or free medical care for children in families with incomes at 300 percent of the Federal poverty level (FPL) or below, which is $70,650 for a family of four. For persons between 300 percent and 500 percent of FPL, there is a sliding scale offered to help offset the cost of care. In addition to charity care, MultiCare provides no-interest payment plans, flexible payment schedules, prompt pay discounts for uninsured and assistance with qualifying for state-sponsored health plans.
- **MultiCare Clinics** provide personalized primary care, including convenient after-hours care and advanced specialty care for individuals and families.
- **MultiCare Urgent Care Centers** offers treatment for minor injuries and illnesses that aren't life threatening yet require medical attention on the same day. They can be a good option at night and on weekends when health care providers may not be in the office.

In addition to MultiCare programs and services, there are several community organizations that also address access to care, including:

- **Project Access Northwest** provides access to specialty care health services for individuals who are uninsured or underinsured and live in King County.
- **The Access to Baby and Child Dentistry** (ABCD) King County program helps establish young children on a lifelong path to good oral health. ABCD connects low-income families with dentists for their children. Parents also receive education on preventing tooth decay early and taking care of their children's teeth.

- **Healthpoint Community Health Centers** provides medical and dental care, as well as complementary and alternative medical services, at 11 King County locations, including Auburn. They also work to promote healthy communities in some of the most culturally and economically diverse communities in King County.
- **Auburn Public Health Center** provides health care services that include family planning, HIV screening, maternity support services, WIC, nutrition services and OB services to individuals in the service area.
- **Christ Community Free Clinic** provides free, urgent medical and dental care to uninsured and low-income individuals in South King County.

Conclusion

Expertise meets compassion

As a leading regional health care system, MultiCare is committed to improving the health of the people and communities we serve. The process of conducting a Community Health Needs Assessment and developing implementation strategies has helped us to better understand the health care needs of our communities and the significant role we play in addressing those needs. In addition, this process has fostered more collaboration among the many community organizations that share our goal of improving the health of people in our region.

The leaders involved in developing the implementation strategies for MultiCare Auburn Medical Center include:

- Pat Bailey, Consultant, MultiCare Auburn Medical Center
- Lois Bernstein, Senior Vice President, Community Services, MultiCare Health System
- Jalane Christian-Stoker, Administrator, Behavioral Health and Outreach Services, MultiCare Good Samaritan Hospital
- Karen Graham, Administrator, South King County Region, MultiCare Medical Associates
- Tim Holmes, Vice President, Behavioral Health and Outreach Services, MultiCare Good Samaritan Hospital

- Hugh Kodama, Vice President, South King County Region, MultiCare Health System
- Chad Krilich, MD, Medical Director, MultiCare Auburn Medical Center
- David Nicewonger, Chief Operating Officer, MultiCare Auburn Medical Center
- Jamilia Sherls, MPH, RN, Community Outreach Liaison, MultiCare Health System
- Lori Tanner, MPH, RD, Director, MultiCare Center for Healthy Living, MultiCare Health System
- Andrea Tull, Government Relations & Public Affairs, MultiCare Health System

This Implementation Strategy is a roadmap that will likely be revised and enhanced as we continue to address the pressing health issues facing our community.

We recognize that these issues are complex, inter-related and influenced by multiple factors. As a result, our strategies and activities address partnerships with key community collaborators. These long-term health issues will require sustained, coordinated approaches to achieve lasting improvements in the health of our community.

Appendix 1

Community Health Needs Assessment (CHNA) and Implementation Strategy

MultiCare Auburn Medical Center

Community Health Needs Assessment

Prepared by:
Tacoma-Pierce County Health Department
Office of Assessment, Planning and Improvement

May 2, 2013

Table of Contents

The Tacoma-Pierce County Health Department has prepared this Community Health Needs Assessment (CHNA) for MultiCare Health System and was the primary collector and reviewer of the quantitative and demographic data. The Health Department, MultiCare Health System, as well as Franciscan Health System all participated actively in the community workshops and qualitative assessment process to further identify and prioritize the County's health needs.

Staff support was provided by the Office of Assessment, Planning and Improvement, within the Tacoma-Pierce County Health Department. The CHNA was conducted using available guidance published by the IRS related to the new requirement for 501(c) (3) Medical Centers. Please note that this Report meets the current draft of IRS requirements as well as the proposed Washington State CHNA requirements. As appropriate, each health system will use this CHNA to develop its own implementation plan. The process, methods, and conclusions of this comprehensive CHNA are summarized in this Report.

Key Findings:

The following are key findings from the CHNA for MultiCare Auburn Medical Center's service area:

- Like many places, the service area is growing older and more racially and ethnically diverse. With aging comes greater need for health services particularly related to chronic conditions. Because managing and preventing chronic conditions is a cooperative effort between providers and patients, health-related communication will need to be tailored to the cultural needs of patients.

- The number of births in the service area has been declining 2% per year since 2009. This drop has been reported across the nation and is thought to reflect changes in reproductive decisions brought by the economic recession. The percent of births that are preterm births are increasing almost 1% per year.

- Both for adults age 18-64 and for adults 65 and older, the death rate in the service area, but not in Western Washington state, is increasing over time. With the exception of diabetes-related deaths, death rates in the service area for adults age 18-64 are not higher than in Western Washington state. In contrast, deaths from cardiovascular disease, cancer, Alzheimer's disease, respiratory diseases and diabetes are more common in the service area for those 65 and older than in Western Washington state. Obesity, an important risk factor for cardiovascular disease, is more common in the service area as well. This suggests the service area will continue to need high levels of preventive and therapeutic care related to cardiovascular disease.

- Although mental health is no worse in the service area, a large proportion of adults and youth suffer from poor mental health. Suicide is a leading cause of death for both children age 1-17 and for adults 18-64.

- Life expectancy, a broad indicator of population health, is flat in the service area, but is increasing in Western Washington state.

- Indicators of health care access were lower in the service area than in Western Washington state. Utilization of preventive services, however, was no different. This suggests that the gap in mortality and life expectancy may be due to behavioral factors such as smoking, obesity and chronic disease management rather than on therapeutic care.

Community members identified three broad directions that would most impact community health:

- Providing access to quality health care for all residents. This includes:
  - Comprehensive behavioral health services,
  - Service equity for minority populations, and
  - Better coordination of care within and between the major health care systems in the area.

- Reducing preventable chronic conditions including substance abuse and obesity-related diseases such as diabetes.

- Meeting the needs of special populations, particularly the homeless and military families.

Priority Health Needs

Priority health needs among residents within the MultiCare Auburn Medical Center service area are listed below. These identified health needs are the result of applying a prioritization process and criteria to the data elements included in this report. (See the Methods section on page 18 for more information about the process.) The priority health needs can provide guidance for MultiCare Health System planners and decision makers regarding where best to provide community benefit programs and services to address the most important health needs of the community.

Priority Needs:

- Prevention and treatment of cardiovascular disease
- Prevention of obesity (children and adults)
- Prevention and treatment of cancer
- Addressing cultural diversity in healthcare delivery
- Prevention of preterm births
- Addressing the needs of an aging population
- Providing for the specific needs of low-income residents
- Prevention and cessation services for adult smoking
- Prevention and treatment of mental illness, including suicide prevention
- Reducing diabetes prevalence and comprehensive services for diabetic patients
- Sufficiency of primary care providers to allow a medical home for all residents, including the uninsured

Introduction

A community health needs assessment is one element in what necessarily must be a comprehensive planning process to strengthen South King County's and Pierce County's health care infrastructure and address community health priorities. This assessment can provide a blueprint for planning how to best address the needs of the Pierce County community. Moving forward with a resource inventory and a current service gap analysis will assist in learning more specifically and strategically what the best means of health care planning are.

Auburn Medical Center is a 162-bed Medical Center located in Auburn, Washington with its primary service area (representing 75% of inpatients served) as shown in the figure below. This report presents quantitative data specific to the Auburn primary service area and qualitative community group data gathered from focus group-type meetings throughout Pierce County and South King County. The quantitative data are presented first, followed by the community group data and concluding with a description of the methods used to collect and analyze data.

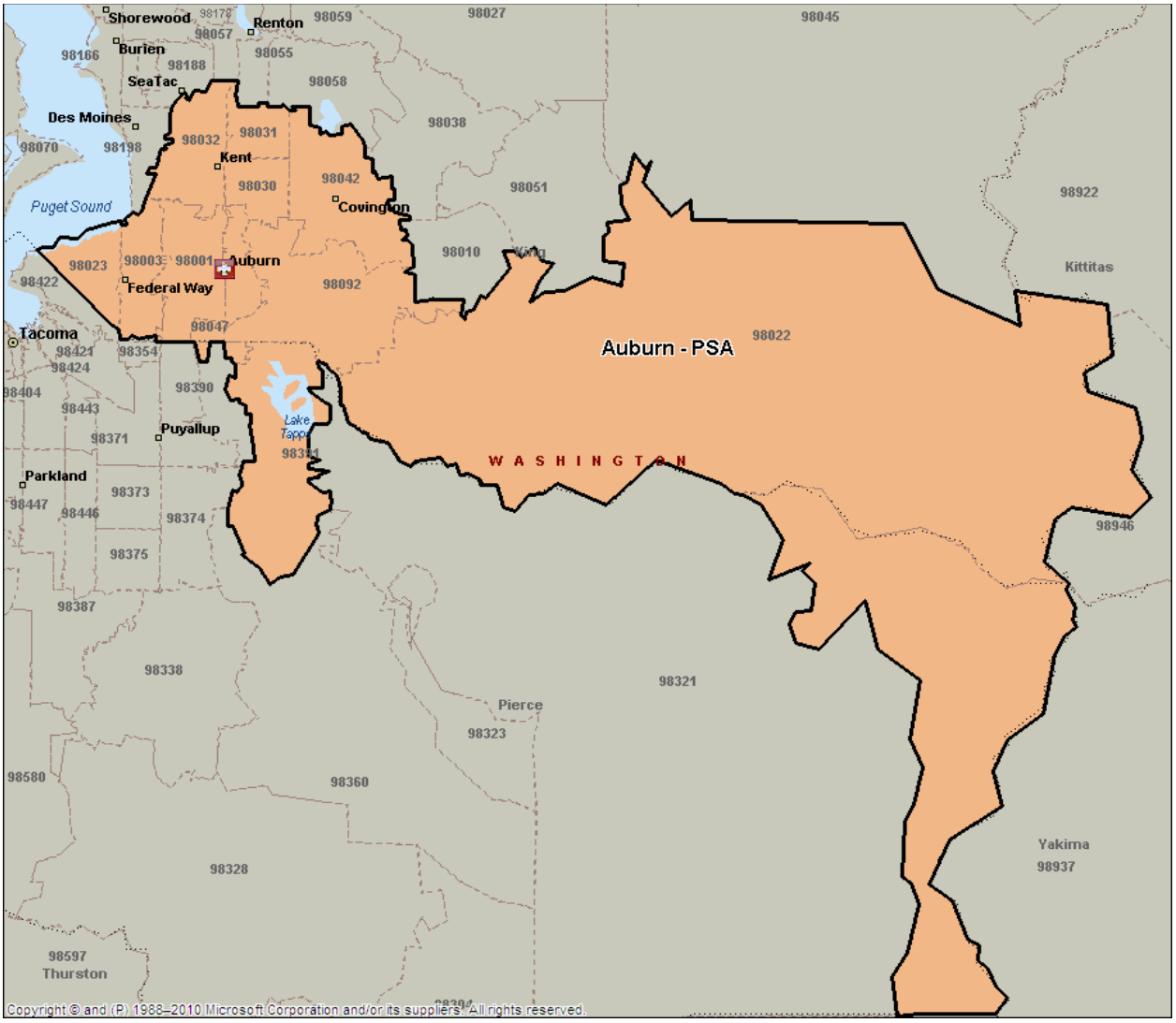


Figure 1 Map of Auburn Medical Center primary service area

Quantitative Data

Demographic profile

Approximately 415,000 people live in the Auburn service area. The demographic characteristics of a community are strong predictors of health and of the magnitude and type of health service needs. The age distribution of residents in the service area has changed over the past decade (Figure 2). Compared to 2000, the 2010 the population has aged; the modal age increased from 35-39 to 45-49. As the population ages, chronic health conditions will become more prevalent and demand for health services associated with those conditions will grow. In addition to therapeutic services, there will be a growing need to help patients manage their chronic conditions, including care management and patient education.

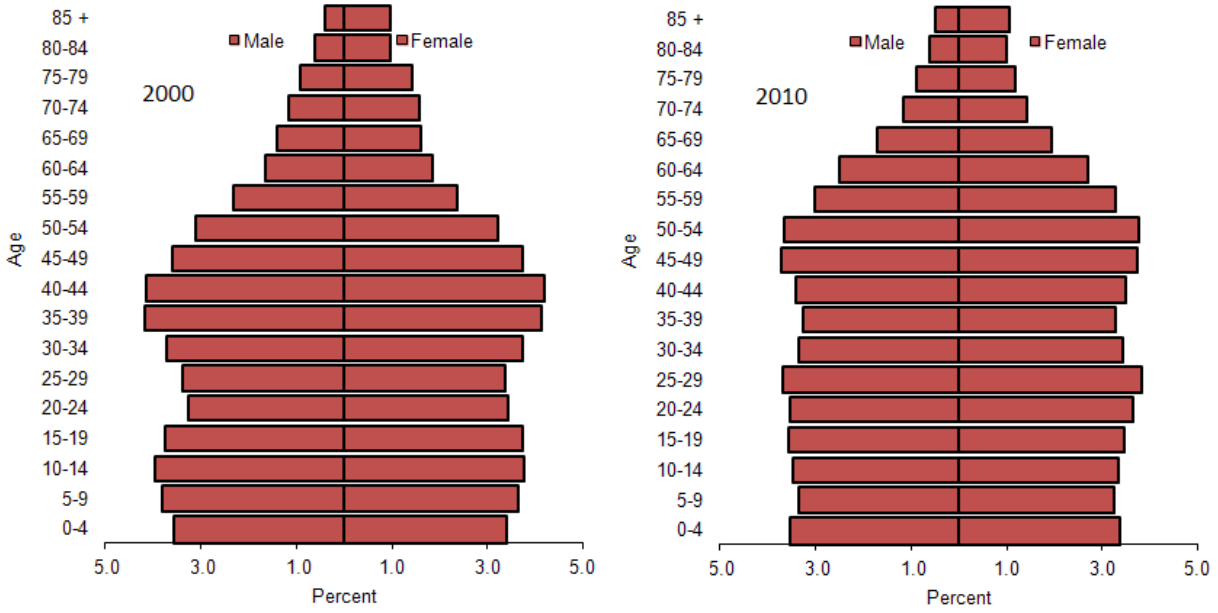


Figure 2 Population pyramid for Auburn service area, 2000 and 2010

Source: Washington State Department of Health and Krupski Consulting, 1990-2009 Population Estimates: Population estimates for public health assessment and 2010 United States Census.

With respect to race and ethnicity, the service area is predominately white non-Hispanic (Figure 3). All subgroups of race and ethnicity grew in size over the last two decades. The rate of growth from 1990 to 2009 was highest for Hispanic (243%), black non-Hispanic (230%) and Asian/Pacific Islander non-Hispanic (219%) group. Health communication, which is vital to preventing and managing chronic conditions, will need to be tailored to the needs of these growing population subgroups.

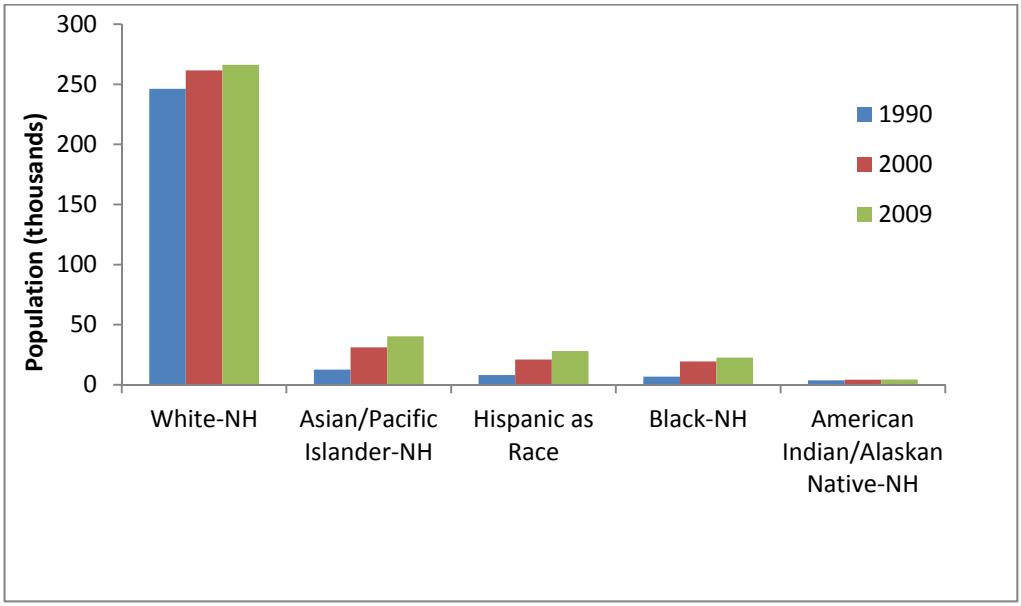


Figure 3 Population by race for Auburn service area, 1990-2009

Source: Washington State Department of Health and Krupski Consulting, 1990-2009 Population Estimates: Population Estimates for public health assessment

In the service area, 11.8% of residents had incomes below the Federal Poverty Level[1], averaged over 2006-2010. This is higher than the Western Washington state prevalence of 10.8% over the same time period.

Pregnancy and childbirth

Birth patterns in the service area have shifted over the past two decades (Figure 4). Note that data for Western Washington state is plotted using the axis on the right. Therefore, the relative position of the two plots is arbitrary. The number of births in the service area has been dropping about 2% per year since 2009. This general pattern of decline was seen in Western Washington state as well. It is probably the result of declining birth rates seen nationally in response to the economic recession.

[1] American Community Survey

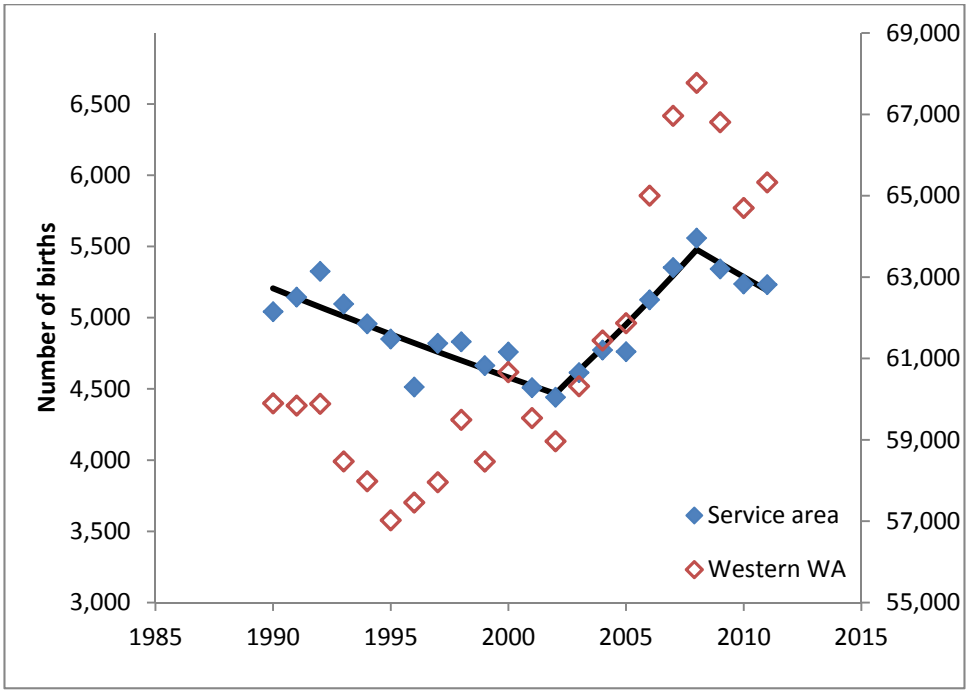


Figure 4 Number of births for Auburn service area

Source: Washington State Department of Health, Center for Health Statistics Birth Certificate Data

Infants born preterm can face multiple acute health concerns and lifelong disabilities. Preterm births in the service area are increasing about 1% per year (Figure 5). The trend is similar to that in Western Washington state.

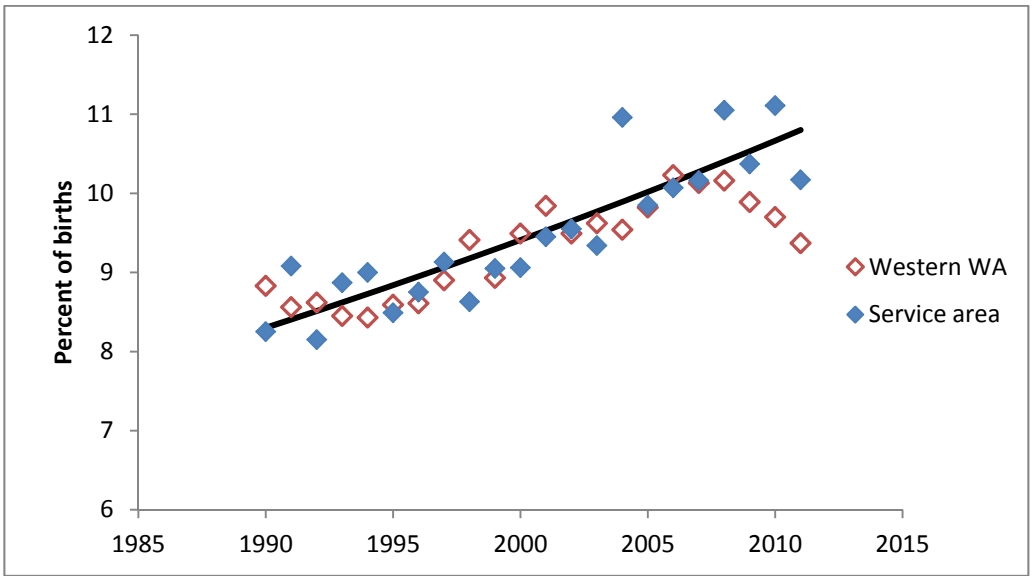


Figure 5 Percent of births <37 weeks gestation for Auburn service area
Source: Washington State Department of Health, Center for Health Statistics Birth Certificate Data

Prevalence of selected health behaviors

Current health behaviors can help to predict future health for a community. Obesity, a major risk factor for cardiovascular disease, is more prevalent among adults in the service area than in Western Washington state (Table 1). There were no meaningful differences between eighth graders in the service area and those statewide.

Table 1 Prevalence of selected health behaviors

	Auburn service area			Comparison area		
	n	Percent	95% CI	n	Percent	95% CI
Smoking						
Percent of adults who currently smoke†	1196	16.5	13.4-19.6	26,238	14.7	14.0-15.4
Percent of 8th graders who smoked in last 30 days*	2368	5.1	3.9-6.3	9495	6.6	5.7-7.5
Substance use						
Percent of 8th graders who drank alcohol in last 30 days*	2361	12.8	10.8-14.8	9459	14.4	13.1-15.7
Percent of 8th graders who used an illegal drug in last 30 days*	2352	8.5	6.4-10.6	9419	10.0	8.8-11.2
Obesity						
Percent of adults who are obese†	1143	30.2	26.4-34	25,110	25.7	24.9-26.5
Percent of 8th graders who are obese*	991	9.3	6.2-12.4	4035	11.3	9.9-12.7

†Source: Behavioral Risk Factor Surveillance System, 2009-2010; comparison area: Western Washington state
*Source: Washington State Healthy Youth Survey, 2010; comparison area: Washington State

Prevalence of selected chronic conditions

Diabetes is expected to grow in prevalence as a result of climbing levels of obesity. Currently, 9% of adults and 3% of eighth graders report being diagnosed with diabetes (Table 2). These rates are similar to those in the comparison areas.

Mental illness is a common and frequently untreated condition that accounts for significant disability, productivity loss, and human suffering. In the service area, about one quarter of eighth graders reported symptoms consistent with clinical depression, while about 14% of adults reported experiencing periods of poor mental health recently (Table 2). There were no differences between service and comparison areas for these indicators of mental illness.

Table 2 Prevalence of selected chronic conditions

	Auburn service area			Comparison area		
	n	Percent	95% CI	n	Percent	95% CI
Diabetes						
Percent of adults with diabetes†	1204	8.5	6.8-10.2	26,364	7.3	6.8-7.8
Percent of adults with prediabetes†	1204	2.8	2.0-3.6	26,364	3.7	3.4-4.0
Percent of 8th graders with diabetes*	997	3.6	2.1-5.1	3932	3.6	2.9-4.3
Mental health						
Percent of adults with poor mental health >10 out of last 30 days†	1190	14.2	11.2-17.2	26,039	12.8	12.1-13.4
Percent of 8th graders with symptoms of depression (sad or hopeless for 2 weeks last 12 months)*	2206	24.5	21.6-27.4	8752	25.2	23.9-26.5

†Source: Behavioral Risk Factor Surveillance System, 2009-2010; comparison area: Western Washington state
*Source: Washington State Healthy Youth Survey, 2010; comparison area: Washington State

Mortality

While death is unavoidable, premature death is sometimes preventable. Deaths among infants (Figure 6) and children age 1-17 (Figure 7) residing in the service area have been declining about 1% and 3% per year, respectively. The most common cause of death for children age 1-17 is unintentional injuries (Figure 8). There were no meaningful differences in child death rates between the service area and Western Washington state.

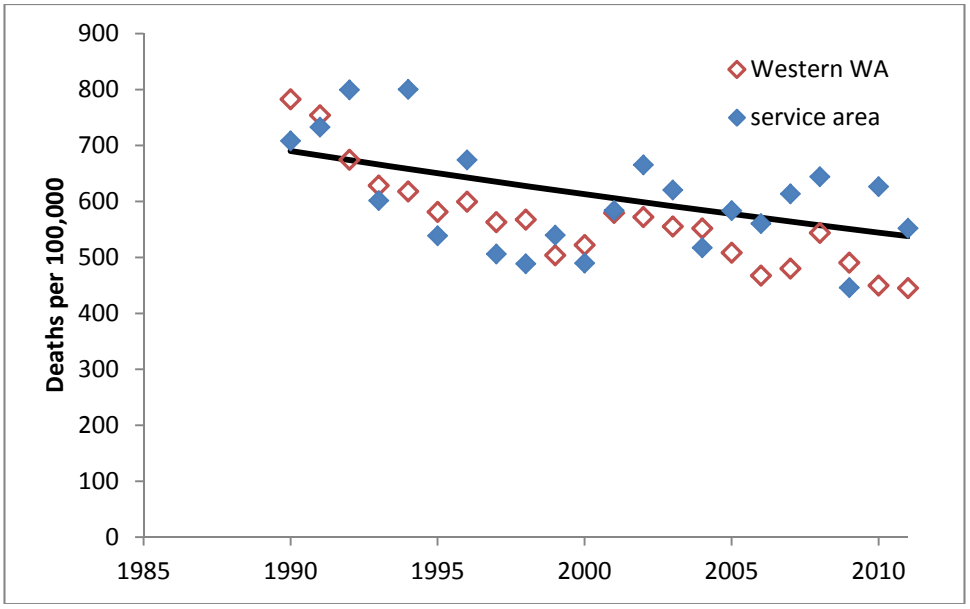


Figure 6 Death rate in the first year of life for Auburn service area
Source: Washington State Department of Health, Center for Health Statistics, Death Certificate Data

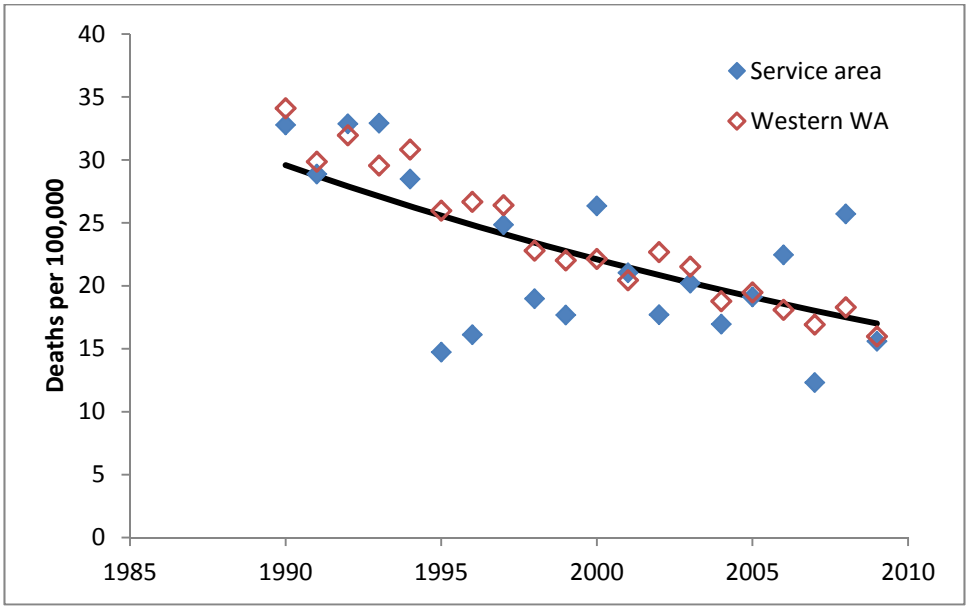


Figure 7 Death rate among persons age 1-17 for Auburn service area
Source: Washington State Department of Health, Center for Health Statistics, Death Certificate Data

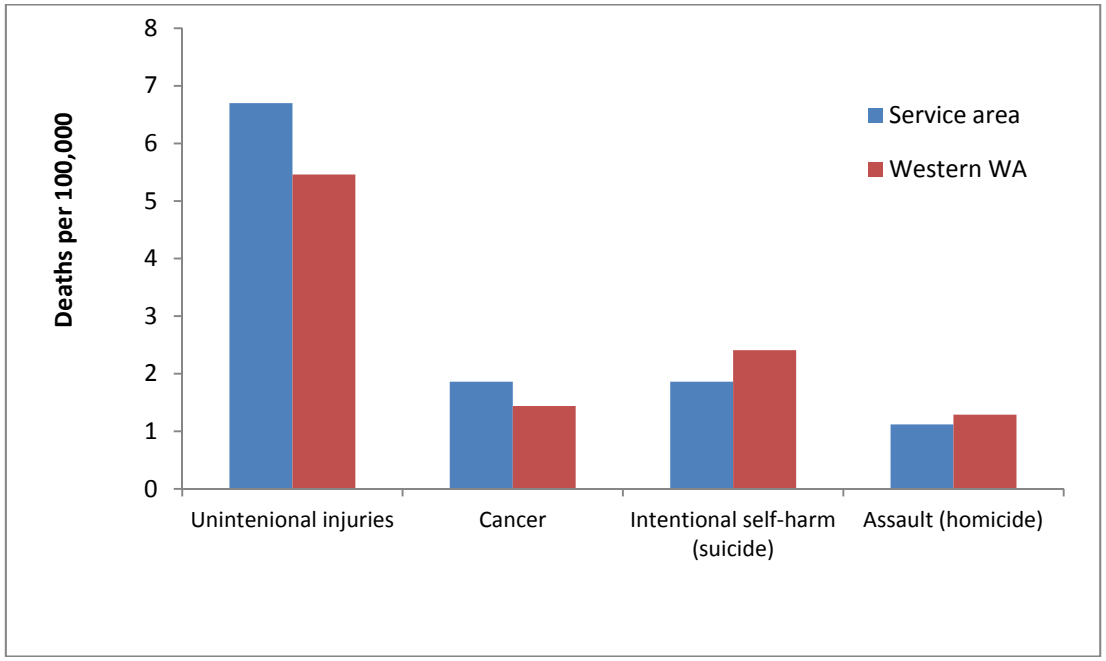


Figure 8 Cause-specific death rates for most common causes, age 1-17 for the Auburn service area, 2007-2009

Source: Washington State Department of Health, Center for Health Statistics, Death Certificate Data

Among adults age 18-64, the rate of death is climbing 1% per year (Figure 9). While in 1990 adult death rate in the service area was substantially lower than that in Western Washington state, 2010 death rates are similar. Cancer, cardiovascular disease and injuries are leading causes of death for this age group (Figure 10).

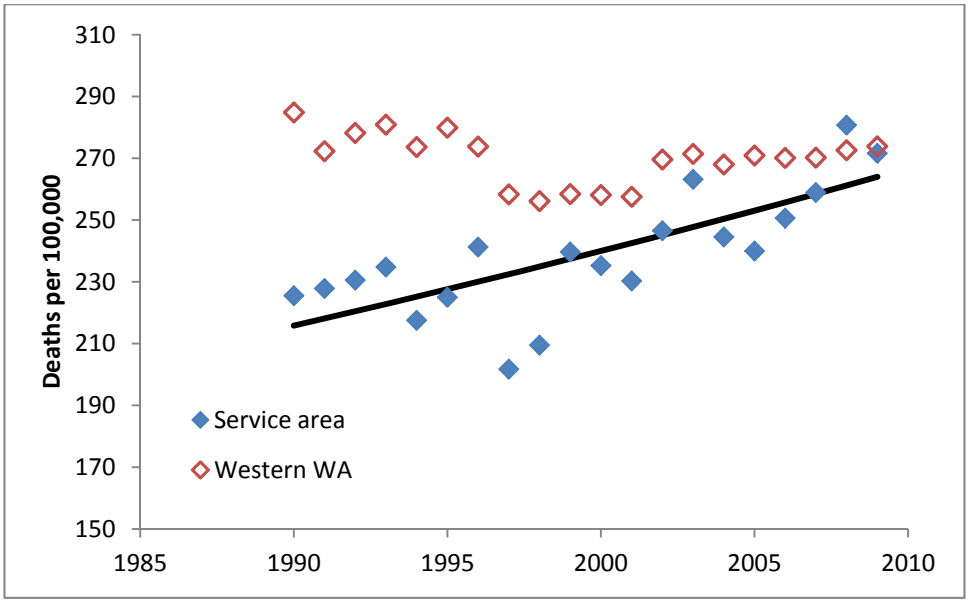


Figure 9 Death rate among persons 18-64 for Auburn service area
Source: Washington State Department of Health, Center for Health Statistics, Death Certificate Data

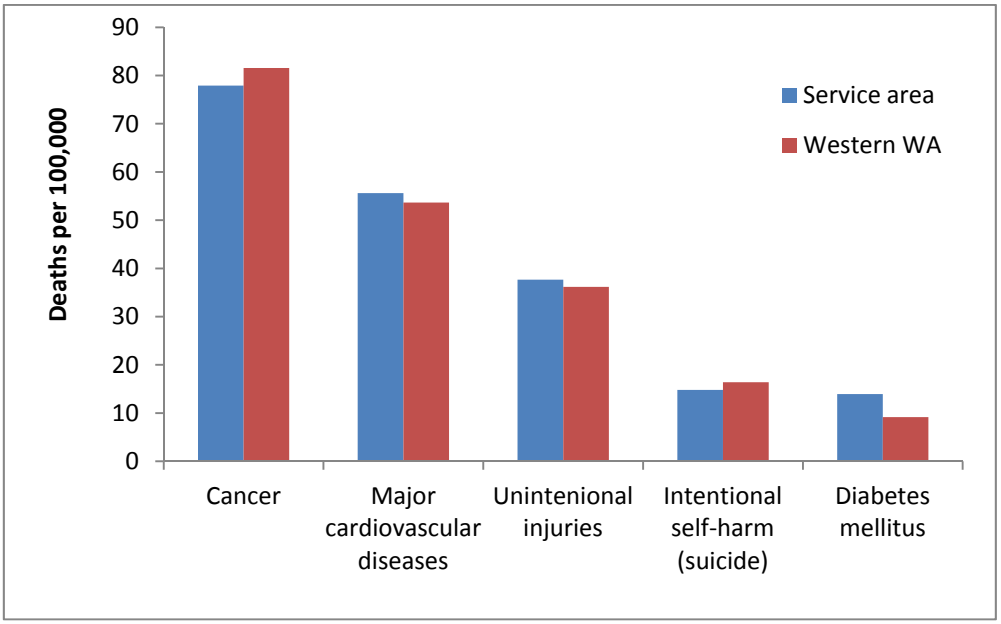


Figure 10 Cause-specific death rates for most common causes, age 18-64 for Auburn service area, 2007-2009
Source: Washington State Department of Health, Center for Health Statistics, Death Certificate Data

For the oldest residents in the service area, the death rate is increasing 1% per year (Figure 11). In contrast, the rate is declining in Western Washington state. Major chronic diseases claim the most lives for this age group (Figure 12). Deaths from cardiovascular disease, cancer, Alzheimer's disease, respiratory diseases and diabetes are more common in the service area than in Western Washington state.

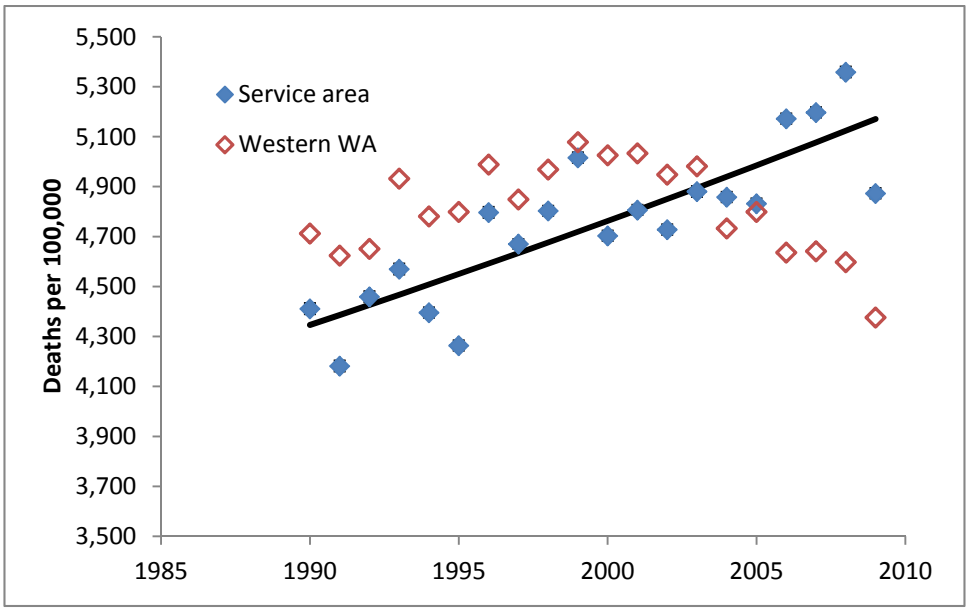


Figure 11 Death rate among persons 65 and older for Auburn service area
Source: Washington State Department of Health, Center for Health Statistics, Death Certificate Data

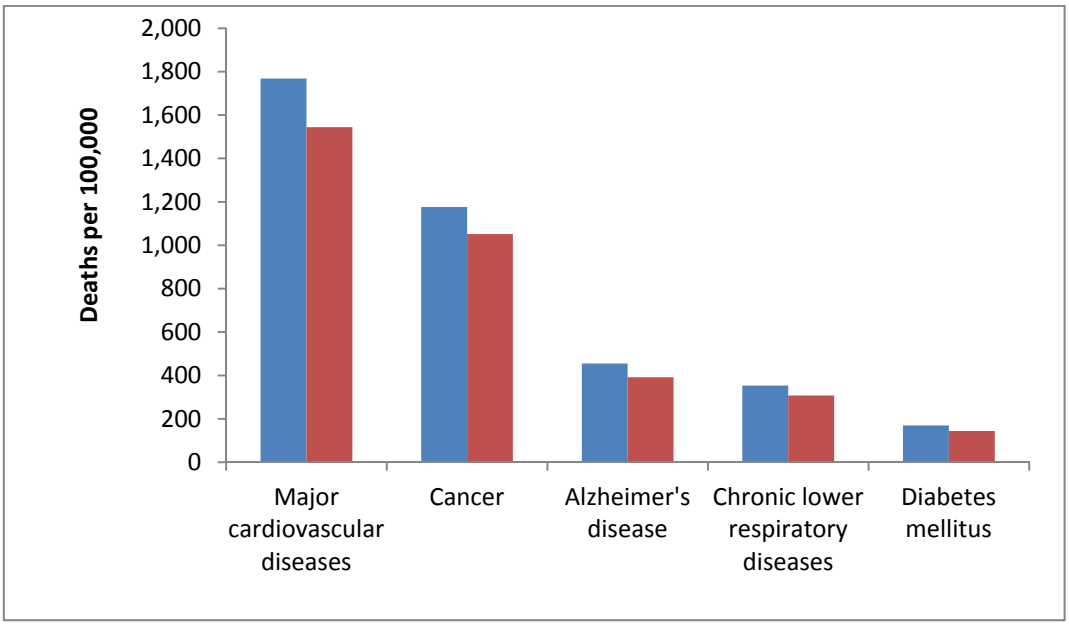


Figure 12 Cause-specific death rates for most common causes, age 65 and older for Auburn service area, 2007-2009
Source: Washington State Department of Health, Center for Health Statistics, Death Certificate Data

Life expectancy is a broad summary measure of population health, calculated from mortality statistics. Life expectancy at birth in the service area is not changing significantly in the service area, but is increasing in Western Washington state (Figure 13). This is resulting in an increasing gap between the service area and the region.

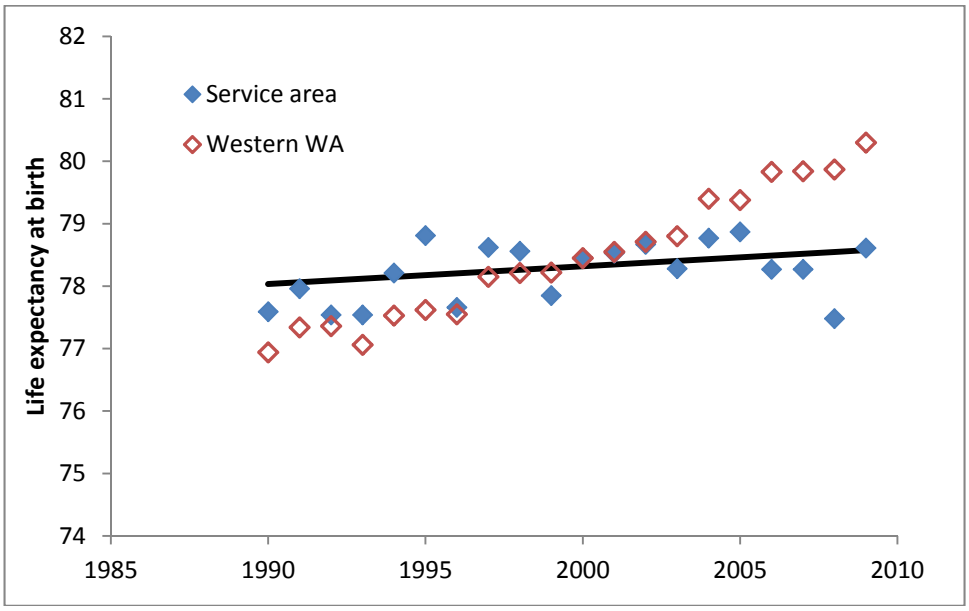


Figure 13 Life expectancy at birth for Auburn service area
Source: Washington State Department of Health, Center for Health Statistics, Death Certificate Data

Access to care

Individuals without health insurance and without a regular provider frequently do not receive needed health care, particularly preventive care. Health care access was lower in the service area than in Western Washington state (Table 3). Nevertheless, cancer screening rates were about the same in both regions.

Table 3 Percent of adults reporting access to health care

	Auburn service area			Western Washington state		
	n	Percent	95% CI	n	Percent	95% CI
Percent of adults 18-64 with health insurance	1202	81.4	77.7-85.1	26,335	86.3	85.6-87.1
Percent of adults with a personal health care provider	1203	73.9	70-77.8	26,321	78.6	77.7-79.5
Percent of women 40-74 with a screening mammogram in last 2 years	246	73.8	66.8-80.8	5335	75.7	74.2-77.3
Percent of adults age 50+ who ever had a sigmoidoscopy or colonoscopy	372	69.4	63.6-75.2	8768	71.8	70.6-73.1

Source: Behavioral Risk Factor Surveillance System, 2009-2010

Community Input

Background

The Tacoma-Pierce County Health Department worked collaboratively with Franciscan Health System and MultiCare Health System to conduct a community health needs assessment that included input from key leaders and community residents representing multiple sectors and population groups in the community. The purpose of this qualitative portion of the community health needs assessment was to hear from the Pierce County and South King County communities about the following five questions:

1. What makes a healthy community?
2. What would a healthy Pierce County look like?
3. What are the strengths, assets and resources of Pierce County?
4. What are the challenges to health in Pierce County?
5. What are the most important health issues that need to be addressed in a community health improvement plan?

Findings

Pierce County Findings

Because the service area for Auburn Medical Center includes the 98391 zip code (which incorporates Lake Tapps, Lakeland Hills and part of Bonney Lake, all in Pierce County), this CHNA includes Pierce County qualitative findings. The population of this zip code is 44,309 (per the decennial census), which is approx. 10% of the service area's total population. Including the qualitative findings allows the reader to align these with the quantitive findings, which were arrived at using data that includes this zip code, as a part of the calculations.

The information from all three data collection methods (see "Community engagement methods") were analyzed, themed and summarized to draw out the most important conclusions. These major findings include:

1. Significant and unique strengths of Pierce County are:
   - Coalitions and collaborations
   - Higher education network
   - Open minds to complementary care
   - Access to local food and farmers markets
   - Volunteer base
   - Faith communities
   - Health care systems
   - Natural assets
   - Arts and humanities

2. Three important factors that most affect the quality of life and health of a community are low crime and safe neighborhoods, good jobs and healthy economy, and good schools.

3. The community problems that have the greatest impact on overall community health are:
    - Substance abuse
    - Behavioral health issues
    - Availability of, and accessibility to, quality medical care and treatment services
    - Chronic diseases (e.g.., diabetes, cancer, heart disease, hypertension)
    - Coordination across systems
    - Addressing the medical care provider shortage
    - Disparities of services for minorities
    - Adult and childhood obesity
    - Needs of military personnel and families
    - Needs of homeless

4. Health improvement planning should focus on strengths, not just deficits.

5. Health improvement planning should consider the mind, body, and spirit.

6. Strengthen the community-based systems in Pierce County that are working to improve health, e.g., community health workers and patient navigators.

King County Findings

The Group Health Research Institute interviewed key informants representing health care, social services and the public in King County. The top themes that emerged from this assessment, as well as representative responses from informants, are included below.

The most frequent themes related to access to care included:

- Primary care (13)
- Mental health (14)
- Dental care (5)
- Health insurance coverage (7)
- Case management (6)
- Health care for youth (5)
- Substance abuse services (4)
- Reproductive health services (3)

The most frequent themes related to social environment included:

- Culturally competent services (17)
- Struggles to take care of basic needs (16)
- The economic downturn (6)
- Trauma and violence (6)

> *We see some of the poorest heath indicators in the county here in [a south King County community]: diabetes, hypertension, asthma, obesity. People see the indicators and assume people don't care about their health, but this is a food desert…It can take two buses to get to a grocery store.*

The most frequent themes related to health behaviors and associated risks included:

- Diabetes (14)
- Obesity (13)

The most frequent themes related to the physical environment included:

- Access to healthy foods (17)
- Resources that support physical activity (13)
- Transportation (5)

> *…just general access and affordable health care and insurance. We also see that preventative health care is lacking in the community, especially for low-income people [from a particular cultural community]. For them, health care is very reactive. Diabetes and prenatal care are disproportionately affecting [this*

Methods

Quantitative data methods

This study uses data from eleven zip codes that represent 75% of inpatients seen at Auburn Medical Center (Figure 1). When possible, we used Western Washington state as a comparison population. This area includes 19 counties west of the Cascade mountain range: Whatcom, Skagit, Snohomish, King, Pierce, Thurston, Lewis, Skamania, Clark, Cowlitz, Wahkiakum, Pacific, Mason, Grays Harbor, Jefferson, Clallam, Kitsap, San Juan and Island counties.

We included six broad indicators of current population health and of future health and health care utilization: demographics, pregnancy and childbirth, health behaviors, mortality and access to health care. These indicate the margin of error for the value estimated. We used Joinpoint regression models to evaluate time trends. Black lines in the figures show trends over time for the service area. Much of the data in this report come from a few key sources. These sources and their limitations are briefly described below.

Selection of Priority Health Needs

Data availability was the primary driver behind which specific measures were included. Thus, important health concerns may have been omitted because reliable data were not available.

We selected priority areas by screening the data elements in the report with respect to four criteria:

- Was a health concern getting worse over time? Were demographic characteristics changing over time?
- Was a health concern significantly worse in the service area than in the comparison area? Were demographic characteristics significantly different in the service area than in the comparison area?
- Were relatively large numbers of people impacted by a health concern?
- Was a health concern repeatedly voiced in community meetings and focus groups?

We then selected health concerns (or demographic factors) that met two or more of these criteria as possible priority needs. Although it is objective, this approach has many limitations. Different selection criteria might have resulted in a different list of priority areas. Trend data were not included for all measures in the report, so some measures had more opportunity to score on the rubric than others. Data about disease prevalence and about health behaviors were at a disadvantage in this regard. The decision about whether large numbers of people were impacted was a relative judgment based on our experience and knowledge, not on a numeric threshold. Finally, the rubric identifies problem areas, but not solutions. For some problem areas, solutions may be unknown or impractical. For these reasons, we view the list of priority needs as a starting point for discussion, not a definitive short list requiring action.

Behavioral Risk Factor Surveillance System

The Behavioral Risk Factor Surveillance System (BRFSS) is an ongoing national telephone survey conducted by the Centers for Disease Control and Prevention. The survey includes adults age 18 years and older and provides state- and county-level data for each calendar year. Topics are wide ranging and include disease prevalence, health care access and use, health behaviors and demographics. There are several biases inherent to BRFSS. First, cell phone-only households are excluded. These households tend to be younger and poorer than households with landlines. Second, BRFSS excludes people in institutions such as Medical Centers and nursing homes and so may underreport responses from people who are ill or in poor health. Third, data are self-reported and so are subject to social desirability bias and recall error. Finally, BRFSS is conducted in English and Spanish, and so under-reports responses from speakers of other languages.

Healthy Youth Survey

This school-based survey is administered in even numbered years throughout Washington state. The survey includes grades 6, 8, 10 and 12. For this report, we included data from schools that were physically located in the service area, recognizing that this may include responses of students residing outside the service area and exclude information about students living in the service area but attending school elsewhere. Topics include health risk behaviors, family, community risk and protective factors, and current health conditions. Like other self-reported survey data, it is subject to social desirability bias and recall error.

Death certificate data

For death certificates, funeral directors collect information about the deceased person, including race and ethnicity, from an informant who is usually a family member or close personal friend of the deceased person. A certifying physician, medical examiner, or coroner generally provides cause-of-death information. Cause-of-death data come from underlying causes of death and not immediate causes. For example, if a person dies of a complication or metastasis of breast cancer, breast cancer would be the underlying cause of death. Data are compiled by the Washington State Department of Health, Center for Health Statistics.

Birth certificate data

The birth certificate system contains records on all births occurring in the state and nearly all births to residents of the state. Information is gathered about the mother, the father, the pregnancy, and the child. The information is collected in Medical Centers and birth centers from worksheets completed by parents or medical staff, from medical charts, or by a combination of these sources. Midwives and family

members who deliver a baby complete the birth certificate and collect the information from a parent or from their records. Data are compiled by the Washington State Department of Health, Center for Health Statistics.

American Community Survey
The American Community Survey (ACS) is a mailed survey conducted every year by the U.S. government to estimate a wide variety of social and economic data for the U.S. population. The ACS replaces the long form of the census for collecting detailed population data and has the advantage of being released annually rather than at 10-year intervals. ACS location of residence is based on census tracts, which don't align with zip code boundaries. A census tract was considered to be in the Medical Center service area if the centroid of the census tract was within the service area.

Decennial United States Census
The census, unlike other surveys, includes responses from the entire population, not just a representative sample. And unlike the ACS, census data are available by zip code. The census collects limited demographic information (age, sex, race, ethnicity, family and housing).

Community engagement methods

The Health Department worked collaboratively with Franciscan Health System and MultiCare Health System to conduct a community health needs assessment that included input from key leaders and community residents representing multiple sectors and population groups in the community. The needs assessment included a Pierce County community survey and a comprehensive community engagement process, as well as incorporating findings from previous South King County key informant interviews conducted by Group Health Cooperative.

Pierce County Community Survey
In December 2011, the Health Department commissioned the Pierce County Community Study, conducted by the Gilmore Research Group in Seattle. More than 500 Pierce County residents were surveyed; 384 (73%) via the internet, 100 (19%) from phone calls and 41 (8%) via intercept surveys conducted at several Pierce County food banks. The Community Study sought Pierce County residents' views on issues related to health care, economic opportunity, important health issues, and issues that impact community health.

Community Engagement Process
To complement the community survey, a community engagement process was implemented to further solicit input from the Pierce County public. This process included three stages:

1. Hold key leader focus groups to gain input on main questions, listening for top themes;
2. Hold community workshops, listening for important health issues in Pierce County; and
3. Invite key leaders to reflect on qualitative and selected quantitative data.

Focus groups utilized the "world cafe" meeting format to allow participants the opportunity to share their observations and reflections. Groups were facilitated by Karen Meyer, Community Liaison Specialist with the Health Department. A key element in all three parts of the community engagement process was the use of a visual (or graphic) facilitator. This allowed for comments to be captured immediately. Furthermore, by utilizing a graphic recorder, all participants were able to be engaged in the

process. If participants provided an email address, they received a copy of the meeting map; thus, building momentum and keeping them engaged in the process. In addition, participants were encouraged to suggest any corrections they felt were necessary.

Key leader focus groups

A series of four key leader focus groups (32 participants) were held in October and November 2012 to solicit input on the strengths, assets and resources, as well as health priorities for Pierce County. Key leaders represented multiple sectors, including local government, education, business, social and health services, and the military. Meetings were held in Puyallup, at the University of Washington-Tacoma, at the Sea Mar Health Clinic (Tacoma) and with the leadership group from the Pierce County Cross Cultural Collaborative.

Community workshops

Seven community workshops were held between December 2012 and January 2013 in Puyallup, Gig Harbor, Tacoma, Bonney Lake, and Lakewood, as well as with the Pierce County Cross Cultural Collaborative. Approximately 80 Pierce County residents attended the community workshops, which were broadly advertised through local print, radio and television media (including on-line) and with multiple community partners.

Participants were asked to consider the challenges to health in Pierce County. After thinking about challenges, participants were asked to address the following, working in small groups:

- Which priorities have the greatest impact (i.e., impact the greatest number of Pierce County residents)?
- Which priorities allow for greatest equity?
- Which priorities are we most ready to address?

Key leader review meeting

Finally, the assessment process involved inviting key leaders (see above definition) to meet again in January 2013 at the Health Department to review the results of the previous community input, as well as some relevant quantitative data. During this meeting, attendees were asked to work in small groups and share their reflections on the data presented, their impressions of the common threads, and to consider what might be missing in terms of health issues that should be included in a community health improvement plan going forward.

King County key informant interviews

The Center for Community Health and Evaluation (CCHE), part of Group Health Research Institute, was asked to conduct the 2012 needs assessment for Group Health Cooperative. In early 2012 CCHE interviewed 23 key informants representing health care, social services and the public in King County. Questions addressed the health-related needs of the South King County population, programs and services intended to address those needs, methods for assessing needs, and methods for monitoring outcomes. Group Health Cooperative gave the Health Department permission to include their findings in this community health needs assessment report.

Conclusion

Nonprofit health care organizations are expected to contribute to overall health in the communities they serve. A systematic approach to assessing community needs can help shape the community benefit strategies developed to meet those needs. The 2010 Affordable Care Act defines explicit expectations for community health needs assessments, such as gathering input from persons who represent the broad interests of the community – including public health—and considering the needs of the most vulnerable populations. The development of this report has attempted to represent the broad interests of the community, per the 2010 Affordable Care Act.

This report can – *and should* – provide strategic guidance to MultiCare Health System going forward regarding the most important health needs of the Pierce County community. As such, the "call to action" for planners and decision makers is as follows:

- Prevention and treatment of cardiovascular disease
- Prevention of obesity (children and adults)
- Prevention and treatment of cancer
- Addressing cultural diversity in healthcare delivery
- Prevention of preterm births
- Addressing the needs of an aging population
- Providing for the specific needs of low-income residents
- Prevention and cessation services for adult smoking
- Prevention and treatment of mental illness, including suicide prevention
- Reducing diabetes prevalence and comprehensive services for diabetic patients
- Sufficiency of primary care providers to allow a medical home for all residents, including the uninsured

MultiCare Health System Program Inventory (Adult and Pediatric Services)

Focus 1: CHRONIC DISEASE

CARDIOVASCULAR DISEASE

PROGRAM	DESCRIPTION
CARDIAC HEALTH & REHABILITATION	A physician-referred comprehensive approach for improving and maintaining cardiovascular health. Weekly sessions include monitored exercise, relaxation and stress management techniques, nutrition education and other classes on cardiovascular health.
CHEST PAIN CENTER	The Chest Pain Centers at MultiCare Good Samaritan Hospital and MultiCare Tacoma General Hospital are two of only six facilities in Washington to be nationally accredited by the Society of Chest Pain Centers. The center is designed to provide diagnosis and treatment within the "Golden Hour" after heart attack symptoms appear. Treatment provided within this one-hour window greatly increases chances of full recovery.
DIABETES & CARDIAC CARE COMMUNITY OUTREACH	Outreach services provide underserved communities with free blood pressure and glucose screenings.
HEART CHECK SCREENING	Offers a comprehensive look at an individual's personal risk for heart disease. It includes a personalized consultation, risk assessment and basic lab tests. Based on these test results, patients are advised on next steps, such as seeking medical treatment or making lifestyle changes.
HEART FAILURE CLINIC	Offers testing, education and support for those suffering from heart failure, or those who are deemed to be at risk. Patients receive testing to determine how well their heart is working, as well as counseling and education on medication, diet, exercise and other lifestyle choices that can help a patient's quality of life.
HEART FAILURE COLLABORATIVE	System-wide heart-failure-focused group that exists to guide seamless evidence-based care to heart failure patients across the care continuum.

HEART HOSPITAL	The Heart Hospital at MultiCare Tacoma General Hospital is home to the highest level of cardiovascular care available in the region. Cardiac and vascular services are offered in one location, providing patients with better connected care. The heart hospital includes cardiac and vascular operating suites, digital cardiac catheterization labs, new cardiovascular intensive care and coronary care units, and a chest pain cardiovascular short stay unit.
INTEGRATED CARDIAC AND DIABETES SERVICES	Offers early intervention for those with pre-diabetes, and medical care, support and education for people with diabetes.
MULTICARE REGIONAL HEART & VASCULAR CENTER PREVENTIVE CARDIOLOGY DEPARTMENT	MultiCare Regional Heart & Vascular Center offers a number of resources, classes, screenings and events to help men and women reduce their risk of heart disease and live a heart-healthy lifestyle.
WEIGHT LOSS AND WELLNESS PROGRAM	A specialized therapeutic lifestyle change program that targets the underlying causes of chronic disease by improving diet, activity and stress management.

CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD)

COPD FOCUS PROGRAM	Aims to help decrease 30-day hospital readmission rates through the use of additional patient education, instruction on disease self-management techniques, as well as increased touch points (phone calls and in-home visits) for patients with a diagnosis of chronic lung diseases, such as Chronic Obstructive Pulmonary Disease (COPD), through the use of respiratory therapists.
MULTICARE PULMONARY CARE CLINICS	Comprehensive services for patients with illnesses that affect the lungs and breathing. Pulmonary and critical care clinical services encompass a variety of disease states, including ambulatory pulmonary and sleep medicine, inpatient pulmonary and critical care medicine.
MULTICARE PULMONARY SPECIALISTS	A multi-physician group and experienced research team, comprising board-certified pulmonologists.
TOBACCO CESSATION	See Tobacco Use Program Inventory.

DIABETES, TYPE 2

CHRONIC DISEASE MANAGEMENT PROGRAM DIABETIC CASE MANAGER	Arranges care for diabetic patients who do not have a diabetes care plan after being discharged from the emergency department or hospital.
DIABETES & CARDIAC CARE COMMUNITY OUTREACH	Outreach services provide underserved communities with free blood pressure and glucose screenings.

DIABETES SERVICES Individual appointments are available for children and adults with diabetes (type 1 and type 2), those who require insulin pump therapy, pregnant women with pre-existing diabetes or gestational diabetes. For individuals whose blood sugar is in the pre-diabetes range, diabetes educators offer early intervention to teach individuals how to modify behavior and prevent the onset of diabetes.

SOUTH SOUND DIABETES SUMMIT A partnership with Novo Nordisk and other community partners to offer a free community diabetes education event with screenings.

YMCA DIABETES PREVENTION PROGRAM Based on the Diabetes Prevention Program, a national study that showed lifestyle changes (diet and exercise) can prevent the development of diabetes. The YMCA offers a 16-week program to decrease the risk of diabetes through promoting healthy weight management, increasing activity and improving nutrition in a friendly group environment.

ASTHMA

ASTHMA AND PULMONARY PROGRAM AT MULTICARE MARY BRIDGE CHILDREN'S HOSPITAL Provides comprehensive evaluation, testing and treatment for children with asthma and other pulmonary disorders. The program has a multidisciplinary team of specialists that includes pediatric pulmonologists, pediatric allergists, respiratory nurse specialists, respiratory therapists, dieticians, social workers and psychologists.

ASTHMA EDUCATION PROGRAM MultiCare Mary Bridge Children's Health Center helps families take charge of asthma with its Asthma Education Program. The program provides an opportunity for children and families to learn how to cope with their asthma and increase their awareness, confidence and self-management skills.

OTHER SERVICES RELATED TO CHRONIC DISEASE

CHRONIC DISEASE SELF-MANAGEMENT PROGRAM Services for chronic disease patients, including home monitoring and self-care skills.

HOME HEALTH This program is designed to help patients manage a wide range of medical conditions while ensuring their safety and fostering independence. The Home Health team includes nurses, physical, speech and occupational therapists, social workers and home health aides.

TRANSITIONS CARE MANAGEMENT PROGRAM	Gives patients with chronic disease a connection between the hospital and their outpatient care and community providers. They assist with follow-up care by initiating in-home visits; identifying barriers to compliance; educating patients on follow-up care resources and solidifying follow-up appointments with primary care providers, specialty providers, laboratories and pharmacies.
MULTICARE HEALTHWISE AND KIDS HEALTH LIBRARY	Free online resources that provide information about a wide range of health topics, from common childhood medical conditions and problems to managing complex chronic diseases.

Program Inventory – **Focus 2: Obesity**

BREASTFEEDING CLASSES	Breastfeeding classes are offered to provide information on the benefits and the "how to" of breastfeeding. Suggestions for overcoming common difficulties and strategies for working and breastfeeding are covered.
CHILDBIRTH SERIES	A comprehensive class covering pregnancy, birth, comfort techniques, medications for birth, cesarean birth, postpartum, breastfeeding and newborn care.
COMMUNITY OUTREACH TO DIVERSE COMMUNITIES	Provides prevention, education, blood pressure screenings and sports physicals at area community events that reach out to underserved communities. Partnerships include: Health Coalition for Communities of Color (C3), Cross Cultural Collaborative, Northwest Leadership Foundation, Latino Action Group, Ebony Nurses and other area coalitions.
CENTER FOR HEALTHY LIVING NUTRITION SERVICES	Registered dietitians with expertise in sports nutrition and weight management offer weight management services including assessments, menu planning and one-on-one and/or group counseling sessions to help families make healthy changes.
CENTER FOR HEALTHY LIVING WEIGHT MANAGEMENT SERVICES	Services include one-on-one nutrition counseling, body fat testing, metabolic rate testing, Biggest Winner Series programs and monthly nutrition talks.
CENTERS OF OCCUPATIONAL MEDICINE	Provides occupational health services for both patients and employers in Pierce and South King counties.
DO SOMETHING HEALTHY	An annual celebration of health and wellness event with free community screenings (blood pressure, cholesterol, BMI, waist/hip circumference, body fat). A celebrity guest speaker encourages and motivates the community to take action for their own personal health. (Average reach is 1,000 people/year).
HEALTHY@WORK CORPORATE WELLNESS PROGRAM	Healthy@Work is well-known for its popular, low-cost health education and prevention programs. Healthy@Work brings proven, effective, community-based programs to businesses and their employees.

HEALTHY@WORK EMPLOYEE WELLNESS PROGRAM

Healthy@Work Employee Wellness Program offers a variety of tools and activities to help MultiCare employees make wellness a way of life. The goal of the program is to improve employee health with nutrition and stress management workshops, physical activity challenges, online tools and more. Employees can save money on their annual health insurance premiums by completing the program.

KIDS IN THE KITCHEN

A program for kids in grades four through seven to teach them about nutrition while cooking up kid-friendly recipes.

MILLION MINUTE MISSION

An online physical activity tracking contest for individuals and company teams raising awareness in the community of the importance of physical activity. Participants are asked to track and log their minutes of physical activity online. The top three companies are recognized at the Roman Meal Sound to Narrows Walk/Run event.

MILLION MINUTE MISSION SCHOOL CHALLENGE

An online physical activity tracking contest for individuals and company teams raising awareness in the community of the importance of physical activity. Participants are asked to track and log their minutes of physical activity online. The top three schools are recognized at the Roman Meal Sound to Narrows Walk/Run event.

PIERCE COUNTY GETS FIT & HEALTHY

A partnership between MultiCare, the YMCA of Pierce and Kitsap Counties and the Tacoma-Pierce County Health Department to promote health and wellness through online nutrition and physical activity programs and an annual community event focused on health.

PEDIATRIC WEIGHT AND FAMILY WELLNESS PROGRAM

A program designed for ages 6-17 that provides access to specialists and health care professionals who can provide expertise in helping families make healthy changes. The program's holistic approach can result in lasting improvements in a child's health and quality of life. If a child's BMI is greater than 85% and he/she has other health problems, or his/her BMI is greater than 95%, the child may benefit from an In-Depth Medical Assessment and participation in the Family Wellness Program.

POWERCOOK

Class that teaches participants how to prepare and freeze 30 nutritious meals. Participants sample finished dishes and take home a free booklet filled with a month's worth of healthy and easy-to-prepare recipes (nutritional analysis included).

READY, SET, GO! 5210

A countywide initiative supported by MultiCare Mary Bridge Children's Hospital, YMCA of Pierce and Kitsap Counties, the Tacoma-Pierce County Health Department, United Way of Pierce County, Franciscan Health System, Boys & Girls Club and many other organizations to combat childhood obesity by promoting healthy life choices for children, youth and families. RSG 5210 delivers a simple, unified message and framework that the community can embrace. The name sums up four key healthy lifestyle recommendations:

- 5 or more fruits or vegetables a day
- 2 hours or less of recreational screen time a day
- 1 hour or more of physical activity per day
- 0 sugary drinks – increasing low-fat milk and water consumption

SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM & EDUCATION (SNAP-ED)

The SNAP-Ed program's goal is to improve the likelihood that persons eligible for food assistance will make healthy food choices within a limited budget consistent with the current Dietary Guidelines for Americans and MyPyramid.

TACOMA-PIERCE COUNTY HEALTH DEPARTMENT'S COMMUNITY TRANSFORMATION PARTNERSHIP (TPCHD-CTP)

TPCHD-CTP supports public health efforts to reduce chronic diseases, promote healthier lifestyles, reduce health disparities and contain health care spending. The prevention grant focuses on four priority areas: tobacco-free living, active living, healthy eating and expanding medical services to prevent and treat chronic diseases. The Tacoma-Pierce County Health Department and its partners (MultiCare Health System, Franciscan Health System, YMCA of Pierce and Kitsap Counties, Metro Parks Tacoma, Gig Harbor and Tacoma school district board members, Boys & Girls Club and others) have developed a comprehensive plan to increase resources for tobacco use prevention, decrease the number of youth who smoke, increase the availability of healthier food choices in the community and in schools, increase opportunities for physical activity and partner with medical providers to expand chronic disease prevention services.

WEIGHT LOSS AND WELLNESS

A specialized therapeutic lifestyle change program that directly targets the underlying causes of chronic illness by incorporating a sensible eating plan, exercise and stress management.

WHOLE, FRESH, LOCAL NUTRITION SERVICES PROGRAM

Healthy food choices are featured in MultiCare Health System's cafeterias and cafés, along with promotion of RSG 5210 healthy food choices.

WOMEN, INFANTS & CHILDREN (WIC)

Provides nutritious foods, plus other benefits, free of charge to eligible families. Services offered at the 11 MultiCare WIC sites in Pierce County include nutritional and breastfeeding support, as well as tips on keeping mothers and their families healthy.

Program Inventory – **Focus 3: Tobacco Use**

CLEAN AIR COMMITTEE The Clean Air Committee supports a tobacco-free policy by providing support and oversight to the program. This committee meets quarterly to address tobacco cessation needs within our community and supports events such as the Great American Smoke Out and QuitSmart classes.

CLEAN AIR FOR KIDS HOME ENVIRONMENTAL ASSESSMENT A Do-It-Yourself assessment to help families identify indoor air pollutants and develop an action plan to alleviate the problems.

HEALTHY@WORK EMPLOYEE WELLNESS PROGRAM – QUITSMART Offered to MultiCare employees with additional one-on-one support through a Wellness Coach.

TOBACCO-FREE ALLIANCE OF PIERCE COUNTY (TAP) Dedicated to improving the health of Pierce County residents by reducing tobacco use. Members including MultiCare, other non-profit organizations, schools, businesses, health care organizations and public agencies. The Alliance's mission is to create community collaborations and networks empowered to promote the prevention of youth tobacco use, tobacco cessation and protection from secondhand smoke.

TOBACCO-FREE WORKPLACE Smoking policy to reduce exposure and access to tobacco on all MultiCare Health System properties.

TOBACCO PREVENTION NETWORK (TPN) Works to provide a non-smoking environment throughout the public housing system by assisting housing authorities and landlords who administer Section 8 vouchers. TPN's goals are to adopt and implement no-smoking policies and connect residents with smoking cessation programs.

TOBACCO USE PHYSICIAN ELECTRONIC VISITS E-visits for patients via MyChart, MultiCare's secure online patient portal.

QUITSMART A free, web-based tobacco cessation series with optional phone support. The 8-week program is designed to teach behavioral skills to help one successfully quit for good.

Program Inventory – **Focus 4: Behavioral Health**

ADULT DAY HEALTH Through this community-based program, adults with physical and developmental disabilities receive therapy services, socialization opportunities and adaptive living skills training to help maintain independence.

ADULT SERVICES Provides care for adults with severe and long-term mental illness based on each individual's unique strengths and preferences. This holistic approach forms the foundation for individuals to achieve stability, overcome significant challenges and restore hope and personal pride.

ASIAN COUNSELING SERVICES (ACS)	Behavioral health clinic primarily serving the Asian/Pacific Island refugee and immigrant communities. ACS has been providing bilingual services for people from Cambodia, Korea, Vietnam and the Pacific Islands since 1985. Specialized, culturally competent and sensitive services are available for people of all ages.
BEHAVIORAL HEALTH HIGH ED UTILIZATION	Identifying patients with the highest Emergency Department utilization rates and providing treatment in a more functional way.
BEHAVIORAL HEALTH NETWORK (BHN)	A program that runs parallel with the managed Medicaid program. Molina identifies their high-cost, high-risk patients and BHN assists with their care transitions.
BRIDGES	A grief support service serving families with children ages 4 through 18 who have experienced the serious illness or death of a family member, relative or friend. Peer support groups are facilitated by trained volunteers.
CELEBRATE SENIORITY	A MultiCare program that actively supports members 55 and better through healthy activities and community connection.
CHEMICAL DEPENDENCY SERVICES	Chemical dependency assessments and outpatient treatment at two locations (MultiCare Good Samaritan Behavioral Health and MultiCare Allenmore Hospital). Counseling services provided with emphasis on motivational enhancement, cognitive-behavioral therapy and community self-help support. Screening, referral, deferred prosecution, intensive groups and aftercare are offered.
CHILD ABUSE INTERVENTION DEPARTMENT AT MULTICARE MARY BRIDGE CHILDREN'S HOSPITAL	Provides medical treatment, psychosocial support, legal advocacy and crisis intervention services for victims of child abuse and their families. Staff also provide strategies for Pierce County parents and the community to prevent child abuse through free programs such as the Children's Advocacy Center of Pierce County, Parenting Partnership and the Sexual and Physical Assault Intervention Program.
CHILD AND FAMILY SERVICES	Child Behavioral Health Specialists work with families, teens and children in a team-based approach. Collaborative care planning that focuses on getting back on track and achieving life goals. Evidence-based treatment, cultural and age-appropriate.
CHILDREN'S THERAPY UNIT (CTU) PSYCHOLOGY SERVICES	Psychologists and therapists offer a full range of individual and family therapy for clients (birth - 18 years) with neuro-developmental disorders, as well as offering traditional behavioral health services for children and teens. The staff at CTU has expertise in working with clients with autism spectrum disorders, cognitive delays and atypical neurological presentations.
COMPREHENSIVE PEDIATRIC DEVELOPMENTAL SERVICES	Provides evaluations, treatment plans, therapy and case management for children with special health care needs.

CRISIS INTERVENTION	Assists patients through behavioral health or psychosocial crises. Also responds to critical care units when there is a code or a patient death. Facilitate the transfer of patients to the community.
DEMENTIA CARE AND CAREGIVER SERVICES	Eldercare services are offered to older adults and their family caregivers who face the daily challenges associated with caring for their loved ones with dementia. Services are designed to help reduce caregiver stress, increase knowledge about the dementia process and skills to care for the challenging behaviors, improve health and well-being for the family.
DOMESTIC VIOLENCE SURVIVOR'S SERVICES	Grant-funded for survivors of domestic violence. Four individual counseling sessions are provided, free of charge, as well as weekly support groups.
GERO-PSYCHIATRIC INPATIENT SERVICES	A 38-bed geriatric psychiatric inpatient unit at Multicare Auburn Medical Center.
HEROS (HELPING ELDERS THROUGH REFERRAL & OUTREACH SERVICES)	HEROS provides services to adults aged 60 and older, who may be isolated, lack family support, be resistant to help or may not know how to find help to keep them safe and healthy.
INTEGRATED BEHAVIORAL HEALTH	MultiCare Good Samaritan Behavioral Health provides a full spectrum of behavioral health services integrated with primary care for adults and children.
INTENSIVE CASE MANAGEMENT AND PEER SUPPORT	An extension of our High Emergency Department Utilizer Program, this program provides intensive case management and intervention services to high-risk people who have chronic behavioral heath conditions or other complex psychosocial issues.
LUCKETT HOUSE	An assisted living community for behavioral health patients.
MOBILE OUTREACH CRISIS TEAM (MOCT)	A county-wide behavioral health crisis response team providing crisis intervention services as well as involuntary detainment investigations and placement in inpatient psychiatric services. Also offers 24-hour behavioral health crisis phone line.
MOBILE INTEGRATED HEALTH CARE	A mobile program that provides primary care services to adults with severe and long-term behavioral health conditions.
OLDER ADULT SERVICES	Provides a variety of programs and services for adults aged 60 and older who are experiencing emotional problems, behavioral disturbance, and/or difficulty coping with age-related changes.
PARENTING PARTNERSHIP	Home visitation program for medically fragile infants in high-risk homes. Support provided to enhance positive parenting attachment with the goal of decreasing the risk of maltreatment for a vulnerable population.
PERIOD OF PURPLE CRYING CAMPAIGN	An effort to reduce the increasing incidence of abuse and Shaken Baby Syndrome. The goal is to educate parents about infant crying and to equip them with tools to help cope with their baby's crying.

PIERCE COUNTY RESPONSIVE CARE COORDINATION PROGRAM (RCCP)	A community-based care transitions program for all six hospitals in Pierce County. Pierce County is contracted through the Centers for Medicare and Medicaid to run this program, of which MultiCare is a partner. The goal is to improve quality of patient care and reduce 30-day hospital readmission rates among the target population from 21 percent to 12 percent, or lower.
PRIMARY CARE BEHAVIORAL HEALTH INTEGRATION	Licensed behavioral health counselors at select MultiCare clinics provide behavioral health counseling for patients in primary care settings. This program is in the early stages of development.
PRISM	A confidential support group for LGBTQ youth ages 14-21 offering a safe place to socialize, get support and discuss life issues.
PROGRAM FOR ASSERTIVE COMMUNITY TREATMENT (PACT)	Specialized behavioral health approach for adults with persistent mental illness and history of poor response to traditional outpatient treatment.
PSYCHIATRIC MEDICAL CONSULTATION SERVICES	Provides psychiatric consultation services for all of MultiCare's hospitals.
PUYALLUP FAMILY SUPPORT CENTER	The Puyallup Family Support Center works to encourage positive parenting skills and build healthy families. Family support workers offer home visits and encouragement to parents to help them build on the strengths of their family.
PUYALLUP FAMILY SUPPORT SERVICES	Offers skills and support to help build healthy families and encourage positive parenting skills, working together with parents, schools and the community to strengthen families with children of all ages, at no cost to families.
PUYALLUP VALLEY INSTITUTE	A division of MultiCare Good Samaritan Behavioral Health that provides counseling and psycho-therapeutic services to adults, children and families for a wide range of behavioral and emotional problems, including marital and family problems, adjusting to life changes, stress management, depression, anxiety, grief and loss, and work- or school-related problems.
RESIDENTIAL SERVICES	Residential treatment for individuals with chronic and serious mental illness. Shared housing resources for individuals with serious mental illness that offer various levels of autonomy.

Program Inventory – **Focus 5: Cultural Diversity**

COMMUNITY OUTREACH TO DIVERSE COMMUNITIES

Provides prevention, education, blood pressure screenings and sports physicals at area community events that reach out to underserved communities. Partnerships include: Health Coalition for Communities of Color (C3), Cross Cultural Collaborative, Northwest Leadership Foundation, Latino Action Group, Ebony Nurses and other area coalitions.

MULTICARE TACOMA FAMILY MEDICINE AND EAST PIERCE FAMILY MEDICINE

Provide high-quality, family medicine education for medical residents, who in turn provide comprehensive care for low-income and underserved patients in a primary care clinic setting.

Appendix 3

Community Health Needs Assessment (CHNA) and Implementation Strategy

Key Community Leaders Involved in Prioritizing Health Needs in King County*

Name	Title	Entity
Antoinette Angulo	Preventive Health Services Director	Sea Mar Community Health Centers
Jason Berry	Executive Director	YMCA: Auburn Valley
Colleen Brandt-Schluter	Human Services Manager	City of SeaTac
Richard Brooks	Executive Director	Renton Area Youth & Family Services
Kevin Brown	Director	King County Parks & Recreation
George Cargill	VP, NW Field Operations	TriWest Health Care Alliance
Greg Dootson	Area Director	Lutheran Community Services International Counseling and Community Services
Susan Eidenschnik	Member	League of Women Voters
Ralph Forquera	Executive Director	Seattle Indian Health Board
Mandi George	Program Director, Chronic Disease Prevention	YMCA: Chronic Disease Management
Gretchen Hansen	Health Advocate Coordinator	Comprehensive Health Education Foundation
Terry Higashiyama	Director, Community Services	City of Renton
Pramila Jayapal	Executive Director	One America
Blishda Lacet	Program Director, Communities Putting Prevention to Work (CPPW)	Public Health - Seattle & King County
Dave Leibman	Commander	Renton Police Department
Miguel Maestas	Associate Administrator	El Centro de la Raza
Jane Moore, MD	Physician	Washington Coalition for Promoting Physical Activity

* Provided by Tacoma-Pierce County Health Department as a component of the CHNA report

Key Leaders Continued

Name	Title	Entity
Alice Park	Project Manager	King County Food and Fitness Initiative
Jennifer Ramirez-Robson	Executive Director	NewFutures
Peter Retztagg	Executive Director	Community for Youth
Cheryl Shaw	Executive Director	Susan G. Komen For the Cure, Puget Sound
Joan St. Clair	Deputy Director	Asian Counseling and Referral Services
Adam Taylor	Project Manager	Global to Local
Jeff Wagner	Mayor Pro-Tem	City of Covington
Ken Weinberg	Chief Executive Officer	Jewish Family Services Refugee and Immigrant Service Centers
Chelene Whiteaker	Policy Director, Member Advocacy	Washington State Hospital Association
Christopher Williams	Superintendent	Seattle Parks and Recreation (Pools Division)
Nancy Wyatt	President and CEO	Auburn Area Chamber of Commerce
Lisa Yohalem	Chief Strategy and Development Officer	HealthPoint
Abbie Zahler	Community Advocacy Supervisor	International Community Health Services

Public Health Professionals Involved in the CHNA

King County

Anna Markee	Health Reform Project Manager Policy, Community Partnerships, and Communications	Public Health - Seattle & King County
Marguerite Ro, DrPH	Chief Assessment, Policy Development and Evaluation	Public Health - Seattle & King County
David Solet, PhD	Epidemiologist III Assessment, Policy Development and Evaluation	Public Health - Seattle & King County
Eva Wong, PhD	Epidemiologist II Assessment, Policy Development and Evaluation	Public Health - Seattle & King County

Pierce County

Anthony L-T Chen, MD, MPH	Director of Health	Tacoma-Pierce County Health Department (TPCHD)
Cindan Gizzi, MPH	Manager, Office of Assessment, Planning,& Improvement	Tacoma-Pierce County Health Department (TPCHD)
Karen Meyer, BS	Community Liaison Specialist	Tacoma-Pierce County Health Department (TPCHD)
Elizabeth Pulos, PhD, MPH	Epidemiologist	Tacoma-Pierce County Health Department (TPCHD)

MultiCare Health System

Allenmore Hospital
Auburn Medical Center
Good Samaritan Hospital
Mary Bridge Children's Hospital
Tacoma General Hospital
MultiCare Clinics

MultiCare

BetterConnected