2016 Community Health Needs Assessment and Implementation Strategy

MultiCare Auburn Medical Center

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Our Commitment to Our Community

The 2016 Community Health Needs Assessment represents the voices of our communities. We know that as a system of health, we must listen to what your voices are saying—about your health needs and issues that affect your ability to thrive.

This year's report highlights the most pressing needs in our hospital service areas, along with strategies to address those needs. MultiCare, our community partners, and community members are working together to improve our communities' health.

We are committed to providing the highest quality community benefit programs and services that help people live their best lives. Together, we can—and will—transform the health of our communities.

Thank you,

William G. "Bill" Robertson
President & CEO
MultiCare Health System

Executive Summary

MultiCare Health System is a not-for-profit health care organization with over 15,000 team members, including employees, providers, and volunteers. MultiCare's integrated community-based system of health includes primary, specialty, and urgent care services, in addition to a wide range of community outreach programs. MultiCare is one of the South Puget Sound's largest health care systems, with locations throughout Pierce, King, Kitsap, and Thurston counties.

Priority Health Needs

In 2015, MultiCare Auburn Medical Center joined forces with the King County Hospitals for a Healthier Community (KCHHC) collaborative to conduct a comprehensive Community Health Needs Assessment. The collaborative consists of all 12 hospitals and health systems in King County and Public Health Seattle-King County. The assessment process included surveys and workshops among area residents, in addition to interviews with community leaders. The resulting report features a robust mixture of quantitative and qualitative findings.

Based on the results of the assessment, Public Health Seattle-King County developed the following list of priority health needs:

- Access to health care
- Tobacco Use
- Obesity
- Early prenatal care and poor birth outcomes
- Behavioral health
- Violence/Injury Prevention

Executive Summary

Continued

Three-Year Focus

MultiCare's Center for Healthy Living and Health Equity convened meetings with Multicare leaders and stakeholders to review the assessment. Based on the data, available resources, and existing programs, the following health needs were selected as the focus of the next three-year implementation period:

- Access to health care, including early prenatal care
- Obesity
- Tobacco use
- Cultural Competency
- Behavioral Health, including violence/injury prevention
- Childhood Immunizations

Each of MultiCare's five hospitals developed an implementation plan, and helped form implementation teams composed of internal staff and community partners. This Community Health Needs Assessment implementation plan is focused on Auburn Medical Center and describes how the hospital will address the identified health care needs by:

- Continuing and strengthening existing programs and services;
- Potentially implementing new strategies, programs or services;
- Collaborating with partner organizations to implement evidence-based strategies across the service area.

MultiCare's community benefit implementation strategies will contribute to long-term, sustainable improvements in community health. Through coordinated efforts with community partners, MultiCare will use these strategies as a roadmap towards better health outcomes.

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About MultiCare

MultiCare Health System is a not-for-profit health care organization with over 15,000 team members, including employees, providers, and volunteers. MultiCare's integrated community-based system of health includes primary, specialty, and urgent care services, in addition to a wide range of community outreach programs. MultiCare is one of the South Puget Sound's largest health care systems, with locations throughout Pierce, King, Kitsap, and Thurston counties.

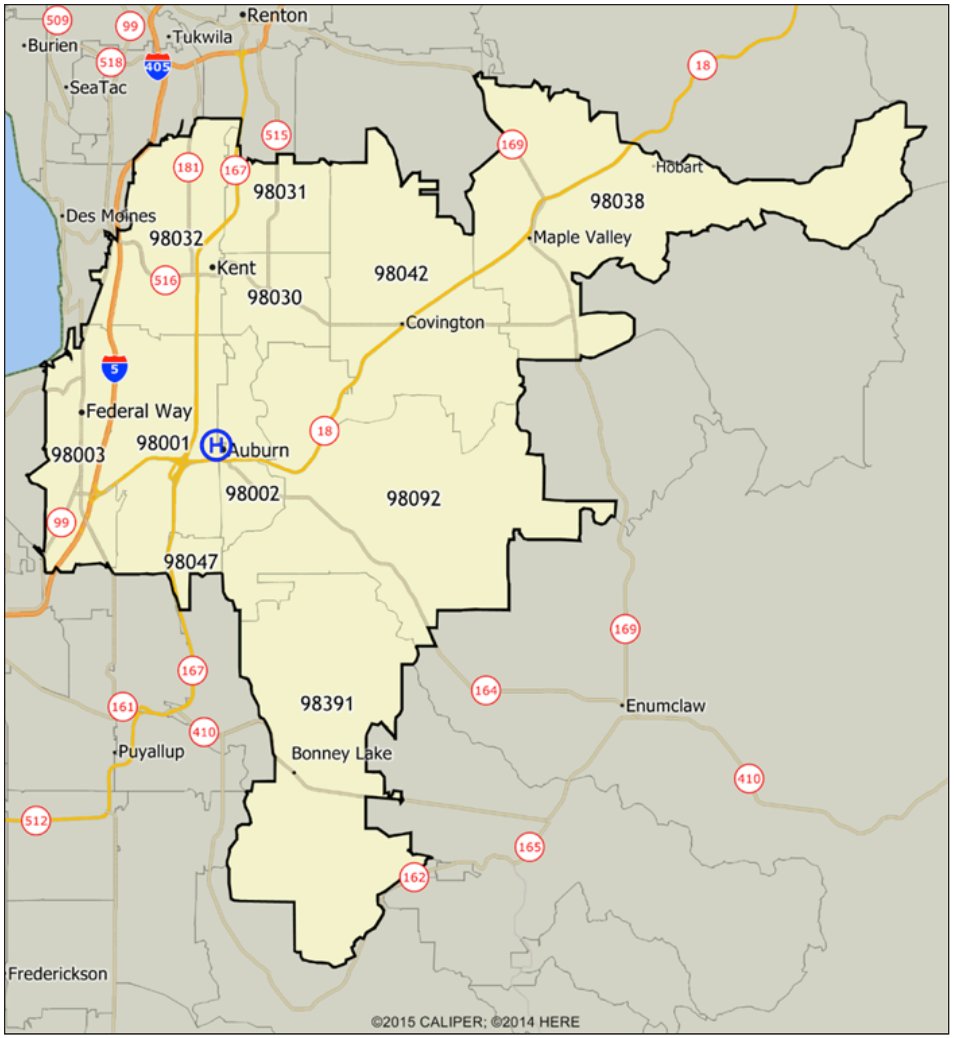
MultiCare facilities include:

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

MultiCare's five hospitals serve individuals of all ages. Mary Bridge Children's Hospital and Health Network serves the pediatric needs of the community, while Tacoma General Hospital, Good Samaritan Hospital, Auburn Medical Center and Allenmore Hospital have specialty services that focus on adult populations.

Meeting Community Needs

MultiCare Auburn Medical Center Service Area



Service area data provided by MultiCare Strategic Development

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 at the left. Approximately 413,000 people live in the South King County service area.

CHNA Methodology

Background and Process

MultiCare Auburn Medical Center worked with the King County Hospitals for Healthier Community collaborative to conduct a comprehensive Community Health Needs Assessment (CHNA). The process included quantitative analysis and qualitative interviews with community leaders and residents of King County representing many sectors and population groups, including low-income residents and others affected by health disparities.

(Please see Appendix 1 for the complete Community Health Needs Assessment, as prepared by Public Health Seattle – King County.)

Criteria for Prioritizing Health Needs

In the CHNA, the HHC collaborative developed a list of priority health needs by using the following criteria:

1. Ability to address health equity, particularly by age, gender, race/ethnicity, geography, socioeconomic status, although not all demographic breakdowns may be available for all indicators.

2. Availability of high-quality data that are population-based (where possible), measurable, accurate, reliable, and regularly updated.

3. Ability to make valid comparisons to a baseline or benchmark.

4. Prevention orientation with clear sense of direction for action by hospitals for individual, community, system, health service, or policy interventions that will lead to community health improvement.

5. Ability to measure progress of a condition or process that can be improved by intervention/policy/system change, and there exists a capacity to affect change.

6. Alignment with local and national health care reform efforts including the triple aim.

The health concerns or indicators that met most criteria became the suggested priority health needs for the hospital service area. The resulting list of priority needs served as a starting point for discussion, rather than a definitive short list requiring action.

CHNA Methodology

Continued

Priority Health Needs Identified by the Health Department

The KCHHC identified the following priority health needs for residents within the MultiCare Auburn Medical Center service area:

- Access to health care
- Tobacco Use
- Obesity
- Early prenatal care and poor birth outcomes
- Behavioral health
- Violence/Injury Prevention

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 and outpatient leaders from each of our five hospitals. The group chose to focus on all six priority health needs, in addition to **Childhood Immunizations** and **Cultural Competency**, over the next three-year period. Violence/Injury Prevention will be addressed within the context of Behavioral Health.

System leaders then worked to create implementation strategies and a resource inventory of existing programs and services offered by MultiCare that address these five identified needs. In addition, we met with community organizations to explore possible community-wide solutions to some of the identified health care needs.

MultiCare Auburn Medical Center Implementation Plan

Auburn Medical Center's implementation plan, 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 the implemention of new strategies
- Collaborating with community organizations to implement evidence-based strategies across the service area

MultiCare Auburn Medical Center Priorities

GOALS

1. Access to care

2. Obesity

3. Tobacco Use

4. Behavioral Health

5. Childhood Immunizations

6. Cultural Competency

STRATEGIES

Women's Health:

- Explore the development of a community resource toolkit that focuses on HPV prevention and screening.
- Explore promoting women's health services at community outreach events.
- Partner with the Muckleshoot tribe to provide low or no cost OB/GYN services.
- Continue to provide free pregnancy tests at the MultiCare OB Access Clinic, in partnership with Maternal Support Services.
- Provide education and support to women who are pregnant or planning to become pregnant, and offer these services in multiple languages.
- Continue to provide virtual care, with translation services, for low-risk pregnancies.
- Promote breast health in partnership with the Carol Milgard Breast Center (CMBC).

Oral Health:

- Explore the creation of an Epic SmartPhrase to refer youth in need to low cost dental care.
- Continue to support Medical Teams International's Mobile Dental Program.

- Promote community awareness and understanding of the Ready, Set, Go! 5210 (RSG! 5210) program and message.
- Increase collaboration with community partners on programs and policies to improve the health of our community.
- Surveillance of participation at community programs, classes, and events.
- Promote weight management programs and services.
- Seek grants like Supplemental Nutrition Assistance Program Education (SNAP-Ed) to provide nutrition education and programming to schools, the WIC program and food bank clients.
- Increase knowledge and best practice education around the benefits of breastfeeding.
- Increase access to healthy food at worksites.
- Increase access to and promotion of physical activity among MultiCare employees and their families.

- Promote access to tobacco cessation resources and support programs.
- Promote partnerships with the Tacoma-Pierce County Health Department.
- Promote insurance-covered pharmacotherapy and/or free or low-cost cessation programs for hospital employees.
- Continue to support the MultiCare tobacco-free policy for all employees and facilities.

- Increase access to behavioral health services.
- Promote integration of physical and behavioral health care.
- Integrate chemical dependency treatment into the medical care setting.
- Expand capacity to provide co-occurring mental health and substance use disorder treatment.
- Focus on high-risk and high utilizers of health care services.
- Increase community capacity to provide inpatient psychiatric services.

- Support and promote access to MultiCare Mary Bridge Immunization Clinics.
- Promote partnerships with the Tacoma-Pierce County Health Department.
- Continue to promote the use of the Washington State Immunization Information System (IIS).

- Promote cultural diversity and health equity awareness among MultiCare staff.
- Increase access to interpreter services.
- Continue to promote health equity partnerships.
- Continue to provide outreach services to ethnic minority and low-income communities.

Focus 1: Access to Care

Our goal is to increase access to health care services in our community.

Providing access to affordable, high-quality care is vital to our community's health. Barriers to health care lead to unmet health needs, delays in receiving appropriate care, lack of preventive services, and hospitalizations that could have been avoided.

According to the CHNA, Auburn community members lack access to needed women's health and oral health services. Many women are still not getting screened for cervical or breast cancer, despite the availability of screening tools; in addition, tooth decay is still one of the most common, yet preventable, diseases among area youth. Our goal is to increase access to health care services in community, through the following strategies and activities:

Women's Health

- Explore the development of a community resource toolkit that focuses on HPV prevention and screening.
- Explore promoting women's health services at community outreach events.
- Partner with the Muckleshoot tribe to provide low or no cost OB/GYN services.
- Continue to provide free pregnancy tests at the MultiCare OB Access Clinic, in partnership with Maternal Support Services.
- Provide education and support to women who are pregnant or planning to become pregnant, and offer these services in multiple languages.
- Continue to provide virtual care, with translation services, for low-risk pregnancies.
- Promote breast health in partnership with the Carol Milgard Breast Center (CMBC), through:
  - Exploring the use of mobile mammography clinics in high-needs areas, including local Tribes.
  - Supporting no-cost mammography screenings.
    - Reach newly eligible Medicaid and Apple Health enrollees at second-annual CMBC Coordinated Care event.
  - Explore supporting future focus groups dedicated to assessing barriers and opportunities for breast health in Latina communities.

Focus 1: Access to Care

Continued

Oral Health

- Explore the creation of an Epic SmartPhrase to refer youth in need to low or no cost dental care.
- Continue to support Medical Teams International's Mobile Dental Program through referrals and shared marketing efforts.

Internal Resources

As a not-for-profit health care system, MultiCare offers programs that increase access to care, improve care coordination, and provide financial assistance for uninsured, underinsured, and low-income populations. Examples of these programs and services include:

- **Personal Health Partners** (PHPs) help patients overcome barriers to care by coordinating services, and ensure open communication between the providers, patients, families, and others. Some examples of services offered include medication management, participation in visits with primary care providers, and conducting home assessments.
- **Charity Care**, or free medical care, exists 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 the 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, discounted services and assistance with qualifying for state-sponsored health plans.
- **Indigo Urgent Care** clinics provide quick care for lower-acuity conditions. Open seven days a week, Indigo Urgent Cares will be serving neighborhoods throughout Pierce, King, Thurston, and Snohomish counties.
- **Urgent Care and Primary Care** clinics provide same- and next-day appointments, a 24-hour nurse line, and are open extended hours weekday evenings and on weekends.
- MultiCare partners with **RediClinics** at Rite Aid pharmacies across Pierce, Snohomish, and King counties. RediClinics offer low-cost, convenient access for many health care needs, including immunizations and laboratory tests. These clinics are available to uninsured individuals and have extended hours to serve patients and families with busy schedules.

Focus 1: Access to Care

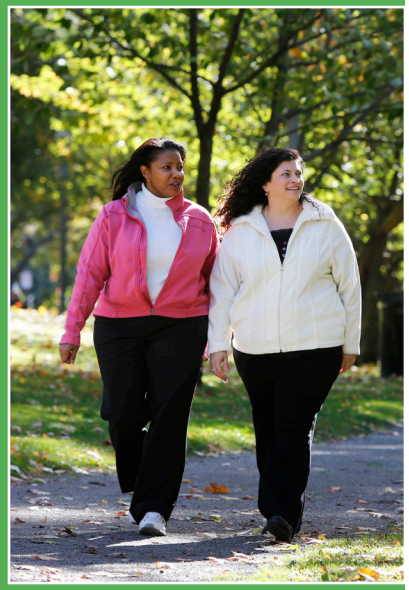
Continued

Community Resources

In addition to the MultiCare programs and services, we also partner with community organizations that work to increase care access. These include, but are not limited to:

- **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.
- **HealthPoint Community Health Centers** provide 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.
- **Medical Teams International** offers free or low-cost urgent dental care services through its Mobile Dental Program.
- The **Seattle and King County Access to Baby and Child Dentistry** program connects low-income children, 0-5 years of age, with private dentists.
- The **Seattle-King County Dental Society** provides donated dental services for low-income residents who do not qualify for Medicaid.
- The **SmileMobile** is a mobile dental office serving low-income children. Services range from examinations and preventive care to fillings and minor oral surgery.
- **Project Access Northwest** collaborates with providers to deliver medical and dental care for uninsured and low-income individuals. Project Access also offers premium assistance for individuals on the health exchange.
- **Statewide Health Insurance Benefits Advisors (SHIBA)** helps clients understand health care coverage options and rights, find affordable health care coverage, and evaluate and compare health insurance plans. Provides free, unbiased, and confidential assistance with Medicare and health care choices.
- **WithinReach** connects families, online, in-person, or through a hotline, with whatever resources they may need, e.g. health care enrollment, food, etc.

Focus 2: Obesity



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

As the CHNA indicates, obesity continues to be a concern among adults and youth in our community. Obesity is linked to many chronic illnesses, including diabetes and cancer, and can lead to premature death. Inadequate nutrition and lack of physical activity are both risk factors for obesity.

Childhood obesity is related to a variety of issues, including environment, behavior and genetics. We know that the most effective long-term strategy in addressing obesity must involve strong community collaborations, improved policies and shared initiatives.

Our goal 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 related resources, especially at community and school events.
  - Increase the number of clinics and primary care clinics that use RSG! 5210 messaging.
  - Increase the number of visits to the RSG! 5210 website.
- Increase collaboration with community partners on programs and policies to improve the health of our community.
  - Collaborate with the First 5 Fundamentals initiative through mini-grants to further expand the RSG! 5210 reach.
- Surveillance of participation at community programs, classes, and events, including:
  - The Women, Infants, and Children (WIC) program and classes.
  - Empowering Women for Wellness.
  - Family Wellness workshops.
  - PowerCook classes.
  - Other related community events and workshops.

Focus 2: Obesity

Continued

- Promote weight management programs and services.
  - Continue to support Smart Phrases in Epic (electronic health record system) to promote the RSG! 5210 message and referral to weight management services.
  - Promote Family Wellness tool kits to the community.
- Seek grants like Supplemental Nutrition Assistance Program Education (SNAP-Ed) to provide nutrition education and programming to schools, the WIC program and food bank clients.
  - Apply for grant funding to support healthy eating and physical activity programs.
- Increase knowledge and best practice education around the benefits of breastfeeding.
  - Increase rates of breastfeeding initiation and duration through the WIC program.
  - Increase awareness and messaging about the benefits of breastfeeding beyond two months of age.
- Increase access to healthy food at worksites.
  - Partner with farmers markets and develop produce delivery programs.
  - Partner with Nutrition Services to continue to offer healthy options in MultiCare cafeterias.
- Increase access to and promotion of physical activity among MultiCare employees and their families.
  - Promote community fitness and running events with employees and their families.
  - Promote the Million Minute Mission (MMM) School and Corporate Challenge to employees, businesses, organizations and schools in the community.

Focus 2: Obesity

Continued

Internal Resources

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

- **Center for Healthy Living & Health Equity** offers health, wellness and exercise programs. Registered dietitians with expertise in sports nutrition and weight management provide services such as health assessments, screenings, menu planning, goal setting and one-on-one and group counseling to help clients make healthy changes.

- **Family Wellness Workshops** equip parents with a positive approach to weight and wellness. All participants receive Family Wellness Toolkits, which provide strategies to support healthy habits. Parents work with the Pediatric Weight and Wellness Team to ask questions, share successes, set goals and tackle new challenges.

- **Ready, Set, Go! 5210** is a community-based initiative in Pierce County that promotes healthy lifestyle choices for youth and families where they live, learn, work and play.

- **Women, Infants, and Children (WIC)** provides healthy foods and other benefits free of cost to eligible families at 11 MultiCare WIC sites throughout Pierce County.

Community Resources

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

- **The Auburn Valley YMCA** is a cause-driven organization focused on youth development, healthy living and social responsibility. Programs, services, and initiatives enable youth to realize their potential, offer families ways to have fun together, empower people to be healthier in spirit, mind and body, welcome and embrace newcomers, and help foster social responsibility.

- **The Blue Ribbon Committee of Auburn** is dedicated to making Auburn the healthiest city in Washington by 2020. Its mission is to optimize the health and well-being of all residents through education, participation and innovation. The committee will initially address child and adult obesity, maternal and child health, and behavioral health, which includes substance abuse.

Focus 3: Tobacco Use

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

Tobacco use in the Auburn Medical Center service area is high. According to the CHNA, 17 percent of adults, and 10 percent of eighth, tenth, and twelfth graders, report cigarette smoking. In addition, e-cigarette use among high school students has increased three-fold in just the last two years.

Cigarette smoking is the leading cause of preventable death. The Centers for Disease Control and Prevention estimate that smoking accounts for more than 480,000 deaths each year in the United States, with almost 42,000 deaths resulting from exposure to secondhand smoke. Smoking causes many serious diseases, including cancer, heart disease, and chronic obstructive pulmonary disease (COPD). Tobacco cessation can significantly reduce the risk of contracting smoking-related diseases and has immediate health benefits.

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

- Promote access to tobacco cessation resources and support programs.
  - Increase provider referrals to tobacco cessation programs.
  - Explore training hospital departments and staff to deliver tobacco cessation and support programming.
  - Explore tobacco cessation trainer certification for MultiCare providers.
  - Provide tobacco cessation materials and resources to provider offices and clinics.
  - Create Smart Phrases in Epic to refer to tobacco cessation services.
  - Explore tobacco cessation coaching and virtual visits.
  - Increase program engagement through social media, apps and website tools.
- Promote partnerships with public health and other community organizations.
  - Explore messaging to the community around the impacts of tobacco, vaping and e-cigarette use.
- Promote insurance-covered pharmacotherapy and/or free or low-cost cessation programs for hospital employees.
- Continue to support the MultiCare tobacco-free policy for all employees and facilities.
  - Explore insurance premium surcharges for employee tobacco use.

Focus 3: Tobacco Use

Continued

Internal Resources

MultiCare offers many services for adults who are ready to quit using tobacco. These include:

- **QuitSmart™** tobacco cessation web-based program and phone support.
- **Tobacco use physician electronic visits** (e-visit) 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** offers the QuitSmart™ eight-week program with free pharmacotherapy for MultiCare employees.

Community Resources

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

- **The Blue Ribbon Committee of Auburn** is dedicated to making Auburn the healthiest city in Washington by 2020. Its mission is to optimize the health and well-being of all residents through education, participation, and innovation. The committee will initially address child and adult obesity, maternal and child health, and behavioral health, which includes substance abuse.
- **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.

Focus 4: Behavioral Health

Our goal is to improve behavioral health outcomes for adults and youth.

Mental health disorders affect an individual's ability to live a full and productive life. According to the CHNA, adults, children and youth with untreated mental illness have poorer health, educational, and socioeconomic outcomes. Affected individuals are at higher risk of intentional injury and suicide, in addition to co-occurring disorders such as alcohol and drug abuse. Those with chronic mental health disorders are also less likely than the general population to seek medical care.

Our goal is to improve behavioral health outcomes through the following strategies and activities:

- Increase access to behavioral health services.
  - Offer an open-access model of care option for clients with mental health and substance use disorder problems through walk-in clinics. Clients can walk in at their convenience for mental health and substance use disorder assessments, and leave with the time, date and provider of their next treatment appointment.
  - Support access and referrals to crisis services for youth, with the establishment of linkages between Emergency Medical Services, MultiCare emergency departments, and other community agencies.
- Promote integration of physical and behavioral health care.
  - Bring a regularly scheduled Mobile Health Clinic to community behavioral health clinics in Pierce County to provide much-needed access to medical care for mentally ill adults who would otherwise not go to primary care clinics.
    - Include this service in the client's Behavioral Health Service Plan.
    - Offer case management and peer support to reduce barriers to accessing primary medical care services.
- Continue to expand the integration of behavioral health providers in medical care settings for youth and adults. Currently, this service is available in 12 primary care clinics in Pierce and King Counties, Mary Bridge specialty clinics and the Center for Childhood Safety.
- Coordinate the assessment and treatment of depression in adolescents ages 12 through 17 through the use of a common depression screening tool (PHQ-9) in primary care, pediatric and behavioral health care settings.

Focus 4: Behavioral Health

Continued

- Integrate chemical dependency treatment into the medical care setting.
  - Coordinate medical treatment and behavioral health treatment for individuals with opiate addictions.
- Expand capacity to provide co-occurring mental health and substance use disorder treatment.
  - Continue to grow the availability of outpatient co-occurring treatment options at MultiCare Behavioral Health.
  - Participate with the Division of Behavioral Health Recovery and the University of Wisconsin in a 5-year plan to implement the Dual Diagnosis Capability in Addiction Treatment (DDCAT) Toolkit.
  - Coordinate with the Division of Behavioral Health Recovery to streamline State standards of care and payment mechanisms that currently pose barriers to co-occurring treatment provision.
- Focus on high-risk and high utilizers of health care services.
  - Expand the availability of an intensive outreach and engagement approach for high utilizers of emergency departments and other crisis-focused services. Work will be done collaboratively among MultiCare, CHI Franciscan Health System and other key community stakeholders.
- Increase community capacity to provide inpatient psychiatric services.
  - In 2016, open a 27-bed inpatient psychiatric unit for adolescents ages 13 through 17 at Tacoma General and Mary Bridge Hospitals.
  - In 2019, open a 120-bed inpatient psychiatric facility in Tacoma in partnership with CHI Franciscan Health System.

Focus 4: Behavioral Health

Continued

Internal Resources

MultiCare offers comprehensive and effective behavioral health services that restore hope and help individuals and families get back on the path toward achieving their life goals. Programs include:

- **Primary Care and Behavioral Health Integration** is a holistic approach that provides a full spectrum of care within many MHS primary care settings to help people get expertly coordinated care for physical and mental health concerns.
- **Mobile Integrated Health Care** provides primary care services to adults with severe and long-term mental illness and coordinates their mental and behavioral health needs. Services are available through a mobile RV that offers regularly scheduled services at four community mental health centers in Pierce County.
- **Child & Family Services** help children with mood, behavioral or other mental health issues to reduce their challenges at school and home and put them on a path to wellness as they grow into adulthood.
- **Adult Services** offer a holistic, person-centered program for adults with severe and long-term mental illness, based on each individual's unique strengths and preferences.
- **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. Services are available for individuals in some community skilled nursing facilities.
- **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 mental health clinic primarily serving the Asian and Pacific Islander refugee and immigrant communities.
- **Mobile Outreach Crisis Team** (MOCT) serves the area as an emergency consultation and intervention service, including a mental health crisis line that can be reached 24 hours a day, 365 days a year.
- **Gero-Psychiatric Inpatient Services** is a 38-bed geriatric psychiatric inpatient unit at MultiCare Auburn Medical Center.

Focus 4: Behavioral Health

Continued

Community Resources

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

- **The Blue Ribbon Committee of Auburn** is dedicated to making Auburn the healthiest city in Washington by 2020. Its mission is to optimize the health and well-being of all residents through education, participation and innovation. The committee will initially address child and adult obesity, maternal and child health, and behavioral health, which includes substance abuse.

- **Catholic Community Services** features 12 family centers across Western Washington that provide a variety of services, including counseling, case management and family support to youth, 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.

- **Metrocenter Y 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: Childhood Immunizations

Our goal is to increase the percentage of youth who have completed the recommended series of childhood immunizations.

According to the CHNA, the South King County service area has one of the highest rates of incomplete immunizations. Getting the recommended doses of childhood vaccines protects kids from serious and sometimes deadly diseases, like whooping cough, tetanus, measles and polio.

In recent years, diseases that were once thought to be eliminated have started making a comeback. Outbreaks of whooping cough and measles have emerged in communities across our state. With low immunization rates, we lose herd immunity—in which the unimmunized or immunocompromised are protected by the immunized majority.

Immunizations are one of the best ways we can protect children. Our goal is to ensure that all kids receive the recommended series of childhood immunizations, through the following strategies:

- Support and promote access to MultiCare Immunization Clinics.
  - Continue to support partnerships with local school districts to ensure that students and families are knowledgeable about immunization resources.
  - Support web and social media tools to increase awareness.
  - Continue promoting access to free vaccines for all children.
- Promote partnerships with public health and other community organizations.
  - Explore messaging to the community that increases knowledge about the safety and effectiveness of vaccines.
  - Support current and future grants to continue and expand immunization services to the community.
- Continue to promote the use of the Washington State Immunization Information System (IIS).
  - Ensure that immunization records are accurate and up-to-date, and that families know when children are due for future immunizations.
  - Identify un- and under-insured children needing vaccines at immunization clinics.

Focus 5: Childhood Immunizations

Continued

Internal Resources

MultiCare Auburn Medical Center and regional primary care clinics offer free immunizations to all children in the community from birth through 18 years of age.

Community Resources

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

- **Public Health-Seattle King County** provides information on local childcare, preschool, and school immunization requirements.
- The **Washington State Department of Health** has up-to-date news, forms, resources and information, including how to access myIR, which allows families to manage immunization records securely online.
- The **WithinReach** Immunization Program promotes immunizations across the lifespan through education, events, partnerships and programs, including the **Immunization Action Coalition of Washington** and **Vax Northwest**.

Focus 6: Cultural Competency

Our goal is to provide culturally competent health care to all members of the community.

Our goal is to provide culturally competent health care to all members of the community.

The Auburn service area is becoming increasingly diverse. According to the CHNA, community members have identified the importance of improving services for all people, regardless of age, race, ethnicity, gender, sexual orientation, language, beliefs or socioeconomic status.

In order to provide quality health care and ensure health equity, the unique cultural, spiritual and communication needs of each individual patient and their families must be addressed. Addressing these needs can minimize barriers that some patients experience when seeking medical care and has the potential to increase both access to health care and patient satisfaction. Culturally competent care allows us to equitably serve the needs of all.

Our goal is to provide culturally competent health care to all members of the community, through the following strategies:

- Promote cultural diversity and health equity awareness among MultiCare staff.
  - Mandate online cultural competency trainings for all MultiCare staff.
  - Offer in-person cultural competency trainings to MultiCare departments.
  - Develop internal cultural diversity council.
  - Offer health equity in-services periodically throughout the year.
  - Develop health equity strategic plan.
  - Explore implementing cultural diversity policies.
- Increase access to interpreter services.
  - Explore utilizing in-house staff interpreters via the Qualified Bilingual Staff Program.
  - Explore offering a language conversion setting on the main website.
  - Explore translating health education materials into the top five languages in the service area.
  - Continue to offer telecommunications devices for hearing impaired patients.

Focus 6: Cultural Competency

Continued

- Continue to promote health equity community partnerships.
  - Further assess interest of community organizations, particularly those that have health equity initiatives.
  - Continue to identify partnership opportunities in the community, especially within faith-based communities.
- Continue to provide outreach services to ethnic minority and low-income communities.
  - 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.
  - Actively participate in Leaders in Women's Health, a community group that addresses breast cancer disparities in Pierce County.
  - Explore developing chronic disease prevention programming in communities of color.

Internal Resources

MultiCare offers the following resources that address cultural competency:

- **Center for Healthy Living and Health Equity** promotes healthy lifestyle choices and addresses health disparities in our communities to improve population health outcomes. Serves as a health equity resource for MultiCare staff, patients and the community.

Community Resources

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

- **Public Health Seattle-King County** tackles known and emerging health risks through policy, programs and treatment in order to protect public health and promote equity.
- **Urban League of Metropolitan Seattle** is devoted to empowering African Americans and other disenfranchised groups to enter the economic and social mainstream.
- **Korean Women's Association** (KWA) provides multicultural social services to meet basic human needs through education, socialization, advocacy, and support.

Conclusion

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 helps us 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 greater collaboration among the many community organizations that share our goal of improving the health of all people in our communities.

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

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King County Community Health Needs Assessment

2015/2016






King County Hospitals for a Healthier Community

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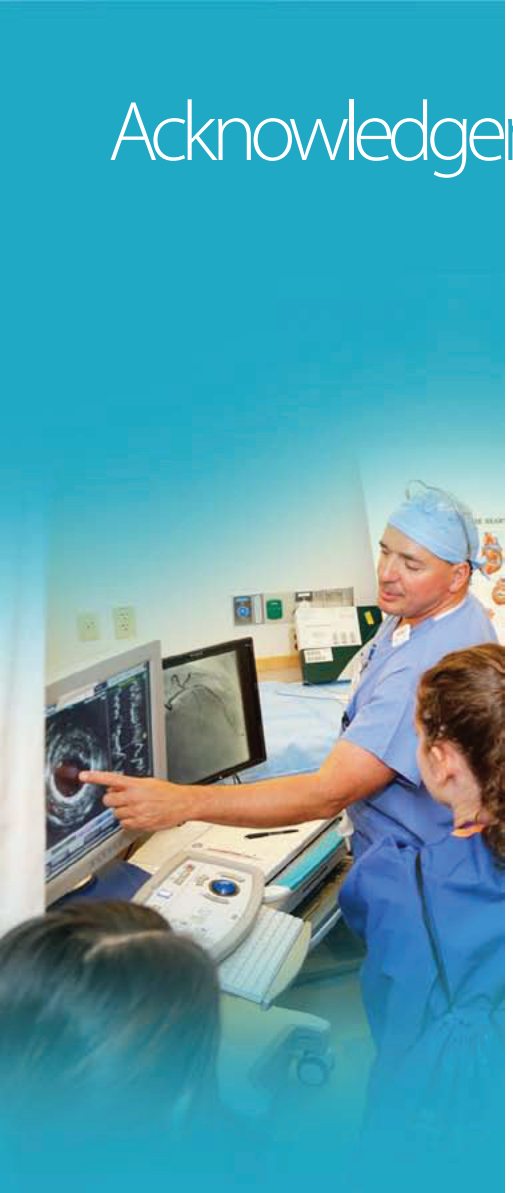

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Community House Mental Health

Community Psychiatric Clinic

Consejo Counseling

Country Doctor Community Health Center

DESC

Duvall Fire Department

Eastside Aid Community

Eastside Human Services Forum

Equal Start Community Coalition

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Feet First Pedestrian Safety Coalition

Forefront

Friends of Youth

Group Health Emergency Department

Harborview Medical Center Emergency Department

Harborview Mental Health

Harborview Spine Center and Concussion Program

Health Coalition for Children and Youth

Highline Medical Center Emergency Department

Hopelink

Issaquah Human Services Commission

Issaquah Police Department

Issaquah Sammamish Interfaith Coalition

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Seattle Children's Hospital Emergency Department

Seattle Counseling Service

Seattle Human Services Coalition

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Shoreline Community College

Snoqualmie Valley Hospital Emergency Department

Sound Mental Health

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Tri-Med Ambulance

Valley Cities Counseling

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Washington State Department of Health

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WithinReach

YMCA

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Summary

King County Community Health Needs Assessment 2015/2016

King County Hospitals for a Healthier Community (HHC) is a collaborative of all 12 hospitals and health systems in King County and Public Health-Seattle & King County. For this report, HHC members joined forces to *identify important health needs and assets in the communities they serve.* HHC members have also worked together to increase access to healthy foods and beverages in their facilities and to address access-to-care issues by assisting with enrollment of residents in free or low-cost health insurance.

This Community Health Needs Assessment (CHNA) is an HHC collaborative product that fulfills Section 9007 of the Affordable Care Act. The report presents data on:

- **Description of Community:** In an increasingly diverse population of 2 million, large health inequities persist. Rates of poverty and homelessness continue to rise.
- **Life Expectancy and Leading Causes of Death:** Life expectancy in King County neighborhoods can vary by up to 10 years. Leading causes of death among older adults are cancer and heart disease, while injuries are the leading causes of death among children, teens, and young adults.
- **Chronic Illness:** Disparities in chronic illness by race/ethnicity, poverty, and neighborhood are considerable. Asthma and diabetes are common in adults and children. The leading causes of hospitalizations (after pregnancy/childbirth) are heart disease, injury, mental illness, and cancer.

"Hospitals are 'cornerstone institutions'; they are major forces in the community and should work to improve conditions. They have influence."

– King County physician

Summary

Continued

Community Input

We invited community coalitions and organizations to tell us about the assets and resources that help their communities thrive. The assets most frequently mentioned were existing partnerships and coalitions, community health centers, faith communities, and food programs.

We also asked community representatives to identify concerns about health needs in their communities. Common themes included:

1) the importance of a culturally competent workforce in addressing health disparities;

2) acknowledgement that health is determined by the circumstances in which people are born, grow up, live, work, and age, which are in turn shaped by a broad set of forces;

3) the need for hospitals to engage with communities and develop authentic partnerships; and

4) the influential role of hospitals as anchor institutions in addressing social, economic, and behavioral factors.

Identified Health Needs, Assets, Resources, and Opportunities

The report integrates data on HHC's identified health needs with input from community organizations about assets, resources, and opportunities related to those needs:

- **Access to Care:** Lack of health insurance is common among young adults, people of color, and low-income populations. For 1 in 7 adults, costs are a barrier to seeking medical care. Opportunities include providing assistance to the uninsured or underinsured, addressing issues of workforce capacity and cultural competency, ensuring receipt of recommended clinical preventive services, supporting non-clinical services, and increasing reimbursement for oral health care.

- **Behavioral Health:** Access to behavioral healthcare, integration of behavioral and physical healthcare, and boarding of mental health patients were identified as key issues. Opportunities include use of standardized referral protocols, coordinated discharge planning, and increased capacity for integrated healthcare.

Summary

Continued

- **Maternal and Child Health:** Disparities in adverse birth outcomes persist, and the percentage of births in which mothers obtained early and adequate prenatal care is too low. Community-based organizations stress the importance of baby-friendly hospitals, quality prenatal care, and ongoing social support, as offered by home visiting programs.

- **Preventable Causes of Death** include obesity, tobacco use, and lack of appropriate nutrition and physical activity. More than half of adults and 1 in 5 teens are overweight or obese, so increasing access to healthy food and physical activity is critical. In the face of declining resources for tobacco prevention/cessation and persistent disparities in tobacco use, evidence-based opportunities include anti-tobacco messaging and brief clinical tobacco screening.

- **Violence and Injury Prevention:** Deaths due to falls and suicide are both rising; and distracted/impaired driving concerns both community members and law-enforcement officials. Opportunities include regional coordination and standard implementation of best practices in violence injury and prevention (including prevention-related primary care assessment/screening).

The HHC collaborative and individual hospitals and health systems already partner or are interested in partnering with community coalitions and organizations in implementing strategies informed by this assessment and other tools. Working together, hospitals and health systems, public health, and communities can reduce healthcare costs and improve the health of all people in King County.

Introduction

King County hospitals play a significant role in the region's overall economy and health. In addition to providing safe and high-quality medical care, these institutions work to improve regional health through community benefit programs that promote health in response to identified community needs. King County's hospitals and health systems have joined forces with Public Health-Seattle & King County to identify our communities' strengths and greatest needs in a collaborative called "Hospitals for a Healthier Community" (HHC).

This assessment embraces a broad concept of health that includes social, cultural, and environmental factors that affect health. Working collaboratively both within and outside the health system environment, King County hospitals can help build on expertise and resources to address critical health needs in King County and to address the "triple aim" of health care.

Members of the King County HHC are collaboratively addressing challenges related to diabetes, obesity, and access to care. All have adopted a Healthy Food in Healthcare pledge, and are working to increase access to healthy food choices within their facilities. During the first open enrollment period under the new Affordable Care Act provisions, each member promoted enrollment in communities where residents were likely to be eligible for free or low-cost health insurance.

The purpose of this first joint county-wide community health needs assessment (CHNA) is to highlight strengths and areas of need that cut across geographies and present opportunities for collaboration between public health, hospitals, health systems, community organizations, and communities.

The Affordable Care Act provides a framework for the existing structure of hospital community benefit programs by requiring a CHNA every three years, accompanied by annual implementation strategies. We hope that interested organizations and the public can use this assessment to coordinate efforts and leverage resources.

In accordance with the Affordable Care Act, this report includes:

1) A description of the community served

2) Leading causes of death

3) Levels of chronic illness

In addition, this report provides qualitative and quantitative information about the following identified health needs:

4) Access to care

5) Behavioral health

6) Maternal and child health

7) Preventable causes of death

8) Violence and injury prevention

Supplemental data for each indicator are presented in Appendix D. Additional indicators for each health need above, as well as data for other health needs, are online at www.kingcounty.gov/health/indicators. Detailed data are reported, when available, for neighborhoods, cities, and regions in King County, and by race/ethnicity, age, income/poverty, gender, or other important demographic breakdowns. When possible, comparisons are also made to the Washington State average and national Healthy People 2020 objectives (www.healthypeople.gov).

Working Together Towards Healthier Communities

Across the region, health care reform is catalyzing new levels of collaboration across hospitals and health systems, public health, social services, housing, community development, and other sectors that address the underlying determinants of health for King County's residents. There is widespread recognition that achievement of the "triple aim" of enhancing the patient experience of care, improving the health of populations, and reducing the per capita cost of health care will require new bridges across systems that have been historically siloed.[i]

The CHNA complements and stands to help accelerate the goals of local and state health transformation plans. The King County Health and Human Services Transformation Plan calls for a shift from what today is a crisis and sick-care oriented system, to one focused on prevention, wellness, and the elimination of disparities. Community partnerships that address the upstream, nonmedical drivers of health are a key part of ultimately achieving the triple aim.

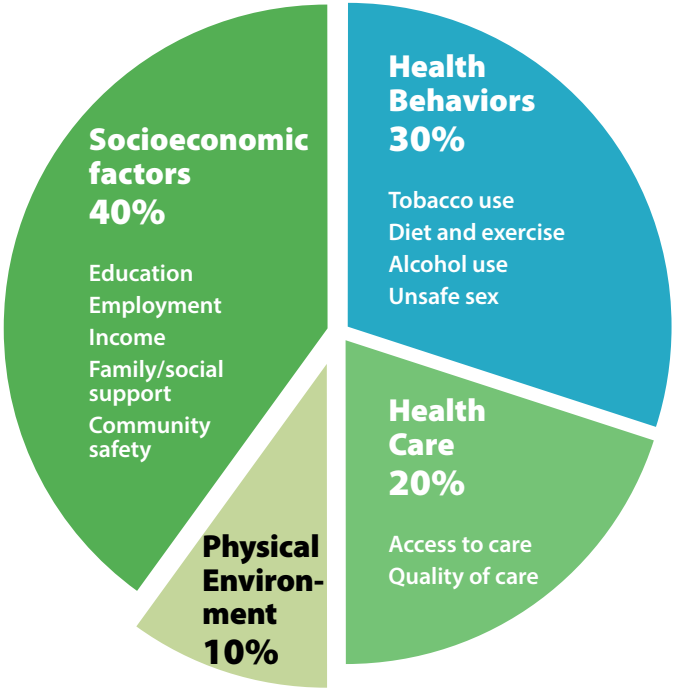
Washington State's roadmap for health transformation, *Healthier Washington*, also recognizes that health happens at the local level, and that communities are at the core of bringing about the changes that will

improve the health of their residents. Regional health assessments and regional health improvement plans are identified as critical elements for driving health transformation. As a foundational piece of regional health assessment work that can be built upon in the years ahead, the CHNA helps lay the groundwork for future community partnerships and well-aligned strategies that will succeed in responding to the identified needs.

Methods

In crafting their approach to this report, HHC members defined health broadly and used a population-based community health framework to identify health needs and establish criteria for selecting key indicators within each health topic. To identify community concerns and assets, they interviewed stakeholders, consulted recent community-based reports, and pulled information from previous hospital CHNAs. While hospitals and health systems reached consensus on a core set of topic areas, each hospital may also gather additional information specific to its service area.

Figure 1: Impact on Population Health



Recognizing that the CHNA is not intended to provide comprehensive data for each specialized topic, indicators for this report were selected according to the following criteria:

1) Ability to address **health equity,** particularly by age, gender, race/ethnicity, geography, socioeconomic status, although not all demographic breakdowns may be available for all indicators.

Introduction

Continued

2) Availability of high-quality data that are population-based (where possible), measurable, accurate, reliable, and regularly updated. Data should focus on rates rather than counts.

3) Ability to make valid **comparisons** to a baseline or benchmark.

4) Prevention orientation with clear sense of direction for **action by hospitals** for individual, community, system, health service, or policy interventions that will lead to community health improvement.

5) Ability to **measure progress** of a condition or process that can be **improved** by intervention/policy/system change, and a **capacity** to affect change exists.

6) Alignment with local and national **health care reform** efforts including the triple aim.

Indicators that satisfied these criteria were analyzed, using appropriate statistical methods, by Public Health - Seattle & King County. Data were compiled from local, state, and national sources such as the U.S. Census Bureau, U.S. Centers for Disease Control and Prevention, Washington State Department of Health, and King County.

Input was also gathered from people representing the broad interests of the communities served by HHC hospitals and health systems. Three methods were used: interviews with stakeholder coalitions; an online survey; and a review of recent reports on local health needs. The following interview questions were used for the in-person interviews and online survey.

1) What are the main concerns you or your organization have about (topic) right now?

2) What are the people, places, and things that make your community healthy, safe, and strong and tell us why these people, places, and things are important? These could include organizations, leaders, coalitions, initiatives, policies, or physical/environmental attributes.

3) What programs or projects are happening or planned that are most relevant to the identified needs?

4) How can hospitals and health systems be involved in addressing the issues you have identified?

5) What are the most significant gaps in resources, coordination, etc. in this area?

6) Is there anything else you would like to add?

Key limitations of this report include **1)** incomplete or inadequate quantitative data on some topics of interest and **2)** our inability to summarize every asset and opportunity in King County. For example, although we report data on fruit/vegetable consumption, comprehensive population-based data on healthy eating are simply not available. In addition, resource limitations

prevent us from mentioning all of the valuable organizations and assets in our communities. We look forward to continuing to learn more about community strengths and resources.

More details about the CHNA methodology are included in Appendix A.

Community Strengths and Resilience

Overall, King County has a strong economy and ranks among the top counties in the nation on indicators of health and wellbeing. In part because of high levels of immigration, we are home to some of the most diverse communities in the U.S. The unique cultural strengths and assets of these communities benefit the entire region. We also benefit from strong institutional assets including faith communities, governments, hospitals and health systems, universities, philanthropies, and non-profits. In addition, many small programs help our communities thrive, and individuals come together to create support networks for friends, family, and neighbors.

However, the benefits of our strong and healthy county are not experienced equally by all. Across the region, communities differ in their assets and their opportunities for improvement. Tracking results over time reveals persistent disparities by race, income, and place.

Displaying data by census tract (see King County Health, Housing and Economic Opportunity Measures map on the next page) helps identify neighborhoods with the greatest opportunities for improving health. The map shows that areas in the southern part of the county and south Seattle, along with pockets in East and North Regions, generally fare worse than other areas.

Looking at one component of the health/well-being index, for example, average life expectancy for King County residents is 82 years, 3 years longer than the national average of 79 years. Within the county, however, life expectancy varies by almost 10 years – from 77 years in South Auburn to 86 years in West Bellevue. Many other health and social indicators—such as housing quality, alcohol-related deaths, obesity, lack of health insurance, and smoking—show similar patterns of inequity.

Despite these disparities, the leading risk factors and causes of illness affect us all and call for collective action to give everyone a fair chance to live a healthy life. Each region of the county is affected by the issues covered in this report and each region has unique assets and resources for addressing them. Working together, hospitals, health systems, public health, community organizations and communities can improve living conditions and residents' ability to lead healthy lives and achieve their full potential.

King County Health, Housing and Economic Opportunity Measures

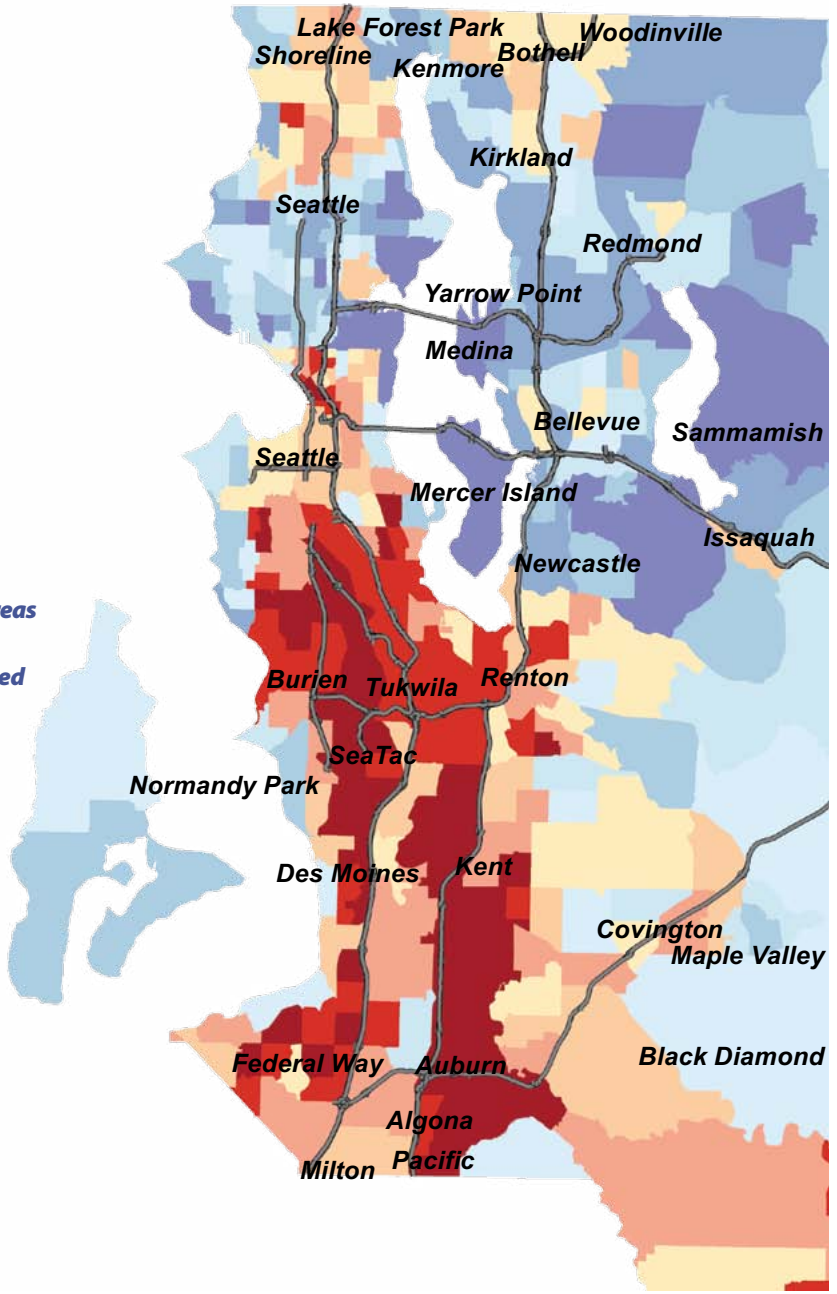
LEGEND — Freeways

RANKING

Census Tracts ranked by an index of health, housing and economic opportunity measures.

Lowest Ranked
Highest Ranked

POPULATION MEASURES	Dark red areas populations most impacted	Dark blue areas populations least impacted
Life expectancy	74 years	87 years
Health, broadly defined:		
Adverse childhood experiences	20%	9%
Frequent mental distress	14%	4%
Smoking	20%	5%
Obesity	33%	14%
Diabetes	13%	5%
Preventable hospitalizations	1.0%	0.4%
Housing:		
Poor housing condition	8%	0%
Economic opportunity:		
Low-income, below 200% poverty	54%	6%
Unemployment	13%	3%



Data Sources: U.S. Census Bureau, BRFSS, CHARS
Produced by: Public Health - Seattle & King County

Opportunities for Better Health

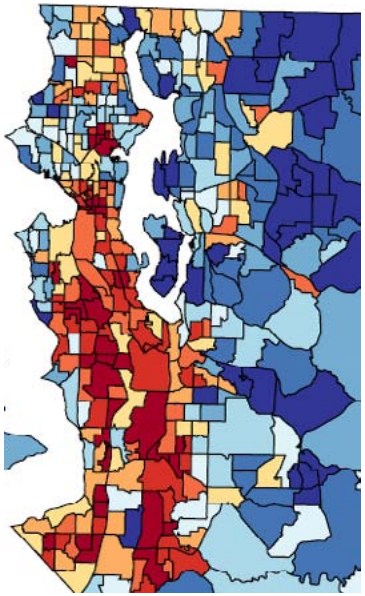
In King County–as in communities across the nation–neighborhood conditions, race, income, language, and education are highly correlated with disease burden and life expectancy. Community health data consistently show that these determinants of health–shaped by local distributions of money, power, and resources–cannot be ignored if we hope to improve individual healthcare and health outcomes.

The relationship between lack of opportunities and poor health is clear: King County neighborhoods with the lowest educational attainment and highest levels of poverty are also the areas with the greatest concentrations of obesity, diabetes, and many other adverse health outcomes. Equal access to opportunities such as education, housing, and jobs is necessary for all people to thrive and achieve their full potential.

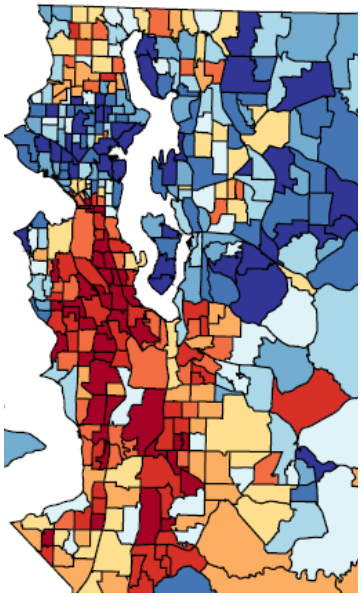
Because health services account for only around 20 percent of overall health, this report highlights community health needs that will require non-clinical as well as clinical approaches by hospitals and health systems and their partners.[ii]

One county, different opportunities

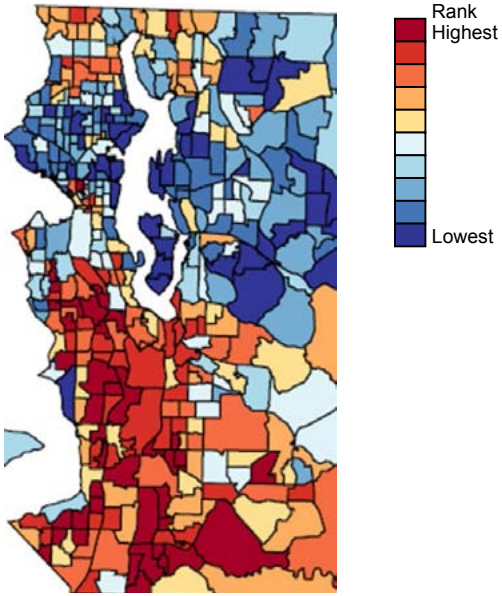
Income <200% poverty



No high school degree



Obesity



What We Heard from the Community– Key Findings

This section reports on common themes and issues that came up in our conversations with community coalitions, other community organizations, and subject matter experts. Additional community input can be found in individual chapters of this report.

Basic Needs

Throughout the community interviews conducted for this report and in previous community assessments, residents voiced the importance of meeting basic needs if they are to fulfill the potential for a healthy life. Basic needs most frequently mentioned included affordable housing, transportation, access to care (adult dental and behavioral health especially), public safety, living wages, and opportunities to purchase healthy food and be physically active. Poverty emerged throughout these conversations, most often as a barrier to improved health.

Community members identified **access to safe and affordable housing** as a major concern. What is being done to improve and preserve existing affordable housing stock and what is being done to encourage new affordable housing? If affordable housing is not preserved, residents may be uprooted from their communities and risk losing long-standing social and emotional connections as well as ties to important social and cultural institutions.

Accessible and affordable transportation was identified as a key component of communities in which economic opportunity might be experienced by all. Ample research supports the notion that reliable transportation to job and education centers can make the difference between poverty and economic stability. King County residents, especially in suburban cities, rely on public transportation – not only to get to their jobs, but also to access healthy food and participate safely in physical activities. Community members identified the need for more efficient bus services and improved connections to multiple parts of the county. Respondents also spoke to the need for additional transportation options, especially for older and/or disabled adults and families.

Respondents are asking hospitals to use their influence not only to promote and protect good health, and prevent ill health, but also to work collaboratively across all sectors **to develop systems to address basic needs and reduce health inequities.** While these issues may seem beyond the realm of a hospital's mission, hospitals locally and nationally are working with communities to address basic needs.

What We Heard from the Community– Key Findings

Continued

Cultural Competency

Multiple service providers, community members, and strategic plans called out the importance of providing culturally competent and respectful services to all people regardless of their race, income, language, beliefs, or the complexity of their situation. Community members expressed the importance of cultural and linguistic competency and that it must be taken into account when designing new interventions, practices, and services. King County hospitals have many opportunities to partner with organizations that, because of their strong ties to particular population groups, can help the hospitals offer culturally specific services. A shortage of bilingual and bicultural behavioral health service providers in King County emerged as a significant workforce capacity issue. (Workforce diversity is addressed in the Access to Care chapter.)

Support for these recommendations also comes from the Washington State's Governor's Interagency Council on Health Disparities, which has called for increased attention to cultural competency and diversity in the healthcare workforce. A new guide released by the Equity of Care initiative, *Becoming a Culturally Competent Health Care Organization,* outlines steps and educational techniques.[iii] Additional guidance on providing culturally and linguistically appropriate services is available from the federal Office of Minority Health.[iv]

Community Input and Inclusiveness

Stakeholders want assurance that traditionally un- and under-represented communities will be at the table during community health needs assessments and improvement processes. Community engagement and empowerment is considered essential to improving the health and wellness of King County communities. Community representatives view hospitals as "major forces in the community" and would like them to welcome community members as full partners in making decisions to improve community conditions. The community-engagement process should offer opportunities for communities to express their views and have a meaningful role in decision-making. What interviewees described is much more than just engagement; it is "power sharing 101."

Many expressed desire for an ongoing, "two-way conversation" with hospitals instead of meetings that happen once every three years. Many believe that ongoing communication between hospitals and

What We Heard from the Community– Key Findings

Continued

community groups will yield more relevant information about community needs than fixed-interval formal assessments. Several different approaches to engagement were suggested. One suggested strategy was to have hospital staff attend community-based coalition meetings on a regular basis. Another was for hospitals to partner with existing community organizations to offer programs jointly. An important take-home message was, "Don't recreate what already exists, but collaborate."

Health Insurance Coverage, Health Literacy, and Navigating Healthcare Services

These three issues were repeatedly highlighted as continuing challenges to improving the community's health. Respondents stressed the fact that some people will always "fall through the cracks" and remain uninsured. They expressed concern about people with incomes above 138% of the Federal Poverty Level (FPL) who didn't enroll in health insurance because they could not afford the premiums, and about those who enrolled but may fall behind in paying their premiums. Lack of access to adult dental care due to the low Medicaid reimbursement rate was also mentioned. But, as one participant said, "Access requires more than health insurance." People also need to understand basic health issues and know how to navigate the healthcare system. Understanding how the health system works, including the specific services and benefits people are eligible for, was identified as a continuing challenge. Patients are afraid of the cost of care. Respondents reported that many people don't know how to shop for health insurance that enables them to continue receiving care from their current provider. Community health workers, cultural navigators, and in-person assisters were perceived as helpful in addressing all three concerns.

Community Assets & Resources

Although never all-inclusive, identification of community assets and resources is essential to a community health improvement process. We invited stakeholders to tell us about the people, places, policies, and programs that help their community thrive. Community strengths relevant to identified health needs are highlighted in each section (e.g. maternal and child health). We capture just a few of the frequently mentioned assets below:

Partnerships, coalitions, and collaborations: Across the board—whether the focus was mental health, violence and injury prevention, healthy eating and

What We Heard from the Community–Key Findings

Continued

active living, or infant mortality—existing partnerships and coalitions were identified as key community strengths that are essential for success in improving the health and well-being of King County communities. At the same time, many respondents believed coordination among community-based organizations could be improved. They stressed the need for increased collaboration between community-based organizations, governmental agencies, advocacy organizations, hospitals and health systems, and the private sector.

Faith institutions: Faith-based institutions and committees were recognized for their tireless efforts to address homelessness, food insecurity, and other basic needs (e.g. Eastside Interfaith Social Concerns Council).

Community health centers: Community health centers, particularly clinics that specialize in providing culturally sensitive and appropriate care, were respected for their outreach to and care for hard-to-reach, underserved, and marginalized communities.

Food programs: Food banks and other food-related programs (e.g. Fresh Bucks) were recognized as valued resources for families struggling with food insecurity, a key health concern.

Description of Community

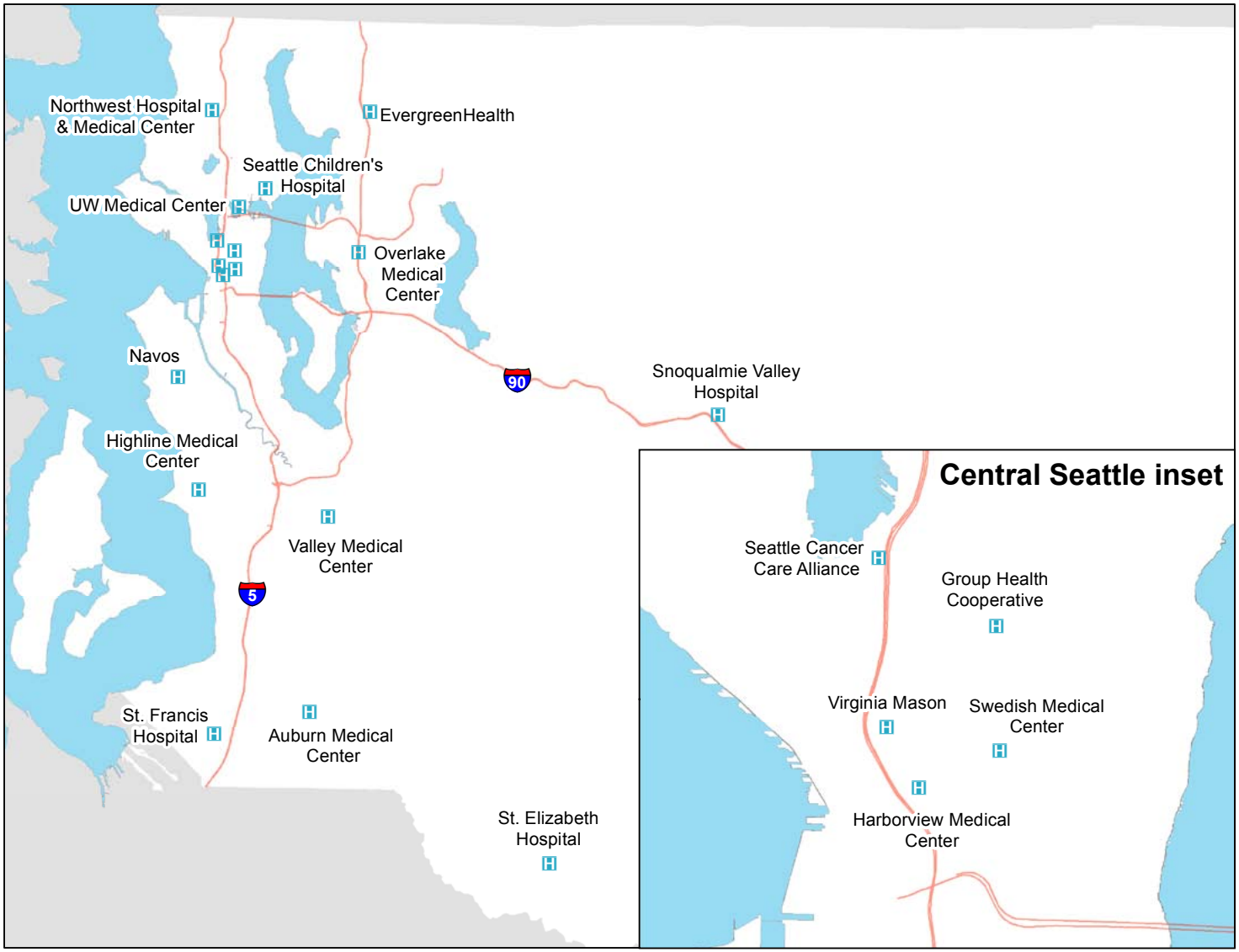
The focus area for this community health needs assessment is King County, the common community for all hospitals participating in the HHC collaborative. King County is the 13th most populous county in the United States. With an estimated 2013 population of 2 million and growing, King County is home to one-third of Washington State's population. King County includes Seattle and 38 other cities, plus unincorporated areas, rural areas, 19 school districts, and 12 hospitals and health systems. South Region has an estimated 704,000 residents, larger than Seattle (617,000), East Region (514,000) and North Region (122,000). More detailed demographic information about King County and the 4 regions is located in Appendix D.

Children and teens represent 21% of the King County population, and 11% of the population are 65 or older. Almost one quarter (24%) of adults has a disability.

King County: home to 2 million and increasingly diverse

King County Hospitals for a Healthier Community

Member hospitals, September 2014



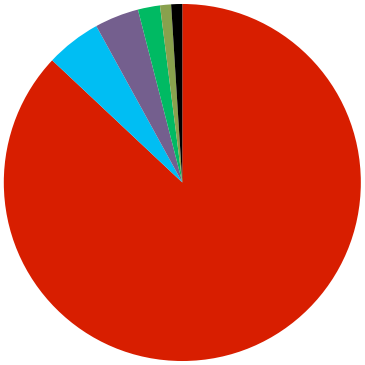
Description of Community

Continued

Changing Demographics

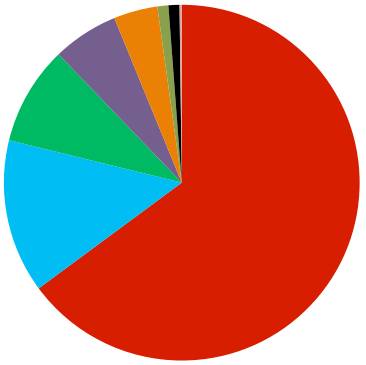
As King County's population continues to grow, it is also experiencing dramatic demographic shifts: increasing diversity, increasing poverty, and large health inequities compared to other large counties in the U.S. Successive waves of immigrants and refugees from Asia, the Horn of Africa, Central America, and the former Soviet Union have transformed the population. Many of our foreign-born residents are refugees with complex needs. As they integrate into society, these new residents can face enormous challenges, including language barriers, isolation, past trauma, poverty, and disability.

King County, 1980
Population: 1,269,898



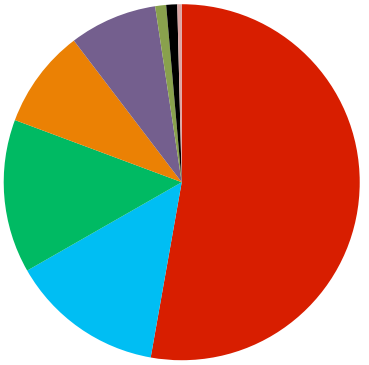
White/non-Hispanic	87%
Asian/Pacific Islander	5%
Black/African American non-Hispanic	4%
Hispanic/Latino	2%
American Indian/Alaska Native	1%
Some other race	1%

King County, 2010
Population: 1,931,249



White/non-Hispanic	65%
Asian/non-Hispanic	14%
Hispanic/Latino	9%
Black/African American non-Hispanic	6%
Multiple race	4%
American Indian/Alaska Native/non-Hispanic	1%
Native Hawaiian/Pacific Islander/non-Hispanic	1%
Some other race	0.2%

Population under age 18 King County, 2010
Population size: 413,502



White/non-Hispanic	53%
Asian/non-Hispanic	14%
Hispanic/Latino	14%
Multiple race	9%
Black/African American non-Hispanic	8%
American Indian/Alaska Native/non-Hispanic	1%
Native Hawaiian/Pacific Islander/non-Hispanic	1%
Some other race	0.4%

Data source: US Census Bureau, Census 1980, 2010
Percentages may not add up to 100% due to rounding

Description of Community

Continued

Students at area school districts speak dozens of different languages;[v] the Tukwila School District has been dubbed "the most diverse school district in the nation."[vi] More than 1 of every 3 residents—and almost half of children—is a person of color, and the diversification trend is expected to continue. The county's fast-growing southern suburbs include several cities and school districts that are already "majority minority"–where people of color make up more than half the population. Approximately 170 languages are spoken in King County, and 1 of every 4 King County residents speaks a language other than English at home—more than twice the rate only 20 years ago. In addition to Spanish (the most frequently spoken language), Vietnamese, Russian, Chinese, Korean, Tagalog, and African languages (primarily Somali) are also common.

King County's population over age 60 is increasing, and will continue to grow as baby boomers age (doubling from 1990 to 2020). Adults older than 60 will comprise 21 percent of the county's total population by 2020, up from 16 percent in 2010.[vii] Since many health conditions increase with age, this has implications for increased burden on the healthcare system.

Increasing Poverty

Poverty continues to rise: almost 1 of every 5 residents—more than 500,000 adults and children—now live in or near poverty (below 200% of the Federal Poverty Level). As poverty shifts from inner-city Seattle to the margins of Seattle and suburban areas to the south, prevalence of chronic diseases and associated risk factors are increasing in those areas. This mirrors what is happening across the nation.[viii] For poverty in particular, looking at King County as a whole masks huge disparities. One indicator of poverty, eligibility for the Free or Reduced-Price Meal program, varied widely in the 2012-2013 school year – from 4% of students in Mercer Island to 79% in Tukwila. With the exception of the rural Skykomish school district, all districts with 50% or more students in the Free or Reduced-Price Meal programs were located in South King County.[ix]

Description of Community

Continued

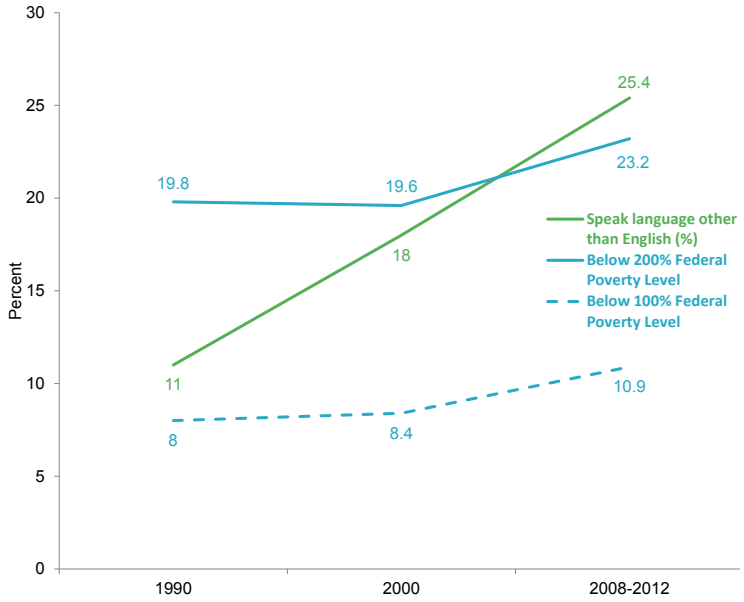
Housing Affordability

As costs for rent and home purchases increase, families have less to spend on other necessities. Almost half of renters and 40% of owners with a mortgage in King County are paying more than 30% of their household income on housing—the threshold for unafford-ability. An estimated 11,561 people took refuge in emergency shelters in 2012-2013, and the number of students experiencing homelessness continued its upward trend to 6,188 students in the 2012-2013 school year.[x]

Stark Disparities by Place, Race, and Income

Overall King County rankings on measures of quality of life, socioeconomic status, and health are among the highest in the country. As with poverty, however, these averages mask stark differences by place, race and income. People of color, people living in poverty, and those living in communities with few opportunities also experience the health-related impacts of inequity. Any efforts to improve the health of the community and to successfully achieve the triple aims of better health, better care, and lower healthcare costs will require strategies that acknowledge and tackle these disparities.

Demographic Trends in King County



Life Expectancy and Leading Causes of Death

King County Community Health Needs Assessment 2015/2016

Life expectancy and leading causes of death are broad foundational health measures often used by local, state, and federal public health agencies to monitor progress in promoting wellbeing, preventing disease and disability, and reducing health disparities.

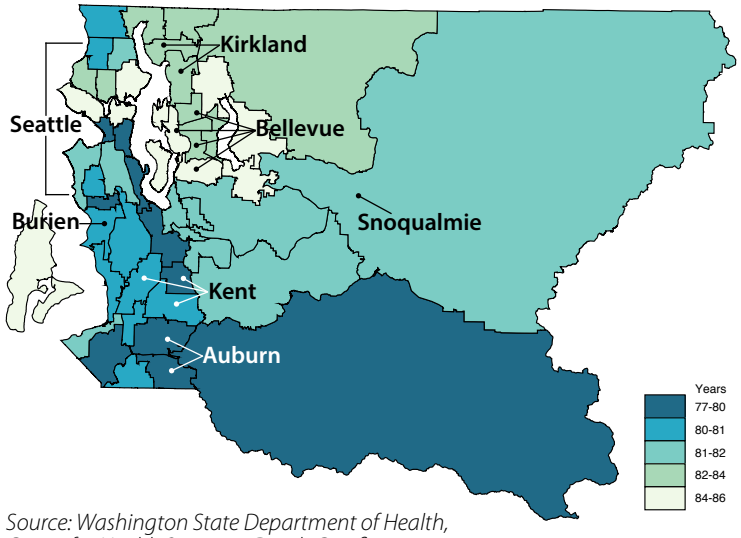
Life expectancy is defined as the number of years a newborn can expect to live if current death rates remain the same during her lifetime. While King County's life expectancy exceeds the national average, the county average masks broad disparities by place and race/ethnicity.

Differences in leading causes of death vary by age. While injuries are a leading cause for children, teens, and young adults, cancer and heart disease are leading causes of deaths for older adults.

Place matters, with shorter life expectancies in southeast Seattle and south King County.

Life expectancy at birth by Health Reporting Areas

King County, 2008-2012



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

Life Expectancy and Leading Causes of Death

Continued

Life Expectancy

In 2012, the average life expectancy for King County newborns was 81.7 years.

- Residents of the South Auburn neighborhood are expected to live an average of 10 fewer years than those in the West Bellevue neighborhood.
- From 2000 to 2012, life expectancy increased steadily in King County overall and in all regions except East Region, where it is already comparatively high.

Leading Causes of Death

In 2012, the top two leading causes of death in King County were cancer and heart disease.

- With the exception of Alzheimer's disease, the rank order of causes of death has been fairly stable over time. Alzheimer's moved from #10 in 1992, to #5 in 2002, and #3 in 2012, because of increases in attribution of death to Alzheimer's rather than other conditions (such as pneumonia, cardiovascular disease, pulmonary embolism, dehydration).
- Among King County residents age 1 to 44 years, the top-ranked causes of death are unintentional injuries, cancer, and suicide. For adults 45 and older, cancer and heart disease dominate the rankings.
- All racial/ethnic groups share heart disease and cancer as the top 2 causes of death.
- Unintentional injury is ranked #3 for American Indian/Alaska Natives, Blacks, Hispanics, and Native Hawaiians, reflecting the relative youth of these populations.

Life Expectancy and Leading Causes of Death

Continued

Leading causes of death by age

King County, 2008-2012 average

Rank	King County	Age < 1	Age 1-14	Age 15-24	Age 25-44	Age 45-64	Age 65-74	Age 75 & older
1	Cancer	Congenital malformations	Unintentional injury	Unintentional injury	Unintentional injury	Cancer	Cancer	Heart disease
2	Heart disease	Sudden infant death syndrome	Cancer	Suicide	Cancer	Heart disease	Heart disease	Cancer
3	Alzheimer's disease	Short gestation and low birth weight	Congenital malformations	Homicide	Suicide	Unintentional injury	Chronic lower respiratory disease	Alzheimer's disease
4	Stroke	Maternal complications of pregnancy	Homicide	Cancer	Heart disease	Chronic liver disease and cirrhosis	Diabetes	Stroke
5	Unintentional injury	Complications of placenta/ cord	Suicide	Congenital malformations	Homicide	Suicide	Stroke	Chronic lower respiratory disease
6	Chronic lower respiratory disease	Bacterial sepsis of newborn			Chronic liver disease and cirrhosis	Diabetes	Unintentional injury	Diabetes
7	Diabetes	Diseases of circulatory system			Diabetes	Chronic lower respiratory disease	Chronic liver disease and cirrhosis	Unintentional injury
8	Suicide	Unintentional injury			Stroke	Stroke	Alzheimer's disease	Parkinson's disease
9	Chronic liver disease and cirrhosis	Necrotizing enterocolitis			HIV/AIDS	Viral hepatitis	Kidney diseases	Influenza and pneumonia
10	Influenza and pneumonia	Respiratory distress			Influenza and pneumonia	Septicemia	Septicemia	Pneumonitis from solids/ liquids
Ave.# per yr.	**11,896**	**101**	**37**	**120**	**512**	**2,315**	**1,683**	**7,129**

Blank cell = too few cases to report in order to protect individual confidentiality. The leading causes of death are ranked by the number of deaths over the 5-year period.

Rate = Deaths per 100,000 population. Rates for all ages are age-adjusted to the 2000 U.S. population.

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

Chronic Illnesses

Chronic illnesses are among the leading causes of death, disability, and hospitalization in King County, Washington State, and the U.S. They are generally characterized by multiple risk factors, a long period of development, prolonged course of illness, and increased incidence with age. This section focuses on chronic illnesses for which the health care delivery system plays a major role in prevention, screening, and treatment: asthma, diabetes, HIV, and cancers of the colon, cervix, and breast.

The leading causes of hospitalization for children and young adults are pregnancy/ childbirth complications, asthma, and injuries.

ASTHMA

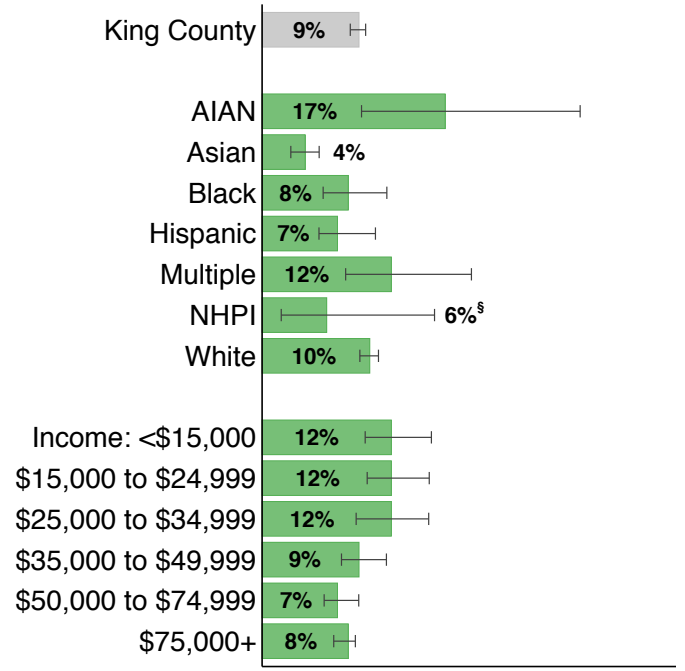
ADULT ASTHMA

From 2009 to 2013, 9% of King County adults reported i) they had been told by a health professional that they had asthma and ii) they still had asthma.

- Women were 1.6 times as likely as men to have asthma.
- Adults with annual household income below $25,000 were 1.5 to 1.7 times more likely to have asthma than those with income above $50,000.

Asthma (adults)

King County, 2009-2013 average

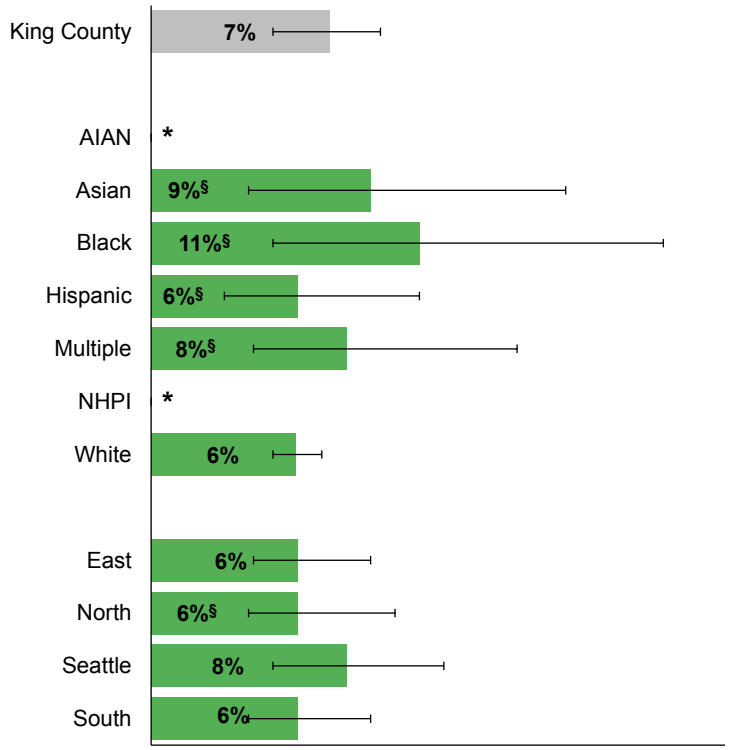


Source: Behavioral Risk Factor Surveillance System.

CHILDHOOD ASTHMA

From 2009 to 2013, 7% of King County children aged 0-17 had asthma. During this period children's asthma decreased in Seattle, but did not change in King County overall.

Current asthma among children age 0-17
King County, 2009-2013 average



Source: Behavioral Risk Factor Surveillance System

DIABETES

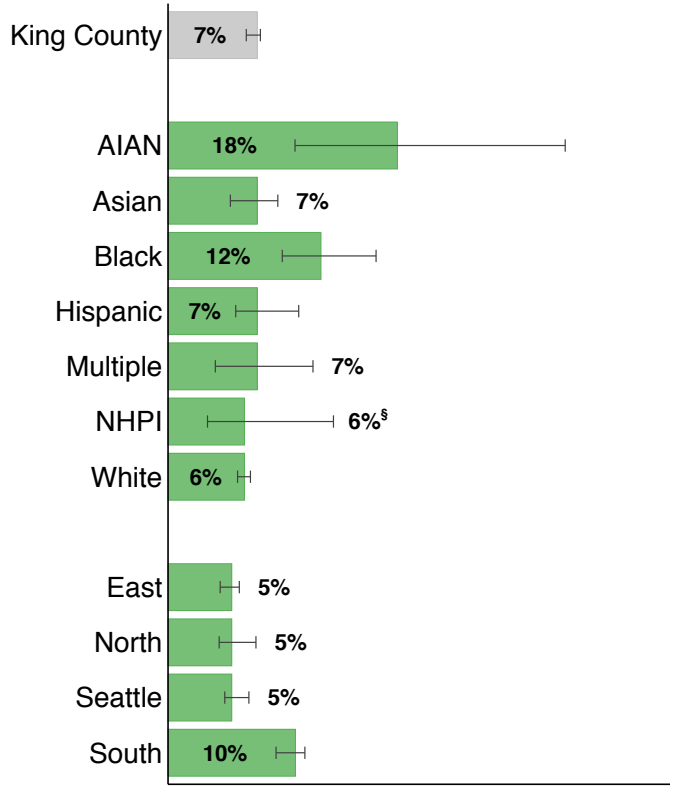
ADULT DIABETES

From 2009 to 2013, 7% of King County adults reported having been told by a doctor that they had diabetes (excluding "pre-diabetes" and diagnoses during pregnancy).

- Adults age 65 and older were 9 times more likely than those ages 45-64 to have diabetes.
- American Indian/Alaska Native adults were about 3 times as likely as white, Asian, and Hispanic adults to have diabetes.
- From 2000 to 2013, adult diabetes rates increased for the county as a whole and in South Region.

Diabetes (adults)

King County, 2009-2013 average



Source: Behavioral Risk Factor Surveillance System.

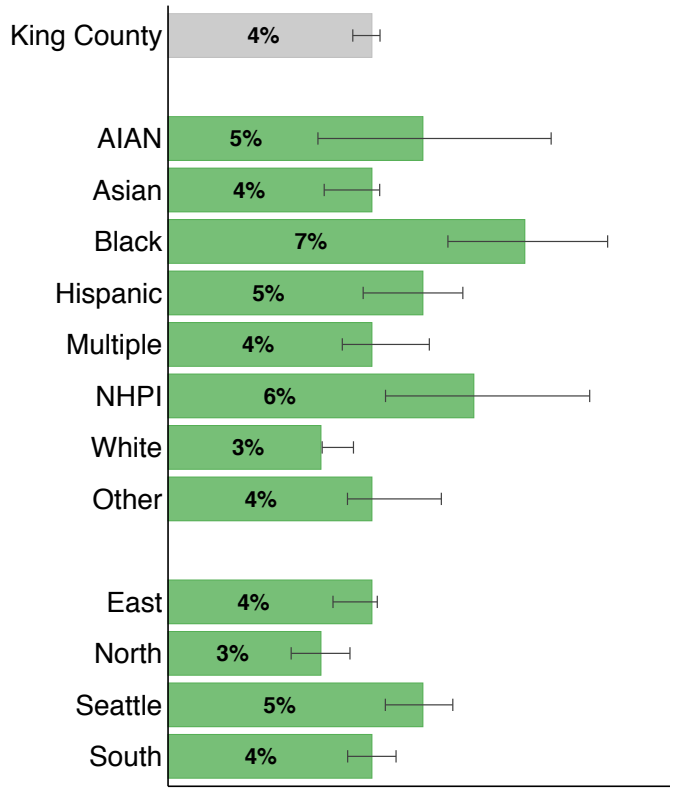
CHILDHOOD DIABETES

From 2008 to 2010, 4% of King County students in 8th, 10th and 12th grades had doctor-diagnosed diabetes. This includes both Type I and Type II diabetes.

- Native Hawaiian/Pacific Islander and Black students were more than 2 times as likely as white students to have been diagnosed with diabetes.
- In contrast with adult diabetes, children's diabetes rates declined from 2004 to 2010 for the county as a whole and in South Region.

Diabetes (school-age)

King County, 2008-2010 average



Source: Healthy Youth Survey.

HUMAN IMMUNODEFICIENCY VIRUS (HIV)

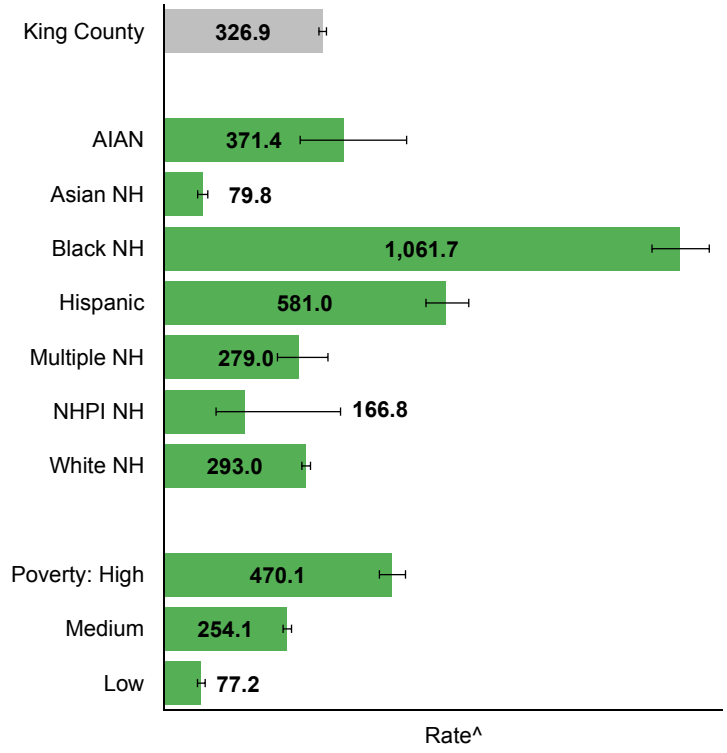
Human immunodeficiency virus (HIV) can lead to acquired immunodeficiency syndrome (AIDS), a condition characterized by progressive failure of the immune system.

HIV PREVALENCE

In 2013, 6,995 King County residents were known to have HIV, a rate of 326.9 cases per 100,000 population.

- The Capitol Hill-Eastlake neighborhood has the highest rate of HIV, a rate 45 times greater than in the areas with the lowest rate (Black Diamond-Enumclaw-Southeast County and Bear Creek- Carnation-Duvall).
- Non-Hispanic Black residents of King County were 13 times more likely to be living with HIV than Asians, the race/ethnicity group with the lowest rates in King County.
- Prevalence rates were even higher among foreign-born Blacks, men who have sex with men, and injection drug users.[xi]

HIV Prevalence
King County, 2013



Source: HIV/AIDS Registry data as of 4/14, Public Health - Seattle & King County
^Rate = Cases per 100,000 population
NH: Non-Hispanic

CANCERS OF THE COLON, CERVIX, AND BREAST

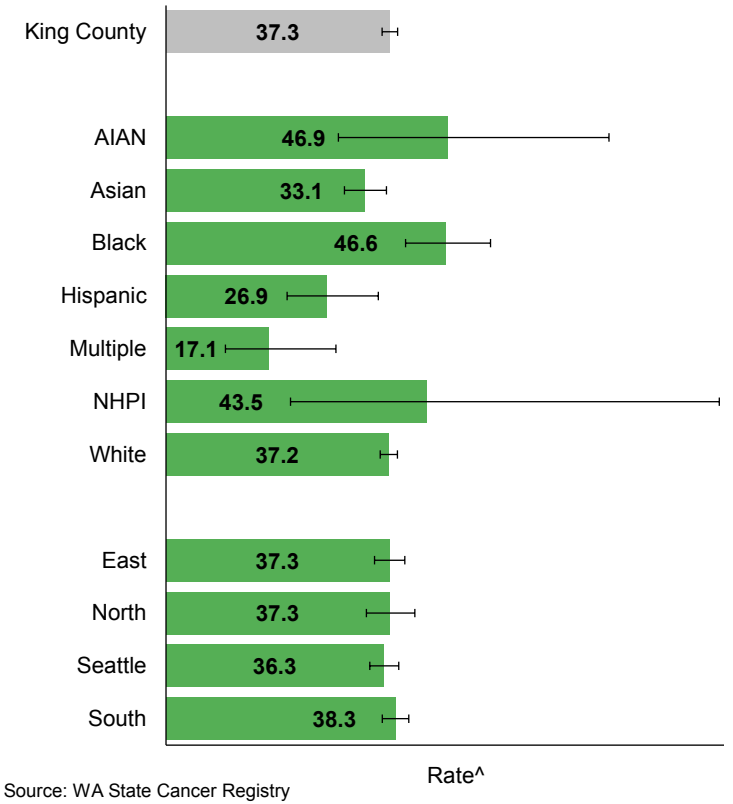
INVASIVE COLORECTAL CANCER

From 2007 to 2011, an average of 691 new cases of invasive colorectal cancer were diagnosed in King County each year, for a rate of 37.3 cases per 100,000 population.

- Even after adjusting for age differences, American Indian/Alaska Native and Black residents had the highest rates of colorectal cancer.
- From 2000 to 2011, the rate of new colon cancer diagnoses declined in King County overall and in all regions except North Region.

Invasive Colorectal Cancer Incidence

King County, 2007-2011 average



Source: WA State Cancer Registry

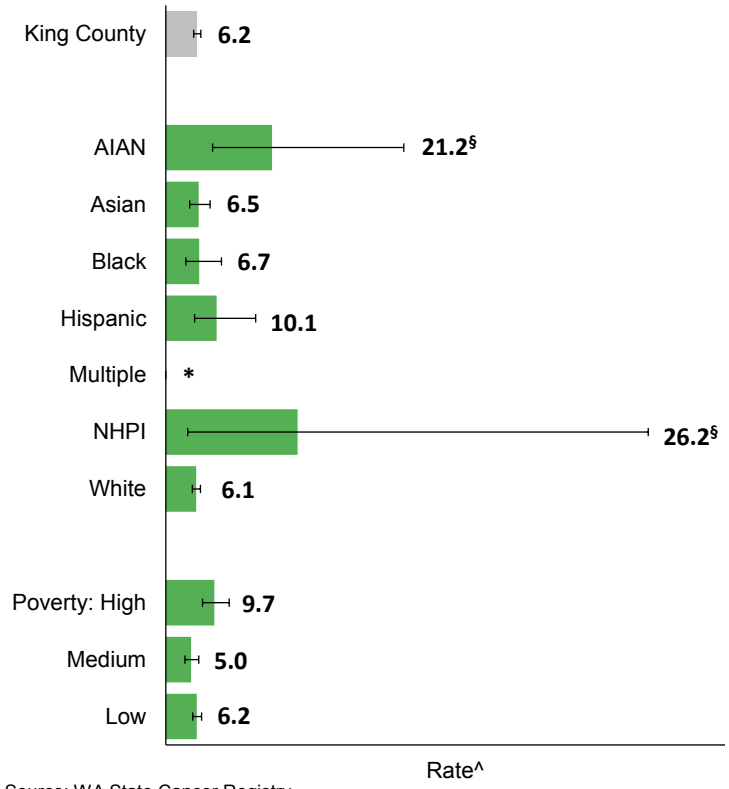
^Rate = Cases of colorectal cancer per 100,000 population, age-adjusted to the 2000 US population.

INVASIVE CERVICAL CANCER

From 2007 to 2011, on average 64 new cases of invasive cervical cancer were diagnosed each year in King County, an average rate of 6.2 cases per 100,000 women.

- American Indian/Alaska Native women were 3.5 times more likely than white women to be diagnosed with cervical cancer.
- Women living in high poverty areas were almost twice as likely as women living in low poverty areas to be diagnosed.

Invasive Cervical Cancer Incidence
King County, 2007-2011 average



Source: WA State Cancer Registry

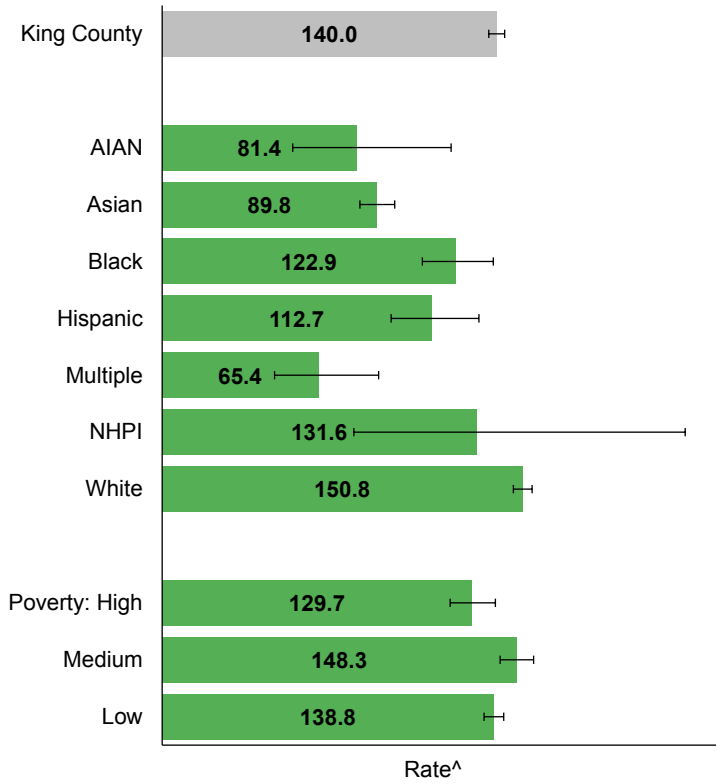
^Rate = Cases of uterine cancer per 100,000 women, age-adjusted to the 2000 US population.

INVASIVE BREAST CANCER

From 2007 to 2011, 1,426 new cases of breast cancer were diagnosed each year among King County women, a rate of 140.0 cases per 100,000 women.

- In King County overall, rates of new diagnoses declined from 2000 to 2006, then flattened out after 2006. Seattle showed a similar pattern, with the plateau starting after 2007. In East Region, rates continued to decline through 2011.
- The rate of new breast cancer diagnoses was highest among King County white women. However, mammography rates were lower among Black women than in white women.

Invasive Breast Cancer Incidence in Women
King County, 2007-2011 average



Source: WA State Cancer Registry

^Rate = Cases of breast cancer per 100,000 women, age-adjusted to the 2000 US population.

LEADING CAUSES OF HOSPITALIZATION

Hospitalization data offer another perspective on the health of King County residents.

- The leading causes of hospitalization among adults were pregnancy/childbirth complications, heart disease, injuries, and mental illness.
- For children and young adults, pregnancy/childbirth complications, asthma, and injuries are the leading causes of hospitalizations. Newborn deliveries and uncomplicated childbirth hospitalizations are not shown.
- The hospitalization rate for heart disease is 54% higher among men than women.

The leading causes of hospitalization are ranked by the number of hospitalizations over the 5-year period. Excludes hospitalization of newborns for delivery.

Rate = Hospitalizations per 100,000 population, age-adjusted to the 2000 US population.

Source: Washington State Department of Health, Office of Hospital and Patient Data Systems, Hospital Discharge Data.

Pregnancy and childbirth complications: Major complications include prolonged pregnancy, high blood pressure (e.g. preeclampsia, eclampsia), Newborn delivery refers to routine hospitalization of a newborn infant after birth.

Heart disease: Major sub-causes include congestive heart failure, cardiac dysrhythmias, acute myocardial infarction (i.e. heart attack), and coronary artery disease.

Unintentional injuries: Major sub-causes include falls, motor vehicle accidents, and poisoning.

Mental illness: Major sub-causes include biopolar disorder, depression, schizophrenia, and alcohol and substance-related disorders.

Cancer and benign tumors: Major sub-causes include uterine cancer, colorectal cancer, prostate cancer, lung cancer, and lymphatic cancer.

Leading causes of hospitalization

By gender, King County, 2008-2012 average

Rank	Female	Male	Total
1	Pregnancy-childbirth complications	Heart disease	Pregnancy-childbirth complications
2	Heart disease	Unintentional injuries	Heart disease
3	Unintentional injuries	Mental illness	Unintentional injuries
4	Mental illness	Cancer and benign tumors	Mental illness
5	Cancer and benign tumors	Infectious and parasitic diseases	Cancer and benign tumors
6	Osteoarthritis	Lower gastrointestinal disorders	Osteoarthritis
7	Lower gastrointestinal disorders	Respiratory infections	Lower gastrointestinal disorders
8	Infectious and parasitic diseases	Osteoarthritis	Infectious and parasitic diseases
9	Respiratory infections	Stroke	Respiratory infections
10	Stroke	Skin infections	Stroke
Ave.# per yr.	**99,049**	**69,484**	**168,534**

Lower gastrointestinal disorders: Major sub-causes include intestinal obstruction without hernia, appendicitis, and diverticulitis.

Infectious and parasitic diseases: Major sub-causes include septicemia (bacterial infection of the blood) and viral infection.

Respiratory infections: Major sub-causes include pneumonia and acute bronchitis.

Access to Care, Use of Clinical Preventive Services, and Oral Health

King County Community Health Needs Assessment 2015/2016

Access to comprehensive, high-quality healthcare facilitates prevention and early detection of disease. Without health insurance, most people cannot afford quality healthcare, and disparities in coverage perpetuate disparities in health and quality of life. Access to health insurance coverage has improved with expansion of Medicaid eligibility and implementation of health insurance marketplaces for Qualified Health Plans. However, for 1 in 7 King County adults, costs are a barrier to seeking needed medical care. Too many adults and children in the county do not receive recommended clinical preventive services or regular oral healthcare services.

Opportunities include assistance for people without health insurance or who struggle to afford health insurance premiums; increased workforce diversity; and increased Medicaid reimbursement of dental care providers.

"Dental care is sorely lacking. There's nothing we're doing as badly."

– Emergency Department physician

ACCESS TO CARE

COVERAGE IS HERE KING COUNTY CAMPAIGN

The first open enrollment period for new health insurance options took place in 2013 and 2014. Organizations in King County partnered on the *Coverage Is Here King County* campaign and, through their collective efforts, enrolled 165,000 residents in new coverage. Each hospital in King County played a role in helping families access new free and low-cost health insurance options. Across all hospitals and health systems, more than 300 staff were trained and certified as In-Person Assisters (IPA) to help community members with enrollment in Medicaid or a Qualified Health Plan through Washington Healthplanfinder. County-wide, hospital staff enrolled over 13,000 individuals. Hospitals also publicized the opportunity to enroll through signage in their facilities, radio ads, websites, speaking engagements, and extensive workforce education. Early data suggest that the proportion of hospital patients with insurance coverage is increasing and use of charity care is declining. For the latest enrollment data, see http://www.kingcounty.gov/healthservices/health/partnerships/HealthReform.aspx

Access to Care, Use of Clinical Preventive Services, and Oral Health

Continued

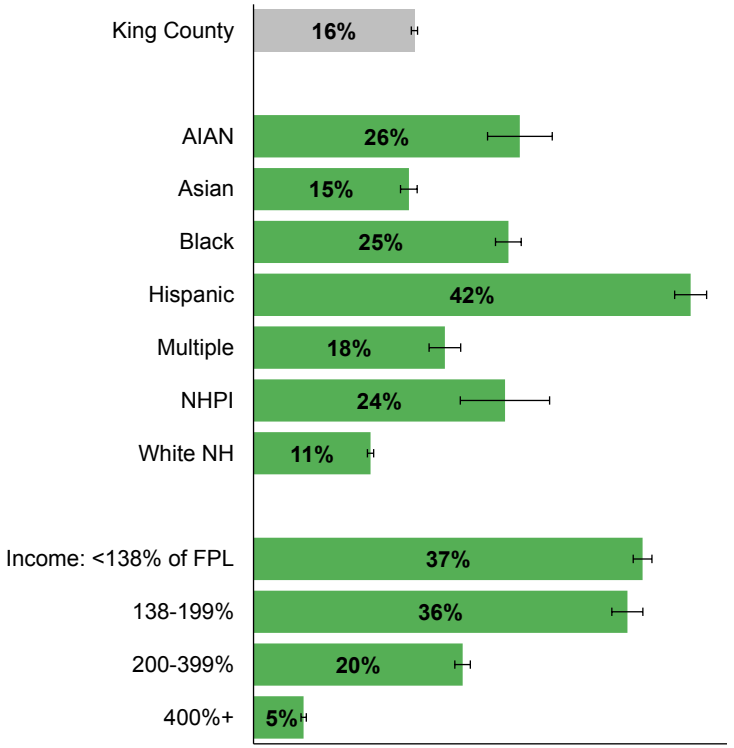
UNINSURED ADULTS

From 2008 to 2012, 16% of King County adults ages 18-64 had no health insurance. Expansion of coverage through the Affordable Care Act has probably reduced this rate, but 2014 data are not yet available. Most adults ages 65 and older are covered by Medicare, so are not included in this indicator.

- Hispanic adults were 3.8 times more likely than non-Hispanic whites to be without coverage.
- Low-income adults (household income less than 200% of the Federal Poverty Level [FPL]) were more than 7 times more likely to be uninsured than those in the highest income households.
- Adults age 65 and older are not included here, as most are covered by Medicare.

Adults age 18-64 with no health insurance

King County, 2008-2012 average



Source: American Community Survey, US Census
FPL, Federal Poverty Level

Access to Care, Use of Clinical Preventive Services, and Oral Health

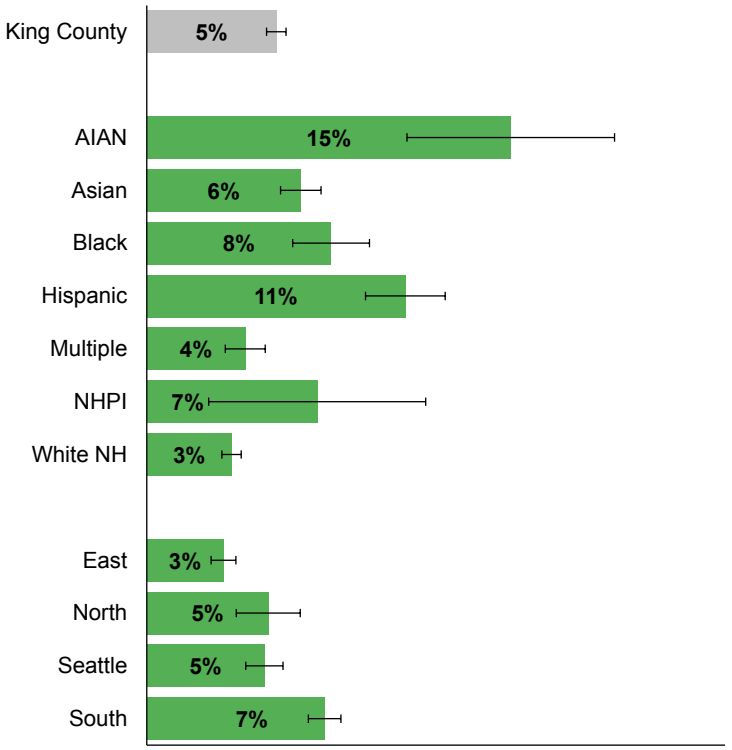
Continued

UNINSURED CHILDREN

From 2008 to 2012, an average of 5% of King County children had no health coverage.

- American Indian/Alaska Native children were 5 times more likely than non-Hispanic white children to be uninsured.
- Children in low-income households (less than 200% of the FPL) were 5 times more likely than those in the highest income households to be uninsured.
- Children living in South Region were more than twice as likely to be uninsured than children living in East Region.

Children age 0-17 with no health insurance
King County, 2008-2012 average



Source: American Community Survey, US Census

Access to Care, Use of Clinical Preventive Services, and Oral Health

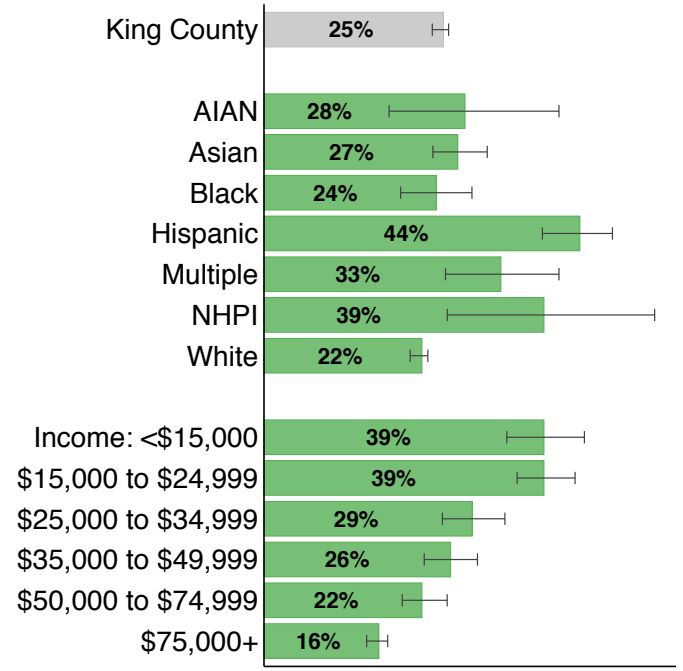
Continued

ADULTS WITHOUT USUAL PRIMARY CARE PROVIDER

From 2009 to 2013, 1 in 4 King County adults did not have anyone they identified as a primary healthcare provider.

- Adults with household income less than $25,000 were 2.4 times more likely than those with incomes over $75,000 to be without a primary care provider.
- Hispanics were twice as likely as whites to have no primary care provider.
- Adults age 18-24 were more than 9 times more likely than those age 65 or older to be without usual primary care provider. In general the likelihood of not having a primary care provider decreased with increasing age.
- From 2000 to 2013, the proportion of adults without a primary care provider increased for the county as a whole and in East and South Regions.

Does not have personal doctor (adults)
King County, 2009-2013 average



Source: Behavioral Risk Factor Surveillance System.

Access to Care, Use of Clinical Preventive Services, and Oral Health

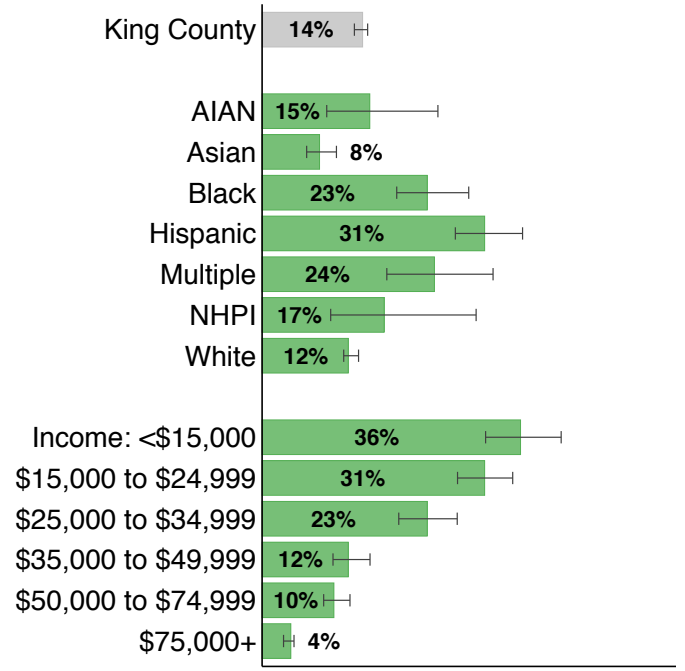
Continued

UNMET MEDICAL NEEDS

From 2009 to 2013, 14% of King County adults reported they needed to see a doctor in the past 12 months but could not, due to cost.

- Hispanics were 3.9 times more likely than Asians to report unmet medical needs.
- Adults with household income less than $25,000 were at least 8 times more likely than those earning more than $75,000 to report unmet medical needs.
- Compared to adults with health insurance, uninsured adults were more than 4 times as likely to have unmet medical needs.[xii]
- In King County, unmet medical need increased from 2000-2004, plateaued from 2004-2007, then increased again from 2007-2013. In East Region, rates held steady through 2006, then began to increase. In South Region, rates increased between 2000 and 2013.

Unmet medical need (adults)
King County, 2009-2013 average



Source: Behavioral Risk Factor Surveillance System.

KEY ACCESS TO CARE ISSUES: COMMUNITY INPUT, RESOURCES, AND OPPORTUNITIES

Community input:

While many residents have found coverage since implementation of the Affordable Care Act, some are not eligible for subsidies or Medicaid, choose not to enroll, or struggle to afford premiums. Community members stressed that the healthcare system should continue to provide charity care for people who fall through the cracks.

For those with coverage, ongoing challenges include access to specialty care, adult dental care, and behavioral health services. Even with increased health insurance coverage, high deductibles and co-pays may deter an individual from seeking care when faced with the challenges of meeting basic needs for food and housing.

The potential loss of services such as case management, integrated mental health, nutrition counseling, and other non-clinical services presents another challenge to maintaining good health.

Assets and resources include:

- Community Health Centers continue to serve all residents regardless of ability to pay. Public Health Centers, tribal clinics, and school-based health centers also serve the health needs of the community (see map of facilities on page 46).
- Local hospitals remain committed to providing charity care to low-income individuals and enrolling residents in health coverage. In 2013, King County hospitals provided a total of $154.5 million in charity care to qualifying patients. Hospitals are still required to meet the state's charity care law and regulatory requirements (WAC 246-453).
- Project Access Northwest connects low-income and uninsured patients with specialty care and provides health literacy education.
- The Pacific Hospital Preservation and Development Authority provides funding for programs that address access to care issues.

Access to Care, Use of Clinical Preventive Services, and Oral Health

Continued

- The Health Coalition for Children and Youth (HCCY) is a coalition of organizations in Washington that work to meet the health needs of children, including medical, dental, and mental health care.
- The First Friday Forum is a coalition of community health centers, social service organizations, government agencies and hospitals that share information related to publicly sponsored health care program eligibility, enrollment, and best practices.
- The Edward Thomas House Medical Respite Care is a collaborative of several hospitals that works to reduce unnecessary hospitalizations by providing respite care for homeless individuals.
- WithinReach connects families, online, in-person, or through a hotline, with whatever resources they may need, e.g. health care enrollment, food, etc.

Opportunities include:

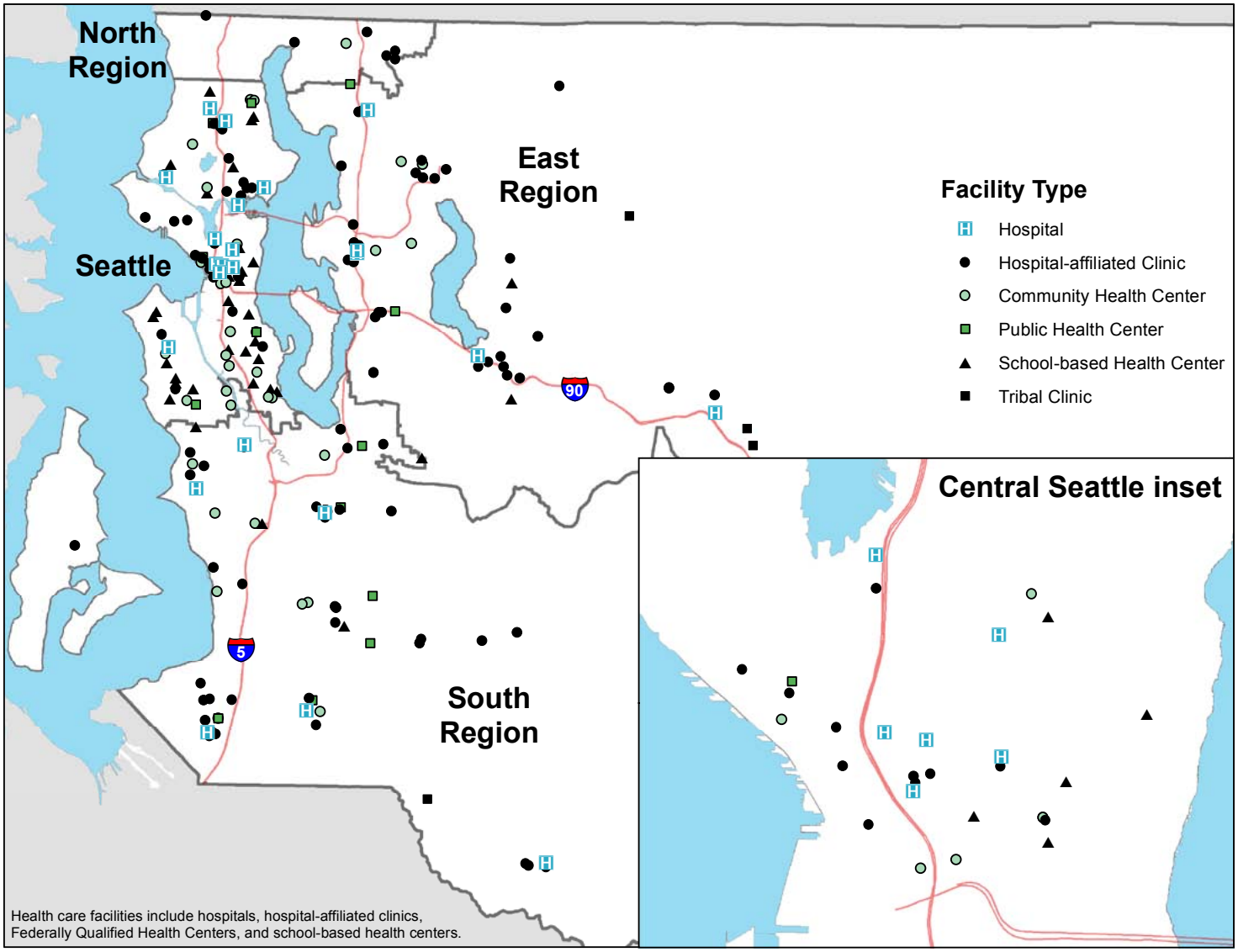
In 2014, several hospitals provided funds to assist low-income households with payment for insurance premiums. To qualify, household income needed to be less than 200% of the Federal Poverty Level (in 2014, approximately $47,700 a year for a family of 4 with 2 children) and had to be enrolled through Washington Healthplanfinder (Washington's health benefit exchange). This ongoing program is managed by Project Access Northwest.

Access to Care, Use of Clinical Preventive Services, and Oral Health

Continued

Hospital and safety net health care facilities

King County, October 2014



Access to Care, Use of Clinical Preventive Services, and Oral Health

Continued

WORKFORCE CAPACITY

Community input:

Community Health Centers report severe shortages of primary care providers. Community members stress the importance of a workforce that reflects our communities' diversity.

Assets and resources include:

- Seattle Jobs Initiative's Healthcare Career Pathway trains diverse, low-income residents in healthcare careers.
- As part of their healthcare workforce strategic plan, Seattle Central Community College's planned expansion of its Nursing and Allied Health programs at the Pacific Tower will double its number of training slots. Programs are expected to begin in fall of 2015. A consortium of local colleges is also creating a program for community health workers/patient care navigators.

USE OF CLINICAL PREVENTIVE SERVICES

Opportunities include:

- Working with alternative as well as allopathic healthcare providers to improve vaccination coverage; improving data on vaccination coverage.

INCOMPLETE VACCINES

In 2014, 13,586 King County children age 19-35 months (almost 2 out of 5 children, or 38%) had not completed the recommended series of immunizations for young children (4:3:1:3:3:1:4 series).

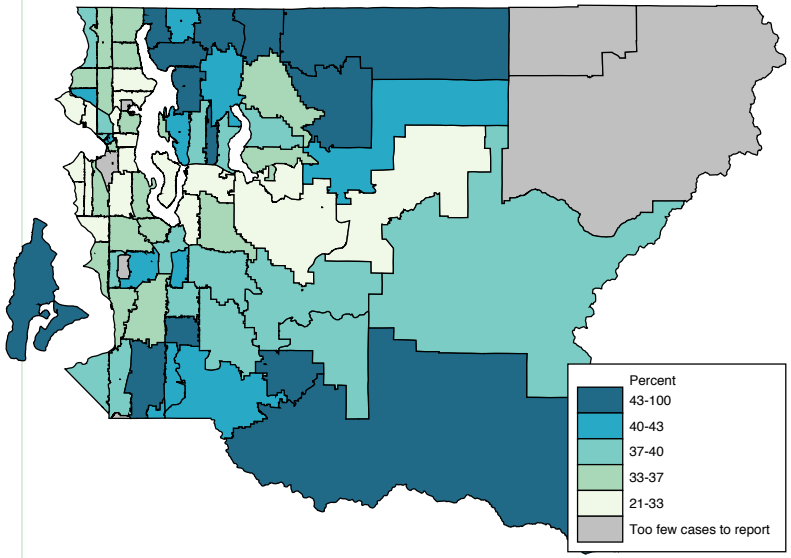
- These estimates are based on vaccination records submitted by healthcare providers to the WA State Immunization Information System (WSIIS). According to past statewide assessments, WSIIS estimates of vaccination coverage underestimate true coverage due to i) incomplete submission of vaccine records, and ii) retention of vaccine records of children after they have moved to another area.
- Children may not receive vaccines for a variety of reasons, including i) barriers to accessing clinical preventive services, and ii) family choices to not have children vaccinated.
- Completion rates are lowest in the South and North regions, representing both low- and high-income areas of King County, respectively.

Community input:

Incomplete vaccinations remain a concern. King County does not meet the Healthy People 2020 objective of reducing incomplete vaccination coverage to 20% of children aged 19-35 months.

Children with incomplete vaccine series, age 19-35 months, by zip code

King County, 2014



Source: Washington State Immunization Information System.

4:3:1:3:3:1:4 series is defined as 4 or more doses of diphtheria, tetanus, acellular pertussis (DTaP) vaccine; 3 or more doses of polio vaccine; 1 measles vaccine; 3 or more doses of Haemophilus influenzae type b (Hib) vaccine; 3 or more doses of hepatitis B (Hep B) vaccine; 1 or more doses of varicella vaccine; and 4 or more doses of pneumococcal conjugate vaccine (PCV).

Access to Care, Use of Clinical Preventive Services, and Oral Health

Continued

Assets and resources include:

- The VAX Northwest Immunity Community program is training parents to be immunization advocates in child care settings, pre-schools, and elementary schools.
- Almost all pediatric providers (~340) are enrolled in the Vaccines for Children Program, a federal program that provides vaccines at no cost to children who might otherwise not be vaccinated.
- Each year, PHSKC's Immunization Program and the Washington State Department of Health visit 50% of clinics enrolled in the Vaccines for Children Program. They assess clinics for best immunization practices and provide education and recommendations to healthcare providers. Additionally, 25% of these clinics receive a site visit from the CDC's AFIX (Assessment, Feedback, Incentives, and eXchange) quality improvement program to increase immunization coverage.
- The WithinReach Immunization Program promotes immunization coverage through a variety of programs, including the Immunization Action Coalition of WA, which raises public awareness and provides education to groups ranging from health care providers to parents, and Vax Northwest, which is a resource for parents to ensure that everyone can find accurate information about the value of vaccines.
- The Department of Health's Child Profile Health Promotion System helps to ensure that Washington's kids get the preventive health care they need, provides free educational resources to families, and tracks individual and population level immunization coverage.
- A grassroots campaign led by Vashon Island resident Celina Yarkin has been lauded for working to improve vaccination coverage among the island's children.

Opportunities include:

- Working with healthcare providers to improve vaccination coverage is extremely important. Patients trust their providers, and a provider's recommendation can shape a caregiver's decision to vaccinate a child.
- Improving vaccination coverage data would help public health practitioners identify pockets of need.
- Sustained work with naturopathic physicians and other providers of complementary and alternative medicine is needed to ensure that the benefits of vaccines are offered to all population groups.

Access to Care, Use of Clinical Preventive Services, and Oral Health

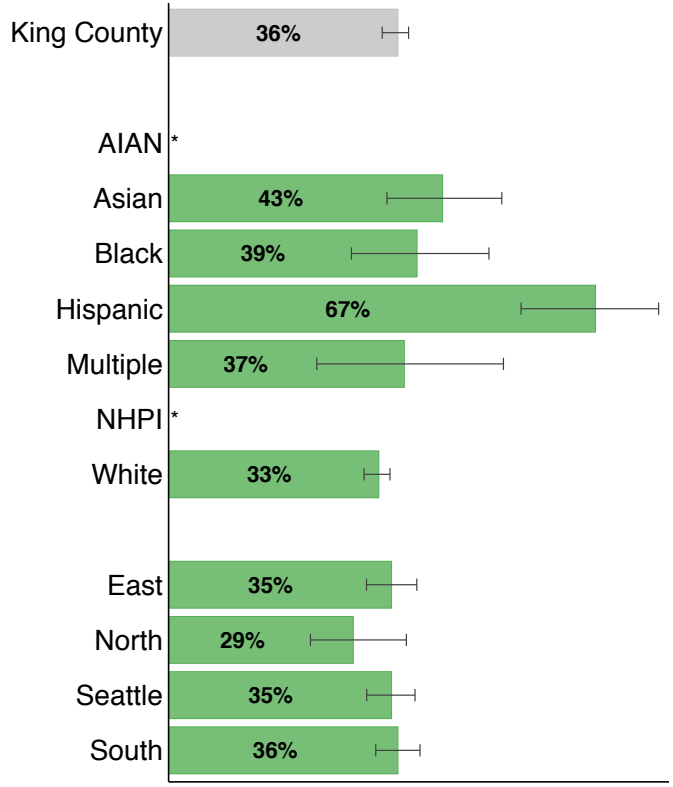
Continued

COLORECTAL CANCER SCREENING

From 2011 to 2013, more than 1 in 3 King County adults age 50-75 (36%) failed to meet colorectal cancer screening guidelines.[xiii]

- Adults with household income below $25,000 were half as likely as those in the highest income households to meet screening guidelines.
- Hispanics were half as likely as non-Hispanic whites to meet screening guidelines.

Colorectal cancer screening guidelines not met (age 50-75)
King County, 2011-2013 average



Source: Behavioral Risk Factor Surveillance System.

Access to Care, Use of Clinical Preventive Services, and Oral Health

Continued

ORAL HEALTH

ADULT DENTAL VISITS

From 2008 to 2012, an average 27% of King County adults reported they did not visit a dentist or dental clinic in the past year.

- American Indian/Alaska Native, Hispanic, and Black adults were about half as likely as whites to have had an annual dental visit.
- About half of adults with household income less than $25,000 had not visited a dentist in the past year.
- From 2001 to 2012, annual dental check-up rates did not change for King County adults overall; for adults in Seattle and South Region, however, fewer adults are getting annual check-ups.

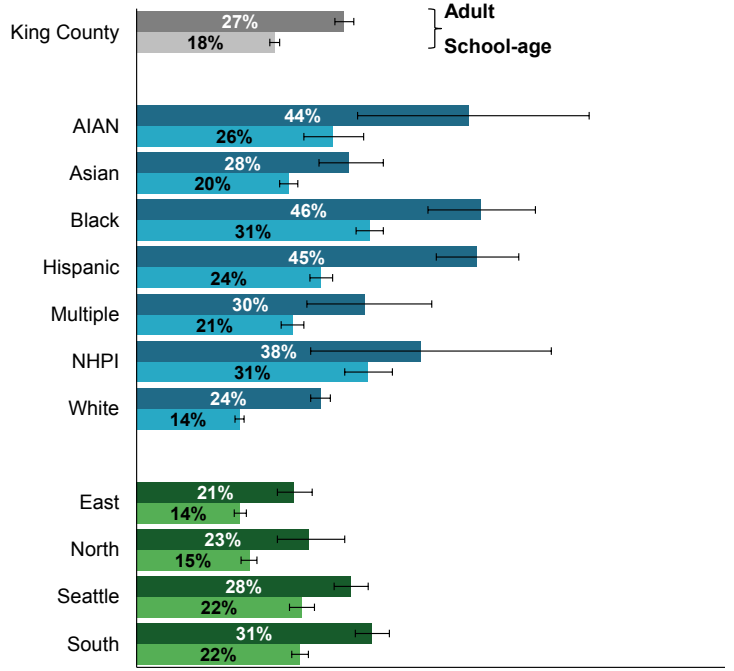
CHILDREN'S DENTAL VISITS

From 2008 to 2012, 18% of students in 8th, 10th and 12th grades reported they had not visited a dentist in the past year for a check-up, exam, teeth cleaning, or other dental work.

- Black and Native Hawaiian/Pacific Islander students were half as likely as white students to have an annual dental visit.
- Between 2004-2012, more students reported visiting the dentist in the county and all regions except Seattle.

No dental checkup in last year

King County, 2008-2012 average



Sources: Behavioral Risk Factor Surveillance System (Adult), Healthy Youth Survey (School-age).

Access to Care, Use of Clinical Preventive Services, and Oral Health

Continued

CHILDHOOD CAVITIES

Dental disease, which affects children's ability to eat, sleep, and learn, is a common, chronic problem among King County children. In 2010, 40.2% of kindergarten and 3rd-grade children had treated or untreated cavities.

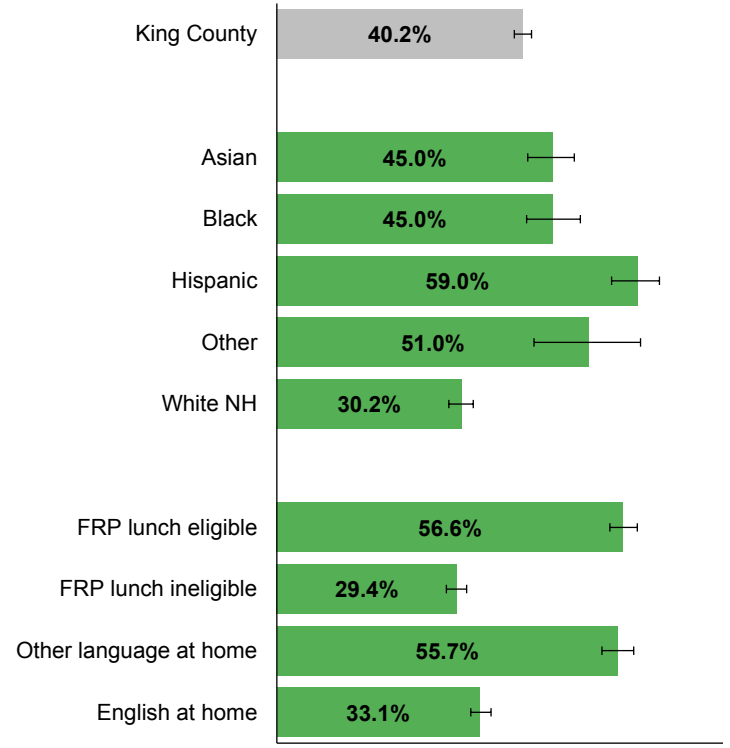
- Children eligible for free or reduced-price school meals were almost 2 times more likely than those from higher-income families to have untreated dental disease.
- Untreated dental disease was also more likely among …

… children of color (compared to white non-Hispanic children)

… children whose family spoke a language other than English at home.

- Use of protective dental sealants was high among all third-grade children.

Childhood cavities
King County, 2010



Source: 2010 King County Smile Survey
FRP, Free/Reduced Price
Other language: language other than English spoken at home
English: English spoken at home

Access to Care, Use of Clinical Preventive Services, and Oral Health

Continued

KEY ORAL HEALTH ISSUES: COMMUNITY INPUT, RESOURCES, AND OPPORTUNITIES

Community input:

Inadequate Medicaid reimbursement is likely to restrict access to adult dental care. While Medicaid now offers coverage for adult dental care, dentists report that reimbursements for private-practice care (only 25 cents on the dollar) are often too low to cover the costs of providing care to Medicaid eligible adults.[xiv]

Assets and resources include:

- Several community health centers have opened new dental clinics in 2014 and plan to open additional clinics in 2015.
- The Seattle and King County Access to Baby and Child Dentistry program connects low-income children, 0-5 years of age, with private dentists.
- The Seattle-King County Dental Society provides donated dental services for low-income residents who do not qualify for Medicaid.
- The SmileMobile is a mobile dental office serving low-income children. Services range from examinations and preventive care to fillings and minor oral surgery.

Opportunities include:

- Increasing reimbursement rates could provide incentive for dentists to accept patients with Medicaid.

ADULT PREVENTABLE HOSPITALIZATIONS

Prevention Quality Indicators (PQIs) are population-specific measures of the rate of adult hospital admissions for the 12 conditions listed in the table (also called "ambulatory care sensitive conditions").

- Good outpatient care or early intervention can potentially prevent the need for hospitalizations for these conditions. Therefore, PQIs are used as indicators of access to high quality, community-based primary care.
- The PQI "All" measure combines the acute and chronic PQIs into a single measure for an overall rate.

From 2008 to 2012 in King County:

- PQI hospitalizations were dominated by COPD/asthma for older adults, congestive heart failure, and bacterial pneumonia.
- Adults older than 75 had the highest rates of PQI hospitalizations (almost 7 times the county average).
- PQIs rates in high-poverty areas were double those of low-poverty areas.
- South Region had almost twice the rate of PQIs as East Region.

Since 2000, the PQI composite rate has declined in King County, East Region, and North Region but not in South Region. The Seattle rate has declined since 2006.

Adult preventable hospitalizations

King County, 2008-2012 average

	Rate	Average# per year
PQI Composite All	**773.7**	**11,766**
PQI Composite - Acute	**327.7**	**4,983**
Dehydration	67.1	1,020
Bacterial Pneumonia	154.3	2,346
Urinary Tract Infection	106.3	1,617
PQI Composite - Chronic	**446.0**	**6,783**
Diabetes- Short Term Complications	37.5	570
Diabetes-Long Term Complications	53.1	807
Diabetes-Uncontrolled	4.6	70
Lower Extremity Amputation (Diabetics)	8.6	131
Adult Asthma (Ages 18-39)	25.0	159
COPD or Asthma in Adults (Ages 40 and older)	209.1	1,844
Hypertension	20.5	312
Congestive Heart Failure	187.4	2,850
Angina	7.3	111

COPD=Chronic Obstructive Pulmonary Disease

Low birth weight is found in the maternal child health section. Perforated appendix admission rate not available.

Data Source: Hospitalization Discharge Data: Washington State Department of Health, Office of Hospital and Patient Data Systems.

Rate = number of hospitalizations per 100,000 population ages 18 and older.

Behavioral Health

King County Community Health Needs Assessment 2015/2016

Behavioral health refers to mental and emotional well-being and/or actions that affect wellness.[xv] Behavioral health conditions encompass both mental health and substance use disorders and are related to physical health and wellness. Mental illness is the second leading cause of disability and premature mortality, and accounts for over 15% of the burden of all diseases in the U.S.[xvi]

Health problems associated with substance abuse include psychosis, depression, drug overdose, skin and lung infections, HIV/AIDS, motor vehicle injuries, and other injuries.

Opportunities include use of standardized referral protocols, coordination of discharge planning across the healthcare system, increased capacity for integrated behavioral healthcare, and increased inpatient capacity for behavioral health.

More than 1 in 4 King County middle and high school students experienced depressive feelings.

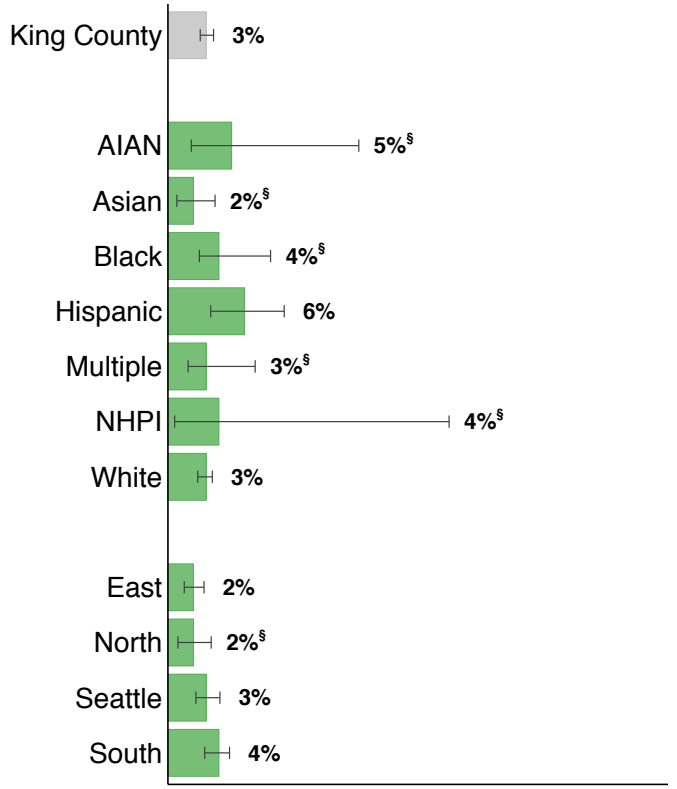
MENTAL HEALTH

ADULT SERIOUS PSYCHOLOGICAL DISTRESS

From 2009 to 2013, 3% of adults in King County experienced "serious psychological distress" (the reported frequency, over the past 30 days, of feeling nervous, hopeless, restless, depressed, worthless, or that everything was an effort).

- The rate for adults with household income under $15,000 was 5 times the county average.
- Data were insufficient to assess trends.

Serious psychological distress (adults)
King County, 2009-2013 average



Source: Behavioral Risk Factor Surveillance System.

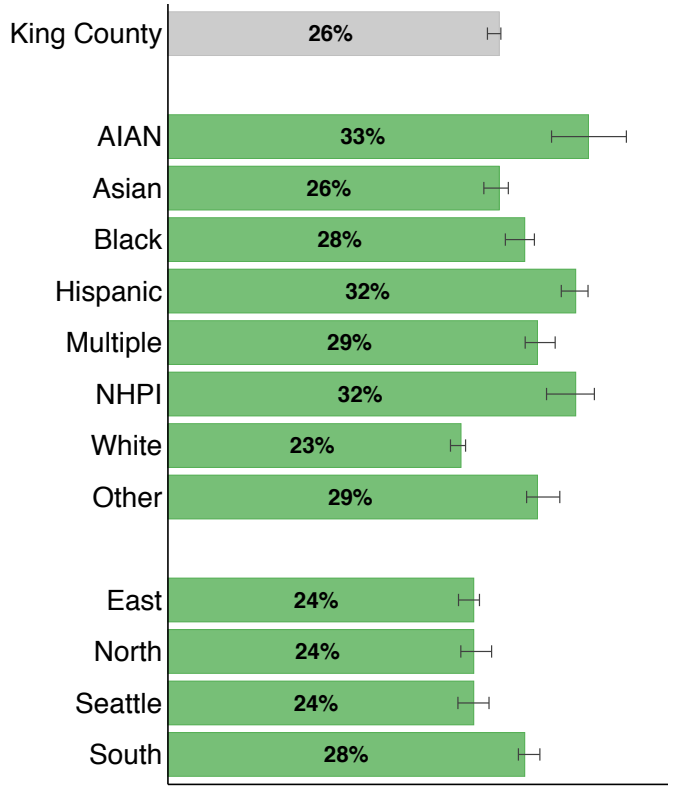
YOUTH WITH DEPRESSIVE FEELINGS

Over 2008-2012, over 1 in 4 (26%) of King County 8th, 10th, and 12th grade students experienced depressive feelings.

- Students were considered to have had depressive feelings if during the past year they reported feeling so sad/hopeless almost every day for 2 or more consecutive weeks that they stopped doing some usual activities.
- Females were 1.5 times more likely than males to report depressive feelings.
- Hispanic, Native Hawaiian/Pacific Islander, and Alaska Native/American Indian youth were more likely than Black and white youth to report depressive feelings.
- From 2004 to 2012, youth rates of depressive feelings decreased for King County overall and for Seattle and North Region.

Youth with depressive feelings (school-age)

King County, 2008-2012 average



Source: Healthy Youth Survey.

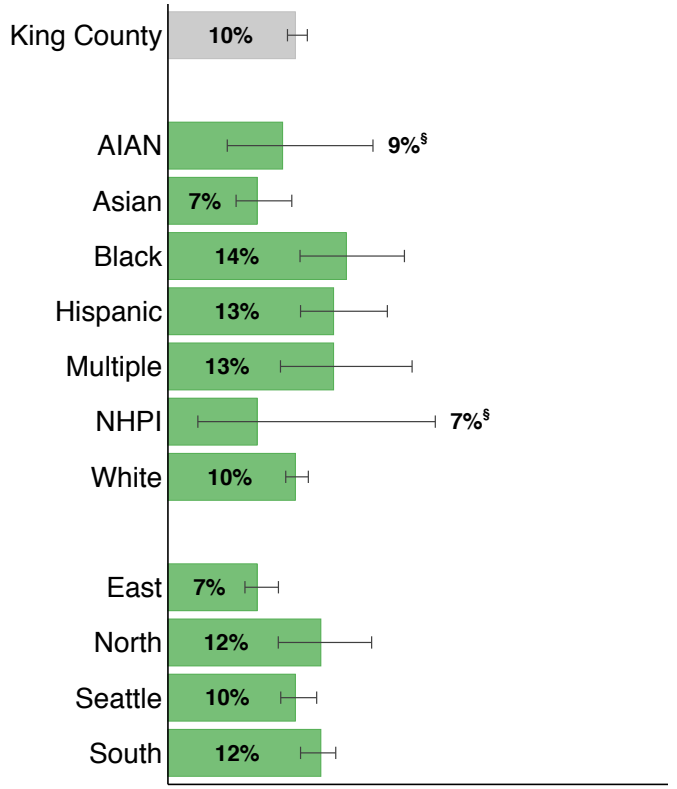
ADULT FREQUENT MENTAL DISTRESS

From 2009-2013, 10% of King County adults experienced frequent mental distress, defined as 14 or more of the past 30 days with poor mental health.

- The rate of frequent mental distress for adults in households with income under $15,000 was 2.4 times the county average.

Frequent mental distress (adults)

King County, 2009-2013 average



Source: Behavioral Risk Factor Surveillance System.

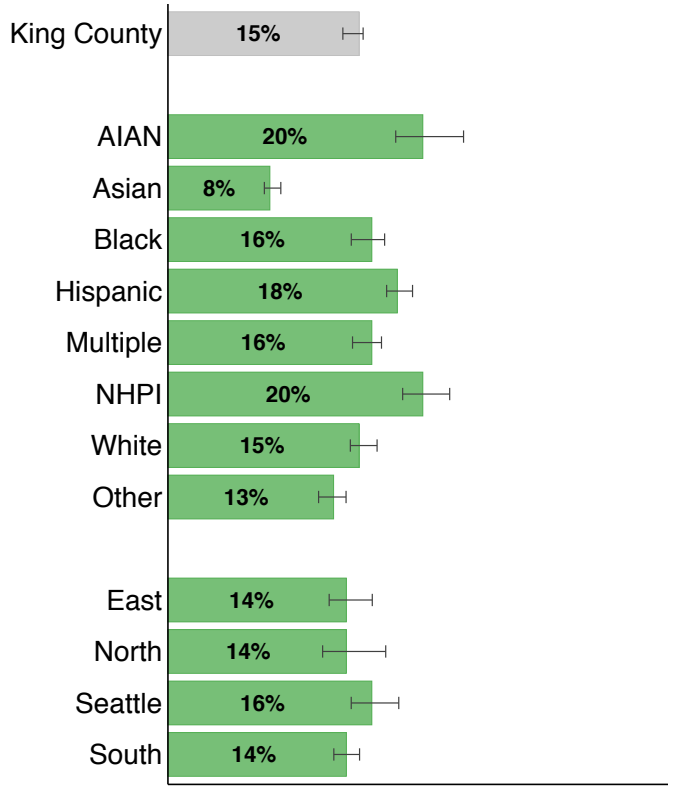
SUBSTANCE ABUSE & CHEMICAL DEPENDENCY

YOUTH BINGE DRINKING

Over 2008-2012, 15% of King County students in 8th, 10th and 12th grades engaged in binge drinking.

- For youth, binge drinking is defined as having 5 or more alcoholic drinks in a row in the past 14 days.
- The binge drinking rate for American Indian/Alaska Native youth was 2.5 times that of the lowest King County rates.
- The binge drinking rate for 12th graders was 1.5 times the county average for students of all grades.
- From 2004 to 2012, rates declined for the county overall and for all regions except East Region.
- Additional substance abuse data are available online.

Binge drinking (school-age)
King County, 2008-2012 average



Source: Healthy Youth Survey.

KEY BEHAVIORAL HEALTH ISSUES: COMMUNITY INPUT, RESOURCES, AND OPPORTUNITIES

Interviews with members of community coalitions and organizations identified three key issues related to behavioral health: (1) **access to behavioral healthcare;** (2) **integration of human services and behavioral and physical healthcare;** and (3) **boarding of mental health patients.**

ACCESS TO BEHAVIORAL HEALTHCARE

Community input:

Those who are seriously mentally ill often face difficulty accessing behavioral health care in a primary care setting. Insurers' regulatory barriers also can limit the range of needed services that are covered. Members of vulnerable populations struggle to access care and need a high level of assertive engagement.

Assets and resources include:

- Peer Bridger program at Navos and Harborview.
- Culturally specific providers including the Seattle Indian Health Board, the Muckleshoot Clinic, the Snoqualmie Nation Clinic, Sea Mar, Consejo, Seattle Counseling Service, Asian Counseling and Referral Service.
- A progressive and supportive community; specific communities like Lesbian, Gay, Bisexual, Transgender, and Questioning (LGBTQ), which provide private funds to cover services.
- The Mental Illness and Drug Dependency funds, which provide additional services for those who do not qualify for Medicaid.
- Specialty courts (Domestic Violence Court, Drug Court, Mental Health Court, Family Treatment Court).

Opportunities include:

- Standardized referral protocols for behavioral health treatment, created in coordination with behavioral healthcare providers, could streamline the process and improve access for patients.
- Some healthcare systems, public health, and universities provide naloxone, an opiate overdose antidote, to individuals in high-risk populations. The drug has been shown to reduce fatalities from opiate use.

INTEGRATION OF HUMAN SERVICES AND BEHAVIORAL AND PHYSICAL HEALTHCARE

Community input:

Community members strongly support hospitals efforts to integrate systems of human services and behavioral and physical healthcare. Serious mental illness is often associated with chronic disease and homelessness, so cross-training staff to address physical health and human services issues as well as behavioral health issues is critical.

Assets and resources include:

- The Partnership Group of community behavioral health providers, which collaborates on policies and practices to promote integration and quality care.
- School based integrated health centers.
- Plymouth Housing Group and DESC, providers of permanent, supportive housing to homeless people with chronic mental illness.

Opportunities include:

- Coordination related to discharge planning (including notification of behavioral healthcare providers and communication of prescriptions to all relevant providers) could create efficiencies and reduce unnecessary emergency department use.
- Clinicians in primary care and emergency departments can use Screening, Brief Intervention, and Referral to Treatment (SBIRT) to identify individuals at risk for substance abuse disorders.
- Many healthcare organizations are increasing their capacity for integrated behavioral healthcare.
- Continued advocacy for improved coordination between mental and physical health services can highlight the importance of this issue.

BOARDING OF MENTAL HEALTH PATIENTS

Community input:

Community members identified the practice of "psychiatric boarding" (involuntarily placing mentally ill patients in emergency rooms without treatment) as a serious problem. Individuals who are in danger of hurting themselves or others should not be "warehoused;" they should receive appropriate treatment in a therapeutic setting.

Assets and resources include:

- A new mobile crisis team and additional Program for Assertive Community Treatment (PACT) team will soon be available to help divert people from hospitals.
- A new transitions program helps hospitals find placement solutions for psychiatric patients.
- The Crisis Solutions Center, operated by the Downtown Emergency Services Center (DESC), offers an alternative to hospitalization.

Opportunities include:

- Some hospitals are planning to open additional psychiatric treatment beds, including beds for adolescents. Medicaid will cover psychiatric services within freestanding psychiatric hospitals for the next two years.
- A new 16-bed evaluation and treatment center will open in King County in 2015.
- The Early Detection and Intervention for the Prevention of Psychosis Program (EDIPPP) educates families and those who routinely interact with youth—teachers, mental health professionals, and doctors—about key signs to look for in young people to identify and prevent psychosis.
- Applying trauma informed care principles within healthcare facilities can reduce unnecessary trauma for people living with a mental illness or trauma impacts.

Maternal and Child Health

Healthy pregnancies, healthy babies, and healthy mothers are important goals for all communities. Mothers' mental, physical, emotional, and socioeconomic well-being – before, during, and after pregnancy – can affect outcomes in infancy, childhood, and adulthood. Maternal and child health outcomes are also markers of overall community health; a healthy community is one which ensures all children thrive and reach their full potential.

While King County has made progress in decreasing rates of poor birth outcomes, it does not meet the Healthy People 2020 objective for prenatal care. Disparities in birth outcomes persist, particularly among Black/African American and American Indian/Alaska Native populations.

Opportunities include participating in the Baby-Friendly Hospital Initiative, using prenatal care as an opportunity to address lifelong health issues, promoting trauma-informed care and the life-course model, and advocating for home visiting and other community support programs.

The time to prevent chronic disease is during pregnancy and early childhood.

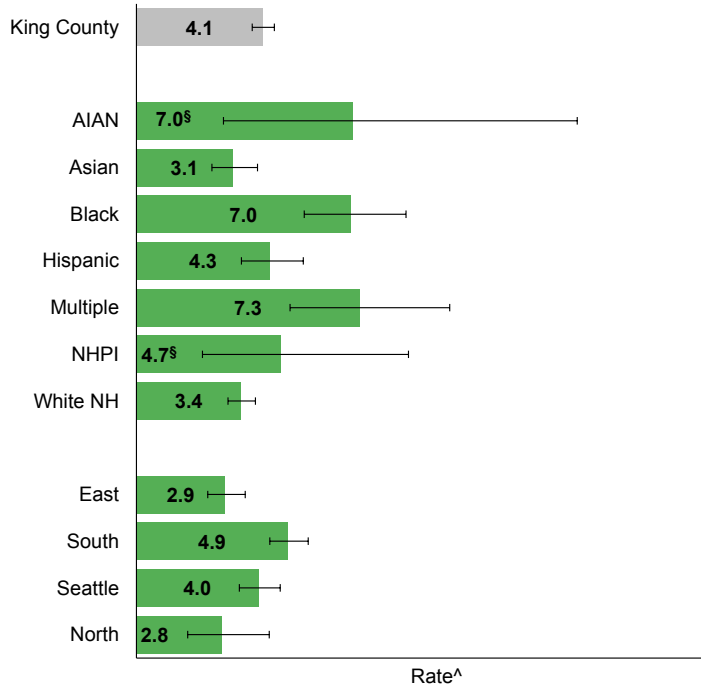
INFANT MORTALITY

The infant mortality rate is the number of babies who die before their first birthday per 1,000 live births in a given year. Two-thirds of infant deaths are associated with labor and delivery-related conditions, birth defects, and prematurity. Because many of these deaths are preventable, infant mortality is a measure of the overall health of a population.

From 2008 to 2012, King County's average infant mortality rate was 4.1 deaths per 1,000 live births.

- Infants born to American Indian/Alaska Native, Black, and multiple-race mothers were 2 times more likely than those born to white mothers to die before their first birthday.
- Infant mortality in high-poverty neighborhoods was twice as high as in low-poverty neighborhoods.
- In King County, infant mortality has declined since 2000.

Infant mortality
King County, 2008-2012 average



Source: Linked Birth-Death Certificate Data, WA State DOH, Center for Health Statistics
^Rate = Deaths per 1,000 live births

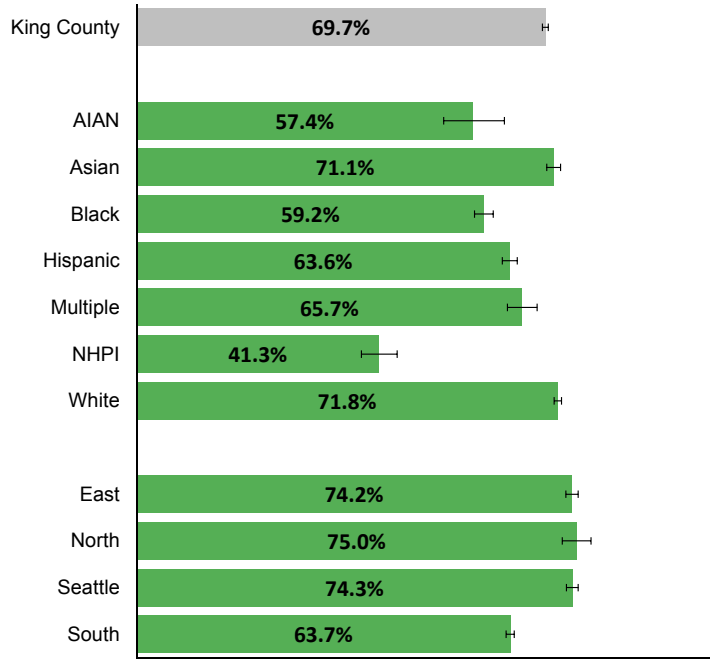
EARLY AND ADEQUATE PRENATAL CARE

Starting prenatal care early in pregnancy and having regular visits improves the chances of a healthy pregnancy. This indicator measures births for which i) prenatal care started before the end of the 4th month and ii) 80% or more of the recommended number of visits occurred.

From 2008 to 2012, 7 out of 10 expectant mothers (69.7%) received early and adequate prenatal care.

- Only about half of teen mothers (51.2%) received early and adequate prenatal care.
- American Indian/Alaska Native, Black, Hispanic, and Native Hawaiian/Pacific Islander mothers were less likely than Asian and white mothers to receive early and adequate prenatal care.
- Early and adequate care increased recently in South Region and Seattle, but declined in East Region.

Early and adequate prenatal care
King County, 2008-2012 average



Source: Birth Certificate Data, WA State DOH, Center for Health Statistics

LOW BIRTH WEIGHT

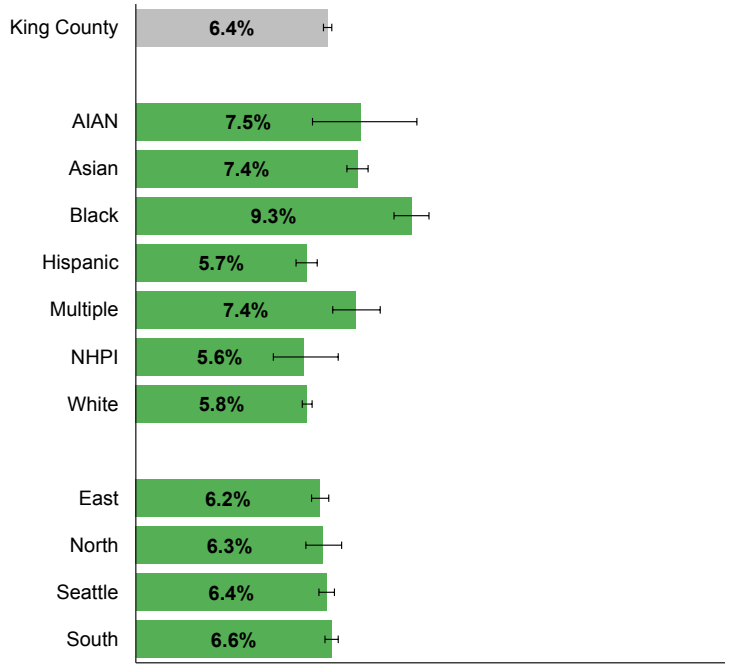
Any infant born weighing less than 2500 grams (about 5.5 pounds) is considered low birth weight. Low birth weight infants are at higher risk of infant mortality, respiratory disorders, and neurodevelopmental disabilities.

From 2008 to 2012, 6.4% of infants born in King County were low birth weight.

- Although King County meets the Healthy People 2020 objective of 7.8% or fewer infants born at low weight, 1,563 low birth weight babies were born in King County in 2012.
- Infants born to Black mothers were more likely to be low birth weight than infants born to mothers of all other racial/ethnic groups (except American Indians/ Alaska Natives).
- After increasing in the early 2000s, rates of low birth weight have recently declined in King County and Seattle. The increase has continued in East Region.

Low birth weight

King County, 2008-2012 average



Source: Birth Certificate Data, WA State DOH, Center for Health Statistics

KEY MATERNAL AND CHILD HEALTH ISSUES: COMMUNITY INPUT, RESOURCES, AND OPPORTUNITIES

Community input:

A community needs assessment produced by United Indians of All Tribes Foundation cited the high rates of poverty among American Indian/Alaskan Native families and inadequate supports for these families to promote the healthy development of their infants.

Community groups stressed the importance of providing adequate opportunities for pregnant women to receive culturally competent care and social support. Without this, they may resort to using the emergency department or other hospital-based care.

Community members also emphasized the importance of recognizing how adverse childhood experiences can lead to chronic disease in adulthood and poor birth outcomes for the next generation.

Assets and resources include:

- The Equal Start Community Coalition which brings together leaders of nearly 30 organizations to promote healthy mothers, families, and communities and seeks to reduce infant mortality.
- The Native American Women's Dialogue on Infant Mortality (NAWDIM), a Native-led collective whose members are concerned about high rates of infant mortality in their communities.
- Governor Inslee's statewide Results Washington framework which calls for reducing birth outcome disparities.
- An objective of the Public Health Improvement Partnership, convened by the Washington State Department of Health, to prevent or reduce the impact of adverse childhood experiences, such as abuse and neglect.
- Nurse Family Partnership and other home visiting and prenatal support programs including MOMs Plus program for high risk pregnant and parenting women. Providers remain concerned that there is not sufficient capacity within these programs.
- The Period of PURPLE Crying curriculum, a new way to help parents understand this time in their baby's life, a promising strategy to reduce the risk of child abuse.

Maternal and Child Health

Continued

Opportunities include:

- The Baby-Friendly Hospital Initiative encourages and recognizes hospitals and birthing centers that offer an optimal level of care for infant feeding and mother/baby bonding. Three hospitals in King County currently have this certification.
- Adverse Childhood Experiences (ACEs) are common and increasingly recognized as significant risk factors for poor adult health outcomes. The ACES Collaborative, an informal work group of providers in Public Health-Seattle & King County, is developing a common framework of trauma-informed care and the life course model (a strength-based framework grounded in understanding and responding to the impact of trauma across the lifespan). The group's goals are to offer technical guidance and support and to promote existing and emerging data and research on the life course model.
- Prenatal care can offer an opportunity to address lifelong health issues with women.
- Many strong community-based organizations provide home visiting and other supports to pregnant and parenting women and are strong partners to healthcare systems.

Preventable Causes of Death

King County Community Health Needs Assessment 2015/2016

Heart disease, cancer, and stroke – all leading causes of death in King County – share many of the same risk factors. Cigarette smoking, obesity, unhealthy diet, physical inactivity, high blood pressure, and high blood cholesterol increase the risk of dying from these diseases. Every one of these risk factors is an appropriate target for prevention-focused interventions. Among prevent-able causes of death, persistent disparities by race/ethnicity, economic status, and neighborhood are common.

Obesity, physical activity, and nutrition opportunities include participating in the Healthier Hospitals Initiative's Healthy Beverages Challenge, offering fitness programs in a variety of settings; information about free or low-cost exercise and cooking programs in languages read by immigrants and refugees, and improving families' ability to afford healthy food by supporting job-training programs, community economic development, and living-wage ordinances.

Tobacco-related opportunities include continuing tobacco prevention and cessation messaging to the public and to patients, and implementing evidence-based brief tobacco screenings.

"I don't think any family prefers to eat processed foods; but at certain times of the month, it's what's consumed because there's not the funds to buy the fresh produce."

–King County mother

Preventable Causes of Death

Continued

HOSPITAL EFFORTS TO EXPAND ACCESS TO HEALTHY FOOD:

Members of the HHC collaborative have adopted the Healthy Food in Healthcare pledge. In addition, 9 of King County's 12 hospitals and health systems have taken the next step and enrolled in the Healthier Hospitals Initiative Healthy Beverages Challenge, which calls on institutions to increase healthy beverage purchases by 20%. Each facility is working with its nutrition team to provide healthier options on its menus, use local ingredients, and provide education to employees, patients, and visitors. Members are adopting additional strategies to improve access to fruits and vegetables through Fresh Bucks, on-site farmers' markets, grocery store vouchers for produce, and free or low-cost food bags.

Preventable Causes of Death

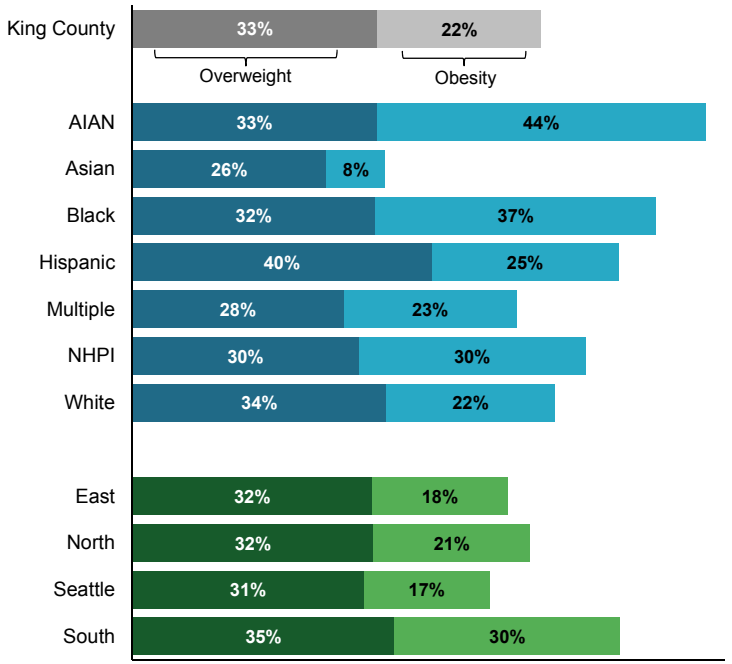
Continued

ADULT OBESITY AND OVERWEIGHT

From 2009 to 2013, 22% of King County adults were obese, reporting a Body Mass Index (BMI) greater than or equal to 30, and 55% of adults were obese or overweight, reporting a BMI greater than or equal to 25.

- American Indians/Alaska Natives were 5.5 times more likely than Asians, and twice as likely as whites, to be obese. Hispanics were 1.5 times more likely than Asians to be overweight.
- Males were more likely to be overweight than females.
- King County obesity rates increased from 2000 to 2008, then flattened out through 2013. At the regional level, obesity rates increased from 2000 to 2013 in all regions except North Region.
- Overweight rates decreased from 2000 to 2013 in King County and East Region.

Obesity and overweight (adults)
King County, 2009-2013 average



Source: Behavioral Risk Factor Surveillance System.

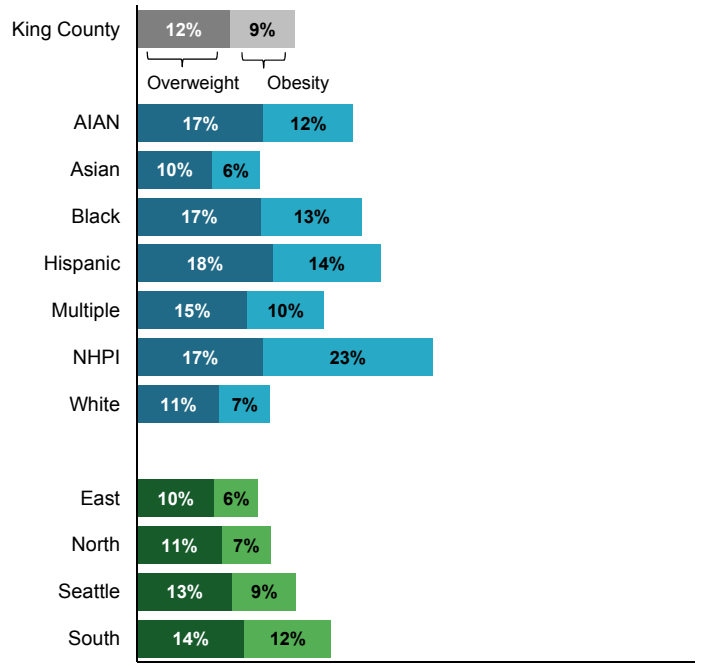
CHILDREN'S OBESITY AND OVERWEIGHT

Students are considered obese if their Body Mass Index (BMI) is in the top 5% for their age and gender, and overweight or obese if their BMI is in the top 15%. From 2008 to 2012, 9% of King County students in 8th, 10th, and 12th grades were obese, and 21% were overweight or obese.

- Native Hawaiian/Pacific Islander students were about 3.5 times more likely to be obese than Asian or white students in grades 8, 10 and 12.
- American Indian/Alaska Native, Black, Native Hawaiian/Pacific Islander, and Hispanic students were more likely than Asian or white students to be overweight.
- Between 2004 and 2012, student obesity rates declined for the county as a whole and for all regions except South Region.

Obesity and overweight (school-age)

King County, 2008-2012 average



Source: Healthy Youth Survey.

PHYSICAL ACTIVITY

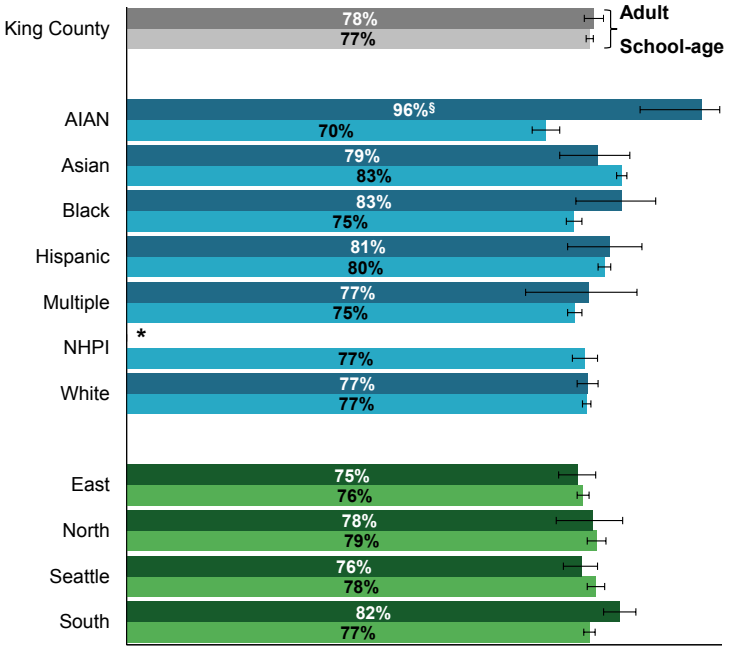
In 2011 and 2013, fewer than 1 in 4 King County adults met physical activity recommendations: muscle-strengthening exercises on 2 or more days per week and either 150 minutes of moderate-intensity or 75 minutes of vigorous-intensity aerobic activity per week.

- Of all race/ethnicity groups, Alaskan Natives/ American Indians were least likely to meet recommendations.
- Adult data were insufficient to assess trends.

From 2008 to 2012, fewer than 1 in 4 students in 6th, 8th, 10th, and 12th grades got the recommended 60 or more minutes of daily physical activity.

- As grade level increased, student participation in physical activity declined, with 12th graders 0.8 times as likely as 6th graders to meet recommendations.
- Rates of not meeting physical activity recommendations among youth decreased between 2006-2012 for the county and in all 4 regions.

Physical activity recommendations not met
King County



Sources: Behavioral Risk Factor Surveillance System, 2011 & 2013 (Adult), Healthy Youth Survey, 2008-2012 (School-age).

ADULT SUGAR-SWEETENED BEVERAGE CONSUMPTION

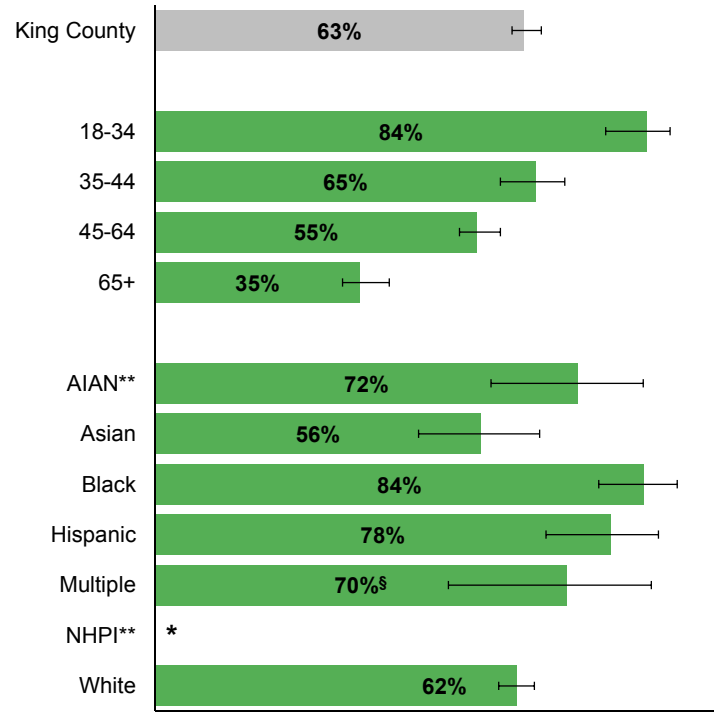
In 2010 and 2012, 63% of King County adults consumed a sugary drink at least once in the past month.

Sugary drink consumption is associated with obesity, diabetes, and diseases of the heart, kidneys, and liver.

- Blacks were 1.5 times more likely than Asians to consume sugar-sweetened beverages in the past month.
- Adults age 18-34 were 2.4 times as likely as those 65 and older to consume sugary beverages;
- Consumption decreased steadily with increasing age.

Sugar sweetened beverage consumption (adults)

King County, 2010 & 2012 average



Source: National Communities Putting Prevention to Work, Behavioral Risk Factor Surveillance System

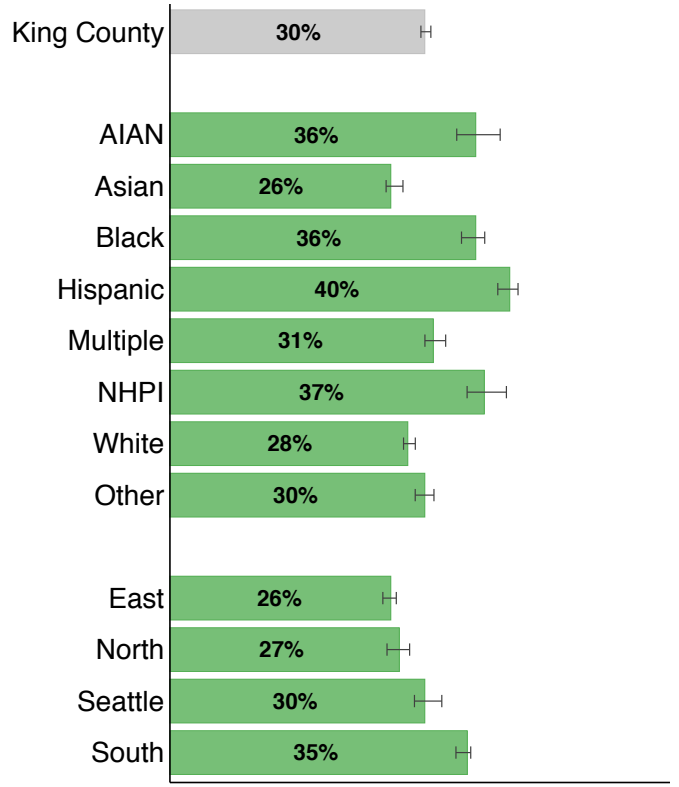
** Alone or in combination with other races

YOUTH SODA CONSUMPTION

From 2008 to 2012, 30% of King County students in 6th, 8th, 10th, and 12th grades consumed one or more non-diet sodas daily.

- Males were more likely than females to drink soda daily.
- Hispanics, Native Hawaiians/Pacific Islanders, Blacks, and American Indians/Alaska Natives were more likely than Asians and whites to drink soda every day.
- South Region students were more likely to consume soda daily than students in the other 3 regions.
- From 2004 to 2012, rates of daily soda consumption decreased for students in the county overall and in all 4 regions.

Daily soda consumption (school-age)
King County, 2008-2012 average



Source: Healthy Youth Survey.

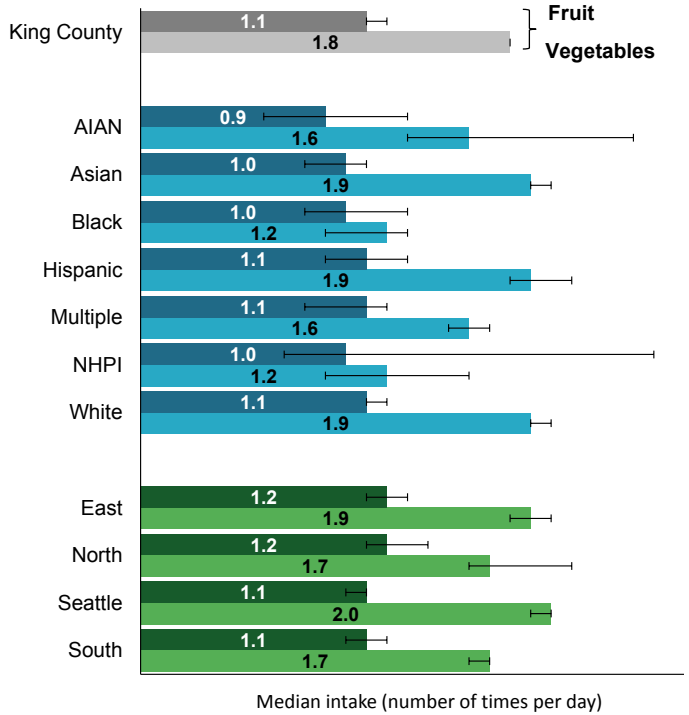
ADULT FRUIT & VEGETABLE CONSUMPTION

Eating fruits and vegetables lowers the risk of developing many chronic diseases and can support weight management. From 2011 to 2013, King County adults ate fruit a median of 1.1 times per day and vegetables 1.8 times per day.

- Women ate fruits and vegetables 20-30% more often than men.
- Adults age 65 and over ate fruits and vegetables 30% more often than adults age 18-24.

Fruit and vegetable consumption (adults)

King County, 2011-2013 average



Source: Behavioral Risk Factor Surveillance System.

KEY OBESITY, PHYSICAL ACTIVITY, AND NUTRITION ISSUES: COMMUNITY INPUT, RESOURCES, AND OPPORTUNITIES

Community input:

- Many low-income families report difficulty being physically active because of public safety issues, lack of exercise-related information in their own language, body-image stigma, cost, and lack of time.
- Recent community-based surveys of low-income women and women of color[xvii] reported on the difficulty of purchasing healthy food with limited food assistance and/or limited income. In addition, low-income families often depend on public transportation when purchasing food, which can make grocery shopping a lengthy and difficult endeavor. Recent Metro bus service reductions may exacerbate this problem. There are fewer transportation options in suburban cities, especially for seniors.

Assets and resources include:

- Local parks, community centers, and pools offer public places for physical activities; some offer programs such as single-gender swim times and scholarships for children.
- The Healthy King County Coalition aims to reduce health inequities by improving nutrition, increasing physical activity, and decreasing smoking rates and other tobacco use.
- The CDC-funded Community Transformation Grant (CTG) is a multi-disciplinary partnership involving Seattle Children's, Public Health, the Healthy King County Coalition, schools, local governments, hospitals, low-income housing groups, and childcare and youth organizations. CTG's goal is to implement changes in communities so that healthy choices will be easier for children and families living in South King County and South Seattle.
- The CDC-funded Partnership to Improve Community Health (PICH) will build on efforts to increase access to healthy foods and physical activity, and reduce exposure to unhealthy foods, beverages, and tobacco products.
- Seven school districts (Auburn, Highline, Kent, Renton, Tukwila, Northshore, and Seattle) implemented new physical education programs to work toward meeting state standards.

Preventable Causes of Death

Continued

- Child care providers who care for 10,739 children in King County received training on actions they can take to improve physical activity at their sites.
- The Fresh Bucks program enables shoppers who receive Basic Food assistance to double their money at farmers' markets.
- The Women Infant and Children Supplemental Nutrition program helps pregnant women, new mothers, and young children eat well, learn about nutrition, and stay healthy.
- Food banks and other feeding programs, sponsored by faith-based organizations, are working to provide healthier options to their customers.

Opportunities include:

- Providing information about free or low-cost cooking and exercise programs in languages read by immigrants and refugees.
- Improving access to places for physical activity, exemplified by ongoing efforts of employers, coalitions, agencies, and communities. These groups are attempting to change the local environment (e.g., by creating walking trails), build new exercise facilities, provide access to existing nearby facilities, and reduce the cost of opportunities for physical activity. Improved access is typically achieved in a particular community through a multi-component strategy that includes training or education for participants. http://www.countyhealthrankings.org/policies/access-places-physical-activity
- Offering fitness programs in a variety of community settings including community wellness, fitness, community, and senior centers. http://www.countyhealthrankings.org/policies/fitness-programs-community-settings
- Helping residents increase their earning capacity (and their ability to buy healthy food) by supporting job training programs, community economic development, and living wage ordinances.

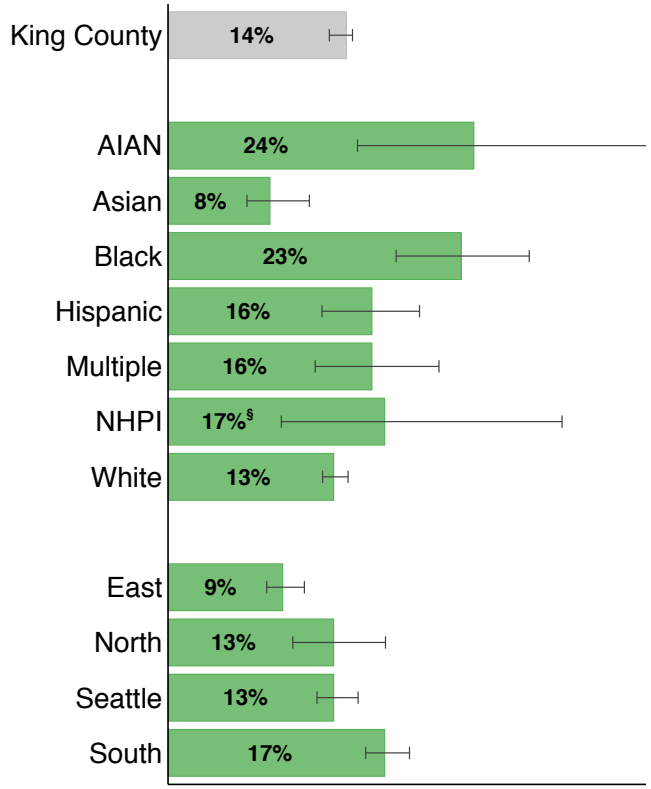
TOBACCO USE

ADULT SMOKING

From 2009 to 2013, 14% of King County adults reported that they currently smoked cigarettes every day or some days.

- Adults with household income less than $15,000 were 4.4 times more likely than those with income at or above $75,000 to be current smokers.
- Adults in South Region were almost twice as likely as those in East Region to be current smokers.
- From 2000 to 2013, adult smoking rates declined for the county overall and for all regions except North Region. After 2005, the overall rate of decline slowed.

Cigarette smoking (adults)
King County, 2009-2013 average



Source: Behavioral Risk Factor Surveillance System.

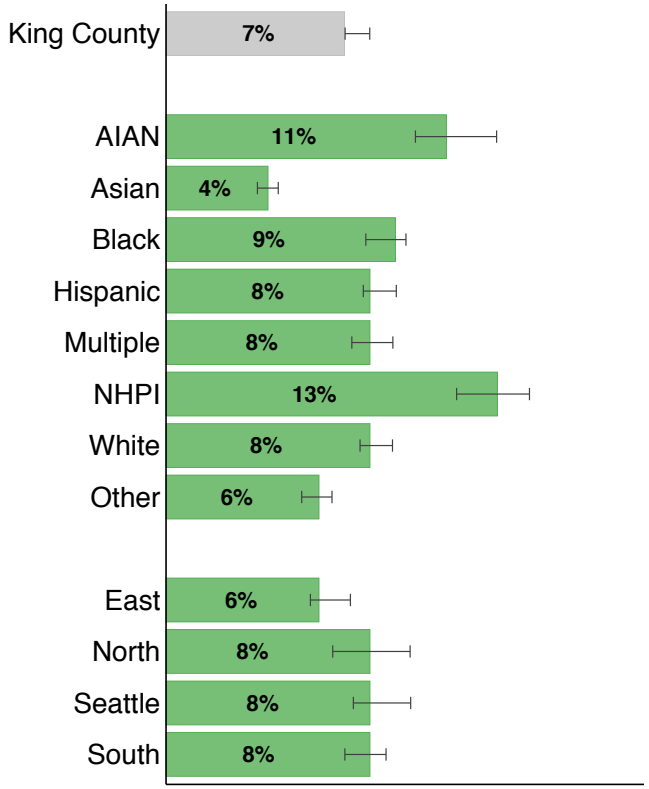
YOUTH SMOKING

School-age students were considered cigarette smokers if they smoked in the last month. This indicator did not include use of other tobacco products. From 2008 to 2012, 10% of students in 8th, 10th and 12th grades were current cigarette smokers.

- 1 in seven 12th graders were smokers.
- Native Hawaiians/Pacific Islanders, and American Indians/ Alaska Natives were about 3 times more likely than Asian students to be current smokers.
- From 2004 to 2012, rates of youth cigarette smoking declined for King County and all 4 of the county's regions.

Cigarette smoking (school-age)

King County, 2008-2012 average



Source: Healthy Youth Survey.

KEY TOBACCO USE ISSUES: COMMUNITY INPUT, RESOURCES, AND OPPORTUNITIES

Community input:

Community members working to reduce tobacco use report an overall decline in resources for prevention and cessation and a corresponding leveling off of previous declines in smoking rates. Disparities persist among Black and American Indian/Alaska Native communities. Stakeholders also report an increase in uses of tobacco alternatives (including e-cigarettes and hookahs) by youth. According to Public Health compliance checks, tobacco retailers are illegally selling e-cigarettes to minors at more than twice the rate (16%) of cigarettes.[xviii]

Assets and resources include:

- Strong partners committed to reducing the prevalence of Tobacco, Marijuana, and Other Drugs (TMOD). These members are part of the Healthy King County Coalition TMOD committee and include Center for Multicultural Health, Asian Pacific Islander Coalition Against Tobacco, Entre Hermanos, Neighborhood House, Gay City, and the Seattle Indian Health Board.
- The Quitline.
- Cessation medication and counseling in combination – the most effective cessation method.
- Behavioral health providers who are increasingly addressing tobacco cessation with patients who have some of the highest smoking rates.

Opportunities include:

- Hospitals are communicating with the public about the ongoing need for tobacco prevention and cessation.
- Many hospitals already have strong tobacco-free policies. These policies could be combined with strong messaging to patients about the impacts of tobacco use.
- Brief tobacco screening and interventions in emergency departments, primary care, dental, and other healthcare settings can improve quit rates. This is an evidence based practice.
- Tobacco-cessation coverage varies by health plan. No mandated coverage standard exists in King County.

Violence and Injury Prevention

This section reports on hospitalizations and deaths from both intentional and unintentional injuries. For each case that results in hospitalization, many more injuries are never reported. Hospitalization data exclude cases where emergency department treatment was received but the patient was not admitted to the hospital.

While some types of injury have declined since the 1990s, recent increases in deaths due to falls, suicide, and poisoning raise new concerns. Among all age groups, falls are a leading cause of emergency department visits and hospital readmissions. Intentional injuries and deaths (assaults, homicides, and suicide) remain problematic for regional communities. And although motor vehicle fatalities have decreased sharply, distracted and impaired driving continue to endanger drivers, passengers, bicyclists, and pedestrians.

Opportunities include prevention-related primary care assessments and screenings, coordination between emergency department staff and law enforcement/ first responders, sharing of emergency department data with the Department of Health, and training of community providers in suicide assessment and treatment interventions.

Violence and injuries are preventable. They are also the leading causes of death for people between the ages of 1 and 44.

INTENTIONAL INJURIES

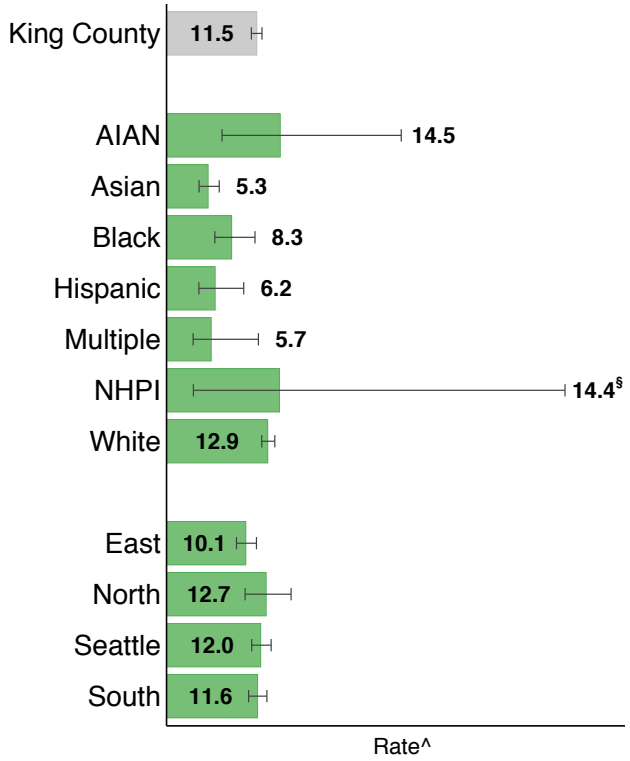
SUICIDE DEATHS

From 2008 to 2012, an average of 233 suicide deaths occurred in King County each year. The 2008-2012 average suicide death rate in King County was 11.5 per 100,000 population.

- The suicide death rate for adults age 45 and older was 1.5 times the county average.
- Males were 3.3 times more likely than females to die from suicide.
- The King County suicide death rate remained stable from 2000 to 2008, but has increased since 2008.
- This measure is also relevant to Behavioral Health.

Suicide deaths

King County, 2008-2012 average



Source: WA State DOH, Center for Health Statistics, Death Certificates.
^Rate = cases per 100,000 population, age-adjusted to the 2000 US population.

SUICIDE HOSPITALIZATIONS

From 2008-2012, an average of 834 non-fatal suicide hospitalizations occurred in King County each year. The 2008-2012 average rate for the county was 41.5 per 100,000 population.

- The suicide hospitalization rate for adults age 18-24 was 1.7 times the county average.
- Adults living in high-poverty neighborhoods were more than twice as likely as those in low-poverty areas to be hospitalized for suicide.
- Suicide hospitalization rates for the county as a whole did not change from 2000 to 2012. Over the same period, however, rates increased in East Region and decreased in South Region.
- This measure is also relevant to Behavioral Health.

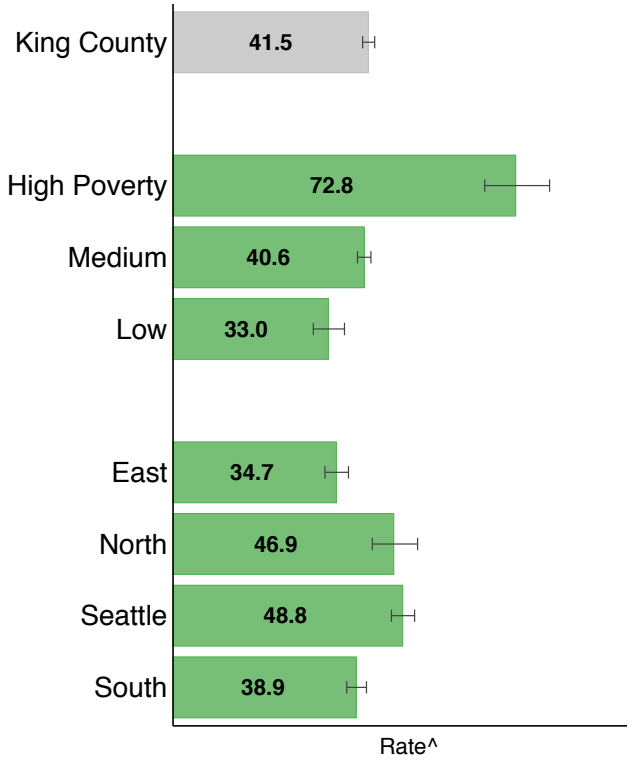
Community input:

Strong community support was expressed for training all community providers -- including those in social work, medical, and mental health -- in suicide assessment and treatment interventions.

Assets and resources include:

- Forefront, a research organization based at the University of Washington, is training health professionals to develop and sharpen their skills in the assessment, management, and treatment of suicide risk.

Suicide hospitalizations
King County, 2008-2012 average



Source: WA State DOH, Office of Hospital and Patient Data Systems.
^Rate = cases per 100,000 population, age-adjusted to the 2000 US population.

Violence and Injury Prevention

Continued

- House Bill 2315 and other bills passed over the past several years require school staff, behavioral healthcare providers, and other healthcare providers to participate in suicide prevention training as part of their licensure.
- The Youth Suicide Prevention Program provides training for students and educators.
- Children's Crisis Outreach Response System (CCORS) provides mobile crisis outreach and crisis stabilization services for children and youth up to age 18.
- The Crisis Solutions Center offers a therapeutic option when police and medics are called to intervene in a behavioral healthcare crisis. The program minimizes inappropriate use of jails and hospitals and provides rapid stabilization, treatment, and referrals for up to 46 individuals.

Opportunities include:

- The National Action Alliance for Suicide Prevention's Zero Suicide in Health and Behavioral Health Care initiative promotes a specific set of suicide-prevention tools and strategies. Healthcare systems around the country, including Henry Ford Health System, have implemented these strategies.
- The Suicide Prevention Resource Center provides updated protocols for suicide prevention for emergency medical service (EMS) providers and others whose jobs put them in contact with people who may be at risk of suicide. The center recommends that emergency departments adopt and adhere to their protocols, which address screening, risk assessment, discharge planning, safety planning and means restriction, patient and family education, and follow-up.
- Patient and family education, support groups, and classes for friends and families of people who are suicidal or have a mental illness or substance abuse disorder can help reduce stigma and make it easier for those in need to access care.
- Improvements in hospital discharge planning and "warm hand-off" referrals (in which primary care providers directly introduce clients to their behavioral healthcare providers at the time of their medical visits) can help transfer trust and rapport to the new relationship.
- Low-barrier mental health and substance-abuse screenings at health fairs can help identify more people at risk for suicide.

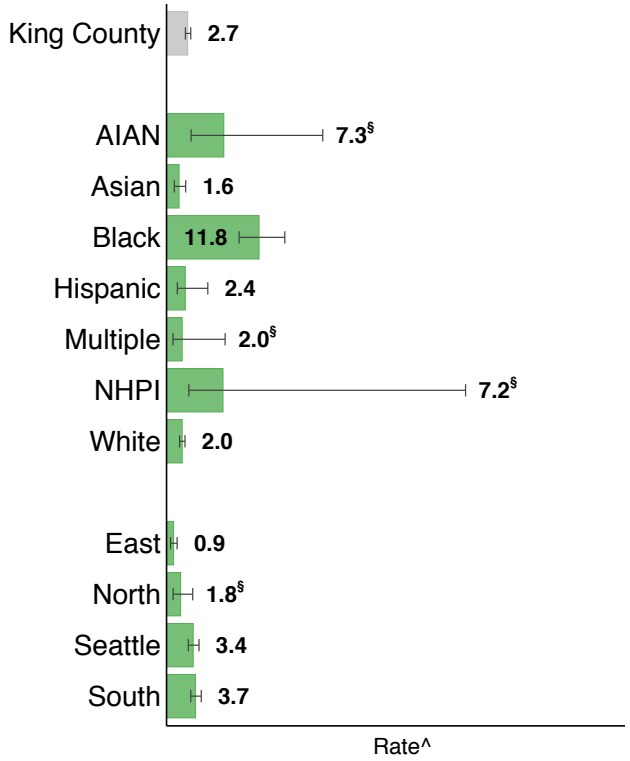
HOMICIDE DEATHS

From 2008 to 2012, an average of 53 homicides occurred in King County each year. The 2008-2012 average rate for the county was 2.7 per 100,000 population.

- From 2008 to 2012, the rate of homicide deaths for Blacks was 4.4 times the county average.
- Homicide deaths for teens and young adults ages 18-24 were 2.5 times the county average.
- From 2000 to 2012, homicide rates decreased in King County and Seattle. The county-wide rate is now one-third of its peak in the 1990s.

Homicide

King County, 2008-2012 average



Source: WA State DOH, Center for Health Statistics, Death Certificates.
^Rate = cases per 100,000 population, age-adjusted to the 2000 US population.

Violence and Injury Prevention

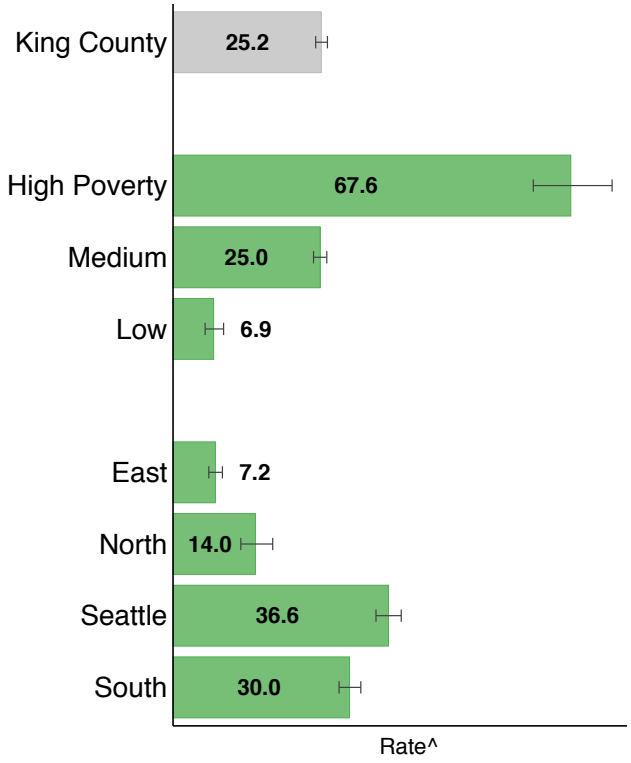
Continued

Assault Hospitalizations

From 2008 to 2012, an average of 502 assault hospitalizations occurred in King County each year (excluding fatalities and emergency-department-only visits). The 2008-2012 average rate for the county was 25.2 per 100,000.

- The rate of assault hospitalizations for adults age 18-24 was 2.3 times the county average.
- The rate of assault hospitalizations for adults living in high poverty areas was 9.8 times higher than those in low-poverty neighborhoods.
- From 2000 to 2012, assault hospitalization rates decreased in King County, North Region, and Seattle.

Assault hospitalizations
King County, 2008-2012 average



Source: WA State DOH, Office of Hospital and Patient Data Systems.
^Rate = cases per 100,000 population, age-adjusted to the 2000 US population.

UNINTENTIONAL INJURIES

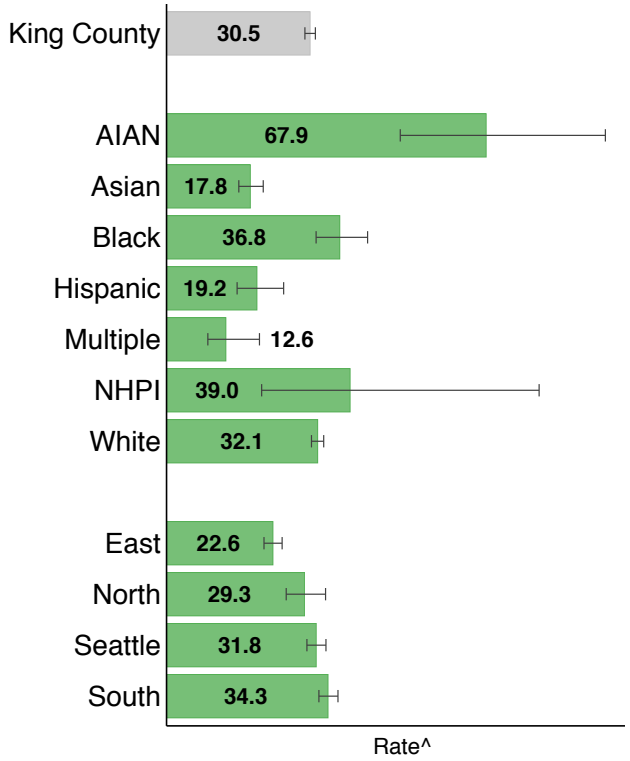
Unintentional injuries include those due to falls, motor vehicle collisions, poisoning, fire, firearms, drowning, and suffocation. Most of these injuries, and the deaths they cause, are preventable. The sections below summarize data on deaths and hospitalizations from all types of unintentional injuries, then on three specific types of injury – those from motor vehicle collisions, falls, and poisoning.

UNINTENTIONAL INJURY DEATHS

From 2008 to 2012, an average of 605 deaths due to unintentional injury occurred in King County each year. The county's average 2008-2012 unintentional-injury death rate was 30.5 per 100,000 population.

- The unintentional injury death rate for adults age 65 and older was 3.5 times the county average.
- Rates for the county as a whole did not change from 2000 to 2012, but have increased in East Region since 2005.

Unintentional injury deaths
King County, 2008-2012 average



Source: WA State DOH, Center for Health Statistics, Death Certificates.
^Rate = cases per 100,000 population, age-adjusted to the 2000 US population.

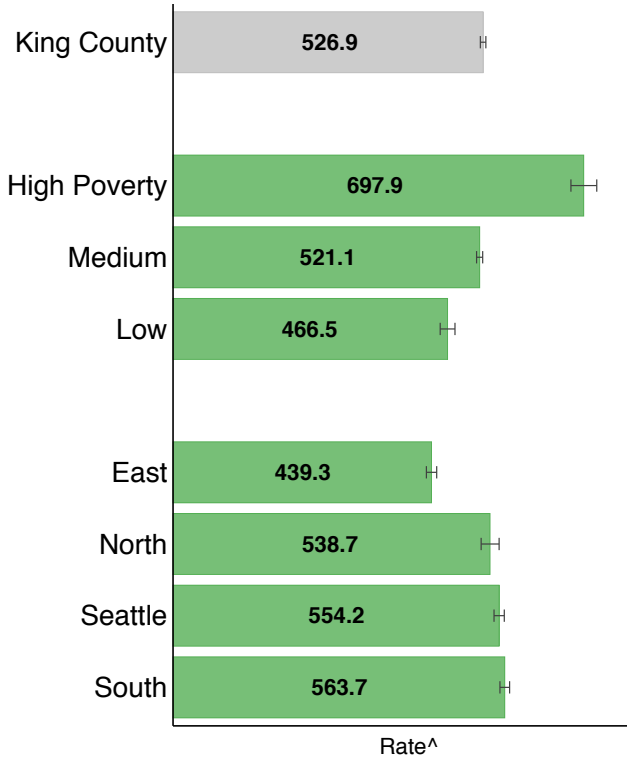
UNINTENTIONAL INJURY HOSPITALIZATIONS

From 2008 to 2012, King County hospitals reported an average of 10,144 hospitalizations for unintentional injuries each year (excluding fatalities). The county's 2008-2012 average rate was 526.9 per 100,000 population.

- For adults age 65 and older, the rate of hospitalization for unintentional injury was 4.1 times the county average.
- For Seattle and East Region, rates have declined since 2000. For North Region and South Region, and King County overall, rates have declined since 2005-2006.

Unintentional injury hospitalizations

King County, 2008-2012 average



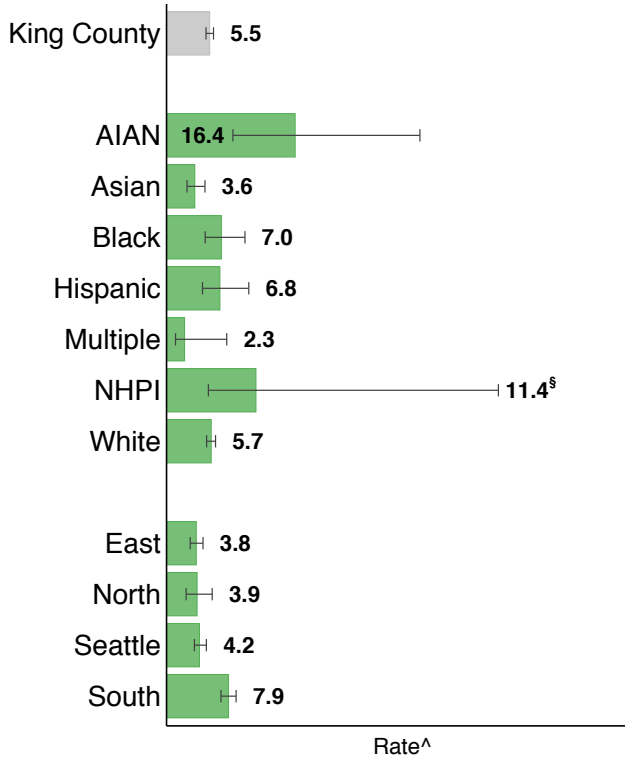
Source: WA State DOH, Office of Hospital and Patient Data Systems.
^Rate = cases per 100,000 population, age-adjusted to the 2000 US population.

MOTOR VEHICLE DEATHS

Motor vehicle deaths result from motor vehicle collision (MVC) and include deaths of vehicle occupants, motorcyclists, bicyclists, and pedestrians. From 2008 to 2012, an average of 107 King County residents died from motor vehicle collisions each year. The 2008-2012 county average rate was 5.5 per 100,000 population.

- The MVC death rate for American Indians/Alaska Natives was 3 times the county average.
- Between 2000 and 2012, MVC death rates declined in King County, Seattle, North Region, and South Region. The rate in East Region began its decline in 2005.

Motor vehicle deaths
King County, 2008-2012 average



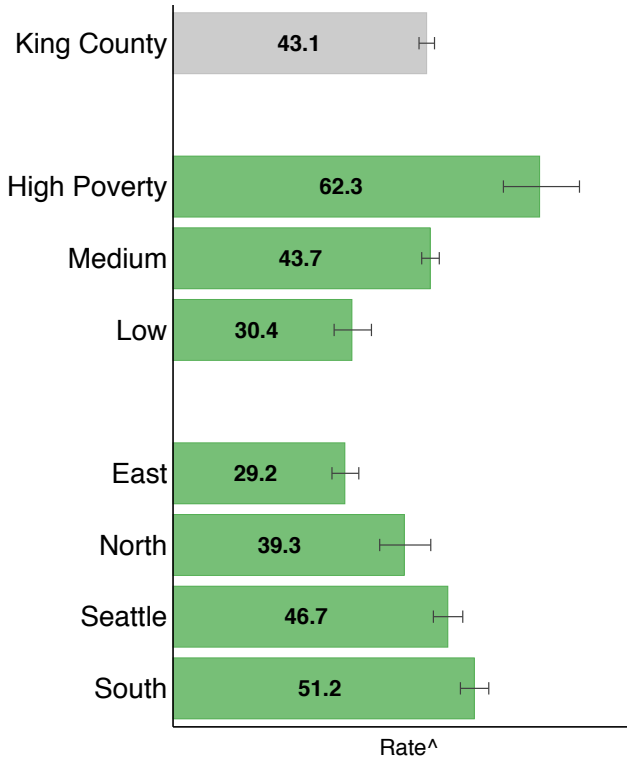
Source: WA State DOH, Center for Health Statistics, Death Certificates.
^Rate = cases per 100,000 population, age-adjusted to the 2000 US population.

MOTOR VEHICLE INJURY HOSPITALIZATIONS

From 2008 to 2012, an average of 857 King County residents were hospitalized for non-fatal motor vehicle collisions (MVC) each year. The 2008-2012 average rate for the county was 43.1 per 100,000 population.

- Adults in high poverty areas were 2 times more likely than those in low-poverty neighborhoods to be hospitalized for MVC.
- The rate of MVC hospitalization for adults age 18-24 was 1.6 times the county average.
- Rates have been decreasing in King County overall and Seattle since 2006, and in the other three regions since 2000.

Motor vehicle injury hospitalizations
King County, 2008-2012 average



Source: WA State DOH, Office of Hospital and Patient Data Systems.
^Rate = cases per 100,000 population, age-adjusted to the 2000 US population.

Violence and Injury Prevention

Continued

Community input:

- Law enforcement officials and community members said they were increasingly concerned about texting, talking, and other uses of mobile devices while driving.
- Law enforcement officials expressed concern about a possible rise in impaired driving related to the legalization of marijuana. They also said that quickly testing the blood of drivers arrested for suspicion of DUI is critical to accurately assessing the level of impairment.

Assets and resources include:

- Law Enforcement: High- visibility patrols by law enforcement; internal coordination; use of skilled drug-recognition experts; use of the Mobile Impaired Driving Unit (MIDU), a self-contained mobile DUI processing center and incident command post.
- Education campaigns.
- Employer-based policies for cell-phone use by drivers.
- The Target Zero Task Force, which focuses on reducing traffic crashes and traffic-related injuries to zero by the year 2030.

Opportunities include:

- Primary-care intake assessments that include questions about cell-phone use while driving, seat-belt use, and driving while impaired.
- Regular communication between law enforcement and emergency department staff to promote shared understanding of legal issues, policies, and efficient blood testing of impaired-driving suspects.

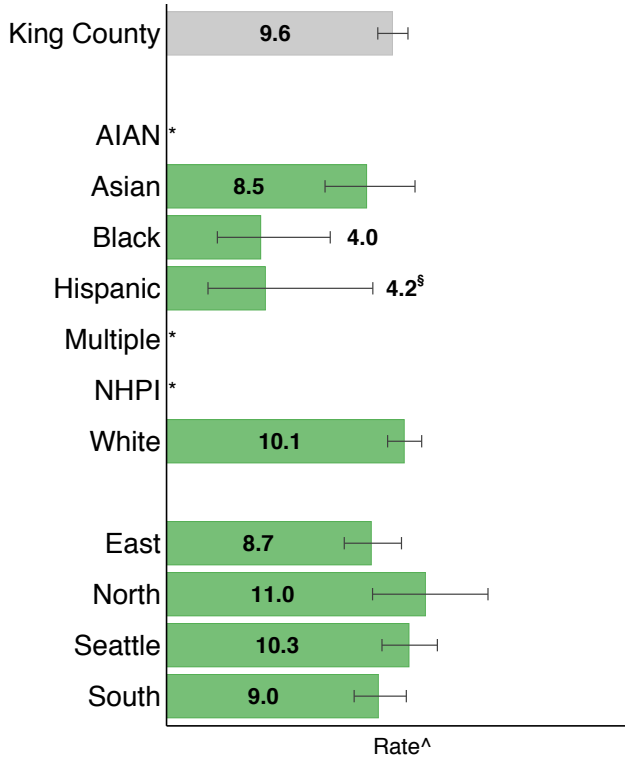
DEATHS FROM FALLS

Deaths are attributed to falls if they were caused by unintentional slipping, tripping, stumbling, or falling. From 2008 to 2012, an average of 183 King County residents died from falls each year. The 2008-2012 average rate for the county was 9.6 deaths per 100,000 population.

- The rate of deaths from falls for adults age 65 and older was 7.4 times the county average.
- From 2000 to 2012, the rate of deaths from falls increased in North Region, Seattle, and King County overall.

Fall deaths

King County, 2008-2012 average



Source: WA State DOH, Center for Health Statistics, Death Certificates.
^Rate = cases per 100,000 population, age-adjusted to the 2000 US population.

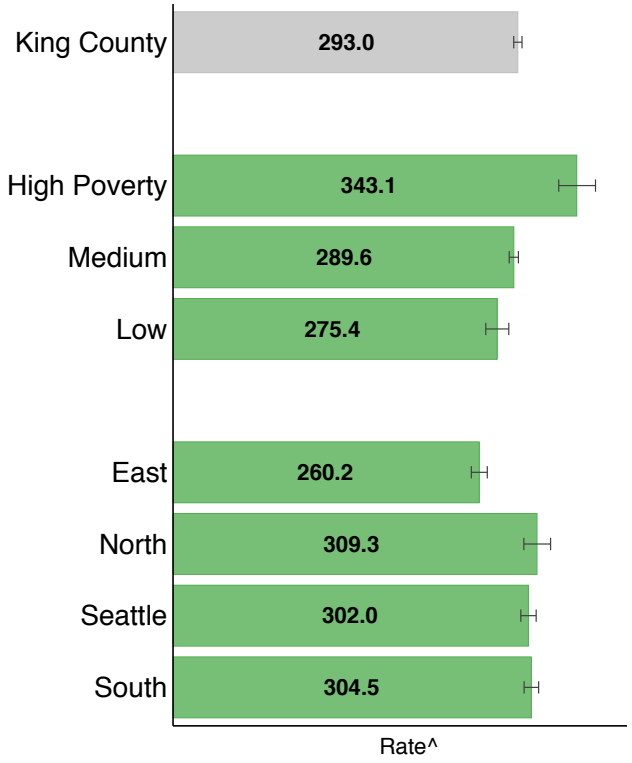
HOSPITALIZATIONS FROM FALLS

From 2008 to 2012, an average of 5,531 King County residents were hospitalized for non-fatal falls each year. The 2008-2012 average rate for the county was 293.0 hospitalizations per 100,000 population.

- The fall hospitalization rate for adults age 65 and older was 5.7 times the county average.
- From 2000 to 2012, fall hospitalization rates decreased in North Region and King County overall. The Seattle rate has declined since 2007.

Fall hospitalizations

King County, 2008-2012 average



Source: WA State DOH, Office of Hospital and Patient Data Systems.
^Rate = cases per 100,000 population, age-adjusted to the 2000 US population.

Violence and Injury Prevention

Continued

Community input:

Falls are a leading cause of emergency department use and hospital readmissions, and their occurrence among all age groups is a top concern. For seniors, physical activity is critical for preventing falls.

Assets and resources include:

- One Step Ahead is a fall-prevention program.
- Harborview Injury Prevention and Research Center is an international leader in injury-prevention research that focuses on reducing the personal impact of trauma and broadening the effectiveness of injury-prevention programs.
- Community and senior centers offer physical-activity programs such as SilverSneakers and EnhanceFitness.

Opportunities include:

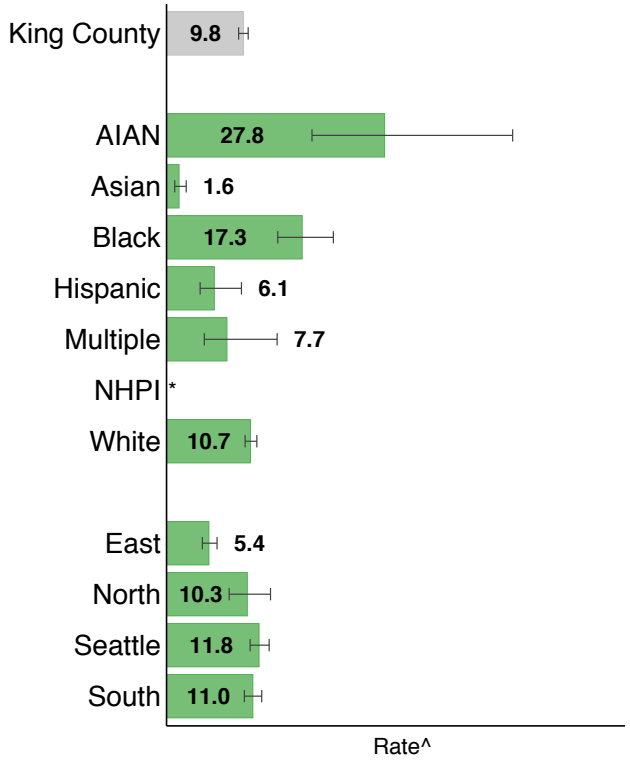
- Primary-care settings use the STEADI toolkit (created by the CDC) to assess seniors' risk of falling.
- Environmental modifications in seniors' homes can reduce the risk of readmissions for repeat falls.

POISONING DEATHS

From 2008 to 2012, an average of 206 King County residents died from unintentional poisonings each year. The 2008-2012 average rate for the county was 9.8 deaths per 100,000 population.

- The unintentional-poisoning death rate for American Indians/Alaska Natives was 17.4 times the rate for Asian residents.
- From 2000 to 2006, death rates from poisoning increased in King County overall, but have flattened out since then. The South Region rate began to plateau in 2008, but the rate continues to increase in East Region.

Poisoning deaths
King County, 2008-2012 average



Source: WA State DOH, Center for Health Statistics, Death Certificates.
^Rate = cases per 100,000 population, age-adjusted to the 2000 US population.

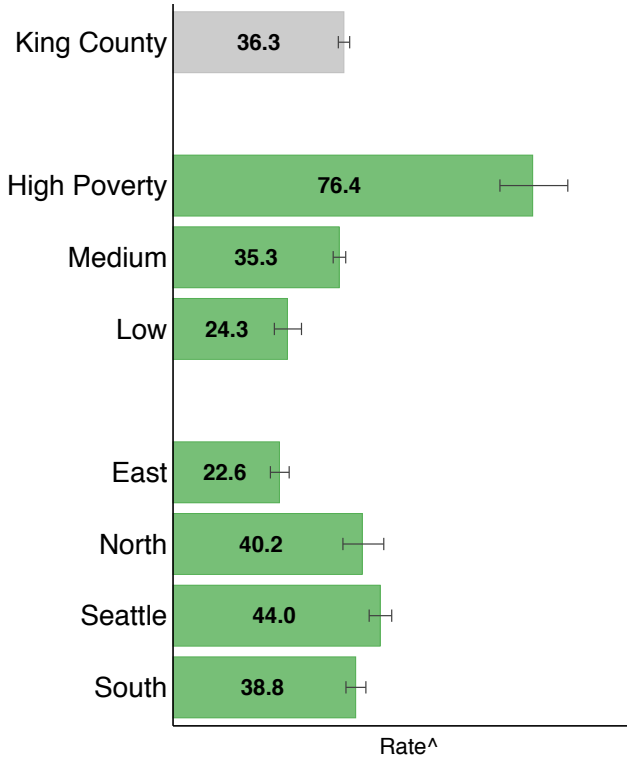
POISONING HOSPITALIZATIONS

From 2008 to 2012, an average of 729 King County residents were admitted to hospitals for unintentional, non-fatal poisoning each year. The 2008-2012 average rate for the county was 36.3 per 100,000 population.

- The poisoning hospitalization rate for adults age 65 and older was 2.1 times the county average.
- Adults living in high-poverty areas were 3 times more likely than those in low-poverty neighborhoods to be hospitalized for poisoning.
- Poisoning hospitalization rates have been flat from 2000 to 2012 in King County overall, and from 2005 to 2012 in North Region. However, rates in Seattle and South Region increased from 2000 to 2012.

Poisoning hospitalizations

King County, 2008-2012 average



Source: WA State DOH, Office of Hospital and Patient Data Systems.
^Rate = cases per 100,000 population, age-adjusted to the 2000 US population.

Violence and Injury Prevention

Continued

KEY VIOLENCE AND INJURY PREVENTION ISSUES

Community input:

Community members expressed the need for increased regional coordination and standard implementation of best practices in violence and injury prevention.

Assets and resources include:

- The Central EMS and Trauma Care Council, which promotes and supports a system of emergency medical and trauma care services in King County.
- Safe Kids Washington (locally, Safe Kids Eastside, Safe Kids Seattle/South King County) implements evidence-based programs, such as car-seat checkups and safety workshops, to help prevent childhood injuries.

Opportunities include:

- Prevention-related primary-care assessments/screenings.
- Coordination between emergency department staff and law enforcement/first responders, including meetings to discuss challenges and opportunities of working with people who are homeless and/or have serious mental illnesses.
- Sharing of emergency department data with the Department of Health to provide a more complete understanding of violence and injury impacts.

EndNotes

[i] *Institute for Healthcare Improvement: http://www.ihi.org/offerings/Initiatives/TripleAim/Pages/default.aspx*

[ii] *New England Journal of Medicine: We Can Do Better – Improving the Health of the American People, Sept. 2007*

[iii] *Health Research & Educational Trust. (2013, June) Becoming a culturally competent health care organization. Chicago, IL: Illinois. Health Research & Educational Trust Accessed at www.hpoe.org. Accessible at: http://www.hpoe.org/Reports-HPOE/becoming_culturally_competent_health_care_organization.PDF*

[iv] *U.S. Department of Health and Human Services: Office of Minority Health. (2013, May). The national CLAS standards. Washington DC. U.S. Department of Health and Human Services: Office of Minority Health.*

[v] *Educating English Language Learners in Washington State, 2009-2010. Washington Office of Superintendent of Public Instruction, January 2011.*

[vi] *Diversity in the Classroom. http://projects.nytimes.com/immigration/enrollment Accessed 6/26/2011.*

[vii] *Washington State Growth Management Population Projections for Counties: 2010 to 2040. "2012 County age and sex projections, five-year intervals and age groups", accessed at http://www.ofm.wa.gov/POP/gma/projections12/projections12.asp.*

[viii] *The Suburbanization of American Poverty, Elizabeth Kneebone, Senior Research Analyst, Metropolitan Policy Program, Spotlight on Poverty and Opportunity, October 23, 2009, http://www.brookings.edu/opinions/2009/1019_poverty_kneebone.aspx. Strained Suburbs: The Social Service Challenges of Rising Suburban Poverty, Scott Allard and Benjamin Roth, Metropolitan Opportunity Series. http://www.brookings.edu/~/media/Files/rc/reports/2010/1007_suburban_poverty_allard_roth/1007_suburban_poverty_allard_roth.pdf*

[ix] *Free or reduced price meals, Communities Count. Accessed at http://www.communitiescount.org/index.php?page=free-reduced-priced-meals*

[x] *Student homelessness, Communities Count. Accessed at http://www.communitiescount.org/index.php?page=student-homelessness*

[xi] *HIV Surveillance and Epidemiologic Program, Public Health-Seattle & King County. Reports available at http://www.kingcounty.gov/healthservices/health/communicable/hiv/epi.aspx*

[xii] *Quality assurance and evaluation of the Affordable Care Act in King County, Washington. Assessment, Policy Development, & Evaluation, Public Health-Seattle & King County, 2014.*

[xiii] *Had Fecal Occult Blood Test (FOBT) within 1 year; sigmoidoscopy within 5 years and FOBT within 3 years; or colonoscopy within 10 years.*

[xiv] *Analysis by Washington State Dental Association, 2014.*

[xv] *Substance Abuse and Mental Health Services Administration. In National Behavioral Health Quality Framework (Overview). Retrieved from http://www.samhsa.gov/data/national-behavioral-health-quality-framework#overview*

[xvi] *Murray CL and Lopez AD (Eds.) (1996): The global burden of disease. A comprehensive assessment of mortality and disability from diseases, injuries, and risk factors in 1990 and projected to 2020. Cambridge MA: Harvard University. As quoted in Mental Health: A Report of the Surgeon General*

[xvii] *Seattle Women and Food Access: Learning from Women in Delridge, 2014. Building a Healthier Tomorrow: Health Equity and Access in Auburn, 2014.*

[xviii] *Personal communication, Scott Neal, Tobacco Program Manager, Public Health-Seattle & King County, 7/25/14.*

Appendix A: Methods

King County Community Health Needs Assessment 2015/2016

Report methods are summarized in the introduction and explained in detail below.

Identification of Health Needs and Selection of Indicators

A committee of representatives from Hospitals for a Healthier Community (HHC), facilitated by Public Health-Seattle & King County (PHSKC) staff, used a community health framework (see Figure 1) and population-based approach for the report to identify health needs and develop criteria for indicators used to measure health needs. The group finalized the selection of indicators with feedback from public health and hospital staff.

HHC representatives planned a succinct report focused on key indicators that relate to the hospitals' and communities' assets and resources and inform future collective strategies. These indicators were to be focused on population-based preventive strategies and promote policy/systems/environmental change for maximum population health impact. It was also recognized that partnerships between hospitals, public health, community organizations and communities are key to successful strategies to address common health needs.

HHC and other representatives were subject matter experts who helped identify population-level health needs. The group reached consensus to focus particularly on access to care, preventable causes of death, maternal and child health, behavioral health, and violence & injury prevention. Each hospital may also gather additional data and community input to address more specific service areas such as cancer care, pediatrics and rural health.

HHC representatives developed criteria to select indicators for the King County CHNA, recognizing that the CHNA is not intended to provide all of the data necessary for each specialized topic. All topic areas were previously identified as areas of concern in other needs assessments. They used the criteria below to identify indicators other than those specified in the mandated topic areas.

Appendix A: Methods

Continued

1. Ability to address **health equity,** particularly by age, gender, race/ethnicity, geography, socioeconomic status, although not all demographic breakdowns may be available for all indicators.

2. Availability of high-quality data that are population-based (where possible), measurable, accurate, reliable, and regularly updated. Data should focus on rates rather than counts.

3. Ability to make valid **comparisons** to a baseline or benchmark

4. Prevention orientation with clear sense of direction for **action by hospitals** for individual, community, system, health service, or policy interventions that will lead to community health improvement.

5. Ability to **measure progress** of a condition or process that can be improved by intervention/policy/system change, and there exists a **capacity** to affect change.

6. Alignment with local and national **health care reform** efforts including the triple aim.

Description of the Data

Quantitative data used in this report are high quality, population-based data sources and were analyzed by PHSKC Assessment, Policy Development & Evaluation Unit. Data come from local, state, and national sources such as the U.S. Census Bureau, U.S. Centers for Disease Control and Prevention, Washington State Department of Health, and King County. Data sources for each indicator are shown in the corresponding graph and full details for each indicator are online. Some data, such as births, deaths, and hospitalizations, are based on information for each event in King County. Other data sources based on surveys follow rigorous sample design and complex survey analysis in order to present population-based percentages. 95% confidence intervals were calculated in order to assess reliability of rates. Additional definitions of data terms are found in Appendix C.

Appendix A: Methods

Continued

Community Input

This community health needs assessment takes into account input from people who represent the broad interests of the communities served by HHC hospitals and health systems. Three methods of gathering information from community members about identified health needs and assets were used.

1. Interviews were conducted by PHSKC staff between January and July of 2014 with stakeholder coalitions with broad representation. This method maximized the number and diversity of stakeholders who could provide input. Coalitions were identified that have expertise on health needs identified through quantitative data, have diverse membership, and have a regional or subregional focus. Stakeholders included those who represent the broad interests of the community, representatives of medically underserved, low-income and minority populations, and populations with chronic disease needs, as well as representatives from the local health department. Stakeholder groups included human service providers, community health centers, behavioral health providers, state, county, and local government staff, fire departments, law enforcement, advocacy organizations, hospital staff, groups focused on health disparities in communities of color, faith communities, labor, and managed care organizations.

A total of 11 coalitions and 99 individual organizations or key informants provided information.

2. An online survey was also available for those who were unable to attend the respective coalition meeting and wished to provide input in writing. Thirty-one individuals responded to the survey.

3. Recent reports on health needs were also reviewed for themes and relevant assets and resources.

The following interview questions were used for the in-person interviews and online survey.

1. What are the main concerns you or your organization have about (topic) right now?

2. What are the people, places, and things that make your community healthy, safe, and strong and tell us why these people, places, and things are important? These could include organizations, leaders, coalitions, initiatives, policies, or physical/environmental attributes.

3. What programs or projects are happening or planned that are most relevant to the identified needs?

4. How can hospitals and health systems be involved in addressing the issues you have identified?

5. What are the most significant gaps in resources, coordination, etc. in this area?

Appendix A: Methods

Continued

6. Is there anything else you would like to add?

The information collected through these methods was analyzed for themes about key issues, available assets and resources, and opportunities. The findings were included in this report.

Interviews were conducted with individuals belonging to the following coalitions, agencies, and organizations:

Those who represent the broad interests of the community

Eastside Human Services Forum

Aging & Disability Services
The Arc of King County
City of Bellevue
City of Kirkland
City of Redmond
Friends of Youth
Hopelink
Issaquah Human Services Commission
Issaquah Sammamish Interfaith Coalition
King County Council
Kirkland City Council
Overlake Medical Center
Redmond City Council
Youth Eastside Services
YWCA Seattle-King-Snohomish

North Urban Human Services Alliance

Center for Human Services
City of Lake Forest Park
City of Shoreline Human Services
Hopelink
Northshore/Shoreline Community Network
Shoreline Community College

Seattle Human Services Coalition

South King Council of Human Services

King County Traffic Safety Task Force

Burien Police Department
Kent Police Department
Kirkland Police Department
Issaquah Police Department
Maple Valley Police Department
Newcastle Police Department
Redmond Police Department
Renton Police Department
Seatac Police Department
King County Emergency Medical Services

Safe Kids Seattle/South King County

Feet First Pedestrian Safety Coalition
Harborview Spine Center and Concussion Program

Appendix A: Methods

Continued

Safe Kids Eastside

Brain Injury Alliance

CarSafe Kids

Duvall Fire Department

Eastside Aid Community

EvergreenHealth

Nick of Time Foundation

Olympic Physical Therapy

Central Region EMS & Trauma Care Council

EvergreenHealth Emergency Department

Group Health Emergency Department

Harborview Medical Center Emergency Department

Highline Medical Center Emergency Department

Multicare Auburn Emergency Department

Northwest Hospital Emergency Department

Overlake Medical Center Emergency Department

Seattle Children's Hospital Emergency Department

Snoqualmie Valley Hospital Emergency Department

St. Elizabeth Hospital Emergency Department

St. Francis Emergency Department

Valley Medical Center Emergency Department

Airlift Northwest

AMR Ambulance

Falck Northwest Emergency Medical Services

Tri-Med Ambulance

Washington Ambulance Association

Public Health-Seattle & King County Emergency Medical Services

Washington State Department of Health

Representatives of medically under-served, low-income and minority populations, and populations with chronic disease needs

Carol Allen, Coordinator, Access to Baby and Child Dentistry Program, Public Health-Seattle & King County

Behavioral Health Partnership Group

Asian Counseling and Referral Services

Catholic Community Services

Community House Mental Health

Community Psychiatric Clinic

Consejo Counseling

DESC

EvergreenHealth

Harborview Mental Health

NAVOS

Seattle Counseling Service

Sound Mental Health

Valley Cities Counseling

YMCA

King County Mental Health Chemical Abuse and Dependency Services

Appendix A: Methods

Continued

Country Doctor Community Health Center

SeaMar Community Health Center

Forefront

Equal Start Community Coalition

Children's Alliance

Local Hazardous Waste Management

Open Arms Perinatal Services

Native American Women's Dialogue on Infant Mortality

Center for Multicultural Health

YWCA

Odessa Brown Children's Clinic

Health Coalition for Children and Youth

Cedar River Group

Childhood Obesity Prevention Coalition

Children's Alliance

Community Health Network of Washington

Molina Healthcare

Neighborhood House

Northwest Health Law Advocates

Odessa Brown Children's Clinic

Partners for our Children

Seattle Children's Hospital

Service Employees International Union Healthcare 1199NW

Washington Chapter, American Academy of Pediatrics

Washington Dental Service Foundation

Washington State Hospital Association

WithinReach

Sallie Neillie, Executive Director, Project Access Northwest

Those with expertise in public health and representatives from the local health department

Alan Abe, Program Manager – Injury Prevention, King County Emergency Medical Services

Jennifer DeYoung, Health Reform Analyst, Public Health-Seattle & King County

Tony Gomez, RS, Manager, Violence and Injury Prevention, Public Health-Seattle & King County

Scott Neal, Tobacco Program Manager, Public Health-Seattle & King County

Lisa Podell, Interim Health Reform Analyst, Public Health-Seattle & King County

Whitney Taylor, Firearm Violence Prevention/Child Fatality Review Program Manager, Public Health-Seattle & King County

Appendix A: Methods

Continued

Crystal Tetrick, Parent Child Health Manager, Public Health-Seattle & King County

Sharon Toquinto, Prevention and Treatment Manager, Mental Health Chemical Abuse & Dependency Services Division, King County

Jim Vollendroff, Division Director, Mental Health Chemical Abuse & Dependency Services Division, King County

Review of existing reports

Recent reports including broad community needs assessments, strategic plans, or reports on specific health needs were reviewed for context and relevant assets, resources, and opportunities. The following reports were reviewed:

1. Preliminary information from the King County Accountable Community of Health (ACH) exploration

2. Delridge Women's Food Access report, 2014

3. Duwamish Valley Cumulative Health Impacts Analysis, 2013

4. Distracted driving report card, 2013

5. Got Green Food Access report, 2014

6. High School Outcomes for DSHS involved youth, 2012

7. Ina Maka Family Program Community Needs Assessment 2012

8. King County Equity and Social Justice report, 2013

9. King County Strategic Plan community adults report, 2014

10. Puget Sound Educational Service District Early Head Start, Head Start, and ECEAP Programs Community Assessment, 2014

11. Regional Equity Network Grantee Recommendations, 2013

12. Seattle Healthy Living Assessment Pilot Implementation Report, 2011

13. Seattle Racial Equity Community Survey, 2013

14. State Policy Action Plan to Eliminate Health Disparities, 2012

15. United Way of King County Investment Plan, 2013

16. Trans* Resource and Referral Guide, 2014

17. Vietnamese Community Assessment Report, 2011

18. Washington State Department of Health Strategic Plan, 2014

19. Washington CAN Health Equity and Access in Auburn, 2014

Appendix A: Methods

Continued

20. Group Health Community Health Needs Assessment, 2013

21. Franciscan St. Elizabeth Community Health Needs Assessment, 2013

22. Franciscan St. Francis Community Health Needs Assessment, 2013

23. Highline Medical Center Community Health Needs Assessment, 2013

24. Multicare Auburn Community Health Needs Assessment, 2013

25. Navos Community Health Needs Assessment, 2013

26. Northwest Hospital Community Health Needs Assessment, 2013

27. Overlake Community Health Needs Assessment, 2011

28. Seattle Children's Hospital Community Health Needs Assessment, 2013

29. Seattle Cancer Care Alliance Community Health Needs Assessment, 2013

30. Snoqualmie Valley Hospital District Community Health Needs Assessment, 2013

31. Swedish Hospital Community Health Needs Assessments, 2013

32. Virginia Mason Community Health Needs Assessment, 2013

Evidence Based Practices

Additional information on evidence based practices is available from the following sources. Hospitals should consult these guides when planning interventions.

1. The Robert Wood Johnson Foundation's What Works for Health

2. The Centers for Disease Control and Prevention's Community Guide to Preventive Services

3. Blueprints for Healthy Youth Development

4. The Substance Abuse and Mental Health Services Administration (SAMHSA)'s National Registry of Evidence-based Programs and Practices

Appendix B: About Hospitals for a Healthier Community

King County
Community Health
Needs Assessment
2015/2016

A collaborative of hospitals and health systems and Public Health-Seattle & King County have joined forces to identify the greatest needs of the communities they serve and develop plans to address them. Working together they can leverage their expertise and resources to address the most critical health needs in our county. A shared approach to community benefits can avoid duplication and focus available resources on a community's most important health needs.

CURRENT PRIORITIES

Obesity & diabetes:

More than half of King County residents are overweight or obese, and diabetes is one of the leading causes of death. Members already address these issues through screening, treatment and education programs. As a first step together, they have **pledged to increase access to healthy food and beverages** for their patients, families, and staff.

Access to care:

About 180,000 King County residents will soon be eligible for free or low-cost health coverage. Members will ensure that residents have **access to new health insurance options** through Washington Healthplanfinder.

Needs assessment:

Members are working together to assess **health needs among communities** in King County and will develop strategies to address these priority areas. The collaborative report will be presented and available to the public in 2015. Individual hospitals will also be publishing their own community health needs assessments.

Appendix B: About Hospitals for a Healthier Community

Continued

Participating Hospitals and Health Systems

EvergreenHealth

CHI Franciscan Health

St. Elizabeth Hospital
St. Francis Hospital
Highline Medical Center
Regional Hospital

Group Health Cooperative

MultiCare Health System

Auburn Medical Center

Navos

Overlake Medical Center

Seattle Cancer Care Alliance

Seattle Children's Hospital

Snoqualmie Valley Hospital District

Swedish Medical Center

Ballard Campus
Cherry Hill Campus
First Hill Campus
Issaquah Campus

UW Medicine

Harborview Medical Center
Northwest Hospital & Medical Center
UW Medical Center
Valley Medical Center

Virginia Mason

Appendix C: Report Structure

For each indicator, this report includes:

- A description of the indicator
- Overall estimate for King County
- Multiple-year averaged estimates for select sub-populations (e.g. race/ethnicity and region) in either a bar chart or map
- A list of sub-populations that have a statistically significant higher burden of risk, disease, or injury than the overall King County population.

The technical appendix includes more complete information for each indicator including (where applicable):

- A table and bar chart of multiple-year averaged estimates by all demographics (e.g. age, gender, race/ethnicity, income or neighborhood poverty level as a measure of socioeconomic status, region)
- A table and bar chart comparing King County to Washington State, the United States, and the Healthy People 2020 Objective
- A table of multiple-year averaged estimates by King County Health Reporting Area (HRA)
- A map of multiple-year averaged estimates by HRA, ZIP code, or region
- Trend chart for King County and regions

Confidence Interval (also known as error bar) is the range of values that includes the true value 95% of the time. If the confidence intervals of two groups do not overlap, the difference between groups is considered statistically significant (meaning that chance or random variation is unlikely to explain the difference). For some indicators, results are reported with a 90% confidence interval, showing the range that includes the true value 90% of the time.

Crude, Age-Specific, and Age-Adjusted Rates

- Rates are usually expressed as the number of events per 100,000 population per year. When this applies to the total population (all ages), the rate is called the **crude rate**.
- When the rate applies to a specific age group (e.g., age 15-24), it is called the **age-specific rate**.
- The crude and age-specific rates present the actual magnitude of an event within a population or age group.

Appendix C: Report Structure

Continued

- When comparing rates between populations, it is useful to calculate a rate that is not affected by differences in the age composition of the populations. This is the **age-adjusted rate**. For example, if a neighborhood with a high proportion of older people also has a higher-than-average death rate, it will be difficult to determine if that neighborhood's death rate is higher than average for residents of all ages or if it simply reflects the higher death rate that naturally occurs among older people. The age-adjusted rate mathematically removes the effect of the population's age distribution on the indicator.

- Some graphs have a * or § symbol. A * means that there are too few cases to protect confidentiality and/or report reliable rates. A § denotes that while rates are presented, there are too few cases to meet a precision standard, and results should be interpreted with caution.

Geographies:

Whenever possible, indicators are reported for King County as a whole and for 4 regions within the county. If enough data are available for a valid analysis, they may also be reported by smaller geographic areas (cities, neighborhoods within large cities, and groups of smaller cities and unincorporated areas). Education data are reported by school district. For more detail, plus maps, see About King County Geographies.

Health Reporting Areas (HRAs):

In 2011, new King County Health Reporting Areas (HRAs) were created to coincide with city boundaries in King County. HRAs are based on aggregations of U.S. Census Bureau-defined blocks. Where possible, HRAs correspond to neighborhoods within large cities, and delineate unincorporated areas of King County. The new HRAs were designed to help cities and planners as they consider issues related to local health status or healthy policy. HRAs are used whenever we have sufficient sample size to present the data.

Federal Poverty Guidelines, issued by the Department of Health and Human Services, are a simplified version of the federal poverty thresholds. The guidelines are used to determine financial eligibility for various federal, state, and local assistance programs. For a family of 4, the federal poverty guideline was $22,050 in 2010; in 2013 it was $23,550.

Appendix C: Report Structure

Continued

Neighborhood poverty levels are based on the proportion of households in a Census tract in which annual household income (as reported in the U.S. Census Bureau's American Community Survey) falls below the federal poverty threshold.

- High poverty: 20% or more households in the neighborhood below poverty threshold.
- Medium poverty: 5% to 19% of households below poverty threshold.
- Low poverty: fewer than 5% of households below poverty threshold.

Race/Ethnicity and Discrimination:

Race and ethnicity are markers for complex social, economic, and political factors that can influence community and individual health in important ways. Many communities of color have experienced social and economic discrimination and other forms of racism that can negatively affect the health and well-being of these communities. We continue to analyze and present data by race/ethnicity because we believe it is important to be aware of racial and ethnic group disparities in these indicators.

Race/Ethnicity Terms:

Federal standards mandate that race and ethnicity (Hispanic origin) are distinct concepts requiring 2 separate questions when collecting data from an individual. "Hispanic origin" is meant to capture the heritage, nationality group, lineage, or country of birth of an individual (or his/her parents) before arriving in the United States. Persons of Hispanic ethnicity can be of any race. 2010 Census terms: Hispanic or Latino, Not Hispanic or Latino, White alone (Not Hispanic or Latino), Black or African American, American Indian or Alaska Native, Asian, Native Hawaiian or Other Pacific Islander, White, Some Other Race, and Two or More Races. Persons of Hispanic ethnicity can be of any race and are included in other racial categories. Racial/ethnic groups are sometimes combined when sample sizes are too small for valid statistical comparisons of more discrete groups.

Some surveys collect race/ethnicity information using only one question on race. These terms are:

- Terms: Hispanic, Non-Hispanic, White Non-Hispanic, Black, American Indian/Alaska Native (AIAN), Asian, Native Hawaiian/Pacific Islander (NHPI), White, and Multiple Race (Multiple).

Appendix C: Report Structure

Continued

Rolling averages:

When the frequency of an event varies widely from year to year, rates are sometimes aggregated into averages – often in 3-year intervals – to smooth out the peaks and valleys of the yearly data in order to view the trend. For example, for events occurring from 2001 to 2010, rates may be graphed as three-year rolling averages: 2001-2003, 2002-2004…2008-2010. Adjacent data points will contain overlapping years of data. Statistical tests comparing data points with overlapping times are not appropriate.

Statistical Significance:

Differences between sub-population groups and the overall county are examined for each indicator. Unless otherwise noted, all differences mentioned in the text are statistically significant (unlikely to have occurred by chance).

The potential to detect differences and relationships (termed the statistical power of the analysis) is dependent in part on the number of events and size of the population, or, for surveys, the number of respondents, or sample size. Differences that do not appear to be significant might reach significance with a large enough population or sample size.

Appendix D: Data for Report Indicators

Description of Community

Life Expectancy and Leading Causes of Death

Chronic Illnesses

Access to Care, Use of Clinical Preventive Services, and Oral Health

Insurance Coverage

Workforce Capacity

Clinical Preventive Services

Oral Health

Preventable Hospitalizations

Behavioral Health

Mental Health

Substance Abuse & Chemical Dependency

Maternal and Child Health

Preventable Causes of Death

Obesity, Physical Activity, and Nutrition

Tobacco Use

Violence and Injury Prevention

Intentional Injuries

Unintentional Injuries

Additional indicators are online at www.kingcounty.gov/health/indicators.

Appendix 2: MultiCare Health System Program Inventory

MultiCare
BetterConnected

Focus 1: Access to Care

Adolescent and Youth Adult Oncology Council

A council composed of youth impacted by a cancer diagnosis, which also includes siblings, parents and spouses of patients. Adolescents and young adults with cancer face a distinctive spectrum of medical and psychosocial challenges that differentiate them from older and younger patients. As a result of little information in medical literature regarding the specific needs, challenges and health care preferences of young adults with cancer who are treated at community medical centers, the council focuses on diminishing gaps so others have a more positive experience.

Carol Milgard Breast Center

Jointly owned by MultiCare Health System, CHI-Franciscan Health, and TRA Medical Imaging, the Carol Milgard Breast Center provides sustainable breast health services for all women in the community in a caring environment that fosters confidence, comfort, peace and dignity for each individual. Financial assistance is available to eligible patients.

Charity Care

MultiCare offers 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 the 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, discounted services and assistance with qualifying for state-sponsored health plans.

Community Partnership Fund

Contributes to not-for-profit community organizations in Pierce, King, Thurston and Kitsap counties that advance initiatives, programs and projects that improve community determinants of health.

Indigo Urgent Care

Provides quick care for lower-acuity conditions. Open seven days a week, Indigo Urgent Cares will be serving neighborhoods throughout Pierce, King, Thurston, and Snohomish counties.

Focus 1: Access to Care

Continued

MultiCare Clinics and Urgent Care Clinics

Provides same- and next-day appointments, a 24-hour nurse line, and are open extended hours weekday evenings and on weekends.

Personal Health Partners

Helps patients overcome barriers to care by coordinating services, and ensuring open communication between the providers, patients, families and others. Some examples of services offered include medication management, participation in visits with primary care providers and conducting home assessments.

RediClinics

Located at Rite Aid pharmacies across Pierce, Snohomish, and King counties. RediClinics offer low-cost, convenient access for many health care needs, including immunizations and laboratory tests. These clinics are available to uninsured individuals and have extended hours to serve patients and families with busy schedules.

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 everything from pregnancy, birth, comfort techniques, medications for birth, cesarean birth, postpartum, breastfeeding and newborn care.

Community Outreach to Diverse Communities

Provides prevention, education and blood pressure screenings at area community events that reach out to underserved communities. Partnerships include: Asia Pacific Cultural Center, Centro Latino, Northwest Leadership Foundation, Ebony Nurses and other area coalitions.

Center for Healthy Living & Health Equity Nutrition Services

Registered Dietitians with expertise in sports nutrition and weight management offer nutrition services including body fat testing, metabolic rate testing, menu planning, goal setting and one-on-one and/or group counseling sessions to help individuals and families make healthy changes. Discounts are available for YMCA members and MultiCare employees. Dietitians are also available for group and corporate nutrition presentations.

Centers of Occupational Medicine

Centers of Occupational Medicine clinics are dedicated to medical, health and wellness services for the workplace. We provide occupational health services for both patients and employers in Pierce and South King counties.

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.

Focus 2: Obesity

Continued

Empowering Women for Wellness: SNAP-Ed Health Outcomes Program

SNAP-Ed Prenatal/Postnatal Health Outcomes Program includes direct education, and working towards policy, systems and environmental changes, with the goals of:

- Achieving healthy pregnancy weight gain within the Institute of Medicine (IOM) recommendations;
- Healthy infant birth weight;
- Reducing postpartum weight retention;
- Reducing maternal and child risk of obesity;
- Demonstrating that SNAP-Ed participation improves nutrition, health status, medical care costs and risk of obesity and chronic disease.

Partners include Tacoma Pierce County Health Department, YMCA of Pierce and Kitsap Counties, and MultiCare Health System. In this program, we offer educational classes to expectant and new mothers so they can learn about nutrition and physical activity. Women are referred to the wellness program by MultiCare providers as well as community organizations. The program is four weeks in length and includes a free YMCA membership during that time.

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 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 Sound to Narrows Walk/Run event.

Focus 2: Obesity

Continued

Million Minute Mission School Challenge

A part of the Million Minute Mission challenge, the school challenge was created to encourage youth to participate in the physical activity challenge. Schools compete and the top three schools are recognized at the Sound to Narrows Walk/Run event.

Center for Diabetes and Nutrition Services

A team of registered nurses, registered dietitians and pharmacists specializes in teaching people with diabetes how to effectively manage their disease. The team works together to provide clients with comprehensive diabetes care, education and nutrition advice in a reassuring and positive atmosphere.

Pierce County Gets Fit & Healthy

The goal of Pierce County Gets Fit & Healthy is to promote health and wellness in the community. It is a major collaborative effort led by the MultiCare Center for Healthy Living & Health Equity, the YMCA of Pierce and Kitsap Counties and the Tacoma-Pierce County Health Department.

Pediatric Weight and Family Wellness Program

A program designed for youth 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 how to fix and freeze 30 nutritious meals. Participants sample finished dishes and take home a free booklet filled with a month worth of healthy and easy-to-prepare recipes (nutritional analysis included).

Focus 2: Obesity

Continued

Ready, Set, Go! 5210

A countywide initiative supported by MultiCare Mary Bridge Children's Hospital, YMCA of Pierce and Kitsap Counties, Tacoma-Pierce County Health Department, United Way of Pierce County, CHI Franciscan Health, 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 programs goal is to improve the likelihood that persons eligible for food assistance will make healthy food choices within a limited budget and choose physically active lifestyles consistent with the current Dietary Guidelines for Americans and MyPlate.

Center for Weight Loss and Wellness

The MultiCare Center for Weight Loss & Wellness offers effective, evidence-based weight loss and wellness programs and procedures in a compassionate and supportive environment. Some of the benefits of our programs include:

- Surgical and non-surgical weight-loss options
- Medical supervision through all stages of your care from board-certified doctors
- Dedicated, one-on-one support from our expert staff

Weight-loss plans personalized to fit your specific needs and health goals

Whole, Fresh, Local Nutrition Services Program

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

Women Infant & Children (WIC)

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

Focus 3: Tobacco Use

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 – Quit Smart

Offered to MultiCare employees with additional one-on-one support through a Wellness Coach.

Tobacco-Free workplace

No-smoking policy to reduce exposure and access to tobacco on all MultiCare Health System properties.

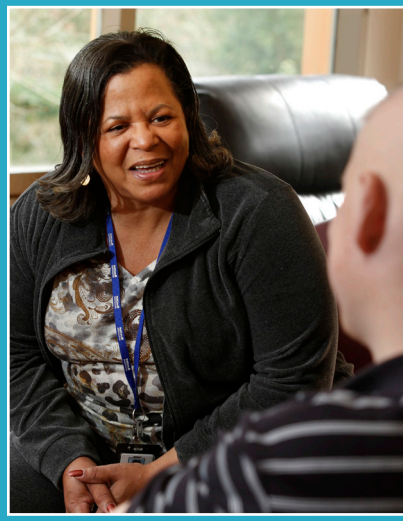
Tobacco Use Physician Electronic Visits

E-visit 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. Each self-paced workshop follows a similar format that includes an online video, reading assignment and a few easy questions. It provides participants with the behavioral change skills and ideas to support quit efforts; such as creating a quit plan, nutrition to maximize your quit possibilities, physical activity for positive brain chemistry and learning to let go of stress.

Focus 4: Behavioral Health



Inpatient Behavioral Health Services

Includes 38 voluntary geropsychiatric inpatient beds and 20 voluntary and involuntary adult inpatient beds at MultiCare Auburn Medical Center.

Psychiatric Consultation Services

Psychiatric ARNPs and MDs who provide outpatient assessment and consultative services to both children and adults. Telepsych providers available for inpatient and Emergency Department consultation.

Chemical Dependency Services

Adult outpatient and involuntary inpatient placement for CD services. Currently only accepting Medicaid and some third party referrals. Services provided in Tacoma and Puyallup.

Child, Adult and Family Psychotherapy

Routine psychotherapy services provided primarily on site at our clinic in Puyallup.

Intensive Case Management and Peer Support

Case management and intensive support services for children and adults with a serious mental illness. Available to Medicaid clients with a mental health benefit. Same day access to an assessment for services is available at the Puysllup location.

Crisis Services

Mobile Outreach Crisis Team (MOCT) is a 24/7 service. Regardless of a person's insurance coverage, MOCT reaches across Pierce County to assess adults who are experiencing a behavioral health crisis.

Residential Services

A full range of residential services for adults with a serious mental illness who are enrolled within our programs: 45-bed, 24/7 staffed Residential Treatment Facility, and houses we own and rent to individuals, Section 8 and HUD housing options, contracts with Boarding Homes within the community. Access to a crisis bed placement at our Residential Facility is initiated by calling the Crisis Line and requesting a crisis bed.

Focus 4: Behavioral Health

Continued

Asian Counseling Services

Dedicated case managers who specialize in treating Asian populations within Pierce County. Medicaid and most private insurances accepted.

High intensity Care Transitions

This program is for identified Emergency Department high utilizers or high risk clients within MultiCare that also have an issue related to mental health or substance use. By providing outreach and engagement, we are able to more functionally meet the needs of our high utilizing patients to reduce the number of unnecessary/ non-essential/avoidable ED visits, and increase overall health.

Employee Assistance Program Services

A comprehensive list of Employee Assistance Program services is available to MultiCare and contracted employees.

Behavioral Health & Primary Care Integration

This program provides access to Behavioral Health services within a primary care or specialty care setting across MultiCare's geographic spread. Services are currently provided to children and adults within 13 different sites.

Program for Assertive Community Treatment

Adult wrap-around services program that treats those with a serious mental illness who have failed at other treatment approaches and who are high utilizers of resources (ie. hospitalization, Emergency Department usage, jail).

Older Adult Services

Program dedicated to providing services to the older adult population and their caregivers. Specialties include dementia and related aging disorders. Outreach services are provided to peoples' homes and nursing homes. At-clinic services are provided in Puyallup.

Children's Therapy Unit (CTU) Psychology Services:

The Children's Therapy Unit Psychology Team is part of a multi-disciplinary service for children with developmental disorders and special health care needs. They provide pediatric psychological assessment, treatment and consultation for children experiencing a variety of emotional and behavioral disorders including youth on the autism spectrum. The staff includes three PhD level psychologists and one Licensed Mental Health Counselor. Their site is in Puyallup, close to Good Samaritan Hospital.

Focus 5: Childhood Immunizations

MultiCare Mobile Immunization Clinics

Provides free immunizations for children with no insurance or inability to pay. Services offered at locations in Tacoma and Puyallup.

MultiCare Hospitals and Primary Care Clinics

Offers free immunizations to all children in the community from birth through 18 years of age.

Focus 6: Cultural Competency

MultiCare Center for Healthy Living & Health Equity

Promotes healthy lifestyle choices and addresses health disparities in our communities to improve population health outcomes. Serves as a health equity resource for MultiCare staff, patients, and the community.

MultiCare Physical Medicine and Rehabilitation Program & MultiCare Tacoma Family Medicine and East Pierce Family Medicine

Provides formal and informal cultural sensitivity education to staff, departments, and resident physicians.

Appendix 3: Community Impact Evaluation 2013-2016






MultiCare
BetterConnected

From 2013 through 2016, all five MultiCare hospitals focused on the following priority health needs in their implementation strategies:

- Chronic Disease
- Obesity
- Tobacco Use
- Behavioral Health
- Cultural Diversity

Each hospital selected its own chronic disease focus area. These focus areas included:

- Allenmore Hospital: Chronic Obstructive Pulmonary Disease (COPD) and Cardiovascular Disease
- Auburn Medical Center: Type 2 Diabetes
- Mary Bridge Children's Hospital: Asthma
- Tacoma General and Good Samaritan hospitals: Cardiovascular Disease

The report below summarizes the impact our strategy plans had on community health throughout the MultiCare service area.

Cardiovascular Disease

Strategy: Promote cardiac education and services, in addition to prevention activities, in the MultiCare service area

- Cardiac education and blood pressure screenings were provided at over 20 community events, including Ethnic Fest, Hilltop Street Fair, and Asia Pacific New Year Celebration.
- Over 550 individuals received blood pressure checks and cardiac education at community events.

Chronic Obstructive Pulmonary Disease

Strategy: Promote COPD self-management programs.

- Inpatient COPD self-management program was developed and implemented.
- After completing the program, over 95% of program participants reported that they have improved knowledge COPD self-management.
- MultiCare supported the American Lung Association Lung Task Force Conference in 2015 which reached over 100 community members.

Type 2 Diabetes

Strategy: Promote Type 2 Diabetes prevention activities.

- Type 2 diabetes risk assessments were completed by over 150 residents at community events, including the Auburn Health Fair, You Me We, and the MultiCare Healthy Living Expo.
- Over 100 community members participated in the Auburn Valley YMCA Diabetes Prevention Program.

Childhood Asthma

Strategy: Increase community awareness of asthma and related screenings and practices.

- Over 20 Mary Bridge community asthma education classes were held and over 40 families participated.
- The Mary Bridge Clean Air for Kids Program received over 600 referrals from families needing asthma and allergy management resources.

Obesity — Youth and Adult

Strategy: Promote community awareness and understanding of the Ready, Set, Go! 5210 program and message.

- Over 225,000 individuals were impacted by the RSG 5210 message.
- Over 2,500 adult and youth were educated on RSG 5210 during outpatient visits.
- An additional 10 community organizations became RSG 5210 partners (n=32).
- In 2014, RSG 5210 "Lunch and Learn", a six-week program, was offered in various schools in the Puyallup and Bethel School District.
  - Groups of 62 mixed 3rd, 4th, and 5th graders reported:
    - An average of 45% reduction in recreational screen time
    - 32% increase in physical activity
    - 17% increase in fruit and vegetable consumption
    - 23% increase in water consumption

Strategy: Promote weight management services in the community.

- Over 500 adults were referred to a MultiCare Center for Healthy Living dietitian for weight management services and approximately 500 people consulted with a dietitian.
- Pediatric Weight and Wellness Program engagement rate increased by 43% through Family Wellness Workshops.
- 340 families participated in Weight and Wellness assessments.
- 550 MultiCare staff received training in providing weight sensitive care.

Strategy: Obtain grants.

- MultiCare Center for Healthy Living received SNAP-Ed grant funding from the USDA/Washington State Department of Health to provide nutrition education to WIC families and students at underserved middle and high schools in Tacoma.
  - Over 1,300 students were served in 2014 and 2015.
  - Annual data revealed an increase of 14% in confidence and an increase of 25% in reach from 2013-2014.

Strategy: Increase knowledge and best practice education of the benefits of breastfeeding.

- Over 6,000 people were provided with breastfeeding education in the community setting.
- Breastfeeding initiation rates of WIC clients reached 88% for WIC clients, a 2 % increase.

Tobacco Use

Strategy: Promote MultiCare QuitSmart™, a tobacco cessation program, internally to patients and externally to the community.

- Participation in QuitSmart™ increased by almost 20%.
- Quit and "cut-back" rate among QuitSmart™ participants increased by 10%.

Behavioral Health

Strategy: Improve access to behavioral health (mental health and chemical dependency) services.

- Approximately 40% of MultiCare primary clinics have a behavioral health provider on staff.
- Over 400 children were served by BRIDGES, a community program for grieving children who have lost family members and close friends.

Cultural Diversity

Strategy: Promote cultural diversity and health equity awareness among MultiCare staff.

- A cultural competency assessment was conducted at MultiCare to identify strengths and areas of improvement.
- A mandatory cultural competency training for staff was implemented in 2016 to improve patient care experiences and address health equity.

Strategy: Increase access to interpreter/ communication services.

- MultiCare has started training bilingual staff to be in-house interpreters via the Qualified Bilingual Staff (QBS) Program, which will improve access to interpreter services. More than 30 staff members have been trained.

Strategy: Participation in the Pierce County Leaders in Women's Health Collaborative which addresses health care disparities.

- MultiCare is supporting a community assets mapping project, led by the Leaders in Women's Health, which will identify strengths that can be used to improve community health and reduce health disparities.