MultiCare

Community Health Needs Assessment 2025

MultiCare Yakima Memorial Hospital

Purpose and Scope

MultiCare Yakima Memorial Hospital

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Yakima Memorial Hospital

Executive Summary

Overview & Identified Priorities

Identified Priorities & Contributing Factors

Executive Summary

Overview & Identified Priorities

Community Health Needs Assessment

The **2025 Yakima County Community Health Needs Assessment (CHNA)** identifies and prioritizes significant health needs among residents within the Yakima County service area. Conducted by **MultiCare Yakima Memorial Hospital** in partnership with local and regional stakeholders, this assessment provides a comprehensive analysis of the health status, disparities, and community conditions affecting the county's population. The process aligns with requirements for nonprofit hospitals under the **Affordable Care Act (ACA) Section 501(r)** and follows established best practices for community health assessment and improvement planning.

The purpose of the CHNA is to evaluate community health needs using both quantitative data and qualitative community input, identify disparities and barriers to health, and inform MultiCare Yakima Memorial Hospital's **2025–2028 Implementation Strategy**. This process reflects the hospital's ongoing commitment to improving health outcomes, addressing inequities, and strengthening collaboration with public health and community partners across Yakima County.

Approach and Methodology

A **mixed-methods approach** was used to ensure a comprehensive understanding of health needs. The assessment integrated:

- **Quantitative data** from public health sources, including the Washington State Department of Health, County Health Rankings, CDC PLACES, and U.S. Census data.
- **Qualitative input** gathered through community engagement efforts, including key informant interviews, community listening sessions, and a countywide community health survey.

Through these methods, the CHNA captured perspectives from residents and stakeholders representing a broad cross-section of Yakima County, including Hispanic/Latino communities, Yakama Nation tribal members, healthcare providers, educators, and social service organizations.

Community Context

Yakima County is located in central Washington and is home to approximately 260,000 residents. The county's economy is largely agricultural, and nearly **54% of residents identify as Hispanic or Latino**, the highest proportion of any county in the state. Furthermore, 39% of the population speaks Spanish at home. This diversity enhances the county's cultural richness and increases the need for language access and equitable healthcare delivery. Geographic size, rural dispersion, and transportation barriers further contribute to health disparities, particularly in access to primary and specialty care.

Executive Summary

Overview & Identified Priorities

Identified Priorities

Through analysis of both quantitative and qualitative data, four primary health priorities were identified for Yakima County: **Behavioral Health, Access to Care, Social Determinants of Health, and Maternal & Child Health**. These priorities represent the intersection of community-identified needs, measurable health disparities, and systemic barriers to care. Each priority area is interconnected, reflecting how social, economic, and behavioral factors collectively influence overall health outcomes.

Behavioral Health

Behavioral health remains the **top priority** in Yakima County. Across listening sessions, key informant interviews, and survey responses, residents described an urgent need for **expanded mental health services, substance use prevention, and crisis response**. Stakeholders consistently emphasized the escalating impact of **fentanyl and polysubstance use**, along with the lack of detoxification and recovery resources, particularly for women, youth, and those without insurance.

Community members also noted widespread challenges in accessing timely and culturally responsive care. Long wait times, workforce shortages, and limited availability of bilingual and bicultural providers continue to restrict access to treatment. The need for integrated behavioral health care and community-based prevention programs was repeatedly highlighted as essential for long-term impact.

Together, these findings reflect a behavioral health system under strain and a community calling for coordinated, equitable solutions.

Access to Care

Access to healthcare services—both primary and specialty care—remains a **significant challenge** for many Yakima County residents. The community survey identified "access to healthcare" as the **most frequently cited barrier to health**, with cost, insurance coverage, and long wait times as the leading concerns. Residents reported traveling long distances for specialty and dental care, and rural populations described transportation and broadband limitations that affect both in-person and telehealth access.

Stakeholders noted that Yakima County continues to face **persistent workforce shortages**, especially in primary care and behavioral health. These shortages create delays in diagnosis and treatment, particularly for those with chronic conditions. While community health centers and hospital partnerships have expanded access for some, systemic challenges—such as affordability, staffing, and care coordination—remain barriers to timely and equitable care. Addressing these gaps will require continued investment in workforce development, service availability, and culturally competent navigation support.

Executive Summary

Overview & Identified Priorities

Social Determinants of Health

The role of **social and economic conditions**—including housing instability, food insecurity, and neighborhood environments—was consistently emphasized as central to community health. Residents described difficulty finding **affordable housing**, with many experiencing overcrowding or substandard living conditions. Stakeholders noted that homelessness and unstable housing contribute directly to poor physical and mental health outcomes, and that limited shelter capacity leaves many individuals and families without consistent support.

Food insecurity remains a major concern, particularly in rural and low-income communities where access to fresh, affordable food is limited. Participants expressed a desire for more community-based solutions such as local food programs, cooking classes, and expanded food assistance.

Maternal & Child Health

Maternal and child health continues to be a **core public health priority** for Yakima County. Data show that rates of **low birthweight, infant mortality, and late prenatal care** exceed state averages, and qualitative input reinforced that many women face barriers to early and consistent prenatal care. Cost, transportation, childcare responsibilities, and limited OB/GYN capacity were frequently cited as challenges.

Stakeholders also identified maternal mental health and postpartum support as emerging needs. Many community members expressed the importance of **culturally appropriate education, home visiting programs, and family-based supports** that promote healthy pregnancies and infant outcomes.

Cross-Cutting Themes

Across all priority areas, several cross-cutting issues were identified:

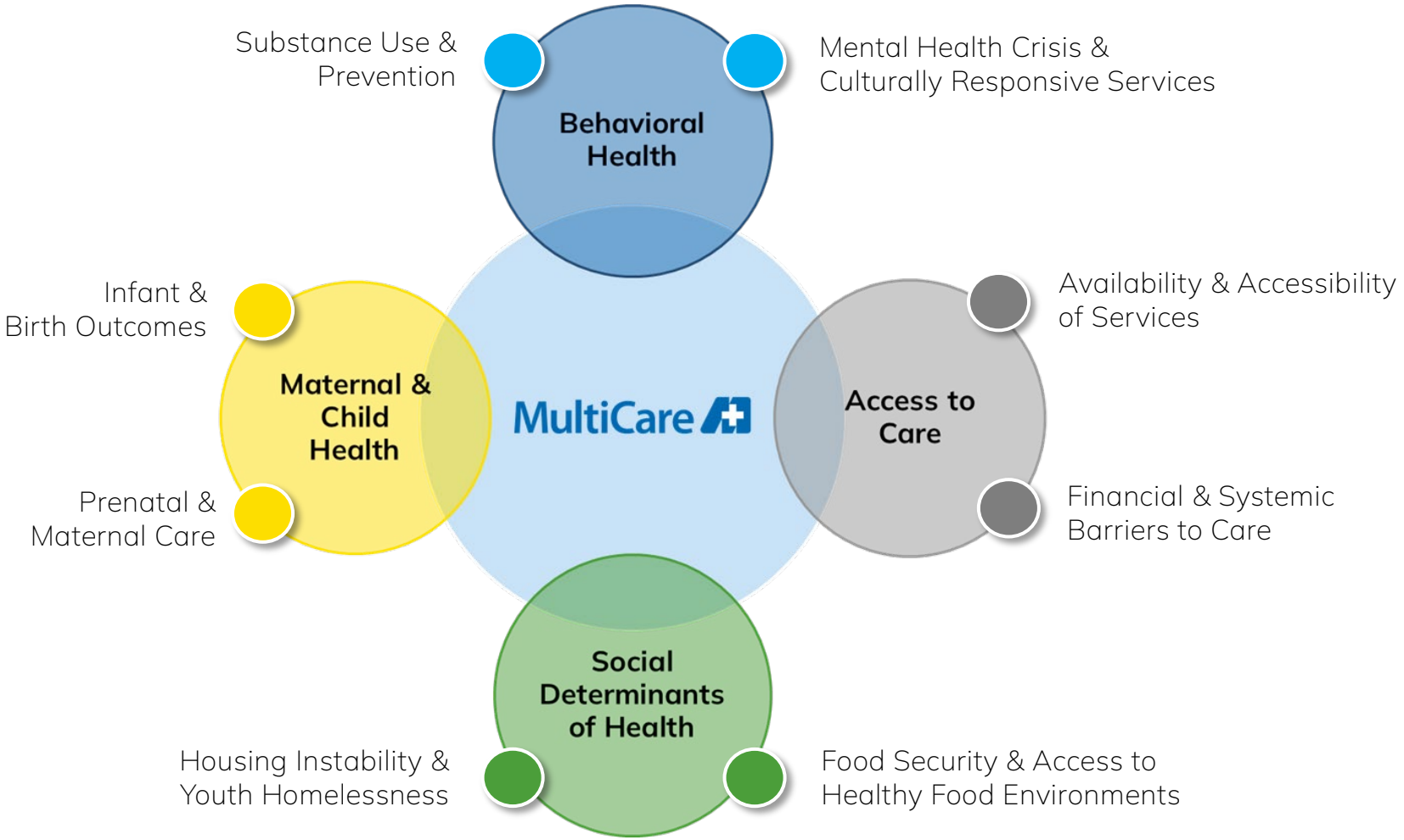
- **Equity and Inclusion:** Persistent disparities exist by income, geography, race, and language.
- **Workforce Capacity:** Shortages in healthcare and behavioral health providers affect all priority areas.
- **Community Collaboration:** Partnerships among healthcare, public health, and social service organizations are critical to addressing interconnected needs.
- **Trust and Cultural Competence:** Building trust through culturally responsive care and community engagement is essential to improving health outcomes.

Next Steps

The findings from this CHNA will inform the development of MultiCare Yakima Memorial Hospital's **Implementation Strategy**, which will guide targeted initiatives and investments from 2025 through 2028.

Executive Summary

Identified Priorities & Contributing Factors



MultiCare
Yakima Memorial Hospital

Introduction

Purpose of CHNA

Defining the Community

Introduction

Purpose of the CHNA

Assessment Process

This Community Health Needs Assessment (CHNA) serves two fundamental purposes for Yakima Memorial Hospital. It's a reflection of its mission-driven commitment to the community and a fulfillment of its federal regulatory requirements.

A Commitment to the Community

For Yakima Memorial Hospital, the CHNA is more than a regulatory requirement; it is a vital part of an enduring commitment to the community it serves. This commitment is realized through a continuous cycle of listening to community voices, analyzing health data and collaborating with local partners to develop and implement sustainable health solutions. This sustained dialogue allows Yakima Memorial Hospital to build on past insights, monitor progress, and adapt strategies as community needs evolve.

Ultimately, this process ensures that hospital strategy, investments, and partnerships are directly responsive to the community's immediate challenges and long-term health disparities. The goal is to create a lasting impact on the health and wellbeing in the community.

Fulfilling a Federal Requirement

This assessment also fulfills the requirements for tax-exempt hospitals as mandated by Section 501(r)(3) of the Internal Revenue Code. These federal regulations require Yakima Memorial Hospital to:

- Conduct a CHNA every three years.
- Adopt an implementation strategy to address the health needs identified in the assessment.
- Incorporate input from community representatives, including those with public health expertise.
- Make the CHNA report widely available to the public.

Community Health Needs Assessments and Implementation Plan Strategies for all MultiCare facilities can be found at https://www.multicare.org/about/community/needs-assessment/.

A paper copy will be made available at main hospital reception front desk. Written comments on this CHNA report can be submitted to healthequity@multicare.org.

Introduction

Defining the Community

Demographic Profile:

Yakima Memorial Hospital's defined service area encompasses **Yakima County, Washington**, a geographically expansive and demographically diverse region located in the heart of Central Washington. The county serves as a regional hub for healthcare, agriculture, and commerce, drawing residents from both urban centers and surrounding rural communities for essential services. The characteristics of this population provide important context for understanding the health needs identified through this assessment.

As of 2024, **Yakima County's population is estimated at 258,523 residents**. The population has grown steadily over the past decade, reflecting both economic development and the county's role as a major agricultural and employment center. The population is nearly balanced by gender, with approximately **50.2% identifying as male and 49.8% as female**, contributing to a relatively stable demographic composition across communities.

Yakima County is distinguished by its **cultural and ethnic diversity**, with **Hispanic or Latino residents comprising approximately 54%** of the total population. This majority-Hispanic population is among the highest proportions in Washington State and plays a vital role in shaping the region's cultural identity, workforce, and community dynamics.

The remaining population identifies primarily as Non-Hispanic White, along with smaller proportions of Native American, Asian, and other racial and ethnic groups. This diversity enriches the community but also underscores the need for **culturally and linguistically responsive healthcare services** to ensure equitable access and outcomes across all populations.

Introduction

Defining the Community

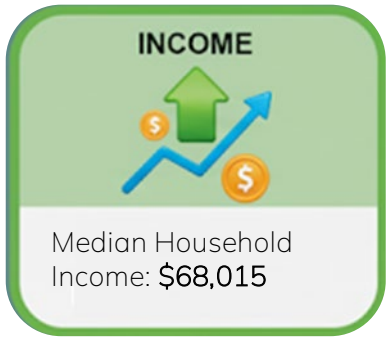
Socioeconomic Profile

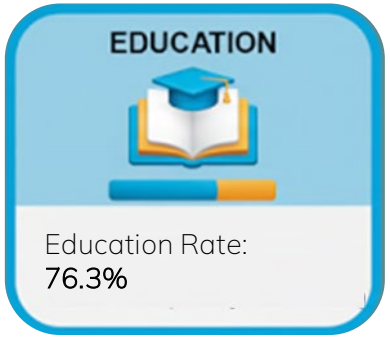
- **Income and Earnings:** Income levels in Yakima County show clear disparities across racial and ethnic groups. In 2023 (inflation-adjusted), **White households reported a median income of $74,812**, compared with **$59,794 for American Indian/Alaska Native households** and **$60,166 for Hispanic or Latino households**. All remain below the **statewide median of $94,952**.

- **Educational Attainment:** Educational attainment in Yakima County remains below the state average. From 2019–2023, **73.7% of men** and **78.9% of women aged 25 and older** had completed high school, compared to **92.2% statewide**. Overall, **76.3% of adults** in the county hold at least a high school diploma. Lower education levels contribute to income disparities, workforce challenges, and barriers to health literacy and career growth.

- **Employment:** Yakima County's **employment rate of 94.2%** is slightly below the **state rate of 95.9%**. Seasonal agricultural work and limited access to higher-wage industries create fluctuations in job stability and household income throughout the year, highlighting the need for ongoing workforce development efforts.

- **Poverty:** Approximately **36.6% of Yakima County residents** live at or below **200% of the federal poverty level**, compared with **22.8% statewide**. These figures underscore the number of working families earning just above the poverty threshold but still facing financial strain due to the rising costs of housing, food, and healthcare.





MultiCare
Yakima Memorial Hospital

Methodology & Approach

Assessment Process
Defining the Service Area
Community Engagement
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Methodology & Approach

Assessment Process

Assessment Process

inHealth Strategies, in collaboration with **MultiCare Health System (MHS)** and **MultiCare Yakima Memorial Hospital (MYMH)**, conducted the **2025 Yakima County Community Health Needs Assessment (CHNA)** using a **mixed-methods research design**. The assessment was developed to meet federal requirements for tax-exempt hospitals and to guide MultiCare's community benefit and strategic planning efforts.

Guided by both **community engagement** and **data analysis**, this process aligns with MultiCare's commitment to equitable, community-centered care — a mission reinforced through programs such as charity care, financial assistance, and population health initiatives.

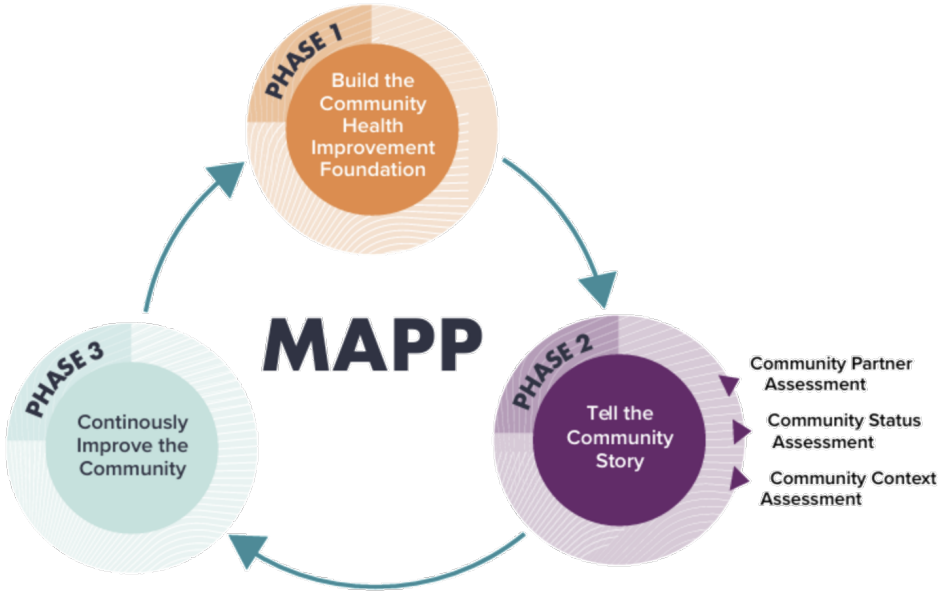
The CHNA process followed the **MAPP 2.0 Framework (Mobilizing for Action through Planning and Partnerships)** developed by the **National Association of County and City Health Officials (NACCHO)**. This approach emphasizes **equity, representation, and community voice**, ensuring that the perspectives of residents most affected by disparities inform every stage of the process.

The assessment included four key phases:

1. **Community Definition and Stakeholder Engagement** – Defining the geographic service area and identifying diverse community and system partners to guide the process.
2. **Data Collection and Analysis** – Integrating both quantitative health indicators and qualitative feedback to capture a full understanding of health across the county.
3. **Prioritization of Health Needs** – Evaluating and ranking identified needs using weighted criteria to determine the most significant community priorities.
4. **Strategic Application of Findings** – Translating findings into actionable strategies and measurable objectives to inform the **2025–2028 Implementation Strategy** for MultiCare Yakima Memorial Hospital.

Methodology & Approach

Assessment Process



Systematic, Criteria-Based Prioritization of Health Needs

The final phase involved a structured process to prioritize the significant health needs identified from our data.

First, a complete inventory of all health needs was compiled. Then a set of weighted criteria was adopted to evaluate and rank each need. The five criteria were:

1. **Magnitude of the Problem:** The scale and prevalence of the health issue.
2. **Severity of the Problem:** The level of disability, morbidity, mortality, and impact on quality of life.
3. **Disparity and Equity:** The extent to which the issue disproportionately affects vulnerable or underserved populations.
4. **Feasibility of Impact:** The evidence-based potential for Yakima Memorial Hospital and its partners to make a meaningful, measurable difference.
5. **Strategic Alignment:** The consistency of addressing the need with the hospital's core mission, the MultiCare system's strategic objectives, and, specifically, the service line and program development plans for the hospital facility.

Methodology & Approach

Defining the Service Area

Service Area

MultiCare Yakima Memorial Hospital's defined service area includes the entirety of **Yakima County, Washington**, a large and geographically diverse region in the heart of Central Washington. The county spans more than **4,300 square miles**, encompassing a mix of urban, suburban, and rural communities. Population centers include **Yakima**, **Selah**, **Toppenish**, **Sunnyside**, **Grandview**, and several smaller areas.

Yakima County functions as a **regional center for healthcare, agriculture, and commerce**, serving as a medical hub for residents across the south-central region of the state. MultiCare Yakima Memorial Hospital provides comprehensive healthcare services, including acute care, emergency services, and specialty care, and collaborates closely with local clinics, federally qualified health centers, behavioral health providers, and community-based organizations to meet the needs of the broader population.

The county's **geography and settlement patterns** play a major role in shaping health access. While the City of Yakima contains the largest concentration of healthcare services, many residents live in rural or agricultural areas where **long travel distances, limited public transportation, and seasonal work schedules** impact access to care. These logistical barriers are compounded by **language differences, financial constraints, and limited broadband access**, which affect both in-person and telehealth utilization.

Yakima County is also home to the **Yakama Nation Reservation**, a sovereign tribal nation that spans roughly 1.1 million acres across the southern portion of the county. The Yakama Nation represents a vital part of the region's population, history, and cultural identity.

The county's economy is deeply tied to **agriculture**, employing thousands of residents in farming, packing, and processing roles. This industry provides economic opportunity but also contributes to **occupational and environmental health risks**, including exposure to pesticides, physical injury, and inconsistent access to employer-sponsored insurance. The combination of rural geography, economic reliance on agriculture, and demographic diversity creates a distinctive public health landscape requiring tailored approaches to care delivery and resource allocation.

In summary, Yakima County's service area is characterized by **rich cultural diversity, economic interdependence, and rural complexity**. These factors shape both the opportunities and challenges in addressing community health needs. Understanding this context is essential to interpreting data findings, prioritizing health issues, and developing strategies that promote equitable access to care across all communities served by MultiCare Yakima Memorial Hospital.

Methodology & Approach

Community Engagement

Community Engagement

Community engagement was central to the CHNA process and ensured that findings authentically reflected the experiences of residents across Yakima County. The project team, led by **inHealth Strategies** in partnership with **MultiCare Yakima Memorial Hospital** and community organizations, prioritized inclusivity, transparency, and representation throughout the engagement process.

A range of qualitative methods were used to capture community perspectives, including:

- **Key Informant Interviews:** Sixteen (16) structured interviews were conducted with leaders from healthcare, education, housing, behavioral health, and social services.
- **Community Listening Sessions:** Ten (10) facilitated listening sessions were hosted by trusted community organizations, with **three conducted entirely in Spanish** to ensure accessibility for Spanish-speaking residents.
- **Community Health Survey:** An anonymous survey, available in English and Spanish, was completed by **129 residents** (including 15 Spanish-language responses) to gather insights on healthcare access, barriers, and community priorities.

All engagement activities intentionally included populations most affected by health inequities, such as Hispanic/Latino residents, agricultural workers, rural families, and those with limited access to care.

Qualitative data was analyzed thematically to identify common patterns, perceptions, and emerging issues. Key findings—such as concerns about behavioral health, cost of care, housing, and food insecurity—were validated through multiple sources to ensure consistency and depth. This approach grounded the CHNA in the **community's lived experience** and ensured that resident perspectives directly shaped the prioritization of needs.

Methodology & Approach

Community Engagement

CHNA Planning Committee

- Omar Gambito, Director, Community Health Partnerships and Education, MultiCare Yakima Memorial
- Mary Quinlan Fabrizio, Assistant Vice President, MultiCare Center for Health Equity and Wellness
- Kimberly Bersing, Chief Operating Officer and Chief Nurse Executive, MultiCare Yakima Memorial

Key Informant Interviews

- Yakima Health District
- Education Services District 105
- City of Yakima
- Yakima Union Gospel Mission
- Harvard School of Public Health
- Yakima Police Department
- AMR Ambulance Service
- Yakima County Human Services
- Board of Yakima County Commissioners
- Community Health Center of WA
- Catholic Charities
- YMCA
- Yakima Valley Community College
- Asian Pacific Islander Coalition (APIC) of Yakima Valley
- Data 2 Insight
- Noah's Ark Homeless Shelter

Listening Sessions

- Yakima Health District
- Yakima Union Gospel Mission
- Yakima County Healthcare Coalition
- Yakima Valley Farmworkers Clinic
- Yakima Neighborhood Health Services
- Triumph Treatment Services
- Camp Hope
- White Swan Clinic
- La Casa Hogar (Spanish)
- OIC Zumba Class Participants (Spanish)
- Nuestra Casa (Spanish)
- Noah's Ark Homeless Shelter

Community Survey

- 129 responses

Methodology & Approach

Data Collection

Comprehensive Mixed-Methods Data Collection & Analysis

To get a complete picture of community health, this assessment used a mixed-methods approach. We combined quantitative data with qualitative insights to cross-validate findings and gain a deeper understanding of the community's needs.

Quantitative Data Collection & Analysis

To complement extensive community engagement, the CHNA incorporated a wide range of **quantitative data sources** to establish an objective, evidence-based understanding of health status, disparities, and contributing factors across Yakima County. Quantitative indicators provided a foundation for comparing Yakima County's outcomes to state and national benchmarks and for identifying trends that inform community health improvement strategies. Data were collected and analyzed from **trusted local, state, and national sources**, including, but not limited to:

- **U.S. Census Bureau (American Community Survey, 5-Year Estimates)** – for demographic, economic, and housing characteristics.
- **Washington State Department of Health (DOH)** – for vital statistics, maternal and child health outcomes, and mortality data.
- **Robert Wood Johnson Foundation's County Health Rankings & Roadmaps (2025)** – for population health metrics, including access to care, health behaviors, and social determinants.
- **Centers for Disease Control and Prevention (CDC) PLACES Data** – for modeled chronic disease and behavioral health risk factors.
- **Washington State Healthy Youth Survey (HYS)** – for youth mental health, substance use, and risk behaviors.
- **Washington State Department of Social and Health Services (DSHS)** – for community-level social service indicators and vulnerable population data.

Quantitative data analysis focused on identifying **patterns, disparities, and changes over time** across key health domains, including Behavioral Health, Access to Care, Social Determinants of Health, and Maternal and Child Health. Where possible, indicators were disaggregated by **race, ethnicity, age, gender, and geography** to better understand inequities among subpopulations.

This data-driven approach provided a baseline for interpreting the community's qualitative feedback, ensuring that lived experiences were understood within the broader context of measurable population health outcomes. Quantitative and qualitative results were later **integrated and validated** to strengthen the overall reliability and depth of the CHNA findings.

Methodology & Approach

Data Collection

Data Gaps and Limitations

While the Yakima County Community Health Needs Assessment draws from a wide range of local, state, and national data sources, several gaps and limitations were identified during the analysis process. In many instances, racial and ethnic breakdowns were not readily available at the county level, limiting the ability to fully assess disparities and outcomes among specific population groups. Additionally, some datasets were dated, reflecting the most recent publicly available information rather than current-year metrics. This lag in data availability may affect the precision of trend analysis and the timeliness of certain findings.

Other limitations include variations in data collection methods across sources, which can influence comparability, and challenges in capturing the experiences of smaller or underserved communities through quantitative data alone. Despite these constraints, the findings provide a comprehensive and reliable overview of community health needs in Yakima County and serve as a strong foundation for continued monitoring, collaboration, and improvement efforts.

Qualitative data was collected through key informant interviews, community listening sessions, and a CHNA survey with stakeholders including individuals with disabilities, youth, immigrant families, people with lived experience of homelessness, and service providers. While efforts were made to engage diverse and underrepresented populations, some perspectives may not have been fully captured due to time and participation limits. These findings provide a snapshot in time and may underrepresent certain populations or areas.

Despite these limitations, combining available quantitative data with qualitative insights offers a strong foundation for identifying key health needs and guiding future planning.

Key informant participants were selected to ensure diversity, including people of color, representatives of marginalized groups, and individuals from sectors such as business, education, healthcare, transportation, and local government.

Future assessments aim to strengthen inclusivity through expanded data partnerships, greater access to disaggregated data, and broader outreach across underrepresented groups.

Methodology & Approach

Integration & Compliance

Integration with Strategic & Compliance Frameworks

This CHNA is designed to be a practical tool for action, not just a static report. Its findings are directly integrated into the hospital's operational and financial planning. The prioritized needs and implementation strategy guide the annual community benefit priorities, ensuring that resources are allocated based on data and the community's most pressing needs.

For compliance, the entire process is documented to meet IRS Section 501(r) regulations. This includes keeping engagement records, making the report public on the hospital's website, and having the implementation strategy formally adopted by hospital leadership. The results will be reported on IRS Form 990, Schedule H, making the CHNA an integral part of a repeating three-year cycle of assessment and action that helps the hospital fulfill its mission.

MultiCare
Yakima Memorial Hospital

Community Profile & Health Needs

Demographic Profile
Health Status Data
Social & Economic Factors
Stakeholder Input

Community Profile & Health Needs

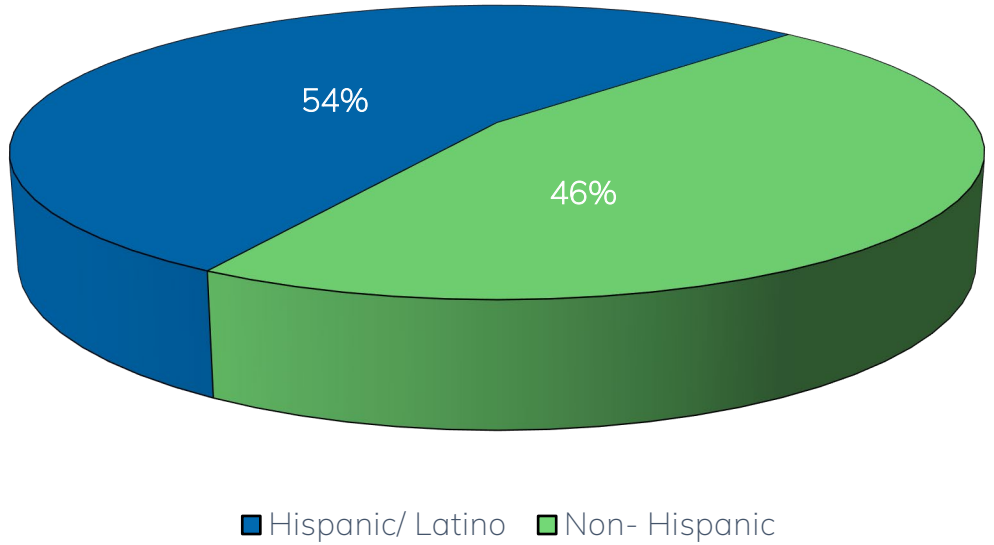
Demographic Profile

Community Composition

As of **2024**, Yakima County has an estimated population of **258,523** residents. This steadily growing and diverse population underscores the county's role as a central hub in Central Washington, contributing to the region's economic, agricultural, and cultural development. The population is relatively balanced in terms of gender, with approximately **50.2%** identifying as **male** and **49.8%** as **female**. This near-equal distribution supports a stable demographic structure across urban and rural communities, fostering a sense of balance in workforce participation, household composition, and community engagement.

Yakima County is also home to a culturally rich and dynamic population, with **Hispanic or Latino** individuals comprising a majority at **54%**, compared to **46%** who identify as **Non-Hispanic**. This strong Hispanic representation plays a defining role in shaping the county's identity, traditions, and social fabric. The influence of Hispanic culture is evident throughout the region in local businesses, cuisine, community celebrations, and the agricultural workforce that drives much of the local economy. This cultural diversity not only strengthens community connections but also enhances Yakima County's position as a vibrant, inclusive, and evolving region within Washington State.

Yakima County 2024 Ethnicity Breakdown



Community Profile & Health Needs

Health Status Data

Health Status Overview

Health status data provides an overview of community wellbeing in Yakima County across four key domains: Behavioral Health, Social Determinants of Health, Maternal and Child Health, and Access to Care. These indicators reflect the many factors that influence health, from individual behaviors and medical conditions to social and environmental conditions. Comparing local data with state and national benchmarks helps reveal areas of progress as well as continuing disparities that need focused attention and action.

Trends across Yakima County highlight several pressing health concerns. Behavioral health continues to be a significant issue, with rising challenges related to substance use and mental health disparities. Social determinants of health, including housing instability, youth homelessness, and food insecurity, also have a substantial impact on community wellbeing. Within maternal and child health, areas such as prenatal and maternal care, along with infant and birth outcomes, remain critical to improving overall health outcomes. Finally, access to care continues to be a major concern, with ongoing gaps in the availability and accessibility of services, as well as persistent financial and systemic barriers that limit equitable access to healthcare.

Several consistent patterns emerge across the service area:

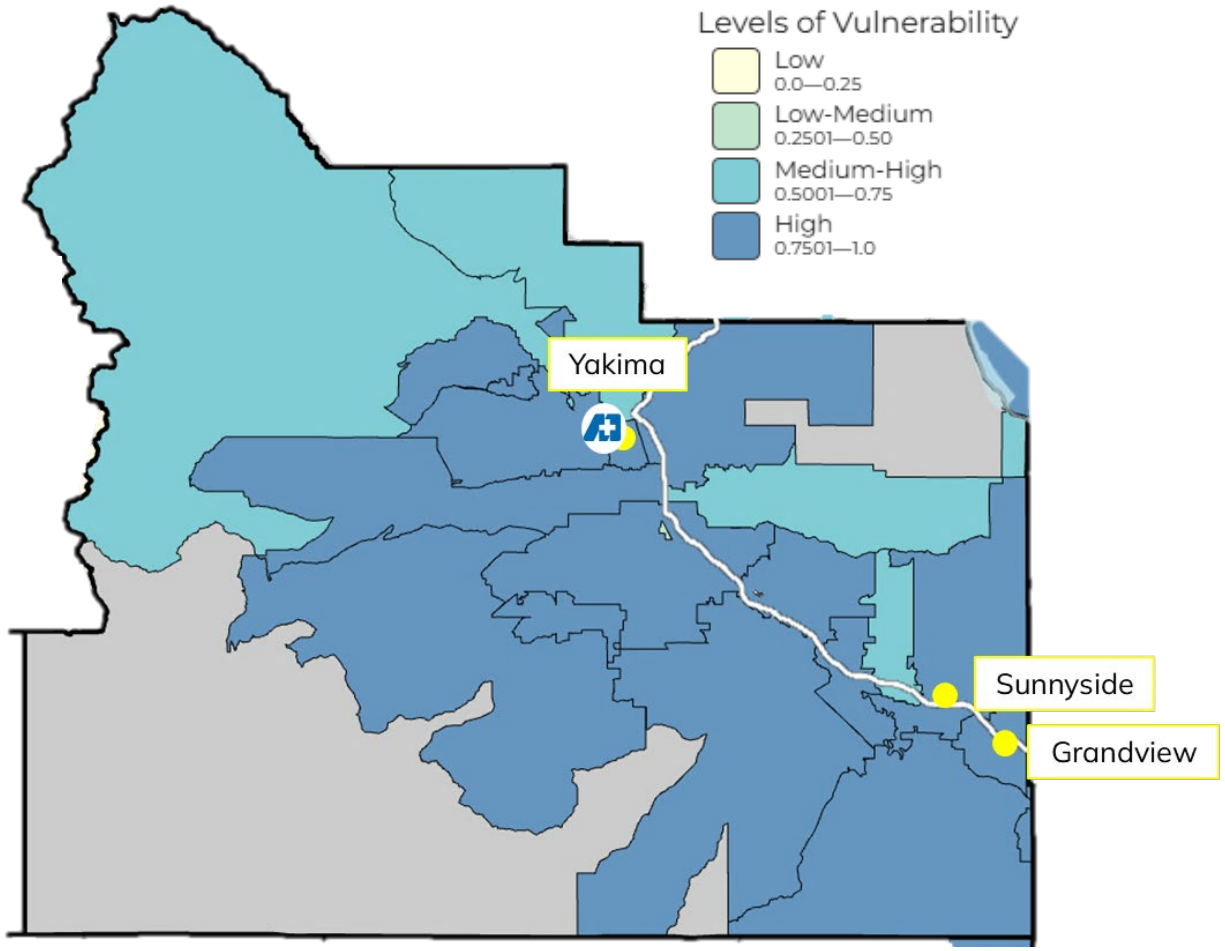
- Behavioral Health: Behavioral health remains a growing concern in Yakima County, with increasing rates of substance use and mental health disparities. Limited access to community-based services often leads residents to rely on emergency departments, highlighting the need for more accessible prevention and treatment options.
- Maternal & Child Health: Maternal and child health outcomes in Yakima County continue to show disparities. Access to quality prenatal and maternal care remains inconsistent, and infant and birth outcomes point to ongoing gaps in support for mothers and families. Strengthening access to affordable, culturally responsive care is essential to improving outcomes.
- Social Determinants of Health: Social and economic conditions continue to shape health outcomes across Yakima County. Housing instability, youth homelessness, and food insecurity present ongoing challenges, particularly among low-income families. Improving access to affordable housing and healthy food environments will be key to fostering equitable health opportunities for all residents.
- Access to Care: Access to healthcare remains a significant challenge in Yakima County. Many residents face barriers such as limited provider availability, transportation difficulties, and financial constraints, all of which restrict timely and equitable access to essential services.

Community Profile & Health Needs

Social & Economic Factors

The Social Vulnerability Index (SVI) by census tract is a CDC measure that identifies communities most vulnerable to external stresses on human health, such as natural disasters, disease outbreaks, or economic downturns. It uses U.S. Census data across four themes—socioeconomic status, household composition, minority status/language, and housing/ transportation—to help target public health resources and support equitable planning.

- Yakima County is characterized by a mix of areas with medium to high vulnerability.
- The highest vulnerability is concentrated in and around the urban core of Yakima.
- These areas show consistently high vulnerability across factors such as socioeconomic status, racial and ethnic diversity, housing, and transportation access.
- They represent the centers of social vulnerability in the county, where challenges of poverty, housing instability, and transportation barriers intersect.



Source: Social Vulnerability Index, 2022

Community Profile & Health Needs

Stakeholder Input

Behavioral Health	Themes From Community Voice and Input
Top Issues	• Behavioral Health was the most frequently raised priority; intertwined with housing insecurity and stigma • Mental health and substance use disorders were the top behavioral health concerns.
Key Barriers	• Shortage of qualified providers & long waitlists • Costs, stigma, lack of culturally responsive services • Limited crisis care, detox, and residential treatment facilities • Disproportionate impact on Latino, immigrant, and Yakima Nation communities • Stable housing mentioned as a need before treatment success
Existing Strengths/Programs	• Health District's harm reduction program • Integrated behavioral health at Central Washington Family Medicine & Yakima Neighborhood Health (Spanish-speaking providers) • NAMI workshops for parent/child engagement • Triumph Treatment Services
Survey Insights	• 18% of survey responses feeling sad or worried a lot, or having mental health issues (e.g. anxiety, depression) • 59% cited "Mental Health Support" as a top challenge • 42% cited problems with drugs/alcohol • 37% called for more mental health services

Community Profile & Health Needs

Stakeholder Input

Access to Care	Themes From Community Voice and Input
Top Issues	• Barriers to accessing care widely cited by interview and listening session participants as a top priority • Shortage of specialty and primary providers, especially in rural areas was a consistent theme
Key Barriers	• High costs, co-pays, prescriptions. • Inadequate insurance (esp. seasonal workers) • Transportation difficulties, long wait times • Lack of cultural competency; mistrust/discrimination • Closure of Astria Regional Medical Center in 2020 • Lack of continuity of care due to a “revolving door” of young doctors
Existing Strengths/Programs	• Dedicated organizations and staff recognized for providing vital support and services • Community resilience and strong desire for positive change • Provider and clinic resources noted: Yakima Valley Farmworkers Clinic, Care-a-Van mobile health clinic, Yakima Neighborhood Health Clinic, Union Gospel Mission, and Central Washington Family Medicine
Survey Insights	• 72% selected Access to Care as top concern • Key issues: long waits, provider shortages, cost/lack of insurance, poor quality/lack of trust

Community Profile & Health Needs

Stakeholder Input

Social Determinants of Health	Themes From Community Voice and Input
Top Issues	• Housing instability and food insecurity were identified among top five priorities • Urgent needs for women, youth, and families experiencing homelessness
Key Barriers	• Lack of affordable, safe, sober housing • Rising costs outpacing wages → displacement • Overcrowded housing conditions and associated spread of disease • Environmental hazards in homes pose health risks • Limited emergency shelter capacity • Access to healthy, affordable food • Challenges with access to food assistance programs
Existing Strengths/Programs	• The developing Yakima County homeless housing strategic plan • Catholic Charities Housing Services, Camp Hope, Yakima Union Gospel Mission • Neighborhood Health Services medical respite program • Food program availability (including WIC)
Survey Insights	• 33% of respondents cited obesity/nutrition as a top challenge (4th overall) • 18% requested more healthy eating programs, affordable food access, and cooking classes

Community Profile & Health Needs

Stakeholder Input

Maternal & Child Health	Themes From Community Voice and Input
Top Issues	• Yakima County has one of state's highest teen birth rates (though improving) • Access to prenatal and pediatric specialty care raised as a concern • Migrant families especially impacted by lack of continuity of care
Key Barriers	• Prenatal care not consistently accessible to vulnerable populations • Limited pediatric specialists; many families travel outside county for services
Existing Strengths/Programs	• Improvements in teen birth rate noted • Access to community clinics and health services • Educational School District 101 health education programs • Nutrition programs for women and children (e.g. ,WIC)
Survey Insights	• Maternal/child health not directly cited in survey, but access challenges noted in comments • Pediatric specialty services flagged as a need

Community Profile & Health Needs

Stakeholder Input

Community Health Survey

A **quantitative community survey** was conducted as part of the 2025 **Yakima County Community Health Needs Assessment (CHNA)** to capture the perspectives of residents across the county regarding their personal health, access to care, and community well-being. A total of **129 residents** completed the survey, including **15 responses in Spanish**, ensuring representation from both English- and Spanish-speaking populations.

Respondents were asked about their experiences accessing healthcare, their perceptions of the community's biggest health challenges, and the services or resources they believe would most improve local health outcomes. The survey results provide valuable insight into the lived experiences of Yakima County residents, complementing the qualitative findings from interviews and listening sessions.

Key Survey Findings

Access to Healthcare

Respondents identified **access to healthcare** as the county's most pressing challenge. The most frequently cited barriers were **long wait times**, **provider shortages**, and the **cost of care.** Many residents reported difficulty finding available providers, particularly for primary and behavioral health services.

Over 40 respondents indicated that cost and lack of insurance limit their ability to seek timely care, while others expressed frustration with delays or poor experiences in local hospital and clinic settings.

Current Health Concerns

The most commonly reported personal health conditions were **obesity**, **mental health challenges** (including anxiety and depression), and **diabetes**. Respiratory conditions such as asthma and heart disease were also noted. These responses reinforce the quantitative data showing elevated rates of chronic disease and behavioral health needs across Yakima County.

Community Health Priorities

When asked to identify the community's biggest health challenges, residents overwhelmingly ranked **access to care** as the top concern, followed by **mental health support** and **substance use**. Obesity, nutrition, and chronic disease prevention were also cited as key priorities. Collectively, these responses highlight a system under strain—where affordability, workforce shortages, and behavioral health access intersect with broader social determinants of health.

Community Profile & Health Needs

Stakeholder Input

MultiCare

Desired Programs and Services

Participants expressed a strong desire for **more primary care providers**, **expanded mental health services**, and **greater access to specialists** without the need to travel outside the county. Respondents also emphasized the importance of **nutrition education**, **affordable healthy food access**, and **safe spaces for physical activity** such as parks and walking paths. Many respondents called for improvements to the community's built environment to make healthy living more accessible.

Health Information Sources

When seeking health information, residents most often rely on **doctors and nurses**, followed by **family and friends**, **social media**, and **community organizations**. This finding underscores the central role of healthcare providers and trusted local partners in shaping community understanding and engagement around health.

Community Perceptions

When asked whether Yakima County helps promote healthy lives, the majority of respondents (76) answered **"somewhat"**, while smaller groups said **"no"** (18) or **"yes"** (8). Many residents feel their community provides some resources but lacks sufficient system-wide support to make healthy living easy or consistent.

In Summary

The survey findings reveal that the **experience of accessing healthcare in Yakima County is often defined by barriers rather than pathways**. Long waits, provider shortages, and high costs create a cycle of delay and unmet need. For many residents—particularly those in rural or lower-income households—seeking care requires navigating logistical challenges such as transportation, language access, and limited appointment availability.

Residents perceive the healthcare system as overextended and, at times, impersonal, describing feelings of **frustration, distrust, and limited communication** with providers. Behavioral health services, in particular, were noted as insufficient, with many expressing concern about rising substance use and inadequate crisis response options.

At the same time, the survey results reflect a **strong desire for prevention, wellness, and system transformation**. Participants called for greater community investment in mental health, affordable care, housing stability, and food access—viewing these as foundational to health improvement. Many also urged stronger collaboration between hospitals, community-based organizations, and policymakers to address inequities and create an environment where health is easier to achieve for all residents.

Community Profile & Health Needs

Stakeholder Input

Listening Sessions

As part of the 2025 **Yakima County Community Health Needs Assessment**, ten community listening sessions were conducted in partnership with trusted local organizations across the county. These sessions were designed to elevate the voices of residents whose experiences are often underrepresented in health planning — including unhoused individuals, immigrant and Latino families, Yakama Nation tribal members, healthcare providers, parents of children with special needs, and individuals in recovery.

Facilitated in accessible, trusted community spaces, three sessions were conducted entirely in Spanish to ensure full participation by Spanish-speaking residents. Each session was guided by trauma-informed and culturally responsive facilitation, allowing participants to speak openly about challenges, strengths, and opportunities for change.
The following summaries capture key perspectives, community-defined priorities, and emerging themes from each session. These insights provide valuable qualitative context that complements the quantitative data and key informant interviews, grounding the CHNA in the lived experiences of Yakima County residents.

Nuestra Casa

Latino Families and Youth

This session centered on Latino families and youth, highlighting pressing issues around **mental health, substance use, and community safety**. Participants described growing concerns about **youth vaping, alcohol, and methamphetamine use**, alongside increased exposure to **gang activity and violence**. Parents emphasized the lack of **safe, structured spaces** for youth engagement and expressed a strong need for culturally appropriate prevention and mentorship programs.

Key Themes:

- Youth vaping and substance use as a rising concern
- Safety and gang involvement impacting family stability
- Lack of culturally relevant prevention and mentorship programs
- Need for safe, supervised youth spaces

Community Profile & Health Needs

Stakeholder Input

Noah's Ark

Families of Children with Autism

This session engaged families raising children with autism and developmental disabilities. Participants reported **extreme challenges accessing Applied Behavior Analysis (ABA) therapy** and other specialized services, citing **long waitlists, workforce shortages, and high costs**. Parents described difficulty finding providers who understand autism spectrum needs and highlighted emotional stress associated with fragmented care.

Key Themes:

- Insufficient ABA and behavioral health providers
- Long wait times and gaps in continuity of care
- Emotional toll on families navigating fragmented systems
- Desire for coordinated, affordable, and autism-informed services

Triumph

Families Impacted by Fetal Alcohol Spectrum Disorders (FASD)

Parents of children with Fetal Alcohol Spectrum Disorders (FASD) described a **lack of awareness, education, and support services** available to families. Participants highlighted stigma and misunderstanding from both healthcare providers and schools. They emphasized the need for **early diagnosis, training for educators, and ongoing parental support** to better manage developmental and behavioral challenges.

Key Themes:

- Limited awareness and education around FASD
- Stigma and misunderstanding from schools and providers
- Lack of early intervention and diagnosis
- Importance of parent support and advocacy networks

White Swan

Yakama Nation Tribal Members

This session, held in the White Swan community, focused on **Yakama Nation tribal elders and families**. Participants described barriers to care related to **geographic isolation, transportation, and limited access to culturally appropriate healthcare**. Elder care, traditional healing practices, and intergenerational knowledge sharing were identified as core community strengths.

Key Themes:

- Transportation and access barriers in rural and tribal areas
- Limited culturally competent and tribal-specific care options
- Importance of traditional practices and cultural identity in healing
- Need for better coordination between tribal and regional health systems

Community Profile & Health Needs

Stakeholder Input

Yakima Health Care Coalition and Yakima Health District

Provider Perspective

Healthcare professionals and public health representatives highlighted **system-level challenges** affecting Yakima County's capacity to meet growing community needs. Workforce shortages, particularly in behavioral health, and limited data-sharing infrastructure were identified as significant barriers. Participants emphasized the importance of **coordinated systems, public health infrastructure, and equitable workforce investment**.

Key Themes:

- Behavioral health and primary care workforce shortages
- Fragmented data sharing and limited care coordination
- Need to strengthen public health infrastructure and collaboration
- Emphasis on integrated, equity-centered system design

Camp Hope

Unhoused Individuals

Participants at Camp Hope described **daily challenges linked to homelessness**, including **co-occurring mental health and substance use issues**, limited access to detox services, and the difficulty of obtaining identification required for housing and employment. They expressed a strong desire for **safe, sober housing options** and supportive recovery environments.

Key Themes:

- Severe shortage of affordable and sober housing
- Barriers to care due to lack of ID and transportation
- Mental health and substance use challenges intertwined with housing instability
- Desire for recovery-focused, low-barrier housing models

La Casa Hogar

Immigrant and Spanish-Speaking Residents

Spanish-speaking participants discussed **barriers to healthcare access, fear of discrimination, and language gaps** that prevent equitable care. Many expressed confusion about insurance options and reported hesitancy to seek services due to **fear of deportation**. Participants emphasized the need for **bilingual providers and culturally safe spaces** to navigate health systems confidently.

Key Themes:

- Fear and mistrust due to immigration status and discrimination
- Lack of bilingual and bicultural healthcare providers
- Insurance literacy challenges
- Importance of culturally safe and language-accessible services

Community Profile & Health Needs

Stakeholder Input

Yakima Union Gospel Mission (YUGM)

Recovery and Reentry

Individuals in recovery and those reintegrating after incarceration identified **stigma, lack of sober housing, and limited access to treatment** as key barriers. Participants highlighted the importance of **peer mentorship, employment support, and integrated behavioral health services** that provide stability during recovery.

Key Themes:

- Limited sober living environments and recovery housing
- Stigma in employment and healthcare
- Need for peer mentorship and reentry support
- Desire for integrated, nonjudgmental recovery programs

Zumba Group

Community Strength and Healthy Living

This session brought together community members participating in Zumba fitness classes. Participants reflected on the **importance of movement, connection, and culturally rooted wellness**. They viewed physical activity and group exercise as a positive, accessible way to support both mental and physical health.

Key Themes:

- Physical activity as a foundation for wellness
- Strong social connections and community motivation
- Desire for more culturally inclusive fitness and health promotion programs

Yakima County Summary: Shared Priorities

Across all sessions, participants consistently emphasized five key, interconnected priorities shaping health in Yakima County:

- **Behavioral Health** – Mental health and substance use disorder treatment access
- **Housing Instability** – Affordable, safe, and sober housing options
- **Access to Healthcare** – Cost, provider shortages, and discrimination in care
- **Food Security** – Affordability, availability, and assistance program barriers
- **Transportation** – Reliable, affordable connections to healthcare, food, and employment

Despite these challenges, community members expressed **deep resilience and commitment to collaboration**, highlighting the dedication of local organizations, the strength of family and cultural ties, and a shared vision for more equitable, connected systems of care.

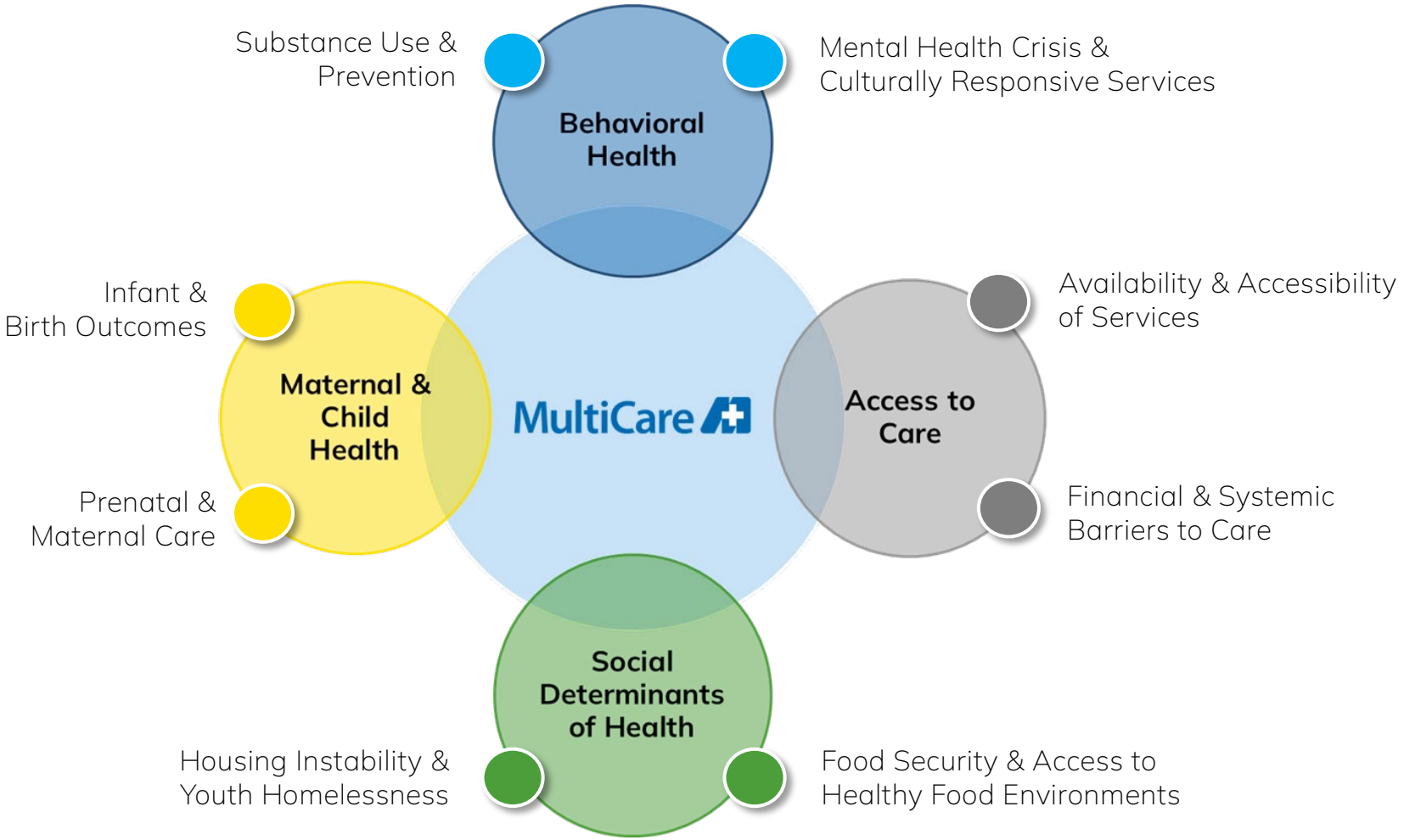
MultiCare
Yakima Memorial Hospital

Prioritization of Needs

Identifying Significant Health Needs
Behavioral Health
Access to Care
Social Determinants of Health
Maternal & Child Health
Conclusion: Priority Needs

Prioritization of Needs

Identifying Significant Health Needs



Prioritization of Needs

Identifying Significant Health Needs

Priority Area	Magnitude	Severity	Disparity & Equity	Feasibility of Impact	Strategic Alignment	Total (out of 25)
Behavioral Health *(Substance Use & Prevention; Mental Health Crisis & Culturally Responsive Services)*	5 – Behavioral health challenges, particularly substance use (fentanyl, meth, alcohol), were repeatedly identified as **acute and worsening crises**. Yakima County shows **higher overdose mortality and ER visit rates** than the state average. Shortage of psychiatrists, counselors, and crisis beds compounds the issue.	5 – Ranked #1 across listening sessions and key informant interviews, and one of the top three in the community survey. Community members repeatedly cited mental health and addiction as **the most urgent concerns**.	5 – Disproportionate impact on **Hispanic/Latino, tribal, rural, and low-income residents**; co-occurring disorders among unhoused individuals; major cultural and linguistic access barriers.	4 – While complex, feasible progress exists through expanding behavioral health integration, harm reduction programs, and mobile outreach models already in Yakima.	5 – Strong local alignment: MultiCare, Yakima Health District, Central Washington Family Medicine, and Triumph Treatment Services all have behavioral health focus areas and infrastructure.	24
Access to Care *(Availability & Accessibility of Services; Financial & Systemic Barriers to Care)*	5 – Yakima County has **provider shortages**, long wait times, and high rates of uninsured/underinsured individuals. Many must travel to Tri-Cities, Spokane, or Seattle for specialty care.	5 – The **most-cited issue in community survey results**, with 82 respondents naming access as the top barrier. Key informants and listening sessions echoed these concerns, particularly regarding **dental and specialty care**.	4 – Disproportionate effects on **rural and low-income residents**, **migrant workers**, and those with language barriers. Access to bilingual care and transportation are major equity gaps.	4 – Feasible through expansion of **telehealth, mobile units, extended clinic hours**, and recruitment incentives. However, systemic constraints (workforce shortages, Medicaid policy) reduce feasibility slightly.	5 – Directly aligns with MultiCare's and Yakima Neighborhood Health's missions and system capacity to expand community-based access models.	23

Prioritization of Needs

Identifying Significant Health Needs

Priority Area	Magnitude	Severity	Disparity & Equity	Feasibility of Impact	Strategic Alignment	Total (out of 25)
Social Determinants of Health *(Housing Instability & Homelessness; Food Security & Healthy Environments)*	4 – Yakima experiences **persistent housing instability, homelessness, and food insecurity**, contributing to ER overuse and chronic disease risk.	5 – Identified as one of the **top three cross-cutting issues** in all listening sessions; the survey confirmed community demand for **better food access, walkable spaces, and affordable housing**.	5 – Profound inequities: disproportionate impact on **unhoused individuals, agricultural workers, and immigrant families**. Substandard housing and food deserts correlate with poorer outcomes.	4 – Feasibility rated high due to existing collaborations (Catholic Charities, Yakima County Human Services, YV Farmworkers Clinic), though large-scale housing investment requires sustained resources.	4 – Moderate alignment; while not the hospital's direct service line, MultiCare partners actively in addressing SDOH through community grants and partnerships.	22
Maternal & Child Health *(Infant & Birth Outcomes; Prenatal & Maternal Care)*	4 – Yakima has **higher infant mortality and low birthweight rates** than the state average, alongside barriers to prenatal care, especially among Hispanic and rural women.	4 – Recognized in several interviews and listening sessions, particularly regarding **prenatal access and maternal mental health**, though not as dominant as behavioral health or access themes.	4 – Inequities linked to income, insurance, transportation, and cultural barriers. Teen pregnancy and late prenatal care rates are higher in Yakima compared to state benchmarks.	4 – Feasible through targeted initiatives (Healthy Start, WIC, perinatal outreach, teleOB). Local providers have infrastructure to address prenatal and early childhood needs.	4 – Aligns with MultiCare's maternal and newborn services and regional perinatal partnerships, but fewer community organizations specialize solely in maternal health.	20

Behavioral Health

Substance Use & Prevention

About Substance Use & Prevention

Substance use and prevention are central to community health because they influence safety, family stability, and long-term wellbeing. Substance use patterns often reflect a complex intersection of social, economic, and behavioral factors—including trauma exposure, stress, and lack of support systems. Communities that experience persistent poverty, limited access to behavioral health services, or social isolation are more likely to face higher rates of addiction and substance-related harm. Addressing these issues requires understanding the root causes, such as adverse childhood experiences, unemployment, and untreated mental health conditions, rather than focusing solely on individual behavior.

Effective prevention strategies extend beyond education campaigns to include early intervention, peer support, and environments that promote healthy coping skills. Partnerships between healthcare systems, schools, and community organizations can help identify risks early and strengthen protective factors like mentoring, family support, and youth engagement. When prevention, treatment, and recovery supports are woven into the community fabric, substance use efforts contribute not only to individual recovery but also to safer, healthier neighborhoods and a more resilient county.

Qualitative Summary

Substance use and addiction continue to have a profound impact across Yakima County, particularly as **fentanyl and methamphetamine use** increase. Stakeholders and residents alike described the community as being at a breaking point, with **limited detox and inpatient treatment options**, long waiting periods, and few recovery supports once individuals leave care. Families expressed frustration at the lack of prevention education and treatment programs for youth, while outreach providers noted that many individuals are not connected to services until they reach a crisis point. Participants in listening sessions emphasized that **addiction affects every community**, regardless of geography or income, and called for strategies centered on compassion, prevention, and early intervention.

Providers, service organizations, and residents stressed that substance use cannot be addressed in isolation—it intersects with **mental health, homelessness, and unemployment**. There is strong support for expanding **peer-led recovery programs, harm reduction strategies, and safe, sober housing options** to help people maintain stability after treatment. Rural and Spanish-speaking communities identified additional barriers related to stigma and lack of culturally appropriate supports. Participants shared that breaking these cycles requires investing in community education, creating safe spaces for youth, and integrating prevention messaging across schools, clinics, and faith-based networks.

Behavioral Health

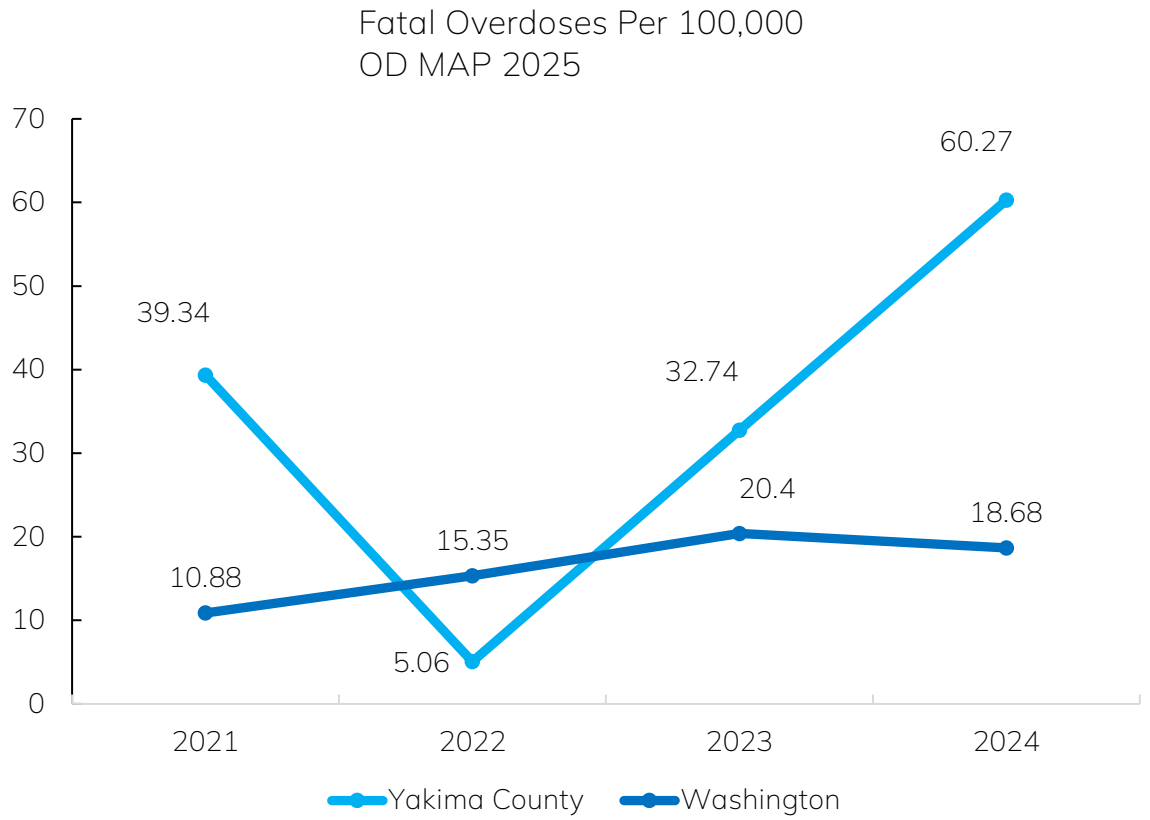
Substance Use & Prevention

Substance Use & Prevention

Substance use remains a significant public health concern in Yakima County, where overdose and substance-related harms continue to outpace statewide levels. In **2024**, the county reported an estimated **490.3** suspected overdoses **per 100,000 residents**—nearly five times higher than the **Washington State** rate of **103.4**. Fatal overdoses also rose sharply to **60.3 per 100,000**, more than triple the state average of **18.7**. These figures illustrate the deepening impact of the opioid crisis, particularly fentanyl, which continues to strain emergency response systems, treatment networks, and community recovery resources.

Beyond opioids, substance use affects many aspects of community wellbeing and safety. Alcohol-involved traffic deaths account for nearly **40%** of all driving fatalities, compared to **32%** statewide. Youth substance use also remains a pressing issue: **7.1%** of **8th graders** reported vaping in the past month, exceeding the state rate of **5.0%**, with particularly high use among **Black/African American (12.4%)** and **gay or lesbian (11.7%)** students. These trends echo concerns raised in community listening sessions about early exposure, limited prevention education, and a shortage of youth-focused interventions.

Together, the data reveal a complex and evolving challenge—one that underscores the need for comprehensive, community-based strategies that strengthen prevention, expand treatment access, and support sustained recovery across Yakima County.

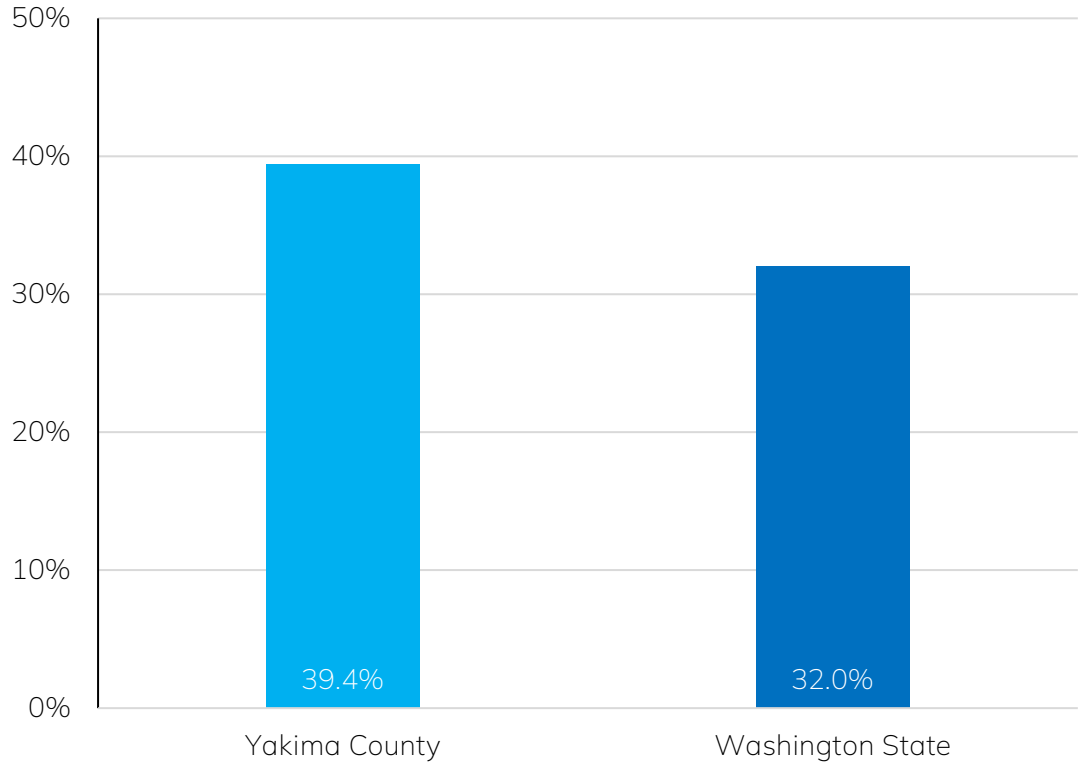


Behavioral Health

Substance Use & Prevention

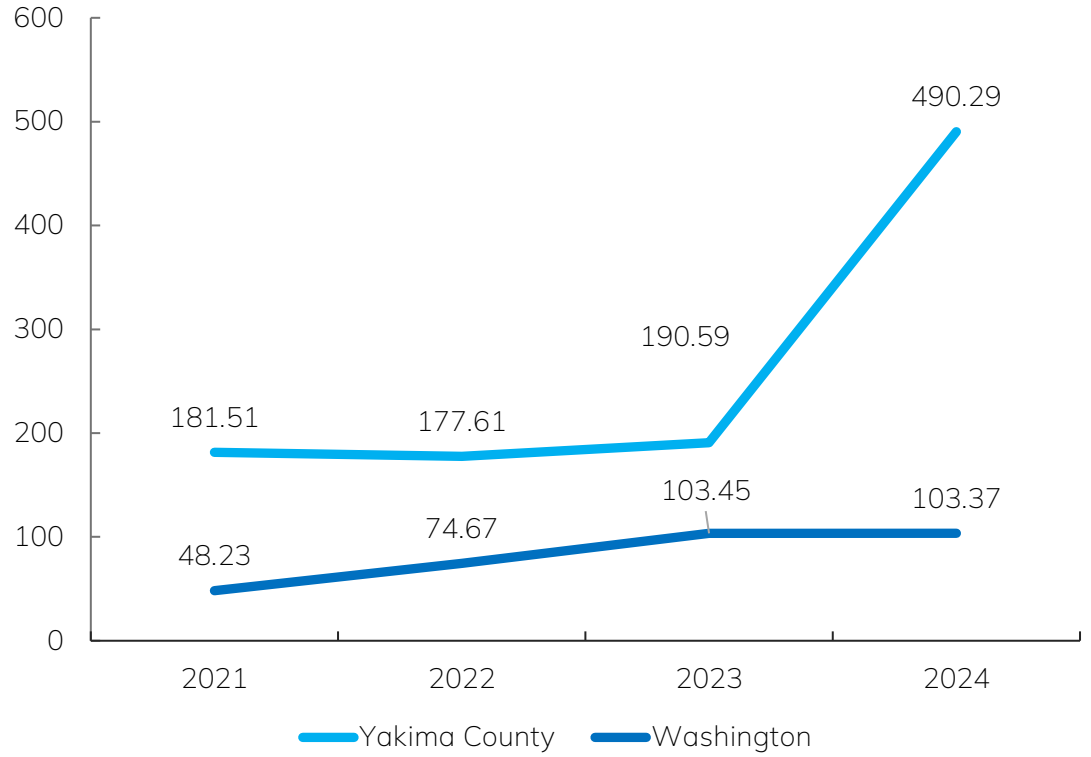
Percentage of Driving Deaths with Alcohol Involved

RWJ County Health Rankings 2025



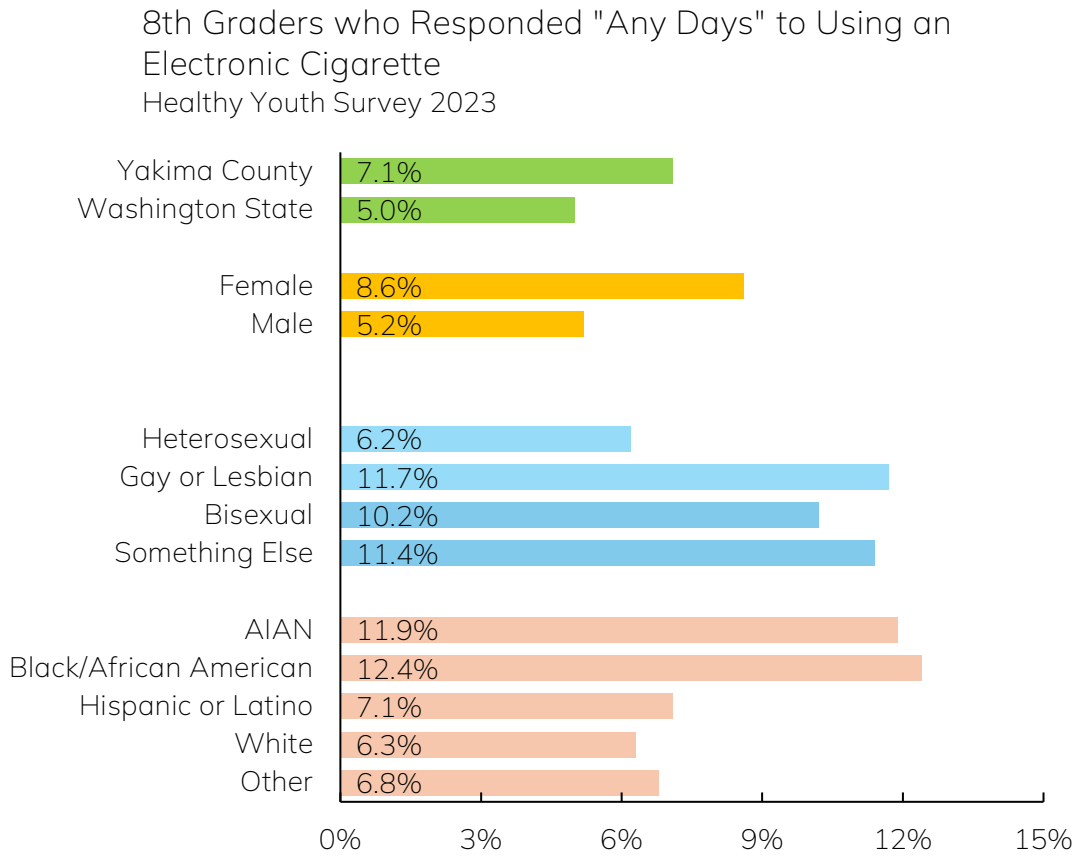
Total Suspected Overdoses Per 100,000

OD MAP 2025



Behavioral Health

Substance Use & Prevention



Behavioral Health

Mental Health Crisis & Culturally Responsive Services

About Mental Health Crisis & Culturally Responsive Services

Mental health is deeply connected to how individuals and communities function, shaping everything from learning and relationships to employment and overall quality of life. When people lack emotional wellbeing, the effects ripple through families, schools, and workplaces. Community-level factors such as discrimination, economic insecurity, and exposure to violence can increase the prevalence and severity of mental health challenges. Because Yakima County is culturally diverse, approaches to care must recognize that experiences of stress, trauma, and healing vary widely across populations.

Culturally responsive services ensure that residents can access care that feels safe, affirming, and relevant to their lived experience. Embedding behavioral health services within schools, primary care, and faith or community settings can help normalize care-seeking and reduce stigma. Bilingual and bicultural providers also play a vital role in bridging trust gaps between health systems and residents. When mental health care is integrated into the broader fabric of community life, it not only addresses crises but also strengthens prevention and resilience for future generations.

Qualitative Summary

Mental health concerns were among the **most commonly cited issues** in Yakima County. Residents described growing anxiety, depression, and trauma across age groups, with limited local resources available to meet demand. Stakeholders noted that many individuals wait months for counseling appointments, and when services are available, they often lack bilingual providers or trauma-informed practices. Listening sessions revealed deep frustration among residents who feel the mental health system is “overwhelmed and out of reach.” Youth, in particular, expressed a desire for **safe, non-clinical spaces** to talk openly about stress, bullying, and family challenges without stigma.

Participants emphasized that the lack of **culturally and linguistically appropriate mental health services** undermines access for Hispanic/Latino and Indigenous residents. Many said they are more likely to seek help from trusted community leaders, schools, or faith institutions rather than formal systems. Stakeholders also described the need for **integrated behavioral health models**, placing mental health professionals within primary care and schools to increase access and normalize care. Residents consistently voiced support for more community-based prevention efforts, crisis response capacity, and youth-specific outreach, underscoring that improving mental health in Yakima County requires both systemic change and culturally grounded engagement.

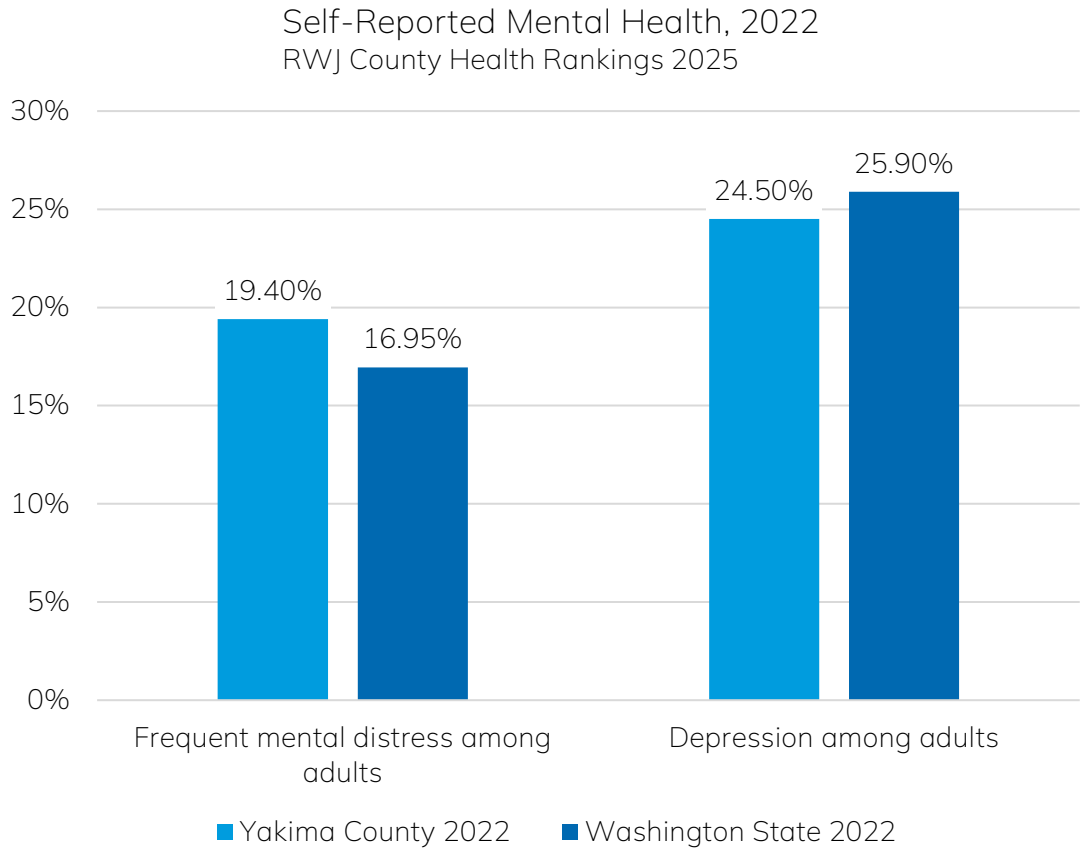
Behavioral Health

Mental Health Crisis & Culturally Responsive Services

Mental Health Crisis & Culturally Responsive Services

Data highlights persistent disparities in mental health outcomes across Yakima County's diverse populations. In 2022, **19.4% of adults** reported **frequent mental distress**, compared to **16.9% statewide**, while **25.9%** reported **depression**, slightly above Washington's **24.5%**. Among youth, the concern is even greater—**10.1% of 8th graders** reported a suicide attempt in the past year, compared to **8.7% statewide**. These data reinforce local accounts of increasing anxiety and depression among youth and families, amplified by social isolation, poverty, and workforce shortages in behavioral health.

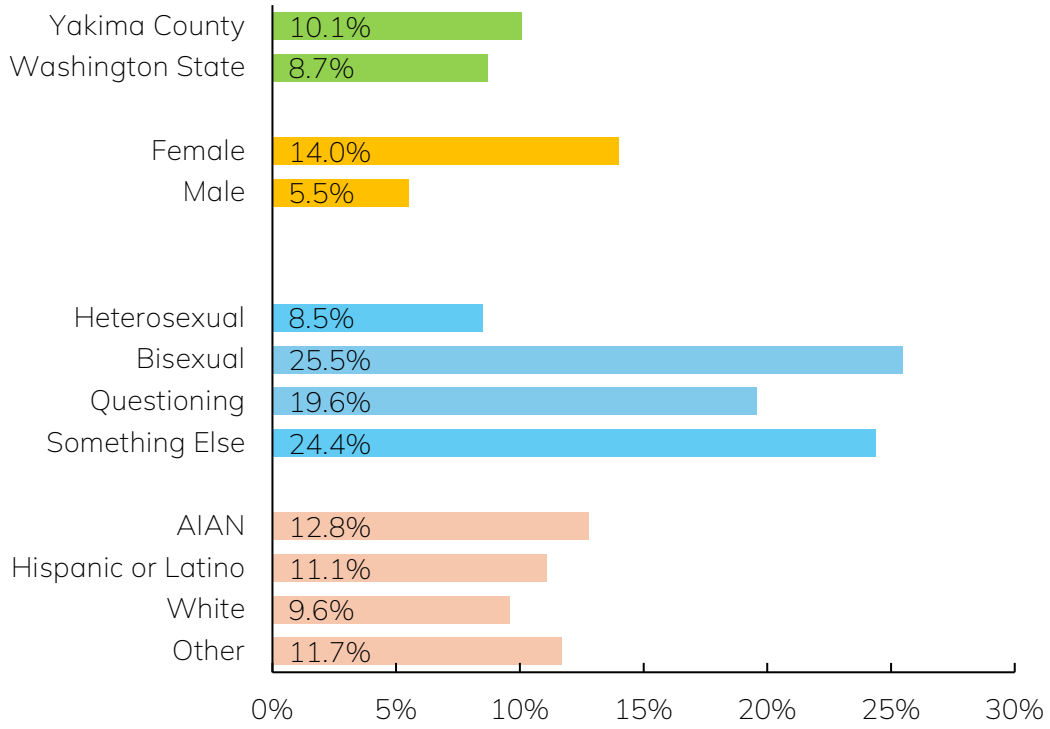
The data also reveals striking disparities by identity and gender. Suicide attempts were reported by **25.5% of bisexual youth**, **24.4% of youth identifying as "something else,"** and **14.0% of females**—highlighting how belonging, acceptance, and trauma intersect with mental wellbeing. For Spanish-speaking and Indigenous communities, the shortage of bilingual providers and culturally aligned care models further limits access. This reinforces the need for trauma-informed, community-based strategies that integrate behavioral health into schools, workplaces, and primary care settings, while building a more representative mental health workforce to reflect Yakima County's diversity.



Behavioral Health

Mental Health Crisis & Culturally Responsive Services

8th Graders who Responded "Any times" to Attempting Suicide Within the Past 12 Months
Healthy Youth Survey 2023



*"The drug addiction is huge. Mental health issues is huge and we're talking like debilitating mental health, which is usually some amount of schizophrenia or. Borderline personality disorder. And it's hard because there is **no place for them to go**"*

– Key Informant Interview

Access to Care

Availability & Accessibility of Services

About Availability & Accessibility of Services

Access to healthcare is a cornerstone of public health, influencing disease prevention, chronic condition management, and health equity. When residents cannot find or reach healthcare services, avoidable conditions worsen and healthcare costs increase. In regions like Yakima County, where rural geography and workforce shortages pose challenges, access depends not just on the presence of providers but on how care is organized and delivered. Reliable transportation, flexible hours, and proximity to care are all essential elements of an accessible health system.

Expanding access means bringing services closer to where people live, work, and gather. Mobile clinics, community-based care sites, and telehealth can bridge distance barriers and improve continuity of care. Equally important is the ability to navigate the system—residents need clear information, language support, and trusted guidance to make informed decisions. When availability and accessibility are strengthened together, healthcare systems become more equitable, responsive, and capable of meeting community needs.

Qualitative Summary

Access to timely and affordable healthcare remains a defining challenge in Yakima County. Residents repeatedly cited long wait times, limited appointment availability, and difficulty securing specialty or behavioral health care as top barriers. Many respondents said they **delay seeking care** until symptoms worsen due to limited providers or lack of transportation, particularly in rural areas. Stakeholders emphasized that healthcare shortages—especially in **primary care, mental health, and dental services**—have been compounded by workforce burnout and turnover since the pandemic. For many, the ability to get care depends as much on where they live as what they can afford.

Participants also expressed frustration with **referral complexity** and lack of coordination between health systems. Navigating coverage, paperwork, and referrals was described as “confusing and exhausting,” particularly for older adults and immigrant families. Residents emphasized the need for **mobile clinics, after-hours care, and improved telehealth access** to bridge rural gaps. Healthcare providers noted that broadband limitations in agricultural areas further restrict telehealth’s impact. There was strong support for expanding the role of **community health workers** and bilingual navigators to connect residents with care, education, and social support services in ways that reflect local realities.

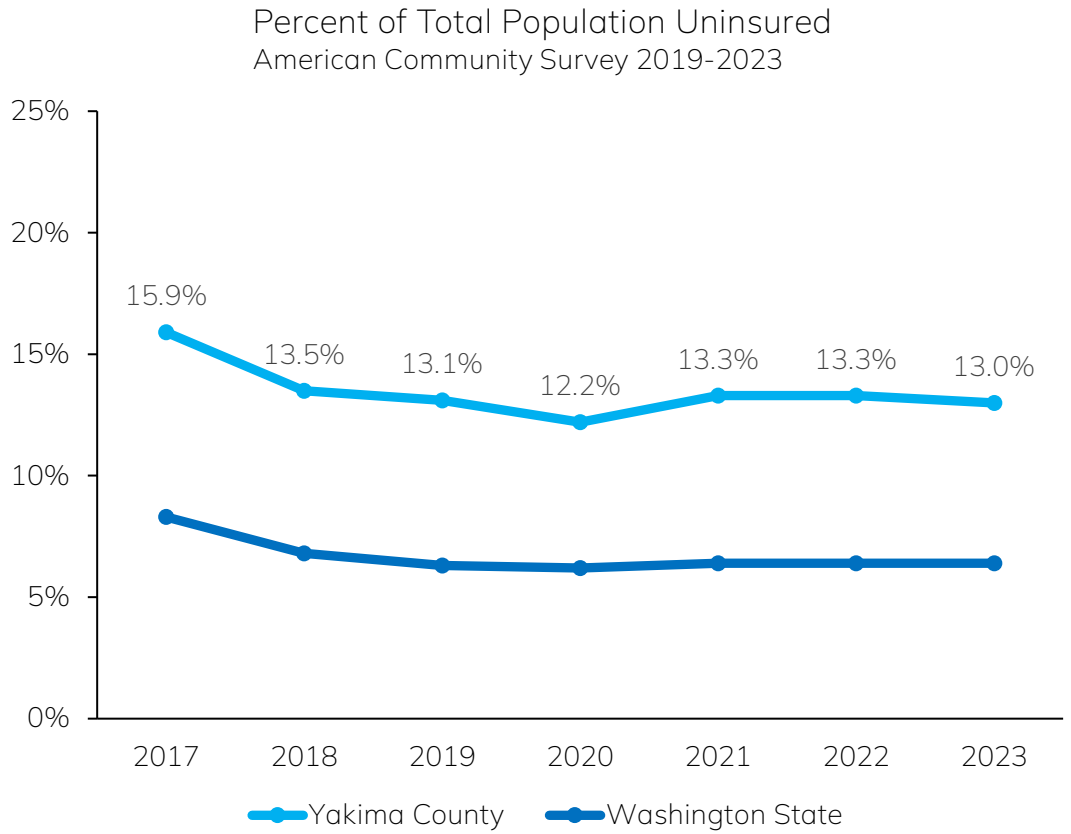
Access to Care

Availability & Accessibility of Services

Availability & Accessibility of Services

Yakima County faces measurable shortages across key parts of the delivery system. **Provider-to-population ratios** are notably higher (worse) than Washington overall and top performers: **Primary care** is **1,620:1** (vs. **1,202:1** WA), **dentistry** is **1,404:1** (vs. **1,152:1** WA), and **mental health** is **245:1** (vs. **186:1** WA). These ratios signal limited appointment availability and longer wait times, particularly in rural areas and for behavioral health access. At the same time, **uninsurance** remains elevated: **13.0%** of Yakima residents were uninsured in **2023**, essentially unchanged from **13.3%** in 2021–2022 and **double** the state rate holding near **6.5%**. Together, high uninsurance and constrained capacity translate into delayed care and heavier reliance on acute settings.

These access constraints are consistent with qualitative reports of long waits, transportation hurdles, and referral complexity. In practical terms, higher provider ratios and persistent uninsurance reduce the likelihood of timely primary, dental, and behavioral health visits—especially for residents working nonstandard hours, older adults, and rural households. Strengthening access will require **capacity expansion** (e.g., recruitment, integrated behavioral health), **coverage and navigation supports** for uninsured/underinsured populations, and **care models** that bring services closer to where people live and work (mobile, after-hours, and telehealth where broadband allows).



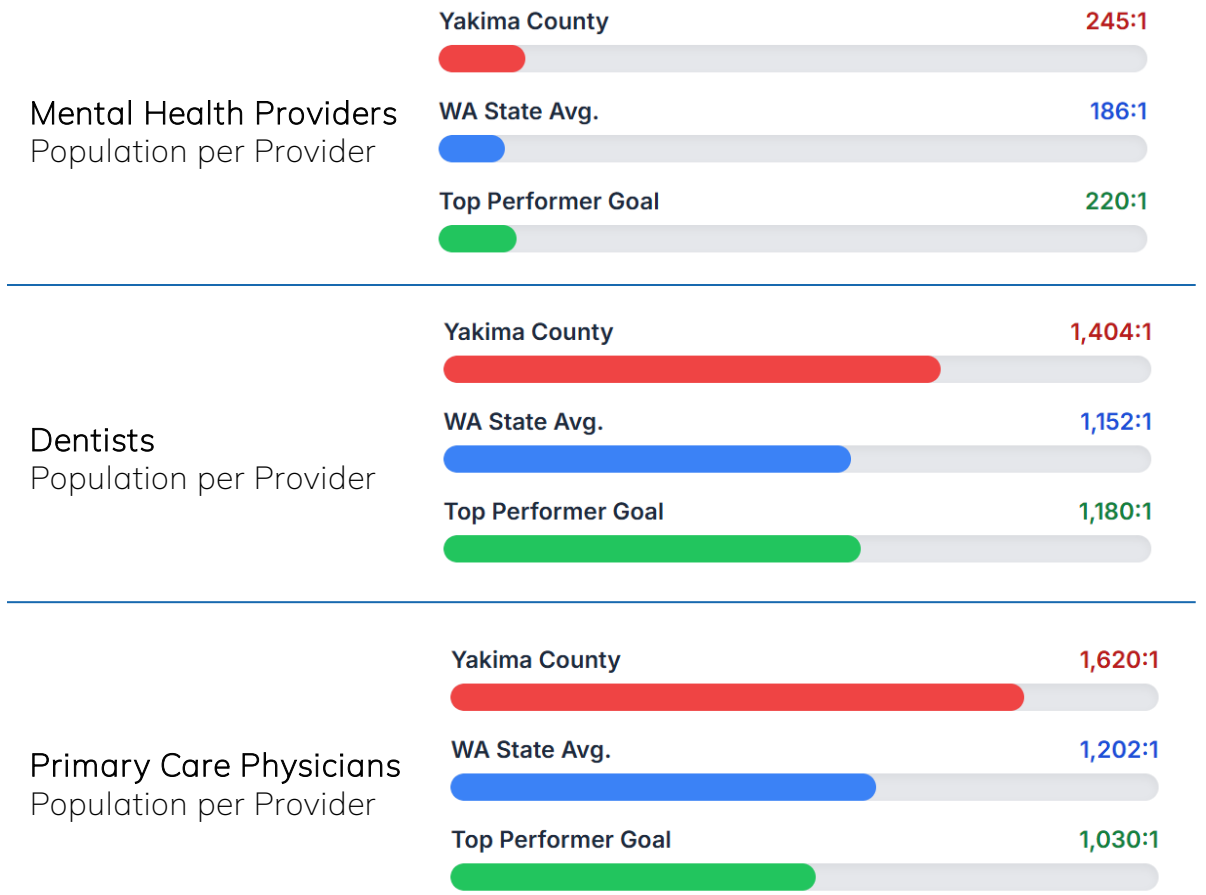
Access to Care

Availability & Accessibility of Services

Access to healthcare remains a persistent challenge across many rural and underserved communities. Limited provider availability, long travel distances, and inadequate transportation options make it difficult for residents to obtain timely care. These barriers are particularly pronounced for those working long or irregular hours in agricultural or hourly-wage jobs, where taking time off for appointments can result in lost income. A shortage of primary care, dental, and behavioral health providers further constrains access to preventive and specialty services.

Economic hardship, lack of insurance coverage, and language or cultural barriers also contribute to disparities in care—especially among immigrant and minority populations. Many residents face additional challenges related to health literacy, distrust of medical systems, and limited knowledge of available programs. Addressing these barriers requires a coordinated approach that strengthens provider capacity, expands affordable and reliable transportation options, and increases culturally and linguistically appropriate outreach. Together, these efforts can help ensure equitable access to essential health services across all populations.

Findings adapted from “Assessing the Barriers and Facilitators to Breast Cancer Screening Among Residents in the Lower Yakima Valley,” Jennifer L. Cruz, MPH; Destiny Jackson; & Sarah Johns, MPH, Harvard T.H. Chan School of Public Health (2024).



RWJ County Health Rankings 2025
Comparison (Shorter Bar = Better Access)

Access to Care

Financial & Systemic Barriers to Care

About Financial & Systemic Barriers to Care

Financial stability and system design determine whether residents can use the care that exists. Even when healthcare services are available, cost and insurance coverage frequently dictate whether individuals seek care at all. In Yakima County, seasonal and agricultural employment patterns often limit access to consistent insurance coverage, creating interruptions in preventive and chronic care. High out-of-pocket costs, medical debt, and the complexity of insurance systems can deter people from managing their health until conditions become severe.

Systemic barriers compound these financial challenges. Complex eligibility requirements, limited Medicaid acceptance, and lack of bilingual support can make navigating healthcare daunting—especially for immigrant and rural populations. These structural issues underscore the need for clear communication, flexible payment systems, and culturally informed navigation assistance. Addressing these barriers is essential for ensuring that access to care depends on need rather than income, language, or social status, advancing the county's goal of health equity for all residents.

Qualitative Summary

Financial constraints were among the **most consistent barriers** to accessing healthcare, affecting residents across age, income, and insurance status. Survey respondents and key informants reported that **cost, lack of insurance, and high deductibles** often deter people from seeking timely care. Participants described choosing between basic needs—such as food, rent, and healthcare—and postponing or forgoing treatment entirely. Seasonal workers and families employed in agriculture reported inconsistent insurance coverage and limited access to employer-based benefits. This financial strain, coupled with system complexity, leaves many residents feeling excluded from preventive and specialty care.

Systemic barriers extend beyond cost. Residents and providers identified **limited Medicaid reimbursement**, **restrictive eligibility criteria**, and **bureaucratic inefficiencies** that make accessing services burdensome. Spanish-speaking and immigrant communities also expressed **fear and mistrust** of healthcare systems, citing past experiences of discrimination and language barriers. Participants called for more transparency, education on navigating insurance, and expansion of **sliding-scale or safety-net programs** to close these gaps. Stakeholders stressed that addressing affordability requires both community-level education and institutional change to build a more equitable, accessible healthcare system.

Access to Care

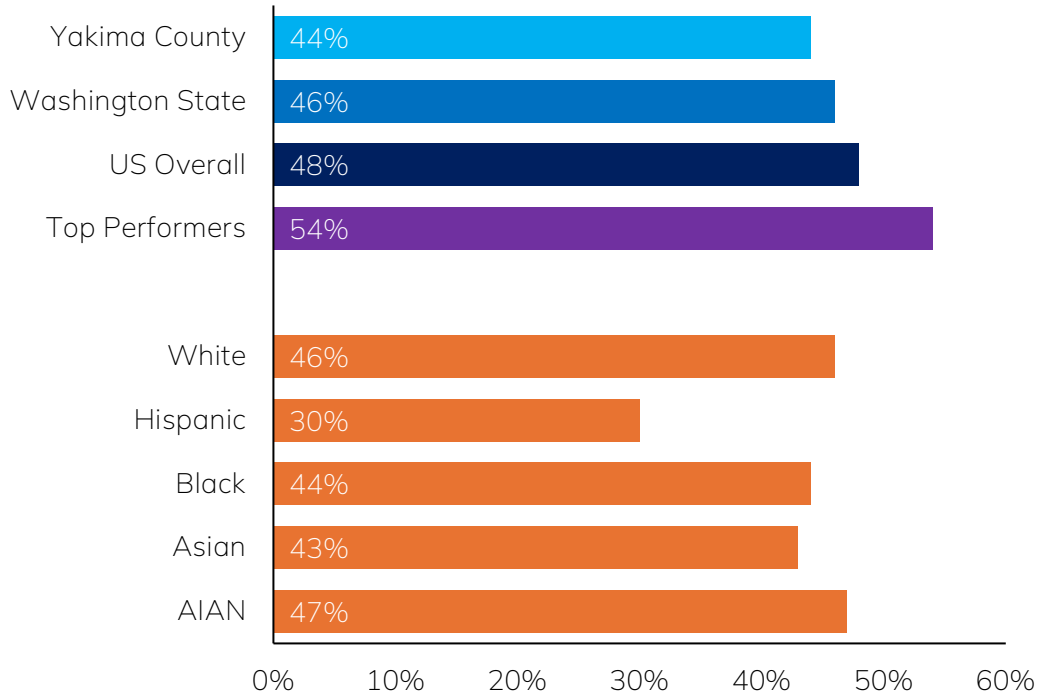
Financial & Systemic Barriers to Care

Financial & Systemic Barriers to Care

Preventive care indicators show **lower utilization** in Yakima County compared to state, U.S., and top performers, with clear **racial/ethnic disparities**. Among female Medicare enrollees aged 65–74, **mammography** screening is **36%** in Yakima (vs. **39%** WA, **44%** U.S., **53%** top performers). Within Yakima, screening is **37%** for White enrollees, but lower for **Black (23%)**, **Asian (26%)**, and **AIAN (22%)**. Similarly, **flu vaccination** among FFS Medicare enrollees is **44%** in Yakima (vs. **46%** WA, **48%** U.S.; **54%** top performers), with **Hispanic** enrollees at **30%**—below **White (46%)**, **Black (44%)**, **Asian (43%)**, and **AIAN (47%)**. These gaps point to affordability and system-navigation barriers that differentially affect older adults and communities of color.

The intersection of **cost**, **coverage**, and **administrative complexity** shows up in both the utilization data and community feedback: residents report high out-of-pocket costs, confusing eligibility, and limited Medicaid acceptance that discourage preventive care and follow-through on referrals. Over time, these barriers shift care into higher-acuity settings and widen disparities in chronic disease management. Evidence-aligned responses include **sliding-scale/safety-net expansion**, **insurance literacy and navigation**, and **bilingual/bicultural workforce growth**, paired with targeted outreach where screening and vaccination rates lag most.

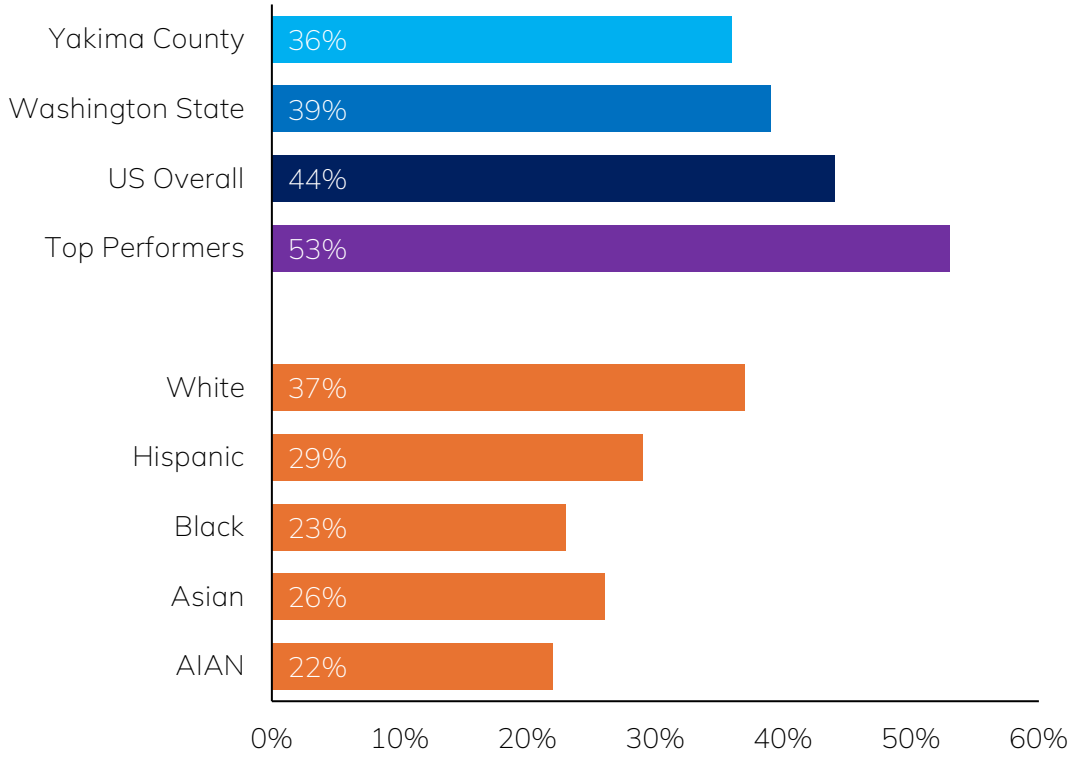
Percentage of Fee-For-Service (FFS) Medicare Enrollees who had an Annual Flu Vaccination
RWJ County Health Rankings 2025



Access to Care

Financial & Systemic Barriers to Care

Percentage of Female Medicare Enrollees Ages 65-74 who Received an Annual Mammography Screening
RWJ County Health Rankings 2025



Assessing the Barriers and Facilitators to Breast Cancer Screening Among Residents in the Lower Yakima Valley

Harvard T.H CHAN School of Public Health

"That was a culture thing, too, because in the depression, my mom said that they didn't trust doctors. They didn't trust them. You don't go see a doctor, the doctor will tell you you're sick or they'll give you a sickness. I think that goes back to the time…so my mom always didn't like going to the doctor at all then. Now you have a lot of distrust in big pharma…because…the recent pandemic and there's a lot of people that you know, they felt lied to…There's a lot of trust that's been lost now"

– Outlying Focus Group

Access to Care

LGBTQ+ Community | South Central Washington

Access to Care: LGBTQ+ Community (South Central Washington)

The **2025 Washington LGBTQ+ Survey**, conducted by the Washington State LGBTQ Commission and **Data 2 Insight**, sheds light on persistent healthcare access disparities among 2SLGBTQIA+ residents statewide. Findings from the **South Central region**, including **Yakima County**, show elevated barriers to care, fewer affirming providers, and greater behavioral health needs compared with other regions. Nearly **one in three respondents statewide** reported delaying or avoiding care due to fear of discrimination or past negative experiences, with even higher rates among transgender and gender-diverse individuals in rural communities.

The findings reinforce the CHNA's **Access to Care priority**, demonstrating that equitable healthcare extends beyond physical access to include **trust, safety, and cultural responsiveness**. For Yakima County, advancing equity will require expanding provider training in LGBTQ+-affirming care, integrating behavioral health within primary care, and strengthening partnerships with local LGBTQ+ organizations. Embedding these inclusive practices into MultiCare's Access to Care strategies ensures that every resident—regardless of identity—can receive care that is affirming, respectful, and equitable.

Key Findings

- **Limited Affirming Care:** Respondents noted a shortage of LGBTQ+-affirming providers and clinics, especially outside urban centers. Many cited discomfort or mistrust stemming from prior experiences of bias in healthcare settings.
- **Privacy & Stigma Concerns:** In smaller communities like Yakima, concerns about confidentiality and fear of social stigma prevent many from seeking sensitive services such as behavioral health, reproductive, and HIV-related care.
- **Behavioral Health Gaps:** Participants identified long wait times and limited gender-affirming or trauma-informed behavioral health supports, contributing to higher rates of stress, anxiety, and depression.
- **Structural Barriers:** Economic hardship, transportation barriers, and insurance limitations compound inequities, particularly for LGBTQ+ residents facing intersecting social and financial challenges.

Source: Gillig, T. K., Crain, C., Janssen, C., Price, E., Warren, O. E., Zarcone, A., & Moreno, Z. (2025). Washington LGBTQ+ Survey Report 2025. Washington State University. https://www.walgbtqsurvey.com/

Social Determinants of Health

Housing Instability & Homelessness

About Housing Instability & Homelessness

Housing is a fundamental determinant of health, influencing safety, stability, and opportunity. When individuals lack stable housing, their ability to manage medical conditions, maintain employment, and participate in community life diminishes. Homelessness and housing instability contribute to higher rates of hospitalization, untreated mental illness, and chronic disease, while also limiting access to preventive care. For families, housing insecurity can disrupt education, strain relationships, and increase exposure to stressors that affect long-term wellbeing.

Approaching housing as a health issue expands the role of healthcare systems beyond clinical care to include partnerships with housing agencies and community organizations. Integrating housing assistance, case management, and recovery supports into health improvement plans allows residents to build stability and independence. When housing and healthcare systems work together, the result is not only improved individual outcomes but also stronger, more resilient communities that support long-term recovery and wellness.

Qualitative Summary

Housing instability emerged as one of the **most urgent and interconnected issues** influencing community health. Participants across listening sessions described how the rising cost of rent, limited affordable units, and lack of transitional housing make it nearly impossible for low-income families to find stability. Individuals experiencing homelessness at Camp Hope spoke about the daily struggles of finding shelter, staying safe, and accessing healthcare without permanent housing. Providers echoed that **housing and health are inseparable**, with homelessness often exacerbating mental illness, chronic disease, and substance use.

Stakeholders emphasized that the region lacks sufficient **permanent supportive housing, medical respite beds, and recovery housing**. Individuals with mental health or substance use disorders are frequently discharged from hospitals into unstable or unsafe environments. Participants described an urgent need for coordinated housing solutions that integrate healthcare, recovery, and social services. Many suggested expanding partnerships between hospitals, local government, and housing authorities to build capacity and create **low-barrier, recovery-oriented housing** options that support both stability and dignity.

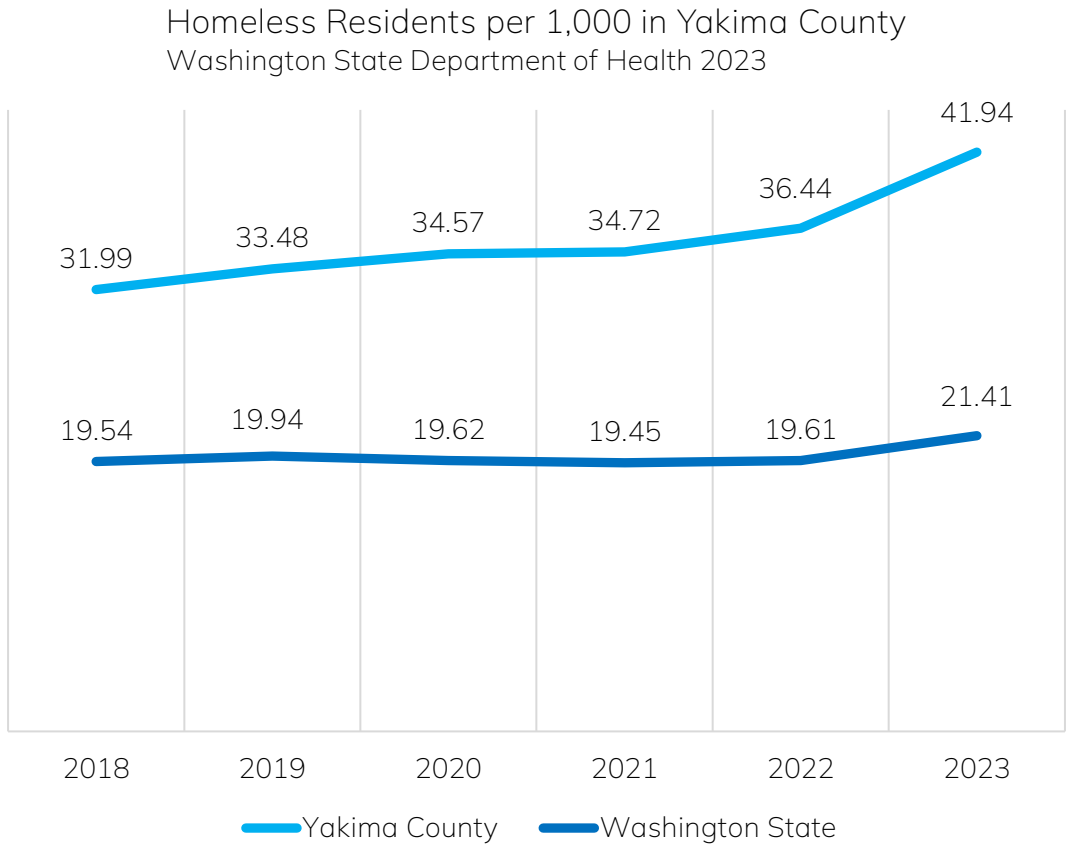
Social Determinants of Health

Housing Instability & Homelessness

Housing Instability & Homelessness

Housing instability continues to impact health and quality of life across Yakima County. Between 2019 and 2023, **15–17% of residents lived below poverty**, and the county's **homelessness rate of 41.9 per 1,000 residents** underscores widespread instability. Additionally, **16.5% of households** face one or more severe housing problems such as cost burden, overcrowding, or inadequate facilities. For many families, rising rent costs and limited affordable options have resulted in increased transiency, particularly among youth and low-income populations.

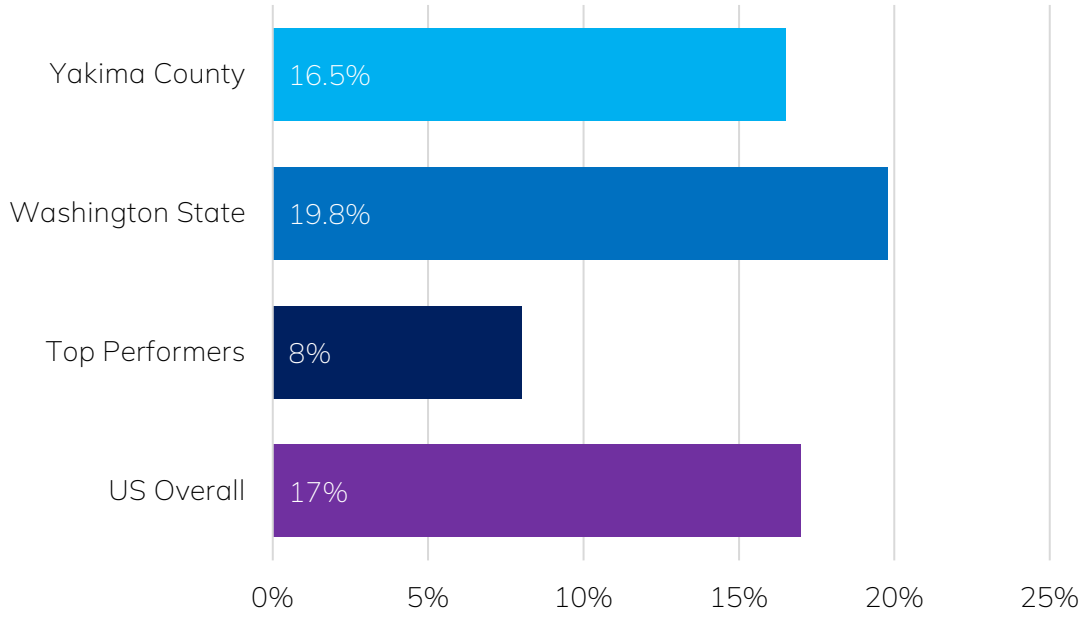
Economic data show that structural barriers such as **low wages** and **seasonal employment patterns** contribute to chronic housing insecurity. These conditions place families at greater risk for illness, behavioral health crises, and missed care. Access to stable, affordable housing serves as both a health and equity issue—reducing emergency healthcare use, supporting recovery from substance use, and improving child and family outcomes. Multi-sector collaboration between hospitals, housing providers, and public agencies is critical for developing permanent supportive housing, transitional programs, and policies that address homelessness as a health priority.



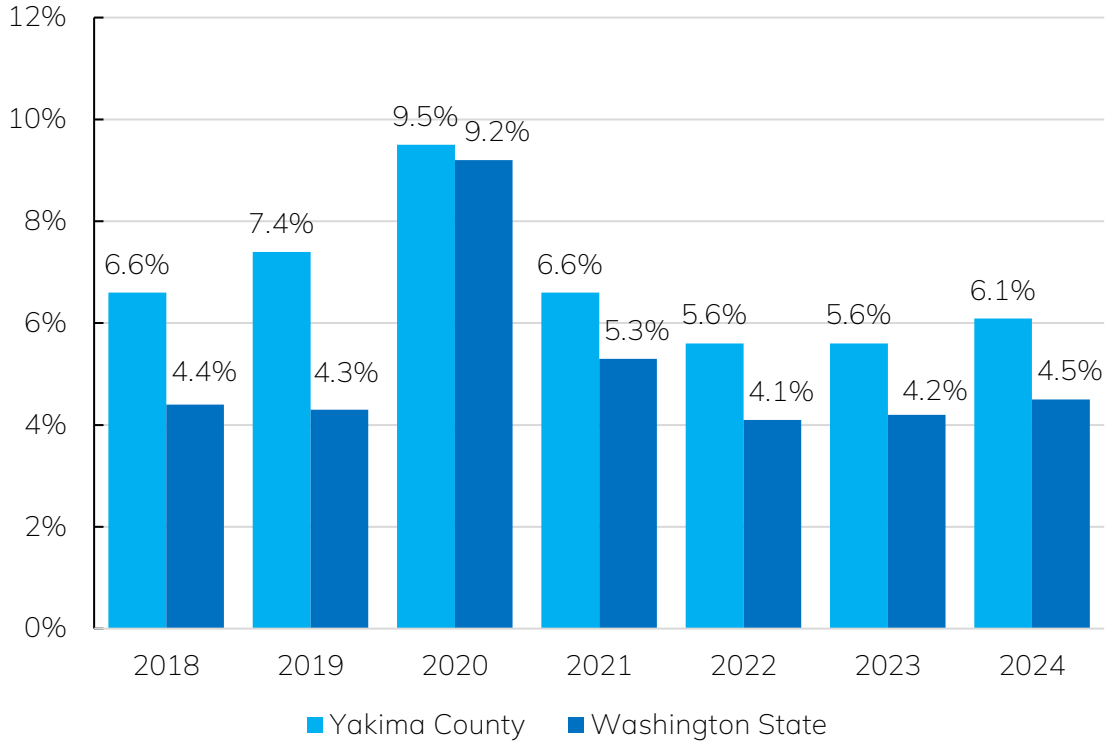
Social Determinants of Health

Housing Instability & Homelessness

Percentage of Households with at Least 1 of 4 Housing Problems: Overcrowding, High Housing Costs, Lack of Kitchen Facilities, or Lack of Plumbing Facilities
RWJ County Health Rankings 2025



Average Annual Unemployment
Bureau of Labor and Statistics 2025

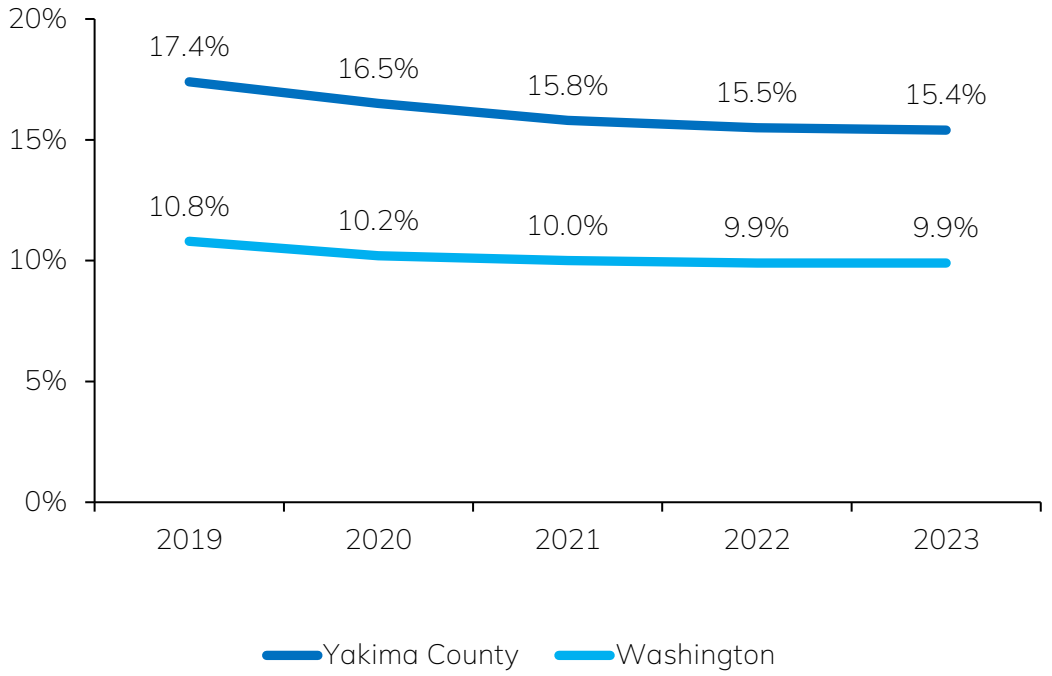


Social Determinants of Health

Housing Instability & Homelessness

Percentage of Persons Living Below the Federal Poverty Level

American Community Survey 2019-2023



% of Population Living Below Federal Poverty Level, by Race

American Indian/Alaskan Native	23.40%
Other Race	20.10%
Hispanic/Latino	17.90%
Yakima County (Overall)	16.50%
Black/African American	16.30%
White	12.30%
Native Hawaiian/Other Pacific Islander	7.80%

Social Determinants of Health

Food Security & Access to Healthy Food Environments

About Food Security & Access to Healthy Food Environments

Access to nutritious, affordable food is essential for physical health, cognitive development, and emotional wellbeing. Food insecurity contributes to a cycle of stress and poor health, particularly when families must choose between groceries, housing, or healthcare. In Yakima County, where agriculture is central to the economy, disparities in food access reflect broader challenges related to income, transportation, and rural infrastructure. Communities with limited grocery options or long travel distances to food sources face higher rates of chronic disease and diet-related conditions.

Improving food environments requires both structural and community-based solutions. Expanding access to local food programs, community gardens, and school-based nutrition initiatives helps residents make healthy choices that align with their culture and budget. Healthcare systems also play a role by connecting patients to food assistance programs and screening for nutrition needs during clinical visits. By addressing food access alongside social and economic factors, communities can create environments that support long-term health for all residents.

Qualitative Summary

Food insecurity continues to impact households throughout Yakima County, especially in rural and agricultural areas. Residents cited **high food prices, limited grocery access, and transportation barriers** as common challenges. Parents reported difficulty affording healthy foods, linking poor diet quality to obesity, diabetes, and other chronic conditions. Participants described relying on food banks or assistance programs, though many expressed frustration with eligibility restrictions or stigma associated with seeking help. Stakeholders noted that food insecurity often intersects with housing and employment instability, compounding stress for families.

Listening session participants highlighted the importance of **culturally appropriate nutrition programs**, particularly for Hispanic/Latino households. Community members expressed enthusiasm for **community gardens, farmers markets, and cooking classes** that emphasize local produce and traditional foods. Key informants called for stronger collaboration between healthcare providers, schools, and food networks to promote nutrition education and connect residents to resources. Expanding local partnerships and transportation solutions could help ensure that access to healthy, affordable food becomes a sustainable part of Yakima County's health improvement efforts.

Social Determinants of Health

Food Security & Access to Healthy Food Environments

Food Security & Access to Healthy Food Environments

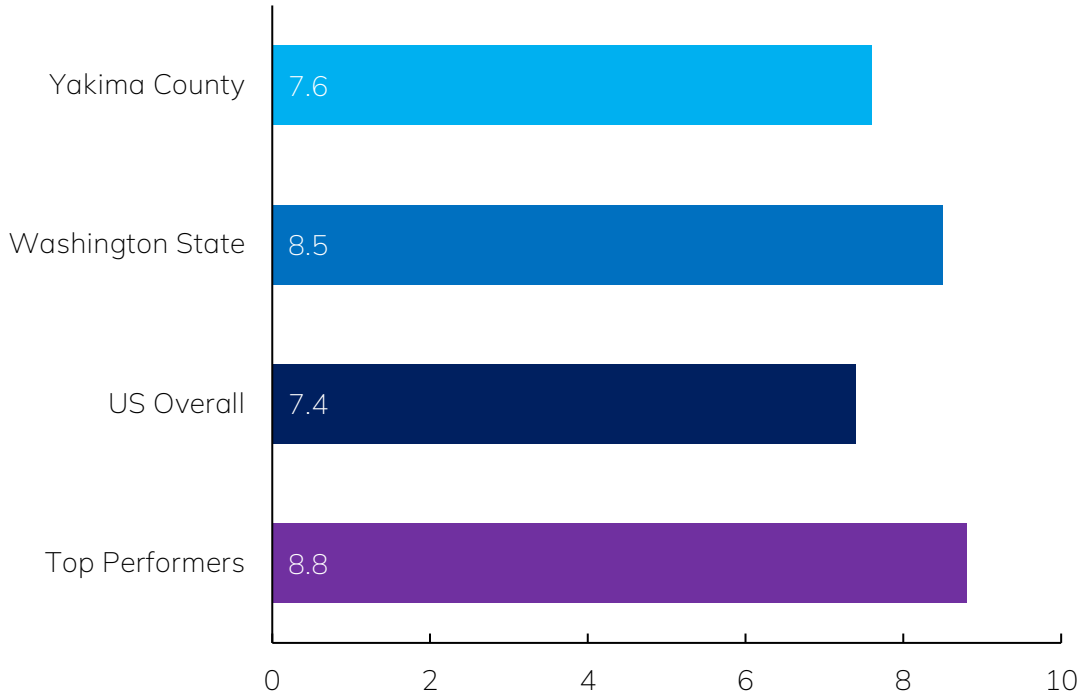
Yakima County's residents face challenges with food security and access to healthy food, highlighted by lower performance on the food environment index and greater reliance on assistance programs, although the overall lack of adequate access to food is lower than the state average. The county's Index of factors that contribute to a healthy food environment **is 7.6** (on a 0-10 scale), which is below the **Washington State score** of **8.5**, suggesting poorer access to healthy food retail, though it is slightly higher than the **US Overall** score of **7.4**.

In Yakima County, approximately **36% of households** reported being *very low food secure* (compared to **33% statewide**), and **17%** reported *low food security*, leaving only 46% of households food secure. This reflects a wider disparity between households experiencing food security and those facing very low security when compared with state-level patterns, highlighting ongoing inequities in food access and affordability.

Children Eligible for Free Lunch or Reduced Lunch program was at **78.8% in 2023 for Yakima County**, which is dramatically higher than the **state's rate of 49.3%**. Furthermore, student surveys indicate that food insecurity impacts households with children, as the % of students reporting that "almost every month" their household had to cut meal size or skip meals due to insufficient money for food is consistently higher in **Yakima County** for all grades shown, reaching **3.1% for 12th graders** compared to the **state's 2.7%**.

Index of Factors that Contribute to a Healthy Food Environment, from 0 (Worst) to 10 (Best)

RWJ County Health Rankings 2025

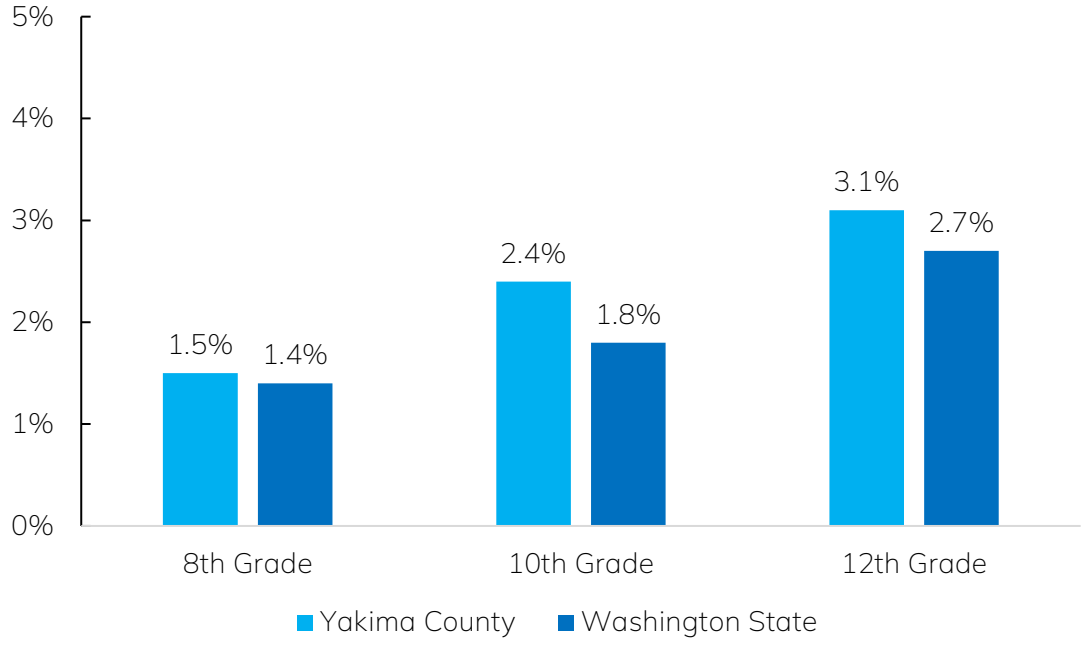


Social Determinants of Health

Food Security & Access to Healthy Food Environments

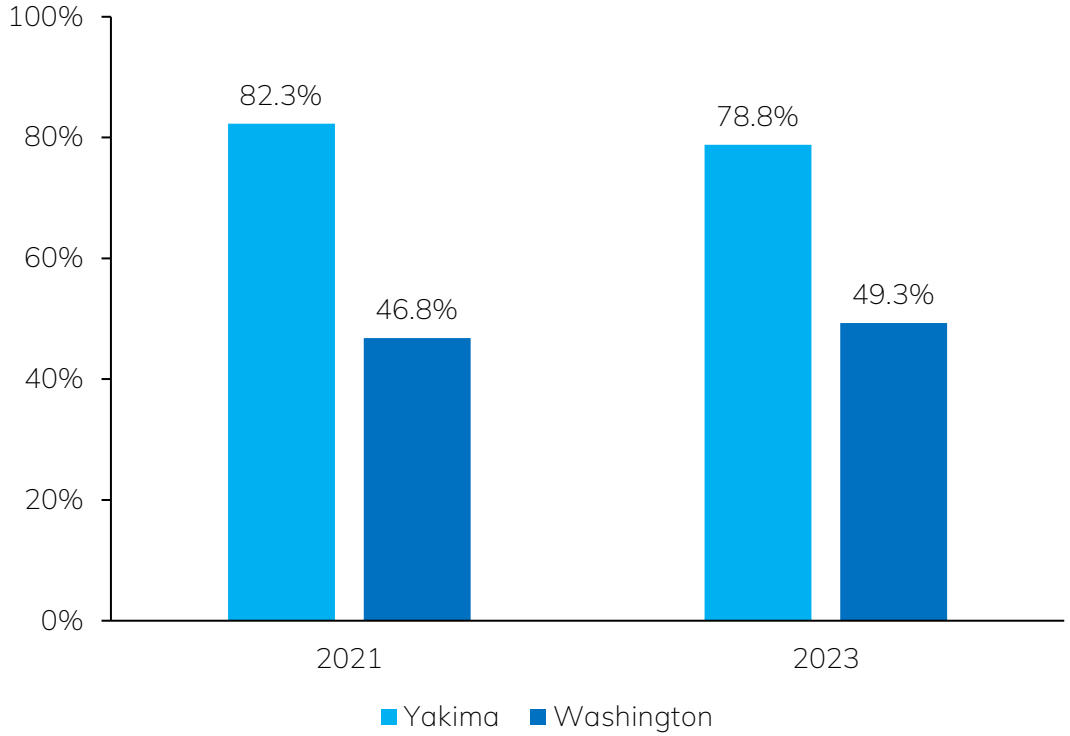
Percentage of Students Reporting That Their Household Had to Cut Meal Size or Skip Meals Almost Every Month in the Past 12 Months Due to Insufficient Money for Food

Healthy Youth Survey 2023



Children Eligible for Free Lunch or Reduced Lunch

RWJ County Health Rankings 2025

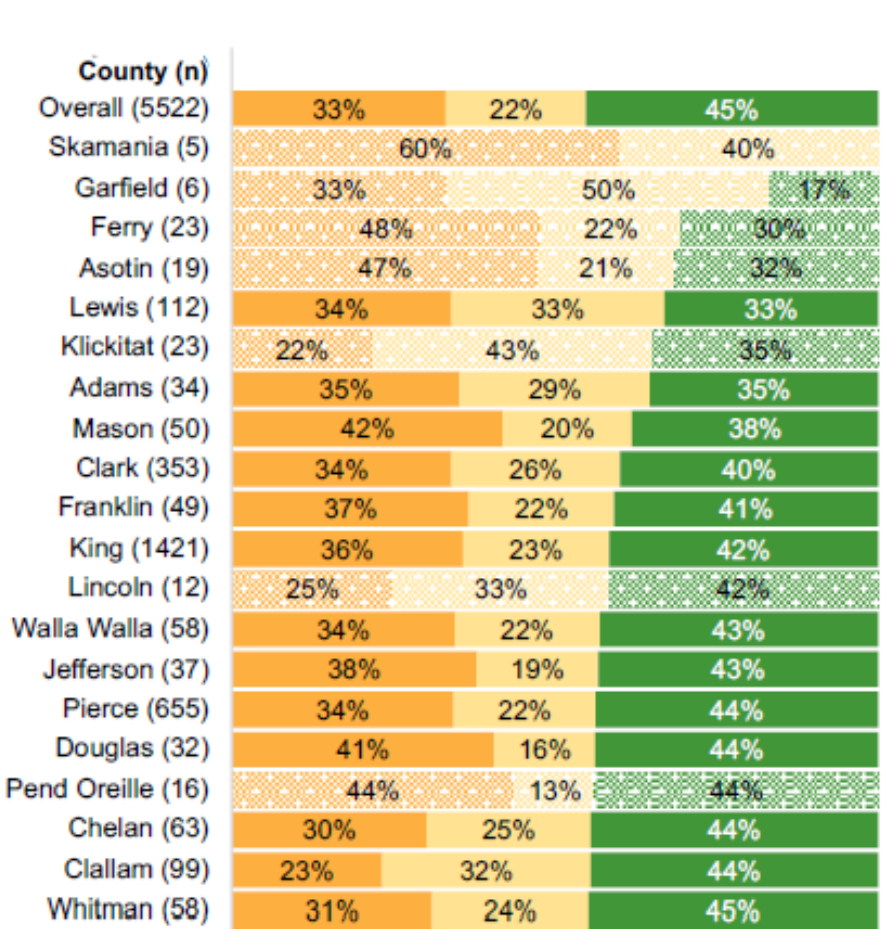


Social Determinants of Health

Food Security & Access to Healthy Food Environments

MultiCare

Household Food Security in the Past Month by County



Source: foodsystems.uw.edu 2025
Textured bars indicate categories with fewer than 30 survey responses

Maternal & Child Health

Infant & Birth Outcomes

About Infant & Birth Outcomes

Healthy birth outcomes are powerful indicators of a community's overall health, reflecting how well systems support women and families before, during, and after pregnancy. Factors such as maternal health, nutrition, access to prenatal care, and environmental quality all contribute to infant wellbeing. When disparities exist—such as differences in low birthweight or preterm birth—they often mirror underlying inequities in income, education, and access to care.

Improving infant outcomes requires a coordinated approach that connects hospitals, clinics, and social services to families early and consistently. Prenatal education, home visiting programs, and culturally tailored maternal support can strengthen engagement and reduce preventable risks. By ensuring every family has the information, resources, and trust they need to navigate pregnancy and early childhood, Yakima County can build the foundation for healthier generations to come.

Qualitative Summary

Disparities in infant and maternal outcomes remain a persistent concern in Yakima County. Providers reported higher rates of **low birthweight, preterm births, and late prenatal care** among Hispanic and Native families, aligning with state data trends. Many stakeholders linked these disparities to **economic insecurity, housing instability, and language barriers** that limit access to consistent prenatal services. Environmental conditions, such as poor air quality and agricultural exposures, were also identified as factors that may affect maternal health. Residents emphasized the importance of trust and clear communication between providers and patients, particularly for mothers with limited English proficiency.

Participants expressed a need for more **comprehensive prenatal education and early intervention**, especially in rural areas. Stakeholders also cited the value of **mobile maternal health services, nurse home visiting programs, and partnerships with community-based doulas** to ensure support throughout pregnancy and postpartum. Integrating culturally informed perinatal care into hospital and clinic settings was viewed as essential to reducing disparities and improving outcomes for mothers and infants across Yakima County.

Maternal & Child Health

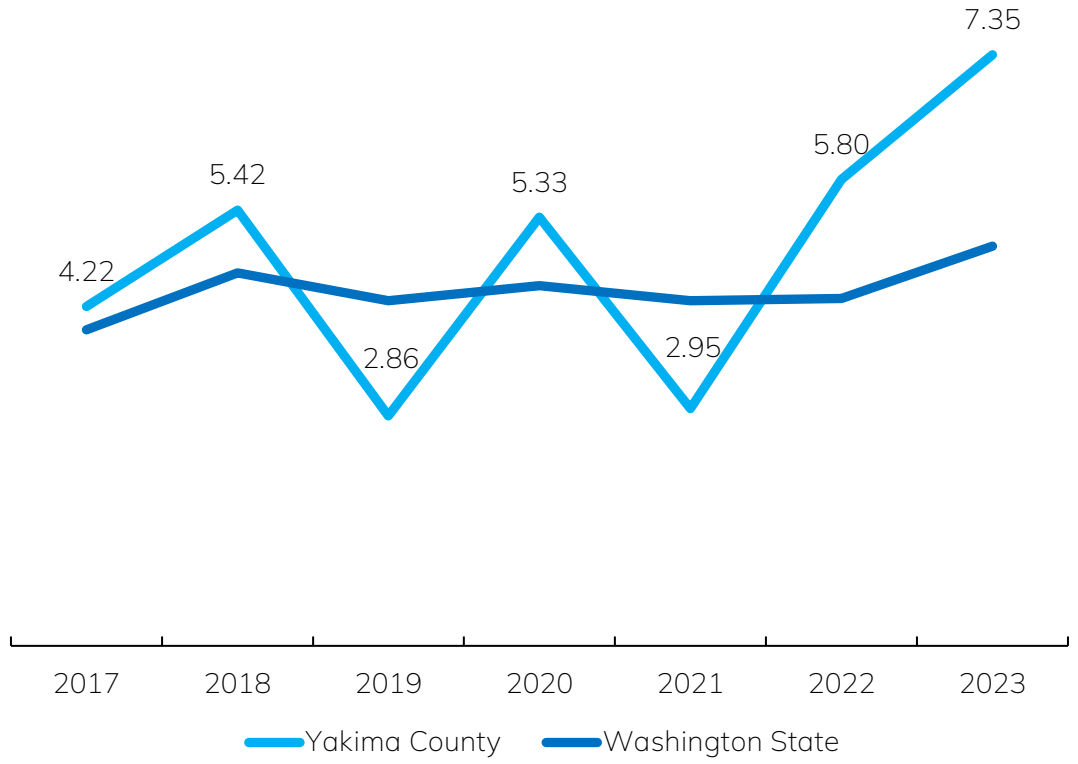
Infant & Birth Outcomes

Infant & Birth Outcomes

The **low birthweight rate** in Yakima County is **6.8%**, slightly above the state's **6.7%**, but disparities emerge by race and ethnicity: **Asian (11.3%)** and **Black (10.0%)** infants are impacted at rates nearly twice those of the overall population. The **preterm birth rate** stands at **39.9%**, compared with **11.1% statewide**, underscoring widespread challenges related to prenatal stress, health conditions, and continuity of care. The **teen birth rate—26 per 1,000 females aged 15–19**—remains more than double Washington's **11.5**, with the highest rates among **American Indian/Alaska Native (40.6)** and **Hispanic (27.3)** youth. Together, these measures indicate the intergenerational effects of poverty, limited reproductive education, and inconsistent maternal healthcare access.

At the same time, the **share of children living in single-parent households** is **19.1%**, below the state's **23.4%**, suggesting that strong family or community networks may help buffer some risks associated with early parenthood. Nonetheless, the overall data show that Yakima families experience a disproportionate burden of early birth and perinatal complications. Expanding **school-based reproductive health programs**, **youth health outreach**, and **integrated maternal-child health services**—particularly those that are culturally and linguistically appropriate—can help reduce preterm births and improve long-term infant health. Investing in these early supports provides a pathway toward healthier families and more equitable outcomes for Yakima County's youngest residents.

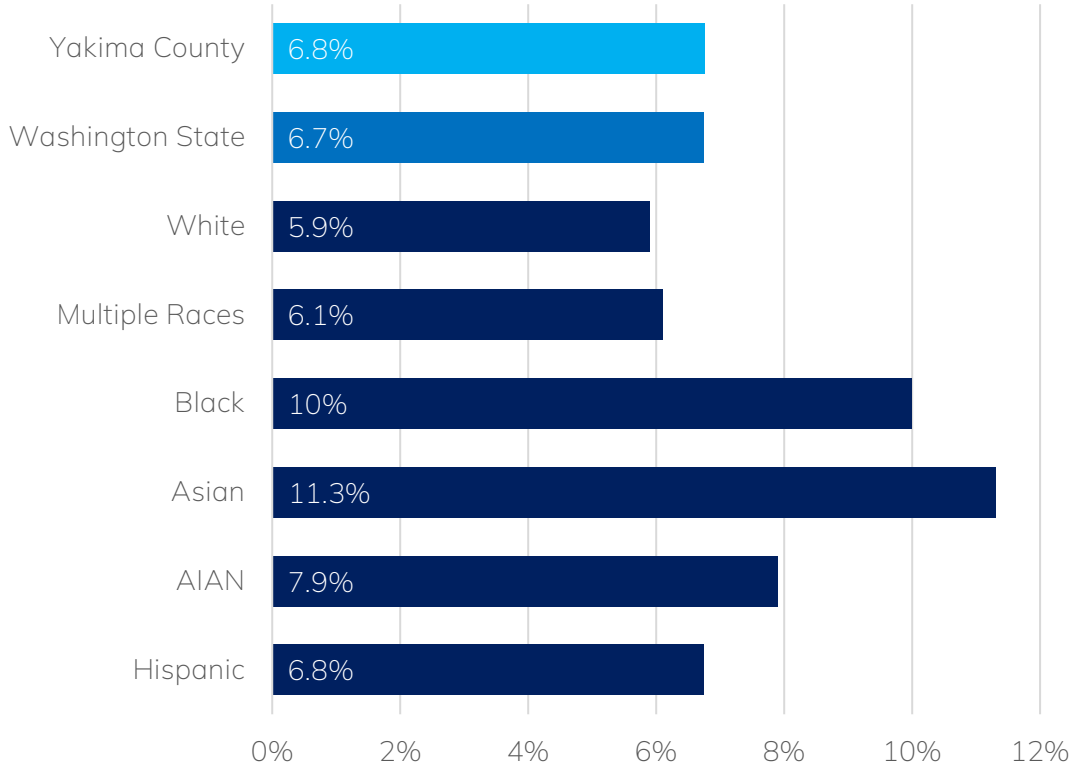
Resident Infant Mortality Rates Per 1,000 Live Births
Washington State Department of Health 2023



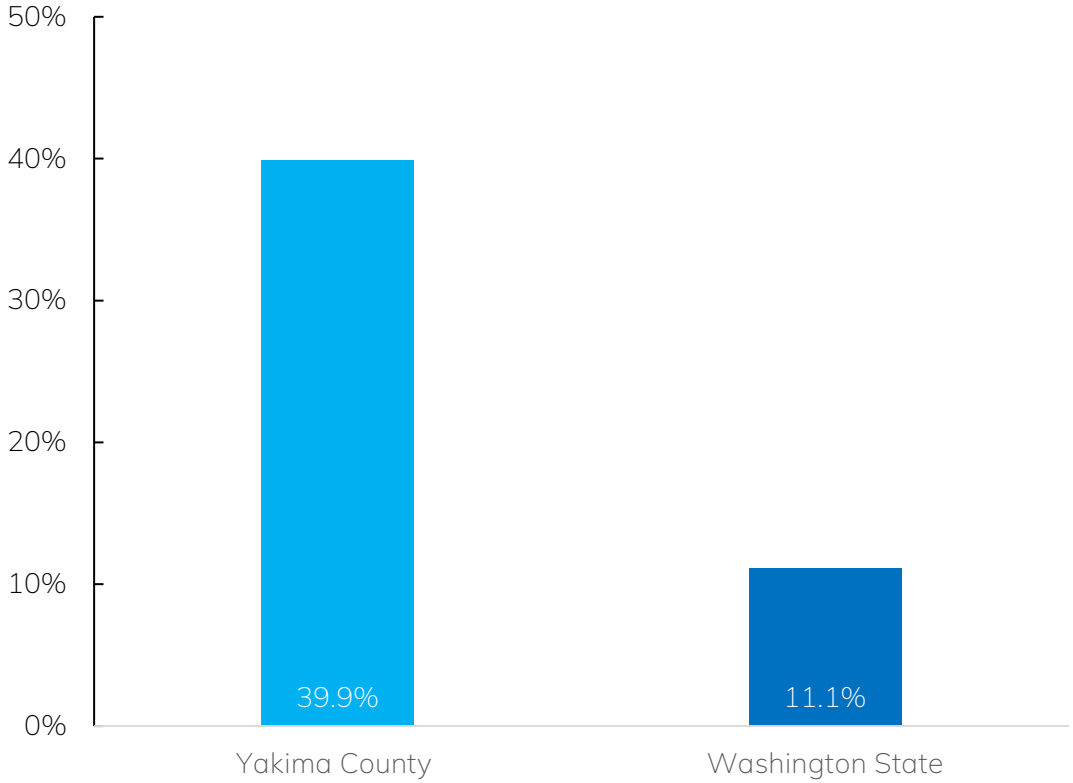
Maternal & Child Health

Infant & Birth Outcomes

Percent Low Birth Weight
RWJ County Health Rankings 2025



Percentage of Pre-Term Births
Washington State Department of Health 2023



Maternal & Child Health

Prenatal & Maternal Care

About Prenatal & Maternal Care

Access to comprehensive prenatal and maternal care supports healthier pregnancies and long-term outcomes for both mother and child. Early and continuous care allows for screening, risk management, and education that improve maternal health across all populations. Barriers such as transportation, cost, and limited provider availability can delay care, particularly for women in rural or low-income communities. When these barriers persist, preventable complications become more likely, affecting families across the lifespan.

Strengthening maternal care involves supporting a continuum of services—from prenatal education and childbirth support to postpartum and family health programs. Integrating community health workers, doulas, and peer educators creates trusted entry points for women who may face cultural or language barriers. Equitable, person-centered care not only improves outcomes but also promotes confidence, empowerment, and long-term wellbeing for families throughout Yakima County.

Qualitative Summary

Access to quality prenatal and maternal care continues to be limited by **provider shortages, transportation barriers, and inconsistent insurance coverage**. Many women described traveling long distances for OB/GYN appointments or struggling to find providers who accept Medicaid. Spanish-speaking mothers shared stories of communication challenges and discomfort during visits due to language differences. Stakeholders noted that fragmented care systems leave many women without adequate postpartum follow-up, contributing to preventable complications.

Residents and providers recommended expanding **group prenatal care models**, **home visiting programs**, and **peer support networks** to fill service gaps. There was also broad support for increasing the number of **bilingual maternal care providers** and community health workers who can bridge cultural and linguistic divides. Stakeholders emphasized that improving maternal health requires a coordinated, family-centered approach that supports women before, during, and after pregnancy—ensuring every mother, regardless of background or income, can access safe, compassionate care.

Maternal & Child Health

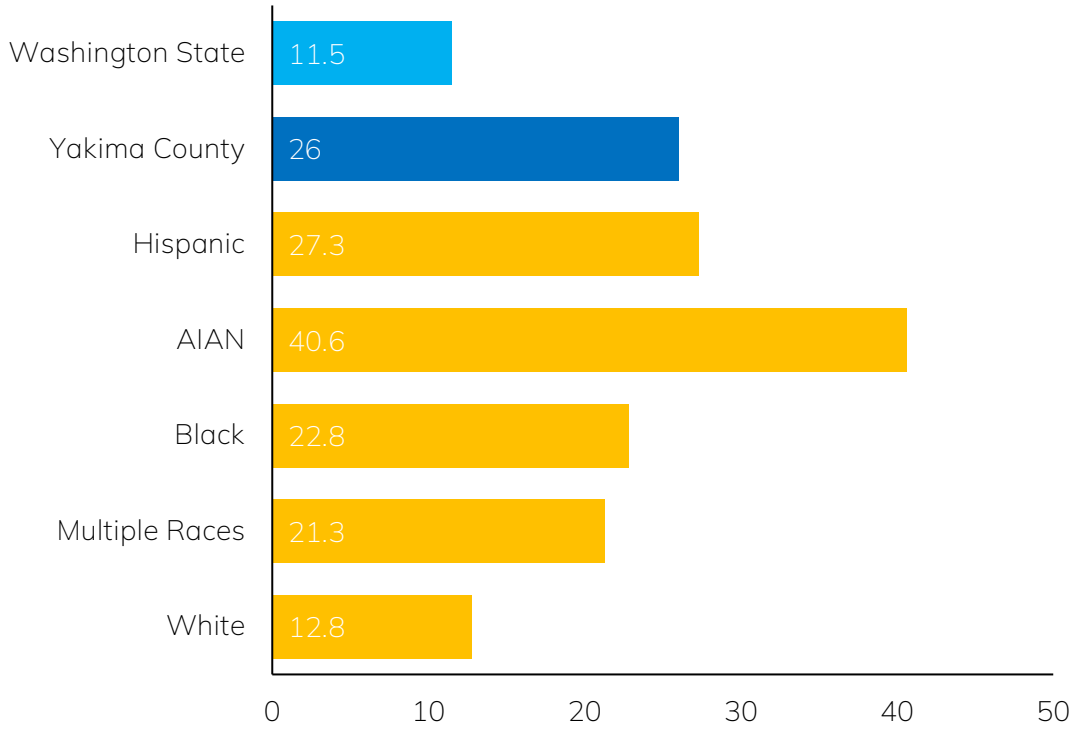
Prenatal & Maternal Care

Prenatal & Maternal Care

Data reflects ongoing barriers to early and comprehensive prenatal care, alongside maternal health risk factors that exceed state averages. In **2023**, **7.5% of mothers** received *late or no prenatal care*, a rate that matches Washington State's but has shown little progress in recent years. **Pre-pregnancy obesity** affects **43.5% of Yakima mothers**, compared with **29.0% statewide**, suggesting higher rates of gestational diabetes, hypertension, and delivery complications. Additionally, more than **half of all births (54.9%)** occur among **unmarried mothers**, compared with **31.7%** statewide. These indicators together highlight socioeconomic and systemic pressures that influence maternal health and access to care.

The data suggest that many women face overlapping barriers related to cost, transportation, and language access that delay or interrupt prenatal engagement. Rural distance and workforce shortages further limit provider availability, while the higher prevalence of obesity underscores the need for integrated prenatal nutrition and wellness programs. Addressing these gaps will require **expanding bilingual prenatal care**, **enhancing chronic-condition management during pregnancy**, and **creating more community-based entry points** for early maternal education and support. Strengthening these preventive measures can help improve pregnancy outcomes and reduce complications that contribute to the county's persistently high infant mortality rate.

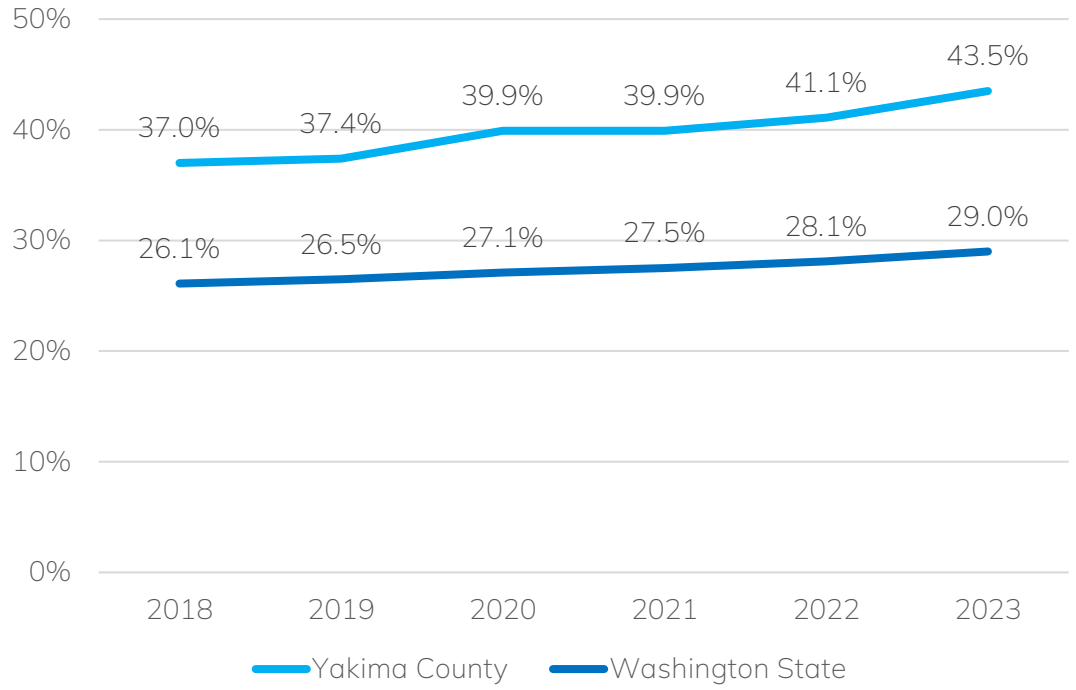
Number of Births per 1,000 Female Population, Ages 15-19
RWJ County Health Rankings 2025



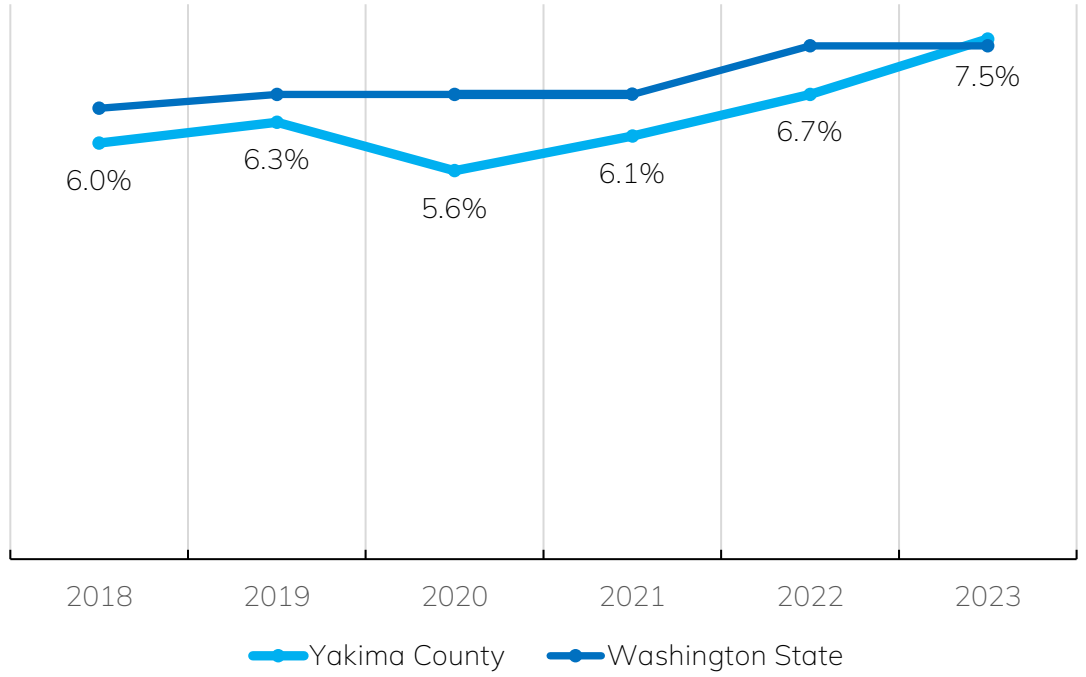
Maternal & Child Health

Prenatal & Maternal Care

Percent Pre Pregnancy Obese-BMI
Washington State Department of Health 2023



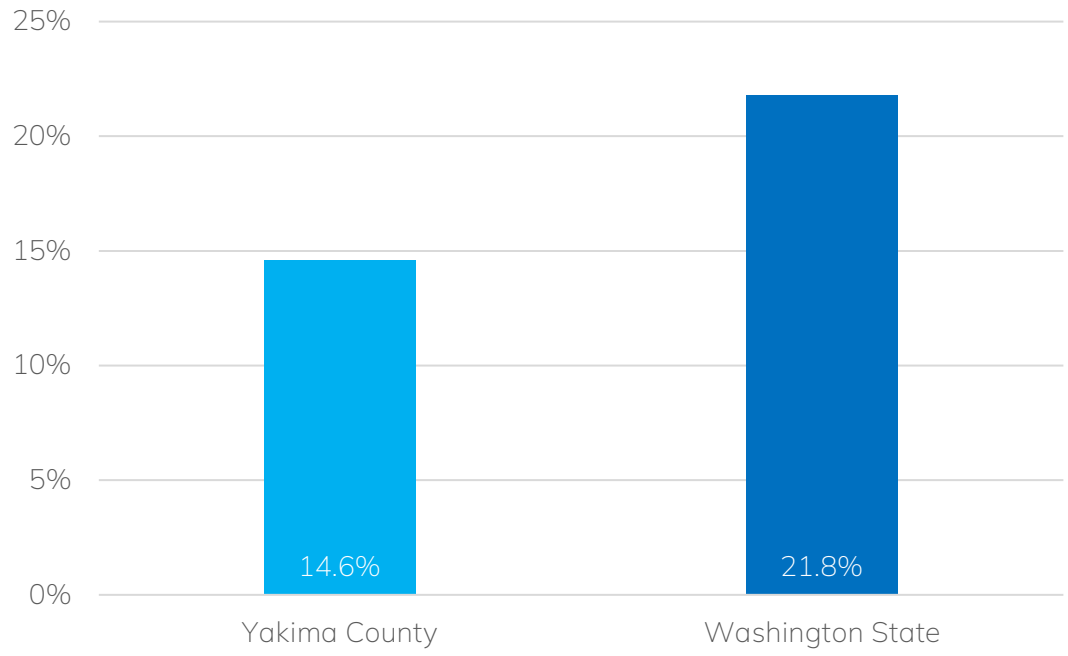
Late or No Prenatal Care
Washington State Department of Health 2023



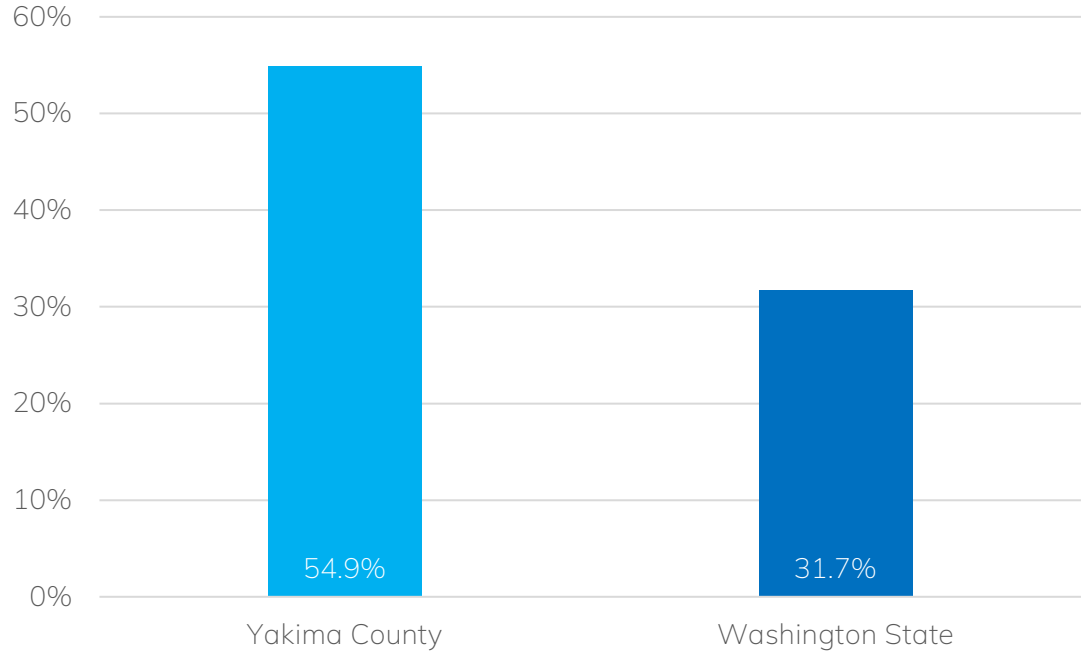
Maternal & Child Health

Prenatal & Maternal Care

2nd Trimester Prenatal Care
Washington State Department of Health 2023



Unmarried Mothers (%)
Washington State Department of Health 2023



Prioritization of Needs

Conclusion: Priority Needs

The findings of this Community Health Needs Assessment for Yakima County highlight four interconnected focus areas that address the community's most pressing health and social challenges. Behavioral Health remains the most urgent concern, encompassing both Substance Use & Prevention and the growing need for Mental Health Crisis and Culturally Responsive Services. These priorities reflect a shared recognition of the prevalence, complexity, and urgency of behavioral health needs and the community's desire for accessible, timely, and inclusive care.

Access to Care also emerged as a key area of concern, particularly around the availability and accessibility of services and the financial and systemic barriers that limit equitable healthcare access across Yakima County. Residents and providers reported ongoing difficulties in securing timely appointments, particularly for primary care, dental, and specialty services. Provider shortages, limited transportation options, and long travel distances for rural residents were frequently cited as obstacles to maintaining consistent care. Even when services are available, high costs, lack of insurance coverage, and complex eligibility requirements often discourage individuals from seeking treatment or following through with referrals.

Social Determinants of Health (SDOH) play a critical role in shaping the overall well-being of Yakima County residents, with Housing Instability & Youth Homelessness and Food Security & Access to Healthy Food Environments emerging as major areas of concern. Across the county, residents and community partners identified the growing lack of safe, stable, and affordable housing as a pressing issue. Rising rental costs, limited housing stock, and seasonal employment patterns contribute to housing insecurity for many families. Youth homelessness, in particular, was described as a hidden yet escalating problem, often linked to family instability, poverty, and limited access to supportive services. Stakeholders emphasized the need for more transitional housing, emergency shelters, and wraparound programs that provide both immediate relief and long-term stability for vulnerable populations.

Maternal & Child Health remains a key priority in Yakima County, with concerns centered on Infant & Birth Outcomes and Prenatal & Maternal Care. Community members and healthcare providers highlighted persistent disparities in maternal and infant health, particularly among Hispanic and low-income families. Premature births, low birth weights, and limited access to prenatal education and support services were identified as ongoing challenges. Residents emphasized that many expectant parents face barriers such as transportation difficulties, inconsistent insurance coverage, and a shortage of obstetric providers particularly in rural areas leading to delayed or fragmented care during pregnancy.

MultiCare
Yakima Memorial Hospital

Impact & Implementation

Community Resources
Prior CHNA Impact Report
New CHNA Implementation Plan

Impact & Implementation

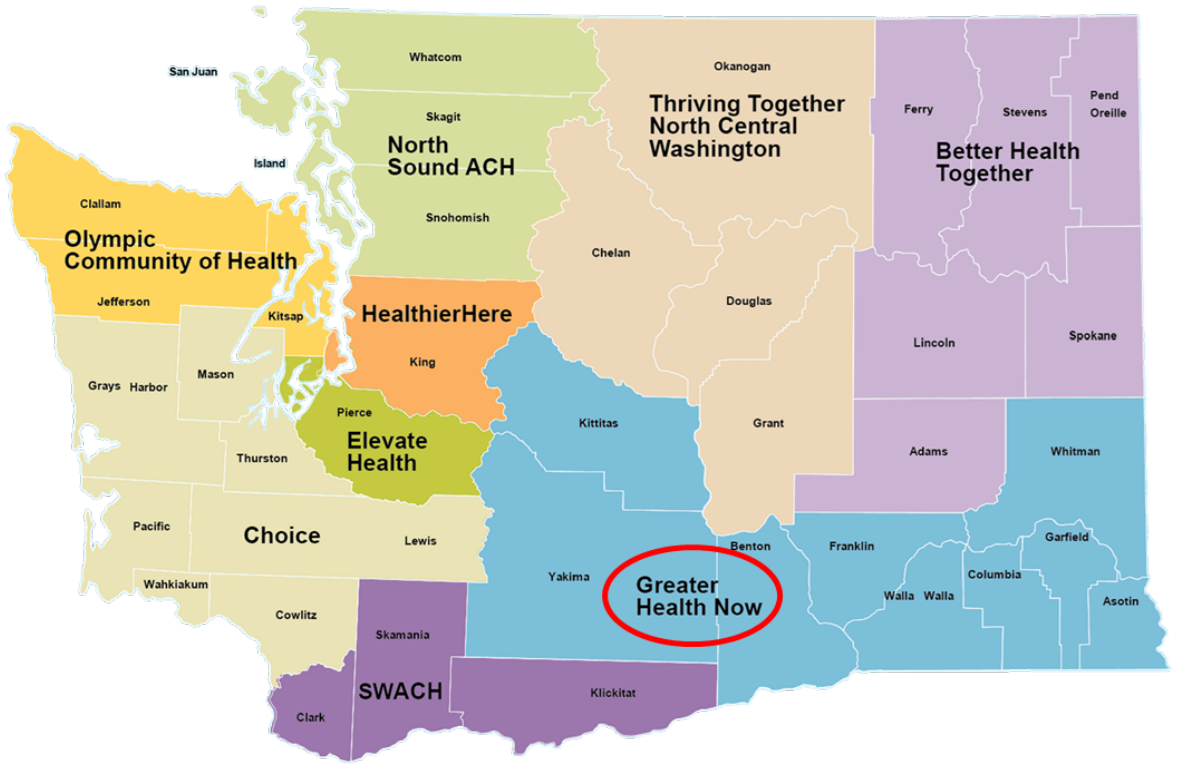
Community Resources

Greater Health Now (GHN) is a nonprofit regional collaborative serving Yakima, Kittitas, Walla Walla, Whitman, Columbia, Garfield, Asotin, Benton, and Franklin Counties. As one of Washington State's Accountable Communities of Health (ACHs), GHN connects healthcare, public health, and community organizations to improve population health and advance equity across South Central Washington.

GHN acts as a backbone organization, fostering collaboration among hospitals, providers, social service agencies, and local leaders to address the social and systemic factors influencing health. Its work is guided by four core focus areas:

- Collective Impact – Aligning community goals and shared accountability to drive measurable health improvement.
- Workforce Development – Building and sustaining a skilled healthcare and social services workforce.
- Community-Based Care Coordination – Integrating medical, behavioral, and social supports for seamless, person-centered care.
- Sustainability – Promoting long-term systems change through aligned funding and policy strategies.

Through these efforts, GHN strengthens care coordination, promotes equitable access, and elevates local voices in health planning. Its work complements MultiCare Yakima Memorial Hospital's mission by advancing regional collaboration and building community capacity for sustainable health improvement.



Impact & Implementation

Community Resources - Existing Outreach

Program/Initiative Name	2022 CHNA Focus Area	Key Activities/Partnerships	Community Impact/Benefit
MultiCare Community Partnership Fund	Health Equity	Provides grants to non-profit organizations in Yakima County; prioritizes projects addressing CHNA priorities and social determinants of health.	Strengthens community-led initiatives and provides financial support to organizations working to improve community health and well-being.
Community Health Education (e.g., ACT! Get up, Get Moving, Diabetes Prevention Program)	Access to Care	Offers a variety of low- or no-cost classes and programs, including exercise, cooking, and health management classes. Partnerships with community organizations to offer classes like yoga and Zumba.	Equips community members with tools and knowledge for a healthier lifestyle, focusing on areas like obesity and diabetes prevention.
Partnerships with Yakima Valley Farmworkers Clinic	Access to Care, Health Equity	Collaborates to provide services such as maternal-fetal medicine and diabetes screenings to the community.	Expands access to specialized care for a vulnerable population, ensuring they receive needed services in a more accessible setting.
NICU to Home Program	Access to Care	A program aimed at reducing wait times for in-home therapy for vulnerable infants.	Improves care coordination and reduces barriers to essential follow-up care for infants after discharge from the neonatal intensive care unit.

Impact & Implementation

Prior CHNA Impact Report

Impact Report Introduction

MultiCare Yakima Memorial Hospital engaged in multiple activities to conduct its community health improvement planning process. These included conducting a Community Health Needs Assessment with community input, identifying collaborating community stakeholder organizations, describing anticipated impacts of program activities and measuring program indicators. This evaluation of impact outlines many of the programs that Yakima Memorial Hospital supported, either through financial or in-kind support, and that addressed the health needs identified in the CHNA.

From 2022 through 2025, Yakima Memorial Hospital focused on the following priority health needs:

1. Access to Care
2. Behavioral Health
3. Health Equity

The tables present strategies and program activities the medical center delivered to help address significant health needs identified in the CHNA report. They are organized by health need and include statements of the strategies' impact and any collaboration with other organizations in our community.

Health Need: Access to Care	
Anticipated Impact (Goal)	Increase access to clinically appropriate preventative, diagnostic and treatment services
Strategy or Program	Summary Description
Stabilize our workforce	• Maintained talent pipelines through residency programs, continued availability of clinical rotations and outreach to community groups • Built on system level MultiCare recruitment structures and strategies to grow local workforce • Improved physician and staff engagement, leadership development and belonging
Common electronic medical record	• Implemented EPIC • Improved access to patient information throughout MultiCare and other EPIC enabled facilities • Implemented MyChart access for patients enabling engagement with their care team, scheduling, and results

Impact & Implementation

Prior CHNA Impact Report

Health Need: Access to Care (cont.)	
Strategy or Program	**Summary Description**
Improve efficiencies for patient scheduling and referrals	• Developed dashboard of out migration to understand opportunities to return care to Yakima • Educated local healthcare providers about Yakima service offerings for specialty services, care, treatment
Increase preventive care	• Partnered with community providers to increase evidence-based screenings • Increased preventative screening offerings (e.g. breast cancer screenings and colorectal cancer screenings)
Reduce avoidable ED visits	• Strengthened transitions of care • Educated community on appropriate ED utilization at events and external communication strategies • Partnered with community clinics to ensure patients have a primary care home
Expand partnership with Yakima Union Gospel Mission	• Partnered with UGM to increase services at their campus • Expanded support for UGM with access to supportive services (e.g. lab and radiology)
Impact	• **Expanded access through system integration:** Successfully implemented the **Epic (electronic medical record system)** in 2024, creating seamless connectivity across MultiCare clinics and improving care coordination, scheduling efficiency, and follow-up management for patients across Yakima County.

Impact & Implementation

Prior CHNA Impact Report

Health Need: Access to Care (cont.)	
Impact (cont.)	• **Reduced avoidable Emergency Department utilization:** The percentage of **Level 4 and 5 ED visits** (low-acuity) decreased from **37% in 2022** to **32.3% in 2024**, reflecting more appropriate use of primary and urgent care settings • **Improved scheduling and referral efficiency:** Time from **referral receipt to appointment** improved dramatically—from establishing a baseline in early 2024 to an average of **4–6 days by mid-year**, well below the 14-day goal, indicating faster access to specialty and follow-up care • **Enhanced local retention of care ("in-system" referrals): 90% of patient referrals** generated within primary care stayed within the primary service area—meeting and maintaining the goal of minimizing out-migration and strengthening continuity of care locally • **Increased preventive screening: Mammogram screening rates** rose from **72% (2022)** to **81.3% (2024)**, surpassing the 75% target and demonstrating strong progress in preventive care engagement • **Progress in workforce stabilization:** Although recruitment remains a focus, open **physician and APP positions** decreased from **50 in 2022** to **44 by 2024**, reflecting gradual improvement in provider staffing and retention efforts
Planned Collaboration	Maintain partnerships with Yakima Union Gospel Mission

Impact & Implementation

Prior CHNA Impact Report

Health Need: Behavioral Health	
Anticipated Impact (Goal)	Improved outcomes for behavioral health patients
Strategy or Program	Summary Description
Co-locate immediate resource for behavioral health crisis in ED	• Evaluated additional opportunities for models of care and opportunities to partner for patients with behavioral health needs
Access to behavioral health inpatient care	• Partnered with MultiCare system resources to evaluate opportunities to expand capacity • Evaluated potential for single bed certification Standardize the use of evidence-based screenings • Implemented the Columbia Suicide Screening in the ED
Standardize use of PHQ-9 in primary care	• Implemented Screening Brief Intervention & Referral to Treatment (SBIRT) in ED and hospital units on patients that meet criteria
Integrated behavioral health in primary care	• Established warm hand-off processes for patients with needs • Increased access to providers with prescribing ability for outpatient needs
Impact	• **Expanded inpatient behavioral health access:** The **average daily census** for inpatient behavioral health increased from **14.5 in 2022** to **17.4 by October 2024**, effectively achieving the goal of maintaining up to **24 staffed beds** • **Integrated behavioral health in primary care:** By late 2024, the hospital successfully implemented behavioral health integration across all **five primary care clinics**, expanding access to screening, brief intervention, and referral within routine care settings • **Adopted evidence-based screening practices:** The **PHQ-9 depression screening tool** was standardized across primary care with the rollout of **Epic**, ensuring consistent screening and follow-up for patients with depressive symptoms. This represents a major systems-level advancement in early identification and coordinated treatment for behavioral health conditions
Planned Collaboration	Comprehensive Healthcare, MultiCare Behavioral Health

Impact & Implementation

Prior CHNA Impact Report

Health Need: Health Equity	
Anticipated Impact (Goal)	Increase access to clinically appropriate preventative, diagnostic and treatment services
Strategy or Program	Summary Description
Expand Diversity, Equity, and Inclusion (DEI)	• Provided Intercultural Competency and Health Equity training offerings and participation
Report quality by REaL to identify health disparities	• Embedded REaL metrics in each • Reported select metrics by Race, Ethnicity and Language (REaL) • Collaborate with partners to implement hospital health equity action plans
Increase workforce diversity	• Incorporated belonging principles into People Operations processes and tools • Implemented MultiCare Academy for Students in Healthcare Camp (MASH)
Impact	• **Strengthened workforce cultural competency:** Participation in **intercultural competency training** rose from **87.3% in 2022** to **96.5% in 2024**, exceeding the 95% goal and supporting a more culturally responsive care environment • **Improved chronic disease screening equity:** The proportion of patients with **overdue HbA1c screenings** decreased overall from **18.5% (2022)** to **13.3% (2024)**. Improvements were seen across all groups, with **Latino patients decreasing from 18.1% to 14.0%** and **non-Latino patients from 16.3% to 12.8%**, narrowing the screening gap between populations • **Reduced readmission disparities by language:** Overall readmissions declined modestly from **10.99% to 10.87%**, while the **Spanish-speaking population** saw a significant reduction—from **13.9% (2022)** to **9.5% (2024)**—outperforming the system target and closing a major equity gap in continuity of care • **Increased equitable preventive care:** Breast cancer screening rates rose for all groups, with **Latino patients increasing from 68.8% (2022)** to **78.7% (2024)** and **non-Latino patients** from **74.1% to 81.6%**, surpassing the 75% goal and reflecting progress toward equitable preventive outreach
Planned Collaboration	Collaborate with MHS Center for Health Equity and Wellness as well as MHS Belonging Advisory Council

Impact & Implementation

New CHNA Implementation Plan

As part of the Community Health Needs Assessment (CHNA) process, each hospital will develop a Community Health Implementation Plan (CHIP) to ensure that identified priorities translate into actionable strategies. These strategies will include clear objectives, measurable outcomes, and cross-sector partnerships that address the most pressing community health concerns. The CHIP serves as a framework for aligning resources, guiding program development, and reinforcing MultiCare's long-standing commitment to improving the health and well-being of children, families, and communities.

While the prior CHNA and CHIP were prepared and released simultaneously, this cycle reflects a deliberate shift in process. By utilizing additional time between the completion of the CHNA and the finalization of the CHIP, we are strengthening opportunities for collaboration, dialogue, and alignment. This enables deeper engagement with community stakeholders, hospital leaders, and system-level decision makers, resulting in a stronger connection between community health priorities and the strategic direction of MultiCare hospitals. In this way, the CHIP is not simply an operational document, but a strategic blueprint that ties community health priorities to long-term organizational goals.

The CHIP will be formally presented for approval and adoption by the Board of Directors no later than May 15th, 2026, in compliance with federal CMS and IRS requirements.

An essential component is the development of a robust data visualization and reporting strategy. This approach translates complex community health data into accessible, dynamic tools that enable internal monitoring of progress in real time. By integrating quantitative indicators with qualitative community insights, these tools allow hospitals and the broader MultiCare system to track performance against stated goals, identify emerging trends, and make timely, data-informed adjustments to implementation strategies.

Importantly, this work will extend across the entire MultiCare system. The intent is not only to strengthen the link between CHNA priorities and hospital-level planning, but also to create a unified framework that connects community health improvement efforts with system-wide strategic initiatives. This alignment ensures that the lessons learned in one community can inform action in others, while promoting consistency in measurement, accountability, and reporting across the system.

The CHNA, CHIP, and data visualization strategy create a continuous cycle of assessment, planning, action, and evaluation. This cycle enables MultiCare hospitals to remain responsive to evolving needs while also advancing long-term system goals. By building a process that is collaborative, transparent, and data-driven, MultiCare is positioning itself to more effectively demonstrate measurable impact for communities.

MultiCare
Yakima Memorial Hospital

Approval & Adoption

Approval & Adoption

Yakima Memorial Hospital

MultiCare Yakima Memorial Hospital has undertaken this Community Health Needs Assessment (CHNA) to better understand the most significant health challenges and opportunities facing individuals and families in our region. This assessment represents an important continuation of our commitment to improving community health, advancing health equity, and ensuring that every person has the opportunity to flourish.

The CHNA process reflects the integration of local and national data sources, health indicators, and social determinants of health with the lived experiences of community members, providers, and local leaders. Through focus groups, key informant interviews, surveys, and collaborative analysis, the CHNA provides a comprehensive picture of the current state of health in our service area. By engaging directly with the voices of those most impacted, MultiCare Yakima Memorial Hospital ensures that this assessment is both evidence-based and community-driven.

This CHNA fulfills federal requirements under the Affordable Care Act and Washington State standards, while also serving as a roadmap for future strategy within MultiCare. The findings and priorities identified here will inform how MultiCare Yakima Memorial Hospital aligns resources, develops innovative partnerships, and strengthens programs that meet the unique needs of our population.

The Board of Directors of MultiCare Yakima Memorial Hospital, together with leadership across MultiCare Health System, has formally reviewed and acknowledges this Community Health Needs Assessment as the official CHNA for the hospital. In doing so, the Board affirms its responsibility to ensure that identified community health needs guide organizational planning, program design, and investment decisions over the next three years.

This acknowledgement reflects more than compliance with state and federal requirements. It affirms a shared vision: to create healthier communities through a commitment to health, equity, and well-being. The Board recognizes that meaningful progress requires sustained collaboration across public health, education, social services, and health care delivery partners.

By endorsing this CHNA, the MultiCare Yakima Memorial Hospital Board and MultiCare leadership signal their dedication to turning assessment into action. This document will serve as a framework for measurable improvement in the identified priority areas (Behavioral Health, Access to Care, Social Determinants of Health, and Maternal & Child Health), transparent reporting, and continued accountability to the communities we serve.

Approved Date: November 25th, 2025

MultiCare
Yakima Memorial Hospital

Appendices

A.1 Qualitative Data Collection
A.2 Sources
A.3 Additional Data

A.1

Yakima CHNA Survey

MultiCare

Demographic Information

1. Age
- Under 18
- 18-24
- 25-34
- 35-44
- 45-54
- 55-64
- 65 and over

2. Gender
- Male
- Female
- Non-Binary
- Prefer not to say

3. Race/Ethnicity
- White
- Hispanic/Latino
- Black or African American
- Asian
- Native American or Alaska Native
- Native Hawaiian or Pacific Islander
- Prefer not to say
- Other, please specify:

4. Do you have access to healthcare in your area?
- Yes, always
- Sometimes
- No, I do not have access

Health And Wellness Questions

5. How would you rate your overall health?
- Excellent
- Good
- Fair
- Poor

6. Have you seen a doctor or nurse in the last year?
- Yes
- No

7. Do you have one main doctor or nurse you see?
- Yes
- No

A.1

Yakima CHNA Survey

8. In the past year, have you faced any challenges in accessing healthcare? (Check all that apply)

- It cost too much
- There were not enough doctors or nurses
- I didn't have a way to get there
- I didn't understand the language
- I didn't have health insurance
- I had to wait a long time
- No challenges
- Other, please specify:

9. Do you have any of these health problems now? (Check all that apply)

- Diabetes
- Heart problems
- Asthma or problems breathing
- Feeling sad or worried a lot
- Obesity or weight-related issues
- Problems with drugs or alcohol
- Other, please specify

10. What are the biggest health challenges in your community? (Check up to 3)

- Access to healthcare services
- Mental health support
- Long-term sickness like diabetes or heart problems
- Problems with drugs or alcohol
- Obesity and nutrition
- Things around us that make us sick (like bad air or unsafe homes)
- Not getting enough exercise
- Learn about how to be healthy
- Other, please specify:

11. How do you typically get information about health and wellness? (Check all that apply)

- My doctor or nurse
- Social media
- Community organizations
- Family and friends
- Local news
- Other, please specify:

12. What type of health services or programs would you like to see more of in your community?

13. What are the three most important things that would help you be healthier?

14. Do you think your community helps people live healthy lives?

15. Any additional comments or suggestions?

A.1

Key Informant Interview Questions

Background Information

- Please state your name, title, and organization as you would like them included in the report.
- Which geographies does your organization primarily serve?
- Which populations does your organization primarily serve?
- What are the greatest strengths of the community your organization serves?

Community Health Needs and Priorities

- What are the most pressing health issues currently affecting your community?
- Which populations in your community face the greatest health disparities, and why?
- What social determinants of health (e.g., housing, employment, education) are contributing to poor health outcomes in your area?
- Where do you see gaps in health services or barriers to care for vulnerable populations?
- Thinking about the community needs you just prioritized, how do hazards like wildfires, smoke, power outages, or other extreme weather events affect these needs?

Current Programs and Opportunities

- What existing programs or services do you feel are working well to improve health equity in the community?
- Please identify one or two community health initiatives or programs that you see currently meeting the community's needs. What characteristics make them effective?
- How well do you feel the hospital/health system collaborates with community organizations to address health needs?

Current Programs and Opportunities

- What existing programs or services do you feel are working well to improve health equity in the community?
- Please identify one or two community health initiatives or programs that you see currently meeting the community's needs. What characteristics make them effective?
- How well do you feel the hospital/health system collaborates with community organizations to address health needs?

Barriers and Strategies

- What cultural or language barriers are preventing individuals from accessing care or health information?
- What strategies do you believe could be implemented to better reach and serve minority populations or communities facing the greatest challenges?
- How can the hospital/health system be more involved in addressing broader social issues (e.g., housing, nutrition, education) that influence community health?

A.1

Key Informant Interview Questions

Final Thoughts

Using the table below, please identify the five most important "issues" that need to be addressed to make your community healthy (1 being most important):

- ❑ Access to healthcare services
- ❑ Affordable housing and homelessness
- ❑ Behavioral health challenges and access to care
- ❑ Food security
- ❑ Economic security (living wage jobs and employment)
- ❑ Access to transportation (safe, reliable, affordable)
- ❑ Racism and discrimination
- ❑ Other (please specify): _____

- What are the most important characteristics of a healthy community?
- Do you have any additional thoughts or suggestions on how the hospital and health system can improve health outcomes and reduce disparities in your community?

Closing

"Thank you for your time and insights. Your responses will help shape our community health initiatives. We will compile the findings into a report and share our next steps. If you have any further input, please feel free to reach out."

A.2

Sources

This Community Health Needs Assessment (CHNA) draws upon a broad range of quantitative and qualitative data sources to provide a comprehensive understanding of health, wellbeing, and social conditions across Yakima County. Demographic, socioeconomic, and population data were primarily derived from the U.S. Census Bureau's American Community Survey (ACS) 5-Year Estimates (2019–2023) and the U.S. Census Bureau's Annual County Population Estimates (2023), which together informed analyses of population size, growth, race and ethnicity, household structure, and economic stability. To supplement these, employment and workforce participation trends were obtained from the U.S. Bureau of Labor Statistics (BLS), while income and poverty measures were validated through the Small Area Income and Poverty Estimates (SAIPE) program. These foundational datasets established the demographic and economic context for interpreting health disparities and social determinants of health.

Core health and social indicator data were drawn from the Robert Wood Johnson Foundation's County Health Rankings & Roadmaps (2025), which aggregates measures from multiple federal and state agencies—including the Centers for Disease Control and Prevention (CDC), the National Center for Health Statistics (NCHS), and the Behavioral Risk Factor Surveillance System (BRFSS)—to provide a standardized framework for comparing counties across health outcomes, clinical care, behaviors, and community factors.

The Washington State Department of Health (DOH) contributed additional population health and surveillance data for the Behavioral Health, Social Determinants of Health, and Maternal and Child Health categories, including prenatal care, preterm birth, low birthweight, infant mortality, and chronic disease prevalence. These indicators were supported by state-level information from the Washington Tracking Network (WTN) and environmental and social vulnerability data from the U.S. Environmental Protection Agency's Environmental Justice Index (2024).

Behavioral health and substance use analyses integrated multiple surveillance systems. Real-time overdose information was drawn from the Overdose Detection Mapping Application Program (ODMAP) to identify patterns of substance use, overdose hotspots, and changes in fatal and non-fatal incident trends. Adult behavioral health indicators, such as frequent mental distress and depression prevalence, were informed by County Health Rankings (2025) and BRFSS, while youth-level trends were captured using the Washington State Healthy Youth Survey (HYS) administered in 2021 and 2023 by the Washington State Department of Health, the Office of the Superintendent of Public Instruction, and partner agencies. These data provided essential insights into youth mental health, substance use, vaping, and risk perception.

A.2

Sources

Access to care measures—including provider-to-population ratios for primary, dental, and mental health services—were sourced from **County Health Rankings (2025)** and the **Health Resources and Services Administration (HRSA) Area Health Resource File (AHRF)**, which together documented healthcare capacity and workforce distribution across Yakima County. Preventive screening and clinical care utilization rates, including mammography and influenza vaccination among Medicare enrollees, were obtained from **Centers for Medicare & Medicaid Services (CMS)** data and integrated into the clinical care analysis. Local access challenges were further informed by qualitative research from the **Harvard T.H. Chan School of Public Health's 2022 study, Assessing the Barriers and Facilitators to Breast Cancer Screening Among Residents in the Lower Yakima Valley**, which provided focus group perspectives on insurance, education, and financial barriers to care.

Social and economic determinants of health were examined through the **U.S. Census Bureau (ACS 2019–2023)**, **U.S. Department of Agriculture (USDA) Food Environment Atlas and Food Access Research Atlas**, **U.S. Bureau of Labor Statistics (BLS)** unemployment data, and the **Centers for Disease Control and Prevention (CDC) PLACES Project (2024 release)**, which modeled community-level estimates for chronic disease and health behavior patterns.

Local housing and student homelessness data were obtained from **SchoolHouse Connection** and the **Office of the Superintendent of Public Instruction (OSPI)** to assess educational stability and youth wellbeing.

Maternal and child health indicators were compiled from multiple validated datasets, including the **Washington State Department of Health's Center for Health Statistics**, **County Health Rankings (2025)**, **CDC WONDER Natality and Infant Mortality Files (2023)**, and the **Washington State DOH Birth Data Dashboards**. These sources provided detailed measures of prenatal care, maternal obesity, preterm birth, teen birth rates, and infant mortality.

Qualitative data collection complemented these quantitative findings. In **2025**, **Key Informant Interviews** were conducted with public health leaders, healthcare providers, educators, and nonprofit executives to identify emerging health issues, system barriers, and opportunities for partnership. **Community Listening Sessions**, held in collaboration with trusted local organizations—including three sessions conducted in Spanish—amplified the perspectives of youth, parents, community advocates, and individuals with lived experience of behavioral health or housing instability.

A.2

Sources

A **Community Health Survey** completed by 129 residents, including 15 Spanish-language respondents, provided additional community perceptions regarding access to care, behavioral health, and social needs. Data from local collaborative partners such as **Greater Health Now (GHN)** further contextualized findings related to regional health improvement efforts, care coordination, and workforce development.

Data from the **Washington State Food Security Survey (2024)** were used to assess county-level food security across Washington State, including the proportions of households classified as Food Secure, Low Food Security, and Very Low Food Security.

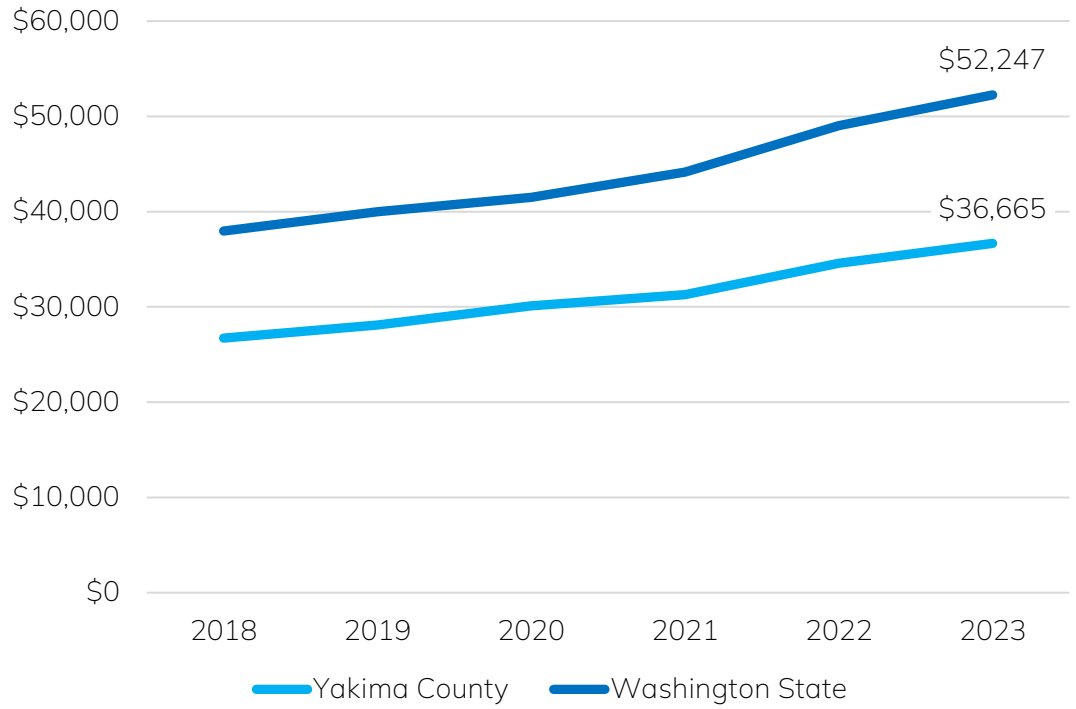
Finally, environmental and comparative frameworks were drawn from the **U.S. Department of Health and Human Services' Healthy People 2030** objectives, **Centers for Disease Control and Prevention (CDC)** national benchmarks, and the **National Center for Health Statistics (NCHS)** life expectancy and mortality files, which provided reference points for goal alignment and long-term population health trends. All quantitative data were validated against the most recent releases available as of **October 2025**, and when multiple datasets reported overlapping indicators, the most recent and methodologically consistent source was prioritized. Together, these diverse datasets and qualitative inputs form the foundation of the Yakima County Community Health Needs Assessment, ensuring that findings are accurate, representative, and reflective of both statistical evidence and community voice.

A.3

Additional Data

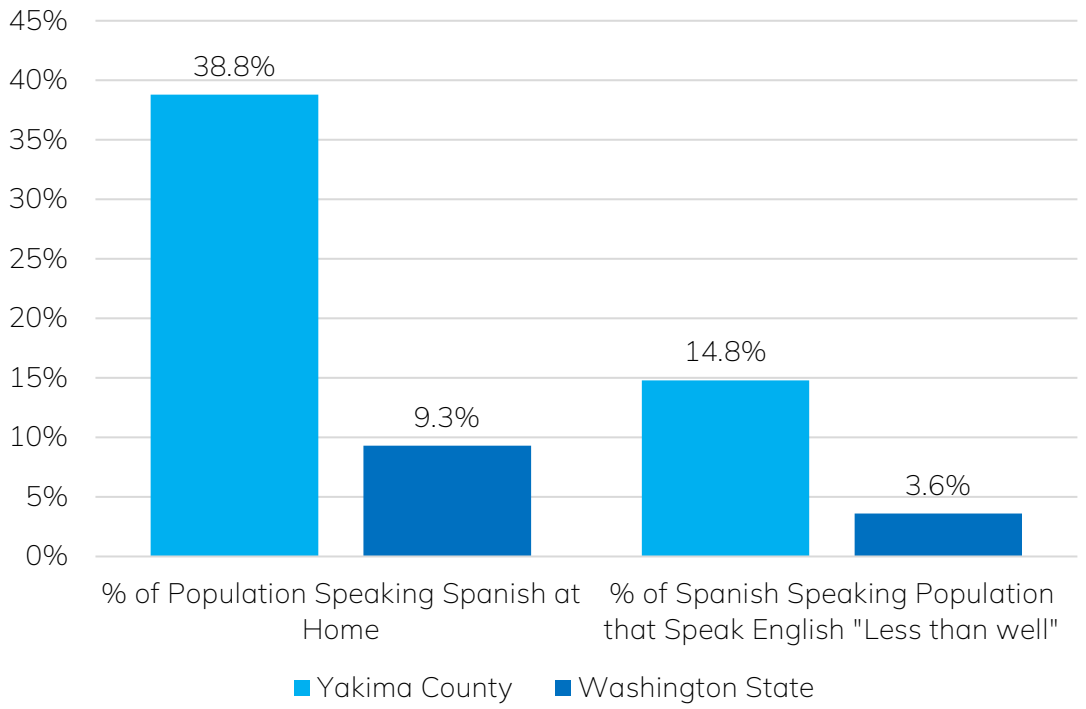
Median Income for Population 16 and Older with Earnings

American Community Survey 2019-2023



Hispanic Population, Primary Language and Linguistic Isolation

American Community Survey 2019-2023



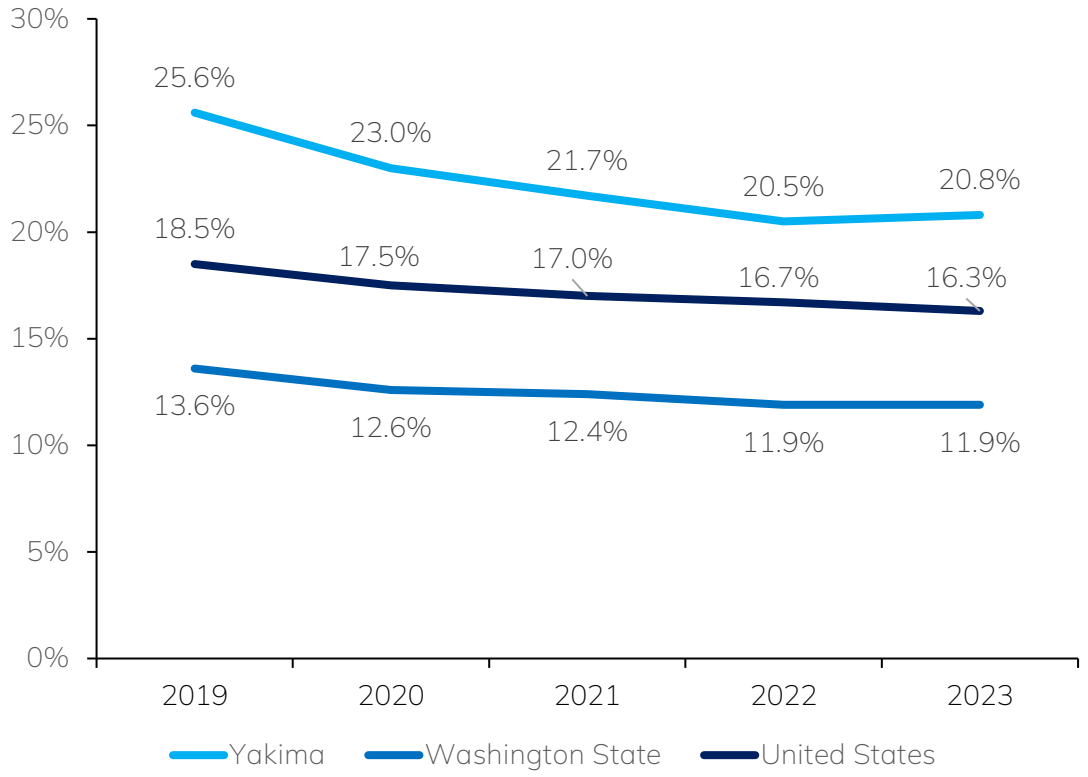
A.3

Additional Data

Leading Causes of Death in Yakima County,
Age-Adjusted Death Rate Per 100,000
Washington State Department of Health 2023

Cause	Yakima County	Washington
Diseases of Heart	203.2	130.0
Malignant Neoplasms	141.7	137.0
Accidents	83.3	72.8
Cerebrovascular Diseases	30.4	33.2
Alzheimer's Disease	26.2	36.1
Chronic Lower Respiratory Diseases	25.2	27.2
Diabetes Mellitus	19.7	20.2
Chronic Liver Disease and Cirrhosis	19.4	13.0
Suicide	13.8	15.4
COVID-19	12.0	10.1

Children Under the Age of 18 Living in Poverty
American Community Survey 2019-2023

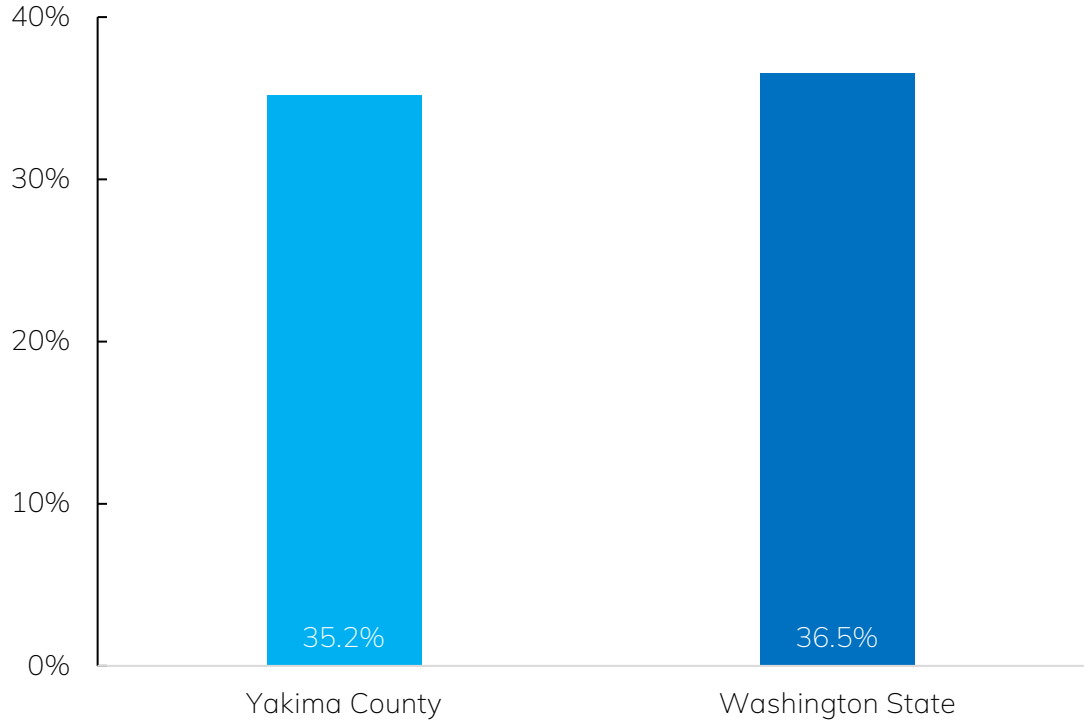


A.3

Additional Data

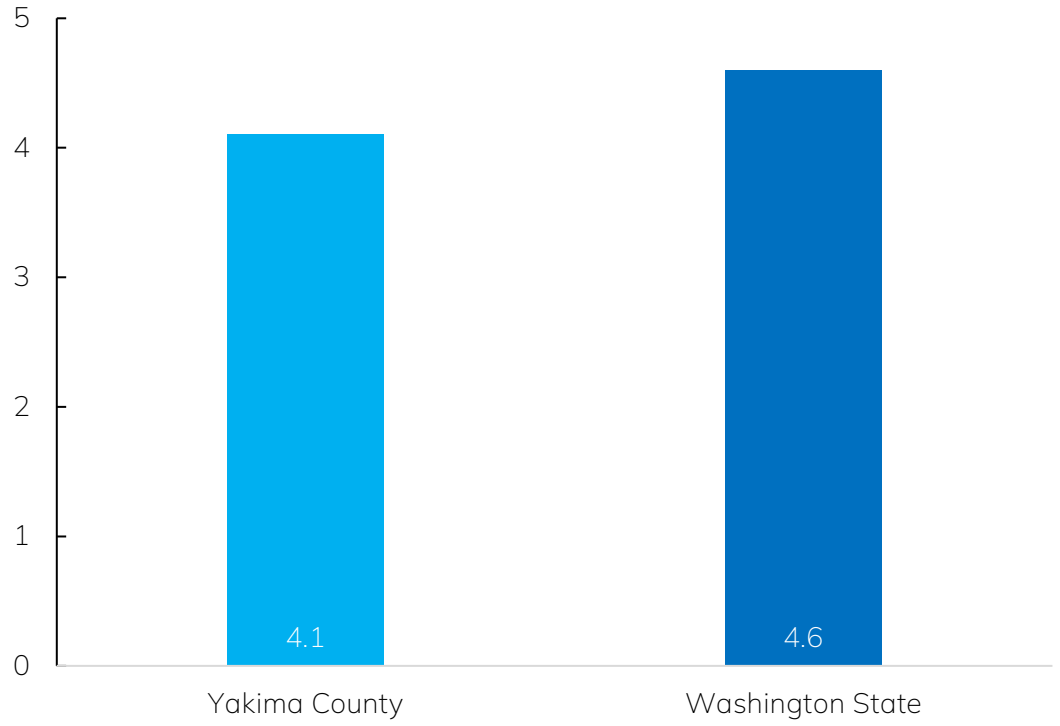
% Household Income Required for Child Care Expenses

RWJ County Health Rankings 2025



Child Care Centers per 1,000 Children

RWJ County Health Rankings 2025

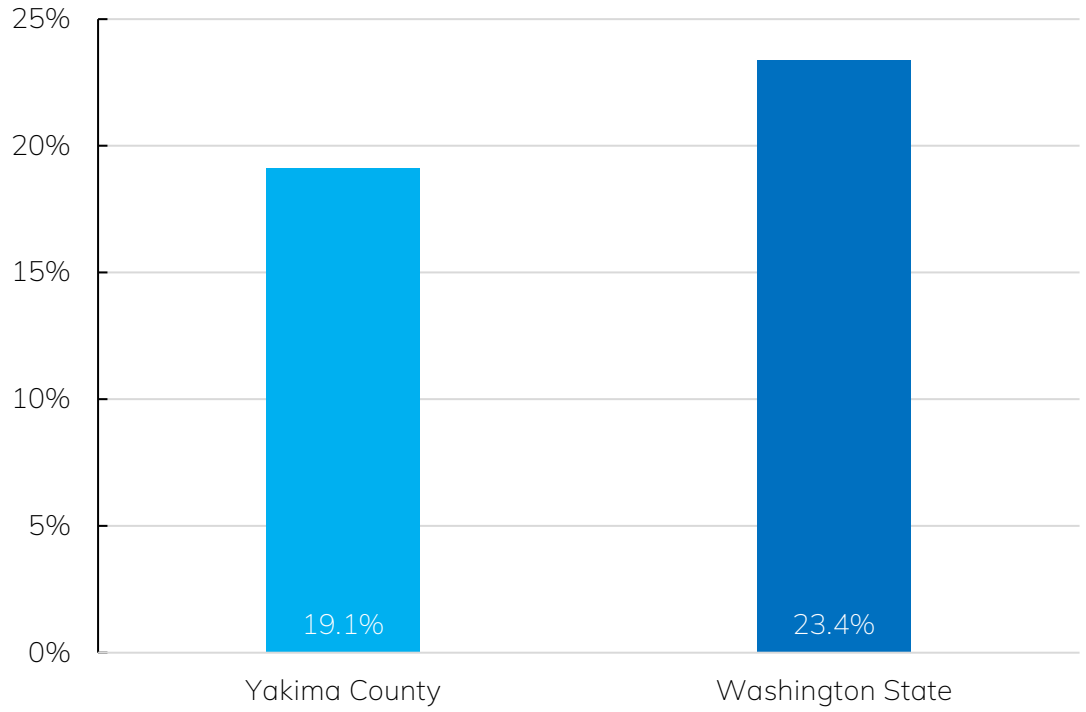


A.3

Additional Data

Percentage of Children That Live in a Household Headed by a Single Parent

RWJ County Health Rankings 2025



MultiCare

Community Health Needs Assessment 2025

MultiCare Yakima Memorial Hospital