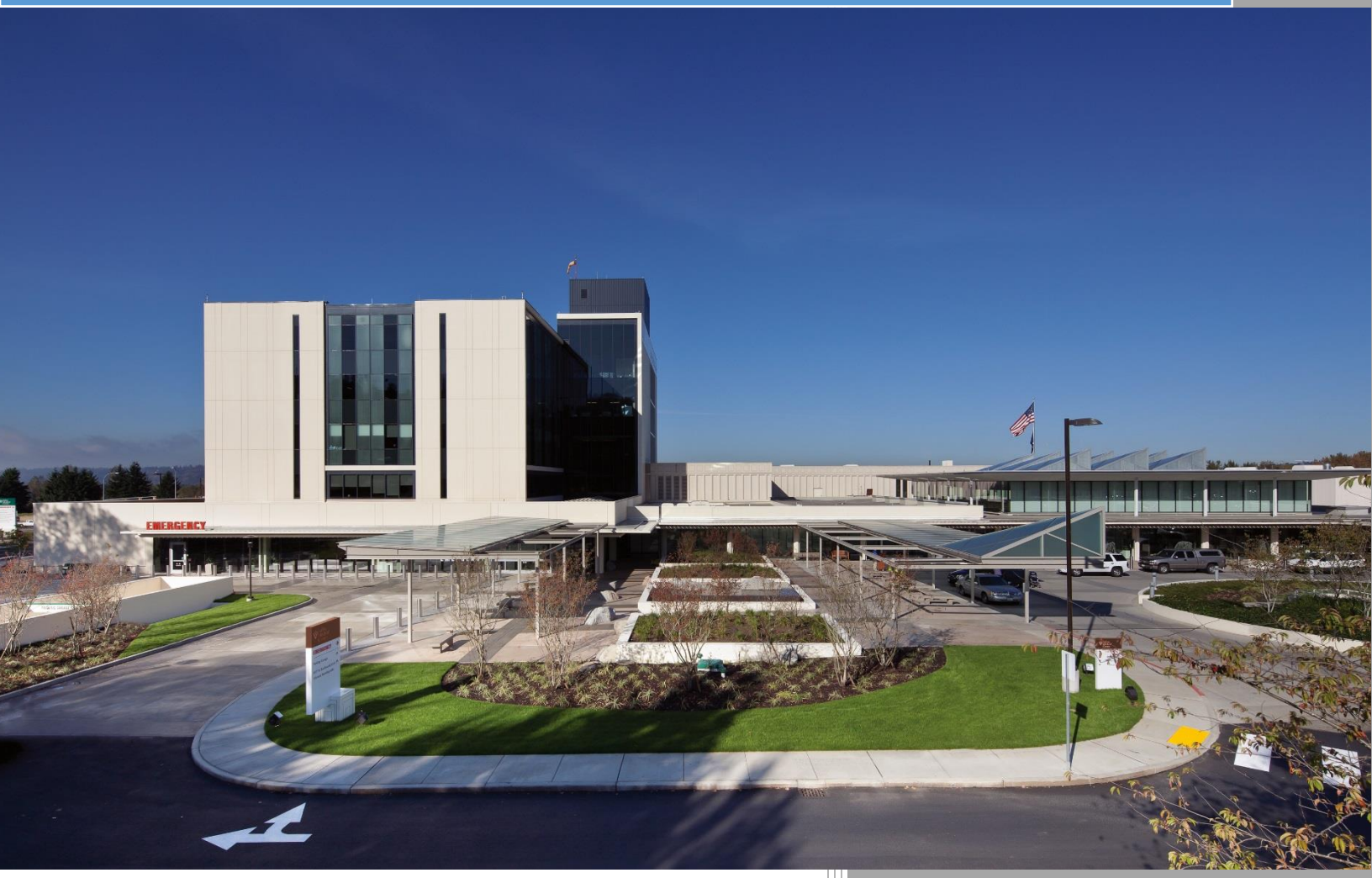
UW Medicine

VALLEY
MEDICAL CENTER

2017 Implementation Strategy



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Introduction

Valley Medical Center conducted a Community Health Needs Assessment (CHNA) in FY17 to assess the significant health needs in the communities served by the hospital. Valley Medical Center (VMC) is a 321-bed acute care hospital and clinic network that serves over 600,000 residents in South King County, Washington. VMC is a thriving medical center and the largest nonprofit health care provider between Seattle and Tacoma. Valley Medical Center is a component entity of UW Medicine, which includes Harborview Medical Center, Northwest Hospital & Medical Center, UW Medical Center, UW Neighborhood Clinics, UW Physicians, UW School of Medicine and Airlift Northwest.

The CHNA and the resulting Implementation Strategy identify and address significant community health needs and help guide the hospital's community health programs and community benefit activities. This Implementation Strategy explains how Valley Medical Center plans to address the selected priority health needs identified by the CHNA.

2017 Community Health Needs Assessment

The CHNA reviewed secondary data available from national, state and local resources to provide a snapshot of health in the hospital service area. These data were compared against benchmark data from the county and the state, and Healthy People 2020 Objectives, when available. Valley Medical Center participated in a collaborative process for the Community Health Needs Assessment as part of the King County Hospitals for a Healthier Community (HHC). HHC is a collaborative of 12 hospitals and health systems in King County and Public Health-Seattle & King County. The HHC members joined together to identify important health needs and assets in the communities they serve. In addition, VMC also conducted a survey to gather information and opinions from community residents and persons who represent the broad interests of the community served by the Hospital. From January 20 through February 3, 2017, 291 persons responded to the survey. The survey was available in an electronic format and the hospital distributed the survey link to community residents and to leaders and representatives of medically underserved, low-income, immigrant and minority populations, and regional, and public health agencies that have "current data or other information relevant to the health needs of the community served by the hospital facility."

Definition of the Community Served

Valley Medical Center is located at 400 South 43rd Street, Renton, Washington 98055. The service area comprises portions of King County and includes 19 ZIP Codes, representing 7 cities or communities.

Valley Medical Center Service Area

City/Community	ZIP Code
Auburn	98001
Auburn	98002
Auburn	98092
Bellevue (Newcastle / Factoria)	98006
Black Diamond	98010
Kent	98030
Kent	98031
Kent	98032
Kent (Covington)	98042
Maple Valley	98038
Maple Valley	98051
Renton	98055
Renton (Newcastle)	98056
Renton	98057
Renton	98058
Renton	98059
Seattle (SeaTac)	98188
Seattle (Tukwila)	98168
Seattle (Tukwila)	98178

The service area for Valley Medical Center includes 567,415 residents. Children and youth, ages 0-19, make up 27% of the population; 62.2% are adults, ages 20-64; and 10.8% of the population are seniors, ages 65 and over. The majority population in the Valley Medical Center service area identifies as White/Caucasian (55.2%), with 16.5% of the population identifying as Asian, 12.3% of the population as Hispanic/Latino, and 8.4% of the population as Black/African American. Individuals identifying as multiracial (two-or-more races) make up 5.2% of the population, while Native Hawaiian/Pacific Islanders are 1.4%, and American Indian/ Alaskan Natives are 0.9% of the population. In the service area, 69.4% of the population 5 years and older speak English only in the home, 12.3% speak an Asian/Pacific Islander language and 8.9% speak Spanish in the home.

The unemployment rate in the hospital service area, averaged over 5 years, was 8.3%; higher than King County (5.0%) and the state rate (5.6%). Among the residents in the service area, 13.3% are at or below 100% of the federal poverty level (FPL) and 28.4% are at 200% of FPL or below. Educational attainment is a key driver of health. In the hospital service area, 11.1% of adults 25 and over lack a high school diploma; 39.7% have a college degree. Health insurance coverage is considered a key component to ensure access to health care and 86.0% of the population in the Valley Medical Center service area has health insurance.

Significant Health Needs

The 2017 CHNA identified significant health needs from a review of the primary and secondary data. These needs included:

- Access to health care
- Chronic diseases (asthma, cancer, diabetes, heart disease)
- Economic insecurity
- Food insecurity
- Housing/homelessness
- Mental health
- Overweight/obesity
- Preventive practices (screenings, vaccines)
- Smoking
- STI/HIV

The following criteria were used by the VMC Board of Directors to determine which significant health needs the hospital will address in the Implementation Strategy:

- Organizational Capacity: There is capacity to address the issue.
- Established Relationships: There are established relationships with community partners to address the issue.
- Ongoing Investment: Existing resources are committed to the issue. Staff time and financial resources for this issue are counted as part of our community benefit effort.

Based on these criteria, VMC selected the following priority needs to focus on in the 2017 – 2019 Implementation Strategy:

- Access to care
- Mental and behavioral health
- Chronic conditions and preventive care (includes overweight/obesity and smoking)
- Family and social support

Access to Care

Goal

Increase access to care for those with unmet medical needs.

Key Valley Medical Center Resources

- Financial Advocacy Program
- Medicaid
- Safety Net Services
- Clinic Network

Key Partner Resources

- FD Cares
- Federally Qualified Health Centers
- Jefferson Terrace Medical Respite
- King County Public Health
- RotaCare and Project Access Northwest
- Telelanguage

Strategies

Provide **enrollment assistance** in the expanded Medicaid Program and health exchanges to help increase access to care. VMC is committed to assist patients with their HIX premiums when needed and financial advocacy services are provided at no cost to the patient.

Continue to **accept Medicaid** patients at a time when most health systems are limiting or closing their panels to Medicaid, particularly in the clinic setting. Across the VMC system we continue to see our Medicaid use rise and self-pay decline. As a result, VMC will aggressively **recruit new providers** to help meet the increased demand and broaden access to care across our service area.

While health care reform has lessened the demand for **RotaCare Free Clinic** services, it has not ended entirely. The clinic will continue to serve those who have no other provider through volunteer clinical staff and funding in partnership with Renton Rotary. Through RotaCare we will focus on providing health care and resources for the homeless.

Provide support to **Project Access Northwest**, which facilitates chronic/advanced care referrals from RotaCare and other safety net clinics for donated services ranging from joint replacement surgery and advanced MRI, to outpatient wound care and physical therapy.

VMC has committed multi-year funding for the **Medical Respite Program** at Jefferson Terrace, a 34-bed transitional unit for homeless patients with ongoing medical needs. VMC makes patient referrals to Jefferson Terrace where the center provides vital medical, social and housing assistance.

GRANT OPPORTUNITY

King County Public Health: Healthcare for the Homeless

Anticipated Impact

VMC anticipates the following impact from these efforts:

- Provide financial assistance to qualified patients.
- Increase availability and access to primary and specialty health care.
- Provide health care and coordination of resources for the homeless and underserved.

Mental and Behavioral Health

Goal

Increase access to mental and behavioral health care resources and services.

Key Valley Resources

- VMC's Psychiatric & Counseling Center
- Clinic Network Screening & Behavioral Health Integrated into Primary Care Program
- ER Intervention Team Counselors
- Inpatient area for transitioning patients

Key Partner Resources

- Mental Health Housing Foundation
- Renton Area Youth & Family Services: Pediatric Behavioral Health
- Sound Mental Health
- Valley Cities: Behavioral Health & Opioid Treatment

Strategies

VMC's Clinic Network will offer the **Behavioral Health Integration Program (BHIP).** BHIP will integrate physical and behavioral health and provide a clinic-based mental health clinician available to patients and providers, in person and over the phone. This program will serve patients with mild or moderate depression, anxiety and related problems. More complex issues will be referred to VMC's Psychiatry & Counseling Clinic.

Depression Clinical Practice Guidelines and Screening are instituted throughout the Clinic Network. We will use standardized referral protocols for identification and treatment, which help identify at-risk patients before a tragic event occurs.

VMC's Pediatric Unit will provide dedicated **inpatient behavioral health support services** for the urgent needs of the pediatric behavioral health population who are awaiting transfer to a psychiatric inpatient facility. The General Medical Floor will provide similar services for the adult population. Our goal is to transition care out of the Emergency Department, while providing a safe environment and social work assistance for patients with behavioral health concerns.

VMC's Psychiatry & Counseling Clinic (PCC) is one of the largest psychiatric groups in the state with 18 providers who offer psychiatry and counseling, and who help connect patients to needed resources not provided within the PCC clinic.

Partner with **Renton Area Youth Services** embedded in Children's Therapy to provide valuable behavioral health resources to the underserved pediatric population.

Offer the **Suicide Prevention Screen** as part of the intake pathway for all patients (ER and inpatient) with automatic consult to/follow-up by social services following the standards determined by national guidelines.

Explore partnership and training opportunities with Valley Cities related to **Suboxone Therapy**.

Anticipated Impact

VMC anticipates the following impact from these efforts:

- Increase awareness and treatment of mental health and behavioral health issues.
- Increase access to available mental and behavioral health services and resources in the community.
- Improve the care of persons with mental and behavioral health issues.

Management of Chronic Conditions & Preventive Care

Goal

Reduce the impact of chronic diseases on health and increase the focus on prevention and treatment education.

Key Valley Resources

- Clinic Network: RN Care Management Team, Eye Clinic, Rehabilitation Services
- Lifestyle Medicine Center: Healthy Foundations, Diabetes Education, Cardiac and Pulmonary Rehabilitation
- Community Outreach Screening Program

Key Partner Resources

- FD Cares
- Hope Heart Institute
- Kent Fire Department
- Renton Technical College
- Safe Kids
- YMCA

Strategies

RN Care Managers will be embedded in primary care clinics to provide individualized care planning and coordination and a resource to advocate for patient needs and resources.

The **Lifestyle Medicine Center** will offer services to improve the health of chronically ill populations and prevent disease.

Offer comprehensive **Diabetes Education** with dedicated Certified Diabetes Educators who provide 1:1 counseling and group education.

Offer Phase II **Cardiac and Pulmonary Rehab** programs to help those who have suffered a cardiac or pulmonary event return to better function and prevent recurrent health issues. Enhance programs with nutrition, physical therapy and exercise.

Offer support groups that give patients and their caregivers added resources, fellowship and education:

- **Better Breathers Club** for those who suffer from asthma/COPD
- **Stroke Club** and **Neurotango** classes
- **Cancer Lifeline** classes and support groups
- **Celiac Disease/Gluten Intolerance** group
- Pre-diabetes group support in partnership with the **YMCA**

Continue the **FD Cares Program** in partnership with the Kent Fire Department. Provide capital and clinical support for the program, which provides non-emergent and chronic medical services to help reduce unnecessary and costly 9-1-1 calls and ED visits.

Participate in **Emergency Department Information Exchange.** This is a web-based communication technology enabling intra- and inter-emergency department communication. It assists clinicians to identify patients who visit the ED more than five times in a 12 month period or patients with complex care needs so they can be directed to the right care setting.

Provide **four outreach programs** for the community that benefit students in grades K-12.

- Trauma Nurses Talk Tough
- A Day in the ED
- Career Fairs
- Safety Events

These programs were created with the belief that if we can *prevent* an injury, young lives can be saved. These programs feature stories of action and consequence with real children and their families and the choices they made that resulted in injury.

Pilot a **Health Coach Program** in collaboration with Renton Technical College (RTC). Program mentors (a.k.a. health coaches) will be trained to build trust with and motivate high-risk patients to cultivate positive health choices and treatment adherence during visits to the patients; homes. Patients will be enrolled and matched with a VMC health facilitator and a registered nurse (RN) care manager at the pilot clinic.

Continue work initiated during the **Community Transformation Grant** and **Healthier Hospital Initiative** to further improve healthy nutrition and beverage options across the VMC system.

Offer **free BMI screening** and referral at local events through our community outreach program.

Focus efforts on **tobacco cessation:**

- **Smoking status added as an additional "vital sign"** and status asked upon check-in throughout the Clinic Network prompting providers to address it with their patients at every visit.
- Valley Medical Center is a **tobacco-free workplace**.

Provide **free and low-cost exercise and nutrition education**:

- **BodyWorks** is a free eight-week program designed to provide parents and caregivers of young people ages 9 to 16 with tools to improve family eating and activity habits and prevent obesity.
- **Healthy Foundations** provides up-to-date education about healthy food choices and addresses lifestyle modification and readiness to change.

Continue **wellness programming** through dedicated community engagement membership programs: GLOW, GoldenCare, Pitter Patter, and Lifestyle Medicine & Fitness Center:

- Free screenings for BMI, blood pressure, blood glucose
- Free health and wellness education focused on nutrition and exercise
- DocTalks by providers who specialize in stroke care, diabetes, obesity, nutrition, exercise, heart disease and oncology

Increase the reach of **F.A.S.T. Stroke Awareness Campaign** to teach the community about signs and symptoms of stroke to improve emergency response time.

Continue enrollment in the **Vaccines for Children Program**, a federal program that provides vaccines at no cost to children who might otherwise not be vaccinated.

Screen all patients through VMCs **Fall Prevention Program** and offer testing to determine mobility and prevent further injury.

Offer **Period of Purple Crying** program to help parents understand why their babies might be crying and assist them with de-escalation techniques to help prevent child abuse.

Continue partnership with **Safe Kids** to help parents avoid putting their baby at risk of injury or accident.

Expand **primary care intake assessment** to include questions about seat belt use, alcohol consumption and distracted driving.

Participate in the **Washington Immunization Information System** (formerly Child Profile) to help ensure patients of all ages get the vaccination coverage they need. Provide free educational resources to families.

Offer a robust **community outreach program** in partnership with community organizations to provide free and low-cost health screenings, including blood pressure, blood glucose and BMI.

Continue to promote health education and the benefits of annual screening through **e-publications, MyChart, DocTalks, health fairs** and other vital awareness events.

Secure grant funding in partnership with Hope Heart Institute to expand free **Heart Health Month screenings** into more schools, businesses and faith based institutions. Launch a pilot for the Heart Health Ambassador Program throughout high schools in Renton to engage students in advocating for heart health with their friends and family members.

Participate in the **South King County Health Fair**, which provides free health screenings and health resources as well as free dental screenings and treatment for the homeless and other vulnerable populations within our hospital district.

GRANT OPPORTUNITIES

- Health Coach Program in partnership with Renton Technical College
- Prehospital stroke assessment
- Lung Cancer Screening Program for un/underinsured
- Healthy Heart Ambassador & Screening Program in Local Schools in partnership with Hope Heart Institute

Anticipated Impact

VMC anticipates the following impact from these efforts:

- Increase the identification and treatment of chronic disease.
- Increase public awareness of chronic disease prevention.
- Increase individuals' compliance with chronic disease prevention and management recommendations.
- Decrease injuries and accidents as a result of preventive education and screening.

Family and Social Support

Goal

Increase access to needed support systems to assist with navigation of the health care system.

Key Valley Resources

- Case Management
- RN Care Management Program
- Palliative Care
- ED Intervention Team
- Chaplaincy Program

Key Partner Resources

- DSHS and Child/Adult Protective Services
- Hopelink and Access Transportation
- Housing Authorities and DESC (Emergency Housing)
- Interpreter Resources

Strategies

Provide **Emergency Department Intervention Team** to help patients and family members cope with serious crises, assaults, mental health issues, and provide information on available community resources. Expand services to 24/7.

Embed Case Management in the ED to facilitate a more synchronized plan of care across the care team.

Expand **Palliative Care** program to the outpatient setting. This will provide continuity of care and improve quality of life for patients and families trying to manage the symptoms and stress of a serious illness.

With launch of **telehealth services**, evaluate options to extend reach of support resources.

Anticipated Impact

VMC anticipates the following impact from these efforts:

- Improve coordination of care.
- Provide needed health care and support service resources.

Evaluation of Impact

Valley Medical Center will monitor and evaluate the programs and activities outlined above. The reporting process includes the collection and documentation of tracking measures. Examples include tracking the Preventive Composite, which includes screening referrals for mammogram, colonoscopy, cervical and pneumovax measures; tracking individual and population level immunization coverage; tracking diabetic eye exams and the Diabetes Composite, including screening for HgA1c, LDL and blood pressure; and monitoring smoking cessation efforts as part of our Physician Quality Reporting System for CMS. An evaluation of the impact of the hospital's actions to address these significant health needs will be reported in the next scheduled Community Health Needs Assessment.

Needs the Hospital Will Not Address

Taking existing hospital and community resources into consideration, Valley Medical Center has chosen not to address the remaining health needs identified in the CHNA: economic insecurity, food insecurity, housing and STI/HIV. VMC cannot address all the health needs present in the community. Given finite and shrinking resources, VMC must focus on the areas where we have the greatest potential for impact that also aligns with our mission and prevents duplication of effort. Community partnerships and grants will be vital to filling the gaps VMC cannot independently address.