

2026 Community
Health Needs
**Implementation
Strategies**

SPARKS OF
POSSIBILITY

Contents

Introduction 2

Report Adoption, Availability & Comments..... 2

Overview: 2026 Community Health Needs Assessment 2

Definition of the Community Served 3

Significant Health Needs To Be Addressed 4

Our Approach..... 5

Implementation Strategies 6

Evaluation of Impact 8

Needs That Will Not Be Addressed 8

Introduction

Valley Medical Center & Clinics (Valley) is a 341-bed acute care, tax exempt hospital and clinic network committed to providing safe, quality, compassionate care since 1947. Valley is the oldest and largest public district hospital in the state of Washington, serving more than 625,000 residents across South King County.

Valley conducted a Community Health Needs Assessment (CHNA) in 2026 to assess the significant health needs in the communities served by the hospital. 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 plans to address the selected priority health needs identified by the CHNA.

Report Adoption, Availability & Comments

The Implementation Strategy was adopted by the Valley Medical Center Board of Trustees on October 19, 2026. The CHNA and related Implementation Strategies are widely available to the public on the hospital's website (website) and can be accessed at www.valleymed.org/about-us/promoting-health-in-our-community. To send comments or questions about this report, please [contact us](#).

Overview: 2026 Community Health Needs Assessment

Valley conducted a CHNA to comply with federal regulations guiding tax-exempt hospitals. The CHNA incorporated data collected from a variety of local, county, and state sources to present community demographics, social drivers of health, healthcare access, birth characteristics, leading causes of death, chronic disease, health behaviors, mental health, substance use, and preventive practices. The analysis of secondary data yielded a preliminary list of significant health needs, which then informed primary data collection.

Twenty-nine (29) stakeholder interviews were completed from January to March 2026. Interview participants included a broad range of stakeholders concerned with health and well-being in King County, with a focus on South King County, who spoke to issues and needs in the community. Valley also conducted surveys with community residents to obtain input on health needs, barriers to care, and resources available to address the identified health needs; 1,745 community members completed this survey. In addition, Valley distributed a survey to community partner groups that work with the hospital to provide healthcare and social service resources to the community; 193 responses were collected from this survey.

Definition of the Community Served

Valley's hospital campus 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 & Clinics Service Area

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

The population of Valley's service area is 625,518. Children and youth, ages 0-17, make up 23.2% of the population; 63.4% are adults, ages 18-64; and 13.3% of the population are senior adults, ages 65 and older. Seniors 65+ are the fastest growing segment compared to the data in the prior CHNA. 45.9% of the population in the service area are non-Hispanic White or Caucasian residents; 20.3% are Asian residents; 14.8% are Hispanic or Latine residents; and 9.1% are Black or African American residents. Individuals identifying as multiracial (two or more races) make up 7.2% of the population. Native Hawaiian or Pacific Islander residents are 1.5% of the population, and American Indian or Alaskan Native residents are 0.6% of the population. Those who identify as a race and ethnicity not listed are 0.6% of the population. In the service area, 65% of the population, ages 5 years and older, speak only English in the home, 14.1% speak an Asian or Pacific Islander language, 9.8% speak Spanish, and 7.3% speak an Indo-European language.

The unemployment rate in the hospital service area, averaged over five years, was 5.4%. This is higher than King County (4.6%) and the state unemployment rate (5%). Among the residents in the service area, 8.5% are at or below 100% of the federal poverty level (FPL) and 20.3% are at or below 200% of FPL. Educational attainment is a key driver of health. In the hospital service area, 10.4% of adults, ages 25 and older, lack a high school diploma, which is higher than county and state rates. 36.9% of area adults have a bachelor's or higher degree, which is lower than county and state rates. Health insurance coverage is considered a key component to ensure access to healthcare, and 93.1% of the population in the Valley service area has health insurance. Kent (98032) has the lowest rate at 88.3%.

Significant Health Needs to Be Addressed

Initially, significant health needs were identified through a review of the secondary health data and validated through stakeholder interviews. The identified significant health needs in alphabetical order included:

Access to Healthcare	Housing Affordability and Homelessness
Birth Factors (e.g. preterm birth and infant mortality)	Intimate Partner Violence
Chronic Health Conditions (e.g. cancer, diabetes, heart disease, high blood pressure)	Mental and Behavioral Health
Food Insecurity	Preventive Care (e.g. screenings and immunizations)

The following criteria were used by Valley to determine the significant health needs the hospital will address in the Implementation Strategy:

- Organizational Capacity: There is capacity to address the issue.
- Established or Potential Relationships: There are established or potential 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, Valley will address access to care, chronic health conditions, mental and behavioral health, and the formalization of partnership infrastructure in the 2026-2029 Implementation Strategies.

Three-Year Progression: Addressing Identified Health Needs

YEAR 1: Map & Engage

- Identify and prioritize gaps
- Inventory effectiveness of existing programs and partners
- Establish/refine care navigation pathways
- Identify 5-8 anchor partners
- Establish baseline and success measures

YEAR 2: Reach & Expand

- Formalize the most successful partnerships
- Increase community-based screening/education
- Strengthen care navigation pathways
- Focus on populations and geographies with the greatest access gaps

YEAR 3: Measure, Improve & Sustain

- Evaluate outcomes
- Redesign or discontinue low-impact activities
- Expand on, and commit to, the most successful partnerships and strategies
- Use results to inform the 2029 CHNA

Our Approach

Valley has a strong community benefit infrastructure and community partner network for supporting communities and patients with vulnerabilities in areas like:

Financial advocacy	Diabetes education
Primary care/medical home	Lifestyle medicine
Care management	Social drivers of health screening and referral
Primary care-based behavioral health pathways	Language translation services and language access
Inpatient psychiatry	
Substance Use Disorder (SUD) navigation	

The results from our CHNA stakeholder interviews included clear guidance for more connected partnerships with community institutions and local governments. Therefore, Valley's Implementation Strategy is focused on increasing access by coordinating care and convening partners to fill critical gaps. To align with this approach and best impact the quantitative health data that underpins these strategies, we are prioritizing the following:

Priority 1: Access to Care

Improve access to healthcare by strengthening Valley's safety-net role, care navigation pathways, and connections to community-based care and resources.

Priority 2: Chronic Health Conditions

Reduce the burden of cancer, cardiovascular disease, and diabetes through prevention, early detection, effective disease management, and community partnerships.

Priority 3: Mental & Behavioral Health

Provide access to mental health and substance-use services through early identification, integrated care, low-barrier treatment, and stronger community connections.

Overarching Priority: Partnership Infrastructure

Use Valley's role as a public hospital and community anchor to convene partners, close gaps, and strengthen the South King County health ecosystem.

Community Health Needs Assessment: Implementation Strategies

	Priority Areas	Strategies	Key Tactics
1	Access to Care <i>OBJECTIVE</i> <i>Improve access to healthcare by strengthening Valley's safety-net role, care navigation pathways, and connections to community-based care and resources.</i>	1.1 Strengthen the community safety net through partnerships and trusted access points 1.2 Improve access to primary and specialty care 1.3 Enhance navigation pathways and transitions 1.4 Reduce barriers to care 1.5 Build access through education and meaningful connections	Develop more formal care pathways with Federally Qualified Health Centers (FQHCs), behavioral health providers, emergency/urgent care providers, community organizations, first responder and social-service agencies; prioritize warm handoffs and closed loops where feasible. - Continue to optimize clinic capacity, scheduling, provider recruitment, and availability. - Expand virtual care capabilities where possible. - Identify and work to close primary/specialty care gaps where community partnerships can extend access. - Provide navigation support through financial advocacy and care management programs. - Expand connections between the hospital/clinics and community-based services and resources. Prioritize warm handoffs and closed loops where feasible. Focus on the barriers Valley can most significantly influence: language access, health literacy, transportation, technology/digital access, and streamlining pathways to access care. Engage with age/cultural/faith-based organizations and schools to bring health education, screening, and navigation closer to residents.
2	Chronic Health Conditions <i>OBJECTIVE</i> <i>Reduce the burden of cancer, cardiovascular disease, stroke, and diabetes through education, prevention, early detection, effective disease management, and community partnerships.</i>	2.1 Create a partner network to strengthen prevention, early detection, and navigation efforts 2.2 Improve chronic disease management for high-risk patients across continuum 2.3 Create community pathways for diabetes prevention and management 2.4 Build a South King County cancer prevention and survivorship network	- Partner with community organizations to increase awareness about cancer screening, signs, symptoms, and when to seek care. - Enhance navigation process for abnormal screening results. - Expand community-based education about cardiovascular and stroke risk factors, including high blood pressure and cholesterol, smoking, and diabetes. - Partner with trusted community orgs to provide screening/educational events/resources. Develop a coordinated systems approach for high-risk patients accessing care across inpatient, outpatient, and community-based services, with specific focus on our highest mortality chronic health conditions (cancer, cardiovascular disease, stroke, and diabetes). - Connect community members with Diabetes Prevention Program, diabetes self-management education/tools, nutrition, physical activity, and lifestyle resources. - Collaborate with FQHCs and age/cultural/faith-based organizations to explore group-based educational opportunities. - Convene cancer-focused nonprofits to amplify the reach and impact of support group and survivorship resources. - Provide genetic/high-risk educational resources. - Connect patients with financial, transportation, and psychosocial resources.

3	Mental & Behavioral Health <i>OBJECTIVE</i> Improve access to mental health and substance-use services through early identification, integrated care, low-barrier treatment, and stronger community connections.	3.1 Strengthen behavioral health pathways	- Continue to optimize primary care-based behavioral health pathways and inpatient psychiatry as resources allow. - Further standardize screening and care escalation pathways. - Strengthen partnerships with community behavioral health organizations. - Improve the hospital-to-community behavioral health handoff.
		3.2 Strengthen substance-use treatment transitions	- Provide medication for opioid use disorder (MOUD) initiation where clinically appropriate. - Ensure patients leaving the hospital have a confirmed community care connection. - Develop shared care pathways with low-barrier SUD providers. - Explore community partnerships for peer-recovery.
		3.3 Strengthen suicide prevention, early intervention, and transition efforts	- Increase awareness of crisis and peer-support resources for youth and adults. - Utilize standardized depression and suicide screening across inpatient and outpatient settings. - Develop stronger community connections for those screening positive for suicide ideation.
4	Partnership Infrastructure <i>OBJECTIVE</i> Use Valley's role as a trusted public hospital and community anchor to convene partners, close gaps, and strengthen the South King County health ecosystem.	4.1 Establish more formalized partner network	Identify 5-8 anchor partnerships to support key identified health needs, such as: primary care, behavioral health/SUD, cancer, diabetes, cardiovascular health, aging community, navigation pathways and transitions, transportation, and/or social needs.
		4.2 Develop shared care transition pathways with the partner network	Create processes to ensure reliable continuum of care between hospital, clinics, and community services.
		4.3 Convene partners around specific gaps	Periodically convene partner network to problem-solve for patients and community members and move towards collective impact. Topics include, but are not limited to: ➤ Who is continuing to struggle with accessing services? ➤ Where are services being duplicated? ➤ What populations aren't being reached, and why? ➤ How can organizations complement each other's services?
		4.4 Use Valley's voice as a trusted public healthcare institution	- Champion health issues and gaps in care. - Collaborate and cultivate a network of advocates and convene conversations with key stakeholders and legislators with the goal of improving health and outcomes. - Measure and share collective impact.

Evaluation of Impact

Valley will monitor and evaluate the programs and activities outlined above, and anticipates the actions taken will help address priority health needs; improve health knowledge, behaviors, and outcomes; increase access to care; and help support good health for our community. Valley is committed to monitoring key initiatives to assess and document impact and collaborative efforts to address health needs. An evaluation of the impact of the hospital's actions to address these significant health needs will be reported annually and included in the next scheduled Community Health Needs Assessment in 2029.

Needs That Will Not Be Addressed

Taking community and stakeholder input and existing organizational and community-based resources into consideration, Valley has chosen to focus on areas where we have the greatest potential for impact that also align with our mission and prevent duplication of effort across the community. Therefore, economic insecurity, food insecurity, housing and homelessness, and intimate partner violence are not explicitly included in the Implementation Strategy priority areas, although many tactics in our high-priority areas overlap and we anticipate will create a positive impact in several of these areas. All of the social driver domains noted are screened for at the primary care level and at each hospital admission, services are provided and/or resources identified for the patient.