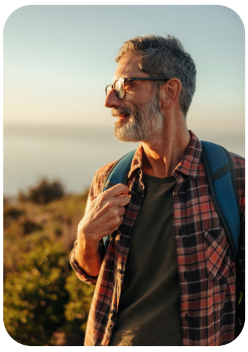

CARING

2023 Community Health Needs

Implementation Strategies

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Introduction

Valley Medical Center (Valley) is a 341-bed acute care, federally tax-exempt hospital and clinic network. Valley 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. Valley is the oldest and largest public district hospital in the State of Washington and serves more than 600,000 residents in South King County.

Valley conducted a Community Health Needs Assessment (CHNA) in FY2023 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 August 21, 2023. The report is widely available to the public on the hospital's web site 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.

2023 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, COVID-19, 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.

Fifteen (15) phone interviews were conducted with community stakeholders. Interview participants included a broad range of stakeholders concerned with health and wellbeing in the service area, who spoke about issues and needs in the communities served by the hospital. 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; 394 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; 18 responses were collected from this survey.

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 seven cities or communities.

Valley Medical Center 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 the Valley service area is 605,859. Children and youth, ages 0-19, make up 26% of the population; 61.6% are adults ages 20-64; and 12.4% of the population are seniors, ages 65 and older. 50.2% of the population in the service area are non-Hispanic White or Caucasian residents; 18.6% are Asian; 13.1% are Hispanic or Latine; and 9% are Black or African American. Individuals identifying as multiracial (two or more races) make up 6.2% of the population. Native Hawaiian or Pacific Islander residents are 1.5% of the population, and American Indian or Alaskan Native residents are 0.8% of the population. Those who identify as a race and ethnicity not listed are 0.6% of the population. In the service area, 66.8% of the population 5 years and older speak only English in the home, 13.5% speak an Asian or Pacific Islander language, 9% speak Spanish, 7.2% speak an Indo-European language, and 3.5% of the population speak some other language in the home.

The unemployment rate in the hospital service area (averaged over 5 years) was 4.8%: higher than King County (4.3%) and lower than the state (4.9%) unemployment rate. Among residents in the service area, 8.7% are at or below 100% of the federal poverty level (FPL) and 21.7% are at 200% of FPL or below (low-income residents). Educational attainment is a key driver of health. In the hospital service area, 10.1% of adults, ages 25 and older, lack a high school diploma; 44.6% have a college degree. 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.

Significant Health Needs the Hospital Will Address

The FY2023 CHNA identified significant health needs from a review of the primary and secondary data. These needs included:

- Access to healthcare
- Chronic health conditions
- Economic insecurity and financial assistance
- Food insecurity
- Housing and homelessness
- Intimate partner violence
- Mental health
- Overweight (healthy eating and active living)
- Preventive care (education, screenings, vaccines)
- Sexually transmitted infections (STI)
- Substance use (marijuana, illegal drugs, alcohol, tobacco)

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 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, Valley will address access to care, behavioral health (mental health and substance use) and chronic health conditions in the FY24 – FY26 Implementation Strategy.

Community Health Needs Assessment: Implementation Strategies

Priority Areas		Objectives	Strategies	Key Tactics
1	Access to Care	Valley is committed to maintaining and improving access to care by offering and partnering with community organizations to provide comprehensive, inclusive, quality healthcare services that are vital to promoting and maintaining health; preventing and managing disease; reducing unnecessary disability and premature death; and fostering health equity.	Provide services and programs aimed at improving access to care. Provide targeted outreach, activities and communication to help build and rebuild trust and relationships with key populations.	1.1 Financial Advocacy program 1.2 Clinic Network services 1.3 Safety net services 1.4 Reduce impact of social drivers of health 1.5 Access to clinical trials 1.6 Community partnerships
2	Behavioral Health	Valley is committed to providing behavioral health services and partnering with other community organizations that provide care and resources that support mental health and wellness.	Provide care for individuals with behavioral health and substance use disorders and/or work to connect patients with needed resources Valley does not offer. Support local and regional initiatives to promote mental health and wellness with focused efforts on diverse and vulnerable populations.	2.1 Psychiatry & Counseling Clinic 2.2 Behavioral Health Integration Program (BHIP) with primary care 2.3 Substance Use Disorder (SUD) initiatives 2.4 Depression & suicide screening 2.5 Inpatient psychiatry providers 2.6 Community education focused on mental wellness & available resources 2.7 Community connections through Health Coach program
3	Chronic Health Conditions	Valley is committed to reducing and preventing the occurrence and severity of preventable and chronic disease in South King County	Continue entity-wide initiatives and support regional efforts to prevent, screen, detect and treat chronic and	3.1 Health Facilitator & RN Care Management programs 3.2 Health Coach program

		through collaborative approaches that improve the network of services across our community. **KEY FOCUS AREAS**: Heart Disease & Stroke Cancer Diabetes Healthy Lifestyle	preventable diseases. Strengthen strategic collaborations between Valley and community-based organizations to improve regional wellness efforts.	3.3 Screening tools & surveys 3.4 Lifestyle medicine, diabetes management & prevention 3.5 Community education & wellness programs

ACCESS TO CARE

Objective: Valley is committed to maintaining and improving access to care by offering and partnering with community organizations to provide comprehensive, inclusive, quality healthcare services that are vital to promoting and maintaining health; preventing and managing disease; reducing unnecessary disability and premature death; and fostering health equity.

- **Strategy 1:** Provide services and programs aimed at improving access to care.
- **Strategy 2:** Provide targeted outreach, activities and communication to help build and rebuild trust and relationships with key populations.

Tactic 1.1: Financial Advocacy Program

- The Financial Advocacy team, available at no cost to the patient, is vital to improving access to care and health equity for the most vulnerable. Services include enrollment assistance in the Medicaid Program and Health Exchange, coordination of alternate funding sources such as grants and other patient assistance programs.

Tactic 1.2: Clinic Network Services

- Support initiatives through technology and process improvement that optimize provider availability.
- Offer advance care planning education and notary services so patients have access to medical treatment that is consistent with their values, preferences and goals, while removing elements of uncertainty and stress from loved ones who may have to make decisions on their behalf.
- Explore piloting palliative care support of local long-term care and skilled nursing facilities.
- Continue to be a primary care Patient-Centered Medical Home (PCMH) for patients throughout our community by achieving National Committee for Quality Assurance (NCQA) standards for a systematic, patient-centered, coordinated care model that supports access, communication, and patient involvement and builds partnerships between clinicians, patients and patients' families.
- Continue to expand reach and breadth of telehealth services understanding that access to technology (devices, education and internet service) can be barriers. Identify educational opportunities and/or partnerships to help reduce these barriers.

Tactic 1.3: Safety Net Services

- Continue to provide safety net pathway of services for patients through a continuum of care from prehospital/first responder network and Emergency Department/ER Intervention Team to discharge planning and medical respite.
- Work and collaboratively partner to better coordinate access to community-based services for discharging complex patients.
- Maintain comprehensive Thrombectomy-Capable Stroke Center certification.
- Continue to be a resource and advocate for identification and support of patients in crisis, often due to abuse, assault and/or sexual assault through the specialized ER Intervention Team and partner organizations.
- Continue and optimize the FD Cares Program created in partnership with the Renton Regional Fire Authority and HealthierHere to identify non-emergent and chronic medical needs and services to help reduce unnecessary and costly 9-1-1 calls/ED visits. The program identifies patients in need and offers follow-up services, social work assistance and referral to appropriate environments of care.

Tactic 1.4: Reduce Impact of Social Drivers of Health to Accessing Care

- Raise awareness among staff and patients about the availability of interpreter services.
- Identify key documents, channels and events that could improve awareness and access to care for non-English-speaking populations in our service area.

- Work to improve health literacy through our messaging, helping individuals obtain, process, and better understand basic health information needed to make appropriate health decisions.
- Engage with ethnically and racially diverse community organizations to understand the unique needs and barriers to accessing care for their constituents and members.
- Offer support programs, services and outreach initiatives that enhance and foster health equity.
- Champion the standards associated with Health Equality Index Leader in Healthcare Equality.
- Network with local transport and housing agencies to help patients with these barriers to care.
- Continue to promote and expand listing of services available through ValleyCares, an online resource focused on supporting self-service access to community-based resources specific to social drivers of health.
- Prioritize inclusivity and a sense of belonging. Continue to train staff on the respective needs of individual populations by providing resources, education and tools that bring awareness to the highest priority groups and gaps identified by the Community Health Needs Assessment.

Tactic 1.5: Access to Clinical Trials

- Continue to support enrollment in clinical trials that offer cutting edge treatment for patients in our community who would otherwise not have access to potentially life-saving or life-prolonging treatment.

Tactic 1.6: Community Partnerships

- African Americans Reach & Teach Health
- American Heart Association
- Be the Match
- Bloodworks Northwest
- Cancer Lifeline
- Communities in Schools
- Consejo Counseling
- FD Cares
- Gurudwara Temple of Washington
- HealthierHere
- HealthPoint
- Hopelink
- Indian American Community Services of Washington (IACS)
- Pacific Islander Community Association of Washington (PICAWA)
- Kent Cultural Diversity Initiative
- Kent Food Bank
- LifeCenter Northwest
- LifeNet Health
- Mother Africa
- Multi-Service Center
- SeaMar SUD Low Barrier Clinic
- SOS Emergency Feeding Program
- Ukrainian Community Center
- United Territories of Pacific Islanders Alliance (UTOPIA)
- Valley Cities
- Valley Girls & Guys
- Vine Maple Place
- YMCA
- YWCA
- Others

BEHAVIORAL HEALTH

Objective: Valley is committed to providing behavioral health services and partnering with other community organizations that provide care and resources that support mental health, substance use treatment and wellness.

- **Strategy 1**: Provide care for individuals with behavioral health and substance use disorders and/or work to connect patients with needed resources Valley does not offer.
- **Strategy 2**: Support local and regional initiatives to promote behavioral health and wellness with focused efforts on diverse and vulnerable populations.

Tactic 2.1: Psychiatry & Counseling Clinic (PCC)

- Valley's PCC offers psychiatry and counseling services and helps connect patients with needed resources. Demand is much greater than capacity, so it is vital to continue collaboration with community providers.

Tactic 2.2: Behavioral Health Integration Program (BHIP) with Primary Care

- BHIP integrates physical and behavioral health, providing mental health clinicians (in person and over the phone) for primary care patients. Valley will continue to offer and evolve the BHIP program, which serves patients with mild or moderate depression, anxiety and related problems.

Tactic 2.3: Substance Use Disorder (SUD) Initiatives

- Evaluate and implement best practices in SUD care, education and support with a focus on low-barrier access and partnership/training opportunities with other local organizations.

Tactic 2.4: Depression & Suicide Screening

- Use of Depression Clinical Practice Guidelines utilizing standardized referral protocols for identification and treatment to help identify at-risk patients before a tragic event occurs.
- Continue offering Suicide Prevention Screen as part of the intake pathway for all patients age 10 and above (ER and inpatient) with consult to/follow-up with social services, as appropriate.

Tactic 2.5: Inpatient Psychiatry Services

- Continue to offer inpatient psychiatry services across our acute care units, providing an invaluable service for a community with limited access to this resource.

Tactic 2.6: Community Education Focused on Mental Wellness & Available Resources

- Leverage support materials and other tools to educate, gather valuable data that can impact and guide medical care, and improve the overall health of the patient.
- Explore creating a community-focused health & wellness podcast with members of Valley's well-being committee.
- Continue to create and distribute mental health resources through Valley's communication channels.

Tactic 2.7: Community Connections Through Health Coach Program

- New in 2023, offer this free service that supports patients coping with loneliness and social isolation by connecting them to resources in the local community. Trained volunteers, supported and mentored by a Registered Nurse and Licensed Social Worker, are available to visit patients remotely or in person.

CHRONIC HEALTH CONDITIONS

Objective: Valley is committed to reducing and preventing the occurrence and severity of preventable and chronic disease in South King County through collaborative approaches that improve the network of services across our community.

KEY FOCUS AREAS - Heart disease, stroke, cancer, diabetes and healthy lifestyle

- **Strategy 1**: Expand entity-wide initiatives and support regional efforts to prevent, screen, detect and treat chronic and preventable diseases.
- **Strategy 2**: Strengthen strategic collaborations between Valley and community-based organizations to improve regional wellness efforts.

Tactic 3.1: Health Facilitators & RN Care Management Program

- Continue to offer health facilitation and RN Care Management for high-risk empaneled patients who need home-based education, assistance monitoring their conditions and help navigating barriers to care.
- Provide post-discharge follow-up for patients at highest risk with conditions such as chronic obstructive pulmonary disease (COPD), congestive heart failure (CHF), sepsis, etc.

Tactic 3.2: Health Coach Program

- Free personalized health coaching. Supports patients in defining health-related goals, provides guidance on improving communication with primary care provider, provides health education and advocacy in navigating the healthcare system, encourages positive lifestyle changes.

Tactic 3.3: Screening Tools & Surveys

- Providers will use available care pathways in ambulatory, inpatient and ED care settings, and use screening tools/surveys to impact and guide medical care known to increase quality outcomes and improve the overall health of the patient.

Tactic 3.4: Lifestyle Medicine, Diabetes Management & Prevention

- Continue to offer comprehensive options for Diabetes Self-Management and Education with Certified Diabetes Educators who provide 1:1 counseling and group community education.
- Partner with community-based organizations who offer a Diabetes Prevention Program and other diabetes support programs.

Tactic 3.5: Community Education & Wellness Programs

- Create health resources and education to share across various channels, including DocTalks, webinars, newsletters, support groups and classes.
- Develop, implement and monitor clinical care pathways for diabetes, high blood pressure and stroke management.

Evaluation of Impact

Valley Medical Center will monitor and evaluate the programs and activities outlined above. The hospital anticipates the actions taken to address priority health needs will improve health knowledge, behaviors, and status; increase access to care; and help support good health. The hospital is committed to monitoring key initiatives to assess impact and has implemented a system to track activities and document anticipated impact. Our reporting process includes the collection and documentation of tracking measures, such as the number of people served 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 in the next scheduled Community Health Needs Assessment.

Needs the Hospital Will Not Address

Taking existing organizational and community-based resources into consideration, Valley has chosen not to address the remaining health needs identified in the CHNA (although many tactics in our high priority areas do overlap and we anticipate will create a positive impact in several of these areas): economic insecurity, food insecurity, housing and homelessness, intimate partner violence, overweight (healthy eating and active living), and STIs. Valley cannot address all the health needs present in the community and must focus on areas where we have the greatest potential for impact that also align with our mission and prevent duplication of effort. Additionally, community organizations and partnerships fill the gaps Valley cannot independently address.