Community Health Needs

IMPLEMENTATION STRATEGIES

2020

UW Medicine | VALLEY MEDICAL CENTER

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Contents

Introduction

Valley Medical Center conducted a Community Health Needs Assessment (CHNA) in FY20 to assess the significant health needs in the communities served by the hospital. Valley Medical Center (Valley) is a 341-bed acute care hospital and clinic network that serves over 600,000 residents in South King County, Washington. Valley is a component entity of UW Medicine and is the oldest and largest public district hospital in the State of Washington.

The CHNA and the resulting Implementation Strategies 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. The Implementation Strategy was adopted by the Valley Medical Center Board of Trustees on October 19, 2020. This report is widely available to the public on the hospital's web site, https://www.valleymed.org/About-Us/Financial-Information/. Written comments can be submitted to Liz Nolan at liz_nolan@valleymed.org.

2020 Community Health Needs Assessment

Secondary and primary data were collected to complete the Community Health Needs Assessment (CHNA). Secondary data were collected from a variety of local, county and state sources to present community demographics, social determinants of health, health care access, birth characteristics, leading causes of death, chronic disease, health behaviors, mental health, substance use and misuse and preventive practices. The analysis of secondary data yielded a preliminary list of significant health needs, which then informed primary data collection.

Primary data were obtained through surveys with 33 community partner stakeholders, public health, and service providers, members of medically underserved, low-income, and minority populations in the community, and individuals or organizations serving or representing the interests of such populations, and 126 surveys from community residents. The primary data collection process was designed to validate secondary data findings, identify additional community issues, solicit information on disparities among subpopulations, ascertain community assets potentially available to address needs and discover gaps in resources.

The CHNA was adopted by the Valley Medical Center Board of Trustees on May 14, 2020. This report is widely available to the public on the hospital's web site, https://www.valleymed.org/About-Us/Financial-Information/. Written comments on this report can be submitted to Liz Nolan, Vice President of Marketing, Outreach & Wellness at liz_nolan@valleymed.org.

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 588,774 residents. Children and youth, ages 0-19, make up 26.2% of the population, 62.3% are adults, ages 20-64, and 11.5% of the population are seniors, ages 65 and over. The majority population in the Valley Medical Center service area identifies as White/Caucasian (53.6%), with 17.4% of the population identifying as Asian, 12.5% of the population as Hispanic/Latino, and 8.5% of the population as Black/African American. Individuals identifying as multiracial (two-or-more races) make up 5.6% of the population, while Native Hawaiian/Pacific Islanders are 1.3%, and American Indian/ Alaskan Natives are 0.9% of the population. In the service area, 68.6% of the population, 5 years and older, speak English only in the home, 13% speak an Asian/Pacific Islander language and 8.8% speak Spanish in the home.

The unemployment rate in the hospital service area, averaged over 5 years, was 5.7%; higher than King County (5.0%) and lower than the state unemployment rate (6%). Among the residents in the service area, 10.9% are at or below 100% of the federal poverty level (FPL) and 25.8% are at 200% of FPL or below. Educational attainment is a key driver of health. In the hospital service area, 10.6% of adults, ages 25 and older, lack a high school diploma; 42.3% have a college degree. Health insurance coverage is considered a key component to ensure access to health care and 91.1% of the population in the Valley Medical Center service area has health insurance.

Significant Health Needs the Hospital Will Address

The 2020 CHNA identified significant health needs from a review of the primary and secondary data. These needs included:

- Access to health care
- Chronic disease management (heart disease, cancer, stroke, diabetes, lung disease)
- Disease prevention (health education, health screenings, vaccines, fall prevention)
- Economic insecurity
- Food insecurity
- Housing and homelessness
- Loneliness/isolation
- Mental health
- Physical or sexual abuse
- Sexually transmitted infections
- Substance use and misuse
- Weight management/obesity

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

- Organizational Capacity: There is capacity to address the issue.
- Established & Available Relationships: There are established and available relationships with community partners to help 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 disorders and disease prevention in the 2020 – 2022 Implementation Strategies.

Community Health Needs Assessment: Implementation Strategy Overview

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Priority Areas		Objective	Strategies	Key Tactics
1	Access to Care	Valley will help lead efforts in South King County and partner with community organizations to provide access to comprehensive, quality healthcare services that are vital to promoting and maintaining health; preventing and managing disease; reducing unnecessary disability and premature death; and achieving health equity.	Expand entity-wide initiatives and support regional efforts to improve access to comprehensive, quality services focused on improving the health of the public. Strengthen strategic collaborations between Valley and community health providers to improve the regional health safety net of care.	1.1 Financial Advocacy Program 1.2 Clinic Network Services 1.3 Safety Net Services: Pre-hospital, Emergency Department, ERIT Team, Discharge Planning & Medical Respite 1.4 Reduce Social Determinant Barriers to Accessing Care 1.5 Community Partnerships
2	Behavioral Health Disorders	Valley will expand its network of mental and behavioral health services and partner with other community organizations to provide care for individuals with behavioral health disorders.	Expand entity-wide services and collaborations to assess and address mental health, behavioral health disorders and opioid overuse. Strengthen the regional network of care for individuals with mental health and substance use disorders. Support local and regional initiatives to promote mental health and wellness across the lifespan with focused efforts on diverse and vulnerable populations.	2.1 Psychiatry & Counseling Clinic 2.2 Behavioral Health Integration Program with Primary Care 2.3 Medication for Opioid Use Disorder (MOUD) Program 2.4 Screening & Brief Intervention Tools 2.5 Emergency Department & Inpatient Support 2.6 Community Wellness Outreach 2.7 Community Partnerships
3	Disease Prevention	Valley is committed to reduce and prevent the occurrence and severity of preventable and chronic	Expand entity-wide initiatives and support regional efforts to prevent,	3.1 Ambulatory Care Management Program 3.2 Screening Tools & Surveys

		disease in South King County through collaborative approaches that improve the network of services across our community. KEY FOCUS AREAS: Heart disease & stroke Cancer COVID Diabetes Healthy lifestyle	screen, detect and treat chronic and preventable diseases.	3.3 Diagnostic Screening 3.4 Lifestyle Medicine & Diabetes Management/Prevention 3.5 Wellness Outreach Programs 3.6 Positively Impact Social Determinant Barriers to Prevention & Wellness 3.7 Community Partnerships
			Strengthen strategic collaborations between Valley and community-based organizations to improve regional wellness efforts.	
			Support local and regional initiatives to promote health and wellness across the lifespan with focused efforts on diverse and vulnerable populations.	

Valley will implement these activities and programs to address the priority needs in our service area. Given the current unprecedented times as a result of COVID-19, Valley anticipates some plans may be modified due to urgent community needs and situational restrictions that may limit how community-based organizations are able to support the health and wellbeing of at-risk individuals and families in the service area.

ACCESS TO CARE

Objective 1: Valley will help lead efforts in South King County and partner with community organizations to provide access to comprehensive, quality healthcare services that are vital to promoting and maintaining health; preventing and managing disease; reducing unnecessary disability and premature death; and achieving health equity.

- Expand entity-wide initiatives and support regional efforts to improve access to comprehensive, quality services focused on improving the health of the public.
- Strengthen strategic collaborations between Valley and community health providers to improve the regional health safety net of care.

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. We anticipate COVID will further increase this need and will work diligently to meet the growing demand.

Tactic 1.2: Clinic Network Services

- Support initiatives that increase provider availability.
- Continue COVID+ RN Care Management Support Services.
- Provide COVID-19 evaluation and testing in concert and coordination with King County Public Health. Evaluate and determine plan for COVID-19 vaccination program.
- 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.
- 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.
- Expand reach and breadth of telehealth services. Understand 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: Pre-hospital, Emergency Department, ERIT Team, Discharge Planning & Medical Respite

- Continue to provide safety net pathway of services for all through a continuum of care from pre-hospital/first responder network and Emergency Department/ERIT to discharge planning and medical respite.
- 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 and ED visits. The program identifies patients in need and offers follow-up services, social work assistance and alternate referral to appropriate environments of care.

Tactic 1.4: Reduce social determinant barriers to accessing care such as language translation, transportation and health equity disparities.

- Continue to provide telelanguage translation services free of charge for any patient or family who could experience language as a barrier to care.
- Identify key documents and explore channels that could improve awareness and access to care for non-English-speaking populations in our service area.
- Engage with ethnically and racially diverse community organizations to understand the unique needs and barriers to accessing care for their constituents and members.
- Support programs, services and outreach initiatives that develop and promote health equity.
- Champion the standards associated with Health Equality Index Leader in Healthcare Equality.
- Network with local transport agencies and programs to help patients with this barrier access the care they need.

Tactic 1.5: Community Partnerships
Access Transportation
Advance Care Registries
Consejo
Domestic Abuse Women's Network (DAWN)
FD Cares
Federally Qualified Health Centers (FQHCs)
Grantors
Health Equality Index
HealthierHere
HealthPoint
Honoring Choices PNW
Hopelink
King County Public Health
King County Sexual Assault Resource Center
Medical Respite
National Committee for Quality Assurance (NCQA)
Renton Regional Fire Authority
SeaMar
Telelanguage
Washington Health Exchange
Washington State Hospital Association
Others to be determined.

Monitoring/Evaluation Approach

- Quarterly and Annual CHNA Implementation Strategy Review
- Annual Community Benefit Gratitude Report
- Monitoring and trending of health screening tools and composites
- Maintain quality certifications and standards of excellence

BEHAVIORAL HEALTH DISORDERS

Objective 2: Valley will expand its network of mental and behavioral health services and partner with other community organizations to provide care for individuals with behavioral health disorders.

- Expand entity-wide services and collaborations to assess and address mental health, behavioral health disorders and opioid overuse.
- Strengthen the regional network of care for individuals with mental health and substance use disorders.
- Support local and regional initiatives to promote mental health and wellness across the lifespan with focused efforts on diverse and vulnerable populations.

Tactic 2.1: Psychiatry & Counseling Clinic (PCC)
VMC's PCC is one of the largest psychiatric groups in the state, offering psychiatry and counseling services and helping connect patients with needed resources not provided within the PCC clinic. Demand is much greater than capacity, so it will be vital to create a network of support between PCC, BHIP and community providers. Build on early successes with the tele-psych program to help increase the reach and access to services and support.

Tactic 2.2: Behavioral Health Integration Program (BHIP)
BHIP integrates physical and behavioral health providing a clinic-based mental health clinician available to patients and providers, in person and over the phone. Valley will continue to offer and explore options to expand and evolve the BHIP program, which serves patients with mild or moderate depression, anxiety and related problems. More complex issues are referred to VMC's Psychiatry & Counseling Clinic as well as community-based mental health organizations.

Tactic 2.3: Medication for Opioid Use Disorder (MOUD) Program
Continue to address opioid overuse through further development of the MOUD program and partnership/training opportunities with other local organizations for buprenorphine treatment. Medications, in combination with counseling and behavioral therapies, provide a whole-patient approach to the treatment of substance use disorders.

Tactic 2.4: Screening & Education Tools
Leverage Epic, Krames Health Library, NAMI 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.

- Depression Clinical Practice Guidelines and Anxiety Screening instituted throughout the Clinic Network using standardized referral protocols for identification and treatment, which help identify at-risk patients before a tragic event occurs.
- Offer the Suicide Prevention Screen as part of the intake pathway for all patients age 10 and above (ER and inpatient) with automatic consult to/follow-up by social services following the standards determined by national guidelines.

Tactic 2.5: Emergency Department & Inpatient Support

- Children's Therapy and Emergency Department to develop tactics to further support pediatric patients in the Emergency setting.
- Valley to explore hiring a new full time Inpatient Psychiatrist to help with training and education for medical teams and programmatic development key to improving the pathways for patients with behavioral health disorders.

Tactic 2.6: Community Wellness Outreach
Focused outreach around suicide prevention and tools/education to help our community address the stress and anxiety resulting from the impacts of COVID-19.

- Identify and implement methods to reduce stress and anxiety and improve mindfulness and resiliency for staff, community organizations and the community at large.
- Broadly promote suicide awareness and prevention services/tools available.
- Expand and promote network of local, regional, national and online behavioral health services and resources available.

Tactic 2.7: Community Partnerships
Childhaven
Healthpoint
Local Addiction Centers
National Alliance on Mental Illness (NAMI)
Navos
SeaMar
Valley Cities
Veterans Administration
Others to be determined.

Monitoring/Evaluation Approach

- Quarterly and Annual CHNA Implementation Strategy Review
- Annual Community Benefit Gratitude Report
- Monitoring and trending of health screening tools and composites

DISEASE PREVENTION

Objective 3: Valley is committed to reduce and prevent 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, COVID, diabetes, healthy lifestyle

- Expand entity-wide initiatives and support regional efforts to prevent, screen, detect and treat chronic and preventable diseases.
- Strengthen strategic collaborations between Valley and community organizations to improve regional wellness efforts.
- Support local and regional initiatives to promote health and wellness across the lifespan with focused efforts on diverse and vulnerable populations.

Tactic 3.1: Ambulatory Care Management Program: Embedded within primary and specialty care to provide individualized care planning and coordination and provide a vital resource to advocate for patient needs and barriers to care. In addition:

- Continue COVID-19 monitoring of high-risk patients to help identify trends that indicate need for treatment and/or admission.
- Explore ways Valley's Health Coach Program can further partner with the Ambulatory Care Managers to deepen the reach of wellness into the patient's home environment.

Tactic 3.2: Screening Tools & Surveys: Leverage Epic and other tools to gather valuable data that can impact and guide medical care, increase positive outcomes to improve the overall health of the patient:

- Social Determinants of Health Screening (consider integrating food security Hunger Vital Sign tool)
- Suicide, Depression & Anxiety Screenings
- Healthy Lifestyle Composite
- Diabetes Composite
- Preventive Care Composite
- Fall Prevention Tool

Tactic 3.3: Diagnostic Screening: Raise awareness about early detection and provide financial advocacy and/or patient assistance, when needed, for uninsured patients:

- Breast screening
- Colon screening
- Lung screening and smoking/vaping cessation
- Diabetes/A1C testing

Tactic 3.4: Lifestyle Medicine & Diabetes Management/Prevention:

- Offer Phase II Cardiac Rehab, Pulmonary Rehab and COVID Recovery programs to help those who have suffered a cardiac or pulmonary event return to better function and prevent recurrent health issues. Enhance programs with wrap-around support for nutrition, physical therapy and exercise.
- Offer comprehensive Diabetes self-management and education with Certified Diabetes Educators who provide 1:1 counseling and group education.
- Develop and launch the CDC recognized Diabetes Prevention Program (DPP) including a virtual platform for heightened patient engagement and access.
- Expand and optimize Healthy Foundations for oncology patients and other populations focused on nutrition, healthy food choices, lifestyle modification and readiness for change.

- Partner with Community Outreach and Ambulatory Care Management Program to promote COVID Recovery program and resources for at-home recovery.

Tactic 3.5: Wellness Outreach Programs
Offer services that provide patients and their caregivers added resources, support through fellowship and education:

SCHOOLS

- Evolve Healthy Heart program to meet the needs of students learning in a virtual world. Health and quality of life at all stages depends on the cumulative effects of behaviors and exposures earlier in life. Work with Renton Regional Fire and Puget Sound Regional Fire Authority to develop online-based learning to teach students about cardiovascular disease, stroke and the importance of healthy habits.
- Continue partnering and deepening relationships with local school districts and Communities in Schools to educate site coordinators, teachers and students about preventive health topics.
- Educate youth about the health dangers of vaping and smoking.

CLASSES, SUPPORT GROUPS & PROGRAMS

- Partner with the YMCA and other local community organizations to expand the reach and impact of the Diabetes Prevention Program.
- Offer support groups and classes that provide education and fellowship:
    - Better Breathers Club for those who suffer from asthma/COPD/COVID-19
    - Stroke Club
    - Cancer Lifeline classes and support groups
    - Birth and New Parent support groups and education
- Continue to offer GLOW, GoldenCare and Pitter Patter membership-based wellness programs.
- Raise awareness about risk factors and warning signs for stroke.
- Identify gaps and missing opportunities to provide better wellness support for our community.

Tactic 3.6: Positively impact social determinant barriers to prevention and wellness related to housing/homelessness, food insecurity and health equity in partnership with other local agencies and programs:

HOMELESSNESS

- Continue the financial support of Edward Thomas House for the temporary sheltering of the medically frail homeless population.
- Partner with Eastside Legal Assistance Program (ELAP) to help raise awareness for their workshops and webinars, providing high-quality, no-cost civil legal aid service to low-incomes residents of King County.
- Collaborate with shelter-based and/or community-based locations in South King County to identify needs related to services, supplies and medical screening.
- Continue to partner with Retirement Connections to fund clothing and baby supplies for inpatient discharges.
- Partner with local clothes bank for clothing drive to benefit low income and homeless patients who are ready to discharge and need clothing.
- Continue Bombas sock distribution, identify new pathways to reach key populations while considering COVID impacts on gathering.

FOOD SECURITY

- Join King County Public Health's Healthy Eating Active Living Program (HEAL) to help develop equitable solutions to improve nutrition and increase physical activity in underserved communities and populations with higher rates of obesity, food insecurity and poor nutrition.

- Explore using the Hunger Vital Sign™ (courtesy of Food Research & Action Center) in health screenings. This two-part tool could be used to identify food insecurity in patient populations and provide direct referral to DSHS's Supplemental Nutrition Assistance Program (SNAP).
- Work with community organizations to pursue additional funding for Pandemic EBT (government benefit support). Publicize information about EBT year-round so children and their parents are aware of how to access food benefits.
- Continue to host live and virtual food drives in partnership with NW Harvest and Food Lifeline to benefit community members in urgent need.

HEALTH EQUITY

- Promote social and health equity by meeting and working with local community groups representing minority populations in Valley's service area with a primary focus of identifying, developing and implementing tactics to address their unique health needs to reduce disparities in healthcare delivery. This work will be informed by the strategies in UW Medicine's Healthcare Equity Blueprint.

Tactic 3.7: Community Partnerships
Afghan Health Initiative
American Heart Association
Anti-Hunger & Nutrition Coalition
Bombas
Cancer IQ
Chambers of Commerce
Cities in our service area
Communities in Schools
Department of Health
Eastside Legal Assistance Program (ELAP)
Edward Thomas House
Food Banks & Faith-Based Institutions
Food Lifeline
Global to Local (G2L)
Grantors
HealthierHere
Hope Women's Shelter
Kent Rotary Club
King County Library System
King County Public Health
Living Well Kent
Local School Districts
Meals on Wheels
Mother Africa
Northwest Harvest
Pacific Islander Community Association of Washington (PICAWA)
REACH
Renton Technical College (RTC)
Retirement Connections
Salvation Army/Renton Rotary
Sustainable Housing for Ageless Generations (SHAG)
Somali Health Board
Sound Generations
Valley Girls & Guys
Vine Maple Place

YMCA
YWCA
Others to be determined.

Monitoring/Evaluation Approach

- Annual CHNA Implementation Strategy Review
- Annual Community Benefit Gratitude Report
- Monitoring and trending of health screening tools and composites
- Monitoring and trending of community engagement

Evaluation of Impact

Valley Medical Center will monitor and evaluate the programs and activities outlined above. The hospital anticipates the actions taken to address significant 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 the implementation of the activities and documents the anticipated impact. Our reporting process includes the collection and documentation of tracking measures, such as the number of people reached/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 we recognize some 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, loneliness/isolation, physical/sexual abuse, STI and weight management/obesity. 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. Community partnerships and grants will be vital to help fill the gaps Valley cannot independently address.