UW Medicine | VALLEY MEDICAL CENTER

# Community Health Needs Assessment | Implementation Strategies

Valley Medical Center participated in the King County Hospitals for a Healthier Community (HHC) collaborative of all 12 hospitals and health systems in King County and Public Health-Seattle & King County. For this report, HHC members joined forces to identify important health needs and assets in the communities they serve. HHC members have also worked together to increase access to healthy foods and beverages in their facilities and to address access-to-care issues by assisting with enrollment of residents in free or low-cost health insurance. This Community Health Needs Assessment (CHNA) is an HHC collaborative product that fulfills Section 9007 of the Affordable Care Act. The report presents data on:

■ **Description of Community:** In an increasingly diverse population of 2 million, large health inequities persist. Rates of poverty and homelessness continue to rise.

■ **Life Expectancy and Leading Causes of Death:** Life expectancy in King County neighborhoods can vary by up to 10 years. Leading causes of death among older adults are cancer and heart disease, while injuries are the leading causes of death among children, teens, and young adults.

■ **Chronic Illness:** Disparities in chronic illness by race/ethnicity, poverty, and neighborhood are considerable. Asthma and diabetes are common in adults and children. The leading causes of hospitalizations (after pregnancy/childbirth) are heart disease, injury, mental illness, and cancer.

To view the complete Health Needs Assessment, click here.

## SUMMARY

### Community Input

Community coalitions and organizations were invited to provide feedback about the assets and resources that help their communities thrive. The assets most frequently mentioned were existing partnerships and coalitions, community health centers, faith communities, and food programs. We also asked community representatives to identify concerns about health needs in their communities. Common themes included: 1) the importance of a culturally competent workforce in addressing health disparities; 2) acknowledgement that health is determined by the circumstances in which people are born, grow up, live, work, and age, which are in turn shaped by a broad set of forces; 3) the need for hospitals to engage with communities and develop authentic partnerships; and 4) the influential role of hospitals as anchor institutions in addressing social, economic, and behavioral factors.

## Identified Health Needs, Assets, Resources, and Opportunities

The report integrates data on identified health needs with input from community organizations about assets, resources, and opportunities related to those needs:

■ **Access to Care:** Lack of health insurance is common among young adults, people of color, and low-income populations. For 1 in 7 adults, costs are a barrier to seeking medical care. Opportunities include providing assistance to the uninsured or underinsured, addressing issues of workforce capacity and cultural competency, ensuring receipt of recommended clinical preventive services, supporting non-clinical services, and increasing reimbursement for oral health care.

■ **Management of Chronic Illness**: The rates of diabetes, cancer, heart disease, stroke and asthma/COPD are reaching epidemic proportions. It is imperative we help patients manage chronic conditions while also giving them the tools to improve their health and prevent further disease.

■ **Behavioral Health:** Access to behavioral healthcare, integration of behavioral and physical healthcare, and boarding of mental health patients were identified as key issues. Opportunities include use of standardized referral protocols, coordinated discharge planning, and increased capacity for integrated healthcare.

■ **Maternal & Child Health:** Disparities in adverse birth outcomes persist, and the percentage of births in which mothers obtained early and adequate prenatal care is too low. Community-based organizations stress the importance of baby-friendly hospitals, quality prenatal care, and ongoing social support, as offered by home visiting programs.

■ **Preventable Causes of Death** include obesity, tobacco use, and lack of appropriate nutrition and physical activity. More than half of adults and 1 in 5 teens are overweight or obese, so increasing access to healthy food and physical activity is critical. In the face of declining resources for tobacco prevention/ cessation and persistent disparities in tobacco use, evidence-based opportunities include anti-tobacco messaging and brief clinical tobacco screening.

■ **Violence & Injury Prevention:** Deaths due to falls and suicide are both rising; and distracted/ impaired driving concerns both community members and law-enforcement officials. Opportunities include regional coordination and standard implementation of best practices in violence injury and prevention (including prevention-related primary care assessment/ screening).

Valley Medical Center has a robust outreach program and partners with community coalitions and organizations in implementing strategies informed by this assessment and other tools. We recognize that by working together, hospitals and health systems, public health, and communities can reduce healthcare costs and improve the health of all people in King County.

## ACCESS TO CARE & PREVENTIVE SERVICES

Access to comprehensive, high-quality healthcare facilitates prevention and early detection of disease. Without health insurance, most people cannot afford quality healthcare, and disparities in coverage perpetuate disparities in health and quality of life. Access to health insurance coverage has improved with expansion of Medicaid eligibility and implementation of health insurance marketplaces for Qualified Health Plans. However, for 1 in 7 King County adults, costs are a barrier to seeking needed medical care. Too many adults and children in the county do not receive recommended clinical preventive services. Opportunities identified include assistance for people without health insurance or who struggle to afford health insurance premiums; use of clinical preventive services; increased workforce diversity; and increased Medicaid reimbursement of dental care providers.

*Strategies to address financial assistance and access to care for those with unmet medical needs:*

Continue **enrollment assistance** in the expanded Medicaid Program and health exchanges to help lessen the burden of bad debt and charity 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 and represent a $240,000 annual cost to VMC.

VMC will continue to make a concerted effort 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 trend rise and self-pay decline. As a result VMC is aggressively **recruiting new providers** to help meet the increased demand and broaden access to care across our service area.

While health reform has lessened the demand for **RotaCare Free Clinic** services, it has not ended it entirely. The clinic will continue to serve those who fall through the gaps of health reform through volunteer clinical staff and funding in partnership with Renton Rotary.

**Project Access Northwest** 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 or physical therapy. We are seeing a decreasing trend with this population as well but feel the demand is still significant enough that we are committed to our continued support this coming year.

VMC 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. Because it's an important resource for some of the most vulnerable in our community, we plan to continue our support.

Language barriers can create barriers to care, so VMC is very proactive in its use of **interpreter services** and its recruitment of bi/multi-lingual staff. 46 VMC providers speak over 20 different languages, which we plan to grow. In addition, VMC uses online and in-person Telelanguage services.

*Strategies to address vaccination coverage:*

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.

Participation in the **Washington Immunization Information System** (formerly Child Profile) to help ensure patients of all ages get the vaccination coverage they need, provides free educational resources to families, and tracks individual and population level immunization coverage.

Integrated **health maintenance reminders and the pediatric vaccine smartset** in provider profiles to ensure it's covered during annual checks.

*Strategies to address preventive care:*

Continue to track the **Preventive Composite** which includes screening referral for mammogram, colonoscopy, cervical and pneumovax measures and has the goal to exceed target each year.

VMC offers a robust **community outreach program** in partnership with many community organizations throughout the year which provides 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.

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.

## MANAGEMENT OF CHRONIC ILLNESS

Chronic illnesses are among the leading causes of death, disability, and hospitalization in King County, Washington State, and the U.S. They are generally characterized by multiple risk factors, a long period of development, prolonged course of illness, and increased incidence with age. Valley Medical Center plays a major role in prevention, screening, and treatment for asthma/COPD, diabetes, heart disease, stroke and cancers of the colon, cervix and breast.

*Strategies to help manage chronic illness:*

Embed **RN Care Managers** into primary care clinics to provide individualized care planning and coordination and a resource to advocate for patient needs and resources

Establishment of the **Lifestyle Medicine Center** that offers services to improve the function of chronically ill populations. Creation of a **Pre-surgical Optimization Program** that helps patients in need of surgery reduce their risk of complications during/after surgery and improve post-surgical outcomes.

Provide comprehensive **Diabetes Education Program** with dedicated Certified Diabetes Educators who offer 1:1 and group education.

Track and aim to exceed the targets for **Diabetic Eye Exam** and the **Diabetes Composite** including screening for HGA1C, LDL and blood pressure.

Continue to offer Phase II **Cardiac & Pulmonary Rehab** programs to help those who have suffered a cardiac or pulmonary event return to better function and prevent recurrent health issues.

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

Implementation of 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.

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

## INTEGRATED BEHAVIORAL HEALTH

Behavioral health conditions are directly related to physical health and wellness and mental illness is the second leading cause of disability and premature mortality. We believe integrated behavioral health with standardized pathways directly improves patient care, is a needed service, and helps provide better care to patients.

*Strategies to integrate and expand behavioral health services:*

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

**Depression Clinical Practice Guidelines & screening** instituted in Clinic Network to help identify at-risk patients before a tragic event occurs and standardize referral protocols for identification and treatment.

VMC's Pediatric Unit provides dedicated **inpatient behavioral health support services** for the urgent needs of the pediatric behavioral health population awaiting transfer to a psychiatric inpatient facility while the General Medical Floor provides similar services for the adult population. This helps transition care out of the Emergency Department, while providing a safe environment and social work assistance.

**VMC's Psychiatry & Counseling Clinic (PCC)** has 18 providers who offer psychiatry and counseling as well as help connect patients to needed resources not provided within the PCC clinic.

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

## MATERNAL/CHILD HEALTH

Healthy pregnancies, healthy babies, and healthy mothers are important goals for all communities. At Valley we recognize it is vitally important that mothers obtain early and adequate prenatal care and ongoing support after delivery to help ensure all children have the opportunity to thrive and reach their full potential.

*Strategies to improve maternal/child health:*

Achieve the **Baby-Friendly Hospital Designation** which recognizes hospitals that offer an optimal level of care for infant feeding and mother/baby bonding.

Provide **free & low cost childbirth & parenting education**:

- **Childbirth Prep** education classes through Parent Trust
- **Text4Baby**: free texting service with prenatal information and education from pregnancy through the first year of infancy
- **Support Groups**:
    - New Mom
    - Parent-Infant
    - Parent-Baby
    - Parent-Toddler
- **Period of Purple Crying** helps parents understand why their baby might be crying and assists them with de-escalation techniques to help prevent child abuse.
- **Circle of Security** is designed to enhance bonding between parents and children, teaching the skills needed to read a child's signals, so parents can be more perceptive, responsive and effective during those formative first years of life.
- Encourage breastfeeding and provide guidance and support through **Certified Lactation Consultants** at Valley's Birth Center.
- Provide important health information and connect parents to vital resources through the **Children's Therapy e-Newsletter**

Offer **free pregnancy testing** as a way to encourage access to early and adequate prenatal care.

Teach **Prenatal Aquatherapy** through Valley's Fitness Center.

**Children's Therapy** offers physical, occupational and speech therapies in a collaborative, family-focused environment. Emphasis is placed on providing the resources necessary for at-risk children and their families through collaboration with several agencies: Early Childhood Development Association of Washington, Neurodevelopmental Centers and King County Interagency KCICC.

## PREVENTABLE CAUSES OF DEATH & ILLNESS

Heart disease, cancer, and stroke – all leading causes of death in King County – share many of the same risk factors. Cigarette smoking, obesity, unhealthy diet, physical inactivity, high blood pressure, and high blood cholesterol increase the risk of dying from these diseases.

*Strategies to decrease preventable causes of death & illness:*

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 through our community outreach program at local events.

Qualify as a **"Fit Friendly Workplace"** by the American Heart Association.

Focus efforts on **tobacco cessation:**

- **Smoking added as an additional "vital sign"** and status asked upon check-in throughout the Clinic Network prompting providers to address it 1:1 with their patients at every visit. Results monitored as part of our Physician Quality Reporting System for CMS.
- Valley Medical Center is a **tobacco-free workplace**. New hires required to sign a non-smoking attestation and non-smoking or commit to quit status qualifies employees for premium discount through our health plan.

Provide **free and low-cost exercise & 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, taught by VMC medical staff.
- **Eat Smart Seminar Series** and **Healthy Foundations** provides important and up-to-date education about healthy food choices and addresses lifestyle modification and readiness to change.

Continue to offer **wellness programming** through dedicated community engagement membership programs GLOW, GoldenCare, Pitter Patter and 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, nutrition, exercise, heart disease and oncology

Improve reach of **F.A.S.T. Stroke Awareness Campaign** to teach the community about signs and symptoms to improve emergency response time as well as ways to prevent stroke and the devastating impact it can have.

## VIOLENCE & INJURY PREVENTION

Violence and injuries are preventable and are the leading causes of death for people between the ages of 1 and 44. Valley is committed to positively impacting these trends through internal initiatives and external partnerships.

*Strategies to prevent violence & injury:*

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.

Continue to provide **Emergency Room Intervention Team** to help patients and family members cope with serious crises, assault, mental health issues, and provide information on additional community resources. Expanded services to 24/7.

The **ER Aftercare Report** includes follow-up information about crisis services and ER case management should issues persist. **After-visit phone calls** help patients access continued services and encourage follow-up care.

**Case Management embedded in the ER** to improve effectiveness and efficiency by facilitating a more synchronized plan of care across the care team.

In tandem with the **FD Cares Program** mentioned previously, which is a fire department-based community injury and illness prevention program, consider implementation of a **PD Cares Program** with our local police departments**.** Evaluate potential for further reducing violence and injury in our community. Regular communication between law enforcement and emergency department staff will promote shared understanding of legal issues, policies, and efficient blood testing of impaired-driving suspects.

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

**Period of Purple Crying** helps parents understand why their baby might be crying and assists them with de-escalation techniques to help prevent child abuse.

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

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

**Trauma Services** at VMC has four outreach programs for the community benefitting students K-12. Trauma Nurses Talk Tough, A day in the ED, Career Fairs and Safety Events were created believing if we can *prevent* an injury in the first place, young lives can be saved. They features stories of action and consequence with real children and their families and the choices they made that resulted in injury.