SWEDISH HEALTH SERVICES

First Hill and Cherry Hill
(Seattle) Campus

Community Health Improvement Plan

2019–2021

SWEDISH

TABLE OF CONTENTS

A MESSAGE FROM OUR CEO

To Our Communities:

As outlined in our 2018 Community Health Needs Assessment, the following social determinants of health emerged across the communities of all Swedish locations during the assessment process: mental health, drug addiction, homelessness, obesity and diabetes, and joint or back pain.

We have completed the development of a Community Health Improvement Plan (CHIP) to specifically address many of these barriers, including strategies and measures, towards making our community a healthier place. The CHIP outlines the process of strengthening our existing programs across the Swedish system along with identifying new programs and resources to support those, and build and sustain our partnerships with key organizations to collaborate on solutions.

The next phase will involve broad implementation of the action plans details included in this 2019- 2022 CHIP, and monitoring and evaluating its short-term and long-term outcomes.

As CEO, I am proud to lead Swedish in creating health for a better world.

R. Guy Hudson, M.D., MBA
Chief Executive Officer
Swedish Health Services

EXECUTIVE SUMMARY

About the Community Health Needs Assessment Process

Nonprofit hospitals, public health agencies, accountable communities of health, and others are required by federal law, state mandates, or agency policy to conduct community health needs assessment every three to five years. This process involves reviewing community health data, identifying and prioritizing community health needs, and developing a community health improvement plan. Historically, community health needs assessments have been planned and conducted independently, but for the first time, stakeholders in King and Snohomish Counties have aligned planning and assessment cycles to leverage resources and improve collaboration for collective impact.

Goal of the Community Health Needs Assessment

In April 2018, community members selected three to five priority areas of focus through a county-wide, coordinated community health needs assessment process. This process provides us with the opportunity to collaborate, identify community needs, and move in the same direction as other organizations. By aligning our resources with and leveraging the expertise of community partners, our collective impacts in King and Snohomish Counties is even greater. Additionally, partners are well-positioned to align timelines and coordinate future improvement cycles.

2019 - 2021 Community Health Improvement Plan Priorities

As a result of the findings of our 2018 Swedish First Hill and Cherry Hill Community Health Needs Assessment (CHNA) and through a prioritization process aligned with our mission, resources and hospital strategic plan, Swedish First Hill and Cherry Hill will focus on the following areas for its 2019-2021 Community Benefit efforts:

- Mental Health
- Drug Addiction
- Obesity
- Homelessness
- Diabetes and Obesity (campus specific)
- Homelessness (campus specific)
- Mental Health (campus specific)

MISSION, VISION, AND VALUES

Our Mission

Improve the health and well-being of each person we serve.

Our Vision

Health for a Better World

Our Values

COMPASSION: We reach out to those in need. We nurture the spiritual, emotional, and physical well-being of one another and those we serve. Through our healing presence, we accompany those who suffer.

JUSTICE: We foster a culture that promotes unity and reconciliation. We strive to care wisely for our people, our resources, and our earth. We stand in solidarity with the most vulnerable, working to remove the causes of oppression and promoting justice for all.

EXCELLENCE: We set the highest standards for ourselves and our services. Through transformation and innovation, we strive to improve the health and quality of life in our communities. We commit to compassionate and reliable practices for the care of all.

DIGNITY: We value, encourage and celebrate the gifts in one another. We respect the inherent dignity and worth of every individual. We recognize each interaction as a sacred encounter.

INTEGRITY: We hold ourselves accountable to do the right thing for the right reasons. We speak truthfully and courageously with respect and generosity. We seek authenticity with humility and simplicity.

SAFETY: Safety is at the core of every thought and decision. We embrace transparency and challenge our beliefs in our relentless drive for continuous learning and improvement.

INTRODUCTION

Since 1910, Swedish has been the region's standard-bearer for the highest-quality health care at the best value. Our mission is to improve the health and well-being of each person we serve. Swedish is the largest nonprofit health care provider in the greater Seattle area with five hospital campuses: First Hill, Cherry Hill, Ballard, Edmonds and Issaquah. We also have ambulatory care centers in Redmond and Mill Creek, and a network of more than 118 primary care and specialty clinics throughout the greater Puget Sound area.

Who We Are

Swedish Health Services is an affiliate of the Providence St. Joseph Health. Providence St. Joseph Health is a new organization created by the association between Providence Health & Services and St. Joseph Health with the goal of improving the health of the communities it serves, especially those who are poor and vulnerable.

Together, our 111,000 caregivers (all employees) serve in 50 hospitals, 829 clinics and comprehensive range of services across Alaska, California, Montana, New Mexico, Oregon, Texas and Washington. In addition to Swedish, the Providence St. Joseph Health family includes: Providence Health & Services, St. Joseph Health; Covenant Health in West Texas; Facey Medical Foundation in Los Angeles; Hoag Memorial Presbyterian in Orange County, California; Kadlec in Southeast Washington; and Pacific Medical Centers in Seattle.

Bringing these organizations together increases access to health care and brings quality, compassionate care to those we serve, with a focus on those most in need.

Our Commitment to Community

Swedish Health Services dedicates resources to improve the health and quality of life for the communities it serves, with special emphasis on the needs of the economically poor and vulnerable. In the last five years, Swedish spent more than $900 million in community benefit. We are making investments that go beyond just the need for free and discounted care by improving access to care and developing new ways to help people stay healthy. In 2017, we spent almost $200 million on community benefit programs, including $23.9 million on free and discounted care. The communities served by Swedish hospitals are defined by the geographic origins of the hospitals' inpatients. The Primary Service Area (PSA) was determined by identifying the ZIP Codes for 70% of the hospitals' patient discharges (excluding normal newborns). The Secondary Service Area (SSA) was determined by identifying the ZIP Codes for 71% to 85% of the hospitals" patient discharges. The service areas for all Swedish campuses focus on King County and Snohomish County.

- Swedish Ballard is located at 5300 Tallman Avenue, NW, Seattle, WA 98107. The PSA consists of 8 cities and 36 ZIP Codes. The SSA consists of 18 cities and 33 ZIP Codes.
- Swedish Edmonds is located at 21601 76th Ave. W., Edmonds, WA 98026. The PSA consists of 5 cities and 9 zip codes. The SSA consists of 6 cities and 9 ZIP Codes.
- Swedish First Hill is located at 747 Broadway, Seattle, WA 98122 and Swedish Cherry Hill is located at 500 17th Avenue, Seattle, WA 98122. These hospitals share the same service area. The PSA consists of 13 cities and 53 ZIP Codes. The SSA consists of 23 cities and 35 ZIP Codes.
- Swedish Issaquah is located at 751 NE Blakely Drive, Issaquah, WA 98029. The PSA consists of 12 cities and 19 ZIP Codes. The SSA consists of 16 cities and 28 ZIP Codes.

Continued on the next page...

Planning for the Uninsured and Underinsured

Our aim is to provide quality care to all our patients, regardless of ability to pay. We believe that no one should delay seeking needed medical care because they lack health insurance. That is why Swedish Health Services has a Patient Financial Assistance Program (FAP) that provides free or discounted services to eligible patients.

Our charity care program provides a 100 percent discount to individuals and families between 0-300 percent of the federal poverty level (formerly 0-200 percent.)

- For example, a family of four with a household income of approximately $75,000 or less would qualify.

In addition, for individuals and families between 301-400 percent of the federal poverty level, Swedish provides a discount of at least 75 percent.

- For example, a family of four with a household income of approximately $75,000 - $100,000 would qualify

One way Swedish Health Services informs the public of FAP is by posting notices in high volume inpatient and outpatient service areas. Notices are also posted at location where a patient may pay their bill. Notices include contact information on how a patient can obtain more information on financial assistance, as well as where to apply for assistance. These notices are posted in English and Spanish and any other languages that are representative of 5% or greater of patients in the hospital's service area. All patients who demonstrate lack of financial coverage by third party insurers are offered an opportunity to complete the Patient Financial Assistance application and are offered information, assistance, and referral as appropriate to government sponsored programs for which they may be eligible.

OUR COMMUNITY

Definition of Community Served

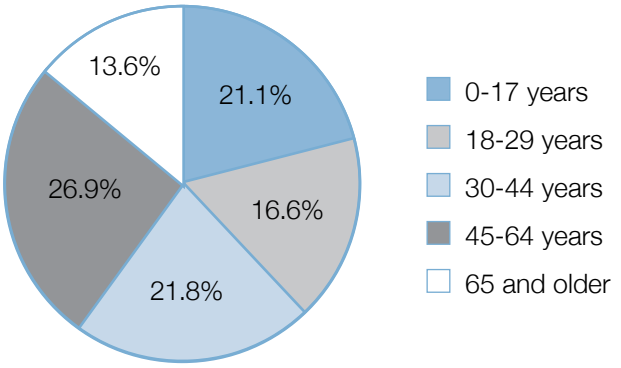
Population for Total Service Area, 2017

	Ballard	Edmonds	First Hill/ Cherry Hill	Issaquah
Population	2,373,420	651,452	2,846,268	1,451,299

Source: Intellimed, ESRI, 2017

Among Swedish campus service areas, Issaquah has the highest percentage of children (22.5%). Edmonds and Issaquah service areas include percentages of children higher than that of the county (21.1%). Edmonds has the highest percentage of seniors (14.1%) among Swedish hospital campuses, which exceeds the percentage of seniors in the county (13.6%).

2017 Population by Age, King and Snohomish Counties



	Ballard	Edmonds	First Hill/ Cherry Hill	Issaquah
Children, ages 0-17	20.5%	21.8%	21.0%	22.5%
Adults, ages 18-64	65.9%	64.1%	65.5%	64.6%
Seniors, 65+	13.6%	14.1%	13.5%	12.9%

Source: US Census Bureau American Community Survey, B01003, 2016

Among the Swedish campuses, the Edmonds service area has the highest percentage of residents who are non-Latino White (65.2%) and Hispanic or Latino (9.6%). The Issaquah service area has the highest percentage of Asians/Pacific Islanders (20.3%), and the Ballard service area has the highest percentage of Blacks/African Americans (7.4%).

Race/Ethnicity*

	Ballard	Edmonds	First Hill/ Cherry Hill	Issaquah
Non-Latino White	61.6%	65.2%	61.4%	59.7%
Asian/Pacific Islander	17.2%	16.4%	18.1%	20.3%
Hispanic or Latino	9.4%	9.6%	9.1%	8.4%
Black/African American	7.4%	5.4%	7.0%	6.8%
Two or more races	6.0%	5.9%	5.8%	5.3%
Other races/ ethnicities	3.6%	3.3%	3.5%	3.2%

Source: U.S. Census Bureau, American Community Survey, 2016; DP05

**Percentages total more than 100% as some persons selected more than one race or ethnicity category.*

Income Poverty

In the Swedish campus service areas, the median household income ranges from $69,153 in the Edmonds service area to $93,153 in the Issaquah service area. This disparity in income might influence health outcomes.

Continued on the next page...

Median Household Income and Unemployment Rate

	Ballard	Edmonds	First Hill/ Cherry Hill	Issaquah
Median household income	$76,160	$69,208	$82,071	$93,153
Unemployment rate	6%	6%	6%	5%

In 2016, the federal poverty threshold for one person was $11,880 and for a family of four it was $24,300. Among Swedish campuses, the Issaquah service area has the lowest rate of individuals living in poverty (8.9%) and the Ballard service area has the highest rates of individuals (10.7%) and children living in poverty (2.7%). The Edmonds service area has the lowest rate of households (1.9%), and seniors living in poverty (0.7%).

Personal/Households Living at or Below Poverty Level

(<100% Federal Poverty Level)

	Ballard	Edmonds	First Hill/ Cherry Hill	Issaquah
Individuals at poverty level	10.7%	9.7%	10.1%	8.9%
Households at poverty level	4.2%	3.0%	4.1%	4.1%
Children living in poverty	2.7%	1.9%	2.6%	2.5%
Seniors living in poverty	1.0%	0.7%	1.0%	0.9%

COMMUNITY NEEDS AND ASSETS ASSESSMENT PROCESS AND RESULTS

Summary of Community Needs Assessment Process and Results

Secondary Data: Secondary data was collected from a variety of local, county, and state sources. Data analyses were conducted at the most local level possible for the hospitals' service areas, given the availability of the data.

Primary Data: Stakeholder surveys and listening sessions were used to gather data and information from persons who represent the broad interests of the community served by the hospitals. Swedish conducted surveys to gather data and opinions from community residents, and hospital leaders and staff who interact with patients and families in the ED and specialty clinics.

The full report and results of the 2018 Swedish (Seattle) Cherry Hill/First Hill Community Health Needs Assessment can be accessed at: https://www.swedish.org/~/media/Files/Providence%20Swedish/PDFs/Mission/2018/CHNASeattle21419.pdf

Identification and Selection of Significant Health Needs

Significant health needs were identified from the Community Health Needs Assessment process. Swedish then identified priorities for the Community Health Improvement Plan associated with the 2018 Swedish Seattle (First Hill/Cherry Hill) CHNA. The priority health needs were: Mental Health, Homelessness, Drug Addiction, Obesity, and Diabetes.

Community Health Needs Prioritized

Swedish First Hill and Cherry Hill will focus on the following areas for its 2019-2021 Community Health Improvement Plan (CHIP):

- Mental Health
- Drug Addiction
- Obesity
- Homelessness
- Diabetes and Obesity (campus specific)
- Homelessness (campus specific)
- Mental Health (campus specific)

Continued on the next page...

Needs Beyond the Hospital's Service Program

The following community health needs identified in the 2018 Swedish CHNA campus reports may not be addressed as part of the current CHIP. An explanation is provided below:

BALLARD	EDMONDS	FIRST HILL/CHERRY HILL	ISSAQUAH
Alcohol overuse	Alcohol overuse	Joint or back pain	Homelessness
High blood pressure	High blood pressure	High blood pressure	Cancer
Joint or Back Pain	Joint or back pain	Cancer	Age-related diseases
Cancer	Cancer	Alcohol overuse	Texting while driving
Smoking	Stroke	Age-related diseases	Alcohol overuse
Age-related diseases	Smoking	Teeth/oral health issues	High blood pressure
Stroke	Asthma	Smoking	Environmental factors
Environmental factors	Environmental factors	Environmental factors	Alzheimer's disease/ dementia
Texting while driving	Texting while driving	Stroke	Teeth/oral health issues
Asthma	Heart disease	Asthma	Asthma
Teeth or oral issues	Teeth/oral health issues	Heart disease	Lack of access to needed medications
Crime	Age-related diseases	Texting while driving	Stroke
Heart disease	Crime	Alzheimer's disease/ dementia	Child abuse and neglect
Alzheimer's disease/ dementia	Lack of access to medical providers	Lack of access to healthy food	Lack of access to medical providers
Lack of access to needed medications	Alzheimer's disease/ dementia	Crime	Smoking
Lack of access to medical providers	Child abuse and neglect	Lack of access to medical providers	Heart disease
Child abuse and neglect	Domestic violence	Lack of access to needed medications	Sexually transmitted infections
Lack of access to a grocery store	Lack of access to needed medications	Child abuse and neglect	Domestic Violence
Sexually transmitted infections	Lack of access to needed medications	Domestic violence	
Domestic violence		Sexually transmitted infections	

Some of these areas are out of our scope of our current community health program expertise, and other non-profits in the community are providing robust services. However, we see the interconnectedness of health, housing, education, and income. If we can improve the health of our workforce, they will be better caregivers and more able to contribute to the economic vitality of our service area.

No hospital facility can address all the health needs present in the community. We are committed to our mission through Swedish Community Benefits granting program and partnering with like-minded organizations in service to our community.

COMMUNITY HEALTH IMPROVEMENT PLAN

Summary of Community Health Improvement Planning Process

Swedish Medical Center, First Hill and Cherry Hill participated in the King County Hospitals for a Healthier Community (HHC) as part of a countywide Community Health Needs Assessment. HHC is a collaborative of hospitals and/or health systems in King County and Public Health-Seattle & King County.

1. INITIATIVE/COMMUNITY NEED ADDRESSED: MENTAL HEALTH AND WELLNESS

Goal (Anticipated Impact): Implement a new program that provides mental health peer support in Swedish emergency departments (ED). This program will be adapted from the ED Connect program implemented by Hoag Hospital Newport Beach ED in partnership with the National Alliance on Mental Health (NAMI). To accomplish this goal and implement a pilot project, Swedish will explore partnering with Navos, one of the largest providers of community mental health services in Washington State.

Develop a psychology postdoctoral fellow training program that provides mental health care in the Swedish community irrespective of patient's ability to pay, while creating a much needed workforce to support integrated behavioral health (BH) care.

Scope (Target Population): People in the Seattle community

OUTCOME MEASURE	BASELINE	FY19 TARGET	FY21 TARGET
Facilitate full implementation of Mental Health peer support program in ED	0	1 selected campus	Swedish-wide roll-out
Integrate program at Swedish recognized clinics without behavioral health services (BHS) at a reduced cost	N/A (new measure)	2 clinics	2-4 Clinics

STRATEGY(IES)	STRATEGY MEASURE	BASELINE	FY19 TARGET	FY21 TARGET
Construct a Swedish NAMI ED Connect implementation plan	Complete Swedish ED Connect Plan	0	1 approved plan	Plan for Swedish-wide roll-out
Explore pilot with Navos	Swedish ED Connect plan collaborates with Navos	0	1 approved plan	Plan for Swedish-wide roll-out
Set up for Swedish-wide system	Unfold ED Connect to the Swedish-wide system	0	1 campus in 2019-2020	Initiate full Swedish-wide roll out in 2021
In 2019, develop a psychology postdoctoral program for primary care that will serve anyone in the Swedish community irrespective of their ability to pay, while creating a much needed workforce to support integrated BH care	2019- Develop plan and have successful recruitment of 2 post-doctoral candidates to provide services in 2020-2021 Identify Swedish Primary Care clinics in high need communities that do not currently have access to BH services (and have space for them to practice) Visits with postdoctoral fellow will be provided free of charge for all patients	0	800-1000 patient visits per postdoctoral fellow per year (2020-2021)	TBD – but anticipate if program is successful, we can continue to expect 800-1000 patient visits per fellow per year

Continued on the next page...

STRATEGY(IES)	STRATEGY MEASURE	BASELINE	FY19 TARGET	FY21 TARGET
Conduct mental health workshops in the community	Adapt a workshop series that can be offered at hospital campuses for any individual in the community to attend for free	0	5 workshops	5 workshops per year per fellow
Assemble next generation of mental health providers	Each year postdoctoral fellows will be trained in a system that provides high quality BH care. They will be a generalist that is capable of meeting the needs of all patients with a behaviorally influenced concern	5	Recruitment of 2 postdoctoral fellows	Continued recruitment of 2 postdoctoral fellows per year (with hopes of accepting more with adequate funding)

Evidence Based Sources

Pingitore, D. P. (1999). Postdoctoral training in primary care health psychology: Duties, observations, and recommendations. *Professional Psychology: Research and Practice*, 30(3), 283-290. http://dx.doi.org/10.1037/0735-7028.30.3.283

Larkin, K. T., Bridges, A. J., Fields, S. A., & Vogel, M. E. (2016). Acquiring competencies in integrated behavioral health care in doctoral, internship, and postdoctoral programs. *Training and Education in Professional Psychology*, 10(1), 14-23. http://dx.doi.org/10.1037/tep0000099

Johnstone, B., Frank, R. G., Belar, C., Berk, S., Bieliauskas, L. A., Bigler, E. D., . . . Sweet, J. J. (1995). Psychology in health care: Future directions. *Professional Psychology: Research and Practice*, 26(4), 341-365. http://dx.doi.org/10.1037/0735-7028.26.4.341

Other Sources

Health Care Blog: https://thehealthcareblog.com/blog/2019/03/14/healthcare-must-open-more-doors-to-mental-health-patients/

Hoag and NAMI: https://www.hoag.org/about-hoag/news-publications/heart-of-hoag/categories/fall-2018/a-profound-beautiful-alliance-nami-and-hoag/

Key Community Partners

NAMI ED Connect:

- Navos Behavioral Health Consortium
- HOAG Memorial Hospital Presbyterian

Postdoctoral Fellow Training: Current relationships exist between the Primary Care BH team and multiple local universities.

Resource Commitment

NAMI ED Connect

- Leader and staff time to research and plan the pilot
- Time for the peer counselors (dependent on pilot plan)

Postdoctoral Fellow Training: This program would require at least a 0.5 FTE to adequately provide support, supervision, leadership, recruitment, and program development. Additional resource commitment would include clinic space and supplies.

2. INITIATIVE/COMMUNITY NEED ADDRESSED: SUBSTANCE ABUSE AND OPIOID USE DISORDER

Goal (Anticipated Impact): Initiate a pilot program at the Ballard Emergency Department (ED) to transition patients with opioid use disorder (OUD) to a Suboxone clinic for treatment. This pilot will be modeled off of the Swedish Edmonds Suboxone program, which began in January 2019. The goal is to address the identified community need through enhanced treatment of patients presenting with OUD with evidence-based guidelines for withdrawal management.

Scope (Target Population): Initially, Ballard ED patients who present with OUD. After the Swedish-system rollout, patients who present in any Swedish ED with OUD. Referral to a network of suboxone Medicaid waivered clinics (both Swedish and partners) will be offered to our patients.

OUTCOME MEASURE	BASELINE	FY19 TARGET	FY21 TARGET
Percent of patients that follow up from the ED to a Suboxone clinic	0%	50%*	80%*

**Targets modeled off of Swedish Edmond's Suboxone program goals, although subject to change.*

STRATEGY(IES)	STRATEGY MEASURE	BASELINE	FY19 TARGET	FY21 TARGET
Ballard pilot of best-practice OUD screening, treatment, and referral from the ED to a Suboxone clinic	Full implementation of Ballard pilot	N/A	Full implementation at Ballard	Continued full implementation at Ballard
Swedish-wide implementation of best-practice OUD screening, treatment, and referral from the ED to a Suboxone clinic	Number of campuses with implemented best-practices	One ED - Edmonds	One additional campus: Ballard Plan full Swedish-wide roll out	Seven EDs all with Suboxone pathway for OUD (Edmonds / Ballard / First Hill / Cherry Hill / Redmond / Mill Creek)
Couple work with Accountable Communities of Health (ACH)	Align with Community partners related to OUD	N/A	Full participation in both North Sound and Healthier Here ED related OUD work	TBD based on ACH partnership

Evidence Based Sources

Multiple guidelines including the WA Bree Collaborative Opioid Guidelines
http://www.breecollaborative.org/topic-areas/current-topics/opioid/

Key Community Partners

Initial community partner for the pilot include Swedish Ballard ED, Swedish Addiction Recovery Clinic at Ballard, and Swedish Ballard Family Practice Clinic. After the Swedish-wide roll out, partners will include multiple agencies such as Federally Qualified Health Centers, Behavioral Health Organizations, and others.

Resource Commitment

Ballard Operations sponsored by Kasia Konieczny (Chief Operating Officer—Swedish Ballard), Quality Division resources, Nursing and Social Work resources, Addiction Recovery team, Swedish Family Practice Clinic at Ballard, and Clinical Transformation and Simulation Services.

3. INITIATIVE/COMMUNITY NEED ADDRESSED: OBESITY AND DIABETES

Goal (Anticipated Impact):

- Increase awareness on the importance of healthy eating and exercise
- Reduce the prevalence of childhood obesity and risk of diabetes in diverse communities

Scope (Target Population): Members of the community contacted at public events, with focused outreach in low income communities

OUTCOME MEASURE	BASELINE	FY19 TARGET	FY21 TARGET
Percentage of "at risk" community members (those who screen positive for diabetes, prediabetes, or with high glucose levels) who are given information for appropriate follow-up (Primary provider, Swedish diabetes center, YMCA, other community clinics)	0%	50%	TBD

STRATEGY(IES)	STRATEGY MEASURE	BASELINE	FY19 TARGET	FY21 TARGET
Sponsor Urban Games (See description below)	Funding: healthy living, wellness programs and outreach	$5,000 in 2018	$20,000 in 2019	TBD
Diabetes screening and health education at Urban Games	Number diabetes screening and health education tables hosted at Urban Games	Hosted 4 tables in 2018 covering the following topics: 1. Prediabetes screening tool and education 2. Blood pressure and CPR education 3. Swedish sports medicine	Host more than 4 tables covering the following topics: 1. Diabetes resources and prediabetes screening 2. Blood pressure 3. Ask the Medical Doctor or Registered Nurse (brief consult on site) 4. Swedish Sports Medicine 5. Expanded outreach services	TBD
Prediabetes screening at community events	Number of community events where Swedish participates by administering prediabetes screenings and/or glucose testing. Events will include community outreach events and health fairs, including Swedish sponsored events, walks/runs, races, etc.	Glucose testing at three events in 2018 Prediabetes screening in 2018	At least one community event for three Swedish campuses during quarters three and four community outreach events 2019	At least one community event for all five Swedish campuses during quarters three and four community outreach events
Offer monthly online cooking classes through Facebook Live, #SwedishEats	# of views of monthly Facebook Live cooking class videos which are open to the community and promote healthy eating lifestyles	745 views (January 2019 video)	1,000+ views Increase community partner outreach and awareness	TBD: Broaden community partner outreach and awareness

Continued on the next page...

Evidence Based Sources

Centers for Disease Control and Prevention:
https://www.cdc.gov/healthyschools/obesity/facts.htm
https://www.cdc.gov/prediabetes/takethetest/
https://www.cdc.gov/diabetes/pdfs/data/statistics/national-diabetes-statistics-report.pdf

American Diabetes Association: https://professional.diabetes.org/sites/professional.diabetes.org/files/media/prediabetes.pdf

Taking Control of Your Diabetes Conference and Health Fair: https://tcoyd.org/tcoyd-bellevue-2019/

Other Sources

Swedish online cooking class videos (Swedish Eats): https://www.facebook.com/pg/swedishmedicalcenter/videos/?ref=page_internal

Key Community Partners

- American Diabetes Association
- Garfield Community Center
- Seattle Park and Recreation, City of Seattle
- Austin Foundation
- Clean Greens and Fresh Bucks
- Seattle Chapter Jack n Jill, Inc.
- Mary Mahoney Professional Nurses Association
- iUrban Teen
- Treehouse
- Black Farmer Collaborative
- Northwest Kidney Center
- Asian Counseling Referral Services (ACRS) Community Farm

Resource Commitment

- Fiscal contribution $5000
- Hours to set-up and staff tables at Urban Games
- Hours to set-up and staff tables at campus community events

URBAN GAMES INFORMATION

Urban Games' vision is a bold community engagement initiative that seeks to build community self-advocacy and individual self-agency centered on health and wellness. Partnering with Youth Centric, a social purpose organization, Urban Games proposes the following goals and outcomes:

- Engage 1,000 Urban Games Youth Ambassadors in year round activities and programs who are committed healthy living and wellness practices.
- Develop a data-informed wellness baseline for each of the Youth Ambassadors for monitoring, coaching, and intervention, as appropriate.
- Track over 10M activity hours (1,000 UG Youth Ambassadors x 30 minutes per day x over 365 days).
- Demonstrate through data analysis how a focused community based effort can improve health outcomes

4. INITIATIVE/COMMUNITY NEED BEING ADDRESSED: HOMELESSNESS

Goal (Anticipated Impact): Develop ongoing partnerships with community-based organizations and city and county entities whose focus is homelessness and providing support for families experiencing homelessness in King and Snohomish Counties. Build collaborative relationships to identify and develop strategies and pathways to reduce homelessness and provide supportive housing. Additionally, this consortium will work to address upstream health needs, such as behavioral health, and social determinants of health, such as employment.

Scope (Target Population): Families experiencing homelessness or unstably housed (i.e. couch surfing) in King and Snohomish Counties.

OUTCOME MEASURE	BASELINE	FY19 TARGET	FY21 TARGET
Develop collaborative strategies focused on moving a percent of the homeless families to stable housing	782 family households (2,624 individuals) experiencing homelessness in King County (2018)[1] 21 family households (60 individuals) experiencing chronic homelessness in Snohomish County (2018)[2] Initial conversations with community partners	House 10% of homeless families	House 10% + of homeless families

STRATEGY(IES)	STRATEGY MEASURE	BASELINE	FY19 TARGET	FY21 TARGET
Meet with housing advocates and community partners in King and Snohomish Counties	# of partners within the campus communities	5 community partner meetings	12 community partner meetings	TBD
Fully integrated housing collaborative strategies with a focus on unhoused families	# of individuals in families with children in the point in time count identified as experiencing homelessness	Initial conversations with community partners	Establish housing collaborative	Fully funded housing strategies align with housing advocates and Swedish goals focused on families experiencing homelessness
Explore assets to invest in innovative ways to provide transitional housing to meet the needs of unhoused families and partner with Providence Supportive Housing	TBD	TBD	TBD	TBD
Administer behavioral health services and training and education resources to transition families to stable housing	TBD	0	Establishing targets in 6 months	TBD

1 http://allhomekc.org/wp-content/uploads/2018/05/FINALDRAFT-COUNTUSIN2018REPORT-5.25.18.pdf
2 https://snohomishcountywa.gov/DocumentCenter/View/54339/2018-Point-In-Time-Report-PDF

Evidence Based Sources

All Home: http://allhomekc.org/king-county-point-in-time-pit-count/

Seattle/King County Coalition on Homelessness: http://homelessinfo.org/

City of Seattle: https://www.seattle.gov/humanservices/about-us/initiatives/addressing-homelessness

Resource Commitment

Swedish Community Health Investment Division
PSJH Housing Learning Collaborative

Key Community Partners

Plymouth Housing
Capitol Hill Housing
Wellsprings
West Seattle Help Link
Ballard Help Line
Mary's Place
Seattle King County Public Health
City of Seattle
United Way
YWCA
Congregation for the Homeless
Vision House
Solid Ground
Seattle Chamber of Commerce – Housing Connector
Providence St. Joseph Health
Others

5. INITIATIVE/COMMUNITY NEED ADDRESSED: DIABETES AND OBESITY—PREDIABETES SCREENING

Goal (Anticipated Impact): Increase awareness of individuals who are at risk for developing prediabetes including screening (X) number of people. Identify and acknowledge additional avenues for improving knowledge to reduce and prevent the risk of developing type 2 diabetes.

See system wide goal for obesity and diabetes for system outcomes.

Scope (Target Population): King County residents - % of those identified with prediabetes (compare with WA State)

OUTCOME MEASURE	BASELINE	FY19 TARGET	FY21 TARGET
# of people tracked and referred to Swedish diabetes education classes, YMCA and Diabetes Prevention Programs (DPPs)	0 (new measure)	TBD	TBD
# of community health fair tabling events	0 (new measure)	TBD	TBD

STRATEGY(IES)	STRATEGY MEASURE	BASELINE	FY19 TARGET	FY21 TARGET
Employ American Diabetes Association prediabetes screening tool digitally or on paper questionnaires to people at Swedish sponsored events and health fairs	# of people who attend events (measure TBD depending on ability to track completion of screening tool)	0	TBD	TBD
Engagement results for referral to providers, education, and resources	# of people connected to providers, education, and resources	50	TBD	TBD

Evidence Based Sources

Centers for Disease Control and Prevention: https://nccd.cdc.gov/DDT_DPRP/Registry.aspx

American Diabetes Association: http://diabetes.org/are-you-at-risk/diabetes-risk-test/

Key Community Partners

American Diabetes Association, YMCA, Public Health—Seattle & King County (CHNA Report)

Resource Commitment: Diabetes educators and staff; Registered Dietitians; Swedish Bariatric, Metabolic, Endocrine Center staff

6. INITIATIVE/COMMUNITY NEED ADDRESSED: COMMUNITY EDUCATION: HOMELESSNESS

Goal (Anticipated Impact):

- Reduce the volume of patients currently taking time in the Emergency Department (ED) that do not have acute needs, and help direct them to appropriate settings.
- Proactively support members in our community who have health care needs, increase access to preventive care resources and address their health concerns in real time to decrease avoidable ED visits.
- Partner with Operation Night Watch/Point in Time Program to address the health concerns of individuals experiencing homelessness by providing medical triage in an identified sanctioned homeless encampment in partnership with community based organizations.

Scope (Target Population): Partner with agencies/organizations currently present in the community who have contact with individuals experiencing homelessness, and evaluate opportunities to provide clinic support at health fairs in partnership with those agencies' interventions.

OUTCOME MEASURE	BASELINE	FY19 TARGET	FY21 TARGET
# of people treated at health fairs	0	TBD	TBD
Impact volume of ED visits by providing minor medical outreach efforts in identified locations supporting individuals experiencing homelessness	TBD	TBD	TBD

STRATEGY(IES)	STRATEGY MEASURE	BASELINE	FY19 TARGET	FY21 TARGET
Partner with Operation Night Watch/Point in Time and Swedish providers. Hold a health fair twice a month and conduct health screens, wound care, minor treatment of ailments such as headaches, colds, coughs, etc.	# of people who are treated	0	TBD	TBD
Elevate awareness and advocate option of using the Swedish County Doctor After-Hours Clinic at Cherry Hill and other Federally Qualified Health Centers	# of people who receive information about the After-Hours Clinic or other Federally Qualified Health Centers	Zero	TBD	TBD

Evidence Based Sources

Public Health—Seattle & King County CHNA, First Hill and Cherry Hill data analytics - Tableau

Key Community Partners

Operation Night Watch/Point in Time, Public Health—Seattle & King County

Resource Commitment

Family practice residents and providers, nurses, certified nursing assistants, ED techs, medical assistants, case managers or social workers

7. INITIATIVE/COMMUNITY NEED ADDRESSED: MENTAL HEALTH—DEPRESSION SCREENING AND MENTAL HEALTH FIRST AID

Goal (Anticipated Impact): Improve depression screening efforts using the Patient Health Questionnaire-2 (PHQ-2) and Patient Health Questionnaire-9 (PHQ-9). Increase number of Swedish caregivers and stakeholders who are trained in Mental Health First Aid.

Scope (Target Population): Swedish patients, caregivers, and community stakeholders

OUTCOME MEASURE	BASELINE	FY19 TARGET	FY21 TARGET
# of Caregivers and community stakeholders trained in Mental Health First Aid	25 people by 4/19	200	# of Caregivers and community stakeholders trained in Mental Health First Aid
Improve % of patients who are screened for depression at primary care clinics using the PHQ-2 or PHQ-9 screenings: Align with current CEI Depression screening measure: Achieve 75% percentile (63.4%) by 2022 Primary care clinics include Central, Cherry Hill Family Medicine, Downtown, First Hill Family Medicine, First Hill	51.46%	54.46%	Improve % of patients who are screened for depression at primary care clinics using the PHQ-2 or PHQ-9 screenings: Align with current CEI Depression screening measure: Achieve 75% percentile (63.4%) by 2022 Primary care clinics include Central, Cherry Hill Family Medicine, Downtown, First Hill Family Medicine, First Hill
# of Caregivers and community stakeholders trained in Mental Health First Aid	25 people by 4/19	200	# of Caregivers and community stakeholders trained in Mental Health First Aid

STRATEGY(IES)	STRATEGY MEASURE	BASELINE	FY19 TARGET	FY21 TARGET
Roll out plan to schedule caregivers to attend Mental Health First Aid Training Promote Mental Health First Aid training to our community partners/"train the trainers"	# of people who attend John Bruels (Mental Health First Aid trainer) offers classes of 10	25 people scheduled on 4/19	Offer a monthly class with the goal of engaging 200 Swedish caregivers (clinical or non-clinical) to provide more mental health knowledge	TBD
Connect people to psychiatry, medication management, and community resources	# of referrals for psychiatry, medication management, and community resources	335 referrals to Quartet Health and various outside providers for ongoing psychiatric care and counseling	595 referrals. As the Behavioral Health resource site is established it is anticipated that we will add 260 more referrals per year because we also will have more resources to give those who "cold call" for referrals and cannot see our providers. Estimate is 5 people a week X 52 weeks.	TBD
Heighten participation in National Alliance on Mental Illness (NAMI) Walk (mental health awareness) to generate access to and awareness of mental health services.	# of participants	40	50-80	100+

Evidence Based Sources

NAMI: namiwalks.org

Well Being Trust: wellbeingtrust.org

Key Community Partners

Mental Health First Aid USA, NAMI

Resource Commitment

Family practice residents and providers, nurses, certified nursing assistants, ED techs, health navigators, patient care coordinator, patient service representatives, care managers, clinical educators, and behavioral health practitioners.

Other Community Benefit Programs and Evaluation Plan

INITIATIVE/COMMUNITY NEED BEING ADDRESSED	PROGRAM NAME	DESCRIPTION	TARGET POPULATION (Low Income or Broader Community)
Access	Family Medicine Emergency Clothing Closet/ Supply Closet	Emergency Clothing & Sundries	Low Income/ Homeless
Education & Workforce	Year Up	Mentorship Training and Technology	Low Income
Outreach	Clean Sweep	Clinical Support Care, Triage and Provision of Emergency Care Packs	Low Income

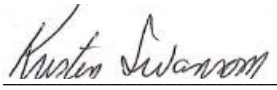
2019 CHIP GOVERNANCE APPROVAL

This community health improvement plan was adopted on **May 14, 2019** by the authorized body of the hospital on **May 14, 2019**. The final report was made widely available[1] on **May 15, 2019**.

05/14/2019

R. Guy Hudson, M.D., MBA
Chief Executive Officer
Swedish Health Services

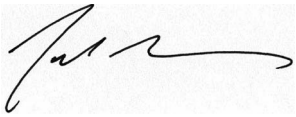
Date



05/14/2019

Kristen Swanson, MSN
Chair Board of Trustees
Swedish Health Services

Date



05/14/2019

Joel Gilbertson
Senior Vice President, Community Partnerships
Providence St. Joseph Health

Date

05/14/2019

Kevin Brooks
Chief Operating Officer, First Hill
Swedish Health Services

Date

CHNA/CHIP CONTACT

Sherry Williams, MPA
Regional Director Community Health Investment
Swedish Health Services
206-386-3407
206-386-6000
Sherry.williams@swedish.org

Request a copy, provide comments or view electronic copies of current and previous community health needs assessments: https://www.swedish.org/about/overview/mission-outreach/community-engagement/community-needs-assessment/assessments-site-list

1 Per § 1.501(r)-3 IRS Requirements, posted on hospital website

APPENDIX

Definition of Terms

Community Benefit: An initiative, program or activity that provides treatment or promotes health and healing as a response to identified community needs and meets at least one of the following community benefit objectives:

a. Improves access to health services;
b. Enhances public health;
c. Advances increased general knowledge; and/or
d. Relieves government burden to improve health.

Community benefit includes both services to the poor and broader community.

To be reported as a community benefit initiative or program, community need must be demonstrated. Community need can be demonstrated through the following:

a. Community health needs assessment developed by the campus or in partnership with other community organizations;
b. Documentation that demonstrates community need and/or a request from a public agency or community group was the basis for initiating or continuing the activity or program; or
c. The involvement of unrelated, collaborative tax-exempt or government organizations as partners in the community benefit initiative or program.

Health Equity: Healthy People 2020 defines *health equity* as the "attainment of the highest level of health for all people. Achieving health equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and health care disparities."

Social Determinants of Health: Powerful, complex relationships exist between health and biology, genetics, and individual behavior, and between health and health services, socioeconomic status, the physical environment, discrimination, racism, literacy levels, and legislative policies. These factors, which influence an individual's or population's health, are known as *determinants of health*. *Social determinants of health* are conditions in the environment in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.

Initiative: An initiative is an umbrella category under which a campus organizes its key priority efforts. Each effort should be entered as a program in CBISA Online (Lyon Software). Please be sure to report on all your Key Community Benefit initiatives. If a campus reports at the initiative level, the goal (anticipated impact), outcome measure, strategy and strategy measure are reported at the initiative level. Be sure to list all the programs that are under the initiative. Note: All Community Benefit initiatives must submit financial and programmatic data in CBISA Online.

Program: A program is defined as a program or service provided to benefit the community (in alignment with guidelines) and entered in CBISA Online (Lyon Software). Please be sure to report on all community benefit programs. Note: All community benefit programs, defined as "programs", are required to include financial and programmatic data into CBISA Online.

Goal (Anticipated Impact): The goal is the desired ultimate result for the initiative's or program's efforts. This result may take years to achieve and may require other interventions as well as this program. (E.g. increase immunization rates; reduce obesity prevalence.).

Scope (Target Population): Definition of group being addressed in this initiative: specific description of group or population included (or not included, if relevant) for whom outcomes will be measured and work is focused. Identify if this initiative is primarily for persons living in poverty or primarily for the broader community.

Outcome measure: An outcome measure is a quantitative statement of the goal and should answer the following question: "How will you know if you're making progress on goal?" It should be quantitative, objective, meaningful, and not yet a "target" level.

SWEDISH

Cherry Hill
500 17th Ave.
Seattle, WA 98122
T 206-320-2000

First Hill
747 Broadway
Seattle, WA 98122
T 206-386-6000

www.swedish.org

We do not discriminate on the basis of race, color, national origin, sex, age, or disability in our health programs and activities.

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 888-311-9127 (Swedish Edmonds 888-311-9178) (TTY: 711).

注意：如果您講中文，我們可以給您提供免費中 文翻譯服務，請致電 888-311-9127 (Swedish Edmonds 888-311-9178) (TTY: 711)

COMM-19-0205-A 5/19