COMMUNITY HEALTH NEEDS ASSESSMENT

2021

Swedish Edmonds

SWEDISH
Edmonds

CONTENTS

LETTER FROM THE CEO

October 2021

To Our Communities:

Swedish is proud to be our community's health care partner, caring for all who walk through our doors. We know access to quality education, employment, housing and health care factor into a person's overall health and well-being.

As an extension of our strategic planning process, every three years we participate in a Community Health Needs Assessment (CHNA) survey. This assessment helps identify the greatest needs of those we serve. With this information, we can better focus on strategies to address them through our own programs and services, as well as in partnership with other like-minded organizations with our community benefit investments.

As outlined in our 2021 report, the following social determinants of health emerged across the communities of all Swedish locations during the assessment process: behavioral health challenges (including mental health and substance use), health care access, racism and discrimination and housing instability and homelessness. With this understanding, we will develop a community health improvement plan (CHIP) to specifically address many of these barriers to improving health. The CHIP will outline a process of strengthening our existing programs, considering new programs that will make a greater impact and partnering with other organizations and providers to collaborate on solutions.

This ensures Swedish is centered on the critical need of the communities in King and Snohomish counties. With implementation of our strategies, our patients and communities can take comfort in knowing we always work toward making our community a healthier place.

R. Guy Hudson, M.D., MBA

Chief Executive Officer

Swedish Health Services

CONTRIBUTORS AND ACKNOWLEDGEMENTS

Swedish 2021 CHNA Project Team

Ballard

- **Lynn Tissell, LSSBB**, Senior Executive Assistant, Swedish Ballard
- **Brandon Eichman**, Material Distribution and Receiving Technician, Swedish Ballard
- **Rebecca Montanez MSN, RN**, Supervisor, Swedish Ballard
- **Rebecca Nesse BSN, RN, CNOR**, Perioperative Services Manager, Swedish Ballard

Cherry Hill

- **Zachary Litvack, MD MCR FAANS FACS**, Chief Medical Officer, Swedish Cherry Hill
- **Kelli Long**, Senior Executive Assistant, Swedish Cherry Hill

Edmonds

- **Suzanne Iverson-Holstine**, Director, Business Development, Service Optimization & Physician Relations, Swedish Edmonds
- **Greg Masters**, Senior Manager Hospitality Services, Swedish Edmonds

First Hill

- **Christopher Chisholm, MD, MS, CPE, FAAEM**, Chief Medical Officer, Swedish First Hill
- **Pam Gallagher Felt**, Chief Financial Officer, Swedish Health Services Downtown Acute
- **Fran Chewning**, Senior Executive Assistant, Swedish First Hill
- **Sadreika Grace, MBA**, Senior Executive Assistant, Swedish First Hill
- **Teresa Davis**, Senior Executive Assistant, Swedish First Hill

Issaquah

- **Michelle Arnold, MD,** Chief Medical Officer, Swedish Issaquah
- **Megan Dockter, BSN, RN**, Manager, Swedish Issaquah
- **Kat Yun, OTR/L, CLT**, Manager Rehab Services, Swedish Issaquah
- **Kelly Huber**, Volunteer Services Manager, Swedish Issaquah
- **Michelle Faulk**, Senior Executive Assistant, Swedish Issaquah

Swedish Cancer Institute

- **Karen McInerney**, Director Women's Cancer Center Network, Swedish Cancer Institute

Swedish Shared Services

- **Erin Torrone**, Senior Community Health Program Coordinator, Swedish Community Health Investment & Partnerships
- **Pinky Herrera**, Community Health Program Manager, Swedish Community Health Investment & Partnerships
- **Jae Lim**, Multicultural Outreach Program Manager, Swedish Community Health Investment & Partnerships
- **Kim Anderson,** Director of Operations & Workforce Integration, Swedish Medical Center
- **Peter Mann-King, MSHCPM**, Program Manager, LGBTQI+ Program Initiative
- **Preshia Rami**, 2nd Year Undergraduate – UW Public Health

- **Jennifer Flores**, Seattle University Nursing Student
- **Anna Seth**, Seattle University Nursing Student

Executive Sponsor Swedish

- **Dr. Nwando Anyaoku, MD, MPH, MBA**, Chief Health Equity Officer, Swedish Medical Center
- **Kevin Brooks**, Chief Operating Officer, Swedish Medical Center

Project Sponsor Swedish

- **Kelly Guy**, Regional Director, Swedish Community Health Investment & Partnerships

Project Manager Swedish

- **Abby Larson**, Project Manager, PM Consulting Services, Swedish Medical Center

Providence

- **Catherine Romberger,** Program Manager, Data & Evaluation, Providence
- **Divya Prakriya**, Senior Community Health Data Analyst, Providence
- **Joshua Mendez,** Community Health Data Analyst, Providence
- **Megan McAninch-Jones**, Executive Director, Investment Strategy & Evaluation, Providence

Snohomish County Collaborative Partners

- Compass Health
  Tom Sebastian, President and Chief Executive Officer
- Community Health Center of Snohomish County
  Thomas Tocher, MD, MPH, FACP – Chief Medical Officer
  Cesar Hernandez, Medical Practice Manager
- Foundation for Edmonds School District
  Deborah Brandi, Executive Director
- Homage Senior Services
  Christine Vervitsiotis
- Snohomish Health District
  Christopher Spitters, MD, MPH – Health Officer
  Katie Curtis, MPH – Prevention Services Director
- South Snohomish County Fire
  Nicole Picknell, Captain Community Resource Paramedic
- Verdant Health Commission
  Zoe Reese, MPA – Director of Community Impact and Grantmaking

Consultant

- **Biel Consulting, Inc.** participated in project planning and completed the Community Health Needs Assessments and working with hospitals on developing, implementing, and evaluating community benefit programs.

EXECUTIVE SUMMARY

Since 1910, Swedish has been the region's standard-bearer for the highest-quality health care at the best value. 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. Swedish's innovative care has made it a regional referral center for leading-edge procedures such as robotic-assisted surgery and personalized treatment in cardiovascular care, cancer care, neuroscience, orthopedics, high-risk obstetrics, pediatric specialties, organ transplantation and clinical research.

Swedish is affiliated with Providence, a national, nonprofit Catholic health system comprising a diverse family of organizations and driven by a belief that health is a human right. With 52 hospitals, over 1,000 physician clinics, senior services, supportive housing and many other health and educational services, the health system and its partners employ more than 120,000 caregivers serving communities across seven states – Alaska, California, Montana, New Mexico, Oregon, Texas, and Washington – with system offices in Renton, WA and Irvine, CA. For more information, visit www.providence.org.

Swedish Edmonds Campus

The Swedish Edmonds campus, formerly known as Stevens Hospital, was operating in the community for 46 years before joining Swedish in 2010. As a community hospital, Swedish Edmonds is one of our most-visited Swedish campuses. The hospital serves communities in South Snohomish County and is the largest employer in the City of Edmonds.

Swedish Edmonds has 217 licensed beds, over 450 physicians and specialists on medical staff and a staff of over 1,400, including clinical and non-clinical personnel. The hospital provides a full scope of medical and surgical services, including Level IV Trauma emergency medicine, diagnostic, treatment, and support services. Swedish Edmonds is unique in its outstanding behavioral health services. In the past year, Swedish Edmonds received awards for its outstanding stroke treatment care, and its commitment to LifeCenter Northwest's organ donation program.

Community Health Needs Assessment

Swedish Edmonds has undertaken a Community Health Needs Assessment (CHNA). The Patient Protection and Affordable Care Act through IRS section 501(r)(3) regulations direct nonprofit hospitals to conduct a CHNA every three years and develop a three-year Implementation Strategy/Community Health Improvement Plan that responds to community needs.

Service Area

Swedish Edmonds campus is located at 21601 76th Ave. W., Edmonds, WA 98026. The community served by the Hospital is defined by the geographic origins of the Hospital's patients whose conditions require admission to the hospital for at least one night. Swedish Medical Center Edmonds provides care to Snohomish County. Based on the availability of data, geographic access to these facilities and primary care, and other hospitals in neighboring counties, census tracts from the following ZIP Codes serve as the boundary for the hospital service area: 98020, 98026, 98043, 98036, 98037, 98087, 98012, 98204 and 98208.

Swedish Edmonds Service Area

Primary City	ZIP Code
Bothell	98012
Edmonds	98020, 98026
Everett	98204, 98208
Lynnwood	98036, 98037, 98087
Mountlake Terrace	98043

Providence Need Index

Within a medical center's total service area there is a high need service area, which is based on the social determinants of health specific to the inhabitants of the service area census tracts. Based on work done by the Public Health Alliance of Southern California and their Healthy Places Index (HPI) tool, census tracts with more people below 200% FPL, fewer people with at least a high school education, more people in limited English households and a lower life expectancy at birth were identified as "high need." In the Swedish Edmonds service area, 28 of 63 census tracts (44.4%) scored as high need.

Methodology

Secondary Data

Secondary data were collected from a variety of county and state sources. For this analysis, census tracts with more people below 200% FPL, fewer people with at least a high school education, more people in limited English households and a lower life expectancy at birth were identified as "high need." The Snohomish County Data Hub link provides access to interactive maps, which visually depict demographics, social risk, and other indicators at the census tract level. The hub includes indicators related to housing, food security, income, education, insurance status, chronic diseases, and more.

Primary Data

Swedish conducted stakeholder interviews and community listening sessions. Listening to and engaging with the people who live and work in the community is a crucial component of the CHNA, as these individuals have firsthand knowledge of the needs and strengths of the community. Swedish conducted

18 stakeholder interviews including 27 participants, people who are invested in the well-being of the community and have first-hand knowledge of community needs and strengths. They also included 9 listening sessions: 7 from King County and 2 from Snohomish County. The goal of the interviews and listening sessions was to identify what needs are currently not being met in the community and what assets could be leveraged to address these needs. Swedish Medical Centers also conducted a community survey in English from July 3 to August 31, 2021. In Snohomish County, 232 community members participated in the survey.

Prioritization of Health Needs

The following findings represent the high-priority health-related needs, based on community stakeholder interview and listening session participant input:

- Behavioral health (includes mental and substance use)
- Homelessness and housing instability
- Racism and discrimination

The following findings represent the medium-priority health-related needs, based on community input:

- Access to health care
- Dental care
- Affordable childcare and preschools
- Food insecurity
- Economic insecurity

The survey respondents selected good paying jobs, assistance getting healthy food, and a caring community as the top three priorities needed to improve the health and well-being of themselves and their families.

Prioritization of Needs for the 2022-2024 CHIP

An ad hoc committee of Swedish leaders from across the system, with experience in the areas of need, were brought together to vote on Swedish's prioritization ranking for the upcoming CHIP (Community Health Improvement Plan). The following needs were prioritized by Swedish leaders:

- Behavioral health challenges (including mental health and substance use)
- Access to health care
- Racism and discrimination
- Housing instability and homelessness

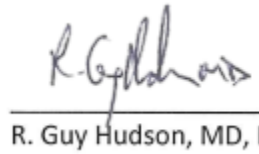
CHNA/CHIP Contact

Kelly R. Guy
Regional Director
Swedish Community Health Investment & Partnerships
Kelly.Guy@Providence.org

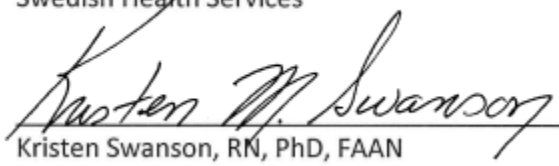
To request a copy free of charge, provide comments, or view electronic copies of current and previous Community Health Needs Assessments, please email CHI@providence.org

2021 CHNA GOVERNANCE APPROVAL

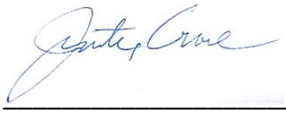
This CHNA was adopted by the Board of Trustees of the hospitals on November 9, 2021. The final report was made widely available by December 28, 2021.



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



Kristen Swanson, RN, PhD, FAAN
Chair Board of Trustees
Swedish Health System



12/7/2021

Justin M. Crowe, PhD
Senior Vice President, Community Partnerships
Providence

CHNA/CHIP Contact

Kelly R. Guy
Regional Director
Swedish Community Health Investment & Partnerships
Kelly.Guy@Providence.org

To request a copy free of charge, provide comments, or view electronic copies of current and previous Community Health Needs Assessments, please email CHI@providence.org

INTRODUCTION

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.

Who We Are

Since 1910, Swedish has been the region's standard-bearer for the highest-quality health care at the best value. 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. Swedish's innovative care has made it a regional referral center for leading-edge procedures such as robotic-assisted surgery and personalized treatment in cardiovascular care, cancer care, neuroscience, orthopedics, high-risk obstetrics, pediatric specialties, organ transplantation and clinical research.

Swedish is affiliated with Providence, a national nonprofit Catholic health system comprising a diverse family of organizations and driven by a belief that health is a human right. With 52 hospitals, over 1,000 physician clinics, senior services, supportive housing, and many other health and educational services, the health system and its partners employ more tha 120,000 caregivers serving communities across seven states – Alaska, California, Montana, New Mexico, Oregon, Texas, and Washington – with system offices in Renton, WA and Irvine, CA. For more information, visit www.providence.org.

Swedish Edmonds Campus

The Swedish Edmonds campus, formerly known as Stevens Hospital, was operating in the community for 46 years before joining Swedish in 2010. As a community hospital, Swedish Edmonds is one of our most-visited Swedish campuses. The hospital serves communities in South Snohomish County and is the largest employer in the City of Edmonds.

Swedish Edmonds has 217 licensed beds, over 450 physicians and specialists on medical staff and a staff of over 1,400, including clinical and non-clinical personnel. The hospital provides a full scope of medical and surgical services, including Level IV Trauma emergency medicine, diagnostic, treatment, and support services. Swedish Edmonds is unique in its outstanding behavioral health services. In the past year, Swedish Edmonds received awards for its outstanding stroke treatment care, and its commitment to LifeCenter Northwest's organ donation program.

Our Commitment to Community

Organizational Commitment

Swedish has been a partner for health in the community for over a hundred years. We've resolved to improve the health of the region beyond normal patient care. This translates to our commitment to charity care, research, community health and education. We see this service as our responsibility to our community and we take it seriously. Swedish invested $258 million in community benefit in 2020, including support to programs that address social determinants of health and improve access to care.

Today our responsibility to community also includes additional access to information. The health care industry is undergoing substantial changes. We believe as the community's leading health care provider, it is our responsibility to also provide information and leadership on these changes.

Governance Structure

Swedish further demonstrates organizational commitment to the community benefit process through the allocation of staff time, financial resources, participation and collaboration. The Chief Strategy Officer at Swedish is responsible for coordinating implementation Federal 501r requirements as well as providing the opportunity for community leaders and internal hospital Executive Management Team members, physicians and other staff to work together in planning and implementing the Community Health Improvement Plan (CHIP).

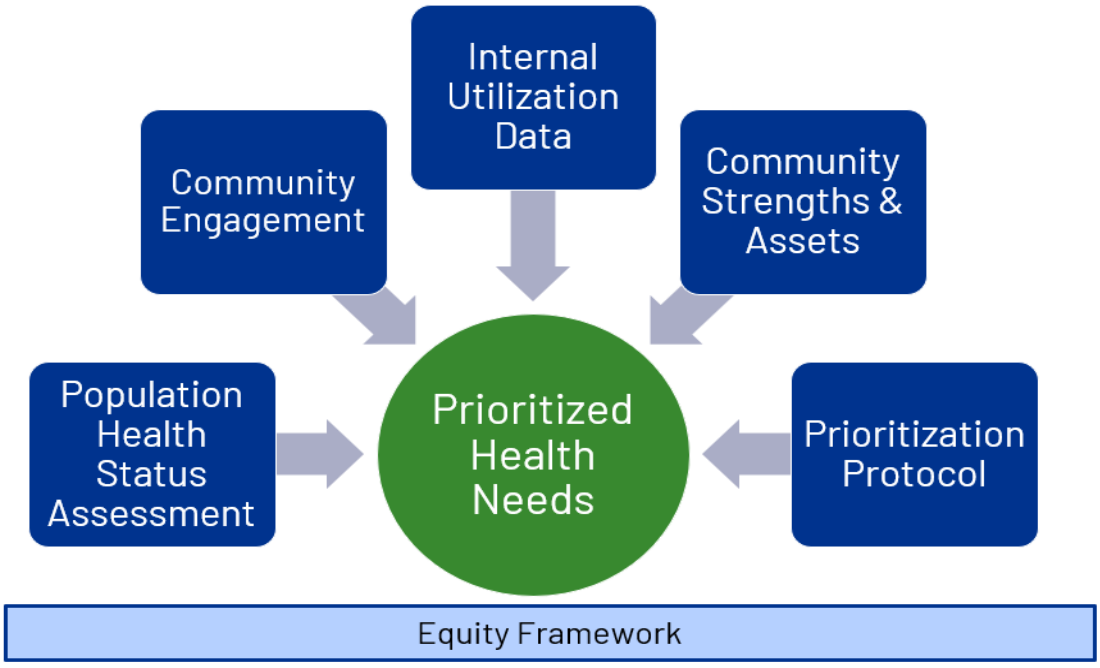
RESPONDING TO THE COVID-19 PANDEMIC

The 2021 Community Health Needs Assessment process was disrupted by the SARS-COV-2 virus and COVID-19, which has impacted all of our communities. While our communities have focused on crisis response, it has required a concentration of resources and reduced community engagement, which impacted survey distribution and community listening sessions. Additionally, the impacts of COVID-19 are likely to effect community health and well-being beyond what is currently captured in secondary and publicly available data. We seek to engage the community as directly as possible in prioritizing needs and through the community health improvement process.

We recognize that in these unprecedented times, COVID-19 is likely to exacerbate existing community needs and may bring others to the forefront. Our commitment first and foremost is to respond to the needs of our communities, particularly individuals who are disproportionately impacted by the economic and social effects of COVID-19. While this is a dynamic situation, we recognize the greatest needs of our communities will continue to change, and it is important that we adapt our efforts to respond accordingly. We are committed to supporting, strengthening, and serving our communities in ways that align with our mission, engage our expertise, and leverage our Community Benefit dollars in the most impactful ways.

CHNA FRAMEWORK

We have adopted a modified approach to Mobilizing for Action through Planning and Partnerships (MAPP), the framework recommended by the National Association of City & County Health Officials (NACCHO). With a basis in equity, our approach includes five key components that feed into identifying and prioritizing community health needs.

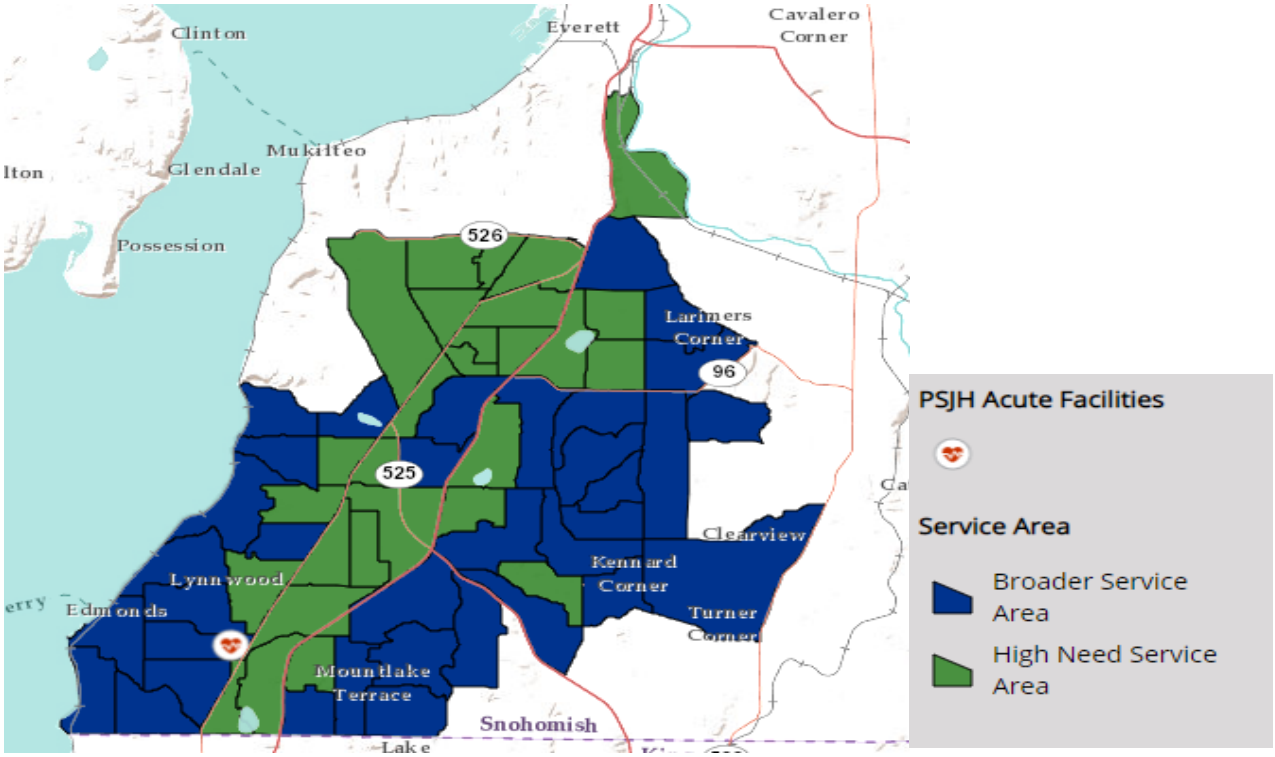


*modified MAPP Framework

OUR COMMUNITY

Hospital Service Area and Community Served

Swedish Medical Center Edmonds provides care to Snohomish County. Snohomish County has a population of approximately 823,512 people. Based on the availability of data, geographic access to these facilities and primary care, and other hospitals in neighboring counties, census tracts from the following ZIP Codes serve as the boundary for the hospital service area: 98020, 98026, 98043, 98036, 98037, 98087, 98012, 98204 and 98208. See map below for further detail, including communities identified as higher need. There are 28 census tracts in the high need service area and 35 in the broader service area.



Service Area Map

Providence Need Index

Within a medical center's total service area there is a high need service area, which is based on the social determinants of health specific to the inhabitants of the service area census tracts. Based on work done by the Public Health Alliance of Southern California and their Healthy Places Index (HPI) tool, the following variables were used to calculate a high need census tract:

- Population below 200% the Federal Poverty Level (American Community Survey, 2019)
- Percent of population with at least a high school education (American Community Survey, 2019)

- Percent of population, ages 5 Years and older in Limited English Households (American Community Survey, 2020)
- Life expectancy at birth (estimates based on CDC, 2010 – 2015 data)

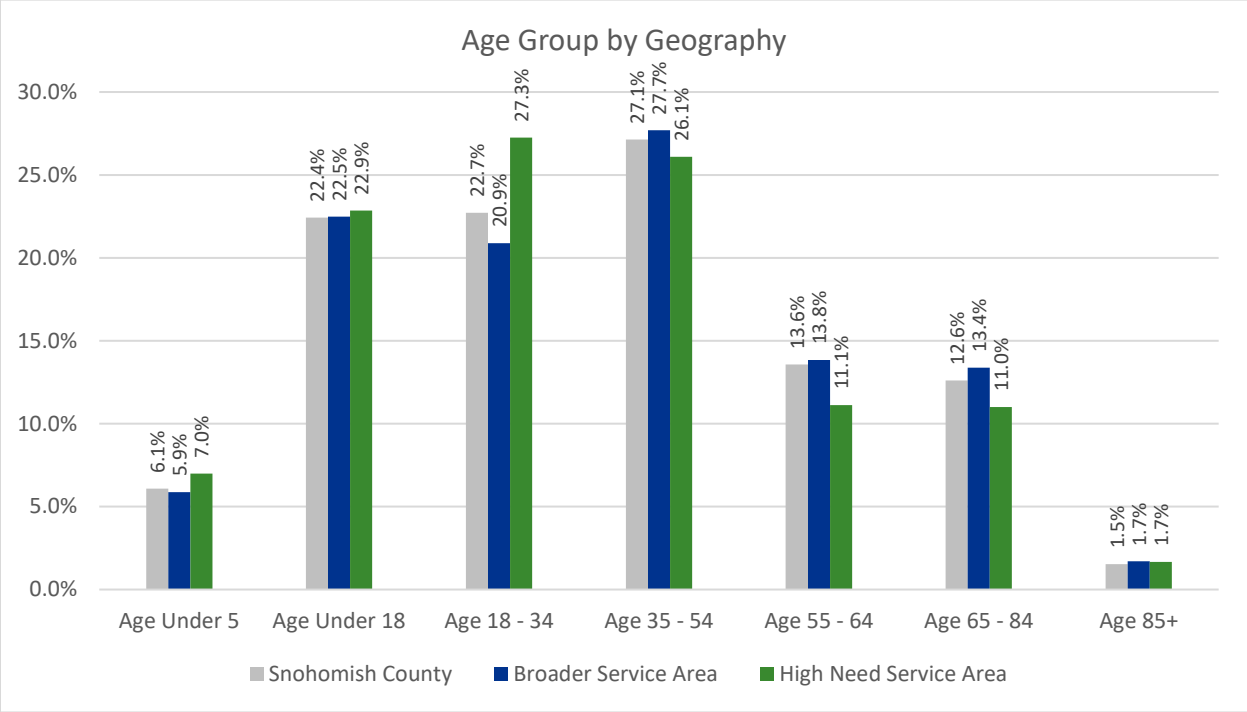
For this analysis, census tracts with more people below 200% FPL, fewer people with at least a high school education, more people in limited English households and a lower life expectancy at birth were identified as "high need." All variables were weighted equally and the average value of the population was assigned to census tracts that did not have an estimated life expectancy at birth. Ultimately, the census tracts were given a score between 0 and 1 where 0 represents the best performing census tract and 1 is the worst performing census tract according to the criteria. Census tracts that scored higher than the average were classified as high need service areas and are depicted in green. In the Swedish Edmonds service area, 28 of 63 census tracts (44.4%) scored above the average of 0.30 for the final rescaled score, indicating a high need.

Community Demographics

The tables and graphs below provide basic demographic and socioeconomic information about the service area and how the high need areas compare to the broader service area. The high need areas include census tracts with lower life expectancy at birth, a lower percent of the population with at least a high school diploma, more households that are linguistically isolated and more households at or below 200% of the Federal Poverty Level (FPL) compared to county averages. (For reference, in 2019, 200% FPL represents an annual household income of $51,500 or less for a family of four.) For the socioeconomic indicators, the broader service area and high need service area values are calculated based on the average of the census tracts within each service area classification.

POPULATION AND GENDER DEMOGRAPHICS

Indicator	Snohomish County	Broader Service Area	High Need Service Area
2019 Total Population	823,512	213,807	163,839
Female Population	412,345 (50.1%)	108,684 (50.8%)	82,675 (50.5%)
Male Population	411,167 (49.9%)	105,123 (49.2%)	81,164 (49.5%)



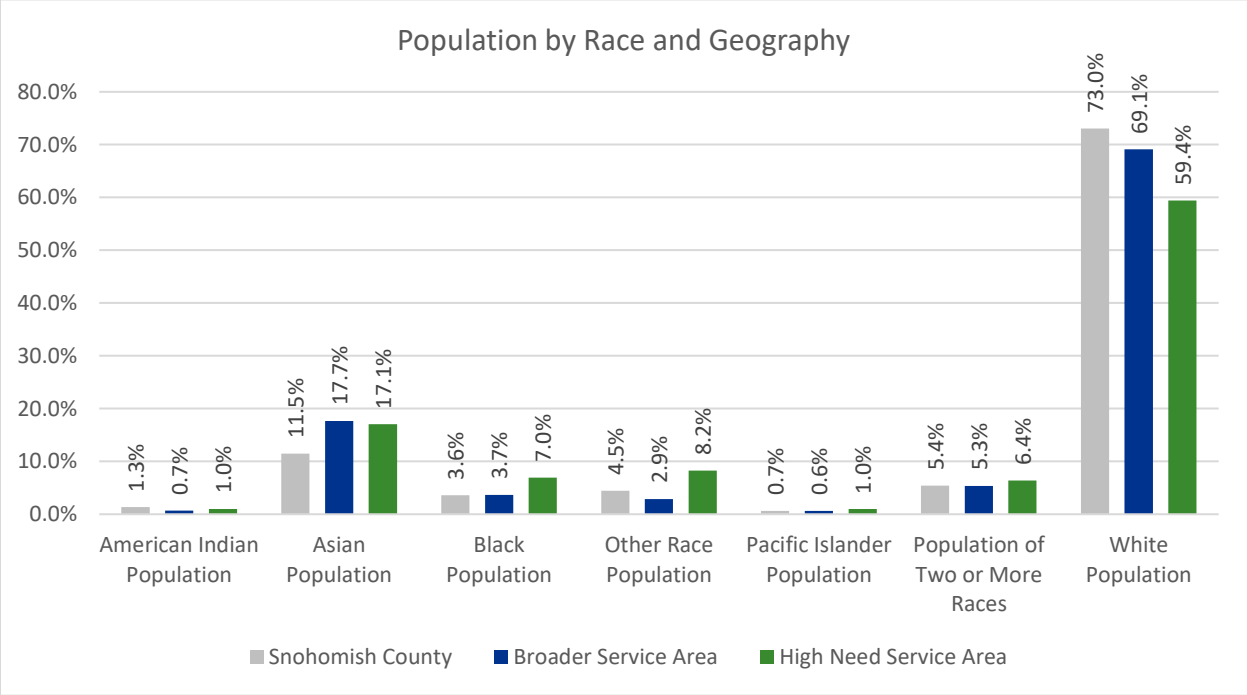
POPULATION, BY AGE

Indicator	Snohomish County	Broader Service Area	High Need Service Area
Population, Age Under 5	50,046 (6.1%)	12,568 (5.9%)	11,444 (7%)
Population, Age Under 18	184,761 (22.4%)	48,096 (22.5%)	37,456 (22.9%)
Population, Age 18 - 34	187,013 (22.7%)	44,660 (20.9%)	44,656 (27.3%)
Population, Age 35 - 54	223,400 (27.1%)	59,209 (27.7%)	42,742 (26.1%)
Population, Age 55 - 64	111,788 (13.6%)	29,584 (13.8%)	18,221 (11.1%)
Population, Age 65 - 84	103,876 (12.6%)	28,603 (13.4%)	18,037 (11%)
Population, Age 85+	12,674 (1.5%)	3,655 (1.7%)	2,727 (1.7%)

POPULATION, BY RACE AND ETHNICITY

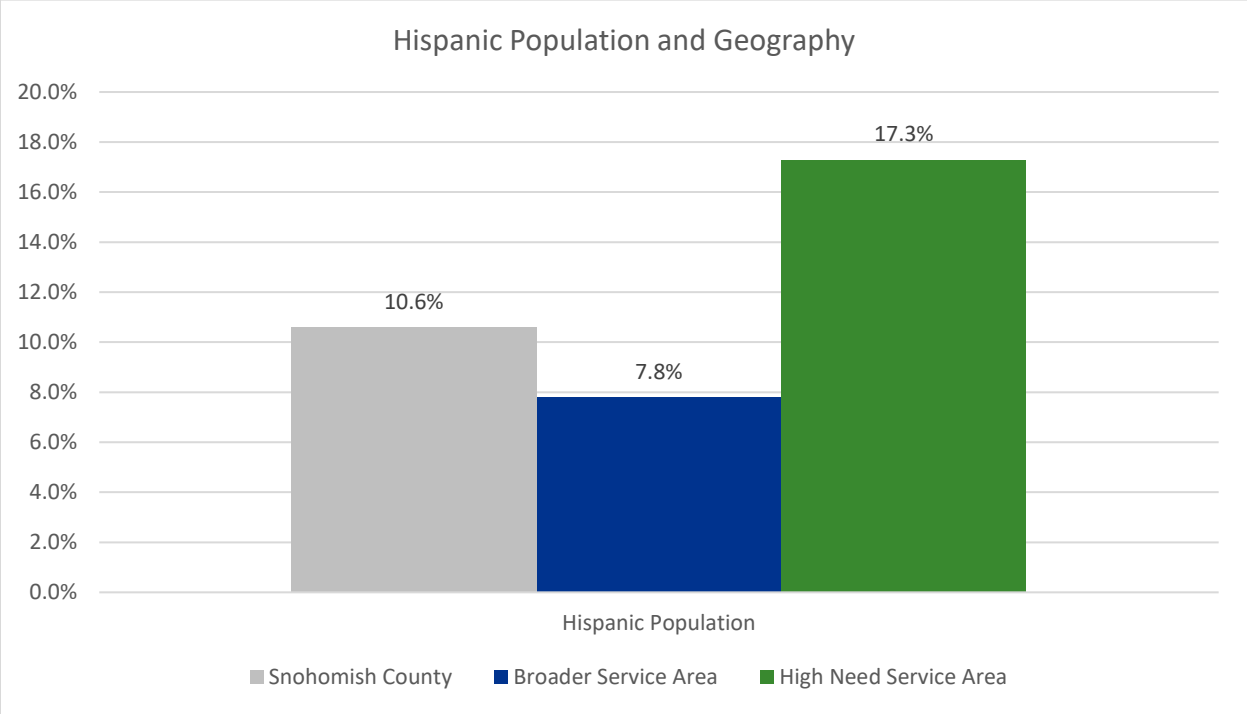
Indicator	Snohomish County	Broader Service Area	High Need Service Area
American Indian Population	10,947 (1.3%)	1,550 (0.7%)	1,603 (1%)
Asian Population	94,441 (11.5%)	37,736 (17.7%)	27,939 (17.1%)
Black Population	29,712 (3.6%)	7,883 (3.7%)	11,399 (7%)

Indicator	Snohomish County	Broader Service Area	High Need Service Area
Other Race Population	36,713 (4.5%)	6,178 (2.9%)	13,497 (8.2%)
Pacific Islander Population	5,414 (0.7%)	1,314 (0.6%)	1,596 (1%)
Two or More Races	44,776 (5.4%)	11,407 (5.3%)	10,416 (6.4%)
White Population	601,509 (73%)	147,739 (69.1%)	97,389 (59.4%)



Hispanic Population in Snohomish County Service Area

Indicator	Snohomish County	Broader Service Area	High Need Service Area
Hispanic Population	10.6%	7.8%	17.3%



NOTE: In the following tables the values for the columns in the broader service area and the high need service area represent the average value of the census tracts in those service area types.

MEDIAN INCOME

The average median household income for census tracts in the high need service area is more than $35,000 lower than the median household income for the broader service area. The average median household income for census tracts in the broader service area is approximately $18,000 higher than that of Snohomish County.

Indicator	Snohomish County	Broader Service Area	High Need Service Area
Median Income	$85,254	$103,604	$67,966

Data Source: American Community Survey, 2019

POPULATION BELOW 200% FEDERAL POVERTY LEVEL

In Snohomish County, 21.3% of the population is considered low-income (200% of the Federal Poverty Level). In the high need service area, 32.8% of the population is low-income.

Indicator	Snohomish County	Broader Service Area	High Need Service Area
Population Below 200% Federal Poverty Level	21.3%	12.5%	32.8%

Data Source: American Community Survey, 2019

SEVERE HOUSING COST BURDEN

Severe housing cost burden is defined as households spending 50% of more of their income on housing costs. The average severe housing cost burden by population in high need service area census tracts is 23.2%, which is higher than the County value (21.7%) and the broader service area census tracts (18.1%).

Indicator	Snohomish County	Broader Service Area	High Need Service Area
Renter Households with Severe Housing Cost Burden	21.7%	18.1%	23.2%

Data Source: American Community Survey, estimates based on 2013 – 2017

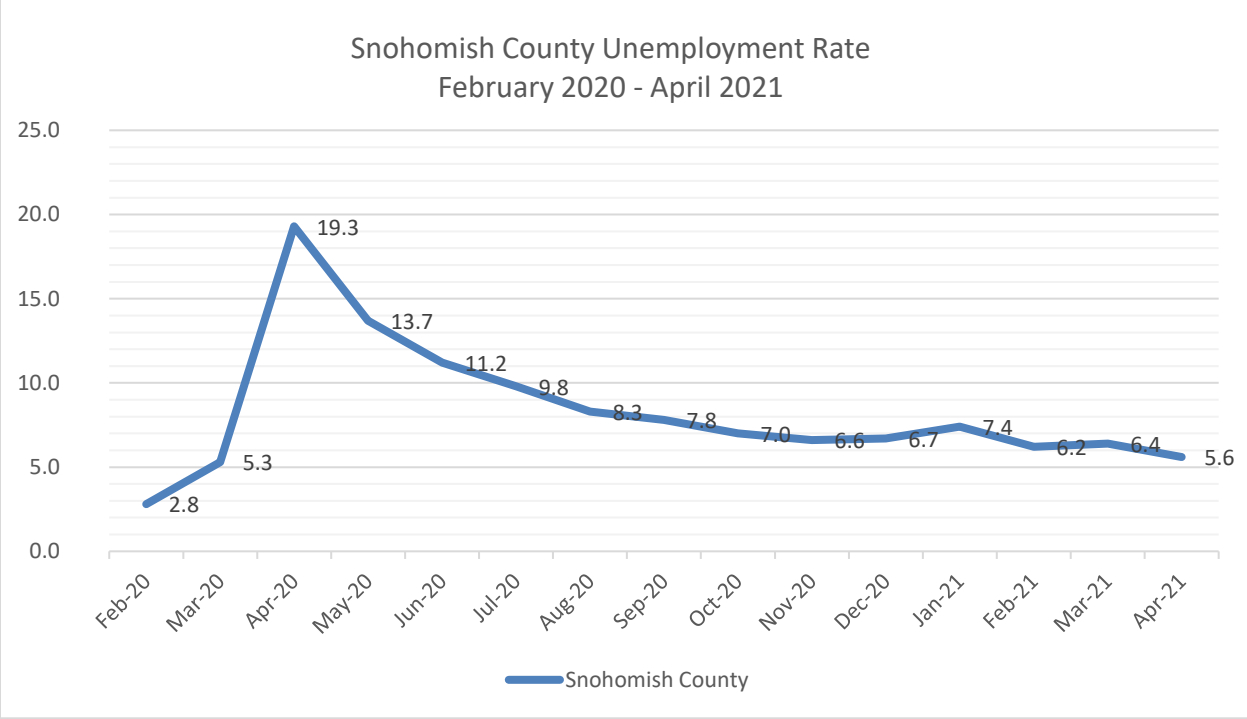
LABOR FORCE UNEMPLOYED

At the end of April 2021, the unemployment rate in Snohomish County was 5.6%.

Indicator	Snohomish County	Washington	United States
Labor Force Unemployed	5.6%	5.5%	6.1%

Data Source: U.S Bureau of Labor Statistics, April 2021

Between February 2020 and April 2020, the unemployment rate for Snohomish County increased 589% from 2.8% to 19.3%.



HOUSEHOLDS RECEIVING SNAP BENEFITS

The Supplemental Nutrition Assistance Program (SNAP) is a government food assistance program that provides nutrition benefits to supplement the food budget of needy families so they can purchase healthy food and move towards self-sufficiency. In the high need service area, 15.7% of households receive SNAP benefits.

Indicator	Snohomish County	Broader Service Area	High Need Service Area
Households Receiving SNAP Benefits	11.1%	6.2%	15.7%

Data Source: American Community Survey, 2013 – 2017 estimates

LANGUAGE PROFICIENCY

In the high need service area, 6.2% of the population lives in a limited English household, compared to Snohomish County (2.8%).

Indicator	Snohomish County	Broader Service Area	High Need Service Area
Population In Limited English Households	2.8%	2.1%	6.2%

Data Source: American Community Survey, 2015 – 2019 estimates

POPULATION WITH A HIGH SCHOOL EDUCATION, AGES 25 AND OLDER

In Snohomish County, 92.6% of the adult population, ages 25 and older, has a high school diploma. 89.2% of the population in the high need service area has a high school diploma.

Indicator	Snohonmish County	Broader Service Area	High Need Service Area
Population, Ages 25 and Older, with a High School Diploma	92.6%	95.5%	89.2%

Data Source: American Community Survey, 2019

HOUSEHOLDS WITHOUT INTERNET ACCESS

Households without internet access are higher in the high need service area (8.2%) compared to Snohomish County (6.6%).

Indicator	Snohomish County	Broader Service Area	High Need Service Area
Households with No Internet Access	6.6%	4.0%	8.2%

Data Source: American Community Survey, 2019

DATA COLLECTION AND PRIORITIZATION OF NEEDS

Secondary Data

Secondary data were collected from a variety of county and state sources. For this analysis, census tracts with more people below 200% FPL, fewer people with at least a high school education, more people in limited English households and a lower life expectancy at birth were identified as "high need." The Snohomish County Data Hub link provides access to interactive maps, which visually depict demographics, social risk, and other indicators at the census tract level. The hub includes indicators related to housing, food security, income, education, insurance status, chronic diseases, and more.

Primary Data

Swedish conducted stakeholder interviews and community listening sessions. Listening to and engaging with the people who live and work in the community is a crucial component of the CHNA, as these individuals have firsthand knowledge of the needs and strengths of the community. Swedish conducted 18 stakeholder interviews including 27 participants, people who are invested in the well-being of the community and have first-hand knowledge of community needs and strengths. They also included 9 listening session: 7 from King County and 2 from Snohomish County. The goal of the interviews and listening sessions was to identify what needs are currently not being met in the community and what assets could be leveraged to address these needs. Full details on the protocols, findings, and attendees are available in Appendix 1.

Community Strengths

While a CHNA is primarily used to identify gaps in services and challenges in the community, we want to ensure that we highlight and leverage the community strengths that already exist, including the following identified for South Snohomish County:

A Spirit of Collaboration Among Community Organizations

Stakeholders shared health care organizations collaborate well and there are many opportunities for meetings to discuss best practices. Stakeholders discussed a sense of collaboration between providers, with very little negative competition. They also shared they have seen organizations work together to leverage one another's strengths to meet community needs.

Priority Community Needs

Listening session participants primarily discussed four community needs: behavioral health challenges, access to health care services, racism and discrimination, and food insecurity. They emphasized the need to better meet the mental health needs of young people in schools and the importance of community and support systems for well-being. Participants spoke about the negative mental health effects of trauma and racism, particularly on Native American communities. Participants also discussed the need for health care professionals to go into communities and meet people where they are, building

trust with communities in non-clinical settings. They discussed a need for improved data sharing and communication among different health providers, and the need for more support navigating the complexity of the health care system. Additionally, they noted concern for increased food insecurity as a result of COVID-19, particularly for young people. The following needs were prioritized based on stakeholder ranking but include feedback from stakeholder interviews and listening session participants.

The following findings represent the **high-priority health-related needs,** based on community input:

Behavioral health challenges and access to care (including mental health and substance use disorders)	Many stakeholders identified mental health and substance use disorders (SUD) as the greatest needs in the community. They shared needing more **BBIPOC (Black, Brown, Indigenous, and People of Color) providers** and better **support for parents** with children with mental health challenges. In Snohomish County, stakeholders shared a need for more **intensive behavioral health services** and more **trained professionals** to meet the demand. Listening sessions participants and stakeholders noted the importance of **spiritual and community aspects of healing** and well-being. Stakeholders in King and Snohomish Counties named **young people** as a population with unmet mental health needs, as well as young people identifying as **LGBTQ+** and **survivors of domestic violence**. Listening session participants were also concerned about needing more mental health support services in schools and better resource integration and navigation through schools. **Patients who speak languages other than English** may face more difficulty navigating the health care system. Most stakeholders and listening session participants shared the **COVID-19 pandemic** has exacerbated mental health needs, adding stress to a system already unable to meet the full demand. Participants were particularly concerned about young people and older adults as a result of increased isolation.
Homelessness and housing instability	Stakeholders spoke to the importance of addressing housing needs first and in conjunction with behavioral health and access to care challenges, as housing is a foundational need. Stakeholders from across King and Snohomish Counties identified the high cost of housing as the biggest challenge for families, noting families are being pushed out of their neighborhoods due to **rising housing costs** and **gentrification**. High housing costs create economic instability, leading to spending tradeoffs. It can also be a source of stress for families, particularly those with **mixed documentation statuses** or those who are **underemployed**. Stakeholders noted a need for more **shelter beds** in King and Snohomish Counties; more **low-income housing**, particularly in Seattle; and more resources to meet the **basic needs** of people experiencing homelessness in Snohomish County. Listening session participants noted a need for more affordable housing that meets the needs of people at all ages. As a result of the **COVID-19 pandemic**, stakeholders spoke about increased homelessness and housing instability. They noted many families are concerned about how they will pay the rent they owe when the eviction moratorium is lifted, affecting mental health and economic stability.

Racism and discrimination	Stakeholders in King and Snohomish Counties discussed racism and discrimination as drivers of other community needs, although they were more frequently prioritized in King County. Stakeholders in Snohomish County noted there is still a lot of work to do to address the issue in the community. In King County, stakeholders noted how racism plays a role in **gentrification**, unsustainable rent prices, and a lack of options for home ownership. Racist hiring practices also affect **employment opportunities** for BBIPOC communities. Racism and discrimination contribute to people not feeling **seen and valued** in the community. Stakeholders and listening session participants discussed how a lack of tribal recognition and land access and historical trauma affect the opportunities, health, and well-being of **Native American communities**. Listening session participants noted a need for more education of young people about the **history** of the United States and racism in the country. The **COVID-19 pandemic** has led to an increase in hate crimes and racism, particularly against the Asian community as noted by Snohomish County stakeholders. It has also highlighted racism as a public health issue and opportunity gaps in education for BBIPOC students.

The following findings represent the **medium-priority health-related needs,** based on community input:

Access to health care	**Transportation** was the main barrier to care discussed by stakeholders and listening session participants in both counties. Stakeholders also identified the **cost of care**, **technology**, **language barriers**, and **health literacy** as barriers. King County stakeholders noted a need for more **wraparound services**, particularly for patients experiencing homelessness. Listening session participants and stakeholders agreed there is a need for health care professionals to go into communities and **meet people where they are** to provide health and wellness information. Participants also noted a need for more **health education**, better **data sharing** among different health care systems, and **continuity of care** with a provider. Certain populations were named as having more barriers to accessing high-quality, respectful care: **patients experiencing homelessness**, **families with mixed documentation statuses**, **Native American communities**, and **individuals identifying as LGBTQ+**. Due to the **COVID-19 pandemic**, some patients delayed accessing routine primary care and chronic disease management, resulting in worsening conditions. While telehealth visits were positive for some, they created increased barriers for patients who speak a language other than English and those that do not have access to or comfort with technology. The COVID-19 vaccine rollout highlighted the importance of building trust with patients and bringing services to community members in non-clinical locations.
Dental care	Many stakeholders in King and Snohomish Counties identified dental care as a big need and one that is linked with overall health and well-being. Stakeholders shared accessing dental care can be especially challenging for patients who are **uninsured** or who have **Medicare** or **Medicaid**. **Transportation** to dental appointments is also a barrier and stakeholders noted the potential benefits of mobile dental units. Populations of particular concern include **people over the age of 65** and **people with low incomes**. The **COVID-19** pandemic resulted in reduced access to dental care and reduced capacity for some dental providers.

Affordable childcare and preschools	Snohomish County stakeholders prioritized this need more often than in King County. Stakeholders emphasized that affordable childcare is foundational for ensuring people can **work** and meet their family's **basic needs**, including accessing health care services. Safe and reliable childcare promotes **stability** in families, and investing in early childhood services improves children's futures and outcomes. Stakeholders' primary concern was the "outrageous" **cost of childcare**, noting many families spend a substantial amount of their income on the service, affecting their economic stability. Families with low incomes have limited options for licensed childcare providers that accept the DSHS **childcare subsidy**. Families that speak languages other than English may have more challenges finding adequate childcare and communicating their needs. As a result of the **COVID-19 pandemic**, many childcare services had to close, forcing some parents to leave jobs to stay home with their children.
Food insecurity	Snohomish County stakeholders prioritized this need more often than in King County. Stakeholders prioritized food insecurity because of the importance of ensuring everyone has access to **nutritious, culturally relevant foods**. They noted there are certain geographic areas, such as **South King County**, where some immigrant and refugee communities are not able to access food that meets their cultural needs. Listening session participants noted the importance of sharing food resources in multiple languages, particularly in South King County. Populations disproportionately affected by food insecurity include families with **mixed documentation statuses** that may not qualify for or may not feel safe applying for food assistance programs. **Survivors of domestic violence, people with low incomes, older adults,** and **families experiencing homelessness** may experience barriers to accessing consistent, nutritious, affordable foods. Listening session participants were concerned about students lacking sufficient meals, which can contribute to issues in school. Stakeholders were particularly concerned about older adults and young people experiencing increased food insecurity during the **COVID-19 pandemic**.
Economic insecurity	Economic insecurity was discussed in both counties, but more frequently prioritized in King County. It was primarily discussed in connection to **housing and food insecurity**. In Snohomish County, stakeholders discussed seeing families living in overcrowded conditions because their income does not meet the cost of living. They also shared families are experiencing **stress** trying to meet their basic needs, such as for sufficient food. King County stakeholders noted finding a good paying employment opportunity can be more challenging **for BBIPOC communities** due to racism in hiring practices. Populations disproportionately affected by economic insecurity include **families with mixed documentation statuses** and **older adults**. The **COVID-19 pandemic** has exacerbated economic insecurity for families that either lost their jobs or needed to stay home to care for their children.

Community Survey

Swedish Medical Centers conducted a community survey in English from July 3 to August 31, 2021. In King County, 744 community members took the survey and in Snohomish County 232 community members participated in the survey. Key highlights are shared below, and a detailed report can be found in Appendix 2.

A majority of survey respondents were between the ages of 35-54 (52.08%). The second largest age group of respondents was 18-34 (39.79%). In comparison, 27.43% of the population was between the ages of 35-54 and 23.61% of the population was between the ages of 18-34.

The survey used a convenience sample, but survey respondents represented communities that were likely under-represented through other sources. The three largest racial groups among survey respondents self-identified as white (62.49%), Black or African American (12.64%) and Asian (8.70%). 63.5% of respondents indicated that their household income was between $30,000 and $59,000.

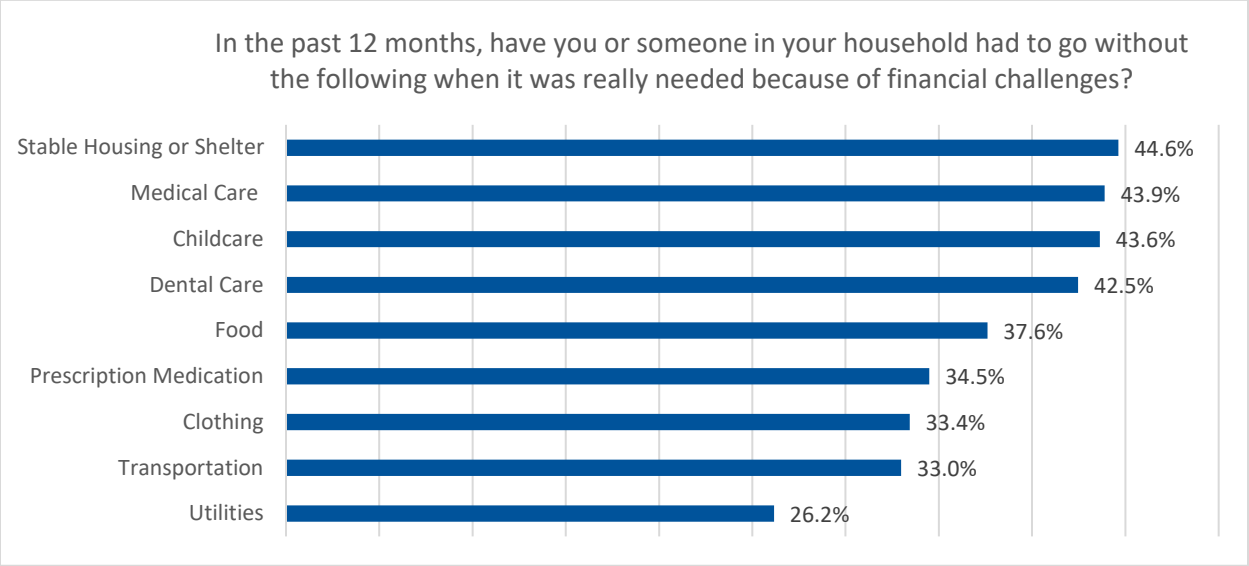
Out of 17 response options, respondents selected good paying jobs (13.67%), assistance getting healthy food (12.08%), and a caring community (10.90%) as the top three priorities needed to improve the health and well-being of themselves and their family.

Table 1. Please select the TOP 3 things needed to improve the health and well-being of you and your family

Response	Count	Percentage
Good Paying Jobs	395	13.67%
Assistance Getting Healthy Food	349	12.08%
Caring Community	315	10.90%
Easy Access to Health Services	283	9.79%
Affordable Housing	261	9.03%

The top 3 categories respondents reported going without within the past 12 months include stable housing and shelter (44.6%), medical care (43.9%), and childcare (43.6%).

Figure 1. In the past 12 months, have you or someone in your household had to go without the following when it was really needed because of financial challenges?



Over 70% of respondents reported having housing of their own. However, 33.85% were concerned about losing their housing. 21.53% of respondents reported staying with friends and family.

Table 2. Which of the following best describes your housing situation today?

Response	Count	Percentage
I have housing of my own and I'm NOT worried about losing it	362	37.47%
I have housing of my own, but I AM worried about losing it	327	33.85%
I'm staying with friends or family	208	21.53%
I'm staying in a shelter, in a car, or on the street	33	3.42%
I'm staying in an Adult foster care facility	23	2.38%
I'm staying in a retirement home	9	0.93%
I'm staying in a nursing home	3	0.31%
Other	1	0.10%

Challenges Obtaining Community Input

Obtaining robust community input during the COVID-19 pandemic was especially challenging and prevented Swedish from completing many in-person conversations. Stakeholder interviews and listening sessions were adapted to be conducted virtually. While video conferencing does facilitate information sharing, there were challenges obtaining the depth of dialogue that would take place in person. Additionally, due to many community organizations engaging in the COVID-19 response, some organizations had limited capacity and were not able to participate in interviews. While efforts were

made to distribute the survey through community partners, limited capacity, COVID-related closures, and survey fatigue may have affected distribution and willingness to participate.

Public Comment

In compliance with IRS regulations 501(r) for charitable hospitals, a hospital Community Health Needs Assessment (CHNA) and Implementation Strategy are to be made widely available to the public and public comment is to be solicited. These reports were made widely available to the public on the website https://www.swedish.org/about/overview/mission-outreach/community-health-investment/community-needs-assessment. Public comment was solicited on the reports; however, to date no comments have been received.

Community Resources

Community stakeholders identified resources potentially available to address the priority health needs. These are presented in Appendix 3.

Review of Progress

In 2018, Swedish conducted the previous Community Health Needs Assessments (CHNA). Significant health needs were identified from the Community Health Needs Assessment process. Swedish then identified priorities for the Community Health Improvement Plans associated with the CHNA. The impact of actions used to address these health needs can be found in Appendix 4.

HEALTH INDICATORS

UNINSURED

In Snohomish County, 6.1% of the population are uninsured. This rate is 9.8% in the high need service area.

Indicator	Snohomish County	Broader Service Area	High Need Service Area
Population with No Health Insurance Coverage	6.1%	4.4%	9.8%

Data Source: American Community Survey, 2019

LIFE EXPECTANCY AT BIRTH

Life expectancy at birth is 78.8 year among the population in the high need service area. This is a shorter life expectancy of the overall population in Snohomish County (80.5 years).

Indicator	Snohomish County	Broader Service Area	High Need Service Area
Average Life Expectancy at Birth	80.5	81.5	78.8

Data Source: CDC National Center for Health Statistics, 2010-2015

LEADING CAUSES OF DEATH IN SNOHOMISH COUNTY

The top three causes of death in Snohomish County are malignant neoplasms (cancer), heart disease and accidents.

Causes of Death	Number of Deaths
Malignant Neoplasms	1331
Diseases of Heart	1055
Accidents	413
Alzheimer's Disease	269
Chronic Lower Respiratory Diseases	292
Cerebrovascular Diseases	238
Diabetes Mellitus	204
Intentional Self Harm	111
Chronic Liver Disease and Cirrhosis	106

Causes of Death	Number of Deaths
Influenza and Pneumonia	76

Data Source: WA State Department of Health Statistics, 2019 All Deaths Dashboard :: Washington State Department of Health

BIRTH INDICATORS

Babies born with a birth weight between 227 grams and 2499 grams are born at low birth weight. 6.2%, or 599 babies, were born at low birth weight in Snohomish County. In comparison, 6.4% of babies were born with low birth weight in the State of Washington.

Indicator	Snohomish County	WA State
Total Births	9,665	84,781
Low Weight Births	599 (6.2%)	5,460 (6.4%)

Data Source: WA DOH Health Statistics, 2019. Birth Risk Factors Dashboard: Birth Risk Factors County :: Washington State Department of Health

ASTHMA PREVALENCE

The rate of asthma is 10.3% in the high need area and 9.9% in Snohomish County.

Indicator	Snohomish County	Broader Service Area	High Need Service Area
Asthma Prevalence	9.9%	9.5%	10.3%

Data Source: Behavioral Risk Factor Surveillance System, 2018

DIABETES PREVALENCE

The rate of diabetes in Snohomish County is 9.7%.

Indicator	Snohomish County	Broader Service Area	High Need Service Area
Diabetes Prevalence	9.7%	8.3%	9.3%

Data Source: Behavioral Risk Factor Surveillance System, 2018

OBESITY PREVALENCE

The rate of obesity in Snohomish County is 31.1%.

Indicator	Snohomish County	Broader Service Area	High Need Service Area
Obesity Prevalence	31.1%	29.1%	31.7%

Data Source: Behavioral Risk Factor Surveillance System, 2018

TOBACCO USE

The Healthy People 2030 objective for smoking is 5% of the population. The service area in Snohomish County exceeds this rate at 13.1%.

Indicator	Snohomish County	Broader Service Area	High Need Service Area
Smoking Prevalence	13.1%	11.2%	14.6%

Data Source: Behavioral Risk Factor Surveillance System, 2018

ALCOHOL CONSUMPTION

Binge drinking is defined as consuming a certain amount of alcohol within a set period of time. For males this is five or more drinks per occasion and for females it is four or more drinks per occasion. The rate of binge drinking in Snohomish County was 15.1%.

Indicator	Snohomish County	Broader Service Area	High Need Service Area
Binge Drinking Prevalence	15.1%	15.1%	15.0%

Data Source: Behavioral Risk Factor Surveillance System, 2018

YOUTH MENTAL HEALTH AND SUBSTANCE USE

Among 10th graders in Snohomish County in 2018, 38% experienced depressive feelings, 22% considered attempting suicide, and 14% had no adults to turn to when feeling sad or hopeless.

Problem or heavy drinking is defined as a student who reports drinking three or more days in the past month and/or one or more binge drinking episodes. Binge drinking is drinking five or more drinks in a row in the past two weeks. Heavy marijuana use is defined as the use of marijuana on 10 or more days within a month. As grade levels increase, the rates of problem or heavy drinking and heavy marijuana use increase among youth, with 17% of 12th graders in Snohomish County reporting heaving drinking and 9% of 12th graders reporting heavy marijuana use.

Indicator	6th grade	8th grade	10th grade	12th grade
Depressive Feelings	N/A	31%	38%	44%
Considered Attempting Suicide	N/A	18%	22%	26%
No Adults to Turn to When Sad or Hopeless	N/A	11%	14%	17%
Problem or Heavy Drinking Among Youth	2%	5%	10%	17%
Heavy Marijuana Use Among Youth	0%	2%	8%	9%

Data Source: WA State Healthy Youth Survey 2018

MENTAL HEALTH INDICATORS FOR SNOHOMISH COUNTY

Poor mental health days are the average number of mentally unhealthy days reported in the past 30 days (age-adjusted). On average, residents in Snohomish County experienced 4.1 poor mental health days compared to an average of 4 mental health days in the State of Washington.

For every 300 residents in Snohomish County, there is one mental health provider, whereas for every 250 residents in the State of Washington, there is 1 mental health provider.

Indicator	Snohomish County	WA State
Mental Health Provider Ratio*	300:1	250:1
Poor Mental Health Days+	4.1	4.0

*Data Source: *County Health Rankings, CMS, National Provider Identification, 2020. + County Health Rankings, BRFSS, 2018*

PHYSICAL INACTIVITY

In Snohomish County, 18.2% of the population are physically inactive.

Indicator	Snohomish County	Broader Service Area	High Need Service Area
Physical Inactivity Prevalence	18.2%	15.7%	19.9%

Data Source: Behavioral Risk Factor Surveillance System, 2018

COVID-19 CASES AND DEATHS, SNOHOMISH COUNTY AS OF 8/11/21

On March 11, 2020, the World Health Organization declared COVID-19 a global pandemic. This is a dynamic situation with cases rising daily. For the most up-to-date information, please visit the COVID-19 Data Dashboard on the Washington State Department of Health Website. As of 8/11/2021, there were 42,682 confirmed cases of COVID-19 in Snohomish County and 457,647 cases of COVID-19 in the state of Washington. As of 8/11/2021, there were 630 deaths due to COVID-19 in Snohomish County and 6,215 deaths due to COVID-19 in the state of Washington.

Indicator	Snohomish County	Washington
Total COVID-19 Cases	42,682	457,647
Total COVID-19 Deaths	630	6,215

Data Source: WA State Department of Health COVID-19 Dashboard, 2020-21 COVID-19 Data Dashboard :: Washington State Department of Health

HOMELESSNESS: POINT IN TIME COUNT FOR KING COUNTY

On January 22, 2019, there were 1,116 individuals experiencing homelessness in Snohomish County. 46% or 517 individuals were sheltered and 54% or 599 individuals were unsheltered, living in places not meant for human habitation such as parks, tents, vehicles, or the street.

Indicator	Unsheltered	Sheltered	Total
Number of Persons, Housed, Sheltered, or Unsheltered	599	517	1,116

Data Source: Snohomish County Point in Time Summary, 2019. [Point In Time (PIT) | Snohomish County, WA - Official Website (snohomishcountywa.gov)]

Hospital Utilization Data

In addition to public health surveillance data, hospitals can provide timely information regarding access to care and disease burden across Snohomish County. Avoidable Emergency Department (AED) use is reported as a percentage of all Emergency Department visits over a given time period. AED use serves as a proxy for inadequate access to or engagement in primary care. Emergency department discharges for 2020 were coded as avoidable Emergency Department (AED) visits based on the primary diagnosis for a discharge. These include diagnoses deemed non-emergent, primary care treatable or preventable/avoidable with better managed care.

Avoidable Emergency Department Visits for Swedish Edmonds

Facility	Non-AED Visits	AED Visits	Total ED Visits	AED %
Swedish Edmonds	24,829	10,171	35,000	29.1%

Avoidable Emergency Department Visits by Patient ZIP Code

Top 10 Patient ZIP Codes	Non-AED Visit	AED Visits	Total ED Visits	AED %
230 - SWEDISH EDMONDS	**24,829**	**10,171**	**35,000**	**29.1%**
98036	3,786	1,599	5,385	29.7%
98026	3,439	1,283	4,722	27.2%
98037	2,304	1,000	3,304	30.3%
98087	2,136	848	2,984	28.4%
98043	2,040	803	2,843	28.2%
98020	1,724	553	2,277	24.3%
98133	1,157	438	1,595	27.5%
98155	1,131	425	1,556	27.3%
98204	848	386	1,234	31.3%
98012	734	279	1,013	27.5%

Avoidable Emergency Department Visits by Patient Race

Facility	Patient Race	Non-AED Visits	AED Visits	Total ED Visits	AED %
SWEDISH EDMONDS	AMERICAN INDIAN OR ALASKA NATIVE	252	126	**378**	33.3%
	ASIAN	1,714	694	**2,408**	28.8%
	BLACK OR AFRICAN AMERICAN	1,882	860	**2,742**	31.4%
	NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER	165	64	**229**	27.9%
	OTHER	3,189	1,324	**4,513**	29.3%
	PATIENT REFUSED	178	67	**245**	27.3%
	UNKNOWN	665	261	**926**	28.2%
	WHITE OR CAUCASIAN	16,773	6,771	**23,544**	28.8%
	Blank	11	*	*	*

*Data suppressed if N<10.

Avoidable Emergency Department Visits by Patient Ethnicity

Facility	Patient Ethnicity	Non-AED Visits	AED Visits	Total ED Visits	AED %
SWEDISH EDMONDS	HISPANIC OR LATINO	2,465	1,014	3,479	29.1%
	NOT HISPANIC OR LATINO	21,447	8,835	30,282	29.2%
	PATIENT REFUSED	276	90	366	24.6%
	UNKNOWN	635	228	863	26.4%
	Blank	*	*	*	*

*Data suppressed if N<10.

Top Diagnoses for Avoidable Emergency Department Visits

Top Diagnoses Groupings	Avoidable Visits	Percent of Avoidable Visits
	10,171	-
Skin Infection	905	8.9%
Substance Use Disorders	871	8.6%
Urinary Tract Infection	784	7.7%
Nonspecific Back and Neck Pain	654	6.4%

2022-2024 CHIP PROCESS AND CRITERIA

The Swedish Acute Care Counsel (ACC) and the Swedish Health Equity Social Justice Responsibility Committee (HESJR) served as the two oversight committees in conjunction with Dr. Nwando Anyaoku, Chief Equity Officer and Kevin Brooks, Chief Operating Officer (Executive Sponsors) to identify and prioritize the top health-related needs in the community for the 2022-2024 CHIP. On September 14, 2021, representatives from ACC, HSJER, Swedish Medical Group (SMG), Swedish Cancer Institute (SCI) and the five Swedish campuses participated in the 2021 Swedish CHNA Prioritization of Need meeting process to review and analyze the aggregated quantitative and qualitative CHNA data, including the needs prioritized by community stakeholders and members.

The Providence Data and Evaluation team presented an in-depth review of publicly available data, internal utilization data, and findings from the stakeholder interviews, listening sessions, and survey. On September 28, 2021, the group reconvened to review the community-identified needs and vote on Swedish priorities for the 2022-2024 CHIP. Using an online poll, participants each voted for three priorities out of the list of community-identified needs:
*In alphabetical order:

- Access to health care
- Affordable childcare and preschools
- Behavioral health challenges and access to care (including mental health and substance use disorders)
- Chronic conditions (e.g. diabetes and obesity)
- Dental care
- Economic insecurity
- Food insecurity
- Homelessness and housing instability
- Racism and discrimination

The following criteria were used in the prioritization process:

- Worsening trend over time
- Disproportionate impact on low income and/or Black, Brown, Indigenous, and People of Color (BBIPOC) communities
- Providence service area/high need service area rates worse than state average and/or national benchmarks
- Opportunity to impact: organizational commitment, partnership, severity, and/or scale of need
- Alignment with existing System priorities

The CHNA team and review committee members discussed their ranking choices and refined the language and scope of the health-related needs.
The results of the primary data ranking and the subsequent qualitative input determined the 2022-2024 CHIP priorities, which were reviewed, confirmed, and/or refined based on committee member input. The list below ranked in order summarizes the significant health needs for the 2022-2024 CHIP identified through the 2021 CHNA process:

- Behavioral health challenges (including mental health and substance use)
- Access to health care
- Racism and discrimination
- Housing instability and homelessness

Alignment with Public Health Priorities

To ensure alignment with local public health improvement process, we incorporated the priorities from the 2018/2019 King County Hospitals for a Healthier Community CHNA and 2018 Snohomish Health District CHNA in the data review presentation.

We also conducted interviews with representatives from Public Health – Seattle & King County and Snohomish County Public Health. There is alignment between the needs identified by both Swedish CHNA process and Snohomish and King Counties information.

Appendix 5 lists the participants in the CHIP prioritization process.

APPENDIX 1 COMMUNITY INPUT

Swedish completed 9 listening sessions.

Listening Session Participants

Community Input Type and Population	Location of Session	Date	Language
King County Listening Sessions			
Listening session with the Ballard Alliance including community representatives and businesses owners	St. Luke's Episcopal Church, Seattle, WA	June 7, 2021	English
Four one-on-one interviews with patients at the Northwest Kidney Centers with chronic kidney diseases	Online (Teams)	July 27-August 4, 2021	English
Listening session with the American Heart Association including patients and volunteers of the organization	Online (Teams)	June 15, 2021	English
Listening session with Eastside Friends of Seniors including older adults	Online (Teams)	June 30, 2021	English
Listening session with the Issaquah School District including school-based mental health counselors	Online (Teams)	June 8, 2021	English
Listening session with the Snoqualmie Tribal Council including Native American tribal councilmembers	Online (Teams)	June 7, 2021	English
Listening session with Olive Crest including foster parents	Online (Teams)	August 17, 2021	English
Snohomish County Listening Sessions			
Listening Session with Homage—Senior Services including older adults	Homage—Seniors Services and online (Teams)	July 8, 2021	English
Listening session with South Snohomish County Fire including first responders	Online (Teams)	June 14, 2021	English

Representatives from Swedish conducted 13 stakeholder interviews in King County and 5 in Snohomish County, including 27 participants overall. Stakeholders were selected based on their knowledge of the community and engagement in work that directly serves people who are economically poor and vulnerable. Swedish aimed to engage stakeholders from social service agencies, health care, education, housing, and government, among others, to ensure a wide range of perspectives. Included in the interviews was the Policy Director from Public Health—Seattle & King County. The Health Officer and Director of Prevention Services Division participated from Snohomish Health District. Stakeholder interviews were conducted from April 20 – August 10, 2021.

Interview Participants

Organization	Name	Title	Sector
King County Stakeholder Interviews			
African Americans Reach and Teach Health Ministry	Kathleen Wilcox	Executive Director	Capacity building nonprofit organization engaging the Black community and allies
	Twanda Hill	Consultant, Digital Equity Project, ELAW	
	Jasmin Tucker	LWCC Program Coordinator	
	Linda Chastine	HIV Program Coordinator	
American Heart Association, Puget Sound	Cherish Hart	Vice President of Health Strategies	Health care
Ballard Alliance	Mike Stewart	Executive Director	Business and economic development, environment, advocacy, and urban design
Ballard High School Teen Health Clinic	Mehrnoush Tehrani	Manager, Family Medicine First Hill and Ballard, Ballard Teen Health Clinic	Mental health, school-based health
	Peter Mann-King	Program Manager, LGBTQI+ Program Initiative	
	Karen Boudoir	ARNP	
	Chelsea Clark	Mental Health Therapist	
Carolyn Downs and Country Doctor Clinics	Michael Craig	Director of Development and Marketing	Health care
	Matt Logalbo	Medical Director	
Eastside Friends of Seniors	Linda Woodall	Executive Director	Aging services
Issaquah School District	Pam Ridenour	Director of Student Interventions	Education
	Alaina Sivadasan	Executive Director of Equity	
Neighborcare Health	Meredith Vaughan	Interim Chief Executive Officer	Health care
New Beginnings	Tamara L'Mehr	Youth and Family Advocate	Domestic violence
Northwest Kidney Centers	Suzanne Watnick	Chief Medical Officer	Health care
Public Health—Seattle & King County	Ingrid Ulrey	Policy Director	Public health
Snoqualmie Indian Tribe	Christopher Castleberry	Councilman	Native American tribe

Organization	Name	Title	Sector
Solid Ground in the Sand Point Area	Kristin Klansnic	Residential Program Manager	Housing, food and nutrition
Snohomish County Stakeholder Interviews			
Community Health Center of Snohomish County	Thomas Tocher	Chief Medical Officer	Health Care
Compass Health	Tom Sebastian	President/CEO	Health Care
Foundation for Edmonds School District	Deborah Brandi	Executive Director	Education
Snohomish Health District	Katie Curtis	Director of Prevention Services Division	Public Health
	Christopher Spitters	Health Officer	
Verdant Health Commission	Zoe Reese	Director of Community Impact and Grantmaking	Health Care

For the listening sessions, participants were asked an icebreaker and three questions (see Listening Session Questions for the full list of questions):

- Community members definition of health and well-being
- The community needs
- The community strengths

For the stakeholder interviews, Providence developed a facilitation guide that was used across all hospitals completing their 2021 CHNAs (see Stakeholder Interview Questions for the full list of questions):

- The community served by the stakeholder's organization
- The community strengths
- Prioritization of unmet health related needs in the community, including social determinants of health
- The COVID-19 pandemic's effects on community needs
- Suggestions for how to leverage community strengths to address community needs
- Successful community health initiatives and programs
- Opportunities for collaboration between organizations

Training

The facilitation guides provided instructions on how to conduct a stakeholder interview and listening session, including basic language on framing the purpose sessions. Facilitators participated in trainings

on how to successfully facilitate a stakeholder interview and listening session and were provided question guides.

Data Collection

Stakeholder interviews were conducted using the Microsoft Teams platform and recorded with the participant's permission. Two note takers documented the listening session conversations.

Analysis

Qualitative data analysis was conducted by Providence using Atlas.ti, a qualitative data analysis software. The data were coded into themes, which allows the grouping of similar ideas across the interviews, while preserving the individual voice. The recorded interviews were sent to a third party for transcription. The analyst listened to all audio files to ensure accurate transcription. The stakeholder names were removed from the files and assigned a number to reduce the potential for coding bias. The files were imported into Atlas.ti. The analyst read through the notes and developed a preliminary list of codes, or common topics that were mentioned multiple times. These codes represent themes from the dataset and help organize the notes into smaller pieces of information that can be rearranged to tell a story. The analyst developed a definition for each code which explained what information would be included in that code. The analyst coded nine domains relating to the topics of the questions: 1) name, title, and organization of stakeholder, 2) population served by organization, 3) greatest community strength 4) unmet health-related needs, 5) disproportionately affected population, 6) effects of COVID-19, 7) opportunities to leverage community strengths, 8) successful programs and initiatives, and 9) opportunities to work together.

The analyst then coded the information line by line. All information was coded, and new codes were created as necessary. All quotations, or other discrete information from the notes, were coded with a domain and a theme. Codes were then refined to better represent the information. Codes with only one or two quotations were coded as "other," and similar codes were groups together into the same category. The analyst reviewed the code definitions and revised as necessary to best represent the information included in the code.

The analyst determined the frequency each code was applied to the dataset, highlighting which codes were mentioned most frequently. The analyst used the query tool and the co-occurrence table to better understand which codes were used frequently together. For example, the code "food insecurity" can occur often with the code "obesity." Codes for unmet health-related needs were cross-referenced with the domains to better understand the populations most affected by a certain unmet health-related need. The analyst documented patterns from the dataset related to the frequency of codes and codes that were typically used together.

FINDINGS FROM COMMUNITY LISTENING SESSIONS

Findings from the community listening sessions are synthesized here by need.

Behavioral health challenges and access to care (including mental health and substance use disorders)

Behavioral health challenges were frequently discussed by listening session participants. They discussed the following needs:

- **More counselors in schools**: There are not enough providers to meet the needs of young people and there are long wait lists for referrals. School counselors are often left to fill the mental health needs for young people, but there are limited resources and not enough infrastructure to connect families to resources outside of the schools. Schools are under-resourced to meet the needs of students and there are inequities between schools.
- **More detox services**: Connecting patients to detox services can be challenging for first responders.
- **More inpatient treatment and wraparound services** for people with a SUD.

Foster parents shared a need for **more specific support services for children with a history of trauma** to connect them to providers that understand their unique support needs and connect them to other young people with similar lived experiences. They also shared the importance of **better communication** between therapists, social workers, guardians, case managers, and other support people to provide coordinated care to patients.

Participants discussed the importance of community and support systems for well-being, particularly for **older adults** and **young people**. Social media can give a sense of connection but is an unhealthy way to meet needs. They shared the importance of extracurricular activities for young people, like sports teams, that create community.

Another population discussed by community participants as having unmet mental health needs were **people living with chronic illnesses**, such as chronic kidney disease. Participants spoke to the challenges of planning life around medical appointments and the importance of cultivating a community of people who are experiencing similar challenges. They noted a need for more support groups, particularly for people experiencing grief and loss.

Participants also discussed the mental health effects of trauma and racism, particularly on **Native American communities**. Genocide, disease spreading, lack of tribal recognition, and lack of land access affect mental health, family dynamics, and overall community well-being. Some of the historical trauma, such as mass graves and boarding schools, have not been fully acknowledged or healed. Participants also discussed the effects of trauma and substance use disorders on families, perpetuating cycles of trauma. They noted a need for more **proactive support of and investment in families**, ensuring parents have the resources they need to take care of themselves and their children.

Participants agreed that there has been increased isolation, anxiety, and depression as a result of the **COVID-19 pandemic** and a need to be more intentional with connections. They were particularly concerned about the mental health effects on young people, noting they are more isolated and disconnected than ever. They shared the importance of young people being connected to adults through schools so that they know there are people who care about them.

Access to health care services

Listening session participants provided many insights into access to care challenges and needs including the following:

- **Improved communication between labs and providers**: Multiple listening session groups noted challenges in communication between labs and health care providers. This lack of communication means patients have to be responsible for bringing their lab results to appointments because they are not always shared directly. It can also mean patients have to repeat labs due to communication issues between providers.
- **Improved data sharing and communication between different health providers**: Multiple listening session groups identified communication as the largest issue in health care. They spoke to the challenges of having to share their own health information with multiple providers because of a lack of communication. Parents of medically fragile children that interact with multiple health care systems shared their experiences of providers not talking with other care providers, resulting in gaps in care and poorer outcomes for their children.
- **More support navigating the complexity of the health care system**: Listening session participants spoke to the difficulty navigating health care and communicating with providers. They shared it is incredibly challenging and frustrating trying to reach a provider and have their questions answered. For parents of medically complex children, they noted it can be a full time job managing their child's health care, getting medical records, and communicating with providers. For foster parents, navigating the system can be more difficult because they may not have all of the relevant health history or access to the child's online medical records, putting the burden on the guardian to remember all pertinent health information.

Listening session participants also noted a need for **more resource coordination** to help people know about available services and access them. They would like to see **better discharge planning** that connects patients to services. Participants spoke to patients being discharged with a lot of information, but little support. They also noted some patients are discharged at odd hours when they cannot access services, which is especially challenging for patients experiencing homelessness.

Participants spoke to the benefits of **co-located services**, noting they would like to see more health care and social services located in one place to reduce the amount of travel and communication needed.

Foster parents and parents of medically complex children discussed the importance of having a trusted team of health care providers, noting they are part of the family support system. They shared the importance of having providers who practice **trauma-informed care** and are sensitive to the unique needs of foster families. Health care settings should also be explicit that they are safe, welcoming places for all patients, specifically that they will not ask about documentation status.

Participants spoke to a need for public health and health care professionals to **meet community members where they are**, such as at churches. Not only should health education and services be available in places that people feel safe and comfortable, but it should be available in multiple languages. Older adults in particular may have challenges accessing information online, therefore providing information in other convenient ways is important.

Participants also discussed the importance and need for more **health education** related to a variety of topics. They shared wanting to see more sex education and drug safety education for young people. They also noted the importance of discussing diet for managing chronic diseases and the benefits of having classes to help patients with certain conditions learn about the specifics of their disease. This may reduce patients' fears and help them build community.

Participants noted barriers to care:

- **Transportation**: This is especially a challenge for older adults and people with limited mobility. Older adults spoke to wanting more transportation options like shuttles.
- **Appointments and services during working hours**: Patients who work may have difficulty getting time off for appointments.
- **Language**: Many forms are only available in English which is challenging for families speaking other languages.

Racism and discrimination

Listening sessions participants discussed the health disparities and social inequities experienced by **Black communities**, including more food insecurity and housing instability as a result of racism.

Participants also discussed the mental health effects of trauma and racism, particularly on **Native American communities**. Genocide, disease spreading, lack of tribal recognition, and lack of land access affect mental health, family dynamics, and overall community well-being. They noted Native American communities are still not able to practice their traditions freely and many promises of aid have been broken. There is generally a lack of recognition and respect of Native American communities. Many people do not realize the Snoqualmie Indian Tribe is in King County.

Listening session participants shared there is an over-representation of BBIPOC children in **foster care** and an under-representation of BBIPOC foster parents. They shared how systemic inequities, including economic insecurity and unmet behavioral health needs, can contribute to this over-representation and the need to take an anti-racist, holistic approach to supporting families.

Participants discussed a need for more education of young people about the **history of the U.S.** and more conversations as a society about racism to address the trauma that many BBIPOC communities have experienced.

As a result of the **COVID-19 pandemic**, participants shared they have seen more racism towards Asian community members, creating fear in the community.

Food insecurity

Listening session participants discussed the importance of sharing food resources in multiple languages, particularly in South King County. They also discussed the importance of meeting **young people's** nutrition needs and ensuring students have a healthy breakfast. Hunger can contribute to behavioral issues.

As a result of the **COVID-19 pandemic**, participants shared they have seen increased food insecurity.

FINDINGS FROM STAKEHOLDER INTERVIEWS

Community Strengths

The interviewer asked stakeholders to share one of the strengths they see in the community and discuss how we can leverage these community strengths to address community needs. This is an important question because all communities have strengths. While a CHNA is primarily used to identify gaps in services and challenges, we also want to ensure that we highlight and leverage the community strengths that already exist. Stakeholders in South Snohomish County all spoke to the same community strength:

A Spirit of Collaboration Between Community Organizations

Stakeholders shared health care organizations collaborate well and there are many opportunities for meetings to discuss best practices. They cited regular meetings of the Chief Medical Officers bringing together the different health care agencies in the county and providing opportunities for information sharing and deepening relationships.

> *"I've experienced that nowhere else in my working career as a public health official, such a smooth relationship and frequency of encountering and freedom to contact my colleagues from the healthcare system."—Community Stakeholder*

Stakeholders discussed a sense of collaboration between providers, with very little negative competition.

> *"There's very little, what I would say negative competition, hopefully, the good kind of competition where we're all trying to raise the bar up, but I think the reason why we tend to be able to create community solutions for community challenges here is because of that sense of commitment to the community and partnership."—Community Stakeholder*

They also shared they have seen organizations work together to leverage one another's strengths to meet community needs.

> *"We have a lot of great partnerships in the community where we can leverage each other's strengths to help to the benefit of the community, which is nice. If there are areas where we just either are having trouble getting to a population or maybe we just don't have a specific program for that, we have a lot of good partnerships in the community to help address some of the unmet needs. Certainly, there are still some that are left unmet, but we do have a lot of great partnerships"—Community Stakeholder*

To leverage this strength of collaboration, stakeholders suggested working together to develop more robust public health infrastructure and social safety net. They suggested organizing to influence policy makers to reconsider our investment in these services. They also suggested drawing on the collaborative nature of organizations and bringing together partners from multiple disciplines.

High Priority Unmet Health-Related Needs

Stakeholders were asked to identify their top five health-related needs in the community. Three needs were frequently prioritized and were categorized as high priority. Five additional needs were categorized as medium priority. The effects of the COVID-19 pandemic will be woven throughout the following sections on health-related needs.

Across the board, stakeholders were most concerned about the following health-related needs:

1. Homelessness/ lack of safe, affordable housing
2. Behavioral health challenges and access to care (including mental health and substance use disorders)
3. Racism and discrimination

Homelessness/lack of safe, affordable housing

Stakeholders spoke to the connection between safe, affordable housing and overall health and well-being. Multiple stakeholders shared the importance of addressing **mental health and substance use disorders** in conjunction with homelessness, noting that even when individuals are housed, they often need support to remain housed and address their behavioral health needs.

> *"Folks who come into those [permanent supportive housing] programs have really, really high needs typically around substance use, long-term mental health conditions, and because they were homeless for so long, oftentimes they're coming in without care. They haven't had proper medication. They haven't had a proper mental health assessment for a long time. They haven't been connected to services. They're typically not very far into their recovery process, if at all."—Community Stakeholder*

Stakeholders also shared that addressing **chronic health conditions** and ensuring **access to health care** services is challenging when people are experiencing homelessness or are unstably housed. They emphasized the need to first meet people's basic needs before we can address their health care needs.

For example, they may not have access to hygiene services, a phone for telehealth appointments, or a refrigerator for certain medications. Stakeholders supporting patients with chronic illnesses, including chronic kidney disease, noted housing instability can contribute to barriers to care.

"When we're seeing those folks [experiencing homelessness] in clinic or having a visit with them, it is very minimally about their blood pressure or their A1C and much more about their safety and what are their basic needs."—Community Stakeholder

Stakeholders from across King and Snohomish Counties identified the high cost of housing as the biggest challenge for families, noting that families are being pushed out of their neighborhoods due to **rising housing costs** and **gentrification**. High housing costs create financial instability, leading to spending tradeoffs.

"When your housing costs take most of your income that you have, then that leaves very little for your health care, and your food, and all the other essentials. That's a constant thing we're hearing in the community right now."—Community Stakeholder

It can also be a source of stress for families, particularly those with **mixed documentation statuses** or those who are **underemployed**.

"Folks who may be a two-parent working household but are making minimum wage and can't afford prevalent rate rent or market-rate housing. I think housing is a big need in our community."—Community Stakeholder

NIMBYism, or the "not in my backyard" attitude towards building affordable housing is an additional challenge for addressing the housing challenges in the area.

Stakeholders spoke to the following housing related needs:

- **More shelter beds**: Stakeholders noted a need for more shelter beds in King and Snohomish Counties, noting there are areas without easy access to shelters in Snohomish County.
- **More low-income housing**: Particularly in Seattle, there are very few low-income housing options.
- **More resources to meet the basic needs of people experiencing homelessness in Snohomish County**: Stakeholders noted not seeing sufficient emergency shelters, outreach teams, and basic support services for people experiencing homelessness in Snohomish County.

As a result of the **COVID-19 pandemic**, stakeholders shared they are seeing more homelessness and housing instability for the community, their patients, and their staff. They attributed this to lost jobs, furloughs, and a lack of childcare. They also noted that many families are concerned about how they will pay the rent they owe when the eviction moratorium is lifted. This is affecting their **mental health** and **economic stability**.

"Even though some cities, including Seattle, did have an [eviction] moratorium, a lot of people now are experiencing a lot of stress and anxiety around the ending of it because it's

compounded interest, right? They will have to pay back the rent plus the new cycle of rent. It's just continually creating a cycle of stress, which creates more health inequities and problems and inabilities to interact in everyday life."—Community Stakeholder

School districts noted that because of the moratorium there may be students who are in the same home, but their families have been unable to pay rent. They have heard some families report owing over $7,000 in rent and utilities, and they expect to see the full effect of the pandemic on housing in the future.

Behavioral health challenges and access to care (including mental health and substance use disorders)

Many stakeholders identified mental health and substance use disorders (SUD) as the greatest need in the community, noting that the crisis is visible to residents. They shared addressing behavioral health needs is really challenging and the **co-occurrence** of mental health and SUD make meeting people's needs even more difficult.

Stakeholders noted the high cost of **housing** and **economic instability** in King and Snohomish Counties contribute to stress and mental health challenges, particularly for families with mixed documentation statuses may have not have access to or fear accessing supportive services.

"The added burden of trying to meet your family's basic needs adds to the pressures and the stresses that our families are feeling. What we see is our families just want to get back to work yet they can't. We find that our families who are undocumented are afraid to seek services because they're afraid to put their name on a list, they're afraid to get caught. There's just so many factors that contribute to our families, social and emotional well-being. I think that's a big part that the district is grappling with."—Community Stakeholder

Stakeholders identified the following community needs related to mental health and SUD:

- **More BBIPOC (Black, Brown, Indigenous, and People of Color) providers**: Stakeholders, particularly those who serve young people, noted that many BBIPOC patients are requesting providers of color, but there are not enough providers to meet that need. They shared there need to be more BBIPOC caregivers in every role related to behavioral health, including front office staff, Nurse Practitioners, physicians, and therapists.
- **Better support for parents**: Stakeholders shared parents with children with anxiety and other mental health challenges need their own support network.
- **More opportunities for people to feel seen and heard**: Stakeholders discussed the importance of people having the chance to talk about their feelings and mental health issues. One stakeholder emphasized the importance of the spiritual and community aspects of healing.
- **More intensive behavioral health services:** In Snohomish County, stakeholders noted the need for more inpatient care.

Stakeholders identified a few populations that may experience increased challenges to accessing mental health services:

- **Young people**: People 18 years and younger were mentioned by numerous stakeholders as having unmet mental health needs. Educators are increasingly seeing students as young as kindergarten exhibiting signs of emotional trauma. They shared there is a lack of pediatric mental health services and challenges for young people accessing those services. They noted it is very hard for families to find therapists who work with young people and there is a need for more counselors and therapists in schools. Stakeholders spoke to the importance of engaging students in schools to ensure their social-emotional needs are met, providing mental health services during the summer when students may not be receiving care, and ensuring childcare centers are equipped to respond to signs of trauma.

  "We don't by any means have everything we need in order to meet the needs of adults and older adults in our communities, but we have far more capacity to do that than with kids and youth. I've been banging this drum for a long time now. I think we have new capacities that are allowing us to do a better job with kids and youth that have significant behavioral health challenges, but man, talk to any teacher, any parents, just broadly across all the spectrums, we just really don't have really the capacity that we need to do right by kids and youth."—Community Stakeholder

- **Young people identifying as LGBTQ+:** This group of young people was specifically identified as a population that has a disproportionate rate of mental health challenges and suicide due to a lack of support, isolation, and discrimination.

  "I think the other piece to highlight here too, is the sense of community and isolation and something at least the groups that I've met with is just feeling that it's really difficult to connect and find community, especially if we're thinking about LGBTQIA+ youth who haven't necessarily come out to their family or at the place that they live. I think that's been extremely challenging to be able to have to be inside at a place that might not be safe or inclusive and be isolated from friends and family that might be more accepting during these times."—Community Stakeholder

- **Survivors of domestic violence**: Stakeholders spoke to the challenges of finding a mental health provider who understands the dynamics of domestic violence and can provide trauma-informed care. Complicating factors, such as their insurance being under the perpetrator's name or not having access to their documents, can prevent people from being able to access services.

Stakeholders discussed the following challenges for addressing the community's behavioral health needs:

- **Cost of care**: For many families, mental health services are too expensive.
- **Transportation**: This can be a barrier for those without reliable transportation and those who have to take multiple buses to appointments.

- **Navigating a complex system, particularly for patients who speak languages other than English**: Finding a provider and getting an appointment can be complicated even for people familiar with the health care system. This is even more challenging for people who speak languages other than English.
- **A lack of behavioral health professionals**: Stakeholders, particularly in Snohomish County, noted a lack of trained staff to meet the demands in the community. Stakeholders from smaller organizations shared they may not be able to compete with larger organizations when hiring caregivers. Particularly for young people and BBIPOC communities, not being able to access a provider that meets one's needs prevents people from addressing their mental health concerns.

A majority of stakeholders in King and Snohomish Counties noted the **COVID-19 pandemic** has exacerbated mental health needs. They shared they are seeing increased anxiety, depression, and substance use, as well as more severe mental health needs that have been unmet during the pandemic.

"We have seen our behavioral health needs, the demand has skyrocketed through COVID and the acuity has increased meaning the diagnosis and the condition presenting has become much more acute."—Community Stakeholder

Economic stress, increased isolation, and a lack of community building has put more pressure on an already stressed system. Stakeholders shared people are having a hard time finding a mental health provider, adding stress to primary care providers who are not equipped to meet the needs.

Stakeholders were particularly concerned about **young people**. They shared they are seeing an increase in teen suicide, kids isolated at home in unsafe, overcrowded and/or stressful situations, and students participating in remote learning without a caring adult present.

"It's not uncommon for us to deliver weekend meal kits to maybe three families that might be living in a single mobile home. How do you deal with three families that are living in one house? They're socially isolated, you can't get out and go do anything, you have how many kids? How do you deal with somebody who's having a temper tantrum and emotional outbursts, or how do you deal with it when your temper flares and there's nobody to turn to?"—Community Stakeholder

Stakeholders, particularly those in Issaquah noted concern for **older adults** who have been isolated during the pandemic and unable to access the usual places where they have social interactions. The severe loneliness and increased depression have meant some older adults have not been able to take care of their physical health.

"During the pandemic, especially last summer, we would get calls [from older adults]: 'I just want to see another human being.'"—Community Stakeholder

While **telehealth** appointments have improved access for some mental health patients, it has created barriers for others. For those patients with a very high level of need, connecting with a therapist using telehealth is not feasible or appropriate. Patients looking to access support groups may not be comfortable engaging through technology.

"Expecting somebody of the level of needs that we typically see to connect with a therapist over Zoom and telehealth, it's just almost laughable. It's just not an appropriate service level for them to meet their needs. It created this situation where we were already struggling to meet people's mental health needs and it just made it exponentially harder. They really need in-person support and getting the in-person support obviously was impossible during COVID. That was a huge, huge stressor in meeting that need."—Community Stakeholder

Some providers saw it was easier for patients with depression to connect via technology rather than coming into the clinic. The services were also beneficial for populations that may live farther away from mental health services or individuals looking to connect with a BBIPOC provider.

Racism and discrimination

Stakeholders in King and Snohomish Counties discussed racism and discrimination as drivers of other community needs, although it was more frequently prioritized in King County. Stakeholders spoke to the connection between racism and **health**, noting that inequities contribute to poorer health outcomes, making people sicker and making addressing health needs harder.

"I would say social determinants of health and, in many cases, systemic and structural racism and how it's played a part in people's overall health outcomes. I don't know that I could put a particular percentage on it, but it's a large chunk."—Community Stakeholder

Stakeholders in **Snohomish County** noted there is still a lot of work to do to address the issue in the community, although they are seeing more conversations around equity. They noted seeing Latino/a students disproportionately affected by some needs in the community.

In King County, stakeholders noted how racism plays a role in **gentrification**, unsustainable rent prices, and a lack of options for home ownership. Racist hiring practices also affect **employment opportunities** for BBIPOC communities. They also discussed the connection between racism, law enforcement, and criminal justice, noting how racism contributes to incarceration and violence.

Racism and discrimination contribute to people not feeling **seen and valued** in the community. Stakeholders and listening sessions participants discussed how a lack of tribal recognition and land access and historical trauma affect the opportunities, health, and well-being of **Native American communities**. Boarding schools and historical trauma are relatively recent history. Listening session participants noted a need for more education of young people about the **history** of the U.S. and about racism in our country.

The **COVID-19 pandemic** has led to an increase in hate crimes and racism, particularly against the Asian community as noted by Snohomish County stakeholders. Stakeholders spoke to hearing about Asian

community members not feeling safe in their community anymore and BBIPOC community members not feeling as welcome in South Snohomish as they used to.

The pandemic has highlighted racism as a public health issue and exacerbated many inequities that already existed in the community. Public Health—Seattle & King County declared racism a public health crisis. It has shown the effects of populations being marginalized and disenfranchised, leading to inequities in health outcomes and access to vaccines.

It also highlighted opportunity gaps in education for BBIPOC students who were less likely to return to school in person during spring 2021, potentially because of limited bus service, but other reasons as well.

> *"I think things that have been identified is the ongoing racism in Seattle public schools and there's very, very limited bus service so that prevented a lot of kids from coming. I just think [COVID-19] has just blown open how racist our school system is."—Community Stakeholder*

Medium Priority Unmet Health-Related Needs

Five additional needs were often prioritized by stakeholders:

4. Access to health care services
5. Dental care
6. Affordable childcare and preschools
7. Food insecurity
8. Economic insecurity

Access to health care services

Stakeholders discussed a variety of barriers to care:

- **Transportation**: This was the main barrier to care discussed by stakeholders in both counties who noted that gentrification has caused many patients in Seattle to move further away from transportation and their care provider. There are limited transportation options for patients and even those with access to transportation services are often late or have to cancel their appointment because of transportation issues. Transportation can be a barrier for older adults who may not be able to easily get in and out of a car or who have a walker or wheelchair.
- **Cost of care**: Patients are afraid to see a provider or go to the hospital because of the high cost of care, even if they have insurance. They may not be able to afford appointments or medication.

> *"Even if folks do have a basic level of health coverage, we see a lot of fear of going to the doctor or the hospital, knowing that their bills are going to be really hard to pay."—Community Stakeholder*

- **Technology**: Stakeholders shared technology reduces barriers for some patients, particularly those patients who may live further away from their primary care clinic. But for patients who do

not have a smartphone or a reliable phone connection to engage successfully with a telehealth visit, technology is a barrier to care. This may be particularly challenging for patients experiencing homelessness.

"[Some patients] can't even take advantage of telehealth because they don't have a smartphone or a reliable phone connection or minutes on the phone or just a life that involves being available at a set 20-minute window of their day. There's so many ways that our healthcare system, even though there are parts of it, like ourselves, that are doing our best to try to be as accommodating as possible for patients who have minimal resources and minimal access, there's just still so many barriers that exist there indirectly."—Community Stakeholder

"Telehealth is really a strategy for us to maintain our connection to our traditional and historic communities. I think that's really exciting but yes, it really also is a major challenge to figure out how do we implement it in a meaningful way."—Community Stakeholder

- **Language barriers**: Many patients experience barriers to getting appointments and accessing the care they need due to language barriers.
- **Health literacy**: Stakeholders spoke to a lack of education on how to access medical records, health care benefits, covered services, costs, medical terminology, etc. Many patients do not understand treatment and preventive measures without support from an advocate. This can be especially challenging for immigrant families navigating an unfamiliar health care system.

Stakeholders shared the following community needs related to access to care:

- **More opportunities for medical professionals to engage with community members in community settings**: Stakeholders shared health care providers need to meet people where they are, in a setting that is safe and comfortable to patients. These community settings allow for more conversation. An example is a neurologist going to a community event and discussing Alzheimer's in an informal way or a rheumatologist talking about Lupus. If people could talk with a medical professional in a safe setting, they may be more likely to engage with the health care setting.
- **Support accessing specialty care** for patients that have low incomes or are uninsured.
- **More BBIPOC providers**: Patients of color want to work with providers of color.

"I've said this over and over, but we really need more people of color across the board. Front office, nurse practitioners, physicians, therapists. We just aren't doing a good enough job, and it is a huge barrier to care."—Community Stakeholder

- **More wraparound services**: King County stakeholders spoke to needing more wraparound services for patients experiencing homelessness.

Certain populations were named as having more barriers to accessing high-quality, respectful care:

- **Patients experiencing homelessness**: Stakeholders agreed it is very challenging to address health care needs when patients do not have their basic needs met. Primary concerns may include needing socks or a refrigerator to store insulin.
- **Families with mixed documentation statuses**: While Washington State provides health care coverage for some care for patients that are undocumented, such as kidney dialysis, these patients do not have access to other kinds of care like transplantation.
- **Native American communities**: Native American health care services are typically concentrated in urban areas, making it more challenging for those living outside these areas. There are also more challenges receiving culturally relevant care and finding a provider who listens to and understands their culture and needs.

> *"Access to good healthcare is very hard for [Native American communities] because most tribes are given a centralized federal funded location, usually in urban areas, and we're not in urban areas. Well we are, but we're spread out still, so getting to Seattle might not be [easy]."—Community Stakeholder*

- **Individuals identifying as LGBTQ+:** Stakeholders shared a need for health care providers to be more welcoming and understanding of the unique needs of patients identifying as LGBTQ+, particularly transgender young people.

Most stakeholders shared that due to the **COVID-19 pandemic** some patients delayed accessing routine primary care and chronic disease management, resulting in worsening conditions. Additionally, some people were isolated in their homes and did not have access to healthy food or physical activity opportunities, which worsened their physical health.

> *"That's been a big impact of COVID, is the unavailability initially of primary care visits and then now, more the hesitancy of some not wanting to go in and not feeling comfortable with going in to receive primary care. That's been something that we are really keeping an eye on for those long-term impacts of how not controlling your diabetes, and your blood pressure, and cholesterol for a good chunk of time definitely is going to have long-term impacts."—Community Stakeholder*

Stakeholders spoke to a lack of routine screening, including vision appointments, STI screening, and routine immunizations.

Increased telehealth appointments and online vaccine registration were very challenging for patients who speak a language other than English, do not have a computer or smartphone, or are not comfortable navigating online. Many community organizations helped patients sign up for appointments, get transportation, and more. Stakeholders from community clinics found patients prefer a phone visit to a video visit. This might be because of the technology but may also be because phone calls are more familiar. The pandemic brought to light how many people do not have internet access or a device to connect to medical care and to socialize. Telehealth appointments may be particularly challenging for older adults and patients with low incomes.

The COVID-19 vaccine rollout highlighted the importance of building trust with patients and bringing services to community members in non-clinical locations.

"It was not efficient for us to be doing a tiny little vaccination clinic of a few hundred patients every Saturday, but it was really important for the people that it served. Trying to strike that balance of investing in the things that reach large numbers of people in a cost-efficient way but also being cost-inefficient to reach the higher need populations."—Community Stakeholder

Dental care

Many stakeholders in King and Snohomish Counties identified dental care as a big need and one that is linked with overall health and well-being.

Stakeholders shared there are barriers to accessing dental services. For example, transplant patients need to have a full dental evaluation, but this can be challenging to access. **Transportation** to dental appointments is also a barrier and stakeholders noted the potential benefits of mobile dental units.

Stakeholders shared accessing dental care can be especially challenging for patients who are **uninsured** or who have **Medicare** or **Medicaid**. Populations of particular concern include **people over the age of 65** and **people with low incomes**. The **COVID-19** pandemic resulted in reduced access to dental care and reduced capacity for some dental providers.

Affordable childcare and preschools

Snohomish County stakeholders prioritized this need more often than in King County. Stakeholders emphasized that affordable childcare is foundational for ensuring people can work and meet their family's basic needs, including accessing health care services. Safe and reliable childcare promotes **stability** in families.

Research shows **investing in early childhood services** and preparing children for kindergarten improves their future and outcomes.

"Talk to any teacher, any parent, just broadly across all the spectrums, we just really don't have really the capacity that we need to do right by kids and youth. I think particularly on the early childhood side, I think we all really can see the research now. If you get kids ready for kindergarten, when they're two and three and four years old, man, you just changed their trajectory on all kinds of fronts, including behavioral health. Not just behavioral health, their economic future, their educational future."—Community Stakeholder

Stakeholders' primary concern was the "outrageous" **cost of childcare**, noting many families spend a substantial amount of their income on the service, affecting their **economic stability**. Families with low incomes have limited options for licensed childcare providers that accept the DSHS childcare subsidy. Families that speak languages other than English may have more challenges finding adequate childcare and communicating their needs.

As a result of the **COVID-19 pandemic**, many childcare services had to close, forcing some parents to leave jobs to stay home with their children. Parents that were laid off may have stopped needing childcare.

"It's put quite a burden on parents when schools had to go remote, and they had to figure out how do they help their child and do their job. I know a lot of parents struggled with that. Then early on when all the childcare was closed, that was really hard because, what do you do with your one-year-old or your three-year-old? You can't just leave them alone and they don't have the school thing to kind of somewhat keep them occupied."—Community Stakeholder

Food insecurity

Snohomish County stakeholders prioritized this need more often than in King County. Stakeholders prioritized food insecurity because of the importance of ensuring everyone has access to nutritious, **culturally relevant foods**. They noted there are certain geographic areas, such as **South King County**, where some immigrant and refugee communities are not able to access food that meets their cultural needs.

The main barrier to food security is **economic insecurity**. Families that are unemployed or under employed may be working hard to make ends meet, but experience **stress** trying to ensure their children are fed.

Populations disproportionately affected by food insecurity include the following:

- **Families with mixed documentation statuses:** These families may not qualify for or may not feel safe applying for food assistance programs.
- **Survivors of domestic violence:** Financial abuse is a tool used in domestic violence situation, which can be linked to food insecurity. Survivors of domestic violence need access to basic resources, including healthy food.
- **People with low incomes:** People with low incomes may have to make spending tradeoffs.
- **Families experiencing homelessness:** Students experiencing homelessness may not get a meal over the weekend, summer, or holidays when schools are closed. While schools are working to meet the food needs of families, families are experiencing food insecurity. If students are not well fed and nourished, then they will not be able to focus and thrive in school.

"Then we realized that if our kids aren't ready to learn Monday morning, then they can't learn. If their basic needs aren't being met, then they're too worried about where their next meal is going to come from, or the roof over their head, or when they have to leave school in a taxicab and go back to the shelter where they're staying because mom and the kids are getting away from an abusive situation."—Community Stakeholder

Stakeholders were particularly concerned about older adults and young people experiencing increased food insecurity during the **COVID-19 pandemic**, which contributes to poorer overall health. School districts in King and Snohomish Counties are seeing more food insecurity in their families. Schools have

been delivering meals to families and seeing them living in overcrowded conditions. Transportation to the food bank or food distribution centers can be challenging for some families. COVID-19 made many people more acutely aware that food insecurity is a need in the community.

"The demand just exploded during COVID in terms of folks who needed and utilized those [food assistance] services."—Community Stakeholder

Economic insecurity

Economic insecurity was discussed in both counties, but more frequently prioritized in King County. It was primarily discussed in connection to **housing** and **food insecurity**. In Snohomish County, stakeholders discussed seeing families living in overcrowded conditions because their income does not meet the cost of living. They also shared families are experiencing stress trying to meet their basic needs, such as for sufficient food. Stakeholders in Snohomish County noted there are families with incomes that allow them to live very comfortably, such as those in the technology industry, while other families are working multiple jobs to make ends meet.

King County stakeholders noted finding a good paying employment opportunity can be more challenging for BBIPOC communities due to **racism in hiring practices**. Snohomish County stakeholders discuss the importance of supporting connecting families to **job skill training** and career coaches to help families make a living wage.

Populations disproportionately affected by economic insecurity include families with **mixed documentation statuses** and **older adults**. Families with mixed documentation statuses may not qualify for unemployment benefits or other assistance. Older adults may have a home, but little extra money to meet their other needs and pay for health care costs.

"The added burden of trying to meet your family's basic needs adds to the pressures and the stresses that our families are feeling. What we see is our families just want to get back to work yet they can't. We find that our families who are undocumented are afraid to seek services because they're afraid to put their name on a list, they're afraid to get caught. There's just so many factors that contribute to our families, social and emotional well-being."—Community Stakeholder

The **COVID-19 pandemic** has exacerbated economic insecurity for families that either lost their jobs or needed to stay home to care for their children.

Community Stakeholders: Opportunities to Work Together

Participants were asked, "What suggestions do you have for organizations to work together to provide better services and improve the overall health of your community?" Stakeholders from Snohomish County shared the following suggestions:

- **Develop school-based health centers**: Stakeholders spoke to the exciting opportunity to bring together multiple partners to collaborate on school-based health services in the Edmonds School District. They shared the importance of prioritizing the health of young people.

- **Avoid duplicating services**: Stakeholders noted there are opportunities to streamline services in the area, bringing together organizations that are addressing the same needs. For example, multiple health care organizations are doing community outreach and there may be ways to do this more collaboratively through partnership.
- **Center community voices**: Stakeholders spoke to avoiding making assumptions about what is needed in the community and instead include more perspectives and voices that are not typically included in conversations.

> *"I think just asking that question of what do you think [the solution is] instead of just assuming that it's me or whatever. That could help to say, 'I know you have ideas on what you think could fix this, how could we partner with you to make those possible?'"— Community Stakeholder*

- **Bring together hospitals and primary care providers to address health care challenges**: They shared seeing an opportunity for partnership between health systems providing inpatient behavioral health services and primary care providers. Stakeholders spoke to overlap in patient populations and the opportunity to better share information and collaborate to serve those patients. This may help address avoidable ED visits.

LIMITATIONS

While stakeholders and listening sessions participants were intentionally recruited from a variety of types of organizations, there may be some selection bias as to who was selected as a stakeholder. Multiple interviewers conducted the session, which may affect the consistency in how the questions were asked. Multiple note-takers affected the consistency and quality of notes across the different listening sessions.

Some stakeholders ranked their priorities one through five, while others identified their top five priorities without ranking. Others chose not to identify priorities, making it more difficult to limit the number of priorities that were identified by stakeholders.

One listening session was comprised of four different one-on-one conversations, which did not allow for conversation between participants.

The analysis was completed by only one analyst and is therefore subject to influence by the analyst's unique identities and experiences.

STAKEHOLDER INTERVIEW QUESTIONS

1. How would you define the community that your organization serves?
2. While a Community Health Needs Assessment is primarily used to identify gaps in services and challenges in the community, we want to ensure that we highlight and leverage the community strengths that already exist. Please briefly share the greatest strength you see in the community your organization services.

3. Please identify and discuss specific unmet health-related needs in your community for the persons you serve. We are interested in hearing about needs related to not only health conditions, but also the social determinants of health, such as housing, transportation, and access to care, just to name a few.
4. Using the table, please identify the five most important "issues" that need to be addressed to make your community healthy (1 being most important). [see table below]
5. Has the COVID-19 pandemic influenced or changed the unmet health-related needs in your community? If yes, in what ways?
6. What suggestions do you have for how we can leverage community strengths to address these community needs?
7. Please identify one or two community health initiatives or programs you see currently meeting the needs of the community.
8. What suggestions do you have for organizations to work together to provide better services and improve the overall health of your community?
9. Is there anything else you would like to share?

Question 4: Using the table below, please identify the five most important "issues" that need to be addressed to make your community healthy (1 being most important). Please note, these needs are listed in alphabetical order.			
	Access to health care services		Few community-building events (e.g. arts and cultural events)
	Access to dental care		Food insecurity
	Access to safe, reliable, affordable transportation		Gun violence
	Affordable childcare and preschools		HIV/AIDS
	Aging problems		Homelessness/lack of safe, affordable housing
	Behavioral health challenges and access to care (includes both mental health and substance use disorder)		Job skills training
	Bullying in schools		Lack of community involvement and engagement
	Community violence; lack of feeling of safety		Obesity and chronic conditions
	Disability inclusion		Opportunity gap in education (e.g. funding, staffing, support systems, etc. in schools)
	Domestic violence, child abuse/neglect		Racism and discrimination

Question 4: Using the table below, please identify the five most important "issues" that need to be addressed to make your community healthy (1 being most important). Please note, these needs are listed in alphabetical order.			
	Economic insecurity (lack of living wage jobs and unemployment)		Safe and accessible parks/recreation
	Environmental concerns (e.g. climate change, fires/smoke, pollution)		Safe streets for all users (e.g. crosswalks, bike lanes, lighting, speed limits)
			Other:

LISTENING SESSION QUESTIONS

1. What makes a health community? How can you tell when your community is healthy?
2. What's needed? What more could be done to help your community be healthy?
3. What's working? What are the resources that currently help your community be healthy?
4. Is there anything else related to the topics we discussed today that you think I should know that I haven't asked or that you haven't shared?

APPENDIX 2 COMMUNITY SURVEY

The Swedish CHNA workgroup collaborated with the Providence Data & Evaluation team to develop the community survey. Some of the questions were adapted from the 2018 Swedish CHNA survey and others originated from a standard set of Providence CHNA questions.

Swedish conducted the community survey from July 3 to August 31, 2021, in English. One set of survey questions were completed for South Snohomish and King Counties. Participants primarily completed the survey online, although some surveys were completed on paper. As a sign of appreciation for participants' time, Swedish provided a $5 gift card to those participants who chose to include their e-mail address. Using a convenience sampling methodology, Swedish invited households in King County and South Snohomish County to respond to the survey. The survey link was shared through Swedish social media accounts, paper flyers at community outreach events, an ad in the Seattle Gay News Pride (with a $10 digital gift card incentive), and the behavioral health clinic at Edmonds. Community partners, including those who participated in stakeholder interviews and listening sessions, shared the survey link with their client/patient populations through newsletters and email lists.

The community survey received 976 responses within the survey region. Data were filtered to only include responses within the survey region. Pivot tables were created for each question and the counts and percentages of the responses per answer choice were recorded. Data were then stratified by County, Household Income, and Race. Significant responses were included in the report.

Survey Demographics

Figure 1. Respondents by County

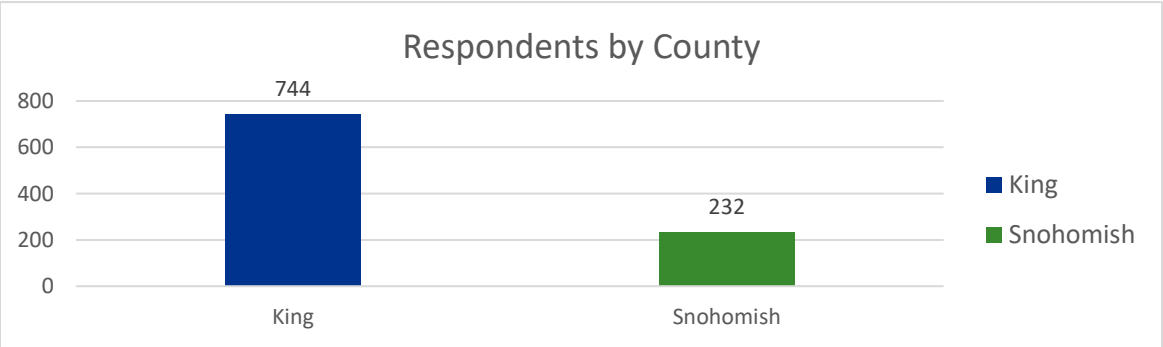


Table 1. Respondents by County

County	Respondents	Population
King County	744	2,236,075
Snohomish County	232	823,512
Total	976	3,059,587

Out of 3,141 responses, 976 were from respondents within the survey area. By ZIP Code, 744 respondents reported they lived in King County, and 242 respondents reported they lived in South Snohomish County.

Table 2. Respondents by Age Group

Age Range	Count	Percentage of Responses	Population
Under 18	7	0.73%	21.33%
18-34	382	39.79%	23.61%
35-54	500	52.08%	27.43%
55-64	35	3.65%	13.26%
65+	36	3.75%	14.37%
Skipped Question	16	-	-
Total Responses	960	100%	

The majority of survey respondents were between the ages of 35 and 54 (52.08%). The second largest age group of respondents was 18-34 (39.79%). In comparison, 23.61% of the general population is between the ages of 18-34 and 27.43% of the population is between the ages of 35-54.

Figure 2. Percentage of Survey Respondents by Race compared to Region Population

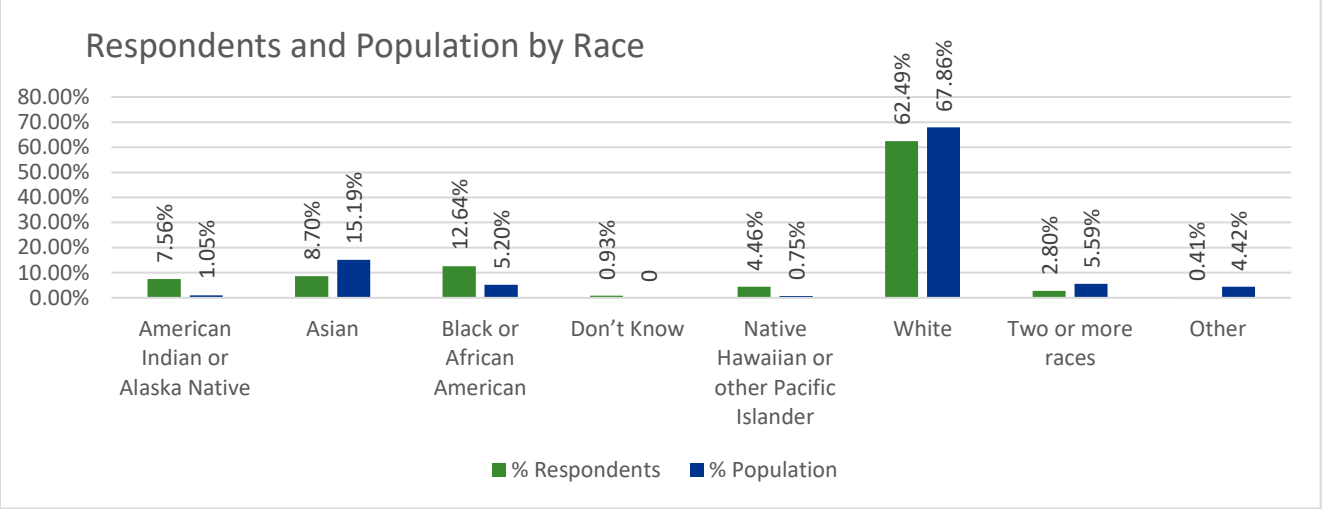


Table 3. Respondents by Race

Race	Count	Percentage	Population
American Indian or Alaska Native	73	7.56%	1.05%
Asian	84	8.70%	15.19%
Black or African American	122	12.64%	5.2%
Don't Know	9	0.93%	-
Native Hawaiian or other Pacific Islander	43	4.46%	0.75%
White	603	62.49%	67.86%
Two or more races	27	2.80%	5.59%
Other	4	0.41%	4.42%
Skipped Question	11	-	-
Total Responses	965	100%	-

The three largest racial groups among respondents to the survey were White (62.49%), Black or African American (12.64%) and Asian (8.70%).

Table 4. Respondents by Ethnicity

Latin/Hispanic/Spanish Origin	Count	Percentage	Population
No	799	84.46%	79.43%
Yes	147	15.54%	20.57%
Skipped	30	-	-
Total Responses	946	100%	-

Table 5. Respondents by Gender Identity

Gender Identity	Count	Percentage	Population
Female	486	50%	50.13%
Male	463	47.63%	49.87%
Non Binary Assigned Female At Birth	2	0.21%	-
Non Binary Assigned Male At Birth	2	0.21%	-
Transgender Woman	2	0.21%	-
Transgender Man	1	0.10%	-
Two Spirit	1	0.10%	-
Fa'afafine	4	0.41%	-
Mahu	2	0.21%	
Choose Not to Describe	9	0.93%	-
Skipped Question	6	-	-
Total Responses	972		

Table 6. Respondents by Sexual Orientation

Sexual Orientation	Count	Percentage
Bisexual	133	13.75%
Choose not to disclose	104	10.75%
Don't know	12	1.24%
Gay	31	3.21%
Lesbian	8	0.83%
Pansexual	9	0.93%
Queer	2	0.21%
Something else	2	0.21%
Straight	666	68.87%
Skipped Question	9	-
Total Responses	967	100%

Table 7. Respondents by Income

Income	Count	Percentage
Less than $19,000	30	3.13%
$20,000 to $29,000	25	2.61%
$30,000 to $39,000	146	15.22%
$40,000 to $49,000	255	26.59%
$50,000 to $59,000	208	21.69%
$60,000 to $69,000	102	10.64%
$70,000 to $79,000	61	6.36%
$80,000 to $89,000	51	5.32%
$90,000 to $99,000	37	3.86%
$100,000 to $150,000	27	2.82%
$150, 000+	17	1.77%
Skipped Question	17	-
Total Responses	959	100%

63.5% of respondents indicated that that their household income was between $30,000 and $59,000.

Survey Questions

Question 1. Please imagine a ladder with steps numbered from zero at the bottom to ten at the top. Suppose we say that the top of the ladder represents the best possible life for you and the bottom of the ladder represents the worst possible life for you.

If the top step is 10 and the bottom step is 0, on which step of the ladder would you say you personally feel you stand at this time?

Table 8. On which step of the ladder would you say you personally feel you stand at this time?

Response	Count	Percentage
0- Worst Possible Life	0	0%
1	13	1.34%
2	67	6.89%
3	166	17.08%
4	184	18.93%
5	230	23.66%
6	149	15.33%
7	72	7.41%
9	50	5.14%
9	19	1.95%
10-Best Possible Life	22	2.26%
Skipped Question	4	-
Total Responses	972	100%

59.67% of respondents ranked they felt they stood on steps 3, 4, and 5.

Question 2. Please imagine a ladder with steps numbered from zero at the bottom to ten at the top. Suppose we say that the top of the ladder represents the best possible life for you and the bottom of the ladder represents the worst possible life for you. On which step do you think you would stand about five years from now?

Table 9. On which step do you think you would stand about five years from now?

Response	Count	Percentage
0—Worst Possible Life	0	0%
1	4	0.41%
2	19	1.97%
3	34	3.52%
4	46	4.76%
5	146	15.11%
6	231	23.91%
7	206	21.33%
8	172	17.81%
9	65	6.73%
10 – Best Possible Life	43	4.45%
Skipped Question	10	-
Total Responses	966	100.00%

63.05% of respondents ranked they felt they would stand on steps 6, 7, and 8 about five years from now.

Question 3. Please select the TOP 3 things needed to improve the health and well-being of you and your family?

Table 10. TOP 3 things needed to improve the health and well-being of you and your family

Response	Percentage
Addressing Homelessness & Housing	7.89%
Affordable Housing	9.03%
Assistance Getting Healthy Food	12.08%
Caring Community	10.90%
Clean Air	4.95%
Easy Access to Health Services	9.79%
Good Paying Jobs	13.67%
Health Education	7.16%
I don't know	0.59%
Information in preferred language	3.70%
Mental Health Services	4.74%
other	0.31%
Safe places to walk or exercise	2.87%
Safe Recreation	1.83%
Substance Use Disorder Treatment	1.14%
Transportation	0.76%
Addressing Racism & Discrimination	8.58%
Skipped Question	11
Total Responses	965

Respondents indicated Good Paying Jobs (13.67%), Caring Community (10.90%), and Assistance Getting Healthy Food (12.08%) as the top three things needed to improve the health and wellbeing of themselves and their family.

Table 11. TOP 3 things needed to improve the health and well-being of you and your family in King County

Response	Percentage
Good Paying Jobs	14.12%
Assistance Getting Healthy Food	13.66%
Affordable Housing	10.39%
Easy Access to Health Services	10.39%
Caring Community	9.71%
Addressing Homelessness & Housing	8.85%
Addressing Racism & Discrimination	7.99%
Health Education	6.13%
Mental Health Services	4.09%
Clean Air	3.77%
Information in preferred language	3.18%
Safe places to walk or exercise	2.77%
Safe Recreation	1.91%
Substance Use Disorder Treatment	1.36%
Transportation	0.82%
I don't know	0.64%
other	0.23%

Within King County, respondents indicated Good Paying Jobs (14.12%), Assistance Getting Healthy Food (13.66%), Affordable Housing (10.39%), and Easy Access to Health Services (10.39%) were needed to improve the health and wellbeing of themselves and their family.

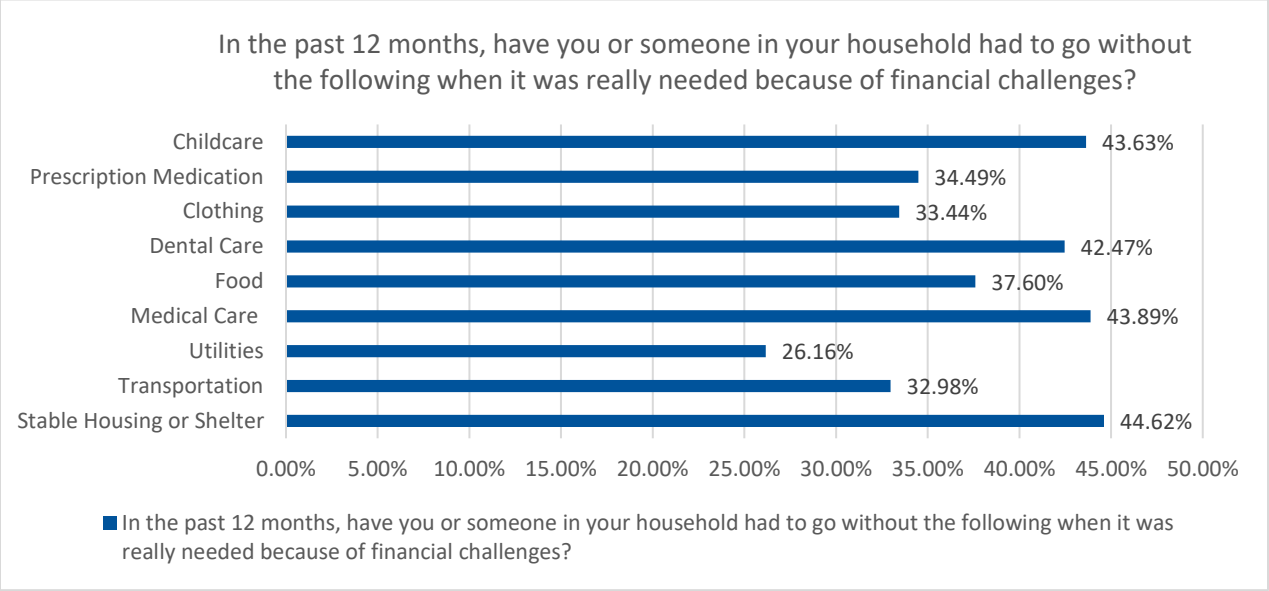
Table 12. Snohomish County: TOP 3 things needed to improve the health and well-being of you and your family in Snohomish County

Response	Percentage
Caring Community	14.70%
Good Paying Jobs	12.23%
Addressing Racism & Discrimination	10.48%
Health Education	10.48%
Clean Air	8.73%
Easy Access to Health Services	7.86%
Assistance Getting Healthy Food	6.99%
Mental Health Services	6.84%
Information in preferred language	5.39%
Addressing Homelessness & Housing	4.80%
Affordable Housing	4.66%
Safe places to walk or exercise	3.20%
Safe Recreation	1.60%
Transportation	0.58%
other	0.58%
I don't know	0.44%
Substance Use Disorder Treatment	0.44%

In Snohomish County, respondents indicated that Caring Community (14.70%), Good Paying Jobs (12.23%), Addressing Racism and Discrimination (10.48%) and Health Education (10.48%) as the most needed things needed to improve health and well-being.

Question 4. In the past 12 months, have you or someone in your household had to go without the following when it was really needed because of financial challenges?

Figure 3. In the past 12 months, have you or someone in your household had to go without the following when it was really needed because of financial challenges?



Among respondents in the survey region, 44.62% indicated that they went without Stable Housing or Shelter, 43.89% indicated that they went without Medical Care, and 43.63% indicated that they went without Childcare.

Table 14. Stratified by County, POC, and Household Income: In the past 12 months, have you or someone in your household had to go without the following when it was really needed because of financial challenges?

Response	King	Snohomish	POC	<$79K
Stable Housing or Shelter	49.79%	28.26%	36.16%	47.61%
Transportation	34.76%	27.39%	31.34%	34.77%
Utilities	22.99%	36.09%	29.38%	26.63%
Childcare	39.73%	56.09%	43.82%	46.52%
Clothing	36.51%	23.58%	35.88%	35.41%
Dental Care	42.27%	43.10%	43.10%	45.23%
Food	38.03%	36.24%	39.94%	40.86%
Medical Care	46.80%	34.63%	40.17%	46.76%
Prescription Medication	37.22%	25.97%	30.88%	37.07%

Within King County, the top 3 categories respondents went without was 49.79% Stable Housing or Shelter (49.79%), Medical Care (46.80%), and Dental Care (42.27%). Within Snohomish County, respondents indicated that 56.09% went without Childcare, 43.10% went without Dental Care, and 36.24% went without Food Respondents of color within the entire survey region indicated that 43.82% went without Childcare, 43.10% went without Dental Care, 40.17% went without Medical Care.

Respondents within the entire survey region whose household income was below $79,000 indicated that 47.61% went without Stable Housing or Shelter, 46.76% went without Medical Care, and 46.52% went without Childcare.

Question 5. My community is a good place to raise children. Consider the quality and safety of school and childcare, after school care and places to play in your neighborhood.

Table 14. My community is a good place to raise children

Response	Count	Percentage
Agree	507	52.27%
Strongly Agree	232	23.92%
Disagree	49	5.05%
Strongly Disagree	11	1.13%
Don't Know	16	1.65%
Neutral	155	15.98%
Skipped Question	6	-
Total Responses	970	100.00%

76.19% of respondents agreed or strongly agreed that their community is a good place to raise children.

Question 6. My community is a good place to grow old. Consider elder friendly housing, transportation to medical services, access to shopping centers and businesses, recreation, and services for the elderly.

Table 15. My community is a good place to grow old

Response	Count	Percentage
Agree	373	38.53%
Strongly Agree	250	25.83%
Disagree	45	4.65%
Strongly Disagree	9	0.93%
Don't Know	11	1.14%

Response	Count	Percentage
Neutral	280	28.93%
Skipped Question	8	-
Total Responses	968	100.00%

64.36% of respondents strongly agreed or agreed that their community is a good place to grow old.

Question 7. I feel safe in my home. Consider everything that makes you feel safe, such as neighbors, presence of law enforcement, etc. and everything that could make you feel unsafe at home, including family violence, robbery, housing conditions, etc.

Table 16. I feel safe in my home

Response	Count	Percentage
Agree	447	46.27%
Strongly Agree	226	23.40%
Disagree	38	3.93%
Strongly Disagree	5	0.52%
Don't Know	8	0.83%
Neutral	242	25.05%
Skipped Question	10	-
Total Responses	966	100.00%

69.67% of respondents strongly agreed or agreed that they feel safe in their home.

Question 8. People of all races, ethnicities, backgrounds and beliefs in my community are treated fairly. Consider any form of discrimination as well as programs and institutions that treat diversity as an asset.

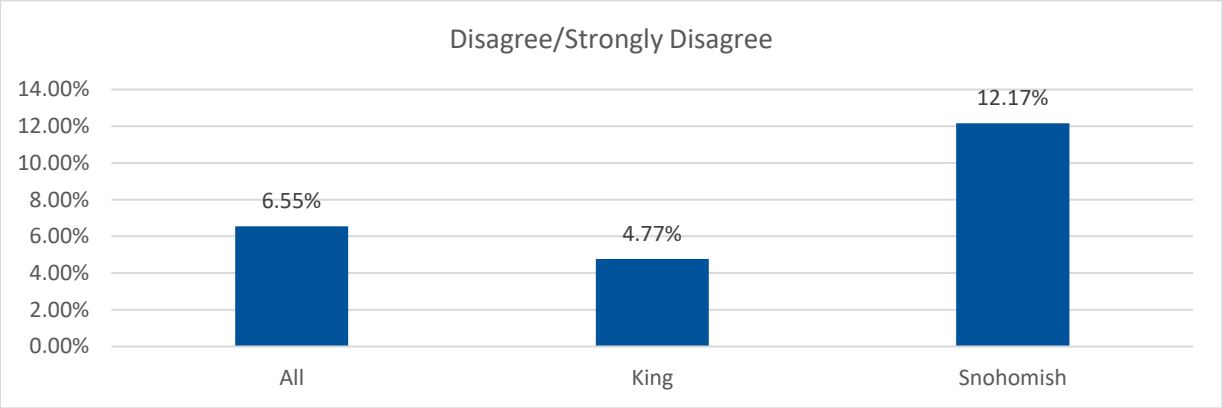
Table 17. Region

Response	Count	Percentage
Agree	421	43.72%
Strongly Agree	198	20.56%
Disagree	56	5.82%
Strongly Disagree	7	0.73%
Don't Know	17	1.77%

Response	Count	Percentage
Neutral	264	27.41%
Skipped Question	13	-
Total Reponses	963	100.00%

64.28% of respondents strongly agreed or agreed that people of all races, ethnicities, backgrounds, and beliefs in their community are treated fairly.

Figure 4. Comparison across areas: Disagree/Strongly Disagree that people of all races, ethnicities, backgrounds, and beliefs in community are treated fairly.



4.77% of the survey respondents within King County disagreed or strongly disagreed that that people of all races, ethnicities, backgrounds, and beliefs in community are treated fairly, while 12.17% of the survey respondents within Snohomish County disagreed or strongly disagreed that that people of all races, ethnicities, backgrounds, and beliefs in community are treated fairly.

Table 18. King County

Response	Percentage
Agree	45.84%
Strongly Agree	19.24%
Disagree	4.50%
Strongly Disagree	0.27%
Don't Know	1.09%
Neutral	29.06%

Table 19. Snohomish County

Response	Percentage
Agree	36.96%
Strongly Agree	24.78%
Disagree	10.00%
Strongly Disagree	2.17%
Don't Know	3.91%
Neutral	22.17%

Table 20. People of Color

Response	Percentage
Agree	35.65%
Strongly Agree	21.17%
Disagree	7.24%
Strongly Disagree	0.56%
Don't Know	1.95%
Neutral	33.43%

Question 9. Do you or a family member have any of the following? (Please select all that apply)

Table 21. Do you or a family member have any of the following

Response	Count	Percentage
Activity Limitation	167	12.14%
Impairment in Body Structure or Function	316	22.97%
Impairment in Mental Function	1	0.07%
Impairment in Mental Function	219	15.92%
None of the above	408	29.65%
Other	5	0.36%
Social Participation Limitation	260	18.90%
Skipped	9	-
Total Responses	967	100.00%

Question 10. Where do you get most of your health information and/or education? (Please select your TOP 3)

Table 22. Where do you get most of your health information and/or education?

Response	Count	Percentage
Healthcare Provider	651	22.94%
Internet	604	21.28%
Places in My Community	480	16.91%
other	18	0.63%
Other Media	411	14.48%
Places of Worship	121	4.26%
School or Work	289	10.18%
Social Media	264	9.30%
Skipped Question	29	-
Total Responses	947	100.00%

The top 3 categories respondents reported obtaining health information and education included their Healthcare Provider (22.94%), Internet (21.28%), and Places in their Community (16.91%).

Question 11. Where do you go for a checkup or routine care? This is care for vaccines, check-ups, disease screenings, etc. (Please select all that apply.)

Table 23. Where do you go for a checkup or routine care?

Response	Count	Percentage
Doctors Office	596	28.99%
Emergency Room	329	16.00%
Free or Low-Cost Clinic	389	18.92%
Home Health	273	13.28%
No Regular Healthcare	108	5.25%
Other	6	0.29%
Residential Nursing Care	177	8.61%
Urgent Care Clinic	121	5.89%

Response	Count	Percentage
Alternative Medicine	57	2.77%
Skipped Question	9	-
Total Responses	967	100.00%

The top 3 categories respondents reported going for checkup or routine care included their Doctor's Office (28.99%), Emergency Room (16.00%), and Free or Low-Cost Clinic (18.92%). 5.89% of respondents reported going to Urgent Care Clinic for routine care.

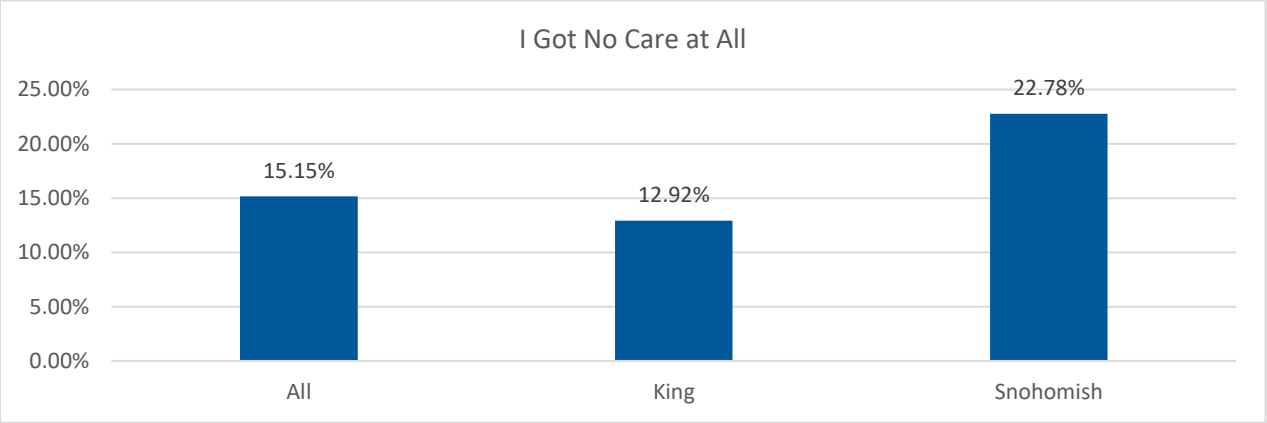
Question 12. In the last 12 months did you or a member of your household get all the care you needed? (Please select all that apply)

Table 24. In the last 12 months did you or a member of your household get all the care you needed?

Response	Count	Percentage
Got no care at all	188	15.15%
Had to delay getting care	167	13.46%
I got all the care I needed	481	38.76%
I don't know	11	0.89%
other	4	0.32%
Some but not all the care I needed	390	31.43%
Skipped Question	18	-
Total Responses	958	100.00%

38.76% of survey respondents in the region indicated they got all the care they needed, 31.43% indicated they got some but not all the care they needed, and 15.15% indicated they got no care at all.

Figure 5. Comparison across Counties: I Got No Care at All



Within King County, 12.92% of respondents indicated that they got no care at all, while in Snohomish County, 22.78% of respondents indicated that they got no care at all.

Table 25. King: In the last 12 months did you or a member of your household get all the care you needed?

Response	Percentage
I don't know	0.83%
I got all the care I needed	40.00%
Got no care at all	12.92%
Some but not all the care I needed	31.88%
Had to delay getting care	14.17%
other	0.21%

Table 26. Snohomish: In the last 12 months did you or a member of your household get all the care you needed?

Response	Percentage
I don't know	1.07%
I got all the care I needed	34.52%
Got no care at all	22.78%
Some but not all the care I needed	29.89%
Had to delay getting care	11.03%
other	0.71%

Question 13. The most recent time you or a member of your household delayed or went without needed health care, what were the main reasons? (Please select all that apply)

Table 27. The most recent time you or a member of your household delayed or went without needed health care, what were the main reasons

Response	Count of Answers	Percentage
Couldn't get an appointment quickly enough	172	9.00%
I got all the care I needed	316	16.54%
Lack of provider awareness/education about my health condition	226	11.83%
Language barriers	119	6.23%
Not having a provider who understands/respects my culture/religion	95	4.97%
Not knowing where to go or how to find a doctor	69	3.61%
other	9	0.47%
Technology barriers/Telehealth services	104	5.44%
Underinsured	37	1.94%
COVID-19	449	23.50%
Distrust/Fear of Discrimination	216	11.30%
No insurance and unable to pay for care	99	5.18%
Skipped Question	24	-
Total Responses	952	100.00%

Question 14. What kind of health coverage or insurance do you have? (Please select all that apply)

Table 28. What kind of health coverage or insurance do you have?

Response	Count of Answers	Percentage
A private plan I pay for myself	75	5.22%

Response	Count of Answers	Percentage
I don't have any health insurance now	220	15.30%
I don't know	44	3.06%
Indian Health Services (IHS)	122	8.48%
Medicaid (Apple Health)	309	21.49%
Medicare	404	28.09%
other	5	0.35%
Private coverage through an employer or family member's employer	237	16.48%
VA, TRICARE, or other military health care	22	1.53%
Skipped Question	16	-
Total Responses	960	100.00%

Question 15. If you do NOT currently have any kind of health coverage or insurance, what are the main reasons why? (Please select all that apply)

Table 29. If you do NOT currently have any kind of health coverage or insurance, what are the main reasons why?

Response	Count of Answers	Percentage
I am waiting to get coverage through my job	85	8.80%
I don't think I need insurance	134	13.87%
I haven't had time to deal with it	236	24.43%
It costs too much	332	34.37%
Not eligible or do not qualify	109	11.28%
other	10	1.04%
Signing up is too confusing	60	6.21%
Skipped Question	358	-
Total Responses	608	100.00%

Question 17. What is your current employment status?

Table 30. What is your current employment status?

Response	Count	Percentage
Employed full time	648	67.08%
Employed part time	163	16.87%
Furloughed	20	2.07%
Homemaker or stay at home parent	15	1.55%
Retired	31	3.21%
Self employed	24	2.48%
Student	14	1.45%
Unable to work due to illness, injury, or disability	21	2.17%
Unemployed	25	2.59%
Working multiple jobs	5	0.52%
Skipped Question	10	-
Total Responses	966	100.00%

Question 18. Which of the following best describes your housing situation today?

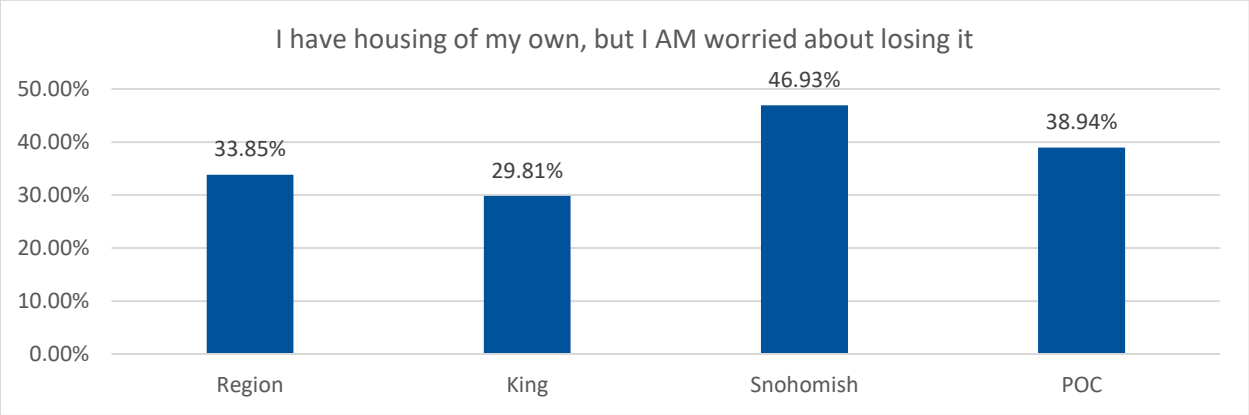
Table 31. Region

Response	Count	Percentage
I have housing of my own and I'm NOT worried about losing it	362	37.47%
I have housing of my own, but I AM worried about losing it	327	33.85%
I'm staying in a nursing home	3	0.31%
I'm staying in a retirement home	9	0.93%
I'm staying in a shelter, in a car, or on the street	33	3.42%
I'm staying in an Adult foster care facility	23	2.38%
I'm staying with friends or family	208	21.53%
Other	1	0.10%

Skipped Question	10	-
Total Responses	966	100.00%

71.32% of survey respondents indicated that they have housing. 33.85% of respondents have housing but are afraid of losing it. 21.53% of respondents were staying with friends or family, 3.62% are staying in a nursing or retirement home or adult foster care facility, and 3.42% were staying in a shelter, car, or street.

Figure 6. Comparison across areas: I have housing of my own, but I AM worried about losing it



33.85% of the survey respondents across the region indicated that have housing of their own but are worried about losing it. 29.81% of the respondents within King County indicated this response, while 46.93% of the respondents within Snohomish County indicated this response. 38.94% of respondents of color across the region also indicated this response.

Table 32. King County

Response	Percentage
I have housing of my own and I'm NOT worried about losing it	40.65%
I have housing of my own, but I AM worried about losing it	29.81%
I'm staying in a nursing home	0.41%
I'm staying in a retirement home	1.22%
I'm staying in a shelter, in a car, or on the street	2.98%
I'm staying in an Adult foster care facility	2.44%
I'm staying with friends or family	22.36%

Response	Percentage
Other	0.14%

Table 33. Snohomish County

Response	Percentage
I have housing of my own and I'm NOT worried about losing it	27.19%
I have housing of my own, but I AM worried about losing it	46.93%
I'm staying in a shelter, in a car, or on the street	4.82%
I'm staying in an Adult foster care facility	2.19%
I'm staying with friends or family	18.86%

Table 34. People of Color

Response	Percentage
I have housing of my own and I'm NOT worried about losing it	31.09%
I have housing of my own, but I AM worried about losing it	38.94%
I'm staying in a nursing home	0.56%
I'm staying in a retirement home	0.28%
I'm staying in a shelter, in a car, or on the street	5.88%
I'm staying in an Adult foster care facility	4.20%
I'm staying with friends or family	18.77%
other	0.28%

Question 19. Altogether, how many people currently live in your home?

Table 35. Me, plus the number of adults

Min	Q1	Med	Q3	Max	STDV	Skipped Question	Total Responses
0	2	2	3	6	0.89	32	944

One outlier response of 33 within the home was not included in this calculation.

Table 36. Me, plus the number of children

Min	Q1	Med	Q3	Max	STDV	Skipped Question	Total Responses
0	2	2	2	8	0.85	71	905

APPENDIX 3 COMMUNITY RESOURCES

Community stakeholders identified community resources potentially available to address the identified community needs. This is not a comprehensive list of all available resources. For additional resources refer to North Sound 2-1-1 for Snohomish County resources at https://www.uwsc.org/211.

Community Need	Community Organization/Initiative
Access to Health Care	**Free vision screening program at Edmonds School District**: Provides complimentary eye exams and hardware to families in need. This program is a partnership between the Foundation for Edmonds School District, the Edmonds School District, and National Vision Cares.
	Community Health Centers of Snohomish County: A community medical, dental, and behavioral health provider that does a lot of outreach services, provides low-barriers services, and serves everyone.
Behavioral Health	**Law Enforcement Assisted Diversion (LEAD) Program**: A program aimed at connecting individuals with social services and resources to address underlying needs and access alternatives to jail time.
	Chronic-Utilizer Alternative Response Team (CHART) Program: A program designed to address the needs of South Snohomish County's most vulnerable residents who have physical health, mental health, legal, and SUD conditions. The goal is to take a coordinated approach to creating an individualized plan for serving the individual and decrease the system impacts associated with the disproportionate overlapping service use.
Community Support and Resources	**ChildStrive**: An organization that provides support to parents and other care givers, helping them meet the needs of infants and toddlers. Home visiting teams include occupational, speech and physical therapists, community health nurses, educators, family counselors, parent educators and family resource coordinators who provider parent coaching.
Housing and Homelessness	**Washington Kids in Transition**: A nonprofit that provides resources for students and families in the Edmonds and Everett School Districts that are experiencing homelessness.
Economic Insecurity	**Swedish Edmonds Project SEARCH**: A collaboration between Swedish Edmonds Hospital and Edmonds School District, this program supports students with developmental disabilities and delays to receive job training skills to help them finding meaningful employment after graduation.

APPENDIX 4 REVIEW OF PROGRESS

Swedish Edmonds approved an Implementation Strategy/Community Health Improvement Plan (CHIP) to address significant health needs identified in the 2018 CHNA. The priority health needs were **access to care – joint and back pain, mental health and wellness, drug addiction, obesity and homelessness**.

To accomplish the CHIP, goals were established that indicated the expected changes in the health needs as a result of community programs and education. Strategies to address the priority health needs were identified and measures tracked. The following section outlines the significant health needs addressed since the completion of the Hospital's 2018 CHNA.

Initiative/Community Need Addressed: Access To Care: Joint and Back Pain

Goal (anticipated impact): The goal is to increase participation in educational seminars on surgical spine and joint options.

Scope (target population): Joint and back pain was one of the top ten problem areas identified by Swedish Edmonds' stakeholders in the Community Health Needs Assessment (CHNA) primary data survey. The target for this initiative are service area residents who seek effective options for relief of joint and back pain from multiple causes.

Key Community Partners: Swedish Medical Group, Proliance Surgeons, Verdant Health Commission, City of Lynnwood, City Of Edmonds, City of Mountlake Terrace, Edmonds Senior Center, Lynnwood Senior Center, Edmonds Beacon, and My Edmonds News.

Progress: The goal was to increase participation from 8 persons in 2018 to 25 persons in 2021. In 2019, there were 22 participants. All educational seminars were cancelled starting in March 2020 due to the COVID-19 pandemic.

Initiative/Community Need Addressed: Opioid Use Disorders, Opioid Withdrawal, and Opioid Overdose

Goal (anticipated impact): Initiate Suboxone therapy in the Edmonds ED and inpatient units to transition patients to a Suboxone clinic to assist in treatment of their opioid use disorder. Conduct follow-up phone calls with all patients presenting with opioid withdrawals or opioid overdose to offer recovery supports and resources.

Scope (target population): Edmonds Emergency Department patients who present with opioid use disorder, opioid withdrawal, and/or opioid overdose. Treat with evidence - based guidelines for brief education and intervention, withdrawal management and work with care team to navigate patients to a Suboxone clinic for establishing care and maintaining Suboxone therapy.

Key Community Partners: Snohomish Health District, Health Care Authority of Snohomish County, SAMSHA, CDC, Ideal Options, Consistent Care and medication assisted therapy service providers.

Progress: Swedish Edmonds initiated Suboxone therapy in the Emergency Department and inpatient units.

- Baseline inductions in 2018: 0
- Total Suboxone inductions in 2109: 56
- Percentage of patients who had a confirmed followed up with ideal option in 2019: 56.6%
- Total suboxone inductions in 2020: 77
- Percentage of patients who had a confirmed followed up with ideal option 2020: 38.8%

In 2020, in addition to inducing patients with Suboxone who were treated in the emergency department, patients on the medical floors, who came in for other medical concerns, were provided with Suboxone. The care navigator followed patients discharged from the hospital who expressed interest in treatment and services endorsing opioid use. The care navigator provided referrals and resources, information on harm reduction, and brief intervention.

COVID-19 impacted the Bridge to Treatment Suboxone program. There was a reduction in the number of patients coming to the emergency department with opioid use. This resulted in a smaller population of patients who qualified for Suboxone inductions. The resources previously available to patients included case management, access to a phone, connection to treatment/insurance, community access to medication/medical support, and access to food. The changes due to COVID-19 included difficulty reaching outpatient organizations, and reduction in outpatient organization staff.

Initiative/Community Need Addressed: Obesity

Goal (anticipated impact): To integrate specialized nutrition services into specialty and primary care providers, improve patient compliance with nutrition service referrals, and to improve care coordination between family and specialty care physicians and registered dietitians. Additionally, this initiative will help establish strong community norms for promoting healthy living through nutritious food and beverages

Scope (target population): Obesity was one of the top ten problem areas identified by Swedish Edmonds' stakeholders in the Community Health Needs Assessment (CHNA) primary data survey. The target population for this initiative are residents within the service area who require nutrition service referrals.

Key Community Partners: Swedish Medical Group.

Progress: Fried foods were eliminated from all patient menus in May 2019 and replaced with healthier food options. Healthy food options offered in the smart market vending machines in the café improved

50% overall. Swedish Edmonds completed translation of patient menus into eight languages, which are available on the intranet. General menus are now available in languages that represent the communities we serve: simplified Chinese, traditional Chinese, Korean, Russian, Somali, Spanish, Tigrigna, and Vietnamese. A limited mini pilot to provide dietician-led nutrition support was launched in the wound healing center in November 2019 with plans to schedule two patients for intake and follow up, follow their progress, and assess program effectiveness prior to expanding the offering to more patients and clinics. The pilot program engaged three patients at the time the program was paused due to COVID-19.

Initiative/Community Need Being Addressed: Mental Health - Inpatient Ligature Reduction Project

Goal (anticipated impact): To create and maintain a ligature-free environment for inpatient psychiatry.

Scope (target population): Mental Health was one of the top ten problem areas identified by Swedish Edmonds' stakeholders in the Community Health Needs Assessment (CHNA) primary data survey. Swedish Edmonds has a 25-bed inpatient mental health unit with an average daily census of 24. In 2018, 550 patients requiring acute mental health treatment were admitted. Patients were admitted on a voluntary basis and an involuntary basis per court-ordered treatment. Suicide is a growing concern across the nation, and the Joint Commission, DNV, DOH and CMS have mandated hospitals to assure that patient care areas are ligature-free.

Key Community Partners: Snohomish County Designated Crisis Responders, Compass Health, Verdant Health, and NBBJ Architects.

Progress: Construction began in September 2019 to reduce/eliminate ligature risks in the 25-bed inpatient behavioral health unit. Updates to all rooms were completed in 2020. Six (6) behavioral health exam rooms in the Emergency Department were also redesigned in early 2020 to reduce/eliminate ligature risk. Safety walks were conducted regularly to continually assess physical environment and address potential risks. A 1:1 sitter protocol for patients at risk of suicide was implemented. The highest recorded need was 14 patients at one time. The Emergency Department applied the Columbia Suicide Screening tool to assess patients and the tool was built into the Electronic Health Record in 2019.

In addition, the Swedish Edmonds partial hospitalization program (PHP) was implemented as a short-term, intensive day treatment program for individuals with acute psychiatric needs. PHP was used as a step-down program for patients from inpatient hospitalization and/or as a preventive step to inpatient hospitalization. PHP was used for individuals older than 18-years who required more intensive, immediate care than traditional outpatient care could offer.

- 5 years ago – PHP maximum census was 1-2 patients
- 4 years ago - PHP maximum census was 10 patients
- 3 years ago – PHP maximum census was 10 patients
- 2 years ago – PHP maximum census was 11 patients

To meet the growing demand for outpatient support during the COVID-19 pandemic, Swedish Edmonds expanded the PHP census to 15 in 2020.

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 Snohomish County. 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 Snohomish County.

Key Community Partners: Capitol Hill Housing, Mary's Place, Plymouth Housing, Healthcare Industry Leadership Table

Progress: Capital funding was provided to build affordable housing units and grant funding were provided for direct rental assistance. Swedish representatives participated in the HILT Affordable Housing Workforce. The Housing Task Force adopted a strategy to build a formal system team focused on providing support to regional efforts.

APPENDIX 5 CHIP PRIORITIZATION PARTICIPANTS

The following Swedish leaders participated in the 2022-2024 Community Health Improvement Plan (CHIP) priority setting process.

- Nwando Anyaoku, MD, MPH, MBA, Chief Health Equity Officer, Swedish Health Services
- Mardia Shands, MA, SPHR, SHRM-SCP, Chief Diversity, Equity, and Inclusion Office
- Kelly Guy, Regional Director, Swedish Community Health Investment & Partnerships
- Chris Beaudoin, MBA, Chief Executive, Community Hospitals
- Elizabeth Wako, MD, Chief Executive, Swedish Seattle Hospitals
- Zachary Litvack, MD MCR FAANS FACS, Chief Medical Officer, Swedish Cherry Hill
- Christopher Chisholm, MD, MS, CPE, FAAEM, Chief Medical Officer, Swedish First Hill
- Michelle Arnold, MD, Chief Medical Officer, Swedish Issaquah
- Lynn Tissell, LSSBB, Senior Executive Assistant, Swedish Ballard
- Donna Jensen, Executive Director Nursing, SMG
- James Martin, MD, Chief Medical Officer, SMG
- Brooke Lippincott, Executive Director Ambulatory Care Services
- Andrea Ramirez, Director of Population Health Puget Sound, Quality and Patient Safety
- Sara Brand, Director of Operations – Ambulatory Behavioral Health
- Lucas Hopkins, Director of Population Health Puget Sound, ACO Support

The Swedish Acute Care Council (ACC) and the Swedish Health Equity Social Justice Responsibility Committee (HESJR) served as the two oversight committees for the 2021 CHNA process.

Acute Care Executive Team

Kevin Brooks, Margo Bykonen, Kristy Carrington, Keegan Fisher, Marybeth Formby, Dr. Chris Dale, Mike Denney, Mona Locke, Jennifer McAleer, Renee Rassilyer-Bomers, Dr. Nwando Anyaoku, Mardia Shands

Acute Care Regional Leaders

Jim Lacy, Andrew Davis, Corin Schneider, Darrin Mooneyham, Andrea Gimse, Pam Gallagher, Geoff Martin, Shelly Livingston, Melissa Norwood, Dr. Jennifer Spence, Cindy Rose, Cindy Paget, Marianne Klaas, Kerry Miles, Brandon Eastman-King, Carol Cleek

Executive Medical Directors

Dr. David Selander, Dr. Naomi Diggs, Dr. Mark Sullivan, Dr. Arooj Simmonds, Dr. Marc Horton

Swedish Edmonds

Dave West, Jennifer Culbertson, Dr. Joel Wasserman

Swedish Community

Chris Beaudoin, Brian Trickel, Dr. Michele Arnold, Dr. Sarah Garber

Swedish Seattle

Dr. Elizabeth Wako, Marci Mann, Cindy Davis, Dr. Chris Chisholm, Dr. Zach Litvack

Swedish Institutes

Melissa Short, Ida Myoung, Shelley Cathrea, Brooke Lippincott

Health Equity, Justice, and Social Responsibility Committee

- Ubah Aden, Swedish Linguistic Services Medical Interpreter II, Community Volunteer
- Nwando Anyaoku, MD, Executive Medical Director, Pediatrics, SHS
- Sarah Brand, MPH, PMP, Director of Operations, Behavioral Health SHS
- Naomi Diggs, MD, Associate Medical Director, Swedish Hospital Medicine
- R. Guy Hudson, MD, MBA, CEO, Swedish Health Services (SHS)
- Jessica Hughes, Board of Governors Chair, SMCF
- Lauren Platt McDonald, Director of Government Relations, WA-MT
- R. Omar Riojas, Board of Trustees Vice Chair, SHS
- Marguerite Ro, PhD, Chief of Assessment, Policy Development and Evaluation/Chronic Disease and Injury Prevention, Seattle-King County Public Health
- Martin Siegel, MD
- Tanya Sorensen, MD, Executive Medical Director for Women's Services
- Kristen Swanson, RN, PhD, Board of Trustees Chair, SHS
- Julia Wang, MD, Resident Physician, Swedish Cherry Hill Family Medicine Residency
- Kevin Wang, MD, Primary Care Physician, Family Medicine Obstetrics
- Jasmin Zavala, MD, Adolescent Medicine Physician, Clinical Director, Sea Mar Community Health Centers Adolescent Clinic

Executive and Content Experts

- Mike Denney, Chief Real Estate Officer, SHS
- Keegan Fisher, VP Chief HR Officer Swedish
- Pinky Herrera, Program Manager, Community Health Investments, SHS
- Mona Locke, Chief Communications Officer, SHS
- Mardia Shands, Chief Diversity, Equity & Inclusion Officer, SHS

The Swedish Health System Board of Trustees is responsible for approving the CHNA and the CHIP reports.

Swedish Health System 2021 Board of Trustees

- Kristen Swanson, PhD, RN, Board Chair
- R. Omar Riojas, Vice Chair
- R. Guy Hudson, MD, MBA, CEO
- Rob Andrews
- Bobbie Berkowitz, RN, PhD

- Rick Cantu
- Naomi Diggs, MD
- Cheryl Gossman, MHA
- R. Guy Hudson, MD, MBA
- Jessica Hughes, Foundation Member
- Diankha Linear, JD (March 2021)
- Monica Pool Knox, MBA
- R. Omar Riojas, JD
- Stan Savage, MBA
- Tanya Sorensen, MD
- Jennifer Spence, MD
- Jonathan Sugarman, MD, MPH
- Kristen Swanson, RN, PhD

SWEDISH

Edmonds

EDMONDS
21601 76th Ave. W.
Edmonds, WA 98026
T 425-640-4000

swedish.org

We do not discriminate on the basis of race, color, national origin, sex, sexual orientation, gender identity or expression, 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 (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 (TTY 711)

COMM-21-0489-B 9/21