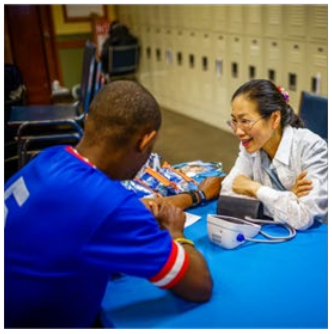
2022 - 2024

COMMUNITY HEALTH IMPROVEMENT PLAN

Swedish Edmonds

Edmonds, WA

SWEDISH
HEALTH FOR GOOD



To provide feedback on this CHIP or obtain a printed copy free of charge, please email Kelly R. Guy at Kelly.Guy@Providence.org.

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EXECUTIVE SUMMARY

Providence continues its Mission of service in Snohomish County through Swedish Medical Center Edmonds. Swedish Edmonds is an acute-care hospital with 217 licensed beds, founded in 1964 and located in Edmonds, WA. The hospital's service area is the following cities in Snohomish County: Bothell, Edmonds, Everett, Lynnwood and Mountlake Terrace, including 823,512 people.

Swedish Edmonds dedicates resources to improve the health and quality of life for the communities it serves, with special emphasis on the needs of the economically poor and vulnerable. During the most recent fiscal year, Swedish Edmonds provided $29.1 million in community benefit in response to unmet needs.

The Community Health Needs Assessment (CHNA) is an opportunity for Swedish Edmonds to engage the community every three years with the goal of better understanding community strengths and needs. The results of the CHNA are used to guide and inform efforts to better address the needs of the community. Through a mixed-methods approach, using quantitative and qualitative data, the CHNA process relied on several sources of information: county and state public health data, qualitative data from interviews with community stakeholders and listening sessions with community members, primary data from a community survey, and hospital utilization data.

Swedish Community Health Improvement Plan Priorities

As a result of the findings of our 2021 CHNA and through a prioritization process aligned with our Mission, resources, and hospital strategic plan, Swedish Edmonds will focus on the following areas for its 2022-2024 Community Benefit efforts:

BEHAVIORAL HEALTH

Behavioral health includes mental health and substance use. Mental health is an important part of overall health and well-being and includes our emotional, psychological, and social well-being. It affects how we think, feel, and act. It also helps determine how we handle stress, relate to others, and make healthy choices. Substance abuse/use, occurs when the recurrent use of alcohol and/or drugs causes clinically significant impairment, including health problems, disability, and inability to meet major responsibilities at work, school, or home.

ACCESS TO HEALTH CARE

Access to care is a key determinant of health that provides preventive measures and disease management, reducing the likelihood of hospitalizations and emergency room admissions. Access to affordable, quality care is important to physical, social, and mental health. Health insurance, local care options, and a usual source of care help to ensure access to health care. Having access to care allows individuals to enter the health care system, find care easily and locally, pay for care, and get their health needs met.

RACISM AND DISCRIMINATION

We acknowledge that all people do not have equal opportunities and access to living their fullest, healthiest lives due to systems of oppression and inequities. Discrimination is treating a person unfairly because of who they are or because they possess certain characteristics or identities.

HOUSING INSTABILITY AND HOMELESSNESS

Housing instability and homelessness are prevalent issues in area communities. Housing instability encompasses several challenges such as having trouble paying rent, overcrowding, moving frequently, staying with relatives, or spending the bulk of household income on housing. Those experiencing homelessness face higher rates of disease and death than the population has stable housing.

INTRODUCTION

Who We Are

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

Our Vision Health for a Better World.

Our Values Compassion — Dignity — Justice — Excellence — Integrity

Swedish Edmonds is a community hospital founded in 1964 and located in Edmonds, WA. The hospital has 217 licensed beds, a staff of more than 1,400, and professional relationships with more than 450 local physicians. Major programs and services offered to the community include the following: a full scope of medical and surgical services, Level IV Trauma emergency medicine, diagnostic, treatment, and support services.

Our Commitment to Community

Swedish Edmonds dedicates resources to improve the health and quality of life for the communities we serve. During 2021, Swedish Edmonds provided $29.1 million in community benefit[1] in response to unmet needs and to improve the health and well-being of those we serve in Snohomish County, WA.

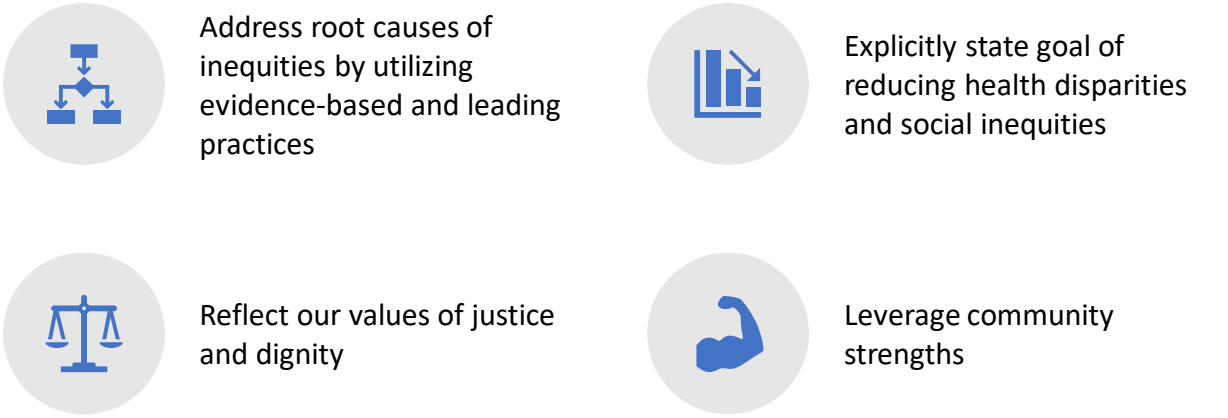
Health Equity

At Providence St. Joseph Health, we acknowledge that all people do not have equal opportunities and access to living their fullest, healthiest lives due to systems of oppression and inequities. We are committed to ensuring health equity for all by addressing the underlying causes of racial and economic inequities and health disparities. Our Vision is “Health for a Better World,” and to achieve that we believe we must address not only the clinical care factors that determine a person’s length and quality of life, but also the social and economic factors, the physical environment, and the health behaviors that all play an active role in determining health outcomes.

To ensure that equity is foundational to our CHIP, we have developed an equity framework that outlines the best practices that each of our hospital will implement when completing a CHIP. These practices include, but are not limited to the following:

[1] Per federal reporting and guidelines from the Catholic Health Association.

Figure 1. Best Practices for Centering Equity in the CHIP



Community Benefit Governance

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).

Planning for the Uninsured and Underinsured

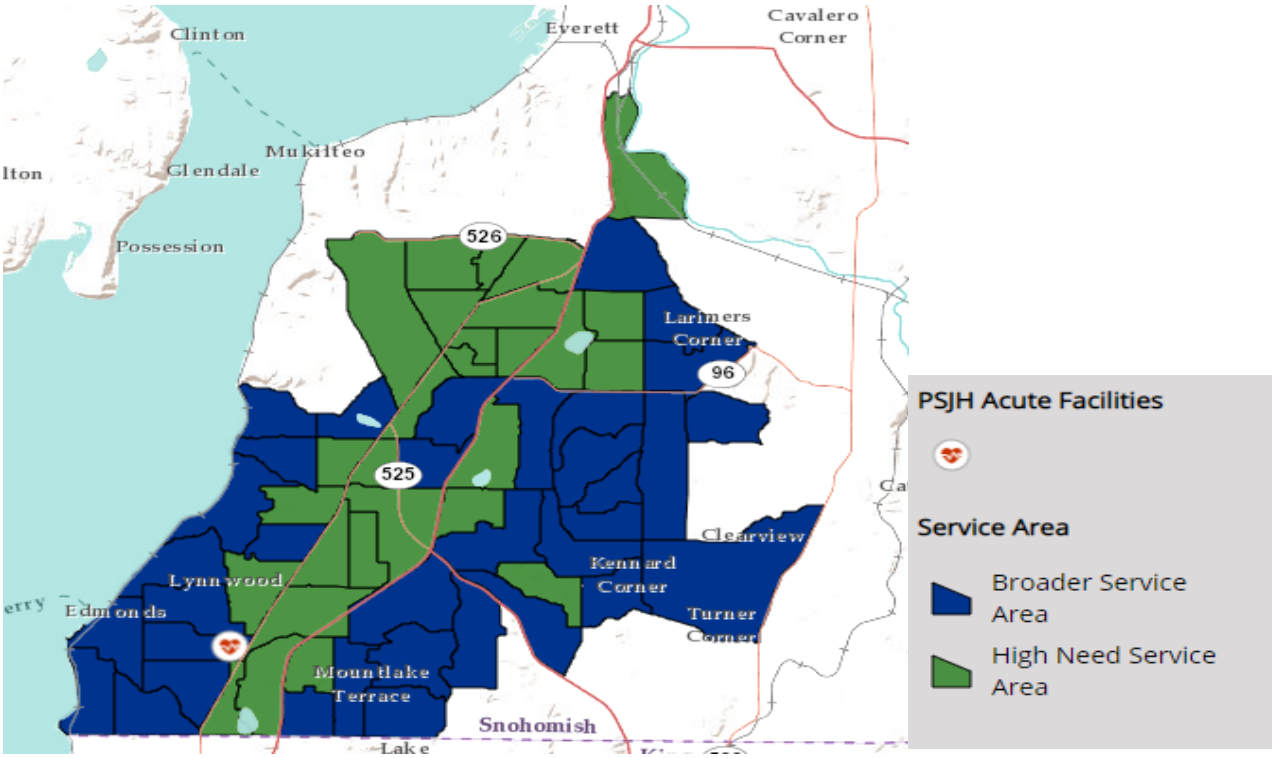
Our Mission is to provide quality care to all our patients, regardless of ability to pay. We believe that no one should delay seeking needed medical care because they lack health insurance. That is why Swedish has a Financial Assistance Program (FAP) that provides free or discounted services to eligible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

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

OUR COMMUNITY

Description of Community Served

Swedish Edmonds' service area is Snohomish County, WA and includes a population of approximately 823,512 people.



Of the over 823,000 permanent residents of Snohomish County, roughly 44% live in the "high need" area, defined by lower life expectancy at birth, lower high school graduation rates, and more households at or below 200% FPL compared to census tracts across the county. For reference, in 2020, 200% FPL represents an annual household income of $52,400 or less for a family of four. These households are more likely to regularly make spending tradeoffs regarding utilities, rent, groceries, medicine, and other basic expenses.

Community Demographics

POPULATION AND AGE DEMOGRAPHICS

In Snohomish County, the high need service area has a higher rate of children, ages 17 and younger (29.9%) than the population of Snohomish County (28.5%). There are fewer seniors, ages 65 and older) in the high need area (12.7%) when compared to Snohomish County (14.1%).

POPULATION BY RACE AND ETHNICITY

In Snohomish County, 10.6% of the population is Hispanic and 17.3% of the high need service area is Hispanic. The majority population in Snohomish County identify as White (73%), 11.5% of the population are Asian, 5.4% are two or more races, 4.5% are other races, and 3.6% are Black/African Americans. The high need service area has a lower percentage of White residents and higher rates of Hispanic, Asians, Blacks, other races, and persons of two or more races.

SOCIOECONOMIC INDICATORS

Income Indicators for Snohomish County Service Area

Indicator	Broader Service Area	High Need Service Area	Snohomish County
Median Income Data Source: American Community Survey Year: 2019	$103,604	$67,966	$85,254
Percent of Renter Households with Severe Housing Cost Burden Data Source: American Community Survey Year: Estimates based on 2013 – 2017 data	18.1%	23.2%	21.7%

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. 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%).

Full demographic and socioeconomic information for the service area can be found in the 2021 CHNA for Swedish Edmonds.

COMMUNITY NEEDS AND ASSETS ASSESSMENT PROCESS AND RESULTS

Summary of Community Needs Assessment Process and Results

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".

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 important, 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. Interviews were conducted with representatives from Public Health – Seattle & King County and Snohomish County Public Health. They also completed 9 listening sessions: 7 from King County and 2 from Snohomish County. The goal of the interviews and listening sessions was to identify the needs not currently being met in the community and what assets could be leveraged to address these needs. Swedish 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
- Economic insecurity
- Food 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.

Significant Community Health Needs Prioritized

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

Needs Beyond the Hospital's Service Program

No hospital facility can address all of the health needs present in its community. The following community health needs identified in the ministry CHNA will not be addressed: dental care, affordable day care and preschools, economic insecurity and food insecurity. Swedish has chosen to concentrate on those needs that can most effectively be addressed given the organization's areas of focus and expertise. In addition, Swedish will collaborate with local organizations that address the aforementioned community needs to coordinate care and referrals to address these unmet needs.

COMMUNITY HEALTH IMPROVEMENT PLAN

Summary of Community Health Improvement Planning Process

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 Anyakou, 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.

The 2022-2024 Community Health Improvement Plan (CHIP) process was impacted by the SARS-CoV-2 virus and COVID-19, which has affected all of our communities. While we have focused on crisis response, it has required a significant re-direction of resources and reduced community engagement in the CHIP process.

This CHIP is currently designed to address the needs identified and prioritized through the 2021 CHNA, though COVID-19 will have substantial impacts on our community needs. These impacts are likely to exacerbate some of the needs identified, and cause others to rise in level of priority. While this is a dynamic situation, we recognize the greatest needs of our community will change in the coming months, and it is important that we adapt our efforts to respond accordingly. We are committed to supporting, strengthening, and serving our community in ways that align with our Mission, engage our expertise, and leverage our Community Benefit dollars in the most impactful ways.

Swedish anticipates that implementation strategies may change and therefore, a flexible approach is best suited for the development of its response to the CHNA. For example, certain community health needs may become more pronounced and require changes to the initiatives identified by Swedish in the enclosed CHIP.

Addressing the Needs of the Community: 2022- 2024 Key Community Benefit Initiatives and Evaluation Plan

COMMUNITY NEED ADDRESSED #1: ACCESS TO HEALTH CARE

Long-Term Goal(s)

To improve access to health care and preventive resources for the uninsured and underinsured.

Strategies and Strategy Measures for Addressing Access to Health Care

Strategy	Population Served	Strategy Measure	Baseline	2024 Target
Offer health education, health fairs, community outreach, and support groups that address to care and preventive practices.	Community at large.	Number and type of activities and persons served.	2,500 persons served.	10% annual increase in persons served.
Provide sponsorships, grant funding and in-kind support to increase access to health care.	Underserved, low-income and minority populations.	Amount of funding provided. List of funded organizations funded and program accomplishments.	5,000 persons served.	10% annual increase in persons served.
Collaborate with community agencies to address health care access.	Swedish staff will collaborate with community groups to focus on policy, advocacy and education.	List of community initiatives and collaborative partnerships.	Participate in one collaborative partnership.	Participate in three collaborative partnerships.

Resource Commitment

Swedish will commit staff time, supplies and equipment, cash and in-kind donations to accomplish these strategies.

Key Community Partners

Snohomish Health District, Health Care Authority of Snohomish County, Swedish Medical Group, Foundation for Edmonds School District, Community Health Centers of Snohomish County.

COMMUNITY NEED ADDRESSED #2: BEHAVIORAL HEALTH

Long-Term Goals

To ensure equitable access to high-quality, culturally responsive and linguistically appropriate mental health and substance use services, especially for vulnerable populations.

An improved workforce of mental health professionals to respond to the community's mental health and substance use needs.

Strategies and Strategy Measures for Addressing Behavioral Health

Strategy	Population Served	Strategy Measure	Baseline	2024 Target
Conduct depression screening and suicide risk assessment screenings for patients in primary care clinics and the ED.	All patients in primary care and ED will be screened for depression. If persons are experiencing depression, they will be further screened for suicide risk.	Number of patients screened for depression and suicide risk. Results of screening assessments.	54% of patients are annually screened for depression.	75% of patients are annually screened for depression.
Support the psychology postdoctoral program for primary care.	Serves anyone in the Swedish community with mental health concerns, irrespective of their ability to pay.	Number of Fellows. Number of patients seen by Psychology Fellow on an annual basis.	Support two postdoctoral fellows in psychology. Each Fellow will provide 800-1,000 visits per year.	Support two postdoctoral fellows in psychology. Each Fellow will provide 800-1,000 visits per year.
Provide community education, outreach and support groups related to mental health and substance use topics.	Community at large.	Education and outreach topics, support groups and events. Number of participant encounters.	1,000 persons served.	10% annual increase in persons served.
Offer Medication Assisted Treatment (Suboxone) in the ED to assist in the	Emergency Department patients who present with opioid use	Number of patients provided with MAT in the ED.	Edmonds campus administered Suboxone to 77 persons.	10% increase in number of persons provided with MAT in the ED.

Strategy	Population Served	Strategy Measure	Baseline	2024 Target
treatment of opioid use disorder.	disorder, opioid withdrawal, and/or opioid overdose.			
Participate in community focused initiatives and collaborative partnerships focused on mental health and substance use topics.	Swedish staff will collaborate with community groups to focus on policy, advocacy and education.	List of community initiatives and collaborative partnerships.	Participate in three collaborative partnerships.	Participate in three collaborative partnerships.
Provide intensive outpatient behavioral health program through the partial hospitalization program.	Persons who are in need of outpatient behavioral health services.	Number of persons served in the outpatient behavioral health program.	Partial hospitalization program (PHP) census 15 persons.	PHP census 15 persons.

Resource Commitment

Swedish will commit staff time, supplies, equipment, cash and in-kind donations to accomplish these strategies.

Key Community Partners

Snohomish Health District, Health Care Authority of Snohomish County, SAMSHA, CDC, Ideal Options, Snohomish County Designated Crisis Responders, Compass Health, Verdant Health, NAMI, Consistent Care and medication assisted therapy service providers, Law Enforcement Assisted Diversion (LEAD) Program, Chronic-Utilizer Alternative Response Team (CHART) Program.

COMMUNITY NEED ADDRESSED #3: HOUSING INSTABILITY AND HOMELESSNESS

Long-Term Goal

Provide a sufficient supply of safe, affordable housing units to ensure that all people in the community have access to a healthy place to live that meets their needs.

Strategies and Strategy Measures for Addressing Housing Instability and Homelessness

Strategy	Population Served	Strategy Measure	Baseline	2024 Target
Provide sponsorships, grant funding and in-kind support to	Underserved, low-income and minority populations.	Amount of funding provided. List of funded organizations funded and	5,000 persons served.	10% annual increase in persons served.

Strategy	Population Served	Strategy Measure	Baseline	2024 Target
address housing and homelessness.		program accomplishments.		
Collaborate with community agencies to address the housing and homelessness.	Swedish staff will collaborate with community groups to focus on policy, advocacy and education.	List of community initiatives and collaborative partnerships.	Participate in two collaborative partnerships.	Participate in four collaborative partnerships.

Resource Commitment

Swedish will commit staff time, supplies and equipment, cash and in-kind donations to accomplish these strategies.

Key Community Partners

Capitol Hill Housing, Mary's Place, Plymouth Housing, Healthcare Industry Leadership Table, Washington Kids in Transition.

COMMUNITY NEED ADDRESSED #4: RACISM AND DISCRIMINATION

Long-Term Goal

To actively work to eliminate social inequities and forms of oppression our communities, ensuring all people have the opportunities and access to live their fullest, healthiest lives.

Strategies and Strategy Measures for Addressing Racism and Discrimination

Strategy	Population Served	Strategy Measure	Baseline	2023 Target
Provide sponsorships, grant funding and in-kind support to focus on increased equity.	Underserved, low-income and minority populations.	Amount of funding provided. List of funded organizations funded and program accomplishments.	1,000 persons served.	10% annual increase in persons served.
Partner with community stakeholders to design/create culturally effective care to address inequities.	Swedish staff will collaborate with community groups to focus on policy, advocacy and education.	List of community initiatives and collaborative partnerships.	Participate in two collaborative partnerships.	Participate in four collaborative partnerships.

Resource Commitment

Swedish will commit staff time, supplies and equipment, cash and in-kind donations to accomplish these strategies.

Key Community Partners

Alliance for Education, Seattle Central College Foundation, Doula Birth Training, Entre Hermanos, Gay City, KinOn Healthy Living PROgram, API Chaya, El Centro de la Raza, African American Health Board, Chinese Information and Service Center, Hopelink, Women's Health Equity Project

2022- 2024 CHIP GOVERNANCE APPROVAL

This Community Health Improvement Plan was adopted by the authorized body of the hospital on April 19, 2022. The final report was made widely available by May 15, 2022.

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