COMMUNITY HEALTH NEEDS ASSESSMENT

2021

Swedish

Ballard | Cherry Hill | First Hill | Issaquah

SWEDISH | HEALTH FOR GOOD

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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

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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.

Joint CHNA

Four Swedish hospitals, First Hill Campus, Cherry Hill Campus, Issaquah Campus and Ballard Campus share a common service area in King County, Washington. Because of their close geographic proximity, these Swedish hospitals chose to conduct a joint CHNA.

Swedish Ballard Campus

Swedish Ballard first opened on March 12, 1928 as Ballard Accident and General Hospital. Over the years, the hospital grew to meet the needs of the community. In 1992, the hospital merged with Swedish Medical Center. The merger was beneficial to both hospitals, increasing access to comprehensive services at lowered costs.

Swedish Ballard is a community hospital and the center of Swedish’s Behavioral Health programs. The campus is highly regarded in the surrounding community. Services include: addiction recovery, behavioral health, cancer outpatient care and infusion center, emergency department, family practice residency program, medical imaging and breast center, midwifery and women’s health, Orthopedic Institute at Ballard, and primary care, ENT and gastroenterology clinics. Swedish Ballard is licensed for 133 beds, employs over 600 individuals, and has more than 200 providers who identify Ballard as their primary campus.

Swedish Cherry Hill

Swedish Medical Center Cherry Hill is 205-bed CMS 5-star acute care hospital located in the Central District of Seattle. Cherry Hill is home to the Swedish Neuroscience and Swedish Heart and Vascular Institutes, and provides specialty care for the community and the region in the disciplines of Neurology, Neurosurgery, Cardiology, Cardiac Surgery, and Vascular Surgery. Cherry Hill is considered one of the best Puget Sound regional hospitals by *US News and World Reports*, and has won multiple awards for cardiac and stroke care.

The Cherry Hill Emergency Room provides to over 22,000 patient encounters per year. We are home to the Carolyn Downs Country Doctor after-hours clinic, providing urgent care for underserved and vulnerable populations. Our hospital-based Wound Care Center provides wound care services for many vulnerable populations in the downtown Seattle area. Our Acute Rehab Unit is the only CARF certified inpatient rehab unit in the northwest to make the Top 100 list of rehab services nationwide.

Swedish First Hill

In 2020, Swedish First Hill had 24,222 hospital admissions, 35,520 ER visits and 19,962 surgeries. Swedish First Hill delivers more babies than any other hospital in Washington State and in 2020 we welcomed 7,552 babies. Our surgical specialists specialize in general, laparoscopic, robotic, hepatobiliary, hernia, oncologic, and breast surgery.

Swedish Issaquah

Located in Issaquah, Washington, the hospital offers the following services:

- Intensive Care/Telemetry
- Emergency Department
- Labor and Delivery
- Post-Partum and Outpatient Lactation
- Surgical Services
- Medical Surgical
- Medical Oncology
- Endoscopy Services
- Medical Imaging
- Outpatient Departments

In 2020, Swedish Issaquah had 5,635 hospital admissions, 23,974 Emergency Department visits and 1,551 newborns. The hospital provided $16 million in community benefit contributions to increase access to care and improve the health of the community.

Community Health Needs Assessment

Swedish King County 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

The Swedish King County service area is comprised of the service areas for four Swedish hospitals: First Hill Campus, Cherry Hill Campus, Issaquah Campus and Ballard Campus.

- Swedish First Hill is located at 747 Broadway, Seattle, WA 98122.
- Swedish Cherry Hill is located at 500 17th Avenue, Seattle, WA 98122.
- Swedish Issaquah is located at 751 NE Blakely Drive, Issaquah, WA 98029.
- Swedish Ballard is located at 5300 Tallman Ave. NW, Seattle, WA 98107.

These hospitals share a service area in King County, Washington. King County has a population of approximately 2.2 million people. Based on the availability of data, geographic access to these facilities and primary care, and other hospitals in neighboring counties, King County serves as the boundary for the hospital service area.

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 King County service area, 159 of 396 census tracts (40.2%) scored as high need.

Collaborative Partners

King County Swedish Medical Centers participated in a collaborative process for the Community Health Needs Assessment as part of the King County Hospitals for a Healthier Community (HHC). King County Hospitals for a Healthier Community (HHC) is comprised of 10 hospitals/health systems in King County and Public Health – Seattle & King County (PHSKC) with the fiscal administrative support of the Washington State Hospital Association (WSHA). The HHC vision is to participate in a collaborative approach that identifies community needs, assets, resources, and strategies toward ensuring better health and health equity for all King County residents. This shared approach avoids duplication and focuses available resources on a community's most important health needs. HHC recognizes that partnerships between hospitals, public health, community organizations and communities are key to successful strategies to address common health needs. The full report and list of assessment partners can be accessed at: https://kingcounty.gov/depts/health/data/community-health-indicators/king-county-hospitals-healthier-community.aspx.

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 King 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 King County, 744 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

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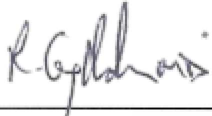
To request a copy free of charge, provide comments, or view electronic copies of current and previous Community Health Needs Assessments, please email CHI@providence.org

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.



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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

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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).

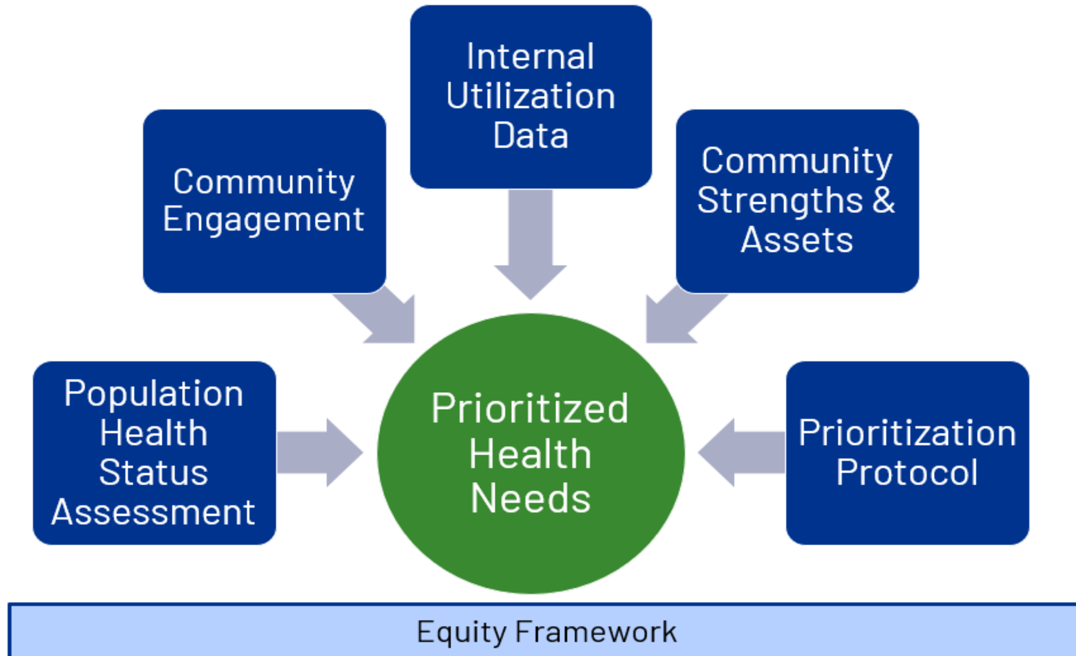
RESPONDING TO THE COVID-19 PANDEMIC

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 5 key components that feed into identifying and prioritizing community health needs.



*modified MAPP Framework

OUR COMMUNITY

Hospital Service Area and Community Served

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- Swedish Cherry Hill is located at 500 17th Avenue, Seattle, WA 98122.
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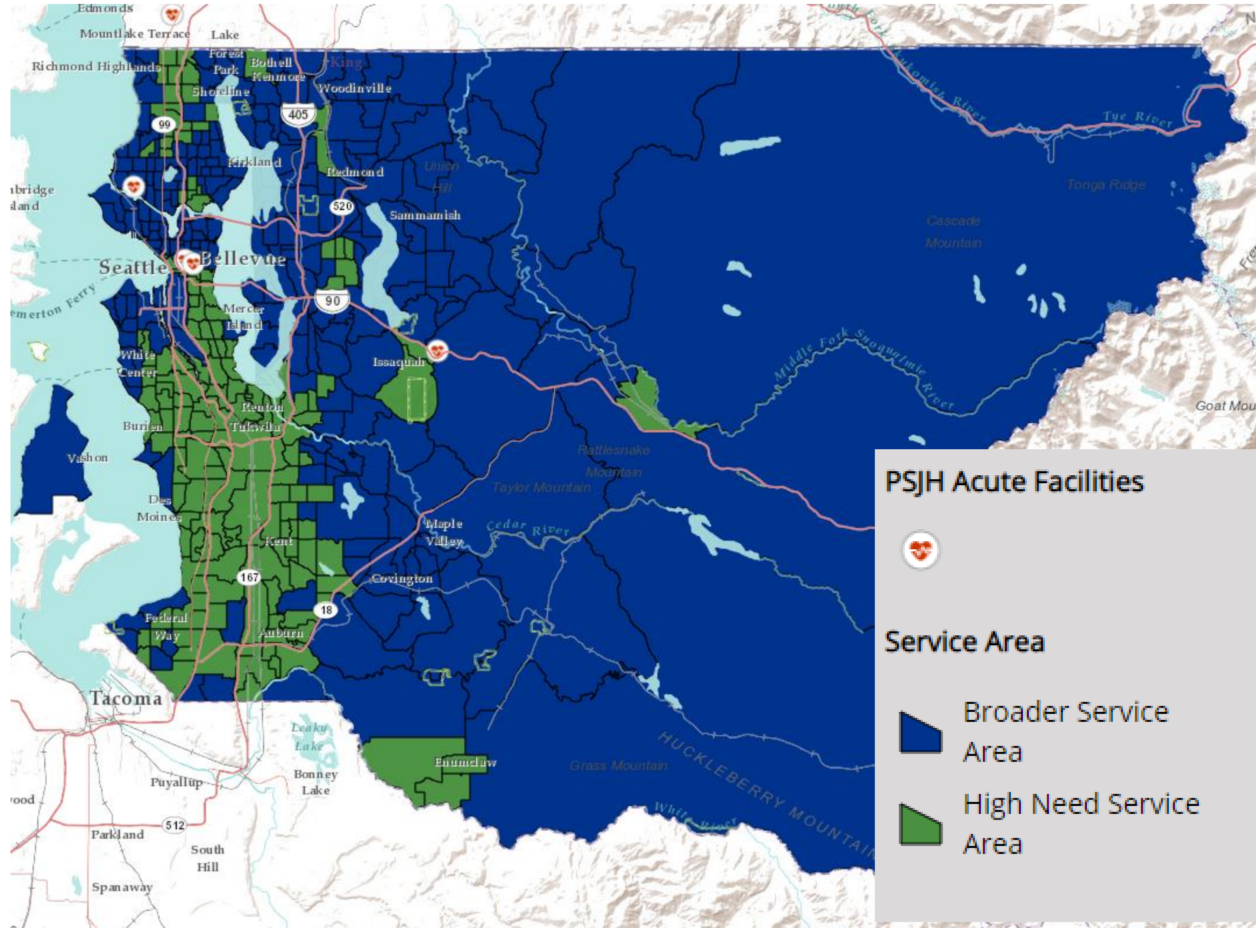
- Swedish Ballard is located at 5300 Tallman Ave. NW, Seattle, WA 98107.

These hospitals share a service area in King County, Washington. King County has a population of approximately 2.2 million people. Based on the availability of data, geographic access to these facilities and primary care, and other hospitals in neighboring counties, King County serves as the boundary for the hospital service area. See map below for further detail, including communities identified as higher need according to the Providence Need Index. There are 159 census tracts in the high need service area and 237 in the broader service area.

Swedish King County Service Area



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

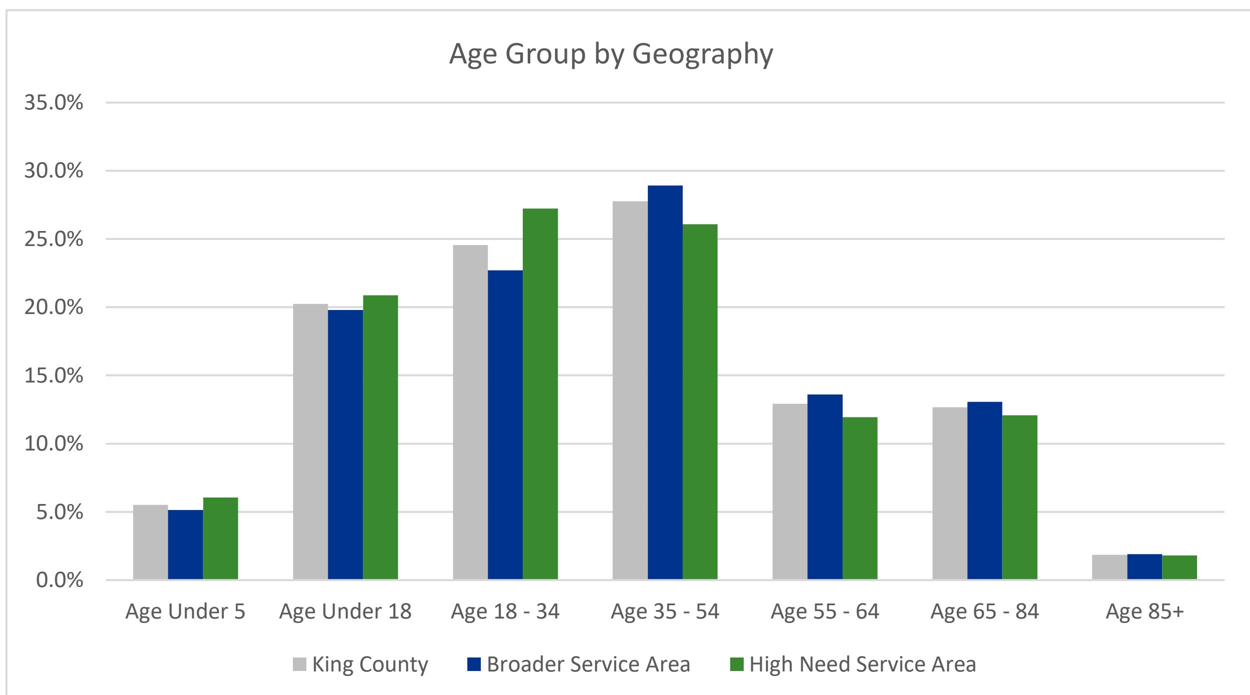
census tracts were given a score between 0 and 1 where 0 represents the best performing census tract and 1 is the worst performing census tract according to the criteria. Census tracts that scored higher than the average were classified as high need service areas and are depicted in green. In the King County service area, 159 of 396 census tracts (40.2%) 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	King County	Broader Service Area	High Need Service Area
2019 Total Population	2,230,621	1,325,719	904,902
Female Population	1,119,486 (50.2%)	667,039 (50.3%)	452,447 (50.0%)
Male Population	1,111,135 (49.8%)	658,680 (49.7%)	452,455 (50.0%)

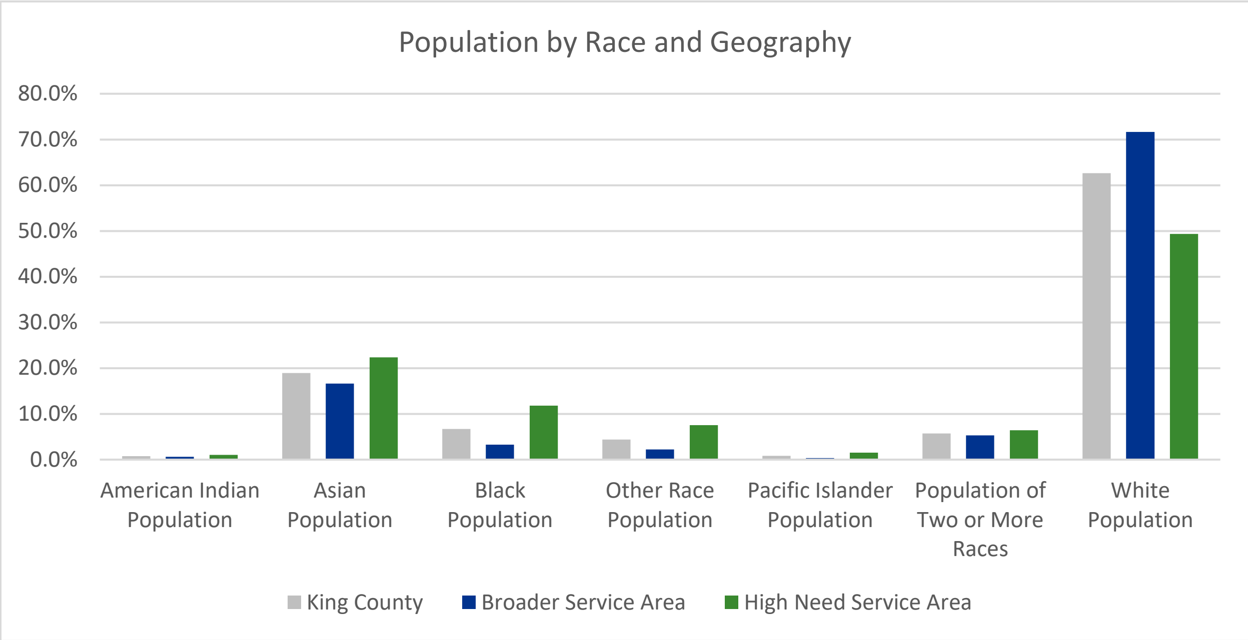


POPULATION, BY AGE

Indicator	King County	Broader Service Area	High Need Service Area
Population, Age Under 5	122,920 (5.5%)	68,239 (5.1%)	54,681 (6.0%)
Population, Age Under 18	451,373 (20.2%)	262,526 (19.8%)	188,847 (20.9%)
Population, Age 18 - 34	547,571 (24.5%)	301,057 (22.7%)	246,514 (27.2%)
Population, Age 35 - 54	619,254 (27.8%)	383,281 (28.9%)	235,973 (26.1%)
Population, Age 55 - 64	288,339 (12.9%)	180,374 (13.6%)	107,965 (11.9%)
Population, Age 65 - 84	282,637 (12.7%)	173,355 (13.1%)	109,282 (12.1%)
Population, Age 85+	41,447 (1.9%)	25,126 (1.9%)	16,321 (1.8%)

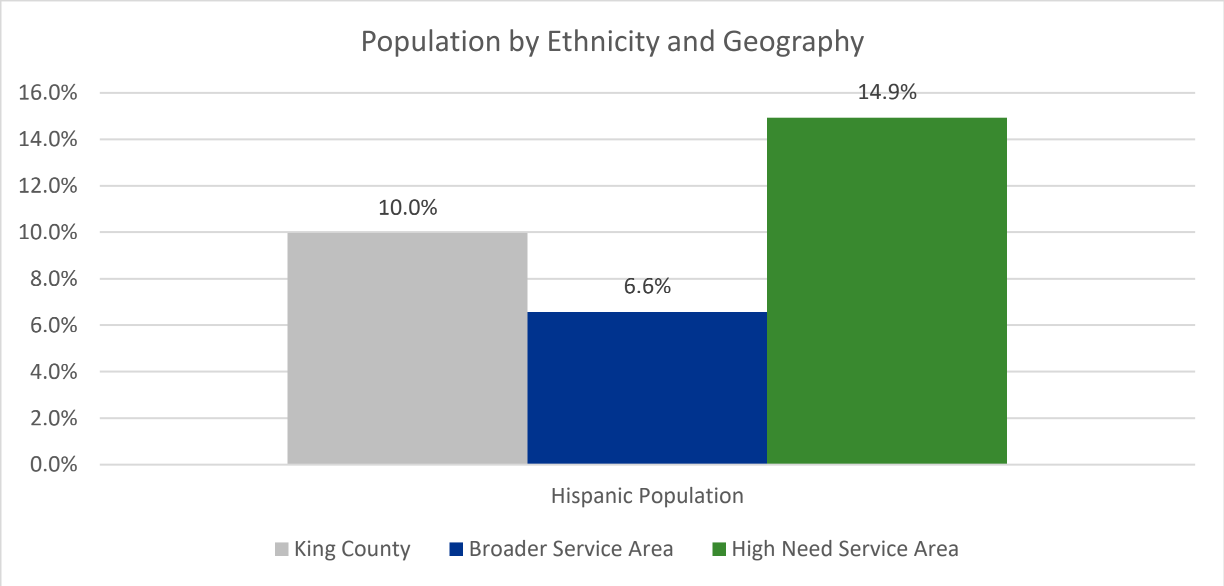
POPULATION, BY RACE AND ETHNICITY

Indicator	King County	Broader Service Area	High Need Service Area
American Indian Population	17,108 (0.8%)	7,995 (0.6%)	9,113 (1.0%)
Asian Population	422,412 (18.9%)	220,209 (16.6%)	202,203 (22.3%)
Black Population	149,777 (6.7%)	43,231 (3.3%)	106,546 (11.8%)
Other Race Population	97,611 (4.4%)	29,580 (2.2%)	68,031 (7.5%)
Pacific Islander Population	18,666 (0.8%)	4,709 (0.4%)	13,957 (1.5%)
Two or More Races	128,127 (5.7%)	69,810 (5.3%)	58,317 (6.4%)
White Population	1,396,920 (62.6%)	950,185 (71.7%)	446,735 (49.4%)



Hispanic Population in King County Service Area

Indicator	King County	Broader Service Area	High Need Service Area
Hispanic Population	222,384 (10.0%)	87,239 (6.6%)	135,145 (14.9%)



NOTE: In the following tables the values for the columns in the broader serivce 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 approximately $25,000 lower than the median household income for King County. The average median household income for census tracts in the broader service area is approximately $25,000 higher than that of King County.

Indicator	King County	Broader Service Area	High Need Service Area
Median Income	$95,063	$121,295	$69,498

Data Source: American Community Survey, 2019

POPULATION BELOW 200% FEDERAL POVERTY LEVEL

In King County, 22% of the population is considered low-income (200% of the Federal Poverty Level). In the high need service area, 35.1% of the population is low-income.

Indicator	King County	Broader Service Area	High Need Service Area
Population Below 200% Federal Poverty Level	22.0%	13.8%	35.1%

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 4.5 percentige points higher than the County value and 7.8 percentige points higher than the average in the broader service area census tracts.

Indicator	King County	Broader Service Area	High Need Service Area
Renter Households with Severe Housing Cost Burden	20.4%	17.1%	24.9%

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

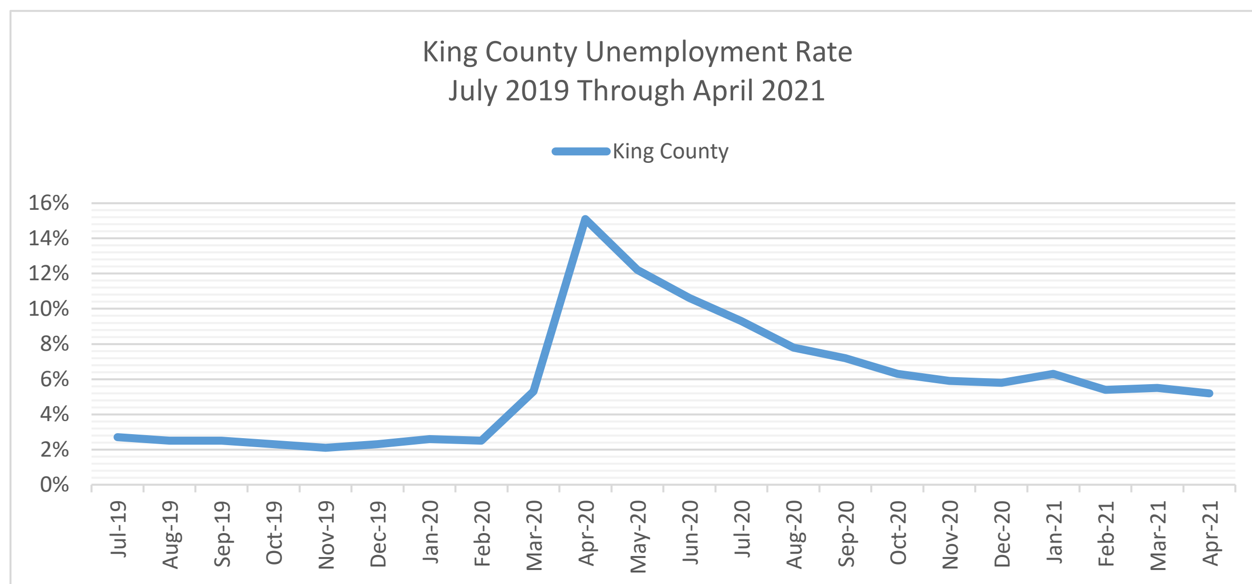
LABOR FORCE UNEMPLOYED

The unemployment rate in King County is lower than the state of Washington and the United States.

Indicator	King County	Washington	United States
Labor Force Unemployed	5.2%	5.5%	6.1%

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

Between February 2020 and April 2020, the unemployment rate for King County increased 504% from 2.5% to 15.1%.



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, 17.8% of households receive SNAP benefits.

Indicator	King County	Broader Service Area	High Need Service Area
Households Receiving SNAP Benefits	9.7%	4.8%	17.8%

Data Source: American Community Survey, 2013 – 2017 estimates

LANGUAGE PROFICIENCY

In the high need service area, 9.5% of the population lives in a limited English household, compared to King County (5.5%).

Indicator	King County	Broader Service Area	High Need Service Area
Population In Limited English Households	5.5%	2.7%	9.5%

Data Source: American Community Survey, 2015 – 2019 estimates

POPULATION WITH A HIGH SCHOOL EDUCATION, AGES 25 AND OLDER

In King County, 93.3% of the adult population, ages 25 and older, has a high school diploma. 87.1% of the population in the high need service area has a high school diploma.

Indicator	King County	Broader Service Area	High Need Service Area
Population, Ages 25 and Older, with a High School Diploma	93.3%	97.0%	87.1%

Data Source: American Community Survey, 2019

HOUSEHOLDS WITHOUT INTERNET ACCESS

Households without internet access are higher in the high need service area (9.3%) compared to King County (6.1%).

Indicator	King County	Broader Service Area	High Need Service Area
Households with No Internet Access	6.1%	4.0%	9.3%

Data Source: American Community Survey, 2019

DATA COLLECTION AND PRIORITIZATION OF NEEDS

Collaborative Partners

King County Swedish Medical Centers participated in a collaborative process for the Community Health Needs Assessment as part of the King County Hospitals for a Healthier Community (HHC). King County Hospitals for a Healthier Community (HHC) is comprised of 10 hospitals/health systems in King County and Public Health – Seattle & King County (PHSKC) with the fiscal administrative support of the Washington State Hospital Association (WSHA). The HHC vision is to participate in a collaborative approach that identifies community needs, assets, resources, and strategies toward ensuring better health and health equity for all King County residents. This shared approach avoids duplication and focuses available resources on a community's most important health needs. HHC recognizes that partnerships between hospitals, public health, community organizations and communities are key to successful strategies to address common health needs. The full report and list of assessment partners can be accessed at: https://kingcounty.gov/depts/health/data/community-health-indicators/king-county-hospitals-healthier-community.aspx.

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 King 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.

The King County Collaborative Health Needs Assessment presents data for King County. Regions were created by King County Public Health to examine geographic patterns at a level below the county level. There are four (4) regions in King County: North, East, South, and Seattle. Data from some of these regions may be reported for some data indicators.

- North region includes: Bothell, Cottage Lake, Kenmore, Lake Forest Park, Shoreline, and Woodinville.
- East region includes: Bellevue, Carnation, Duvall, Issaquah, Kirkland, Medina, Mercer Island, Newcastle, North Bend, Redmond, Sammamish, and Skykomish.
- South region contains: Auburn, Burien, Covington, Des Moines, Enumclaw, Federal Way, Kent, Maple Valley, Normandy Park, Renton, Tukwila, SeaTac, White Center/Boulevard Park, and Vashon Island.

The full data report can be accessed at: https://kingcounty.gov/depts/health/data/community-health-indicators/king-county-hospitals-healthier-community.aspx.

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. 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 King County:

Diverse, Resilient, and Resourceful Community Members
King County includes people from many different places in the world and many have overcome significant challenges in their lives. Stakeholders shared community members are continually working hard to better themselves and their lives for their children and their community.

Community Members Supporting One Another
The closeness of community members is a strength. People share resources with one another, help each other find food, childcare, and other necessities. When people come together, they draw inspiration and strength from one another.

Organizations Working Together
Community organizations want to do good work and serve the community. Organizations, including government, business, and health care, are working hard to find new and creative ways to keep people safe and healthy, adapting to the changing 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 stakeholders 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 took 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.

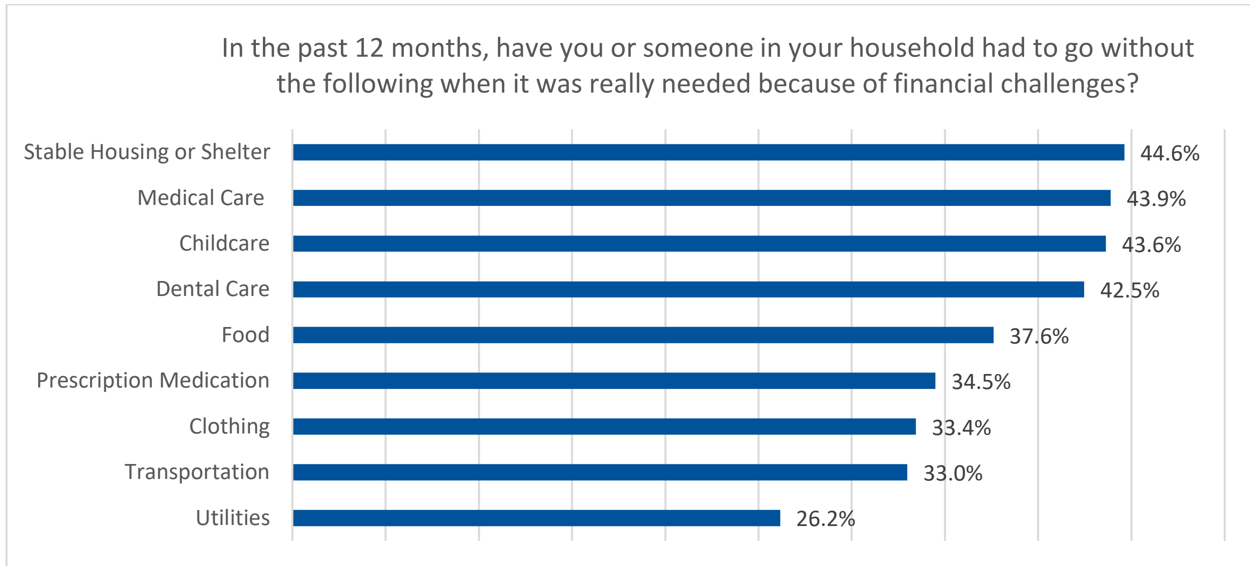
Out of 17 response options, respondents selected good paying jobs (13.67%), assistance getting healthy food (12.08%), and a caring community (10.90%) as the top three things needed to improve the health and well-being of themselves and their family.

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%

King County Health Priorities

The 2021-2022 King County Hospitals for a Healthier Community collaborative needs assessment identified community priorities. A review of over 48 community needs assessments, strategic plans, or reports – many with community engagement components and all conducted since the previous assessment – was completed. A variety of community engagement activities conducted by community and governmental organizations confirmed the themes as priorities and enabled King County residents to elaborate on them. The priorities are:

- Housing access and quality
- Access to health care and other services (such as transportation and food)
- Support for youth and families (including mental health)
- Community growth and development

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 King County, 5.3% of the population are uninsured. This rate is 8% in the high need service area.

Indicator	King County	Broader Service Area	High Need Service Area
Population with No Health Insurance Coverage	5.3%	3.4%	8.0%

Data Source: American Community Survey, 2019

LIFE EXPECTANCY AT BIRTH

Life expectancy at birth is 79 year among the population in the high need service area. This is over three years less than the life expectancy of the overall population in King County (82.4 years).

Indicator	King County	Broader Service Area	High Need Service Area
Average Life Expectancy at Birth	82.4	82.5	79.0

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

ASTHMA PREVALENCE

The rate of asthma is 9.8% in the high need area and 8.8% in King County.

Indicator	King County	Broader Service Area	High Need Service Area
Asthma Prevalence	8.8%	8.8%	9.8%

Data Source: Behavioral Risk Factor Surveillance System, 2018

DIABETES PREVALENCE

The rate of diabetes in King County is 8.5%.

Indicator	Snohomish County	Broader Service Area	High Need Service Area
Diabetes Prevalence	8.5%	9.9%	7.1%

Data Source: Behavioral Risk Factor Surveillance System, 2018

OBESITY PREVALENCE

The rate of obesity in King County is 23.2%.

Indicator	King County	Broader Service Area	High Need Service Area
Obesity Prevalence	23.2%	22.5%	26%

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 King County exceeds this rate at 10.9%.

Indicator	King County	Broader Service Area	High Need Service Area
Smoking Prevalence	10.9%	9.4%	14.2%

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 King County was 17.1%.

Indicator	King County	Broader Service Area	High Need Service Area
Binge Drinking Prevalence	17.1%	18.5%	16.7%

Data Source: Behavioral Risk Factor Surveillance System, 2018

PHYSICAL INACTIVITY

In King County, 14.4% of the population are physically inactive.

Indicator	King County	Broader Service Area	High Need Service Area
Physical Inactivity Prevalence	14.4%	12%	18.3%

Data Source: Behavioral Risk Factor Surveillance System, 2018

COVID-19 CASES AND DEATHS, KING 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 118,149 confirmed cases of COVID-19 in King County and 457,647 cases of COVID-19 in the state of Washington. As of 8/11/2021, there were 1,690 deaths due to COVID-19 in King County and 6,215 deaths due to COVID-19 in the state of Washington.

Indicator	King County	Washington
Total COVID-19 Cases	118, 149	457,647
Total COVID-19 Deaths	1,690	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 25, 2019, there were 11, 198 individuals experiencing homelessness in King County. 53% or 5,971 individuals were sheltered and 47% or 5,228 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	5,228	5,971	11,198

Data Source: All Home Count Us In Report, 2019 KING-9.5-v2.pdf (kcrha.org)

Hospital Utilization Data

In addition to public health surveillance data, hospitals can provide timely information regarding access to care and disease burden across King 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 King County Hospitals

Facility	Non-AED Visits	AED Visits	Total ED Visits	AED %
First Hill Campus	18,952	8,789	27,741	31.7%
Ballard Campus	10,043	4,125	14,168	29.1%
Cherry Hill Medical Center	9,564	4,762	14,326	33.2%
Swedish Issaquah	15,172	4,966	20,138	24.7%
Region Total	**53,731**	**22,642**	**76,373**	**29.6%**

Avoidable Emergency Department Visits by Hospital and Patient ZIP Code

Facility and Top 10 Patient ZIP Codes	Non-AED Visit	AED Visits	Total ED Visits	AED %
FIRST HILL CAMPUS	**18,952**	**8,789**	**27,741**	**31.7%**
98104	1,478	1,210	2,688	45.0%
98118	1,441	621	2,062	30.1%
98122	1,341	704	2,045	34.4%
98101	856	559	1,415	39.5%
98144	923	398	1,321	30.1%
98108	780	345	1,125	30.7%
98126	560	270	830	32.5%
98121	518	302	820	36.8%
98106	590	229	819	28.0%
98116	609	181	790	22.9%
Facility and Top 10 Patient ZIP Codes	**Non-AED Visit**	**AED Visits**	**Total ED Visits**	**AED %**
BALLARD CAMPUS	**10,043**	**4,125**	**14,168**	**29.1%**
98107	1,647	668	2,315	28.9%
98117	1,593	513	2,106	24.4%
98103	1,141	430	1,571	27.4%
98199	1,021	313	1,334	23.5%
98119	774	254	1,028	24.7%
98133	413	187	600	31.2%
98109	453	145	598	24.2%
98104	182	199	381	52.2%
98115	280	101	381	26.5%
98125	200	107	307	34.9%
Facility and Top 10 Patient ZIP Codes	**Non-AED Visit**	**AED Visits**	**Total ED Visits**	**AED %**
CHERRY HILL MEDICAL CENTER	**9,564**	**4,762**	**14,326**	**33.2%**
98122	1,094	595	1,689	35.2%
98118	1,011	480	1,491	32.2%
98144	944	432	1,376	31.4%
98104	475	401	876	45.8%
98108	511	225	736	30.6%
98101	304	258	562	45.9%
98112	323	121	444	27.3%
98178	289	138	427	32.3%
98106	232	118	350	33.7%
98126	247	95	342	27.8%
Facility and Top 10 Patient ZIP Codes	**Non-AED Visit**	**AED Visits**	**Total ED Visits**	**AED %**
SWEDISH ISSAQUAH	**15,172**	**4,966**	**20,138**	**24.7%**
98029	2,311	736	3,047	24.2%

Facility and Top 10 Patient ZIP Codes	Non-AED Visit	AED Visits	Total ED Visits	AED %
98027	2,114	725	2,839	25.5%
98075	1,317	392	1,709	22.9%
98045	905	275	1,180	23.3%
98059	829	281	1,110	25.3%
98074	828	233	1,061	22.0%
98065	797	242	1,039	23.3%
98006	713	207	920	22.5%
98038	457	134	591	22.7%
98024	421	130	551	23.6%

Avoidable Emergency Department Visits by Patient Race for Swedish King County Hospitals

Facility	Patient Race	Non-AED Visits	AED Visits	Total ED Visits	AED %
FIRST HILL CAMPUS	AMERICAN INDIAN OR ALASKA NATIVE	365	208	573	36.3%
	ASIAN	2,066	713	2,779	25.7%
	BLACK OR AFRICAN AMERICAN	3,974	2,203	6,177	35.7%
	NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER	245	136	381	35.7%
	OTHER	2,442	1,087	3,529	30.8%
	PATIENT REFUSED	118	45	163	27.6%
	UNKNOWN	381	132	513	25.7%
	WHITE OR CAUCASIAN	9,347	4,249	13,596	31.3%
	Blank	14	16	30	53.3%
BALLARD CAMPUS	AMERICAN INDIAN OR ALASKA NATIVE	105	69	174	39.7%
	ASIAN	609	206	815	25.3%
	BLACK OR AFRICAN AMERICAN	599	379	978	38.8%
	NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER	74	33	107	30.8%
	OTHER	855	332	1,187	28.0%
	PATIENT REFUSED	84	30	114	26.3%
	UNKNOWN	176	54	230	23.5%
	WHITE OR CAUCASIAN	7,536	3,021	10,557	28.6%
	Blank	*	*	*	*
CHERRY HILL MEDICAL CENTER	AMERICAN INDIAN OR ALASKA NATIVE	120	99	219	45.2%
	ASIAN	940	384	1,324	29.0%
	BLACK OR AFRICAN AMERICAN	2,714	1,545	4,259	36.3%
	NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER	143	76	219	34.7%

Facility	Patient Race	Non-AED Visits	AED Visits	Total ED Visits	AED %
	OTHER	1,078	522	1,600	32.6%
	PATIENT REFUSED	113	51	164	31.1%
	UNKNOWN	140	74	214	34.6%
	WHITE OR CAUCASIAN	4,313	2,006	6,319	31.7%
	Blank	*	*	*	*
ISSAQUAH CAMPUS	AMERICAN INDIAN OR ALASKA NATIVE	121	43	164	26.2%
	ASIAN	1,502	421	1,923	21.9%
	BLACK OR AFRICAN AMERICAN	623	240	863	27.8%
	NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER	68	26	94	27.7%
	OTHER	1,072	396	1,468	27.0%
	PATIENT REFUSED	267	74	341	21.7%
	UNKNOWN	948	309	1,257	24.6%
	WHITE OR CAUCASIAN	10,570	3,455	14,025	24.6%
	Blank	*	*	*	*

Avoidable Emergency Department Visits by Patient Ethnicity by Swedish King County Hospitals

Facility	Patient Ethnicity	Non-AED Visits	AED Visits	Total ED Visits	AED %
FIRST HILL CAMPUS	HISPANIC OR LATINO	1,775	743	2,518	29.5%
	NOT HISPANIC OR LATINO	16,581	7,811	24,392	32.0%
	PATIENT REFUSED	172	66	238	27.7%
	UNKNOWN	411	152	563	27.0%
	Blank	13	17	30	56.7%
BALLARD CAMPUS	HISPANIC OR LATINO	577	231	808	28.6%
	NOT HISPANIC OR LATINO	9,101	3,779	12,880	29.3%
	PATIENT REFUSED	133	43	176	24.4%
	UNKNOWN	227	71	298	23.8%
	Blank	*	*	*	*
CHERRY HILL MEDICAL CENTER	HISPANIC OR LATINO	735	308	1,043	29.5%
	NOT HISPANIC OR LATINO	8,512	4,307	12,819	33.6%
	PATIENT REFUSED	129	54	183	29.5%
	UNKNOWN	186	88	274	32.1%
	Blank	*	*	*	*
ISSAQUAH CAMPUS	HISPANIC OR LATINO	974	324	1,298	25.0%
	NOT HISPANIC OR LATINO	12,636	4,160	16,796	24.8%
	PATIENT REFUSED	481	135	616	21.9%
	UNKNOWN	1,080	345	1,425	24.2%

Top 20 Diagnoses for Avoidable Emergency Department Visits at Swedish King County Hospitals

Facility and Top 20 Diagnoses Groupings	Avoidable Visits	Percent of Avoidable Visits
FIRST HILL CAMPUS	**8,789**	**-**
Skin Infection	1,022	11.6%
Substance Use Disorders	953	10.8%
Urinary Tract Infection	522	5.9%
Psychosis	468	5.3%
Bronchitis and Other Upper Respiratory Disease	465	5.3%
Nonspecific Back and Neck Pain	440	5.0%
Anxiety and Personality Disorders	349	4.0%
Headache/Migraine	294	3.3%
Dizziness	275	3.1%
Asthma	224	2.5%
Tonsillitis	215	2.4%
Mood Disorders, Episodic	205	2.3%
Screenings and Follow-Up Encounters	166	1.9%
Inflammatory Bowel Disease	165	1.9%
Pneumonia Including Aspiration Pneumonia	160	1.8%
Dermatitis and Rashes	157	1.8%
Antepartum Conditions and High Risk Pregnancy	147	1.7%
Gastroenteritis and Intestinal Infections	143	1.6%
Musculoskeletal Injury - Knee	136	1.5%
Diabetes Mellitus	132	1.5%

Facility and Top 20 Diagnoses Groupings	Avoidable Visits	Percent of Avoidable Visits
BALLARD CAMPUS	**4,125**	**-**
Skin Infection	613	14.9%
Substance Use Disorders	498	12.1%
Urinary Tract Infection	335	8.1%
Nonspecific Back and Neck Pain	212	5.1%
Dizziness	180	4.4%
Anxiety and Personality Disorders	171	4.1%
Headache/Migraine	143	3.5%
Bronchitis and Other Upper Respiratory Disease	126	3.1%
Psychosis	114	2.8%
Tonsillitis	108	2.6%
Mood Disorders, Episodic	100	2.4%
Asthma	93	2.3%
Oral and Dental Disease	91	2.2%
Dermatitis and Rashes	87	2.1%
Pneumonia Including Aspiration Pneumonia	82	2.0%
Gastroenteritis and Intestinal Infections	79	1.9%
Neurologic Disease - Other	76	1.8%
Hypertension	63	1.5%
Musculoskeletal Injury - Knee	57	1.4%
Inflammatory Bowel Disease	51	1.2%

Facility and Top 20 Diagnoses Groupings	Avoidable Visits	Percent of Avoidable Visits
Facility and Top 20 Diagnoses Groupings	**Avoidable Visits**	**Percent of Avoidable Visits**
CHERRY HILL MEDICAL CENTER	**4,762**	-
Substance Use Disorders	413	8.7%
Skin Infection	390	8.2%
Psychosis	321	6.7%
Urinary Tract Infection	277	5.8%
Nonspecific Back and Neck Pain	274	5.8%
Dizziness	253	5.3%
Headache/Migraine	238	5.0%
Bronchitis and Other Upper Respiratory Disease	216	4.5%
Anxiety and Personality Disorders	208	4.4%
Neurologic Disease - Other	145	3.0%
Hypertension	125	2.6%
Tonsillitis	116	2.4%
Mood Disorders, Episodic	111	2.3%
Pneumonia Including Aspiration Pneumonia	93	2.0%
Asthma	84	1.8%
Diabetes Mellitus	82	1.7%
Dermatitis and Rashes	68	1.4%
Screenings and Follow-Up Encounters	67	1.4%
Musculoskeletal Injury - Knee	66	1.4%
Epilepsy and Seizure Disorders	65	1.4%
Facility and Top 20 Diagnoses Groupings	**Avoidable Visits**	**Percent of Avoidable Visits**
ISSAQUAH CAMPUS	**4,966**	
Urinary Tract Infection	449	9.0%
Skin Infection	403	8.1%
Bronchitis and Other Upper Respiratory Disease	388	7.8%
Nonspecific Back and Neck Pain	309	6.2%
Dizziness	283	5.7%
Substance Use Disorders	248	5.0%
Headache/Migraine	233	4.7%
Anxiety and Personality Disorders	188	3.8%
Tonsillitis	158	3.2%
Pneumonia Including Aspiration Pneumonia	157	3.2%
Hypertension	126	2.5%
Inflammatory Bowel Disease	112	2.3%
Neurologic Disease - Other	109	2.2%
Gastroenteritis and Intestinal Infections	98	2.0%
Dermatitis and Rashes	90	1.8%

Facility and Top 20 Diagnoses Groupings	Avoidable Visits	Percent of Avoidable Visits
Asthma	89	1.8%
Musculoskeletal Injury - Knee	82	1.7%
Acute Otitis Media and Sinusitis	81	1.6%
Psychosis	77	1.6%
Benign Gynecologic Neoplasms	69	1.4%

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
Solid Ground in the Sand Point Area	Kristin Klansnic	Residential Program Manager	Housing, food and nutrition

Organization	Name	Title	Sector
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 King County primarily spoke to three main strengths in the community:

Diverse, Resilient, and Resourceful Community Members

King County includes people from many different places in the world and many have overcome significant challenges in their lives. Stakeholders shared they see community members continually working to better themselves and their lives for their children and their community. Stakeholders spoke to the **immigrant** and **refugee communities** in King County and their persistence and resilience.

"I think the diversity in our communities is a strength and the resilience that we see in our communities is remarkable. So many of them are immigrants, refugees, have real socioeconomic challenges, and the resilience that we see if you were to just sit in the lobby of one of our clinics, is pretty remarkable, in terms of what they've gone through in their personal lives and their families, and yet they just keep going and they keep trying to be healthier and better in whatever ways they need to. It is pretty amazing to watch."—Community Stakeholder

Others spoke to the resourcefulness of **older adults** maintaining their independence and **Native American communities** persevering and staying on ancestral lands.

"We're unapologetically Snoqualmie. We're here. We stayed here. We're making some noise. It's exciting."—Community Stakeholder

To leverage this strength, stakeholders recommended **elevating the voices of community members**, including young people. They shared that building upon the knowledge of community members and the trust within communities can help organizations make decisions with communities. They also noted the importance of ensuring **BBIPOC community members are in positions of power and decision making**, noting a need for improved representation of BBIPOC people doing the work in communities.

"We need more people of color to have a seat at the table to support and influence decision-making, which directly impacts their communities, as well as more community collaboration between other organizations."—Community Stakeholder

Community Members Supporting One Another

The closeness of community members is a strength. People share **resources** with one another, and they help each other find food, childcare, and other necessities.

"There is a real closeness in many of the communities. They look out for each other, and they refer each other to different either healthcare organizations or social organizations, or where they can find food, how they can get from place to place through a transportation service. They help each other out with childcare, and I'm always inspired by what we see in the clinics from our patient population."—Community Stakeholder

When people come together, they draw **inspiration** and **strength** from one another. Specifically, the Native American community strives to take care of the whole community.

"I think just bringing that sense of togetherness and bringing the whole together, we now understand that individuals don't succeed if the whole can't. We really focus on the whole first."—Community Stakeholder

To leverage this strength, stakeholders suggesting supporting **peer to peer learning** for young people and **community health workers** to help people navigate complicated systems. They also suggested asking community members which organizations and people they **trust** and working with them to meet needs. They noted bringing health care services to where people are comfortable and feel safe, building upon the relationships within the community.

When addressing community well-being, a stakeholder shared the importance of **remaining grounded in tradition and cultur**e, creating space for practicing traditions and connecting to the spiritual aspects of healing.

Organizations Working Together

Community organizations want to do good work and serve the community. Organizations, including government, business, and healthcare, are working hard to find new and creative ways to keep people safe and healthy, adapting to the changing needs. The COVID-19 pandemic has been an opportunity for many organizations to come together supporting families. **Schools**, **food banks**, and **churches** are all examples of organizations that have been key partners in collaborations and meeting specific community needs. The Black churches were specifically named as meeting the needs of Black and African American communities.

"The Black churches and the Black communities are used to having to be at the forefront of making things better. It's a place that we trust… The churches are just—This is just part of the fabric in our community that make things happen."—Community Stakeholder

To leverage this strength, stakeholders suggested creating connections between organizations doing similar work to create a **collective impact**.

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 people experiencing 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 King County shared the following suggestions:

- **Continue to ensure collaboration between health care and community based organizations**: Stakeholders noted organizations need to work together to bring services to people, lessening transportation and scheduling barriers. This may also make navigating the health care system easier for people who speak languages other than English or are unfamiliar with the systems. Partnerships may help break down silos between organizations, promote cross-referrals between organizations, and improve connection to community resources. Health care organizations can be connecting patients to resources such as food banks and childcare centers.

  "We need to do a better job of not just focusing on healthcare but focusing on all of the needs of our patients, so more whole-person care, whole-person centered care. The way to do that from what we're thinking is that we need to better engage in these community organizations."—Community Stakeholder

- **Give community members a voice and space in decision making:** Stakeholders emphasized community voices need to be included in decision making. Too often BBIPOC community members are not listened to or given any ownership over an initiative. They also noted the importance of organizations listening to trusted community partners. Using an equity framework is another way to ensure community voices are centered.

  "A sense of ownership is empowering because not having a voice and being able to address your needs is so hurtful, it just makes you feel insignificant. That's how you erase people. Being able to communicate and have ownership in that process and maybe develop and change, being able to change a little bit to make it right, that's helpful."—Community Stakeholder

- **Incentivize collaboration**: Too often organizations compete for funding, preventing collaboration.
- **Continue virtual provider meetings**: During COVID-19, many provider meetings moved to a virtual platform, which allowed for easier participation. Some stakeholders would like to see these virtual meetings persist.

- **Share data between organizations**: Many organizations serve the same populations and would benefit from more data sharing. For example, the school districts would be interested in seeing the rates of young people in the Emergency Room for mental health needs.
- **Work together on addressing complex needs**: Behavioral health challenges, domestic violence, and homelessness are all complex community challenges that should be addressed collectively. The school districts would like to see more collaboration on addressing behavioral health challenges in schools and easier referral process to community resources. The domestic violence response system in fragmented. Efforts are underway to ensure an interconnected, responsive system that meets the needs of survivors. There are also opportunities for health care to work with housing partners to address the health care and behavioral health needs of people experiencing homelessness or in transitional housing.
- **Invest in prevention work**: Stakeholders discussed the importance of investing in health education and working with young people to support healthy futures. This includes talking about healthy relationships, mental health, and more.

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
	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

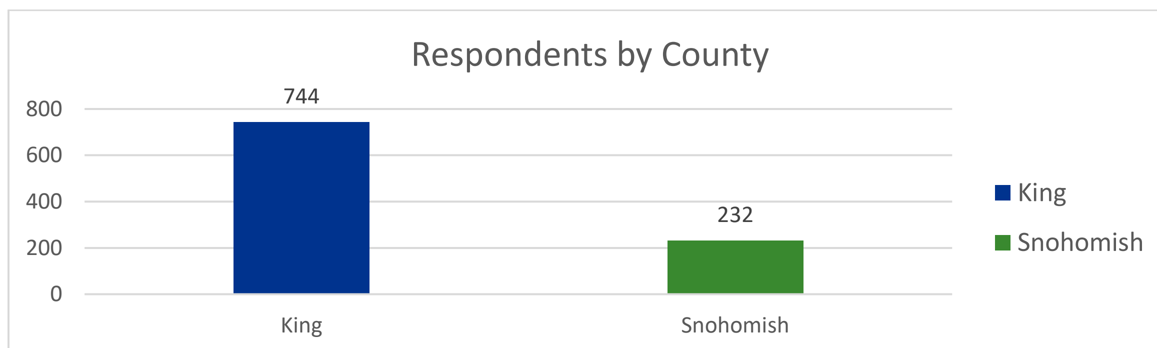


Table 1. Respondents by County

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

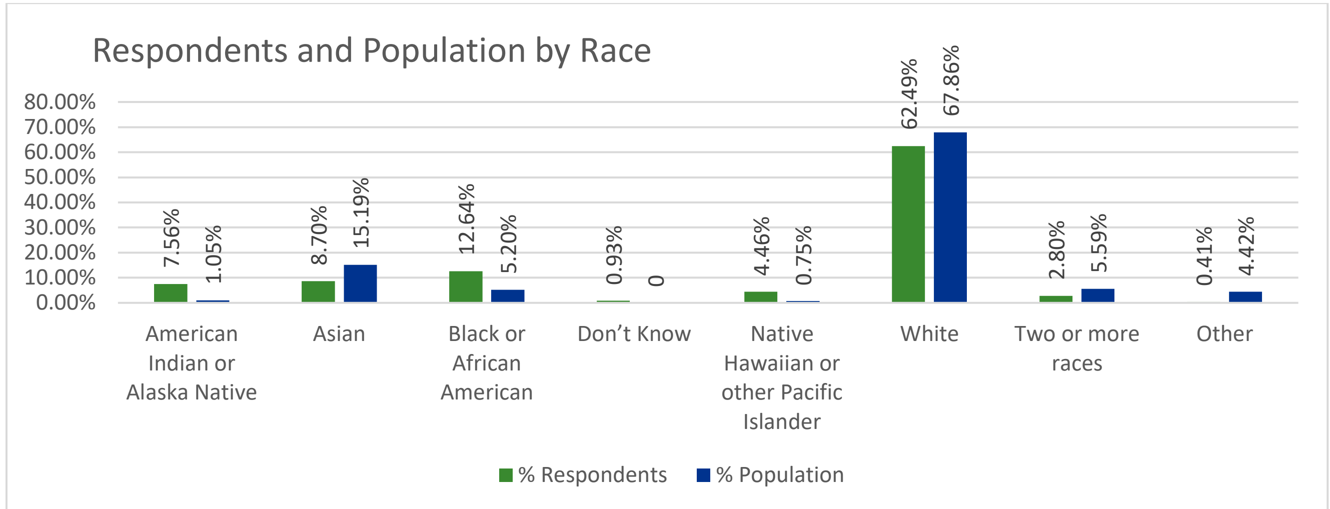


Table 3. Respondents by Race

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.

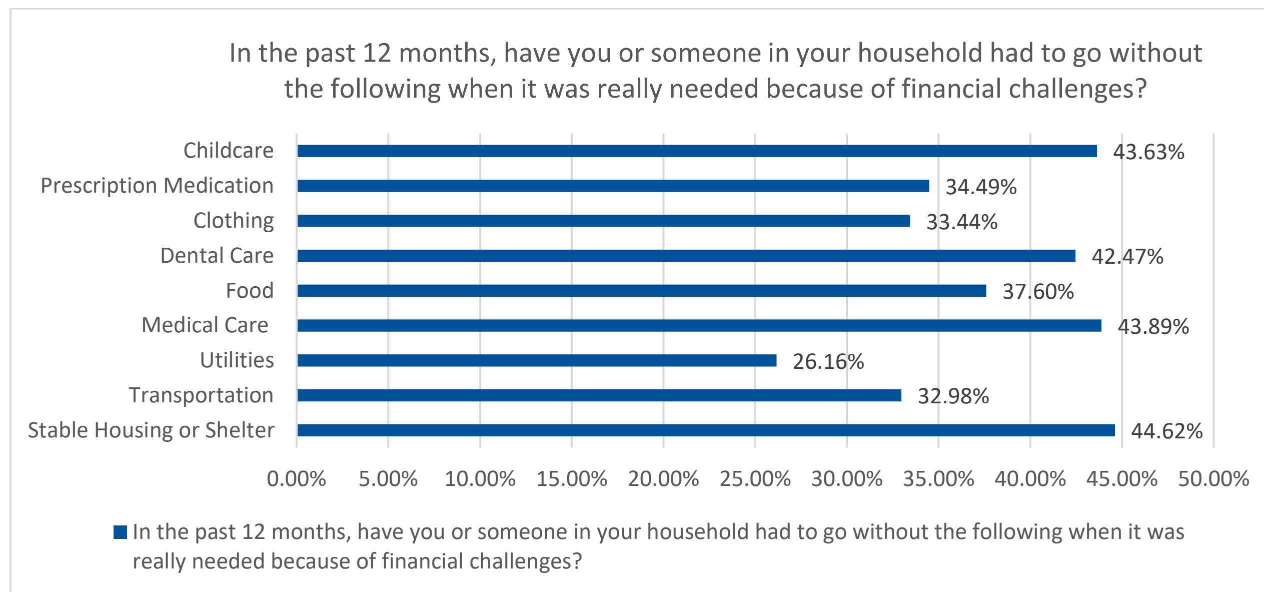
Table 12. Snohomish County: TOP 3 things needed to improve the health and well-being of you and your family in Snohomish County

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.

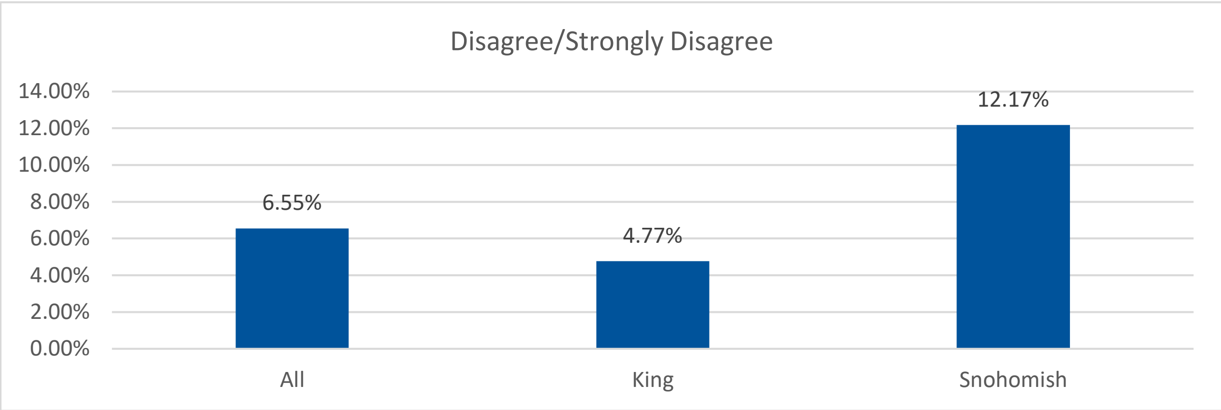
Table 17. Region

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%
Neutral	264	27.41%

Response	Count	Percentage
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%

Response	Percentage
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%
Alternative Medicine	57	2.77%
Skipped Question	9	-

Response	Count	Percentage
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.

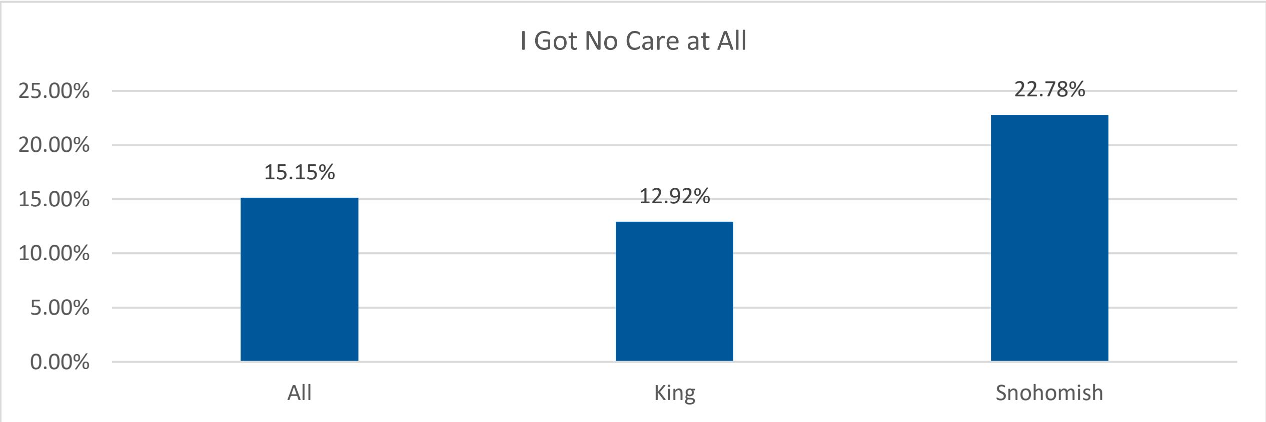
Question 12. In the last 12 months did you or a member of your household get all the care you needed? (Please select all that apply)

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%

Response	Count of Answers	Percentage
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%
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%

Response	Count of Answers	Percentage
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%

Response	Count	Percentage
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%

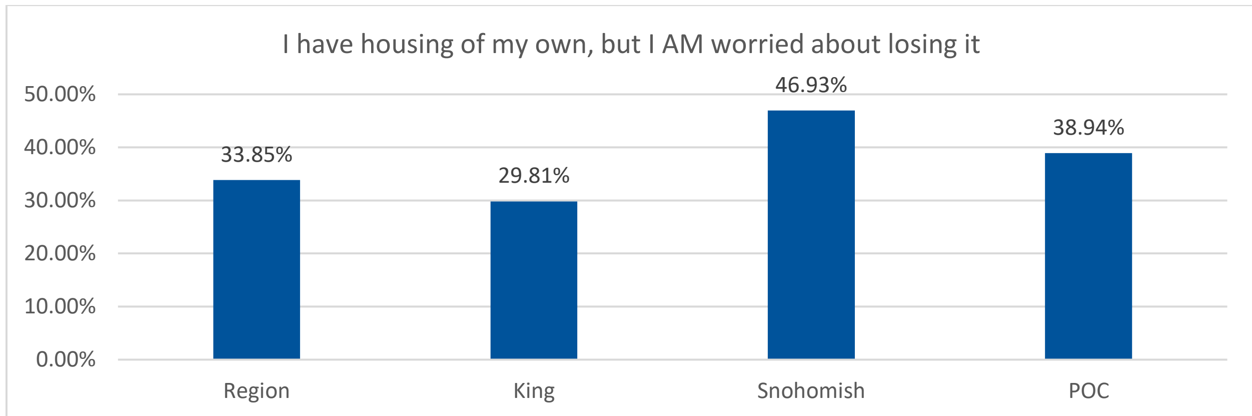
Question 18. Which of the following best describes your housing situation today?

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%
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%

Response	Percentage
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 King County 2-1-1 at https://wa211.org/region/king-county/.

Community Need	Community Organization/Initiative
Access to Health Care	**Community Health Care Foster Adoption Clinic:** Provides trauma-informed medical, dental, and behavioral health care for families and children touched by foster care, kinship care, and adoption. Families appreciated the co-located services and services sensitive to the needs of foster and adoption families.
	Healthcare for the Homeless Network: Nimble teams that meet people experiencing homelessness where they are and provide health education and some primary care.
	Hepatitis Education Project: A low-barrier program committed to improving health of underserved communities disproportionately impacted by viral hepatitis.
	Neighborcare Street Outreach: Meets the health care and shelter needs of people experiencing homelessness wherever they are to provide nursing support and links to health care.
	Seattle Indian Health Board: Offers a variety of services, including health care, mental health care, and mobile outreach for the urban American Indian and Alaska Native population.
	The Max Clinic at Harborview: Addresses the needs of patients with complex medical and social needs who are not well-engaged in HIV care as it is traditionally organized.
Food Insecurity	**Farmers markets partnered with health centers**: The Neighborcare Health at Meridian in North Seattle partners to bring a farmer's market to the clinic to help patients have access to healthier food.
	Emergency Feeding Program in Renton: Provides food to diverse communities in South King County.
	Issaquah Food and Clothing Bank: Collaborates with the Issaquah Schools Foundation and Issaquah School District to address the food needs of families.
Housing and Homelessness	**Imagine Housing**: Develops permanent affordable rental homes in East King County and offers individualized support to residents.
Mental Health	**Valley Cities Behavioral Health Care**: Provides mental health services and substance use disorder treatment to families, children, people experiencing homelessness, and veterans.
	Swedish School-Based Mental Health Services within the Seattle and Issaquah School Districts.
	Churches, particularly Black churches that have established trust in their communities.

Community Need	Community Organization/Initiative
Community Support and Resources	**Digital Equity Project with AARTH**: Supporting access to technical devices for African American and African born individuals ages 55 and above.
	Sammamish Community YMCA: Provides support for students and affordable before and after school care.

APPENDIX 4 REVIEW OF PROGRESS

Swedish King County hospitals approved an Implementation Strategy/Community Health Improvement Plan (CHIP) to address significant health needs identified in the 2018 CHNA. 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 priority health needs addressed since the completion of the hospitals© 2018 CHNAs.

Swedish Ballard

The priority health needs for Swedish Ballard were mental health, obesity and diabetes, drug addiction, and homelessness. These needs were addressed through a commitment of Community Benefit programs and resources.

Initiative/Community Need Addressed: Mental Health and Wellness

Goal (Anticipated Impact): Implement a new program that provides mental health peer support in Swedish emergency departments (ED). This program will be adapted from the ED Connect program implemented by Hoag Hospital Newport Beach ED in partnership with the National Alliance on Mental Health (NAMI). Develop a psychology postdoctoral fellow training program that provides mental health care in the Swedish community irrespective of patient's ability to pay, while creating a much needed workforce to support integrated behavioral health (BH) care.

Scope (target population): Residents of Swedish communities.

Progress:

- Swedish funded two post-doctoral behavioral health fellowships. The Fellows have engaged with 520 clients needing mental health assessment and treatment.
- ED Connect program was rolled out to Swedish campus Emergency Departments.
- Developed Mental Health First Aid Training and MHFA Instructor Training.

Initiative/Community Need Addressed: Obesity and Diabetes

Goal (anticipated impact): Increase awareness on the importance of healthy eating and exercise and reduce the prevalence of obesity and risk of diabetes in diverse communities.

Scope (target population): Members of the community with focused outreach in communities with low incomes.

Progress:

- 175 community members, who screened positive for diabetes or prediabetes or with high glucose levels, were given information for appropriate follow-up (primary provider, Swedish

diabetes center, YMCA, community clinics). Twenty three of these community members enrolled in a diabetes management program.
- Provided sponsorship for the Urban Games. Provided diabetes screening and health education at the Urban Games.
- 5 community events provided prediabetes screening or glucose testing for 540 community members.

Initiative/Community Need Addressed: Substance Use Disorder and Opioid Use Disorder

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

Scope (target population): Ballard ED patients who present with OUD. After the system rollout, patients who present in any Swedish ED with OUD will be treated. Referral to a network of Suboxone Medicaid waivered clinics and partners will be offered to our patients.

Progress:

- Ballard completed a pilot of best-practice OUD screening, treatment, and referral from the ED to a Suboxone clinic. 60% of patients in the pilot program were followed up from the ED to a Suboxone clinic.
- The Ballard Campus ED administered Suboxone to 23 persons.
- The Ballard campus participated in the Emergency Department Buprenorphine Learning Collaborative through King County Public Health.
- Ballard was the first ED in King County to distribute NARCAN free to patients.
- The Swedish Ballard Bridge Clinic supported patients through Tele-Health and virtual group sessions during COVID to accommodate physical distancing requirements.
- Swedish, with leadership from Addiction and Recovery Services, hosted the first National Women and addiction summit (1/24/20- 1/25/20), which was attended by over 250 health care professionals from across the country.
- Swedish, with leadership from the Addiction and Recovery Services, hosted Washington Summit for Mental Health and Opioid Use Disorder (1/22/20-1/23/20), which was attended by over 250 multidisciplinary health care professionals from across WA state.

Initiative/Community Need Addressed: Homelessness

Goal (anticipated impact):

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

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

Progress:

- Provided minor medical outreach efforts in identified locations supporting individuals experiencing homelessness. 934 people were treated.
- Partnered with Operation Night Watch/Point in Time and Swedish providers. Held health fairs and conducted health screens, wound care, and minor treatment of ailments.
- Elevated awareness of using the Swedish County Doctor After-Hours Clinic at Cherry Hill and other Federally Qualified Health Centers instead of the ED for non-emergency care.

Initiative/Community Need Addressed: Support group for Patients receiving Electroconvulsive Therapy (ECT)

Goal (anticipated impact): Improve the continuum of care and support for patients receiving Electroconvulsive Therapy (ECT), which is a procedure used to treat certain mental health conditions. Engaging in peer support is vital for persons undergoing ECT. Patients and their families/support systems that are candidates for ECT have often been battling the mental health condition and the mental health system for some time. Often these patients and families/support systems feel isolated, anxious, and fearful.

Scope (target population): Persons receiving intensive Electroconvulsive Therapy (ECT) or maintenance ECT, patients who have finished or stopped ECT treatments, and prospective ECT patients.

Progress: Partnered with NAMI-Seattle chapter to develop, facilitate, market, and support the group. NAMI-Seattle provided a formal peer-facilitator training (group dynamics, etc.). NAMI-Seattle chapter mentored the support group and supported its needs, in collaboration with Swedish and Seattle Neuropsychiatric Treatment Center. Due to COVID restrictions, the support group met over ZOOM.

Initiative/Community Need Addressed: Community Education: Teen Health, Adult Diabetes, Heart Health, and Weight Management

Goal (anticipated impact): Partner with Ballard community events to provide health education and outreach to the community addressing issues of heart health, diabetes prevention, teen health, healthy BMI and exercise.
Scope (target population): Youth and adults in the Ballard community.

Progress:

- NARCAN was made available for dispensing at the Ballard High School Teen Clinic.
- Mental health support was provided at the Ballard High School Teen Clinic. There were 2,006 teen encounters provided by an LSW therapist and MSW intern, partners from Sound, including two therapists and prevention interventionist.
- Contraceptive support was provided at the Ballard High School Teen Clinic by a nurse practitioner and family practice residents. In FY20, 41 students received contraceptives.
- 40 flu vaccines were administered at the Ballard Food Bank.
- Community health screening was conducted at the Ballard Food Bank.
- Swedish Ballard made Community Partner Investments to the Greenwood Senior Center/Phinney Neighborhood Association, Ballard NW Senior Center, Ballard P-Patch / GROW and the Ballard Alliance. These programs provided direct services to seniors, persons experiencing homelessness and the food insecure.

Swedish First Hill and Cherry Hill

The priority health needs for Swedish First Hill and Cherry Hill were: obesity and diabetes, drug addiction, mental health and homelessness. These needs were addressed through a commitment of Community Benefit programs and resources.

Initiative/Community Need Addressed: Obesity and Diabetes

Goal (anticipated impact): Increase awareness on the importance of healthy eating and exercise and reduce the prevalence of obesity and risk of diabetes in diverse communities.

Scope (target population): Members of the community with focused outreach in low income communities.

Progress:

- 217 community members, who screened positive for diabetes, prediabetes, or with high glucose levels, were given information for appropriate follow-up (Primary provider, Swedish diabetes

center, YMCA, community clinics). 36 of these persons enrolled in diabetes management program.
- Provided sponsorship for the Urban Games. Provided diabetes screening and health education at the Urban Games.
- 5 community events provided prediabetes screening or glucose testing for 540 community members.

Initiative/Community Need Addressed: Mental Health—Depression Screening and Mental Health First Aid

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

Scope (target population): Swedish patients, caregivers, and community stakeholders

Progress:

- 54.5% of patients were screened for depression at primary care clinics using the PHQ-2 or PHQ-9 screenings.
- 123 caregivers and community stakeholders trained in Mental Health First Aid.
- 75 persons participated in National Alliance on Mental Illness (NAMI) Walk (mental health awareness) to generate access to and awareness of mental health services.

Initiative/Community Need Addressed: Mental Health and Wellness

Goal (anticipated impact): Implement a new program that provides mental health peer support in Swedish emergency departments (ED). This program will be adapted from the ED Connect program implemented by Hoag Hospital Newport Beach ED in partnership with the National Alliance on Mental Health (NAMI). To accomplish this goal and implement a pilot project, Swedish will explore partnering with Navos, one of the largest providers of community mental health services in Washington State. Develop a psychology postdoctoral fellow training program that provides mental health care in the Swedish community irrespective of patient's ability to pay, while creating a much needed workforce to support integrated behavioral health (BH) care.

Scope (target population): Residents of Swedish communities.

Progress:

- 47% of Swedish primary care clinics have implemented depression screening for patients.
- 324 persons were referred to psychiatry, medication management and community resources.
- Swedish funded two post-doctoral behavioral health fellowships. The Fellows have engaged with 520 clients needing mental health assessment and treatment.
- ED Connect program was rolled out to Swedish campus Emergency Departments.

- Developed Mental Health First Aid Training and MHFA Instructor Training. 30 people participated in Mental Health First Aid training.

Initiative/Community Need Addressed: Substance Use Disorder and Opioid Use Disorder

Goal (anticipated impact): Transition ED patients with opioid use disorder (OUD) to a Suboxone clinic for treatment. The goal is to address the identified community need through enhanced treatment of patients presenting with OUD with evidence-based guidelines for withdrawal management.

Scope (target population): ED patients who present with OUD. Referral to a network of Suboxone Medicaid waivered clinics and partners will be offered to our patients.

Progress:

- Implemented best-practice OUD screening, treatment, and referral from the ED to a Suboxone clinic.
- The First Hill Campus ED administered Suboxone to 32 persons.
- The Cherry Hill Campus ED administered Suboxone to 27 persons.
- Swedish, with leadership from Addiction and Recovery Services, hosted the first National Women and addiction summit (1/24/20- 1/25/20), which was attended by over 250 health care professionals from across the country.
- Swedish, with leadership from the Addiction and Recovery Services, hosted Washington Summit for Mental Health and Opioid use disorder (1/22/20-1/23/20), which was attended by over 250 multidisciplinary health care professionals from across WA state.

Initiative/Community Need Addressed: Diabetes and Obesity

Goal (anticipated impact): Increase awareness of individuals who are at risk for developing prediabetes including screening . Identify additional avenues for improving knowledge to reduce and prevent the risk of developing type 2 diabetes.

Scope (target population): King County residents.

Progress:

- 175 people were tracked and referred to Swedish diabetes education classes, YMCA and Diabetes Prevention Programs (DPPs).
- Provided diabetes health information at 5 community health fairs.
- 520 persons with screened with the American Diabetes Association prediabetes screening tool at Swedish sponsored events and community health fairs.

Initiative/Community Need Addressed: Homelessness

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

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

Progress:

- Provided minor medical outreach efforts in identified locations supporting individuals experiencing homelessness. 934 people were treated.
- Partnered with Operation Night Watch/Point in Time and Swedish providers. Held health fairs and conducted health screens, wound care, and minor treatment of ailments.
- Elevated awareness of using the Swedish County Doctor After-Hours Clinic and other Federally Qualified Health Centers instead of the ED for non-emergency care.
- Medical Teams International (MTI) mobile dental coach treated 32 persons who were experiencing homeless. 5 of these were referred for additional care.

Swedish Issaquah

The priority health needs for Swedish Issaquah include the following: joint and back pain, obesity and diabetes, mental health, homelessness and drug addiction. These needs were addressed through a commitment of Community Benefit programs and resources.

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

Goal (anticipated impact): Due to the impact of joint and back pain in the Swedish Issaquah community, this initiative seeks to increase outreach and education for individuals impacted by joint and back pain, with an emphasis on non-surgical alternatives.

Scope (target population): Joint and back pain was one of the top four problem areas identified by stakeholders in the 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.

Progress:

- 26 people attended the Gibson EK High School fitness presentation.
- 722 people attended 5 Swedish Sports Medicine Combine events.

Initiative/Community Need Addressed: Obesity and Diabetes

Goal (anticipated impact): Increase awareness on the importance of healthy eating and exercise and reduce the prevalence of obesity and risk of diabetes in diverse communities.

Scope (target population): Members of the community with focused outreach in low income communities.

Progress:

- 217 community members, who screened positive for diabetes, prediabetes, or with high glucose levels, were given information for appropriate follow-up (Primary provider, Swedish diabetes center, YMCA, community clinics). 29 of these persons enrolled in diabetes management program.
- Provided sponsorship for the Urban Games. Provided diabetes screening and health education at the Urban Games.
- 5 community events provided prediabetes screening or glucose testing for 540 community members.

Initiative/Community Need Addressed: Mental Health and Wellness

Goal (anticipated impact): Implement a new program that provides mental health peer support in Swedish emergency departments (ED). This program will be adapted from the ED Connect program implemented by Hoag Hospital Newport Beach ED in partnership with the National Alliance on Mental Health (NAMI). To accomplish this goal and implement a pilot project, Swedish will explore partnering with Navos, one of the largest providers of community mental health services in Washington State. Develop a psychology postdoctoral fellow training program that provides mental health care in the Swedish community irrespective of patient's ability to pay, while creating a much needed workforce to support integrated behavioral health (BH) care.

Scope (target population): People in Swedish communities

Progress:

- 2 mental health workshops were presented in the community.
- Case managers were embedded in the Issaquah School District.
- Swedish funded two post-doctoral behavioral health fellowships. The Fellows have engaged with 520 clients needing mental health assessment and treatment.
- ED Connect program was rolled out to Swedish campus Emergency Departments.
- Developed Mental Health First Aid Training and MHFA Instructor Training. 30 people participated in Mental Health First Aid training.

Initiative/Community Need Addressed: Homelessness

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

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

Progress:

- Provided minor medical outreach efforts in identified locations supporting individuals experiencing homelessness. 934 people were treated.
- Partnered with Operation Night Watch/Point in Time and Swedish providers. Held health fairs and conducted health screens, wound care, and minor treatment of ailments.
- Elevated awareness of using the Swedish County Doctor After-Hours Clinic and other Federally Qualified Health Centers instead of the ED for non-emergency care.
- Medical Teams International (MTI) mobile dental coach treated 32 persons who were experiencing homeless. 5 of these were referred for additional care.

Initiative/Community Need Addressed: Substance Use Disorder and Opioid Use Disorder

Goal (anticipated impact): Transition ED patients with opioid use disorder (OUD) to a Suboxone clinic for treatment. The goal is to address the identified community need through enhanced treatment of patients presenting with OUD with evidence-based guidelines for withdrawal management.

Scope (target population): ED patients who present with OUD. Referral to a network of Suboxone Medicaid waivered clinics and partners will be offered to our patients.

Progress:

- Implemented best-practice OUD screening, treatment, and referral from the ED to a Suboxone clinic.
- The Issaquah Campus ED administered Suboxone to 17 persons.
- Swedish, with leadership from Addiction and Recovery Services, hosted the first National Women and addiction summit (1/24/20- 1/25/20), which was attended by over 250 health care professionals from across the country.

- Swedish, with leadership from the Addiction and Recovery Services, hosted Washington Summit for Mental Health and Opioid use disorder (1/22/20-1/23/20), which was attended by over 250 multidisciplinary health care professionals from across WA state.

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
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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

<u>Executive and Content Experts</u>

- 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.

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- 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
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