



# SWEDISH

## Community Health Implementation Plan 2016-2018

Swedish Health Services  
First Hill and Cherry Hill  
Seattle Campus



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# Executive Summary

Swedish Medical Center continually strives to honor its commitment to create healthier communities together. Partnering with others of similar intention, we conduct a formal community health needs assessment to learn about the greatest needs and assets from the perspective of some of the most marginalized groups of people in the communities we serve. This assessment helps us develop collaborative solutions to fulfill unmet needs while continuing to strengthen local resources.

What follows is the Community Health Implementation Plan (CHIP) for Swedish Seattle (First Hill and Sherry Hill). The CHIP is designed to be the “action plan” that will respond to the specific needs that were discovered during the assessment process.

These plans are based on community health data and identifiable gaps in available care/services. It was determined that emphasis on these issues would ultimately have the greatest impact on the community’s overall health.

The objective of the implementation plan is to measurably improve the health of the citizens in a specific community. The plan’s target population includes the community as a whole, and specific population segments including minorities and other underserved demographics. The CHIP includes components of education, prevention, disease management and treatment, and features collaboration with other agencies, services and care providers.

The Swedish Seattle CHIP prioritize the health needs identified in the Community Health Needs Assessment (CHNA).

*The Community Health Needs Assessments (CHNA) are a collaborative product that fulfills Section 9007 of the Affordable Care Act. Each CHNA presents data on:*

- Description of the Community
- Life Expectancy and Leading Causes of Death
- Chronic Illness

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

The Community Health Implementation Plan (CHIP) is a road map to identify goals, strategies and tactics to improve the health our community. The five key health risks spelled out in the CHNA are:

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

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

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

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

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

# Introduction

## *Creating healthier communities, together*

We're pleased to present the 2016-18 Community Health Needs Assessment for Swedish Seattle (First Hill/Cherry Hill) Hospital.

As health care continues to evolve, Swedish is responding with dedication to its Mission and a core strategy to create healthier communities, together. Partnering with others of similar intention, Swedish became a member of the King County Healthier Hospitals Coalition (HHC), a collaborative of all 12 hospitals and health systems in King County including Public Health-Seattle & King County. The purpose of this first joint county-wide community health needs assessment (CHNA) is to highlight strengths and areas of need that cut across geographies and present opportunities for collaboration among public health, hospitals, health systems, community organizations, and communities

This assessment embraces a broad concept of health that includes social, cultural, and environmental factors that affect health.

It guides our community benefit investments, not only for our own programs but also for many partners, toward improving the health of entire populations. Through strategic programs and donations, health education, charity care, medical research and more, Swedish provided more than 175 million in Community Benefit in 2015.

In accordance with the Affordable Care Act, this report includes:

Outline an Implementation plan about the following identified health needs:

1. Access to care
2. Preventable causes of death
3. Maternal/child health
4. Behavioral health
5. Violence and injury prevention

Using these priorities Swedish Seattle dove deeper to identify the specific needs for the people in communities we serve, and to develop a standalone implementation plan that addresses those needs.

Detailed data are reported, when available, for neighborhoods, cities, and regions in King County, and by race/ethnicity, age, income/poverty, gender, or other important demographic breakdowns. When possible, comparisons are also made to the

Washington State average and Healthy People 2020 objectives. Healthy People 2020 objectives are science-based, national objectives ([www.healthypeople.gov](http://www.healthypeople.gov))

## Community Strengths and Resilience

King County has a strong economy and on a county level ranks high on national indicators of health and wellbeing. In part because of high levels of immigration, we are home to some of the most diverse communities in the US. These communities have unique cultural strengths and community assets to draw on that benefit the entire region. In addition, we have strong institutional assets including faith communities, government, hospitals and health systems, universities, philanthropy, and non-profits. There are also numerous existing programs that help the community thrive, and many people have strong networks to support them.

Yet, the benefits of a strong and healthy community are not felt equally by all. When looking across issue areas in different parts of our county, it is clear that every community has assets yet also opportunities for improvement. At the same time, some areas face persistent disparities in health by race, income, and place.

When important health and social measures are presented by geographic area it becomes clear that our opportunities for better health begin where we live, learn, work, pray, and play. For example, King County residents live an average of 82 years, three years longer than the national average of 79 years. However, life expectancy within the county varies by almost 10 years. South Auburn residents live an average of 77 years; west Bellevue residents live an average of 86 years.

Many other health and social indicators reflect similar patterns of inequity, such as housing quality, alcohol-related deaths, obesity, lack of health insurance, and smoking. Despite these disparities, the leading risk factors and causes of illness affect us all and call for collective action to give everyone a fair chance to live a healthy life. Each region of the county is affected by the issues addressed in this report and each region has unique assets and resources to address them. Working together, hospitals, health systems, public health, community organizations and communities can improve the conditions in which people live and their ability to lead healthy lives to achieve their full potential.

Supplemental data can also be found in the Appendices. Additional indicators for each health need as well as data for other health topics are online at [www.kingcounty.gov/health/indicators](http://www.kingcounty.gov/health/indicators)

# Purpose and process

Swedish has developed a Community Health Implementation Plan (CHIP) designed to address key health needs identified in our community health needs assessment. The prioritized needs were chosen based on community health data and identifiable gaps in available care and services. In the course of our collaborative work, we determined that emphasis on these needs would have the greatest impact on the community’s overall health with significant opportunities for collaboration. Each Swedish hospital then dove deeper into the King County and Snohomish data and prioritized specific needs for its specific community. Below are the Swedish system needs and the needs for King County.

Swedish prioritized needs	King County prioritized needs
<p><b>Access to Care</b></p> <p><b>Preventable causes of death</b></p> <p><b>Maternal/child health</b></p> <p><b>Behavioral health</b></p> <p><b>Violence and injury prevention</b></p>	<p><b>Access to Care</b></p> <p><b>Preventable causes of death</b></p> <p><b>Maternal/child health</b></p> <p><b>Behavioral health</b></p> <p><b>Violence and injury prevention</b></p>

**Plan objective**

The objective of this Implementation plan is to measurably improve the health of individuals and families living in the communities served by Swedish Seattle (First Hill/Cherry Hill)

The plan’s target population includes the community as a whole, and specific population groups including minorities and other underserved demographics.

This plan includes components of education, prevention, disease management and treatment, and features collaboration with other agencies, services and care providers. It will be facilitated by the hospital, through our mission services with assistance from key staff in various departments.

## Description of Swedish Seattle Targeted Community

Note: As the specialty referral site for Swedish Health Services, the Swedish Seattle Community reflects all of King and Snohomish Counties

In this section we provide a definition of the community served by our hospitals, which includes a description of the medically underserved, low-income and minority populations.

Swedish Seattle has two locations: Swedish First Hill and Swedish Cherry Hill.

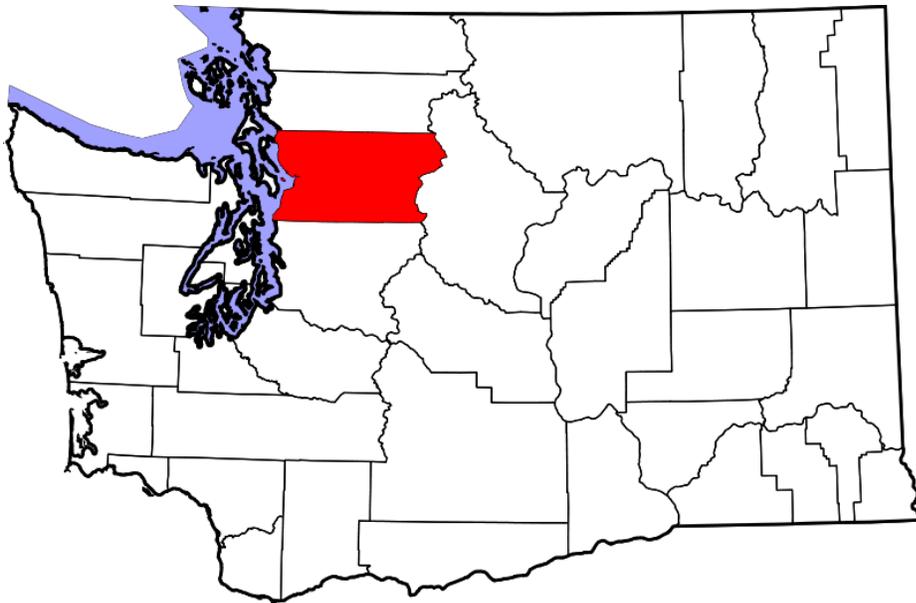
## Population and age demographics

### King County



Total population is about 1.9 million people. Age demographics are substantially higher for ages 25-64 in King County evenly distributed; age under 18 (youth) comprise the third largest proportion of the population. In 2012 the population comprised:

- 15 to 24 years (12%)
- 25 to 44 years (31%)
- 45 to 64 years (27%)
- 65 to 74 years (6%)
- 75 years and older (5%)
- Under 18 years (21%)



Total population is about 713,335 people in 2010. Approximately 10 percent of the population is age 65 or older; with a median age of 31.

### Ethnicity

Among King County residents in 2010, 71 percent were white, 6.5 percent African American, 1 percent American Indian, 15.8 percent Asian/Pacific Islander, and 4.8 percent were of two or more races.

Among Snohomish County residents in 2010, 74 percent were white and 9 percent were Asian. Hispanics are the fastest growing racial group with 125 percent growth from 2000 – 2010.

### Income levels and housing

In 2013, the median household income for King County was \$71,834, and the county's unemployment rate was 6.5 percent. Those living near to poverty are 25.4%, with 12.4% living in poverty.

The median household income for Snohomish County was \$67,394, and the county's unemployment rate was 5.8 percent. Those living below poverty was 10 percent.

### Health care and coverage

The share of King county residents who are ages 64 and younger and uninsured was 16.9 percent in 2012; with 33.8% of this age population eligible for insurance but uninsured. The top two causes of death in King County were cancer and heart disease.

## Description of Community Seattle

# Zip Codes: 98122, 98102, 98144, 98112,

This section provides a description of the community served by Swedish Seattle campuses Hospital, which includes a description of the medically underserved, low income and minority populations.

Swedish Seattle Hospital is located on First Hill and Cherry Hill neighborhoods in Seattle, Washington. Other major medical providers:

- Group Health
- University of Washington Medical Center
- Seattle Children's
- Harborview Medical Center
- Virginia Mason Medical Center
- Pacific Medical Centers
- Poly Clinic

# Priority health need: Access to Care

This section outlines the plan to address unmet access to care needs in our community.

## Community needs addressed:

Medicaid, uninsured and underinsured populations

## Goal

Provide access to care for young adults and families, people of color and low income and underserved communities.

## Strategies

- Continue community engagement and outreach efforts to strengthen stable partner relationships by developing innovative programs with partners aimed at providing services to the underserved.
- Continue serving as a safe, supportive environment for all members of the community.
- Refine data management processes of patient and community populations.
- Develop innovative ways to become more inclusive, especially for the LGBTQ communities.
- Identify innovative models of care to increase primary care utilization and reduction of unnecessary emergency room usage

## Action plan

### Current tactics

- Accountable Care Act (ACA) insurance outreach and sign up
- Global to Local connection desk
- Partnering with Federally Qualified Health Clinics/centers

### Future tactics

- Build assessable environment (quality housing, trails/ sidewalks/bike lanes, healthy food outlets, health care centers, schools, libraries, transit system with the input of community based organizations like InterIm CDA, International District council and Department of Neighborhoods BUILD Grant.
- Supports for diverse cultural and linguistic needs
- Outreach to LGBTQ community, families and advocates

### Measurement

- Client data from FQHC on patient population with or without primary care
- Epic patient data using gender identity as a maker
- Funding to in language care management
- Data from ED visits of uninsured, and Medicaid patients

## Existing community resources

- WithinReach
- Somali Health Board
- InterIM CDA
- Global to Local
- Entre Hermanos
- Consejo Counseling
- St Joseph School
- City of Seattle, Seattle Police Department (SPD)
- Gay City
- Ceder River Clinics

# Priority health need: Preventable Causes of Death

This section outlines plan to address the unmet preventable causes of death needs in our community.

## Community need addressed:

- Diverse communities with a low rate of resources to provided proactive engagement
- Inability to get preventative services
- Hospitalization that could have be prevented

## Goal

To reduce the prevalence of obesity, diabetes and other preventable chronic diseases and deaths.

## Strategies

- Participate in regional coordination and standard implementation of best practices in violence, injury prevention including prevention related to primary care assessment and screening.
- Focus on obesity, tobacco use, and lack of appropriate nutrition and physical activity.
- Provide emergency preparedness education through school and community meetings
- Empower community clinics in care management of general health issues.

## Action plan

### Current tactics

- Outreach programs

### Future tactics

- Engage primary care provider, Seattle Public schools and afterschool programs to inform and educate students
- Provider education
- Emergency preparedness education in school, home bound and community center
- Implementation community health clinics referral system and preventative health education
- Increase proportion of people receiving timely prevention and screening services appropriate for life stage

### Measurement

- Number of preparedness classes, training and kit distribution
- Decrease in City of Seattle police crime report

## Existing community resources

- YMCA
- InterIM CDA
- American Preparedness
- Seattle Police Department
- City of Seattle Department of Neighborhoods
- First Hill Improvement Association
- CenterStone
- Central District Association
- Squire Park Community Council

# Priority health need: Maternal/Child Health

This section outlines the plan to address Maternal/Child Health needs in our community.

## Community need addressed

- Social disparities of health support for women and babies
- Disparities in adverse birth outcomes
- Focus on low weight babies
- Quality care, ongoing social support, home visiting program

## Goal

Reduce the percentage of low weight babies

## Strategies

- Develop a holistic plan to incorporate in home, care doulas care, clinical expertise and education for all women especially women and families of diverse backgrounds.
- Increase information and education to women from diverse communities
- Development of a care plan for new mothers and new families

## Action plan

### Current tactics

- Pediatrics service outreach to families
- New mother education

### Future tactics

- Development of a robust doula program for in language care and support
- Focused outreach to community based programs for all women
- Increase work with March of Dimes
- Advance education for care management

### Measurement

- Increased health outcome from primary care provider
- EPIC data from NICU of premature and low weight babies
- Qualitative summaries of family support workers and navigators to drive quality improvement

## Existing community resources

- Open Arms
- WithinReach
- Mary's Place
- Eastside Baby Corner
- Country Doctor
- Odessa Brown Clinic
- WIC

# Priority health need: Behavioral Health

This section outlines the plan to address behavioral health in our community.

## Community needs addressed

- Primary Care Embedded Behavioral Health Specialists
- Primary Care Co-Located Psychiatric Consultation
- Community Partnership Network

## Goal

Provide high quality, accessible care to patients in a manner which de-stigmatizes behavioral and mental health and connects patients to resources best suited for their care needs

## Strategies

- Align internal strategies to address the needs of mental health patients with the goals and objectives of the King County ACH.
- Invest in upstream interventions that address needs of mental health patients and substance abuse.

## Action plan

### Current tactics

- To coordinate design and implementation across delivery system that is financially sustainable over time with valid metrics and outcome measures.
- Integrate with current community based services that provides continuity of care.

### Future tactics

- Behavioral Health Specialists (BHS) are social workers and psychologists integrated in the primary care team. They will be embedded in to the care model.
- Expert consultation for severe psychiatric illness or to serve patients who are not improving to stabilize and help return them to primary care support. .
- Formalized partnerships between Swedish Medical Group and community mental health agencies who provide wrap-around care for patients with severe, persistent, mental illness who require more services than can be delivered within a primary care setting. These partnerships allow for a streamlined continuum-of-care and bi-directional feedback to ensure positive patient health outcomes.

### Measurement

- Decreased symptoms
- Increased quality
- Increased patient satisfaction
- Increased provider satisfaction

- Increased access to care

### **Existing community resources**

- Asian Counseling & Referral Service
- Catholic Community Services of Western Washington (youth / families)  
Community House Mental Health Center (adults)
- Community Psychiatric Clinic (adults / youth)
- Consejo Counseling & Referral Services (adults / youth)
- Downtown Emergency Service Center (adults)
- EvergreenHealth (adults)
- Navos (adults / youth)
- SeaMar Community Health Centers

# Priority health need: Violence and Injury Prevention

This section outlines plan to address unmet needs for violence and injury prevention in our community.

## Community needs addressed:

- Increase of random physical violence in community
- Education, prevention and training
- Isolation

## Goal:

Increase proportion of people who feel safe in their neighborhood/community

## Strategies:

- Strengthening policies, programs, community norms and systems that lead to the prevention of injury and violence.
- Invest in local prevention resources
- Support statewide coalitions and advisory committees
- Educate and empower community members
- Community clean up and park activation
- Develop a social environment (social cohesion, low crime, civic engagement)

## Action plan

### Current tactics

- Community awareness

### Future tactics

- Engage the community to evaluating prevention programs, interventions, and policies
- Develop violence prevention trainings and technical assistance to local, regional, and state programs and organizations
- Communicate public health approaches to injury and violence prevention, emerging issues, and prevention practices supported by the best available evidence to grassroots community organizer and leaders

### Measurement

- Decrease of reports to Seattle Police department and Department of Neighborhoods
- Increase community council meeting with topics of violence prevention
- Increased collection risk factors in high impact communities

## Existing community resources

- YMCA
- InterIM CDC
- Seattle Police Department
- Seattle Youth Violence Prevention Initiative
- City of Seattle Department of Neighborhoods
- First Hill Improvement Association
- Central District Chamber
- CenterStone

# Needs not directly addressed

This section explains why Swedish is not addressing a community need identified in the Community Health Needs Assessment.

## **Injury and Violence-related Mortality**

The incident of injury and violence-related mortality is high compared to other counties in Washington State. Swedish will not be considering police violence at this time.

## **Maternal/Child Health**

The incidence of low birth weight babies and other maternal and child health measures are high in King County. Swedish will not be considering clinical research at this time.

# Next Steps

## Inventory of current programmatic work impacting leading community health issues

Through survey of programmatic and clinical leads, an inventory of current work will be compiled.

## Gap analysis of current programming and community health needs

An analysis of data from the CHNA and the programmatic inventory will help identify opportunities for greater impact in the community.

### Resources:

King County Accountable Community of Health

<http://www.kingcounty.gov/elected/executive/health-human-services-transformation/ach/leadership-council/~media/elected/executive/constantine/initiatives/hhs-transformation/documents/rhip/RHIP-framework-slides.ashx>

Maternal and child health—Public Health-Seattle & King County

[www.kingcounty.gov/healthservices](http://www.kingcounty.gov/healthservices)

Accountable Community of Health (ACH)

[http://www.hca.wa.gov/hw/Pages/communities\\_of\\_health.aspx](http://www.hca.wa.gov/hw/Pages/communities_of_health.aspx)

Washington State Injury and Violence Prevention

<http://www.doh.wa.gov/Portals/1/Documents/2900/2016-IVP-ProgramFS.pdf>

# CHIP approval

2016-2018 CHIP approval

A handwritten signature in black ink, appearing to read 'R. Q. H.', is written over a horizontal line.

Swedish Interim CEO Guy Hudson MD, MBA

Date 5/15/2017