PROVIDENCE
Regional Medical Center
Everett

Everett, Snohomish County Community Health Needs Assessment 2017-2019

Providence Regional Medical Center Everett

Everett, Wash.

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Executive summary

Creating healthier communities, together

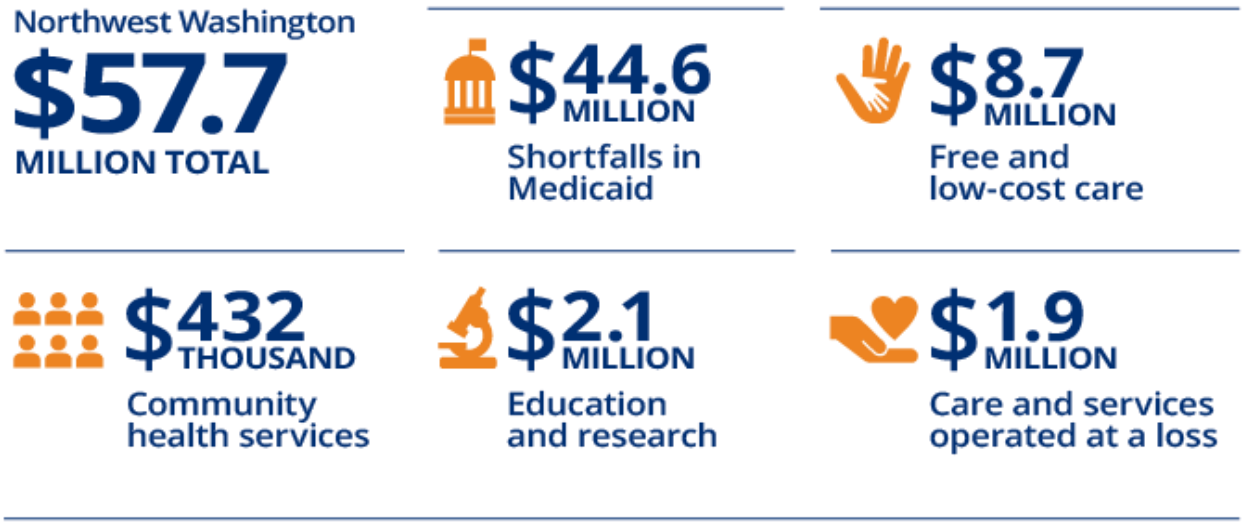
Providence Health & Services is a not-for-profit network of hospitals, care centers, physicians, clinics, home health services, a health plan and other affiliated programs. Providence in northwest Washington includes the integrated delivery system of Providence Regional Medical Center Everett (PRMCE), Providence Medical Group, Providence Home Care of Snohomish County, and Providence Institute for a Healthier Community. When the Sisters of Providence began our tradition of caring 160 years ago, our ministry greatly depended on partnering with others in the community who were committed to doing good. This same pioneering spirit continues today as our calling and our promise.

As health care continues to evolve, Providence is responding with dedication to its Mission and a core strategic outcome to *create healthier communities, together*. Partnering with community organizations, we conduct a formal community health needs assessment every three years to learn about the greatest needs from the perspective of some of the most marginalized groups of people in communities we serve. Following the CHNA, a community health improvement plan is developed to provide details about the strategies and tactics that PRMCE will implement in order to respond to the significant health needs in our community. Additionally, the assessments help guide our community benefit investments, not only for our own programs, but those that we support in our community.

Community benefit

The Providence Mission reaches out beyond the walls of care settings to touch lives in the places where relief, comfort and care are needed. One important way we do this is through community benefit spending, with a special focus on those who are poor and vulnerable. Many of Providence's programs and funding not only enhance the health and well-being of our patients, but the whole community. Providence's community benefit investments connect families with preventive care to keep them healthy, fills gaps in community services and provides opportunities that bring hope in difficult times.

Through strategic programs and donations, health education, charity care, medical research and more, Providence Health & Services provided $591 million in community benefit across Alaska, California, Montana, Oregon and Washington during 2015. In 2015, Providence Regional Medical Center provided a total of $57.7 million in community benefit, including $8.7 million in free and low-cost care so the underinsured and uninsured could access health care



Assessment overview

With input and guidance from our many partners, including the Providence Northwest Washington Community Ministry Board's Mission and Healthier Communities Committee and the Providence Institute for a Healthier Community, PRMCE developed the 2017-2019 community health needs assessment. PRMCE utilized a three step approach to identify the significant health needs that Providence will address in this CHNA cycle. In the first phase, baseline data from the 2013 assessment was updated and evaluated based on the methodology adopted from the Snohomish Health District; comparing local data to state and national data as well as Healthy People 2020 goals; identifying negative trends in local data; and evaluating the size and seriousness of the problem. The second phase included evaluating the data based on the need for improvement, the disproportionate impact on sub-populations, and the level of community resources dedicated to improving the indicator. And finally, the third phase included a weighted scoring based on the linkage to our strategic plan, the amount of resources relative to community need, and our confidence in our ability to have an impact on the health issue. Throughout the process, we utilized a framework that evaluated health and community need in a holistic framework that included social determinants of health, lifestyle choices, and clinical care.

Overview of PRMCE prioritized needs

PRMCE is actively involved in a number of community programs to address needs. During this current cycle, and based on the evaluation process, we have identified three significant health needs that PRMCE will address in the current CHNA cycle:

1. **Primary care access**
2. **Substance abuse (opioid / illegal drug use)**
3. **Homelessness**

PRMCE made a commitment to focus on these three needs because we believe we can have the greatest impact using our expertise and a focused ability to influence outcomes. At the same time, Providence is also actively involved in supporting our community through many other community benefit programs. In addition, the Providence Institute for a Healthier Community is identifying new health and well-being measures that are designed to encourage broader improvements for larger populations of people, including many served through our community benefit programs.

Each of the health needs we have identified include a metric and measurable goal that will be used as an indicator of community progress. We also will develop specific metrics to gauge the effectiveness of the implementation strategies identified. We evaluate our community benefit implementation strategies during our annual strategic planning and budget cycle. This review enables us to identify any needed modifications or additional areas of emphasis that may be necessary.

Prioritized need #1 – Access to primary care

Lack of access to primary care presents barriers to good health. Addressing these barriers will improve health in the community and will help people get the right care, at the right time, and in the right care setting. In Snohomish county, adults with at least one person they think of as their personal doctor or healthcare provider has decreased from 79.1 percent in 2011 to 75.9 percent in 2013. Additionally over the last ten years, the number of primary care physicians in the community has remained relatively unchanged. In 2013, Snohomish county had a primary care physician ratio of 1 physician per 1,932 residents, which is well below the State (1,190:1) and National (1,040:1) averages.

Need	Snohomish County Indicator
Access to Primary Care	• 75.9% of adults 18 and over have at least one person they think of as their personal doctor or healthcare provider (decline from prior period) • 1,932:1 residents per primary care physician ratio (slight decline from prior period)

See page 17 for additional indicators.

Prioritized need #2 – Homelessness

Homelessness has a high negative impact on an individual's health status and homeless individuals are high users of medical systems. The Public Health Service Act[1] defines a homeless person as an individual without permanent housing who may live on the streets; stay in a shelter, mission, single room occupancy facility, abandoned building or vehicle; or in any other unstable or non-permanent situation. Accurate estimates of homelessness are difficult to obtain. However, based on an annual Snohomish County Point in Time field survey, the number of homeless in shelters or precariously housed has gone down while unsheltered has gone up. The January 2016 Point in Time count showed that 1,118 persons in 878 households did not have a permanent place to stay.

Need	Snohomish County Indicator
Homelessness	• 0.06% of population unsheltered (increase from prior period) • 471 unsheltered individuals (increase from prior period) • 489 sheltered individuals (decrease from prior period) • 1,118 persons in 878 households homeless

See page 17 for additional indicators.

Prioritized need #3 – Substance abuse: opiod/illegal drug use

Substance abuse has a significant health and social impact on individuals and the community. Abuse of prescription opioids for pain – such as morphine, oxycodone, hydrocodone or fentanyl, or illegal drugs such as heroin - is a serious problem in Snohomish county. While the prescription opioid mortality rate per 100,000 population in our community has gone down from 7.5 in 2010 to 5.2 in 2014, the heroin overdose mortality rate per 100,000 population has climbed from 2.4 in 2010 to 7.2 in 2014.

Need	Snohomish County Indicator
Substance Abuse: opioid / illegal drug use	• 5.2 per 100,000 population - prescription opioid mortality (down from prior period) • 7.2 per 100,000 population - heroin overdose mortality (up from prior period)

See page 18 for additional indicators.

Results from previous CHNA and CHIP

This report also evaluates results from our previous CHNA (2014-2016). During that time the prioritized health needs that PRMCE focused on were access to primary care and access to first trimester prenatal care. Providence responded by making investments of time, resources, and funding in programs that were most likely to have an impact on these needs. Data comparing 2011 to 2013 continues to show primary care access as a barrier in Snohomish County. The number of pregnant women receiving prenatal care in the first trimester remains unchanged. As more current metrics become available, we will continue to monitor the impact on both of these indicators. A few of the highlights of the programs that Providence participated in include:

Name	Type of Program	Support Type
Providence Everett Healthcare Clinic	Primary care for low-income or uninsured.	Providence funded program
STARCare	Outreach to patients that have recently visited the hospital or emergency department and did not have a primary care provider.	Providence funded program
Project Access Northwest	Assistance for uninsured/underinsured individuals, matching patients with specialty providers and assisting with health insurance premiums.	Funding to non-Providence program
Circle by Providence	Application for smartphone or tablet providing pregnancy resources and tools.	Providence funded program
Education	Social media campaign promoting importance of first trimester prenatal care.	Providence funded program

See page 20 for additional results

[1] Section 330, 41 U.S.C., 254b

Introduction

Creating healthier communities, together

As health care continues to evolve, Providence is responding with dedication to its Mission and a desire to *create healthier communities, together*. Partnering with others of goodwill, we conduct a formal community health needs assessment every three years to learn about the greatest needs in our community, especially considering members of medically underserved, low-income, and minority populations or individuals.

This assessment helps us develop collaborative solutions to fulfill unmet needs while continuing to strengthen local resources. It guides our community benefit investments toward improving the health of entire populations, with a special focus on those who are poor and vulnerable.

Serving Snohomish County

Providence Health & Services in northwest Washington has a long history of serving the community beginning when the Sisters of Providence established a hospital in Everett in 1905. Today, Providence cares for the community through a comprehensive network of facilities and services from the beginning to the end of life, including primary and specialty care, hospital care, home care and hospice. By working with our team of compassionate caregivers, we strive to deliver the best in quality and affordable care to our patients and their families. In northwest Washington, Providence includes:

- **Providence Regional Medical Center** is a 501 bed acute care tertiary referral center serving patients who reside in Snohomish County as well as from the surrounding region of Skagit, Whatcom, Island, and San Juan counties. It is the only Level II trauma center in Snohomish County and has a large and busy emergency department.
- **Providence Medical Group Northwest** is a network of primary care, urgent care, and specialty physicians providing care to children and adults in 12 locations throughout Snohomish County.
- **Providence Hospice and Home Care of Snohomish County** provides home care and inpatient hospice services in Snohomish County.
- **Providence Institute for a Healthier Community** is a partnership between Providence, business, government and non-profits aimed at encouraging residents of Snohomish County to make small but important behavioral changes to improve their overall health.

About us

Providence Health & Services is a not-for-profit Catholic health care ministry committed to providing for the needs of the communities it serves – especially for those who are poor and vulnerable. Providence's combined scope of services includes 34 hospitals, 600 physician clinics, senior services, supportive housing and many other health and educational services. The health system and its affiliates employs more than 82,000 caregivers (employees) across five states – Alaska, California, Montana, Oregon and Washington – with its system office located in Renton, Washington. Our community health activities are rooted in the charitable work the Sisters of Providence started 160 years ago when they answered a call for help from a new pioneer community in the West.

Our Mission:
As people of Providence, we reveal God's love for all, especially the poor and vulnerable, through our compassionate service.

Our Values:
Respect, Compassion, Justice, Excellence, Stewardship

Our Vision:
Simplify health for everyone

Our Promise:
Together, we answer the call of every person we serve: Know me, Care for me, Ease my way.

Description of community

This section provides a definition of the community served by the hospital and how it was determined. It also includes a description of the medically underserved, low-income and minority populations.

As a tertiary referral center, PRMCE serves patients from the surrounding region consisting of Skagit, Whatcom, Island, San Juan and Snohomish counties. However, the primary geographic area in which the majority (more than 75 percent) of PRMCE's patient population resides is Snohomish County. PRMCE serves one out of every four residents of Snohomish County and for this reason the geographic definition for the CHNA is Snohomish County.

Community profile

Snohomish County is located in northwest Washington State between Puget Sound on the west and the Cascade Mountains to the east, and between Skagit County to the north and King County to the south. The county land area is comprised of 68 percent forest land, 18 percent rural, 9 percent urban/city and 5 percent agricultural.

Population and demographics

The total population of Snohomish County is 757,600 (as of April 1, 2015). The county has experienced an annual average population growth rate of 1.2 percent since 2010.

Ethnicity

Among Snohomish county residents, in 2015, 80.3 percent of residents were white, 9.9 percent Asian, 2.9 percent African American, 1.6 percent Alaska Native/American Indian, 0.5 percent native Hawaiian/Pacific Islander, and 4.8 percent were two or more races.

Race	2010	2015	Snohomish County Trend
White	82%.1	80.3%	Down
Asian	9.05%	9.89%	Up
African American	2.68%	2.88%	Up
Alaska Native or American Indian	1.56%	1.57%	Unchanged
Native Hawaiian or other Pacific Islander	0.48%	0.53%	Unchanged
Two or more races	4.14%	4.83%	Up

Source: State of Washington Office of Financial management, each race category includes Hispanic population

Age demographics

The median age for Snohomish County is 37.5. Nearly 24 percent of the population is under the age of 17, 11 percent over the age of 65 and 24 percent adults between the age of 18 and 64.

Population by Age Groups	Snohomish County
Age 0-4	6.42%
Age 5 – 17	17.27%
Age 18 – 24	8.76%
Age 25 – 34	14.1%
Age 35 – 44	14.19%
Age 45 – 54	15.43%
Age 55 – 64	12.6%
Age 65+	11.23%

Source: Community Commons: US Census Bureau, American Community Survey. 2010-14.

Income and employment

In 2015, the mean household income was $83,440 for Snohomish county and the unemployment rate was 4.8 percent, trending down from 2010 levels. The share of those with incomes below the federal poverty line for all ages was 10.3 percent.

Metric	2010	2015	Snohomish County Trend
Unemployment (Civilian labor force)	10.7%	4.8%	Down
Mean Household Income	$81,512	$83,440	Up
Individuals below 100% of Federal Poverty	9.8%	10.3%	Up

Source: Factfinder.Census.gov/Snohomish County, www.esd.wa.gov/labormarketinfo

Health care and coverage

The share of Snohomish county residents who were uninsured was 12.2 percent in 2015, relatively unchanged from the previous period, although those with public insurance (Medicaid, Medicare, other government) went up by 1.5 percent during the same period.

Race/Ethnicity	2010	2015	Snohomish County Trend
Uninsured – Total Population	12.7%	12.2%	Unchanged
Insured with Private Insurance	73.9%	72.8%	Down
Insured with Public coverage	23.2%	24.7%	Up

Source: Factfinder.Census.gov/Snohomish County

Leading causes of death

Heart disease is the leading cause of death in Snohomish county followed by cancer.

Rank 2014	Cause of Death
1	Heart Disease
2	Cancer
3	Accidents (unintentional Injuries)
4	Alzheimer's disease
5	Chronic lower respiratory disease
6	Diabetes
7	Suicide
8	Chronic liver disease and cirrhosis
9	Pneumonitis due to solids and liquids
10	Influenza and pneumonia

Source: Washington State Department of Health, Center for Health Statistics

Health and well-being[2]

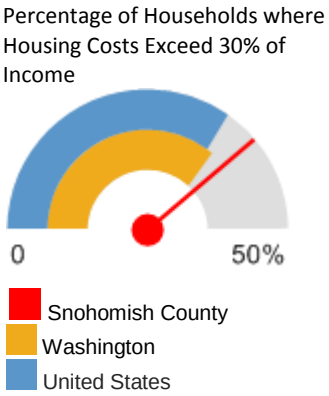
The following indicators are the social determinants of health which influences community health and well-being.

Housing cost burden (30 percent)

This indicator reports the percentage of the households where housing costs exceed 30 percent of total household income, and provides information on the cost of monthly housing expenses for owners and renters. A measure of housing affordability and excessive shelter costs is important anywhere in the Puget Sound area. The data also serves to inform the development of housing programs to meet the needs of people at different economic levels.

Report Area	Total Households	Cost Burdened Households (Housing Costs Exceed 30% of Income)	Percentage of Cost Burdened Households (Over 30% of Income)
Snohomish County	271,514	105,279	38.77%
Washington	2,645,396	962,508	36.38%
United States	116,211,096	40,509,856	34.86%

Data Source: US Census Bureau, American Community Survey. 2010-14. Source geography: Tract

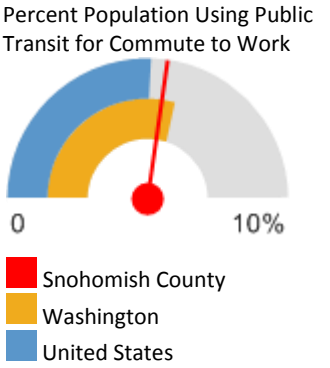


Use of public transportation

This indicator reports the percentage of population using public transportation as the primary means to commute to work. Public transportation includes buses or trolley buses, streetcars or trolley cars, subway or elevated rails, and ferries.

Report Area	Total Population Employed Age 16	Population Using Public Transit for Commute to Work	Percent Population Using Public Transit for Commute to Work
Snohomish County	354,718	19,379	5.46%
Washington	3,171,197	187,675	5.92%
United States	141,337,152	7,157,671	5.06%

Data Source: US Census Bureau, American Community Survey. 2010-14. Source geography: Tract

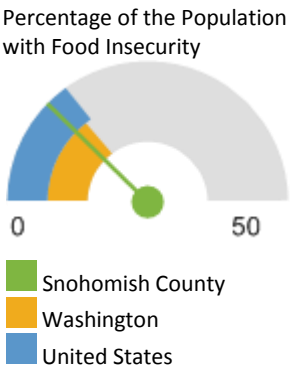


Food insecurity rate

This indicator reports the estimated percentage of the population that experienced food insecurity at some point during the report year. Food insecurity is the household-level economic and social condition of limited or uncertain access to adequate food.

Report Area	Total Population	Food Insecure Population, Total	Food Insecurity Rate
Snohomish County	724,627	89,520	12.35%
Washington	6,971,406	1,017,900	14.6%
United States	320,750,757	48,770,990	15.21%

Data Source: Feeding America. 2013. Source geography: County



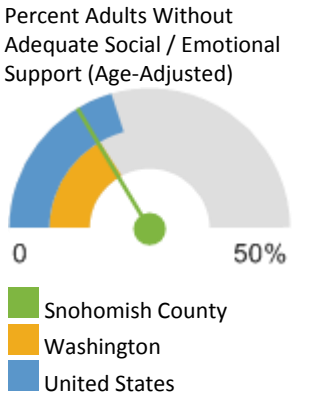
[2] Summary information and data source: Community Commons www.communitycommons.org

Lack of social or emotional support

This indicator reports the percentage of adults aged 18 and older who self-report that they receive insufficient social and emotional support all or most of the time. As a measure, it has relevancy because social and emotional support are vital for navigating the challenges of daily life as well as for good mental health. Social and emotional support are also linked to educational achievement and economic stability.

Report Area	Total Population Age 18	Estimated Population Without Adequate Social / Emotional Support	Crude %	Age-Adjusted Percentage
Snohomish County	531,332	87,670	16.5%	16.5%
Washington	5,083,627	854,049	16.8%	16.9%
United States	232,556,016	48,104,656	20.7%	20.7%

Data Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the Health Indicators Warehouse. US Department of Health Human Services, Health Indicators Warehouse. 2006-12. Source geography: County

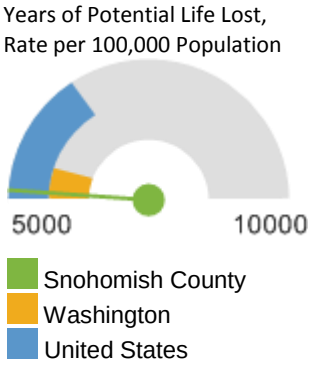


Premature death

This indicator reports years of potential life lost before age 75 per 100,000 population for all causes of death, age-adjusted to the 2000 standard. Years of potential life measures premature death and is calculated by subtracting the age of death from the 75-year benchmark. A measure of premature death can provide a unique and comprehensive look at overall health status and is relevant to individual and population health.

Report Area	Total Population Census 2010	Total Premature Deaths, 2011-2013 Average	Total Years of Potential Life Lost, 2011-2013 Average	Years of Potential Life Lost, Rate per 100,000 Population
Snohomish County	713,335	2,118	36,437	5,108
Washington	6,724,540	21,409	372,734	5,545
United States	312,732,537	1,119,700	20,584,925	6,588

Data Source: University of Wisconsin Population Health Institute, County Health Rankings. Centers for Disease Control and Prevention, National Vital Statistics System. Accessed via CDC WONDER. 2011-13. Source geography: County

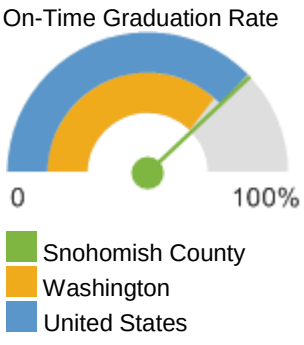


High school graduation rate (NCES)

Within the report area 75.9 percent of students are receiving their high school diploma within four years. This is less than the Healthy People 2020 target of 82.4 percent. This indicator is includes because research suggests education is one the strongest predictors of health (Freudenberg Ruglis, 2007).

Report Area	Average Freshman Base Enrollment	Estimated Number of Diplomas Issued	On-Time Graduation Rate
Snohomish County	8,951	6,794	75.9
Washington	85,123	62,764	73.7
United States	4,024,345	3,039,015	75.5
HP 2020 Target			> =82.4

Data Source: National Center for Education Statistics, NCES - Common Core of Data. 2008-09. Source geography: County

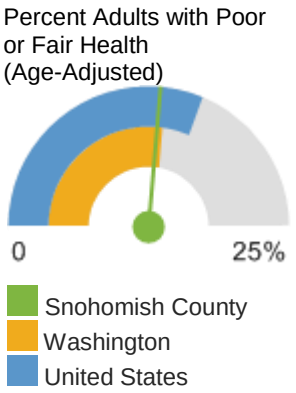


Poor general health

Within the report area 13 percent of adults age 18 and older self-report having poor or fair health in response to the question "Would you say that in general your health is excellent, very good, good, fair, or poor?" This indicator is relevant because it is a measure of general poor health status.

Report Area	Total Population Age 18	Estimated Population with Poor or Fair Health	Crude Percentage	Age-Adjusted Percentage
Snohomish County	531,332	69,073	13%	13.2%
Washington	5,083,627	706,624	13.9%	13.7%
United States	232,556,016	37,766,703	16.2%	15.7%

Data Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the Health Indicators Warehouse. US Department of Health Human Services, Health Indicators Warehouse. 2006-12.



Process, participants and data collection

This section provides a description of the processes and methods used to conduct the assessment; describes data and other information used; the methods of collecting and analyzing the information, and any parties with whom we collaborated with. This section also provides a summary of how we solicited input and took into account input received from persons who represent the broad interests of the community.

Assessment

As part of our Mission, every three years Providence Regional Medical Center Everett conducts a community health needs assessment and uses its findings to develop implementation strategies. The assessment is an evaluation of key health indicators of the Snohomish county community. The objectives of the CHNA are to understand and prioritize the greatest needs in our community and to determine how Providence is best positioned to respond to those needs

PRMCE utilized a three step approach to identify the significant health needs that Providence will address in this CHNA cycle. In the first phase, baseline data from the 2013 assessment was updated and evaluated based on the methodology adopted from the Snohomish Health District; comparing local data to state and national data as well as Healthy People 2020 goals; identifying negative trends in local data; and evaluating the size and seriousness of the problem. The second phase included evaluating the data based on the need for improvement, the disproportionate impact on sub-populations, and the level of community resources dedicated to improving the indicator. And finally, the third phase included a weighted scoring based on the linkage to our strategic plan, the amount of resources relative to community need, and the confidence in our ability to have an impact on the health issue. Throughout the process we utilized a framework that evaluated health and community need in a holistic framework that included social determinants of health, lifestyle choices, and clinical care.

Participants and methods of input

Part of our deep commitment to serve those who are poor and vulnerable includes collaborating with community partners, such as social service and government agencies, charitable foundations, community organizations, universities and many others, to identify the greatest unmet needs among the communities we serve. In the Snohomish County area, Providence is a member of various community-wide committees and groups that are working to increase the health of our communities. We express our sincere gratitude to those committee's as well as other participants who influenced the development of the community health needs assessment. Development of the plan requires input and guidance from a wide range of individuals and organizations. The community partners provide the public health perspective and the interests of members of medically underserved, low-income, and minority populations or individuals. These and other participants enable Providence to gather and evaluate information and input to help inform the community needs assessment. Appendix II includes a complete list of sources and participants.

CHNA Advisory Group

The Providence Northwest Washington senior leadership team, serving as the CHNA Advisory Group, has accountability for the ongoing planning, budgeting, and implementation of community benefit activities. The CHNA Advisory Group is tasked with completing key objectives outlined by the CHNA requirements, including the identification of health issues and prioritizing health needs within the community. The advisory group identifies community partners and stakeholders representing broad interests across the community who will have influence on or can offer guidance to the CHNA and the subsequent CHIP. Outcomes of the CHNA and implementation strategies are integrated into the overall strategic planning and budgeting process. The advisory group is co-led by the Providence Northwest Washington Region Chief Strategy Office and the Vice President for Mission Integration.

Providence Northwest Washington Region Community Ministry Board - Mission and Healthier Communities committee

The Providence Northwest Washington Regional Community Ministry Board serves as the governing body for PRMCE and represents a broad cross section of the community. The Mission and Healthier

Communities committee of the Board helps ensure that the Providence Mission, core values and vision are integrated throughout the northwest Washington region of Providence. The committee is responsible for recommending and overseeing policies and programs designed to enhance the health of our local community.

Providence Institute for a Healthier Community

The Institute is a partnership between Providence, business, government, healthcare providers, schools and other non-profits aimed at encouraging residents of Snohomish County to make small but important behavioral changes to improve their health. PIHC serves as the convener and facilitator by helping establish innovative community partnerships to support health and well-being. To date, the Institute has initiated four centers; center for health priority and progress, center for health education and healing, center for workforce health and productivity and center for community health transformation. Each center is represented by two co-chairs comprising of a Providence director and a community-based partner. Each center has additional participants who together reflect a broad representation of the community.

PIHC Focus Groups

The focus groups were jointly created by the Providence Institute for a Healthier Community, the University of Washington Bothell School of Nursing and Health Studies, Lutheran Community Service, and Elway Research, Inc. Throughout the summer and fall of 2015, 130 individuals participated in focus groups and listening sessions held at 12 separate locations. To ensure that we gave a voice to a representative cross section of Snohomish County, some participants were selected at random and some based on demographics. Participants were asked a series of questions about how they defined health and wellness; what optimal health and wellness looked like to them; what barriers they face to achieving good health; and what makes for a healthy community. In addition to informing the CHNA, these results will be incorporated with other survey data to produce the Health and Well-Being Monitor described below.

PIHC Community Health Summit

Sponsored by the Providence Institute for a Healthier Community, the Snohomish county “At the Edge of Amazing” community health summit brings together more than 450 members of the community, including social service and healthcare professionals, to learn about best practices from local, state and national experts. The 2015 inaugural session included participants setting a vision and priorities for a healthier future in Snohomish County. The 2016 session focused on community connections and identifying best practices that can be replicated in our community.

Snohomish County Health Leadership Coalition

Made up of leaders in healthcare, education, business and economic development, human services, non-profit organizations and the faith community, the Snohomish County Health Leadership Coalition leverages its leadership accountability and expertise to address the challenge of delivering sustainable healthcare. Through the Providence Institute for a Healthier Community, Providence in the Northwest Region, serves as the backbone administrative support to the coalition.

PIHC Survey - Health and Well-Being Monitor

A joint collaboration between Elway Research, Inc.; the School of Nursing and Health Studies at the University of Washington-Bothell; and the Providence Institute for a Healthier Community was formed to developed the first-ever, county-wide Health and Well-Being Monitor. The monitor defines and measures health through the eyes of Snohomish County residents. It is used to prioritize the health issues that are important to those who live and work within the region. The monitor assesses changes over time to inform project planning and decision-making, provides feedback on progress toward community health goals, and allows for a more informed and compassionate conversations around what it takes to improve health and well-being.

To develop the monitor, Snohomish County a sampling of over 1,000 residents were contacted through street interviews, newspaper polling, targeted focus groups in underserved populations, and a county-wide telephone and online survey. Participants were asked to measure 24 aspects of their health in six key areas identified as relevant by the community: security and basic needs; emotional and spiritual health;

work learning and growth; physical health; relationships and social connections; and neighborhood and environment. Respondents also self-reported their current state of overall health, physical health, mental/emotional health and life satisfaction/well-being. The results of the survey formed the basis for the Snohomish County Health and Well-Being Monitor. The initial report was used to inform the current CHNA. As the monitor moves into the next phase of development, it will provide a more robust set of data points to consider for future CHNA's and CHIP's.

Workplace Health and Productivity Initiative

To co-create local solutions to the impact of rising health care costs on employers (health insurance, medical costs, absenteeism, etc.), the Center for Workforce Health and Productivity at the Providence Institute for a Healthier Community partnered with the Economic Alliance of Snohomish County to launch the Snohomish County Workplace Health and Productivity initiative. As a first step PIHC and EASC worked with an econometrics firm and the Integrated Benefits Institute, a leading research organization in the field of workplace health and productivity, to produce an economic report showing the total burden of health on Snohomish County employers; an estimate of the current impact and potential gains; and an employer health costs benchmark report to leading Snohomish County employers. The results will form the basis for a series of professional forums aimed at delivering solutions that improve employee health.

Data collection

To conduct the assessment, data about the demographics and health factors of the community were analyzed to determine Providence's focus and plan to address the identified needs (see Appendix I for a comprehensive list of health indicators). In the process of selecting indicators, consideration was given to data characteristics which included the integrity of the data source and the availability of multi-year data to identify trends.

Local data sources

Local quantitative data sources, evaluations and reports were used as the first step in the assessment.

1. Providence Institute for a Healthier Community - Snohomish County Health and Well-Being Monitor
2. Snohomish County Human Services Low Income Needs Assessment
3. Providence Institute for a Healthier Community - Snohomish County Assessment of Health
4. Snohomish County Health District

State and national data sources

State and national data sources were used as the secondary data source. Where available, county-level data was compared to state and national indicators.

1. Community Commons (www.communitycommons.org)
2. Robert Wood Johnson County Health Rankings (www.countyhealthrankings.org)
3. United States Census Bureau (www.Census.gov/Snohomish County)
4. CDC National Center for Health Statistics (www.cdc.gov/nchs/)
5. CDC Behavioral Risk Factor Survey (www.cdc.gov/brfss)

Community and stakeholder input

In addition to the data sources listed above, community and stakeholder input was important to help ensure that the broad interests of the community were represented in the process, especially those members of medically underserved, low-income and minority populations. Community and stakeholder input opportunities were made available as follows:

1. PIHC focus groups
2. PIHC Snohomish County Survey of Health
3. Providence Northwest Washington Region Community Ministry Board – Mission and Healthier Communities committee members
4. PIHC Edge of Amazing Summit participants
5. Snohomish County Human Services - Low Income Community Needs Assessment

Prioritization process and criteria

The prioritization methodology for this community health needs assessment utilized a three step approach. See Appendix I for a complete list of health indicators and trends.

Phase I – Over 200 indicators were evaluated in Phase I of the process. These indicators were prioritized using a methodology adopted from the Snohomish Health District. Data was scored and prioritized by the CHNA Advisory Group using the following:

- Comparison to local, state and national data
- Trending (up/down)
- Comparison to goal (such as Healthy People 2020)
- Size and seriousness of problem

Phase II – Indicators from Phase I were grouped into three areas: health behaviors, health outcomes and social determinants of health. These groupings were used to ensure that Providence was evaluating the community more broadly than the traditional health behaviors and outcomes. Areas that were evaluated in this Phase II included:

Group	Indicator category
Health behavior	• Access to dental care • Access to primary care • Mammograms • Physical Activity • Pregnancy • Substance Abuse
Health outcomes	• Asthma • Cancer • Diabetes • Heart Disease • Mental health • Obesity
Social determinants of health	• Housing • Homelessness • Nutrition • Poverty • Transportation • Health insurance coverage

The data was then scored by the Providence Northwest Washington Region Community Ministry Board - Mission and Healthier Communities committee based on the following parameters.

- Need for improvement on indicator
- Disproportionate impact on sub populations
- Level of community resources dedicated to improving indicator

After the committee feedback was obtained, results were compared to feedback from participant-oriented sources such as the PIHC Health and Well-Being Index, PIHC focus groups and the Snohomish County Low Income Needs Assessment.

Phase III – The Northwest Washington Region senior leadership team and CHNA Advisory Group completed a survey to rate the indicators from Phase II. A weighted score was generated based on the response to the following:

- Linkage to the strategic plan
- Availability of resources relative to community need
- Confidence in Providence's ability to have an impact

The information from Phase III was reviewed by the senior leadership team to identify the significant health issues that Providence should address.

Identified priority health needs

This section describes the significant priority health needs that were identified during the CHNA. Potential resources in the community to address the significant health needs are also described in the section.

Identification of significant health needs

As a Mission-driven organization, we work hard to ensure that community benefit planning is guided by our core values and that our assessments reflect the real needs of the communities we serve. Each year many people of Providence bring this long time commitment to life. As the assessment is developed, the Providence Northwest Washington Region Community Ministry Board - Mission and Healthier Communities committee provides guidance to the CHNA Advisory Group and tracks progress against the CHIP. The Providence senior leadership team, serving as the CHNA Advisory Group, has accountability for the ongoing planning, budgeting, implementation and evaluation of community benefit activities. The Providence Northwest Washington Region Community Ministry Board adopts the final plan. Once we finalize the CHNA, its outcomes and CHIP implementation strategies are then integrated into our operational strategic planning and budgeting process.

There are a number of health needs in our community; however, due to lack of identified effective interventions, resource constraints, or absence of expertise, Providence cannot directly address all needs in a CHNA. Based on the prioritization analysis completed in Phase III described earlier, PRMCE chose three indicators as the significant focus for the 2017-2019 needs assessment and implementation plan:

- **Access to primary care**
- **Homelessness**
- **Substance abuse (opioid/illegal drug use)**

Given the scope of care we provided to our community, we will also have an indirect impact on other community needs through our ongoing work as engaged partners with community-led collaborative efforts. Additionally, several other Providence programs are designed to improve the health of our community in a variety of other areas.

PRMCE priority health need #1 – Access to primary care

Rationale:

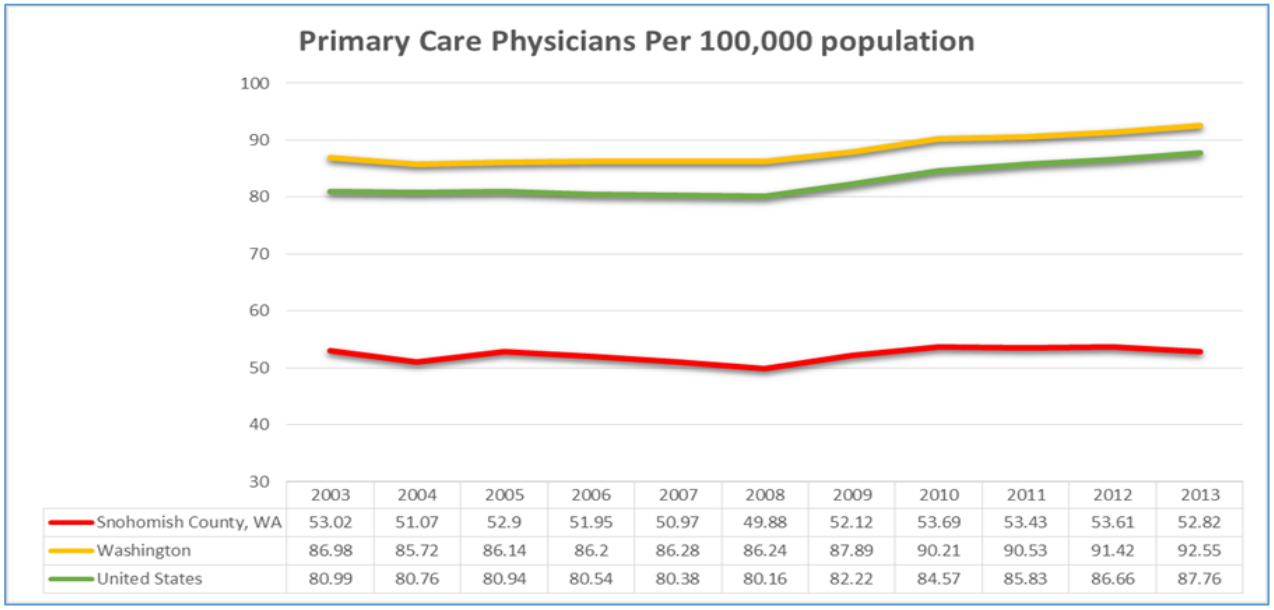
Access to primary care has always been a great challenge for the community. Lack of access disproportionately effects the poor and presents barriers to good health. Addressing these barriers will improve health in the community and will help people get the right care, at the right time, and in the right care setting. Individuals who have a primary care provider are more likely to receive preventive care, chronic disease management and medication management, all of which lead to better health outcomes. Those without access to a primary care provider may choose to receive care in an emergency department for non-emergent conditions because they feel they have nowhere else to go, or they defer care until an illness progresses. Because challenges persist, we are again addressing this indicator that was in our prior CHNA so that PRMCE can continue to focus on this barrier.

Indicators:

In Snohomish county, adults with at least one person they think of as their personal doctor or healthcare provider has decreased from 79.1 percent in 2011 to 75.9 percent in 2013. Additionally over the last ten years, the number of primary care physicians in the community has remained relatively unchanged. In 2013, Snohomish county had a primary care physician ratio of 1 physician per 1,932 residents, which is well below the State (1,190:1) and National (1,040:1) averages.

Indicator Description	Snohomish County			Washington State	United States	Healthy People Goal
	2011	2013	Trend	2013	2013	2020
Adults 18+ with at least one person they think of as their personal doctor or healthcare provider	79.1%	75.9%	Down	72.5%	76%	83.9%
Population per primary care provider	1949:1	1932:1	Down	1190:1	1040:1	NA
Primary care physicians per 100,000 population	53.69	52.82	Down	92.55	87.76	NA

Source: Robert Wood Johnson County Health rankings, CDC Behavior Risk Factor Surveillance System.



PRMCE priority health need #2 – Homelessness

Rationale:

Homelessness has a high negative impact on an individual's health status and homeless individuals are high users of medical systems. The Public Health Service Act[3] defines a homeless person as an individual without permanent housing who may live on the streets; stay in a shelter, mission, single room occupancy facility, abandoned building or vehicle; or in any other unstable or non-permanent situation. Stability of the family home aids in physical, mental and emotional health and healing. PRMCE has participated in many community efforts to directly address homelessness in addition to evaluation of solutions for health care services for the homeless population, and our intent is to expand efforts in this area.

Indicators:

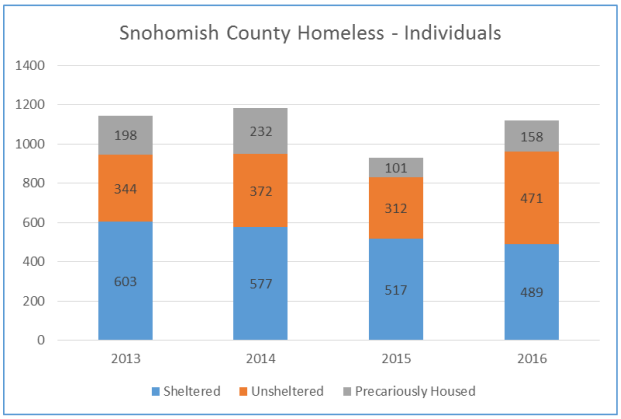
Accurate estimates of homelessness are difficult to obtain. However, based on an annual Snohomish County Point in Time field survey, the number of homeless in shelters or precariously housed has gone down while unsheltered has gone up. The January 2016 Point in Time count showed that 1,118 persons did not have a permanent place to stay.

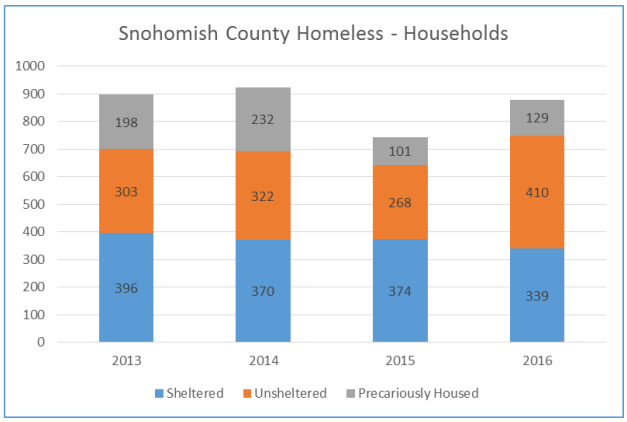
Indicator Description	Snohomish County		
	2014	2016	Trend
Unsheltered households	322	410	Up
Sheltered households	370	339	Down
Precariously housed households	198	129	Down
Unsheltered individuals	372	471	Up

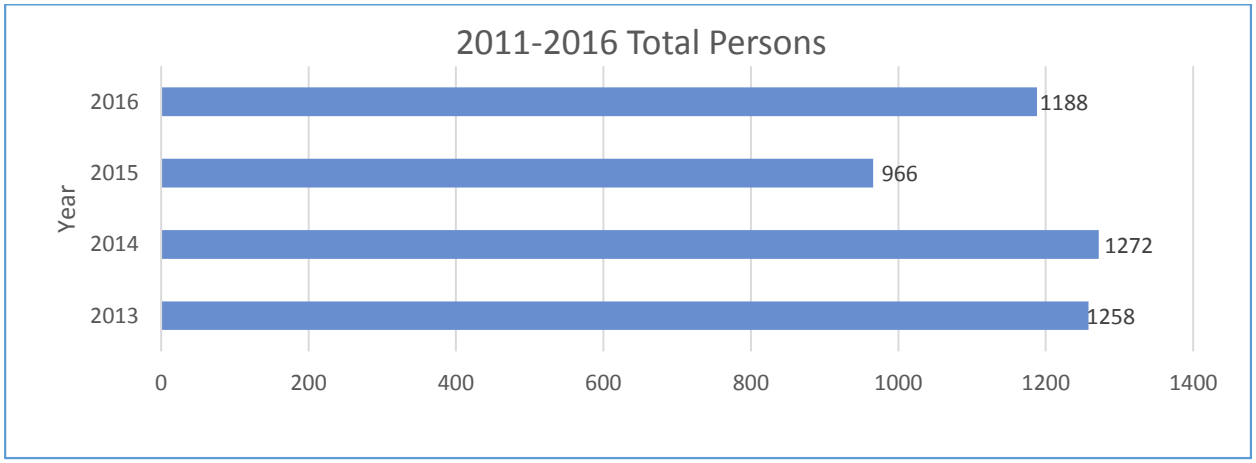
[3] Section 330, 41 U.S.C., 254b

Indicator Description	Snohomish County		
	2014	2016	Trend
Sheltered individuals	577	489	Down
Precariously housed individuals	232	158	Down
% of Population Unsheltered	0.049%	0.06%	Up

Source: Snohomish County 2016 Point in Time Survey







PRMCE priority health need #3 – Substance abuse (opioid/illegal drug use)

Rationale:

Substance abuse has a significant health and social impact on individuals and the community. Abuse of prescription opioids for pain – such as morphine, oxycodone, hydrocodone or fentanyl, or illegal drugs such as heroin - is a serious problem in Snohomish county.

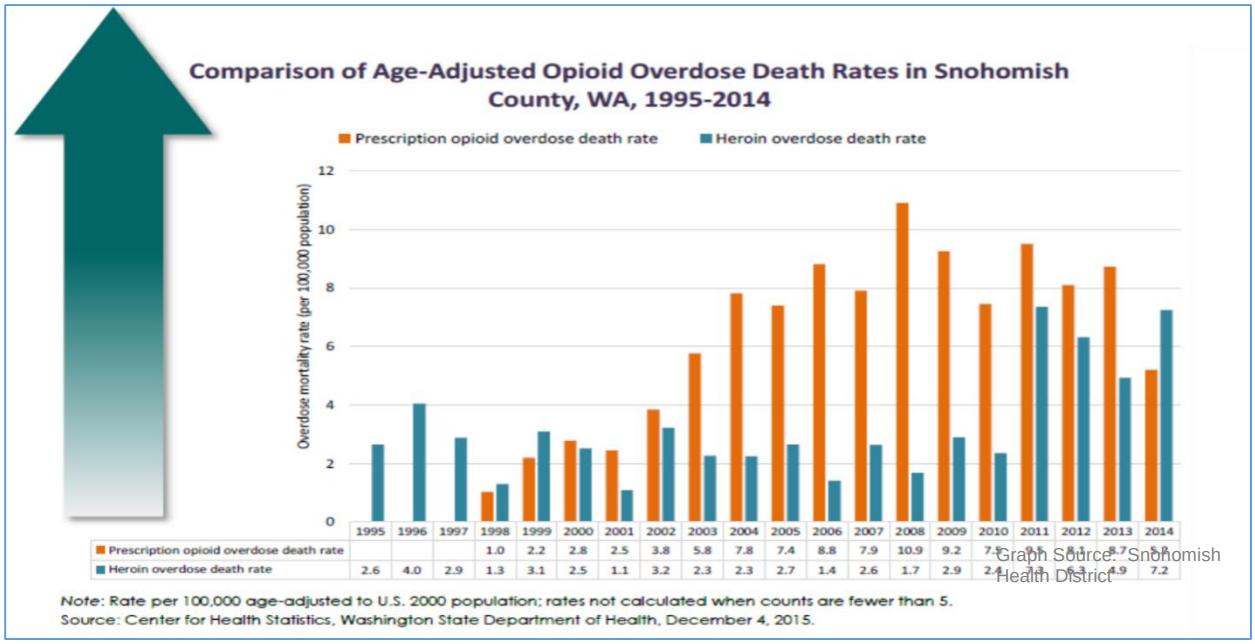
Indicators:

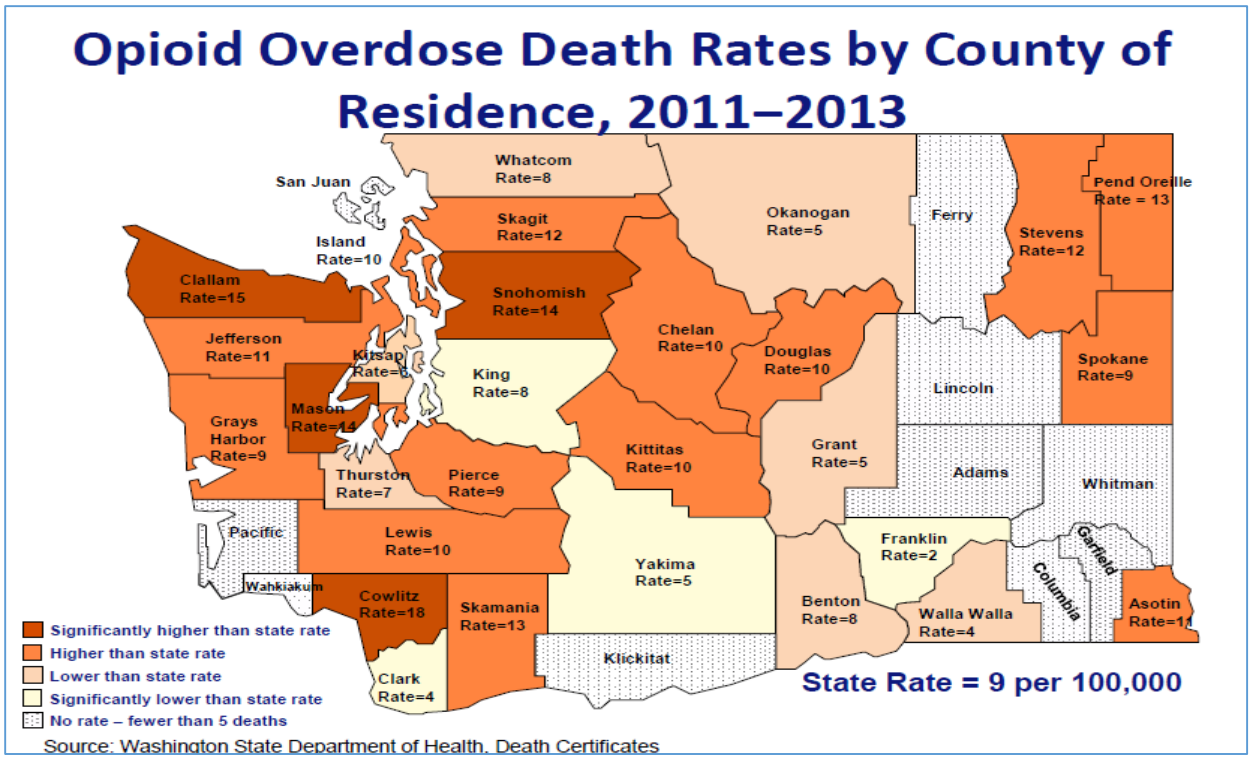
In Snohomish county, death from prescription opioid overdose per 100,000 population has been decreasing since 2005, but the heroin overdose death rate has been increasing significantly since 2008. In 2014, heroin overdose deaths exceeded prescription opioid overdose deaths.

Indicator Description	Snohomish County		Washington State	United States	
	2002-2004	2011-2013	Trend	2011-2013	2013
Mortality attributed to any opiate rate per 100,000 population	8.4	14.1	Up	8.6	9.0
	2010	2014	Trend	2014	2014
Prescription opioid mortality rate per 100,000 population	7.5	5.2	Down	5.5	5.9

Indicator Description	Snohomish County		Washington State	United States	
	2010	2014	Trend	2013	2013
Heroin overdose mortality rate per 100,000 population	2.4	7.2	Up	2.9	2.7

Source: Kaiser Family Foundation National Survey on Drug Use, Washington Department of Health, Center for Health Stats (http://www.doh.wa.gov/DataandStatisticalReports/VitalStatisticsData)





Evaluation of 2014-2016 CHIP

This section describes the activities that Providence participated in to address the significant health needs identified in the previous assessment as well as the results of those activities.

2014-2016 significant community health needs

The significant community health needs identified in the prior CHNA were:

1. Physical abuse (youth)
2. Obesity
3. Suicide
4. Dental (youth dental decay)
5. Primary Care Access – *Providence focus area*
6. Prenatal Care (first trimester) – *Providence focus area*

Providence identified access to primary care and first trimester prenatal care as the two areas that Providence focused on for the 2014-2016 plan. Providence collaborated with various Snohomish County partners to develop a community health improvement plan to address these two significant health needs. An overview follows that evaluates the CHIP and its impact on the identified needs.

PRMCE prioritized need #1 – Access to primary care

Goal

Increase the proportion of adult residents in Snohomish County who "have one person they think of as their personal doctor or health care provider" through tactics designed to:

1. Increase the number of new primary care providers
2. Retain existing primary care providers in the community
3. Increase awareness about primary care services available

Indicators

Indicator Description	Snohomish County			Washington State	United States	Healthy People Goal
	2011	2013	Trend	2013	2013	2020
Adults 18+ with at least one person they think of as their personal doctor or healthcare provider	79.1%	75.9%	Down	72.5%	76%	83.9%

Source: Robert Wood Johnson County Health rankings.

Subsidized programs and services

Providence provides subsidized programs and services as a regular part of our operations. These are clinical and social services provided by Providence despite a financial loss because they meet an identified Snohomish County need that is not met elsewhere in the community. Programs and services that address access to primary care include:

- Providence Everett Healthcare Clinic: PEHC was designed to provide free or discounted primary care to low-income or uninsured patients. The clinic also serves as a training site for nursing students.

- Primary care for refugees: Many refugees in Snohomish County face challenges as they settle into a new community, including access to primary care. PEHC partnered with the Snohomish Health District to provide primary care and immunizations to the refugee population.

- Patient services representatives and in-person assisters: Patient service representatives initiate financial assistance paperwork and care coordinators directly assist qualified patients with obtaining health insurance.

Other Providence programs and services

Providence also operates programs and provides services that meet community needs, but are not categorized as "subsidized" or as "community benefit" by IRS definition because no unreimbursed costs are incurred in the delivery of the service. These programs and services improve health outcomes, and those that address access to primary care include:

- Emergency Department Social Work program for primary care: The emergency department social workers help patients who have multiple emergency department visits to establish a primary care so patients develop a relationship for continuing care and know what to expect from a primary care provider.

- STARCare: The Providence Medical Group care management team promotes access to primary care through preventive outreach, intensive care management and check-ins with patients who have recently visited the hospital or emergency department and did not have a primary care provider.

- Medicare annual wellness visit: Providence Medical Group provides extensive wellness visits for new Medicare patients to develop a personalized plan to prevent disease and address chronic conditions.

- Tele-health: PMG offers various tele-health applications for the community to download to a smartphone, other mobile device, or a computer. One such product is Health eXpress which is live video or audio access to primary care services. Tele-health solutions are designed to make primary health care convenient and easy to access.

- In-home primary care: PMG implemented an in-home primary care practice model in order to serve home bound primary care patients.

- Providence Medical Group primary care services: To serve more of the community population, PMG expanded primary care capacity by enlarging clinic space in Monroe, North Everett and Mill Creek and recruited additional providers to the community.

- Educational material: Brochures and other information are available in the emergency department and at community health fairs to educate the community on the value of connecting with a primary care provider and the advantages of receiving care in the most appropriate setting.

- Tulalip Health Clinic: Providence partners with the Tulalip Tribes to manage the tribal health clinic and provision the Epic integrated electronic health record. This effort directly relates to our desire to expand access to primary care, which is low within the Native American communities. This also allows for clinical integration with Providence specialists, the emergency department, and inpatient care settings to help reduce utilization and transition patients back to a Tulalip Health Clinic primary care provider.

- Health education training: Washington State University partnered with PRMCE to utilize the hospital as a training site for new medical students enrolled at the WSU Everett campus. Additionally, PRMCE will serve as the inpatient training site for the SeaMar Community Health Center primary care residency program.

Investment funding support

Often there are organizations that provide services in Snohomish County that address community needs. As good stewards of our own and others' resources, Providence is careful not to duplicate services and instead partners with these organizations to ensure Snohomish County needs are served. Providence makes community investments and offers funding support to organizations known to have ongoing, positive community outcomes. Some of the organizations or events that Providence has provided funding to in

order to increase the awareness about the importance of primary care include: Project Access Northwest, Compass Health, Lutheran Community Services – Familias Unidas, Ubuntu Expose and Senior Services of Snohomish County.

PRMCE prioritized need #2 – First trimester prenatal care

Goal:

Increase the proportion of female residents in Snohomish County who obtain prenatal care in the first trimester by increasing awareness through education and outreach. Engaging in early prenatal care decreases the likelihood of maternal and infant health risks. The number of pregnant women who received first trimester prenatal care increased only slightly from the previous CHNA and is just below the Healthy People 2020 goal.

Indicators:

Indicator Description	Snohomish County			Washington State	United States	Healthy People Goal
	2010	2014	Trend	2014	2003	2020
Pregnant women receiving prenatal care in the first trimester	79.5%	79.6%	No Change	80.1%	77.9%	77.9%

Source: CDC National Center for Health Statistics

Subsidized programs and services

Providence provides subsidized programs and services as a regular part of our operations. These are clinical and social services provided by Providence despite a financial loss because they meet an identified Snohomish County need that is not met elsewhere in the community. Programs and services that address access to prenatal care include:

- Providence Midwifery Clinic: This clinic provides comprehensive prenatal care to the community with a focus on the underserved. The clinic was expanded in order to serve a larger portion of the community.

Other Providence programs and services that benefit the community

Providence also provides programs and provides services that meet community needs, but are not categorized as “subsidized” or as “community benefit” by IRS definition because no unreimbursed costs are incurred in the delivery of the service. These programs and services improve health outcomes, and those that address access to prenatal care include:

- Midwifery education: Developed an educational brochure for patients that focuses on the benefits and need for first trimester prenatal care, including screenings to identify babies or mothers at risk for complications, outcomes associated with women who receive prenatal care, and the long-term impact of adverse birth outcomes on a child’s health.

- Circle by Providence: Circle is an application available at no cost that can be downloaded to a smartphone or table. It provides access to a vast network of resources and tools from early pregnancy through baby’s first year, including a checklist to guide expectant mothers through the early stages of pregnancy.

- Centering Pregnancy: Providence Medical Group offers group-based prenatal care, incorporating patient assessment, support and education. It provides patients the opportunity to spend time with their provider while learning from other pregnant women at the same time. Research shows that women in group based prenatal care programs are happier and have healthier babies.

- Community events and educational material: Providence hosts many community events and provides educational materials promoting the importance of first trimester prenatal care. These events have included the Mill Creek Festival, Aquasox Healthier Community Day and Healthy Baby.

- Social media campaign: Providence developed and ran a prenatal care campaign specifically to target younger females that use Facebook and Twitter to educate them about the benefits of first trimester prenatal care.

- Education: PRMCE and PMG offer various educational classes geared to support pregnancy, birth and family education. Classes focus on early prenatal care, how to determine signs of pregnancy and wellness care processes to help prepare and educate women for timely entry into prenatal care before pregnancy.

- Labor and delivery Services: PRMCE labor and delivery services are provided to help women in our community have healthy pregnancies and births. The Maternal Fetal Medicine Program provides specialized services for evaluation of high-risk pregnancies.

Investment funding support

Often there are organizations that provide services in Snohomish County that address community needs. As good stewards of our own and others' resources, Providence is careful not to duplicate services and instead partners with these organizations to ensure Snohomish County needs are served. Providence makes community investments and offers funding support to organizations known to have ongoing, positive community outcomes. Some of the organizations or events that Providence has provided funding to in order to increase awareness of the importance of prenatal care include Aquasox Healthier Communities Day, March of Dimes and Stanwood Camano Island Women's Expo.

Addressing 2017-2019 identifed needs

This section describes how Providence will develop and adopt an implementation strategy (i.e. community health improvement plan) to address the prioritized community needs and how to identify other community resources.

Plan development

Providence in Northwest Washington created the Institute for a Healthier Community as a resource to promote health and well-being in Snohomish County. Through the Institute, Providence assumes a greater role in community health, well beyond the delivery of health care services. PIHC serves as a bridge between the healthcare system and the community, promoting innovative partnerships both upstream and downstream of conventional health care, helping our community define health and well-being. PIHC affects health behavior changes through partnerships that focus on four core areas:

- **Center for Health Priority and Progress (Aim Well)** is dedicated to developing initiatives to promote a community based view of vibrant health and well-being. A health and well-being monitor is the first step towards this goal. Residents help create the monitor by defining what health means and what measurements are important through focus groups and surveys to create a shared community voice.

- **Center for Health Education and Healing (Live Well)** is focused on making health resources, such as curricula, tools and professional education, more accessible to Snohomish County residents to improve health literacy.

- **Center for Workforce Health and Productivity (Work Well)** is committed to working with employers who want to increase productivity and build competitive advantage through a healthier work place and workforce. By providing wellness tools, resources, and forums to share best practices, the center will help support desired outcomes.

- **Center for Community Health Transformation (Partner Well)** is devoted to establishing population health initiatives based on collective impact or collaboration models through innovative community partnerships. This includes the LiveHealthy2020 initiative of the Snohomish County Health Leadership Coalition in which 130 signatories from an array of sectors (non-profit organizations, businesses, health care providers, schools, etc.) are collaborating to create a shared health agenda to improve activity, nutrition, mental and emotional well-being and civic health.

PRMCE and the Institute will consider the prioritized health needs identified through this community health needs assessment and develop strategies to address those needs. The full plan will be documented in a community health improvement plan. The CHIP will describe the actions Providence intends to take, and the resources that the hospital intends to commit to address each of the three health needs and the anticipated impact of these actions. Because partnership is important to addressing health needs, the CHIP will also describe any planned collaboration between Providence and other facilities or organizations in responding to the health need.

Resources available

Providence and community partners cannot address the significant Snohomish county health needs independently. Improving Snohomish County health requires collaboration across many stakeholders. To that end, Snohomish County has tremendous health care assets that, working together, can make tangible, measureable differences in our community. PIHC and its LiveWell Center partnered with North Sound 211 to connect people with a clearinghouse to enable users to more easily find and access health and well-being information and tools, and connect with the many community assets in Snohomish county. The

database called LiveWellLocal™[4] provides opportunities for individuals to connect with a wide range of local resources that support wellness and enhance quality of life for individuals, families and communities in Snohomish County.

Next steps

The CHNA Advisory Group will evaluate potential partnerships and programs to align them where possible with the significant needs identified for our community. The community health improvement plan will be finalized no later than the 15th day of the fifth month following completion of the CHNA. When complete, the CHIP will be attached to this community health needs assessment report as Appendix III.

[4]https://www.resourcehouse.info/providence/SpecialTopics/LiveWell

2017 - 2019 CHNA approval

This Snohomish County health needs assessment was adopted on November 17, 2016 by the Providence Northwest Washington Community Ministry Board. The final report was made widely available[5] on December 31, 2016.

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To provide comments or request a copy of our current and previous community health needs assessments visit or write to the address above or view electronic copies of the documents at www.communitybenefit.providence.org/community-health-needs-assessments/.

[5] Per § 1.501(r)-3 IRS Requirements

Appendices

Appendix I – Health indicators and trends

Health Behaviors

Category	Indicator Description	Snohomish County	WA State	United States	Local Trend	Source* See below
Dental Care	10th grade students have been to the dentist in the past year (2014)	78.70%	79.00%	NA	Up	8
Dental Care	Adults visited dentist or dental clinic in past year (2012)	69.22%	67.68%	67.20%	No change	5
Primary Care	Adults 18+ with at least one person they think of as their personal doctor or healthcare provider (2013)	75.9%	72.5%	76.0%	Down	5
Primary Care	Adults with routine medical check-up in past year (2013)	56.93%	61.62%	68.20%	Down	5
Primary Care	Adults who did not see a provider in the past year due to cost (2013)	16.3%	15.5%	15.3%	Up	5
Screening	Adults age 50+ had colonoscopy or sigmoidoscopy (2013)	72%	71%	61%	Up	5
Screening	Women age 50+ who have had mammogram in past 2 years (2013)	82.3%	77.5%	77%	Up	5
Screening	Women age18+ with pap test in past three years (2006-2012)	75.9%	75.4%	78.5%	Not Available	1
Nutrition	Adults 18+ consuming less than 5 servings of fruits and vegetables per day	75.0%	74.6%	75.7%	Not Available	1
Physical Activity	Population with Access to adequate exercise opportunities (2014)	95.0%	88.0%	91.0% (Top US performers)	Not Available	2
Physical Activity	Adults 20+ who report no leisure time for physical activity (2012)	19.10%	18.00%	20% (Top US performers)	Up	2
Physical Activity	Percent of adults physically inactive (2013)	17.5%	16.8%	21.8%	Down	1
Pregnancy	Pregnant women receiving prenatal care in the first trimester (2014)	79.55%	80.09%	77.99%	No Change	4
Pregnancy	Pregnant women who smoke during pregnancy (2014)	7.82%	9.57%	5.91%	Down	10
Pregnancy	Teen pregnancy rate (age 15-17yrs) per 1,000 population (2014)	11.27	13.34	26.5	Down	10
Substance Abuse- Alcohol	Adults who focus on binge-drinking (2013)	15.94%	16.83%	16.80%	Down	5
Substance Abuse- Alcohol	Adults who report heavy-drinking (2013)	4.6%	6.6%	6.2%	Down	5
Substance Abuse- Alcohol	Alcohol use among 10th grade students in the past 30 days (2014)	18.7%	20.6%	23.5%	Down	8
Substance Abuse – Drug	Mortality attributed to any opiate rate per 100,000 population (2011-2013)	14.1	8.6	9.0	Up	10
Substance Abuse - Drug	Prescription opioid mortality rate per 100,000 population, age adjusted (2014)	5.2	5.0	3.8	Down	10
Substance Abuse- Drug	Heroin overdose mortality rate per 100,000 population, age adjusted (2014)	7.2	2.9	3.4	Up	10
Substance Abuse-Drug	Illegal drug use among 10th graders (excluding Marijuana) in past 30 days (2014)	4.2%	4.4%	5.6%	Down	8
Substance Abuse- Smoking	Adults who are current smokers (2013)	17.3%	16.0%	19.0%	Up	5
Substance Abuse–Smoking	Marijuana use among 10th graders (in the past 30 days) (2014)	16.00%	18.10%	23.50%	Not Available	8

Health Outcomes

Category	Indicator Description	Snohomish County	WA State	United States	Local Trend	Source* See below
Asthma	Adults 18+ who have ever been told by a doctor they had asthma (2013)	16.1%	15.8%	14.1%	No Change	5
Birth	Infant mortality per 100,000 population (2013 – 2014)	3.57	4.54	6	Down	4
Birth	Percent of live births with low birth weight (2014)	6.12%	6.44%	9.43%	Up	4
Birth	Percent of births that are premature (2014)	9.22%	9.49%	11.39%	Up	10
Cancer	Cancer incidence per 100,000 females (adjusted) – Breast (2012)	176.5	171.8	129.6	Up	7
Cancer	Cancer incidence per 100,000 females (adjusted) – Cervical (2013)	6.6	6.9	7.6	Not Available	1
Cancer	Cancer incidence per 100,000 population (adjusted) – Lung and Bronchus (2012)	56.42	59.69	54.48	Down	7
Cancer	Cancer incidence per 100,000 population – Prostate (2012)	125.02	110.93	114.14	Down	7
Cancer	Cancer incidence per 100,000 population – Colon and Rectal (2012)	41.07	36.49	38.51	Down	7
Diabetes	10th grade students who were ever told they had diabetes (2014)	3.3%	3.2%	NA	Down	8
Diabetes	Adults 20+ who have ever been told by doctor they have diabetes (2013)	9.6%	8.5%	9.7%	Up	5
Heart Disease	Adults 18+ who have ever been told by doctor they have high cholesterol (2012)	42.1%	39.7%	38.5%	Not Available	1
Heart Disease	Adults 18+ who have ever been told by a doctor they have coronary heart disease or angina (2012)	3.60%	3.80%	4.40%	Not Available	1
Heart Disease	Adults 18+ who have ever been told by a doctor they have high blood pressure or hypertension (2010)	28.6%	27.0%	28.2%	Not Available	1
Heart Disease	Death due to coronary heart disease per 100,000 population (2014)	140.8	141.8	171.8	Not Available	1
Heart Disease	Deaths due to cerebrovascular disease (stroke) per 100,000 population	35.1	35.4	37.3	Not Available	1
HIV	Rate of HIV per 100,000 population (2010)	114.73	196.47	353.16	Down	1
HIV	Rate of new HIV cases, per 100,000 (2014)	4.9	6.4	15	Down	4
Injury	Motor vehicle injury hospitalization rate, per 100,000 population (2014)	44.29	44.2	44.25	Up	9
Injury - Mortality	Unintentional injury (accident) mortality rate per 100,000 population (2014)	44.0	42.9	39.4	Up	10
Injury - Mortality	Motor-vehicle mortality rate per 100,000 population (2013 – 2014)	5.35	7.57	11.5	Up	4
Life Expectancy	Life expectancy at birth (2010 – 2014)	80.34	80.4	78.7	No Change	4
Mental Health - Depression	10th grade students feeling sad or hopeless / depression (2013-2014)	36.30%	34.90%	29.40%	Up	8
Mental Health - Suicide	10th grade students seriously considering suicide in past year (2013-2014)	21.20%	20.50%	17.30%	Up	8
Mental Health - Suicide	6th grade students seriously considering suicide in past year (2014)	16.20%	15.00%	NA	Up	8
Mental Health - Suicide	Death due to intentional self-harm (suicide) per 100,000 population (2013-2014)	16.29	13.53	19.52	Up	10
Mental Health	Adults receiving needed emotional support only sometimes, rarely or never (2012)	25.13	22.79	20.70%	NA	5
Poor Health	Adults reporting good, very good, or excellent health (2013)	81.76%	84.27%	83.10%	Down	5

Category	Indicator Description	Snohomish County	WA State	United States	Local Trend	Source* See below
Poor Health	Adults reporting 14 or more days per month where poor health interferes with normal activities (2013)	13.84%	14.74%	NA	Down	5
Pertussis	Pertussis, rate per 100,000 population (2013-2014)	3.37	8.61	9.1	Down	4
STD	Chlamydia cases per 100,000 population female ages 15-24 (2013)	2117.3	2717.6	3340.8	No Change	4
STD	Gonorrhea rate per 100,000 population (2013-2014)	56.97	88.06	102.38	Up	4
STD	Syphilis rate per 100,000 population (2013-2014)	3.51	4.71	5.53	Up	4
Weight	Adults who are overweight, but not obese (BMI=25-29.9) (2013)	36.12%	34.28%	35.4%	Down	5
Weight	Adults who are obese (BMI>/= 30.0) (2013)	27.51%	27.14%	29.4%	Up	5

Social Determinants of Health

Category	Indicator Description	Snohomish County	WA State	United States	Local Trend	Source*See below
Education	Students receiving high school diploma within 4 years. (2014)	75.9%	73.7%	75.5%	Not Available	1
Education	Population age 25 years and older without a high school diploma or equivalent (2014)	8.71%	9.82%	13.7%		1
Housing	Occupied housing units with one or more substandard conditions (2010-2014)	38.4%	36.8%	35.6%	Not Available	1
Housing	Housing units that are vacant (2010-2014)	6.9%	9.5%	12.5%	Not Available	1
Housing	Percent of households spending >30% of income on housing (2010-2014	38.8%	36.4%	34.9%	Not Available	1
Homeless	Total Persons in emergency shelter, transitional housing, precarious housing and unsheltered situations (2016)	1,188	NA	NA	Up	6
Homeless	Total households in emergency shelter, transitional housing, precarious housing and unsheltered situations (2016)	878	NA	NA	Up	6
Household Income	Mean household income (2014)	$83,440	$79,195	$74,596	Up	3
Nutrition	Children Eligible for Free/Reduced Price Lunch(2013-2014)	38.3$	46.3%	52.35%	Up	1
Nutrition	Percentage of total population experiencing food insecurity but are ineligible for State or Federal nutrition assistance.	40%	31%	29%	Not Available	1
Nutrition	Percent of restaurants that are fast-food establishments (2010)	51%	46%	27% (Top US performers)	Down	2
Nutrition	Low income population that do not live close to grocery store (2007 -2010)	3.00%	5.00%	1% (Top US performers)	No change	2
Poverty	Population living at or below 100% Federal Poverty Line (2014)	10.3%	13.5%	15.6%	Up	3
Poverty	Children (<18y/o) living below 100% Federal Poverty Line (2014)	14.0%	18.1%	21.9%	Up	3
Provider - Dental	Population per dental provider (2014)	1507:1	1290:1	1340:1 (Top US performers)	No Change	2
Provider - Mental Health	Population per Mental health care provider (2015)	413:1	380:1	370:1 (Top US performers)	No Change	2
Provider - Primary Care	Population per Primary Care provider (2013)	1932:1	1190:1	1040:1 (Top US performers)	No Change	2
Transportation	Households with no motor vehicle	4.9%	6.9%	9.1%	Not Available	1

Category	Indicator Description	Snohomish County	WA State	United States	Local Trend	Source*See below
Transportation	Percentage of population using Public Transportation as primary means to commute to work	5.5%	5.9%	5.1%	No Available	1
Uninsured	Uninsured (2014)	12.2%	12.9%	14.2$	No Change	3
Uninsured	Percent of adults 65+ years uninsured (2013)	2.37%	1.65%	1.40%	Up	5
Uninsured	Percent of adults 18-64 years uninsured (2013)	16.95%	20.54%	20%	Down	5
Uninsured	Percent under 18 years uninsured (2012)	4.36%	6.73%	8.1%	Down	5

1. Community Commons (www.communitycommons.org)
2. Robert Wood Johnson County Health Rankings (www.countyhealthrankings.org)
3. United States Census Bureau (www.Census.gov/Snohomish County)
4. CDC National Center for Health Statistics (www.cdc.gov/nchs/)
5. CDC Behavioral Risk Factor Survey (http://www.cdc.gov/brfss/brfssprevalence)
6. Snohomish County Point In Time Survey (https://snohomishcountywa.gov/documentcenter/view/34385)
7. National Cancer Institute SEER Program (http://seer.cancer.gov/faststats)
8. Healthy Youth Survey (http://www.doh.wa.gov/DataandStatisticalReports/DataSystems/HealthyYouthSurvey)
9. Washington State Hospital Discharge Data (CHARS)
10. Washington Dept.of Health, Center for Health Stats (http://www.doh.wa.gov/DataandStatisticalReports/VitalStatisticsData)

Other sources of data

Name	Source / Link
Snohomish County Health and Well Being Monitor	http://www.pihcsnohomish.org/aimwell/health-monitor/
Snohomish County Workplace and Productivity Initiative	http://www.pihcsnohomish.org/workwell/workplace-health/
Snohomish County Human Services – Snohomish County Low Income Community Needs Assessment	http://snohomishcountywa.gov/DocumentCenter/View/32779

Appendix II – Summary of community input

Information, surveys or feedback from the following individuals and organizations were used to inform the community health needs assessment.

Name	Description	Participant Description
Providence Institute for a Healthier Community	PIHC is a partnership between Providence, business, government, healthcare providers, schools and other non-profits aimed at encouraging residents of Snohomish County to make small but important behavioral changes to improve their health. PIHC serves as the convener and facilitator by helping establish innovative community partnerships to support health and well-being.	Representatives and center co-chairs: 1. Center for Health Priority and Progress – AimWell • Janine Holbrook, PRMCE nursing administration • Jody Early, Ph.D., associate professor, UW Bothell School of Nursing 2. Center for Health Education and Healing – LiveWell • Kevin Clay, M.D., family practice, PRMCE chief of ambulatory services 3. Center for Community Health Transformation – PartnerWell • Julie Zarn, PRMCE director of emergency, trauma and urgent care • Ken Roberts, vice dean, academic and community partnerships, Washington State University Medical School 4. Center for Workplace Health – WorkWell • Jim Stephanson, Snohomish County Economic Alliance • Darren Redick, PRMCE vice president support services Other participants in the Institute include • The Boeing Company • Boys & Girls Clubs • Coastal Community Bank • Cocoon House • Community Foundation of Snohomish County • Elway Research • Everett Community College • Integrated Benefits Institute • Providence General Foundation • Snohomish Health District • The Herald, Sound Publishing • Tulalip Tribes • United Way Snohomish County • WSU North Puget Sound • YMCA Snohomish County
CHNA Advisory Group	In Northwest Washington, the Providence senior leadership team serves as the CHNA Advisory group with accountability for the ongoing planning, budgeting, and implementation of community benefit activities. Outcomes of the CHNA and CHIP are integrated into the overall strategic planning and budgeting process. The advisory group is co-led by the region's chief strategy office and itsvice president for Mission.	Members of the NWR Senior Leadership Team and the CHNA Advisory Group include: • Darren Redick, vice president support services • DeAnne Okazaki, manager strategic services • Diane Torrance, director executive and community relations • Hiral Das, University of Washington, MHA candidate • Joanne Roberts M.D., chief medical officer • John Brozovich, vice president Mission and spiritual care (co-owner) • Kathleen Groen, human resources director • Kim Williams, chief operating officer • Liga Z Mezarups, chief nursing officer • Lori Kloes, executive director, PG foundation • Michael Langford, senior director, finance

Name	Description	Participant Description
		• Mitesh Parikh, vice president service line development • Preston Simmons, chief executive officer • Rebekah Couper-Noles, vice president operations, Providence Medical Group • Thomas Yetman M.D., chief executive, Providence Medical Group • Tom Brennen, chief strategy officer (co-owner)
Providence Northwest Washington Community Ministry Board - Mission and Healthier Community committee	The Committee meets every other month with the goal of assuring the Providence Mission, Core Values and Vision are integrated throughout the organization. The committee is responsible for recommending and overseeing policies and programs designed to enhance the health of our local community.	Members of the Board Mission and Healthier Community committee include: • Bob Leach, D.A. Davison • Carol Whitehead, Everett School District • David Allen, UW Bothell School of Nursing • DeAnne Okazaki, Providence Regional Medical Center Everett • Dora Alcorta, outreach, St. Mary Magdalen Church • Bob Downey, retired fire chief • Bob Drewel, retired Snohomish County executive • Bob Farrell, Community Health Center, community member • Gail Larson, retired hospital executive, community member • Kim Williams, Providence Regional Medical Center • Maribeth Carson, SP, Sisters of Providence, Mother Joseph Province • Michael Sullivan, retired hospital executive, community member • Preston Simmons, Providence Regional Medical Center Everett • Scott Forslund, Providence Institute for a Healthier Community • Steve Schmutz, Archbishop Murphy High School • Susan Reis, MD, physician, community member • Susie Borovina, Providence Medical Group, community member • Tom Brennan, Providence Regional Medical Center
Snohomish County Health Leadership Coalition	The Snohomish County Health Leadership Coalition leverages its leadership accountability and expertise to address the challenge of delivering sustainable healthcare. Through the Providence Institute for a Healthier Community, Providence in the Northwest Region, serves as the backbone administrative support to the coalition.	The following organizations are represented on the Snohomish County Health Leadership Coalition: • The Boeing Company • Boys & Girls Club of Snohomish County • City of Mukilteo • County Executive, Snohomish County • Economic Alliance Snohomish County • The Everett Clinic • Everett Public Schools • Leadership Snohomish County • Premera Blue Cross • Providence Medical Group • Providence Regional Medical Center Everett • Senior Services of Snohomish County • SNO-Isle Public Library • Snohomish Health District • Sound Publishing • Tulalip Tribes • United Way of Snohomish County • Verdant Health Commission • WSU Medical School • WSU North Puget Sound • YMCA of Snohomish County

Name	Description	Participant Description
PIHC focus groups	The focus groups were created jointly by Providence, the University of Washington Bothell, Lutheran Community Service, and Elway Research, Inc. Throughout the summer and fall of 2015, focus groups and listening sessions consisting of 130 individuals at 12 separate locations were conducted so that we could understand how people feel about health and wellness. Participants were selected partly at random and partly based on demographics to ensure that we gave a voice to a representative cross section of Snohomish County.	The demographics and composition of the focus groups include: 1. Commitment Focus Group • Everett North: Income >$65,000 • Everett South: Income <$65,000 • Arlington: Age group: 25-45 years old • Monroe: Age group 45-65 years old 2. Community-based Participatory Structured Listening Session • Everett: College youth, ethnic minority groups • Everett: Adults living in low income or transitional housing • Everett: Latina mothers, non-native to U.S. • Lynnwood: Latina females, lay health workers/promoters • Lake Stevens: Low income females, mixed ethnicities • Granite Falls: Caucasian, middle age, lower income • Arlington: Senior citizens, Caucasian, female, lower income • Marysville Native Americans, Tulalip Tribes
PIHC Edge of Amazing	Sponsored by PIHC, the Edge of Amazing is a once a year, one day event designed to bring together more than 450 members of the community, social services and healthcare professionals to learn best practices from local, state and national experts. In the 2015 inaugural session participants laid out a vision and priorities for a healthier future in Snohomish County. The 2016 session focused on community connections and identifying best practices that can be replicated in our community.	Due to the number of participants (450+) in the sessions, a full listing is not provided. Representative sectors of the community include: • Housing • Food/nutrition • Education • Social justice • Transportation • Tribal • Health advocacy • Workforce • Domestic violence • Civic leadership • Non-profit organizations • Local and state government • Small businesses • Healthcare providers • Youth • Seniors
PIHC survey	Street interviews, photo sharing, newspaper polling, telephone and online surveys were conducted to measure 23 aspects of health in six key areas identified as relevant by the community: security and basic needs; emotional and spiritual health; work learning and growth; physical health; relationships and social connections; and neighborhood and environment.	To reach a representative audience within the community, we partnered with a cross-section of local organizations to create the report and gather data. Through the partnerships, we were able to reach a wide sampling of over 1,000 residents. Due to the number of participants in the survey, a full listing is not provided. Individuals were selected at random. Community partners included: • Boys & Girls Clubs • Everett Community College • Housing Hope • Lutheran Community Services • Seattle City Club • Snohomish County Human Services • Snohomish Health District • The Everett Herald • Tulalip Tribes • University of Washington - Bothell • Verdant Health Commission

PROVIDENCE
Regional Medical Center
Everett

Community Health Improvement Plan

2017 - 2019

Providence Regional Medical Center Everett

Everett, Washington

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Providence Regional Medical Center Everett
1321 Colby Avenue
Everett WA 98201

Executive summary

LEADERSHIP MESSAGE

Providence Health & Services is a not-for-profit network of hospitals, care centers, physicians, clinics, home health services, a health plan and other affiliated programs. Providence in northwest Washington includes the integrated delivery system of Providence Regional Medical Center Everett (PRMCE), Providence Medical Group, Providence Home Care of Snohomish County, and Providence Institute for a Healthier Community.

Understanding community needs for better health

To learn about the greatest health needs from the perspective of some of the most marginalized groups of people, Providence Regional Medical Center Everett conducts a Community Health Needs Assessment every three years.

Key findings in Snohomish County, Washington include a high rate of opioid overdose deaths that is above the state average. In addition, rising rates of homelessness and a lack of access to primary care create barriers to health for those who are poor and vulnerable.

Working to remove barriers to health, together

Based on data and input gathered in the 2017 assessment, Providence's community benefit investments and programs will be prioritized to address the following areas of need over the coming years:

1. **Primary care access**
2. **Opioid Abuse**
3. **Homelessness**

"We are committed to focus on these three areas because they are core to our Mission of caring for those who are poor and vulnerable," said Kim Williams, chief administrative officer for Providence Health & Services in Northwest Washington. "Working together with our community partners, I believe we have the expertise and focused ability to make a great impact."

Providence brings together like-minded partners to develop community health plans, including the Snohomish Health District and the Providence Northwest Washington Community Ministry Board. The next step in addressing identified needs is implementing the Community Health Improvement Plan.

Measuring our success

Guided by the Community Health Needs Assessment, Providence Health & Services invested more than $62 million in community benefit across northwest Washington in 2016. Through programs and donations, health education, charity care, medical research and more, Providence fulfills unmet needs and improves the health and well-being of those we serve – especially for the most poor and vulnerable.

Each of the health needs we have identified include a metric and measurable goal that will be used as an indicator of community progress. We also will develop specific metrics to gauge the effectiveness of the implementation strategies identified. We evaluate our community benefit implementation strategies

during our annual strategic planning and budget cycle. This review enables us to identify any needed modifications or additional areas of emphasis that may be necessary.

ASSESSMENT PROCESS

PRMCE utilized a three step approach to identify the significant health needs that Providence will address in this CHNA cycle. In the first phase, baseline data from the 2013 assessment was updated and evaluated based on the methodology adopted from the Snohomish Health District; comparing local data to state and national data as well as Healthy People 2020 goals; identifying negative trends in local data; and evaluating the size and seriousness of the problem. The second phase included evaluating the data based on the need for improvement, the disproportionate impact on sub-populations, and the level of community resources dedicated to improving the indicator. And finally, the third phase included a weighted scoring based on the linkage to our strategic plan, the amount of resources relative to community need, and our confidence in our ability to have an impact on the health issue. Throughout the process, we utilized a framework that evaluated health and community need in a holistic framework that included social determinants of health, lifestyle choices, and clinical care.

NEEDS PROVIDENCE IS NOT DIRECTLY ADDRESSING

There are a number of other health needs in our community such as obesity, dental access, and mental health. However, due to the lack of identified effective interventions, resource constraints, or absence of expertise, Providence cannot directly address all needs in a CHNA. Give the scope of care we provide to our community, we will also have an indirect impact on other community needs through our ongoing work as engaged partners with community-led collaborative efforts. Additionally, several other Providence programs are designed to improve the health of our community in a variety of other areas.

Introduction

CREATING HEALTHIER COMMUNITIES, TOGETHER

As health care continues to evolve, Providence is responding with dedication to its Mission and a desire to *create healthier communities, together*. Partnering with others of goodwill, we conduct a formal community health needs assessment every three years to learn about the greatest needs in our community, especially considering members of medically underserved, low-income, and minority populations or individuals. This assessment helps us develop collaborative solutions to fulfill unmet needs while continuing to strengthen local resources. It guides our community benefit investments toward improving the health of entire populations, with a special focus on those who are poor and vulnerable.

SERVING SNOHOMISH COUNTY

Providence Health & Services in northwest Washington has a long history of serving the community beginning when the Sisters of Providence established a hospital in Everett in 1905. Today, Providence cares for the community through a comprehensive network of facilities and services from the beginning to the end of life, including primary and specialty care, hospital care, home care and hospice. By working with our team of compassionate caregivers, we strive to deliver the best in quality and affordable care to our patients and their families. In northwest Washington, Providence includes:

- **Providence Regional Medical Center** is a 501 bed acute care tertiary referral center serving patients primarily who reside in Snohomish, Skagit, Whatcom, Island, and San Juan counties. It is the only Level II trauma center in Snohomish County.
- **Providence Medical Group Northwest** is a network of primary care, urgent care, and specialty physicians providing care to children and adults in multiple locations throughout Snohomish County.
- **Providence Hospice and Home Care of Snohomish County** provides home care and inpatient hospice services in Snohomish County.
- **Providence Institute for a Healthier Community** is a partnership between Providence, business, government and non-profits aimed at encouraging residents to make small but important behavioral changes to improve their overall health.

ABOUT US

Providence Health & Services is a not-for-profit Catholic health care ministry committed to providing for the needs of the communities it serves – especially for those who are poor and vulnerable. Providence's combined scope of services includes 34 hospitals, 600 physician clinics, senior services, supportive housing and many other health and educational services. The health system and its affiliates employs more than 82,000 caregivers (employees) across five states – Alaska, California, Montana, Oregon and Washington – with its system office located in Renton, Washington. Our community health activities are rooted in the charitable work the Sisters of Providence started 160 years ago when they answered a call for help from a new pioneer community in the West.

Our Mission:
As people of Providence, we reveal God's love for all, especially the poor and vulnerable, through our compassionate service.

Our Values:
Respect, Compassion, Justice, Excellence, Stewardship

Our Vision:
Simplify health for everyone

PURPOSE OF THIS PLAN

In 2017, Providence Regional Medical Center Everett conducted a community health needs assessment. This community health improvement plan is designed to address key health needs identified in that assessment. The prioritized needs were chosen based on community health data and identifiable gaps in available care and services. In the course of our evaluation, we determined that emphasis on these needs would have the greatest impact on the community's overall health and provide significant opportunities for collaboration. These are:

1. **Primary care access**
2. **Opioid Abuse**
3. **Homelessness**

OUR OVERALL GOAL FOR THIS PLAN

As we work to create healthier communities together, the goal of this improvement plan is to measurably improve the health of individuals and families living in the areas served by Providence Regional Medical Center Everett. 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.

Community Profile

As a tertiary referral center, PRMCE serves patients from the surrounding region consisting of Skagit, Whatcom, Island, San Juan and Snohomish counties. However, the primary geographic area in which the majority (more than 75 percent) of PRMCE's patient population resides is Snohomish County. PRMCE serves one out of every four residents of Snohomish County and for this reason the geographic definition for the CHNA is Snohomish County.

Population and Demographics

The total population of Snohomish County is 757,600 (as of April 1, 2015). The county has experienced an annual average population growth rate of 1.2 percent since 2010.

Ethnicity

Among Snohomish county residents, in 2015, 80.3 percent of residents were white, 9.9 percent Asian, 2.9 percent African American, 1.6 percent Alaska Native/American Indian, 0.5 percent native Hawaiian/Pacific Islander, and 4.8 percent were two or more races.

Age Demographics

The median age for Snohomish County is 37.5. Nearly 24 percent of the population is under the age of 17, 11 percent over the age of 65 and 24 percent adults between the age of 18 and 64.

Income and Employment

In 2015, the mean household income was $83,440 for Snohomish County and the unemployment rate was 4.8 percent, trending down from 2010 levels. The share of those with incomes below the federal poverty line for all ages was 10.3 percent.

Health Care and Coverage

The share of Snohomish county residents who were uninsured was 12.2 percent in 2015, relatively unchanged from the previous period, although those with public insurance (Medicaid, Medicare, other government) went up by 1.5 percent during the same period.

HEALTH AND WELL-BEING

The following indicators are the social determinants of health which influences community health and well-being.

Housing cost burden (30 percent)

This indicator reports the percentage of the households where housing costs exceed 30 percent of total household income, and provides information on the cost of monthly housing expenses for owners and renters. The data also serves to inform the development of housing programs to meet the needs of people at different economic levels. In Snohomish County, 38.7 percent of households spend over 30 percent of their income on housing, compared to 36.4 percent in Washington and 34.9 percent in the United States.

Use of public transportation

This indicator reports the percentage of population using public transportation as the primary means to commute to work. Public transportation includes buses or trolley buses, streetcars or trolley cars, subway or elevated rails, and ferries. In Snohomish County, 5.5 percent of the population use public transit to commute to work, compared to 5.9 percent in Washington State and 5 percent in the United States.

Food insecurity rate

This indicator reports the estimated percentage of the population that experienced food insecurity at some point during the report year. Food insecurity is the household-level economic and social condition of limited or uncertain access to adequate food. In Snohomish County, the food insecurity rate is 12.4 percent compared to 14.6 percent in Washington State and 15.2 percent in the United States.

Lack of social or emotional support

This indicator reports the percentage of adults aged 18 and older who self-report that they receive insufficient social and emotional support all or most of the time. As a measure, it has relevancy because social and emotional support are vital for navigating the challenges of daily life as well as for good mental health. Social and emotional support are also linked to educational achievement and economic stability. In Snohomish County, 16.5 percent of adults do not have adequate social/emotional support compared to 16.9 percent in Washington and 20.7 percent in the United States.

High school graduation rate (NCES)

Within the report area 75.9 percent of students are receiving their high school diploma within four years. This is less than the Healthy People 2020 target of 82.4 percent. This indicator is relevant because research suggests education is one the strongest predictors of health (Freudenberg Ruglis, 2007). In Snohomish County, the on-time graduation rate is 75.9 percent compared to 73.7 percent in Washington and 75.5 percent in the United States.

Poor general health

Within the report area 13 percent of adults age 18 and older self-report having poor or fair health in response to the question "Would you say that in general your health is excellent, very good, good, fair, or poor?" This indicator is relevant because it is a measure of general poor health status. In Snohomish County, 13.2 percent of adults report poor or fair health compared to 13.7 percent in Washington State and 15.7 percent in the United States.

Summary of Providence prioritized needs

There are a number of health needs in our community; however, due to lack of identified effective interventions, resource constraints, or absence of expertise, Providence cannot directly address all needs in a CHNA. Based on the prioritization analysis completed in Phase III, PRMCE chose the three indicators described below as the significant focus for the 2017-2019 needs assessment and implementation plan.

Access to Primary Care

Increase the proportion of adult residents in Snohomish County who have one person they think of as their personal doctor or health care provider.

- Improve the patient experience with new access options, digital tools, and convenient access
- Increase the number of primary care physicians per 1,000 population
- Increase awareness about primary care services available

Opioid Abuse

Reduce the morbidity and mortality caused by the abuse of opioid medications and illegal opioids.

- Increase awareness of and access to treatment options
- Educate about opioid abuse
- Develop evidence-based community standards and protocols.

Homelessness

Improve the overall health and well-being of our patients by connecting them to stable housing.

- Identify solutions to the health care needs of the homeless population post discharge
- Expand participation in community efforts to directly address homelessness

Given the scope of care Providence provides to our community, we will also have an indirect impact on other community needs through our ongoing work as engaged partners with community-led collaborative efforts. Additionally, Providence has many other community benefit programs that are designed to improve the health of our community in a variety of other areas.

Priority health need: Access to primary care

This section outlines Providence's plan to address access to primary care in our community with measurable and achievable goals over a three-year period.

Community needs addressed

Lack of access to primary care presents barriers to good health. Addressing these barriers will improve the health of the community and will help people get the right care, at the right time, and in the right care setting. Individuals who have a primary care provider are more likely to receive preventive care, chronic disease management and medication management, all of which lead to better health outcomes. Those without access to a primary care provider may choose to receive care in an emergency department for non-emergent conditions because they feel they have nowhere else to go, or they defer care until an illness progresses.

Goal

Increase the proportion of adult residents in Snohomish County who have one person they think of as their personal doctor or health care provider.

Objectives

- Improve the patient experience with new access options, digital tools, and convenient access
- Increase the number of primary care physicians per 1,000 population
- Increase awareness about primary care services available

Action plan

A. Provide primary care services in a manner that is convenient to the patient.

B. Connect individuals that utilize the emergency department as their primary care source to a more appropriate care setting in the community (primary care clinic, urgent care center, etc.).

C. Collaborate with community partners to increase the available workforce and interest in the health care sector.

D. Ensure primary care is available to a broader number of low income, uninsured and underinsured individuals.

Partners in collaboration

Some of the organizations and programs that Providence partners with to impact the goal of improving access to primary care include:

- Archbishop Murphy High School
- CHART – Chronic Utilizer Alternative Response Team
- COPE Health Scholars
- Everett Public Schools
- Express Care

- HealthExpress
- Project Access Northwest
- Providence Everett Healthcare Clinic
- Providence Institute for a Healthier Community
- Providence Medical Group
- Seamar Community Health - Family Residency Program
- Snohomish Health District – Refugee Program
- Snohomish County Human Services
- United Way of Snohomish County
- Washington State University North - Medical School

MEASUREMENT

Indicator Description	Snohomish County			Washington State	United States	Healthy People Goal
	2011	2013	Trend	2013	2013	2020
Adults 18+ with at least one person they think of as their personal doctor or healthcare provider	79.1%	75.9%	Down	72.5%	76%	83.9%
Population per primary care provider	1949:1	1932:1	Down	1190:1	1040:1	NA
Primary care physicians per 100,000 population	53.69	52.82	Down	92.55	87.76	NA

Source: Robert Wood Johnson County Health rankings, CDC Behavior Risk Factor Surveillance System.

Priority health need: Opioid Abuse

This section outlines Providence's plan to address opioid abuse in our community with measurable and achievable goals over a three-year period.

Community needs addressed

Substance abuse has a significant health and social impact on individuals and the community. Abuse of prescription opioids for pain – such as morphine, oxycodone, hydrocodone/fentanyl, or illegal drugs such as heroin, is a serious problem in Snohomish County.

Goal

Reduce the morbidity and mortality caused by the abuse of opioid medications and illegal opioids.

Objectives

Implement prevention and intervention strategies to address opioid abuse including

- Increase awareness of and access to treatment options
- Educate about opioid abuse
- Develop evidence-based community standards and protocols

Action plan

A. Ensure identified inpatients, emergency department patients, and chronic utilizers of community service programs are connected to the appropriate resource for education, counseling, treatment, etc.

B. Engage youth in the community with a focus on addiction, including education on the effects of illegal drug use.

C. Collaborate with community medical providers and other stakeholders to develop and promote adoption of uniform opioid prescribing policies and practices.

D. Improve the mental/emotional health of the community through programs embedded in primary care such as social workers and total health screening tools.

E. Advocacy at the State level for programs, legislation, etc. that will have a positive impact on opioid abuse.

Partners in collaboration

Some of the organization and programs that Providence partners with to impact the goal of reducing opioid abuse include:

- CHART (Chronic Utilizer Alternative Response Team)
- City of Everett - Everett Streets Initiative
- Community Health Center of Snohomish County
- Compass Health

- Everett Police Department – PAARI (Police Assisted Addiction and Recovery Initiative)
- North Sound Emergency Medicine
- Pharmacies
- Providence Advocacy
- Providence Drug and Alcohol Addiction Treatment
- Providence Institute for a Healthier Community
- Providence Medical Group
- Safe Kids Inside Out Program
- School Districts
- Seamar Community Health Center
- Snohomish County Children & Youth Mental Wellness Fair
- Snohomish County Health Leadership Coalition
- Snohomish County Human Services – SBIRT
- Snohomish Health District
- The Everett Clinic
- Western Washington Medical Group

MEASUREMENT

Indicator Description	Snohomish County		Washington State		United States
	2002-2004	2011-2013	Trend	2011-2013	2013
Mortality attributed to any opiate rate per 100,000 population	8.4	14.1	Up	8.6	9.0
	2010	2014	Trend	2014	2014
Prescription opioid mortality rate per 100,000 population	7.5	5.2	Down	5.5	5.9
	2010	2014	Trend	2013	2013
Heroin overdose mortality rate per 100,000 population	2.4	7.2	Up	2.9	2.7

Source: Kaiser Family Foundation National Survey on Drug Use, Washington Department of Health, Center for Health Stats (http://www.doh.wa.gov/DataandStatisticalReports/VitalStatisticsData)

Priority health need: Homelessness

This section outlines Providence's plan to address homelessness in our community with measurable and achievable goals over a three-year period.

Community needs addressed

Homelessness has a high negative impact on an individual's health status and homeless individuals are high users of medical systems.

Goal

Improve the overall health and well-being of patients by connecting them to stable housing.

Objectives

Identify solutions to the health care needs of the homeless population within PRMCE and expand PRMCE's participation in community efforts to directly address homelessness.

Action plan

A. Identify solutions for patients that are ready to be discharged from the hospital but do not have access to stable housing for:
    a. Medical respite
    b. Medical rest
    c. Permanent housing

B. Evaluate processes in order to reduce the time it takes to place an inpatient into permanent housing (e.g. assessments, guardianship, advocacy, housing alternatives, etc.).

C. Provide medical screening and other healthcare services for homeless individuals, including assessments to determine individual need.

Partners in collaboration

Some of the organization and programs that Providence partners with to impact homelessness include:

- Everett Gospel Mission
- CHART Chronic Utilizer Alternative Response Team
- City of Everett
- Cocoon House
- Compass Health
- Domestic Violence Services
- Everett Streets Initiative
- Foundations Church Cold Weather Shelter
- Housing Hope
- Interfaith Association Family Shelter
- Providence Institute for a Healthier Community
- Project Homeless Connect

- Snohomish County Human Services
- Total Health
- United Way of Snohomish County
- YMCA

Measurement

Indicator Description	Snohomish County		
	2014	2016	Trend
Unsheltered households	322	410	Up
Sheltered households	370	339	Down
Precariously housed households	198	129	Down
Unsheltered individuals	372	471	Up
Sheltered individuals	577	489	Down
Precariously housed individuals	232	158	Down
Population Unsheltered	0.049%	0.06%	Up

Source: Snohomish County 2016 Point in Time Survey

Healthier Communities Together

Objective

Providence and our partners cannot address the significant community health needs independently. Improving community health requires collaboration across community stakeholders. Our community benefit team will continue to evaluate our partnerships and programs and endeavor wherever possible to align them with other community efforts.

The chart below outlines some of the community resources that are designed to have a positive impact on the identified community needs.

Program	Description	Program Leader	Health Indicator		
			Homeless	Opioid Abuse	Primary Care
CHART (Chronic utilizer Alterative Response Team)	Connecting chronic utilizers of social services with housing, transportation and other social services. PRMCE works to obtain primary care, detox or other health services.	City of Everett	x	x	x
Cocoon House	Provides short and long term housing to homeless teens and their children.	Cocoon House	x		
Community Pathways	Group of community medical providers that develop common community wide-protocols, check-list and toolkits for prescribing opioids.	Providence		x	
Compass Health	Provides mental and chemical dependency services to all ages, income levels and ethnic cultures.	Compass Health	x	x	
Digital Technology	Digital platform allows patients to view their medical record and schedule appointments online. Encourages patients to be more engaged in their own primary care.	Providence			x
Emergency Department Social Workers	Social workers in the emergency department assist identified frequent use patients with establishing primary care and a care plan so patients develop relationship for continuing care.	Providence			x
Everett Gospel Mission	Food, shelter for men, women and children who are homeless	Everett Gospel Mission	x		
Everett Streets Initiative	Task force to identify strategies for addressing street-level social issues (homelessness, mental illness, addiction).	City of Everett	x	x	
ExpressCare	Convenient and fast primary care located within Walgreen stores in three locations in Snohomish county.	Providence			x
Health Express	Virtual health care provided via a tablet, smartphone or computer.	Providence			x
Housing Hope	Promotes and provides affordable housing and tailored services to reduce homelessness and poverty.	Housing Hope	x		

Program	Description	Program Leader	Health Indicator		
			Homeless	Opioid Abuse	Primary Care
In-Home Primary Care	Healthcare practice serving home bound elders in Snohomish County.	Providence			x
Interfaith Association Family Shelter	Services for families experiencing poverty and homelessness.	Interfaith Association -	x		
Live Well Local	Searchable database for individuals, case managers, health coaches, etc. to find community resources.	Providence	x	x	x
LiveHealthy 2020	A community movement across Snohomish County to enhance health and well-being.	Snohomish County Health Leadership Coalition	X	x	x
Medical Respite	Pilot program to provide medical respite for PRMCE inpatients that need low-level care (wound care, antibiotics), but do not have stable housing.	Providence	x		
Medical Rest Beds	Homeless patients discharged from PRMCE that need medical rest are connected with the Everett Gospel Mission for assignment to one of eight medical rest beds.	Providence	x		
Mercy Housing	Affordable housing and supportive services		x		
PAARI (Police Assisted Addiction and Recovery Initiative)	Individuals presenting to the Everett Police Department requesting assistance are connected to a residential inpatient program.	Everett Police		x	
Permanent Housing for Inpatients	Permanent housing solution for patients that are ready to be discharged from the hospital, however the patient is non-decisional, with no family, or no family with capacity to offer housing support.	Providence	x		
Poverty Simulation	Poverty simulation to learn about and understand the situations some of the most vulnerable in our community experience every day.	United Way of Snohomish County	x		
Project Access Northwest – Premium Assistance	Premium assistance program provides support to those that may need assistance with paying insurance premiums.	Project Access Northwest			x
Project Access Northwest – Primary Care	Low income, uninsured or Medicaid patients that are discharged from the hospital are provided assistance coordinating follow-up appointments with a primary care provider prior to discharge.	Project Access Northwest			x
Project Homeless Connect	One-day community event to provide medical screening, dental care and other services for homeless individuals.	United Way of Snohomish County	x		x

Program	Description	Program Leader	Health Indicator		
			Homeless	Opioid Abuse	Primary Care
Providence Drug and Alcohol Addiction	Chemical dependency, outpatient, inpatient, detox and stabilization.	Providence		x	
Providence Everett Healthcare Clinic	PEHC offers free and discounted primary care to low income, uninsured patients.	Providence			x
Reduction in cycle time	Evaluating processes to reduce cycle times to place inpatients into permanent housing (assessment, guardianship, advocacy, locating alternative housing, etc.).	Providence	x		
Refugee Program	Providence Everett Healthcare Clinic assists with providing primary care and immunizations to refugees that are completing requirements for permanent residency.	Snohomish Health District			x
Safe Kids Inside Out Program	Use of organs to show how substance abuse can affect the brain and other organs, primarily outreach to children.	Providence		x	
SBIRT Counselors	SBIRT counselors are placed in the PRMCE emergency department to provide screening, brief intervention and referral for treatment for those abusing/addicted to drugs or have mental health issues.	Snohomish County Human Services		x	
Seamar Marysville Family Medicine Residency	Primary care physician residency program to train and graduate family medicine providers who are committed to the underserved.	Seamar Community Health Center Marysville			x
Snohomish Health District – Drug Overdose program	Connect emergency department patients that have been seen for drug overdosed with education and referrals for drug treatment and other community resources.	Snohomish Health District		x	
Social Workers in Primary Care	Social workers/mental health professionals embedded into primary care.	Providence		x	x
STARCare	Outreach and care management with hospital patients who do not have a primary care provider.	Providence			x
Total Health	Screening patients seen in a primary care setting for social needs such as homelessness, nutrition, domestic violence, transportation, education, etc.	Providence	x		
Washington State University - North	Medical School program in Everett.	Washington State University			x

Plan Approval

The PRMCE community health needs assessment was adopted on November 17, 2016 by the Providence Northwest Washington Chief Executive Officer, Community Ministry Board Chair and the SVP Community Partnerships of Providence St. Joseph Health. The final report was made widely available on December 31, 2016.

The Community Health Improvement Plan was added to the community health needs assessment in April 2017.

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To provide comments or request a copy of our current and previous community health needs assessments visit or write to the address above or view electronic copies of the documents at http://communitybenefit.providence.org.\