PROVIDENCE
Regional Medical Center
Everett

Community Health Needs Assessment

Providence Regional Medical Center Everett

2019

To provide feedback about this Community Health Needs Assessment or obtain a printed copy without charge, email DeAnne Okazaki, Administrative Program Director at deanne.okazaki@providence.org

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MESSAGE TO THE COMMUNITY

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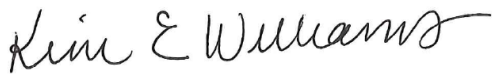
As a not-for-profit Catholic health care ministry, Providence Regional Medical Center Everett (PRMCE) embraces its responsibilities to provide for the needs of the communities we serve. We extend this work through our Community Health Needs Assessment (CHNA) efforts. A healthy community relies on many people and many resources. When the Sisters of Providence began our tradition of caring over 160 years ago, our ministry greatly depended on partnering with others in the community who were committed to doing good, and we continue those partnerships today.

Providence's vision of "Health for a Better World" starts with our commitment to understanding and serving the needs of the community, especially those who are poor and vulnerable. With each investment we make and partnership we develop, we find ways to best address and prioritize our region's most challenging needs as identified through our CHNA. In 2018, driven by our Mission to care for our community, Providence in Northwest Washington invested more than $73 million in community benefit. Together with our partners, we are building communities that promote and transform health and well-being.

With input and guidance from many of our community partners - including the Snohomish Health District and the Providence Northwest Washington Community Ministry Board, Mission and Healthier Communities Committee - we complete a CHNA every three years to identify the greatest unmet needs among the communities we serve. The objectives of the CHNA are to understand the greatest needs in the community, determine how PRMCE is best positioned to respond to those needs, and develop implementation strategies that will lead to health improvement. In the coming year, we will focus our efforts on supporting and growing programs that address access to mental health care and primary care services, opioid use disorder and homelessness.

Our ultimate goal is to identify solutions that transform the health of our communities and collectively with our partners achieve Health for a Better World. We invite you to learn more about how we are working to meet community needs and help people live their healthiest lives.

Sincerely,



Kim E. Williams, RN, MS, FACHE
Chief Executive Officer
Providence Regional Medical Center Everett
Northwest Washington Service Area

EXECUTIVE SUMMARY

Understanding and Responding to Community Needs, Together

Improving the health of our communities is fundamental and a commitment rooted deeply in our heritage and purpose. Our mission calls us to be steadfast in serving all with a special focus on our most poor and vulnerable neighbors. This core belief drives the programs we build, investments we make, and strategies we implement.

Knowing where to focus our resources starts with our Community Health Needs Assessment (CHNA), an opportunity in which we engage the community every three years to help us identify and prioritize the most pressing needs, assets and opportunities. The 2019 Community Health Needs Assessment was approved by the Northwest Washington Service Area Board of Directors on October 17, 2019.

Our Starting Point: Gathering Community Health Data and Community Input

Through a mixed-method approach using quantitative and qualitative data, the CHNA process used several sources of information to identify community needs. Information collected included data from Snohomish Health District, Providence Institute for a Healthier Community (PIHC), Behavioral Risk Factor Surveillance System, Health & Well-Being Monitor™ (HWBM), hospital level data and more.

The annual HWBM is used to understand what health and well-being means from the point of view of the community including people who have chronic conditions, are from diverse communities, or are low-income and medically underserved. While the CHNA is developed every three years, PRMCE is tapping into an annual cycle of HWBM research, augmented by a growing number of community-level HWBM's that deliver deeper insights into subgroups such as homeless families with children experiencing school attendance problems, low-income housing systems, and communities comprised of geographic sub-regions of Snohomish County such as the Stillaguamish Valley.

The PRMCE process benefits from this annual discovery, which provides guidance that is both more current than a triennial assessment, and provides trending data. For instance, the PRMCE 2020-2022 CHNA effort got underway in early 2019 and PRMCE used the current, comprehensive countywide measure of well-being. During the time PRMCE was compiling data and assessing potential priorities, PIHC conducted the 2019 annual HWBM survey. As PRMCE was reviewing and prioritizing information into late summer, PIHC was able to provide new trending information spanning the past three annual surveys. Some key findings from the Health & Well-Being Monitor™ include:

- The measure of well-being has declined 2.6% since 2017.
- Of the Six Dimensions of Health™ on which the community defines its health and well-being, countywide changes in multiple areas reinforced potential areas of focus.

- 50% of respondents experienced poor health in the last month.
- 29% of respondents lack at least 1 basic need (transportation, power & water, education, food, job, personal safety, housing, or healthcare).
- 26% of respondents experienced discrimination in the last 12 months; more than twice as many as 2017.

Identifying Top Significant Health Related Needs, Together

Through a collaborative process engaging our many partners and community members, including the Providence Northwest Washington Service Area Community Ministry Board's Mission and Healthier Communities Committee, the Snohomish Health District, and PIHC, the 2020-2022 CHNA was developed. PRMCE utilized a three step approach to identify the significant health needs of the community and those that PRMCE will address in this CHNA cycle. In the first phase, baseline data from the 2016 assessment were 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. The third phase included an evaluation based on the linkage to our strategic plan, the amount of resources relative to community need, and our confidence in our ability to have a positive impact. Throughout the process, we utilized a holistic framework that evaluated community need including social determinants of health, lifestyle choices, and clinical care. Through this evaluation process, the follow priority areas were agreed upon:

Priority #1: Access to mental health care
Priority #2: Opioid use disorder
Priority #3: Housing/homelessness
Priority #4: Access to primary care

PRMCE made a commitment to focus on these four areas because we believe that we can have the greatest impact and positive influence on outcomes. At the same time, PRMCE is also actively involved in supporting our community through many other community benefit programs. In addition, PIHC is identifying new health and well-being measures that are designed to encourage broader improvements for larger populations of people.

Each of the health needs we have identified will correspond to a measurable goal that will be used to gauge the effectiveness of the implementation strategies identified, as well as community progress. 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.

INTRODUCTION

Mission, Vision, and Values

Our Mission: As expressions of God's healing love, witnessed through the ministry of Jesus, we are steadfast in serving all, especially those who are poor and vulnerable.

Our Vision: Health for a Better World

Our Values: Compassion – Dignity – Justice – Excellence – Integrity

Who We Are

Providence Health & Services in northwest Washington has a long history of serving the community beginning when the Sisters of Providence established a Providence Regional Medical Center Everett in 1905. Today, Providence Health & Services 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. Major programs and services offered in northwest Washington include inpatient acute care, an emergency department serving as a Level II trauma center, behavioral health, cancer services, women's services, rehabilitation, chemical dependency, primary care, and specialty care. In northwest Washington, Providence Health & Services includes:

- **Providence Regional Medical Center Everett (PRMCE)** is a 530 bed acute care tertiary hospital 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. PRMCE is split into two campuses: the smaller Pacific Campus which includes the Pavilion for Women and Children, and the larger Colby Campus, which includes an Emergency Department and a Cancer Center. PRMCE has a medical staff of more than 1,230 providers and professional relationships with many medical groups in the community.
- **Providence Medical Group Northwest (PMG)** is a network of primary care, specialty care, walk-in services, and ExpressCare centers providing care to children and adults in 15 locations throughout Snohomish County.
- **Providence Hospice and Home Care of Snohomish County (PH&HC)** provides home care and inpatient hospice services in Snohomish County.
- **Providence Institute for a Healthier Community (PIHC)** is a partnership between PRMCE, businesses, government and non-profits aimed at encouraging residents of Snohomish County to make behavioral changes to improve their overall health.

Our Commitment to Community

PRMCE dedicates resources to improve the health and quality of life for the communities it serves, with special emphasis on the needs of the poor and vulnerable. In response to unmet needs and to improve the health and well-being of those we serve, PRMCE provided a total of $73.3 million in community benefit in 2018[1] including $13.5 million in free and low-cost care so the underinsured and uninsured could access health care.

Figure 1. PRMCE Community Benefit

PRMCE further demonstrates organizational commitment to the CHNA through the allocation of staff time, financial resources, participation, and collaboration to address identified community needs. PRMCE is responsible for ensuring compliance with Federal 501r requirements as well as providing the opportunity for community leaders and internal hospital management team members, physicians, and other staff to work together in planning and implementing the Community Health Improvement Plan (CHIP).

[1] A community benefit is an initiative, program or activity that provides treatment or promotes health and healing as a response to identified community needs and meets at least one of the following community benefit objectives: a. Improves access to health services; b. Enhances public health; c. Advances increased general knowledge; and/or d. Relieves government burden to improve health. Note: Community benefit includes both services to the economically poor and broader community.

OUR COMMUNITY

Description of Community Served

PRMCE provides Snohomish County communities with access to advanced medical care. The hospital's community extends from Skagit County in the north, King County in the south, and the Cascade Mountains in the east, and the Puget Sound in the west. Snohomish County includes a population of approximately 805,624 people, an increase of 7.6 percent from the 2016 CHNA.

Hospital Service Area

The community served by the hospital is defined based on the primary geographic area in which the majority of PRMCE's inpatient population resides. As a tertiary referral center, PRMCE serves patients from the surrounding region consisting of Skagit, Whatcom, Island, San Juan, and Snohomish Counties. However, more than 75 percent of PRMCE's patient population resides in 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.

Snohomish County is located in northwest Washington State. The county land area is comprised of 68 percent forest land, 18 percent rural, 9 percent urban/city, and 5 percent agricultural.

Figure 2. Snohomish County map, PRMCE primary service area

The following table details the zip codes and cities in Snohomish County.

Table 1. Cities and Zip codes in service area

Cities/ Communities	ZIP Codes
Arlington	98223
Bothell	98011, 98021, 98034, 98041
Brier	98036
Darrington	98241
Edmonds	98020, 98026
Everett	98201, 98204, 98207, 98213, 98275, 98203, 98206, 98208, 98272, 98290

Cities/ Communities	ZIP Codes
Gold Bar	98251
Granite Falls	98252
Index	98256
Lake Stevens	98258
Lynnwood	98036, 98037, 98046
Marysville	98259, 98270, 98271
Mill Creek	98012, 98082
Monroe	98272
Mountlake Terrace	98043
Mukilteo	98275
Snohomish	98290
Stanwood	98292
Sultan	98294
Woodway	98020

Community Demographics

Please see appendix 2 for additional demographic data.

Population by Race

The total population of Snohomish County is 805,624. Among Snohomish County residents, 73% of residents are white, 12% Asian, and 4% African American. Of the population, 11% are Hispanic, and 5% report two or more races.

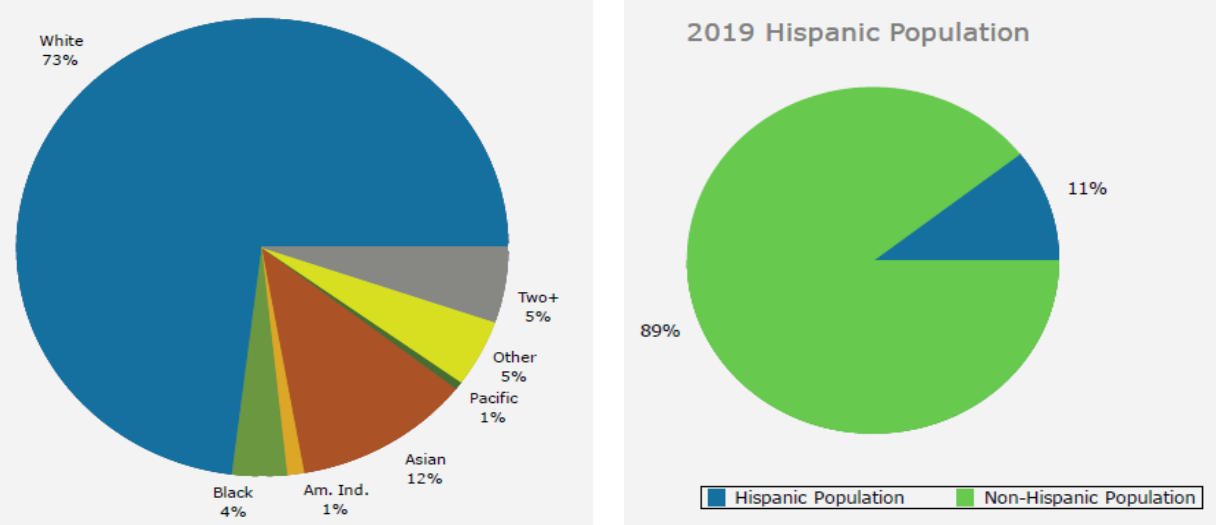


Figure 3. Population by race and ethnicity in Snohomish County. Source: ESRI, US Census

Population by Gender and Age Group

The median age for Snohomish County is 38.6 years for males and 40.5 years for females. Nearly 25% of the population is under the age of 19. In the next five years, the population over the age of 65 is expected to increase.

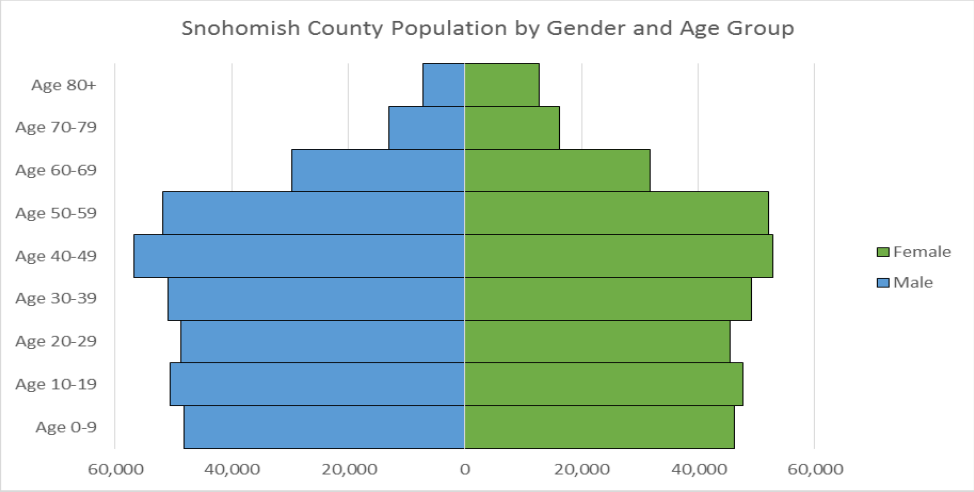


Figure 4. Snohomish County population by gender and age group. Source: ESRI, US Census

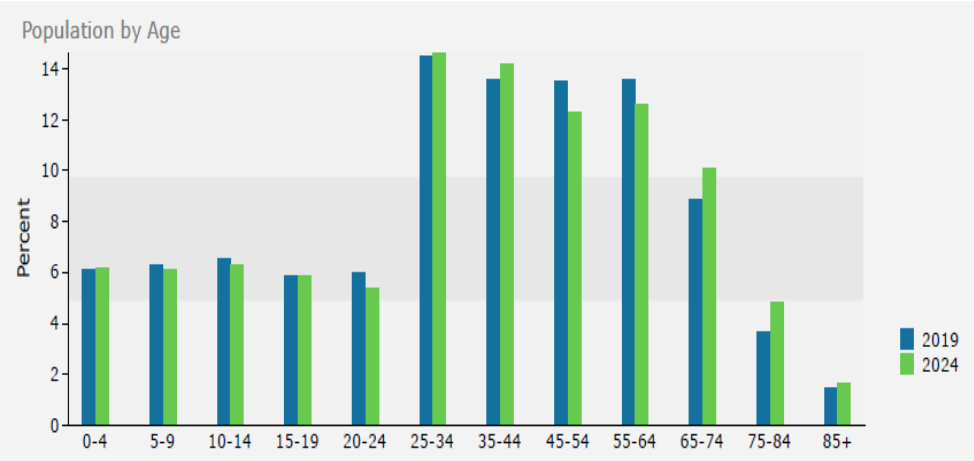


Figure 5. Snohomish County population by age group, 2019 and predicted 2024. Source: ESRI, US Census

Language Spoken at Home

19.4% of households in Snohomish County speak a language other than English at home. This is equal to that of the State and lower than the United States.

Table 2: Households that do not speak English at home

	Snohomish County	State	United States
Language spoken at home other than English	19.4%	19.0%	21.2%

Health & Well-being

Through the Providence Institute for a Healthier Community (PIHC), PRMCE compiles a comprehensive view of health and well-being based on the annual Snohomish Countywide Health & Well-being Monitor™ (HWBM). The 2019 research, augmented by four years of trend data, defines the state of our health and well-being, and reveals some emerging trends. Selected results from the HWBM are available on the following pages.

Background on the HWBM

In 2015, PIHC worked with a broad cross-section of individuals to create a community-based participatory research initiative by working with hundreds of people across our county, listening to learn how our community defines health and well-being, the levels of satisfaction with well-being, and how much it can be improved. The resulting framework was used to develop and implement an annual Health & Well-Being Monitor™. Utilizing a respected research firm, a stratified random sample of 600 to 750 individuals are reached annually through a combination of telephone and online surveys.

The original qualitative research surfaced 24 common attributes among a broad cross section of community members. Those attributes linked to six overall dimensions of health defined by our community, and vetted against other existing well-being frameworks in the United States and abroad. PIHC organizes everything it does around these six dimensions of health because that is how the community members define well-being. Those six dimensions include:

1. Relationships and social connections
2. Mental, emotional and spiritual health
3. Neighborhood and environment
4. Physical health
5. Security and basic needs
6. Work, learning and growth

Four years of survey data have validated this as a stable and reliable community standard of well-being. The HWBM is designed so that any self-defined community can run a tailored version, connecting their priorities to the overall impact on well-being, and comparing the tailored results to the annual countywide benchmarks. The tailored HWBM is contributing to a common dataset that has surpassed 4,000 responses. This provides local insights not before available to individual organizations.

Figure 6: Summary of Health and Well-Being Monitors

The HWBM is organized into four components:

1. The Countywide Core4™ Well-being Index score
2. The Core4™ Composite Measure
3. The Six Dimensions of Health
4. A Topical Issues Report

Countywide Core4™ Well-Being Index Score

In 2019, the countywide Health & Well-Being™ Index score was 7.51 on a scale of 1 (low) to 10 (high). This was a 2.6% decline from 2017. Each Core4 index item (satisfaction with life, physical health, mental health, and overall well-being) has declined since 2017. The index combines the scores of the four leading indicators displayed below. A hallmark of the HWBM is that it includes measures of satisfaction, in addition to performance ratings.

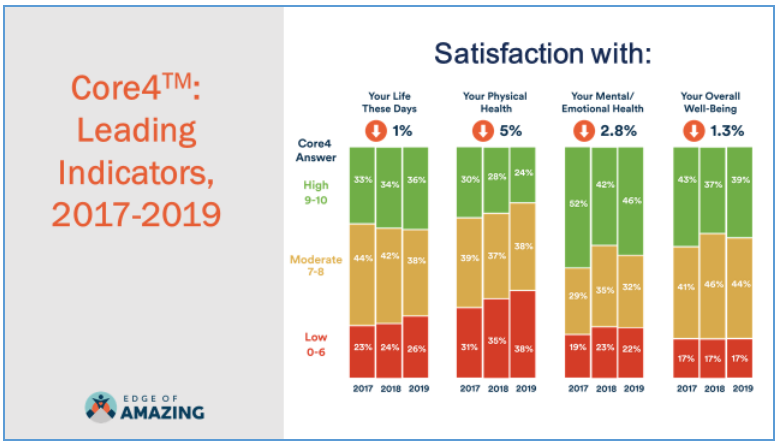


Figure 7. Core4 Leading Indicators

Core4™ Well-Being Composite Measure

The composite measure shows the distribution of well-being across the population, along with the community's capacity to improve. The measure is strongly correlated with a range of more objective health measures. The measure shows a dramatically lower percent of respondents are at high levels of well-being on all four leading indicators. Less than half (49%) of the county population reports overall positive levels of well-being, down from 55% in 2017.

- 11% or 95,000 people are Flourishing (all scores rated 9 - 10), with an average index score of 9.7
- 38% or 320,000 people are Positive (all scores rated 7 – 10), with an average index score of 8.4.
- 41% or 340,000 people are Mixed (negative and positive scores), with a Health & Wellbeing Index score of 6.8.
- 9% or 77,000 people are Struggling (all scores rated 0 – 6), with an average index score of 3.9.

Figure 8. Well-being composite Measure

Countywide and at individual community levels, a higher Core4™ Index Score is linked to fewer poor physical, mental, and debilitating health days per month. Depending on the indicator, every one-point decline in the Core4™ Index Score adds 2 to 5 weeks of poor health per year.

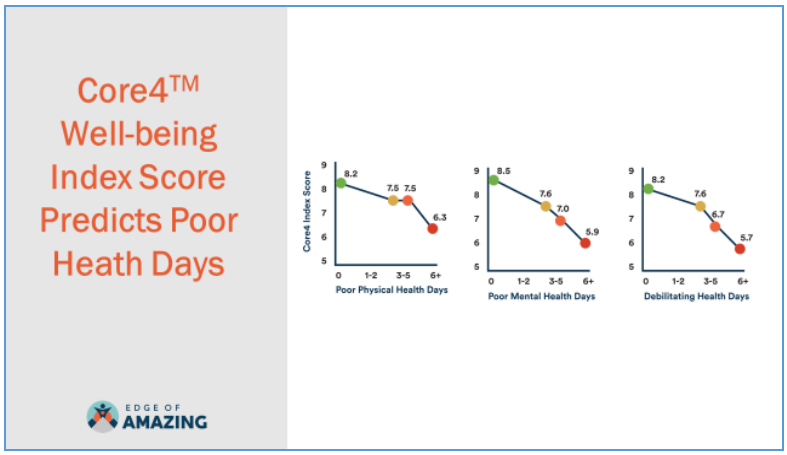


Figure 9. Well-being Index Score Predicting Poor Health Days

The numbers below show that with each step up the ladder from Struggling to Flourishing, people are exhibiting enhanced health behaviors that are aligned with standards such as those included in the Behavioral Risk Factors Surveillance Survey (eating more fruits and vegetables, talking more with neighbors, exercising more regularly, getting a good night's sleep more often, gathering more frequently with family and friends).

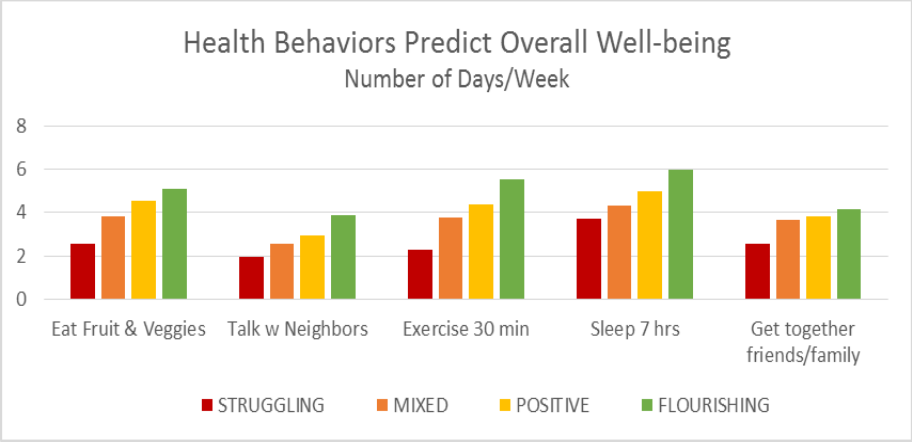


Figure 10. Health Behaviors that Predict Overall Well-being

Six Dimensions of Health & Well-being

The annual HWBM tracks key indicators from the Six Dimensions of Well-being™ as defined by our communities. A selection of key indicators from each dimension of well-being helps to set a backdrop for the process of selecting key CHNA priorities. The key indicators and the trend over the past three annual surveys are identified below.

Dimension of Health: Mental, Emotional and Spiritual Health

Emotional Well-being

Nearly half of residents report high levels of emotional well-being. However this is down 1.9% from 2017.

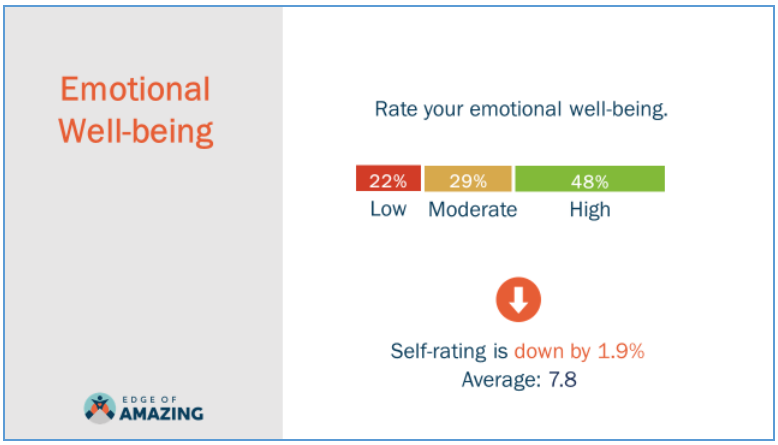


Figure 11. Emotional Well-being rating

Religion & Spirituality

The importance of religion and spirituality has declined consistently since 2017 and decreased by 11.5% overall. Just over one in 3 people say that they are highly connected spiritually.

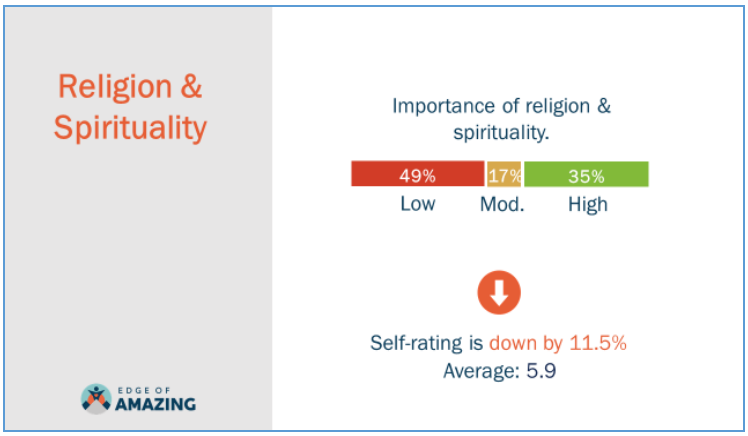


Figure 12. Religion and spirituality

Sense of Purpose and Meaning

Having a sense of purpose and meaning is up by nearly 2.5% from 2017. This suggests that people are finding a sense of meaning from other aspects of their lives.

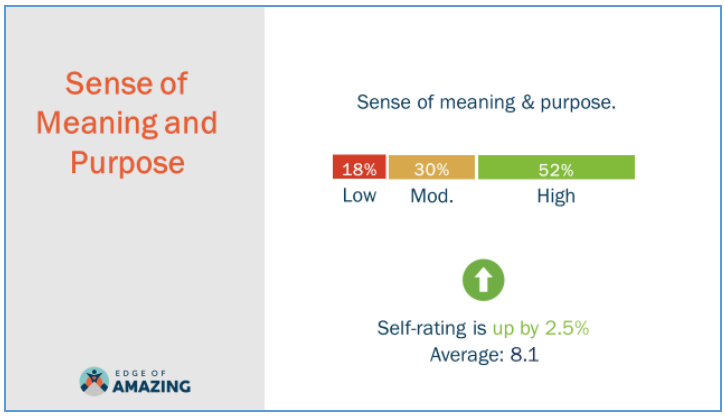


Figure 13. Sense of Purpose and meaning

Poor Mental Health Days

Since 2017, Snohomish County residents reported a 27% increase in poor mental health days per month and are now averaging 5.2 days per month. This shift translates to 1.1 added poor mental health days per capita per month or nearly two weeks per year.

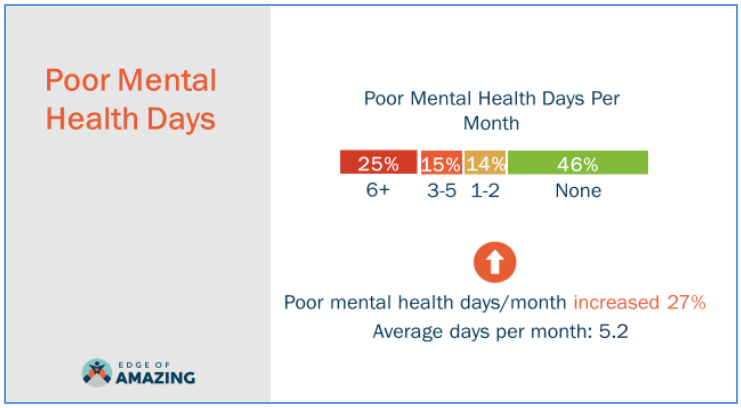


Figure 14. Poor mental health days per month

Debilitating Health Days

Residents report an average of 4.1 debilitating health days per month where poor physical or mental health kept them from their usual activities. This has increased by 24% since 2017, nearly two additional weeks per year on average.

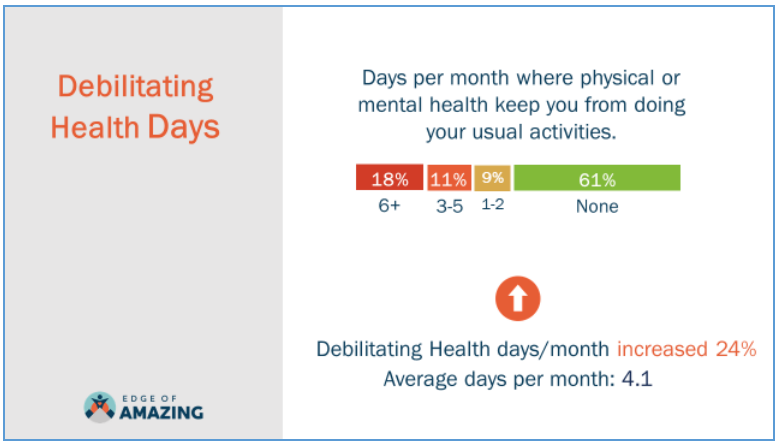


Figure 15. Debilitating health days per month

Dimension of Health: Relationships and Social Connections

Friends and Neighbors

Each year we ask how many days per week people talk to their neighbors or get together with friends. Both are consistently trending downward from 2017. Individuals are connecting with friends 3.5 days per week, down 9.8%. Individuals are talking with neighbors 2.6 times per week, down 8%.

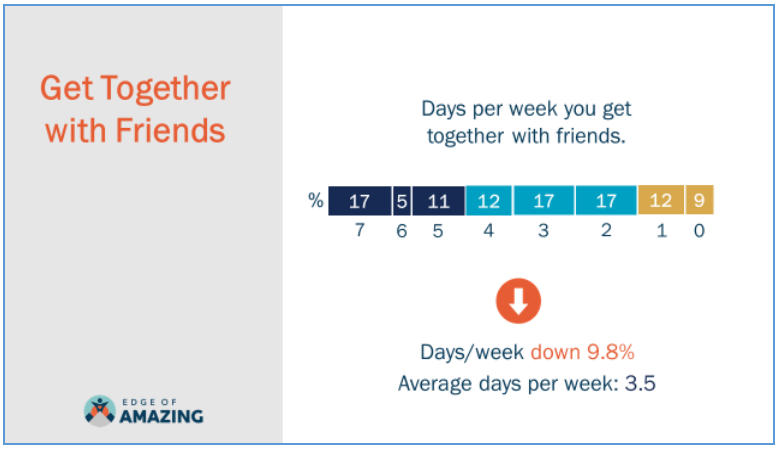


Figure 16. Days per week individuals get together with friends

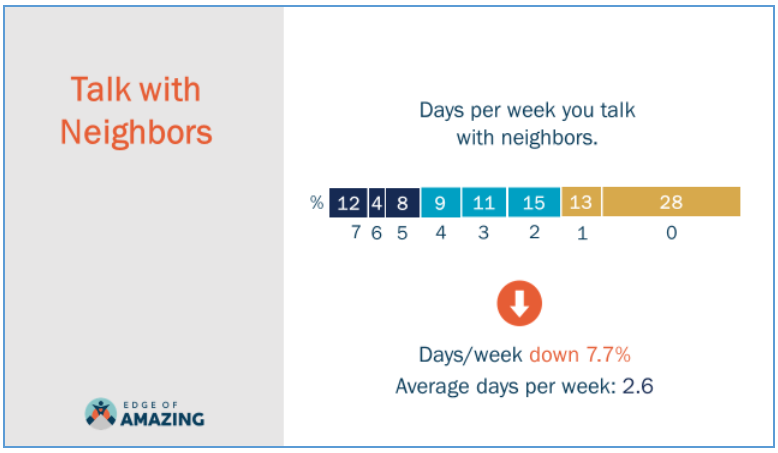


Figure 17. Days per week individuals talk with neighbors

Sense of Community Belonging

The sense of belonging to a community has declined 6.5% since 2017. Overall, 45% of individuals now report a weak sense of connection to their community.

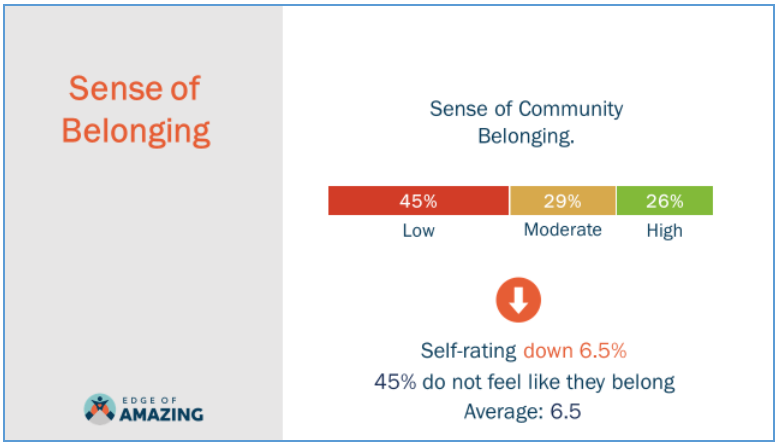


Figure 18. Sense of beloning to the community

Discrimination

26% of survey participants reported that they are experiencing discrimination or are being treated unfairly because of race, ethnic background, gender or sexual orientation. This has more than doubled from 12% in 2017. Of those who experience discrimination, nearly 1 in 5 now experience it frequently or almost always.

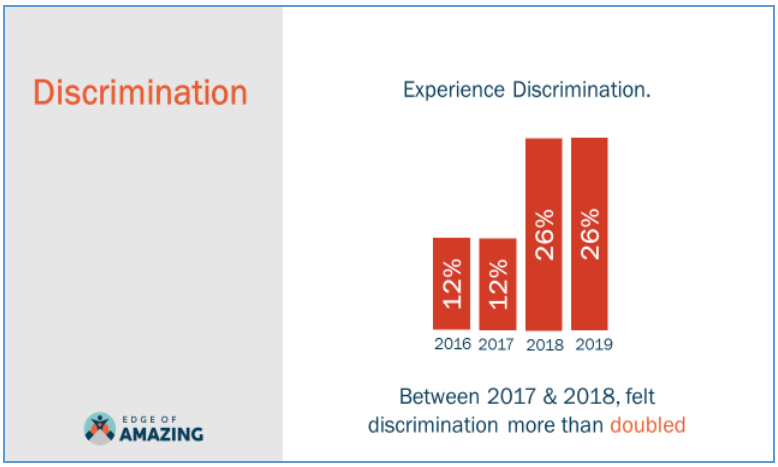


Figure 19. Percent of individuals experiencing discrimination

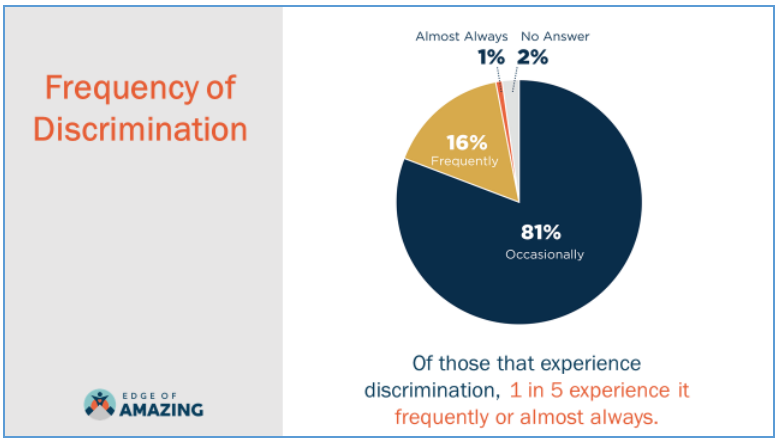


Figure 20. Frequency individuals experience discrimination

People of color report higher levels of discrimination at 31% in 2018, increasing to 45% in 2019. In 2018, 38% of individuals who speak another language at home report discrimination, increasing to 46% in 2019.

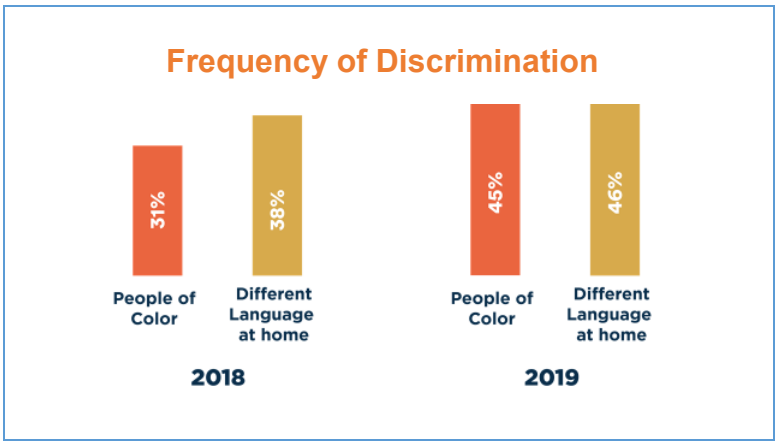


Figure 21. Frequency of discrimination for people of color and those speaking different language at home

Dimensions of Health: Neighborhood and Environment

Rating of Neighborhood

20% of individuals report that the quality of the neighborhood that they live in as low or moderate quality. This has trended down 2.5% since 2017.

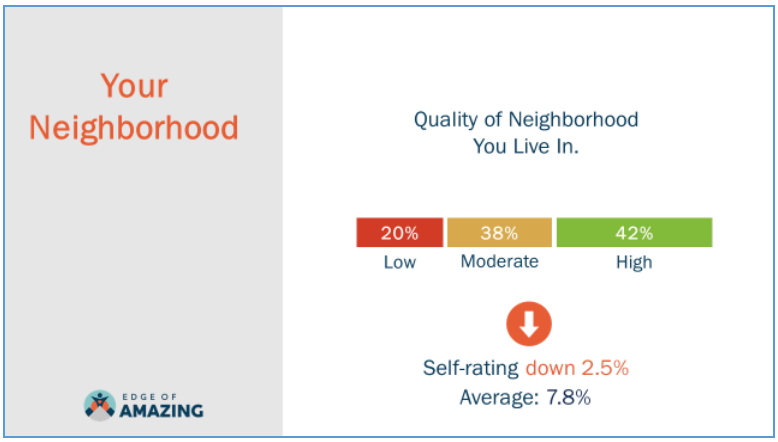


Figure 22. Quality of the neighborhood you live in.

Dimensions of Health: Work, Learning and Growth

Job Stability

The rate of people without a stable job or those worried about losing their job is 7.5%, down by 11% from 2017. Even with a drop in concerns about job security, feelings of financial security are unchanged (see security and basic needs).

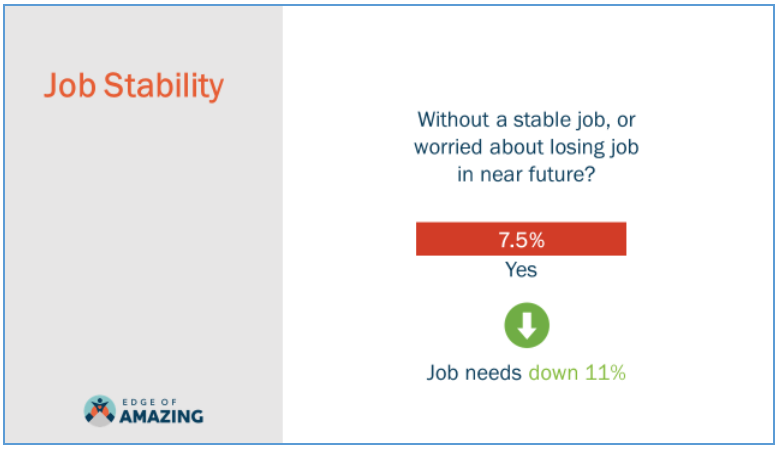


Figure 23. Individuals without a stable job or worried about losing job.

Work or Job

26% of individuals rate the quality of their work or job low. This is up 1.6% from 2017.

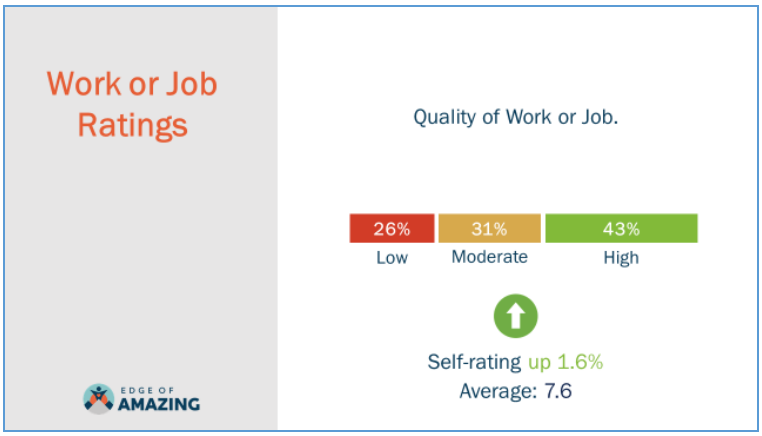


Figure 24. Individuals reporting the quality of work or job

Learning and Growth

Residents in 2019 report 1.3% higher level of optimism about learning and growth opportunities from 2017.

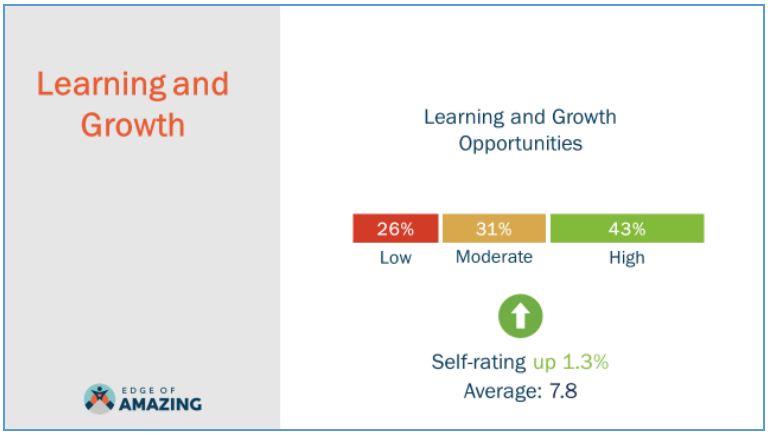


Figure 25. Opportunities to learn and grow

Education

Individuals who want more education and training to get a sustainable job increased by 14% from 2017.

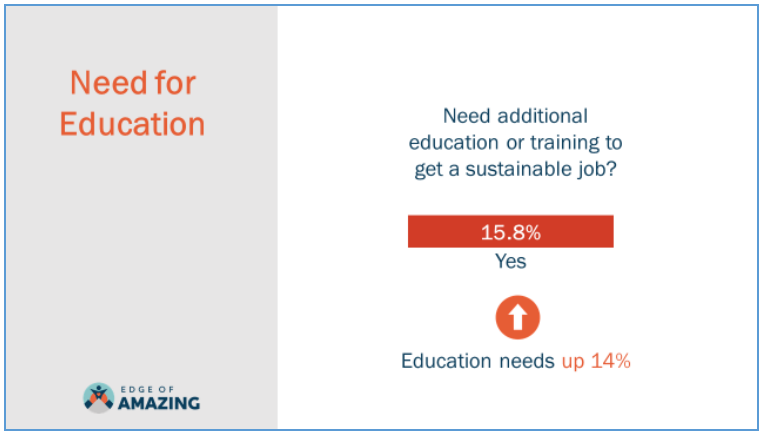


Figure 26. Individuals reporting they need additional educaton to get sustainable job

Dimension of Health: Security & Basic Needs

This dimension includes access to a range of needs people have including what is commonly referred to as social determinants of health. Social determinants of health are conditions in the environment in which people live, work, play, worship and age.[2] Poverty, unemployment, educational achievement, housing, and food access are just some of the social determinants that impact healthy behaviors. Without a network of support and a safe community, families cannot thrive. Ensuring access to social and economic resources provides a foundation for a healthy community.

Financial Security

The overall feeling of financial security are unchanged from 2017, despite a 23% decline in the county unemployment rate (4.3% to 3.3%).

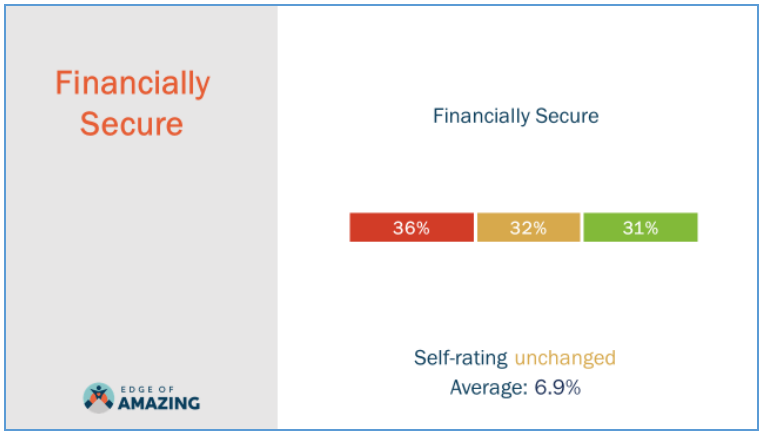


Figure 27. Individuals feeling financially secure

TotalHEALTH 7™ Social Needs

At a countywide level PIHC tracks a projected profile of key social determinant needs, which we call the TotalHEALTH7™. TotalHEALTH7™, a community-level initiative, is used to screen people in clinical and community-partner settings for a range of medical and non-medical needs, using a community case management platform linked to a list of over 2,000 local resources through PIHC's LiveWellLOCAL.org™ online well-being resource hub. This provides deeper insights into security and basic need for more than 2,600 participants screened over the past 18 months. The HWBM tracked trends over three years on these seven measures from 2017 through 2019.

Trends include:

- 16% lack education to sustain a living wage; trending higher than 2017
- 8% can't pay utility bills, unchanged from 2017
- 7.5% lack a stable job, trending lower
- 5% don't have enough food to eat; unchanged
- 5% lack transportation, trending lower

[2] https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health

- 5% are housing insecure, unchanged
- 3% report being unsafe at home, somewhat improved

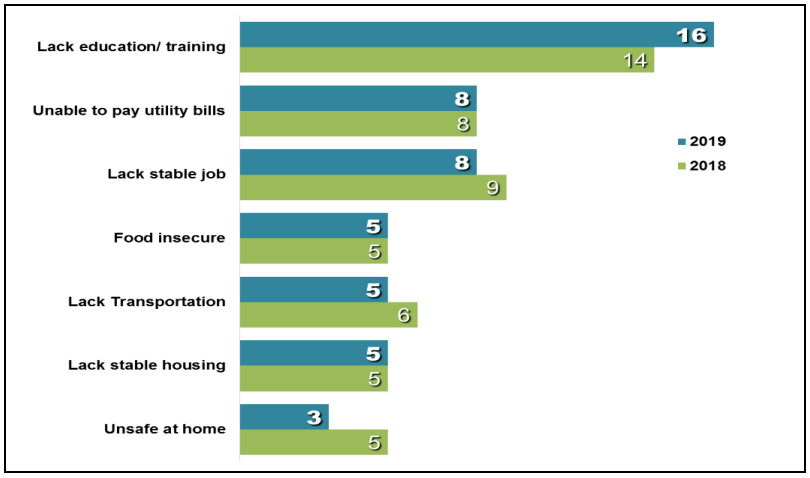


Figure 28. Percent of population lacking basic needs in Snohomish County

Dimensions of Health: Physical Health

Physical Health

Self-rating of physical health is down by 4.5% from 2017. Reports of poor physical health days are up 46% from 2017. In 2017, the average number of poor physical health days was 4 – 6 days per month or three weeks per year on average per person. This is primarily driven by people who report 6+ days of poor physical health, which has risen from 19% in 2017 to 26% in 2019.

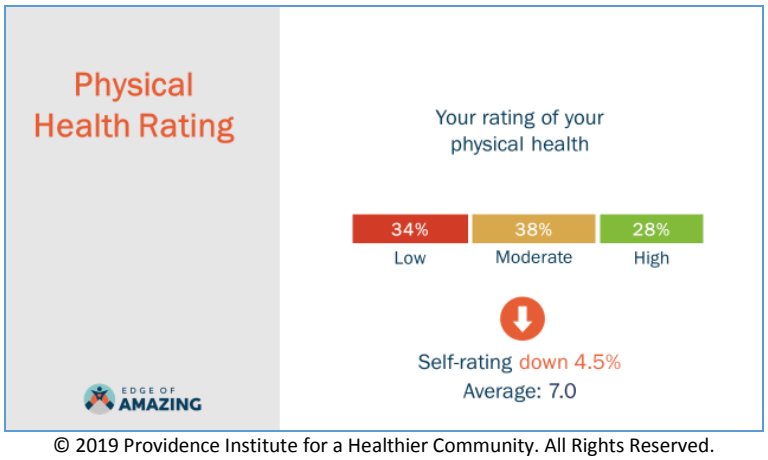


Figure 29. Individuals rating their physical health

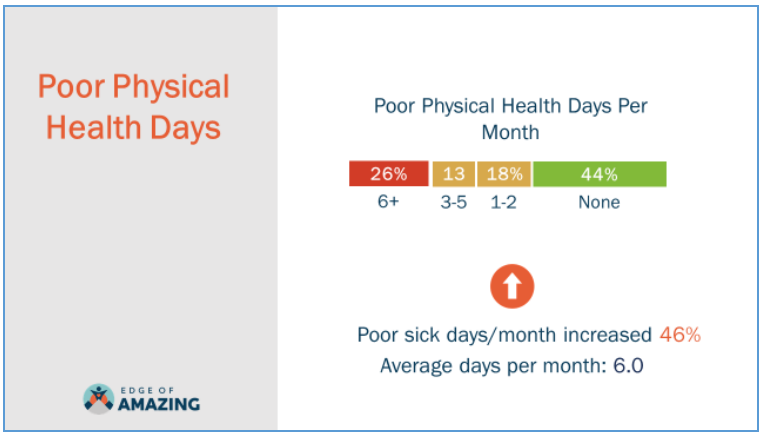


Figure 30. Number of poor physical health days per month

Exercise, Nutrition & Sleep

The amount of time an individual consumes the daily recommendation of fruits and vegetables, a key indicator of healthy eating, is relatively unchanged at 4.1 days per week. On average, people reported receiving the recommended 7 hours of sleep per night only 4.6 days per week. 71% of the population are not getting at least 7 hours of sleep per night, down 2.5% from 2017. Healthy physical activity of at least 30 minutes per day, 5 days per week are unchanged from 2017 with 50% of the County population not meeting standard.

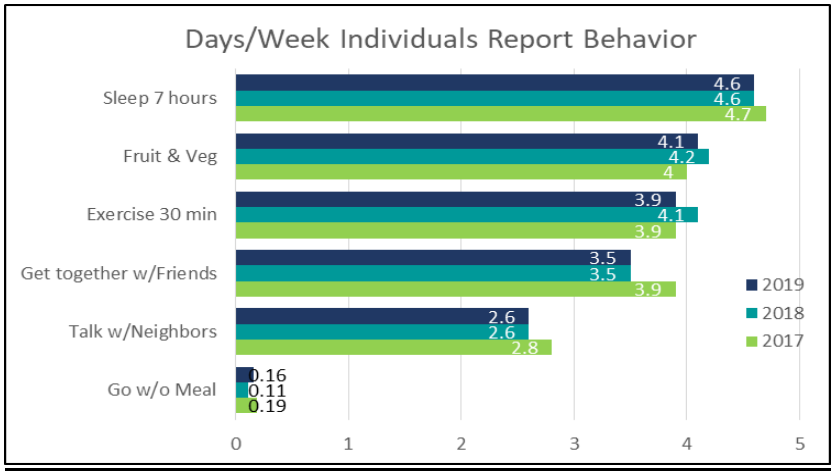


Figure 31. Average number of days per week people reported healthy behavior

Health Conditions

Overall, 37% of individuals said they have a health condition that requires treatment or special care. This has been rising, and compares to about 45% nationwide.

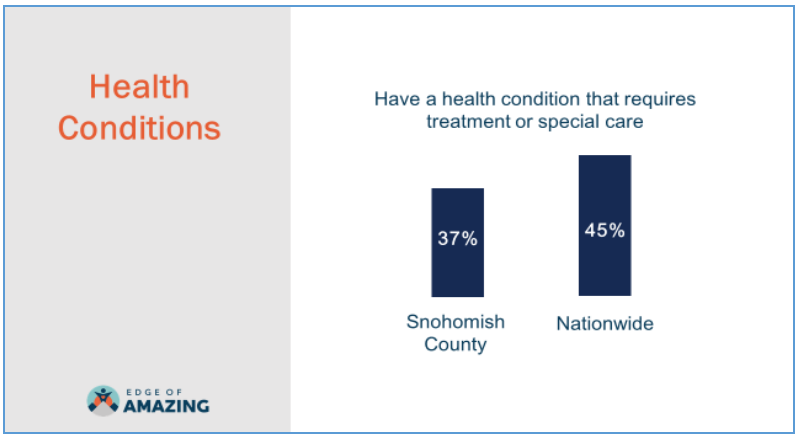
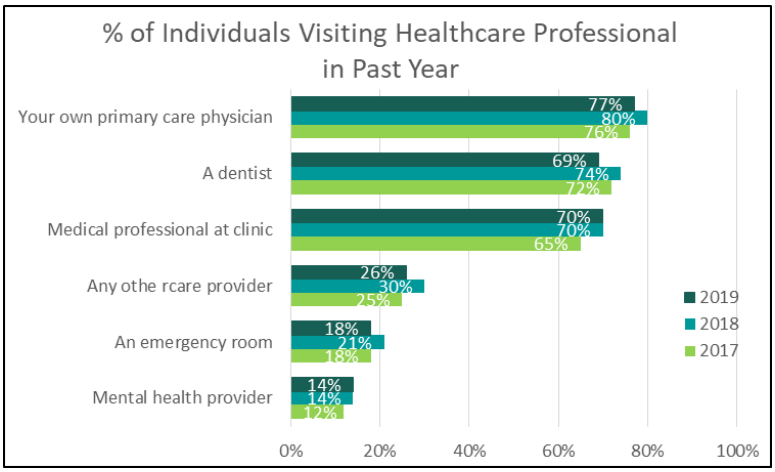


Figure 32. Percent of individuals that have a health condition requiring special treatment

Visit to Health Professionals

Individuals were asked how many times in the last year they visited a health care professional. In 2019, 77% of respondents had made at least one visit to their primary care physician, 69% to a dentist, and 70% to a medical professional at a clinic.



Source:
Figure 33. The percentage of respondents who reported visiting a health care professional in the last year

Topical Issues Report

In 2018 we reported on an alarming rise in reported discrimination, and the effects it has on well-being. This year we identified the first year-over-year trend data and added new insights into two areas: opioid use and homelessness.

Homelessness

Two in three (66%) people report that homelessness is a problem in their community or neighborhood. Nearly 1 in 3 (29%) view homelessness as crisis or significant issue in their own neighborhood. Overall well-being was also lower among people who perceived homelessness as a crisis in their neighborhood than those who perceived it as a crisis in their community. Additionally, the rating of one's neighborhood went down as perception of a homelessness

crisis in the community went up. The cities where individuals rate it as a crisis are Everett (37%), Lynnwood (35%), Marysville (33%), and Snohomish (31%).

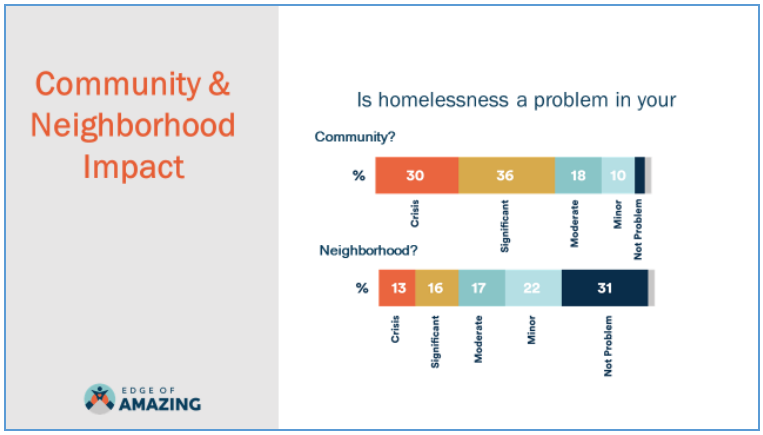


Figure 34. Percent of individuals reporting homelessness as a problem in their community or neighborhood

Homelessness is personal for a significant number of respondents. 42% know someone who is now or has been homeless, including 1 in 5 (18%) mentioning a family member or close personal friend, 1 in 4 (24%) an acquaintance, and 2% reported they are or have been homeless. The study found that on average, if you know someone who is homeless your overall well-being was measurably lower. We also found that people who know a homeless person have lower well-being Index scores than people who simply rate homelessness as a community or neighborhood crisis.

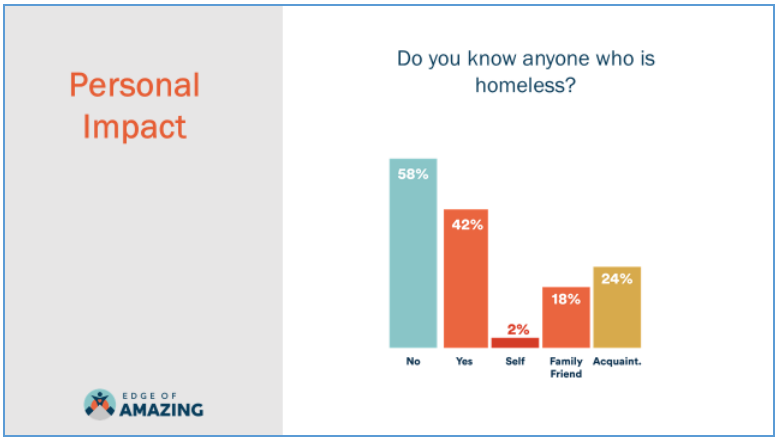


Figure 35. Percent of Snohomish County residents reporting they know someone who is homeless

Opioid Abuse Disorder

Over half (53%) said that opioid use in their community is a crisis or significant problem. 50% indicated that they knew someone that was or has been addicted to opioids. Those who view opioids as a neighborhood crises rate their neighborhoods much lower. Naming it a crisis was highest in the communities of Monroe (44%), Marysville (39%), Arlington (37%), and Everett (35%).

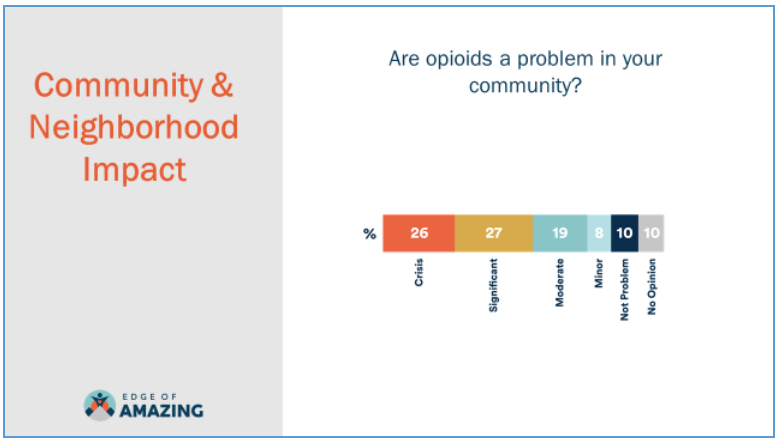


Figure 36. Percent of individuals reporting opioids are a problem in their community or neighborhood

As a personal issue, the opioid epidemic is clearly at a tipping point. 415,000 people in Snohomish County, half of the population, report having a personal relationship with someone who is struggling with opioids, including 33% with a family member or close personal friend, 20% an acquaintance, and 2% have been affected themselves.

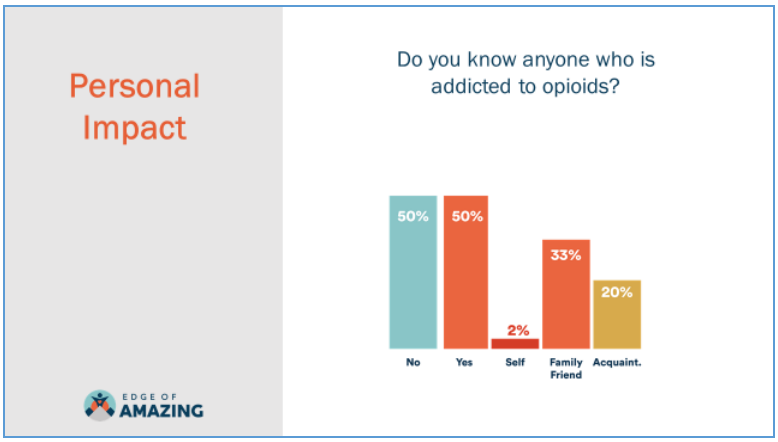


Figure 37. Percent of individuals reporting that they know someone addicted to opioids

Unlike homelessness, viewing opioids as a community crisis or personally knowing someone struggling with opioids did not negatively impact well-being. While concerns about opioids may not have lowered well-being, it is affecting the quality of neighborhood life. 46% of those who said opioids were minor or not a problem rated their neighborhood as excellent compared to 37% who saw opioids as a crisis or significant problem. Those who view opioids as a neighborhood crisis rated their neighborhoods much lower than people who felt the same way about homelessness.

Community Health & Well-being, Secondary Data Sources

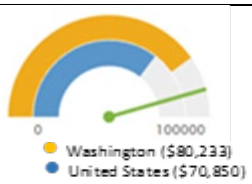
The Health & Well-being Monitor™ supplies a unique community-based trending data of well-being based on attributes of greatest importance to the people who live here. Analytics validate the self-reported satisfaction measures through the linkage to a range of more objective outcomes. Additionally, PRMCE also supplements measured community health and well-being data with more traditional data from secondary sources depicted below.

Family Income

Snohomish County is a relatively prosperous community. The median family income exceeds that of the state and the national median at $91,181.

Table 3. Median family income

Area	2013 – 2017
Snohomish County	$91,181
Washington	$80,233
United States	$70,850



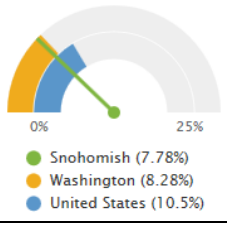
Source: US Census Bureau, American Community Survey, Graph from CARES Engagement Network

Insurance - Uninsured Population

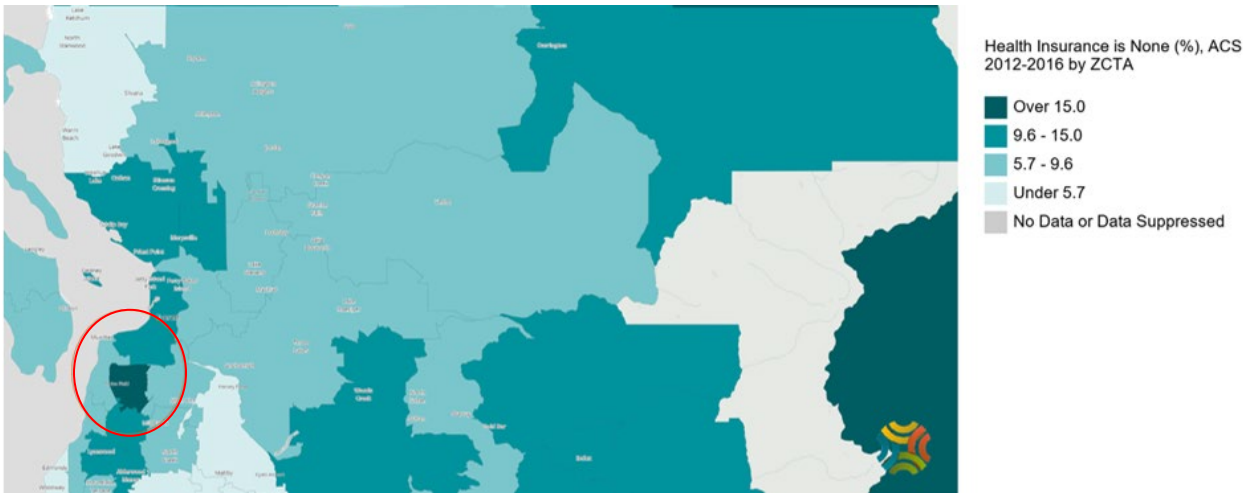
Lack of insurance is a primary barrier to healthcare access including regular primary care, specialty care, and other health services that contributes to poor health status. In Snohomish County 7.78% of the population are without health insurance coverage. The rate of uninsured people is less than the state average of 8.28%. The map below shows the insurance coverage by location, with the greatest area of vulnerability in the South Everett/Casino/Everett Mall area.

Table 4. The percentage of the total population without health insurance coverage

Area	2013-2017
Snohomish County	7.8%
Washington	8.3%
United States	10.5%



Source: US Census Bureau, American Community Survey, Graph from CARES Engagement Network



Source: American Community Survey

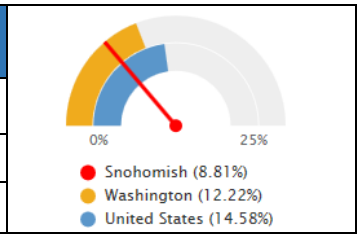
Figure 38. Snohomish County insurance coverage by location

Poverty

Within Snohomish County 8.81% or 67,118 individuals are living in households with income below the Federal Poverty Level. That increases to 22.6% at 200% below the Federal Poverty Level. This indicator is relevant because poverty creates barriers to access including health services, healthy food, and other necessities that contribute to poor health status.

Table 5. The percentage of individuals living in households with income 100% or 200% of the Federal Poverty Level

Area	200% Below Poverty	100% Below Poverty
Snohomish County	22.6%	8.81%
Washington	29.3%	12.22%
United States	33.6%	14.58%



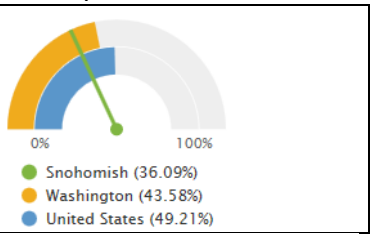
Source: US Census Bureau, American Community Survey, Graph from CARES Engagement Network

Children Eligible for Free/Reduced Price Lunch

Within Snohomish County 42,550 public school students or 36% are eligible for free/reduced price lunch out of 117,895 total students enrolled. This indicator assesses vulnerable populations which are more likely to have multiple health access, health status, and social support needs.

Table 6. The percentage of public school students eligible for free/reduced price lunch

Area	2010-2011	2016-2017
Snohomish County	31.17%	36.09%
Washington	40.17%	43.58%
United States	48.15%	49.21%



Source: National Center for Education Statistics, Graph from CARES Engagement Network

Snap Benefits

The Supplemental Nutrition Assistance Program (SNAP) is the largest federal nutrition assistance program. SNAP provides benefits to eligible low-income individuals and families. 11.8% of Snohomish County households receive SNAP benefits compared to 13% in the state.

Table 7. Percent of households receiving SNAP benefits

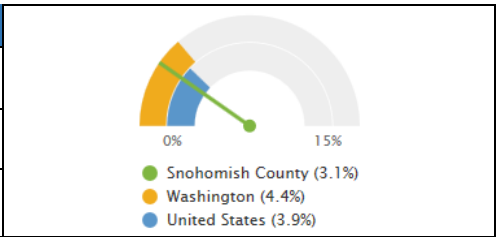
	Snohomish County	Washington	United States
Food insecurity/Households on SNAP	11.8%	13.9%	13.1%

Employment

The percentage of people unemployed in Snohomish County was 3.1% in June 2019, which was lower than the state percentage. Unemployment creates financial instability and barriers to access including insurance coverage, health services, healthy food and other necessities that contribute to poor health status.

Table 8. The percentage of people unemployed

Area	June 2018	June 2019
Snohomish County	3.9%	3.1%
Washington State	4.4%	4.2%
United States	4.2%	3.9%



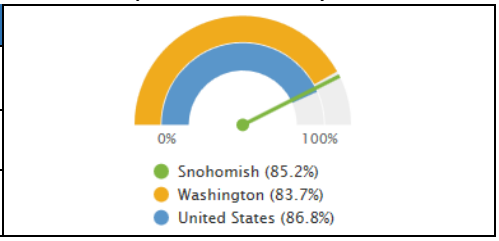
Source: US Department of Labor, Bureau of Labor Statistics, CARES Engagement Network

Education - High School Graduation Rate

Within Snohomish County 85.2% of students are receiving their high school diploma within four years.

Table 9. The percentage of students who receive their high school diploma in four years

Area	2011-2012	2016-2017
Snohomish County	79.7%	85.2%
Washington State	78,7%	83.7%
United States	81.8%	86.8%



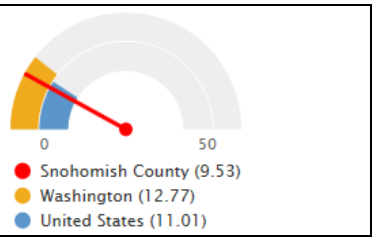
Source: US Department of Education, EDFacts, Graph from CARES Engagement Network

Recreation and Fitness Facility Access

Recreation and fitness facilities encourages physical activity and other healthy behaviors. Snohomish County has 9.53 recreation and fitness facilities per 100,000 population, which is fewer facilities than at the state and national levels.

Table 10. The number per 100,000 population of recreation and fitness facilities

Area	2010	2016
Snohomish County	9.11	9.53
Washington State	11.48	12.77
United States	9.68	11.01



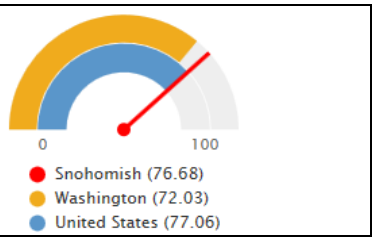
Source: US Census Bureau, Graph from CARES Engagement Network

Food Environment - Fast Food Restaurants

Fast food restaurants are defined as limited-service establishments primarily engaged in providing food services (except snack and nonalcoholic beverage bars) where patrons generally order or select items and pay before eating. This indicator provides a measure of healthy food access and environmental influences on dietary behaviors. Snohomish County has more fast food restaurants per 100,000 population than the state.

Table 11. The number of fast food restaurants per 100,000 population

Area	2010	2016
Snohomish County	74.72	76.68
Washington State	70.55	72.03
United States	69.14	77.06



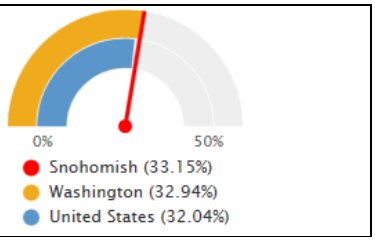
Source: US Census Bureau, Graph from CARES Engagement Network

Housing Cost Burden

The housing cost burden measures housing affordability. In Snohomish County 33.15% of households (includes owners and renters) experience housing costs that exceed 30% of the total household income. For renters alone, the housing cost burden rises to 50%. A greater percentage of households in Snohomish County experience housing cost burden compared to the state and country.

Table 12. The percentage of the households where housing costs exceed 30% of total household income

Area	2013-2017
Snohomish County	33.15%
Washington State	32.94%
United States	32.04%



Source: US Census Bureau, American Community Survey, Graph from CARES Engagement Network

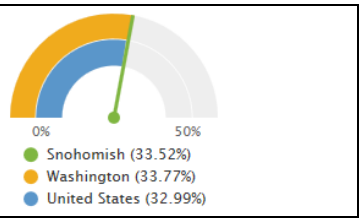
Housing - Substandard Housing

Nearly 34% of housing units (owned and rentals) in Snohomish County have at least one of the following conditions: 1) lacking complete plumbing facilities, 2) lacking complete kitchen

facilities, 3) one or more occupants per room, 4) monthly owner costs as a percentage of household income greater than 30%, and 5) gross rent as a percentage of household income greater than 30%. This measure assesses the quality of the housing inventory and its occupants.

Table 13. The percentage of owner- and renter-occupied housing units classified as substandard

Area	2013-2017
Snohomish County	33.52%
Washington State	33.77%
United States	32.99%



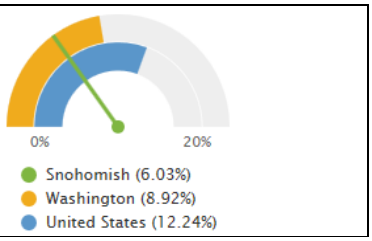
Source: US Census Bureau, American Community Survey, Graph from CARES Engagement Network

Housing - Vacancy Rate

Only 6% of housing units in Snohomish County are vacant, which is half of the national percentage of 12%. While this indicator is positive, lower vacancy rates limits the ability of those seeking housing to find affordable housing units.

Table 14. The percentage of housing units that are vacant

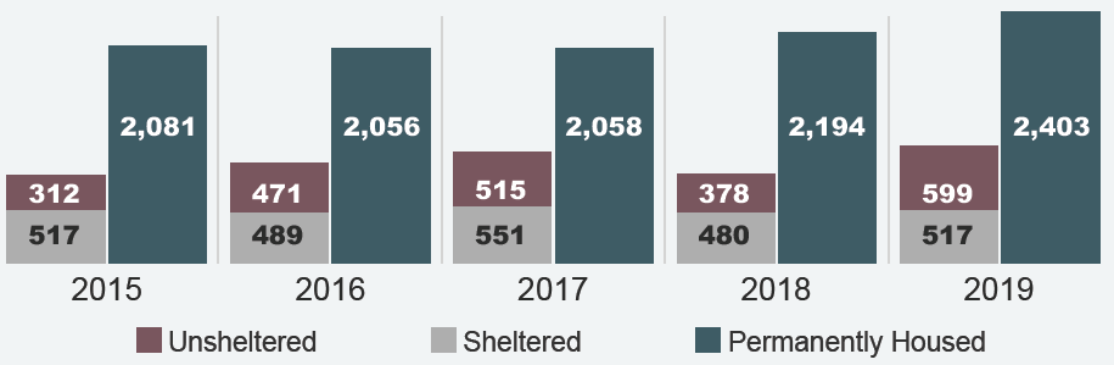
Area	2013-2017
Snohomish County	6.03%
Washington State	8.92%
United States	12.24%



Source: US Census Bureau, American Community Survey, Graph from CARES Engagement Network

Housing – Homelessness

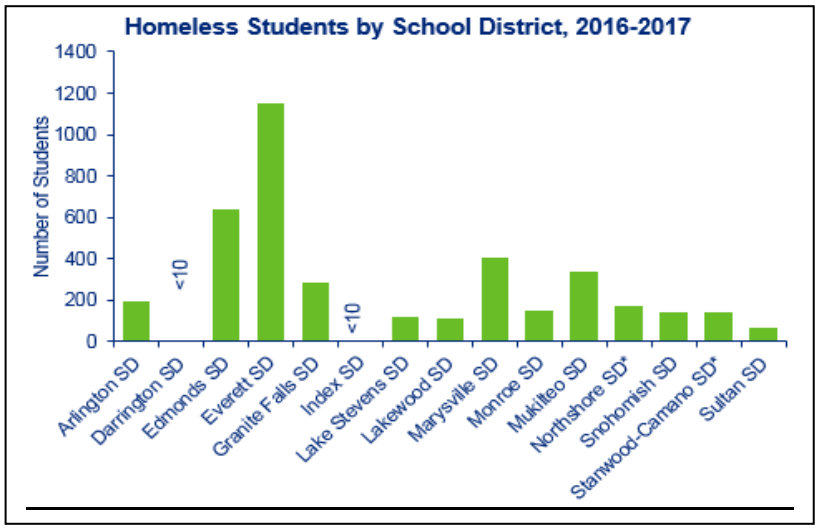
Homelessness negatively affects a person's health and well-being. A person experiencing homelessness is defined as an individual without permanent housing who may live on the streets, stay in a shelter, a mission, single room occupancy facility, abandoned building or vehicle, or in any other unstable or non-permanent situation. According to the annual Snohomish County Point in Time field survey conducted by Snohomish County Human Services, the number of unsheltered individuals has increased by 92% from 2015 to 2019. The number of individuals sheltered is unchanged from 2015, an indication that the shelter capacity in the community has not changed.



Source: Snohomish County Point In Time Survey 2019, Snohomish County Human Services
Figure 39. Number of people experiencing homelessness in Snohomish County by shelter type

Housing – Students experiencing homelessness

Snohomish County has fifteen public school districts. The Northshore School District has the highest enrollment at nearly 22,000 students followed by Edmonds School District and Everett School District. Everett School District, the third largest, has significantly more students experiencing homelessness (those without permanent housing) than any other district



Source: Washington State Office of Superintendent of Public Instruction, 2018, Snohomish Health District.
Figure 40. Number of students experiencing homelessness in Snohomish County by school district

Clinical Care

Federally Qualified Health Centers

Federally Qualified Health Centers (FQHCs) provide health care to vulnerable populations; they receive extra funding from the federal government to promote access to ambulatory care in areas designated as medically underserved (see Appendix 4). The number of FQHCs per 100,000 population for Snohomish County is much lower at 1.26 which is lower than the state number, 3.21, and the national number, 2.81

Table 15. Number of FQHCs per 100,000 population

Area	Number of FQHCs	Number of FQHCs per 100,000 Population
Snohomish County	9	1.26
Washington State	216	3.21
United States	8,768	2.81

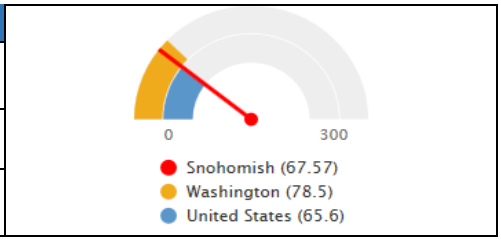
Source: US Department of Department of Health & Human Services, Center for Medicare & Medicaid, CARES Engagement Network

Access to Dentists

Snohomish County has more dentists per 100,000 population than that of the United States, but is well below the state average.

Table 16. Number of dentists per 100,000 population

Area	2010	2016
Snohomish County	62.7	67.57
Washington State	71.3	78.5
United States	58.9	65.6



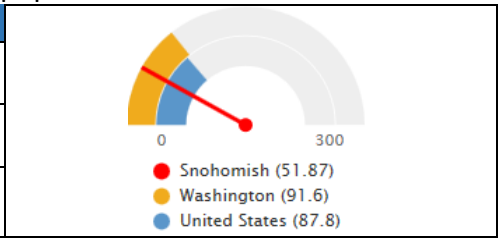
Source: US Department of Health & Human Services, HRSA, Graph from CARES Engagement Network

Access to Primary Care

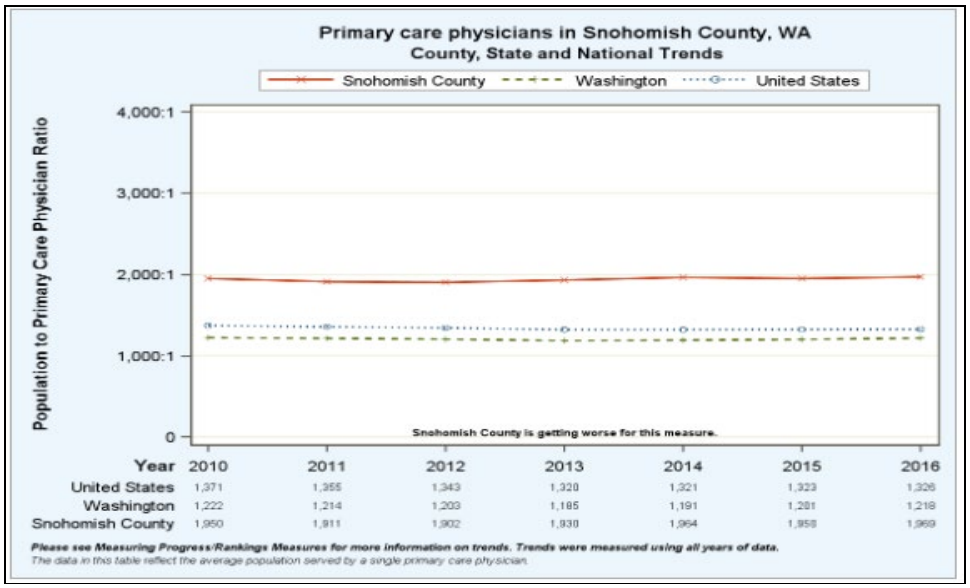
Doctors classified as "primary care physicians" include general family medicine, general practice, general internal medicine, and general pediatrics. Snohomish County has fewer primary care providers per 100,000 population compared to the state and the United States at 51.87 per 100,000 population (or a ratio 1,969 to 1). These ratios/trends have remained generally flat since at least 2010.

Table 17. Number of primary care physicians per 100,000 population

Area	2010	2016
Snohomish County	53.69	51.87
Washington State	90.21	91.6
United States	84.57	87.8



Source: US Department of Health & Human Services, HRSA, Graph from CARES Engagement Network



Source: Robert Wood Johnson, County Health Rankings

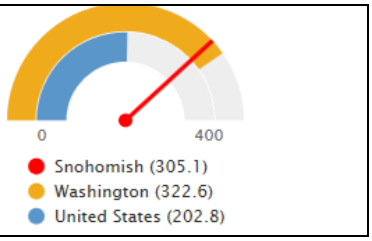
Figure 41. Population to primary care physician ratio in Snohomish County

Access to Mental Health Care Providers

There are 305 mental health professionals per 100,000 population in Snohomish County. This means there are more mental health professionals per person at the County level compared to the country, but fewer compared to the state. This includes psychiatrists, psychologists, clinical social workers, and counsellors that specialize in mental health care. Due to the lack of mental health providers, patients experience long wait times or insufficient care by facilities unequipped to treat them.

Table 18. Number of mental health care providers per 100,000 population

Area	2015	2017
Snohomish County	430	305.1
Washington State	400	322.6
United States	390	202.8



Source: County Health Rankings, Graph from CARES Engagement Network

OVERVIEW OF CHNA FRAMEWORK AND PROCESS

The CHNA process is based upon the understanding that health and wellness happen across our communities, not just in medical facilities. In gathering information on the communities served by the hospital, we looked not only at the health conditions of the population, but also at socioeconomic factors, the physical environment, and health behaviors. We also invited key stakeholders and community members to provide additional context to the data through community surveys and community forums. As often as possible, equity is at the forefront of our conversations and presentation of the data, which often have biases based on collection methodology.

In addition, we recognize that there are often geographic areas where the conditions for supporting health are substantially worse than nearby areas. Whenever possible and reliable, data are evaluated at the zip code or census block group level. These smaller geographic areas allow us to better understand the neighborhood-level needs of our communities and better address disparities within and across communities.

To conduct the assessment, data about the demographics and health factors of the community were analyzed to determine PRMCE's focus and plan to address the identified needs. 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. In addition to the quantitative data, 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.

Data Limitations and Information Gaps

While care was taken to select and gather data that would tell the story of the hospital's service area, it is important to recognize the limitations and gaps in information that naturally occur. For example, not all data are available to be analyzed by zip code, race/ethnicity or other socio-economic factors. Data may have a time lag and therefore may be several years old. Additionally, some data may not be available for trend analysis due to changes in definition or data collection methods.

Process for Gathering Comments on Previous CHNA

The 2016 CHNA was posted on the hospital website with information on how and to whom to inquire with to provide feedback and obtain copies of the CHNA at no charge.

Summary of Comments Received

No public comments have been received to date.

HEALTH INDICATORS

See Appendix 1 for a list of additional quantitative data used in the assessment.

Snohomish County Summary

According to the Robert Wood Johnson Foundation County Health Rankings, Snohomish County is ranked as the 3rd healthiest county in the State of Washington in both health outcomes and health factors. County Health Rankings are based on a model of population health that emphasizes the many factors that, if improved, can help make communities healthier places to live, learn, work, and play.

Health outcomes in the County Health Rankings represent measures of how long people live and how healthy people feel. Length of life is measured by premature death (years of potential life lost before age 75) and quality of life is measured by self-reported health status (percent of people reporting poor or fair health and the number of physically and mentally unhealthy days within the last 30 days), and the percent of low birthweight newborns.

Health factors in the County Health Rankings represent the focus areas that drive how long and how well we live, including health behaviors (tobacco use, diet and exercise, alcohol and drug use, sexual activity), clinical care (access to care, quality of care), social and economic factors (education, employment, income, family and social support, community safety), and the physical environment (air and water quality, housing, and transit).

County	Health Outcomes	Health Factors
Adams	34	33
Asotin	21	28
Benton	12	18
Chelan	10	8
Clallam	26	17
Clark	9	12
Columbia	37	22
Cowlitz	29	30
Douglas	13	19
Ferry	39	39

County	Health Outcomes	Health Factors
Franklin	15	35
Garfield	25	10
Grant	24	31
Grays Harbor	35	36
Island	4	5
Jefferson	5	9
King	2	1
Kitsap	8	4
Kittitas	11	14
Klickitat	20	20

County	Health Outcomes	Health Factors
Lewis	27	32
Lincoln	14	16
Mason	28	37
Okanogan	32	34
Pacific	36	27
Pend Oreille	38	29
Pierce	19	24
San Juan	1	2
Skagit	16	23
Skamania	22	21

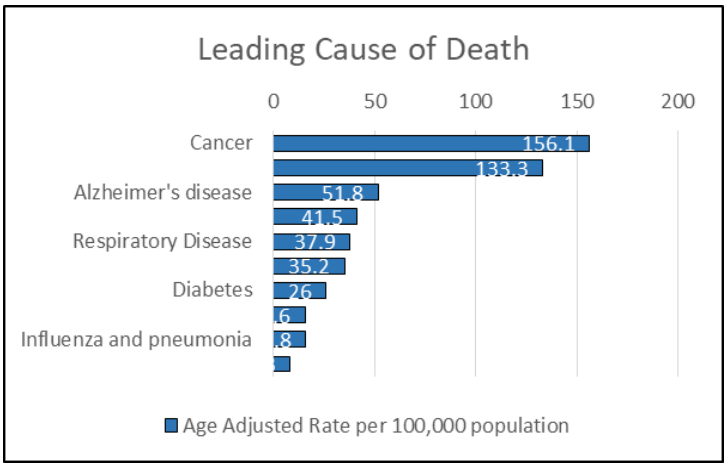
County	Health Outcomes	Health Factors
Snohomish	3	3
Spokane	23	15
Stevens	30	26
Thurston	6	7
Wahkiakum	33	25
Walla Walla	18	11
Whatcom	7	6
Whitman	17	13
Yakima	31	38

Source: Robert Wood Johnson, County Health Rankings & Roadmaps, 2018

Figure 42. County Health Rankings by health outcomes and health factors in Washington State

Mortality – Leading Cause of Death

Cancer is the leading cause of death in Snohomish County, followed closely by heart disease based on an age adjusted rate per 100,000 population.



Source: CDC Wonder, 2018

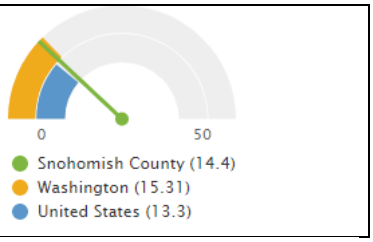
Figure 43. Leading causes of death in Snohomish County based on age adjusted rate

Mortality - Suicide

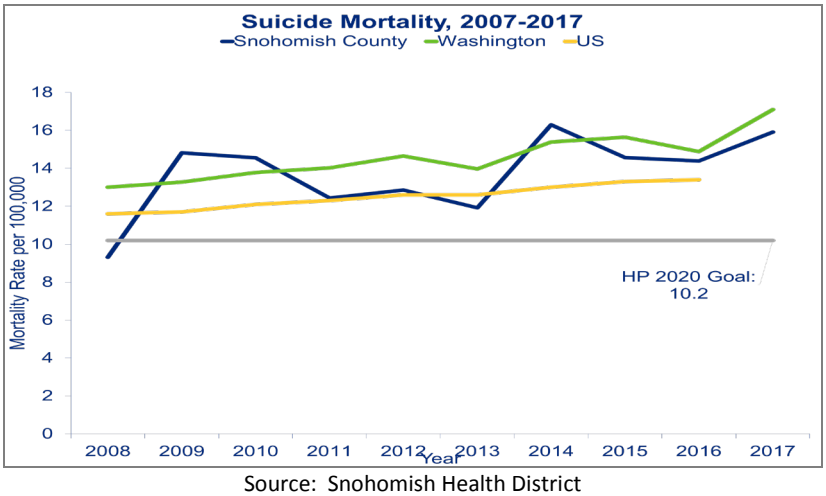
The rate of death due to intentional self-harm (suicide) per 100,000 population in Snohomish County is below that of the state, but still not meeting the Healthy People 2020 goal of 10.2.

Table 19. The number of deaths due to suicide per 100,000 population

Area	2013-2014*	2017
Snohomish County	16.3	14.4
Washington State	13.5	15.3
United States	19.5	13.3



Source: Center for Disease Control and Prevention, Graph CARES Engagement Network, *WA Dept of Health, Center for Health statistics



Source: Snohomish Health District

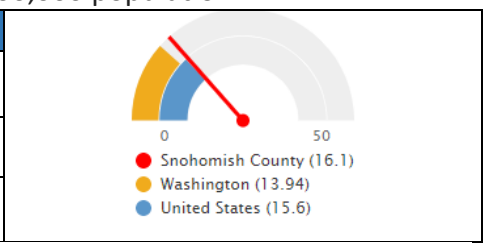
Figure 44. The number of deaths due to suicide per 100,000 population

Mortality - Drug Poisoning

The rate of death due to drug poisoning per 100,000 population in Snohomish County is 16, which is higher than the state but lower than the nation's rate. The Snohomish County rate has been unchanged for the last several years.

Table 20. The number of deaths due to drug overdose per 100,000 population

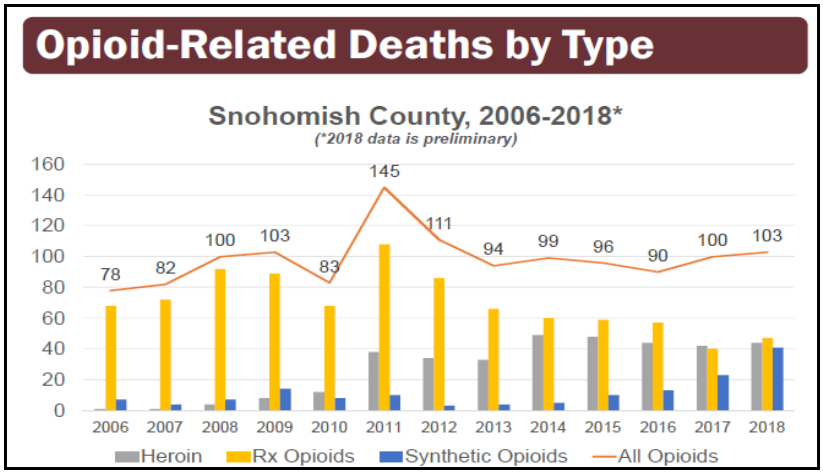
Area	2010	2017
Snohomish County	16	16
Washington State	13	14
United States	12	18



Source: Center for Disease Control and Prevention, Graph CARES Engagement Network

Mortality - Opioid

While the prescription opioid mortality rate in our community has been dropping since 2011, the heroin and synthetic opioid related deaths have increased.



Source: Washington State Department of Health, Graph: Snohomish Overdose Prevention

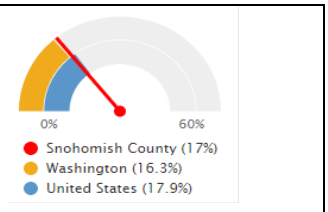
Figure 45. The opioid-related deaths by type in Snohomish County

Depression (Medicare Population)

The percentage of the Medicare population (age 65 and above) with depression in Snohomish County is 17%, increasing from just under 15% in 2011.

Table 21. The percentage of Medicare beneficiaries with depression

Area	2011	2017
Snohomish County	14.6%	17.0%
Washington State	14.4%	16.3%
United States	15.3%	17.9%



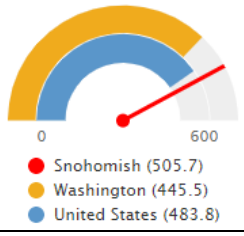
Source: Centers for Medicare and Medicaid Services, Graph CARES Engagement Network

Cancer Incidence - All Sites

The age adjusted incidence rate, or number of cases per 100,000 population per year, for cancer at all sites is higher in Snohomish County than that of the state and nation. Cancer is the leading cause of death and it is important to identify cancers separately to better target interventions. In Snohomish County, breast is the number one cancer site.

Table 22. Age adjusted cases per 100,000 population per year of cancer at all sites

Area	2011-2015
Snohomish County	505.7
Washington State	445.5
United States	483.8



Source: State Cancer Profiles, Graph CARES Engagement Network

Table 23. Age adjusted incidence rate of the five most common cancer sites in Snohomish County

Cancer Site	Age-Adjusted Rate
1 – Breast	139
2 - Lung & Bronchus	60.3
3 – Prostate	106.8
4 - Colon & Rectum	38.1
5 - Melanoma of the Skin	32

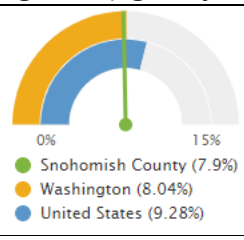
Source: State Cancer Profiles

Diabetes (Adult)

The percentage of adults aged 20 and older who have ever been told by a doctor that they have diabetes remains steady in Snohomish County at 8%. Diabetes is a prevalent problem in the U.S. and may indicate an unhealthy lifestyle. It also puts individuals at risk for further health issues.

Table 24. Percentage of adults 20 years and older with a diabetes diagnosis (age-adjusted)

Area	2010	2015
Snohomish County	8%	7.9%
Washington State	8.1%	8%
United States	8.9%	9.2%



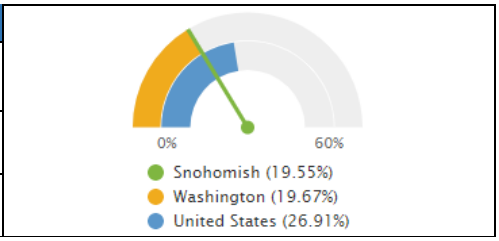
Source: Centers for Disease Control & Prevention, Graph CARES Engagement Network

Heart Disease

The percentage of the Medicare population (age 65 and above) with ischemic heart disease in Snohomish County is comparable to the state percentage and lower than the national percentage. Heart disease is a leading cause of death in the U.S. and is also related to high blood pressure, high cholesterol, and heart attacks.

Table 25. Percentage of Medicare beneficiaries with heart disease

Area	2011	2017
Snohomish County	19.95%	19.5%
Washington State	20.6%	19.67%
United States	29.85%	26.91%



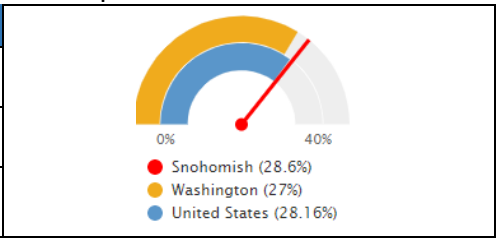
Source: Centers for Disease Control & Prevention, Graph CARES Engagement Network

High Blood Pressure

In Snohomish County, 29% of adults aged 18 and over have high blood pressure or hypertension. Uncontrolled high blood pressure can lead to stroke, heart attack, and poor quality of life. Treatment and lifestyle choices can help control high blood pressure.

Table 26. Percentage of adults aged 18 and older with high blood pressure

Area	2011-2015
Snohomish County	28.6%
Washington State	27%
United States	28.1%



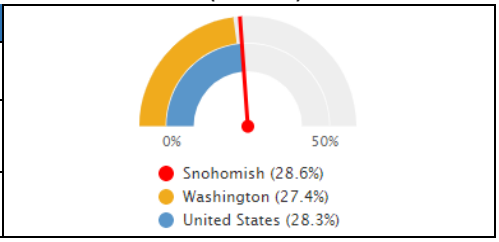
Source: Centers for Disease Control & Prevention, Graph CARES Engagement Network

Obesity - Adult

28.6% of Snohomish County adults aged 20 and older self-report that they have a Body Mass Index (BMI) greater than 30.0, which is considered obese. Excess weight may indicate an unhealthy lifestyle and puts individuals at risk for further health issues.

Table 27. Percentage of adults with a self-reported BMI greater than 30.0 (obese)

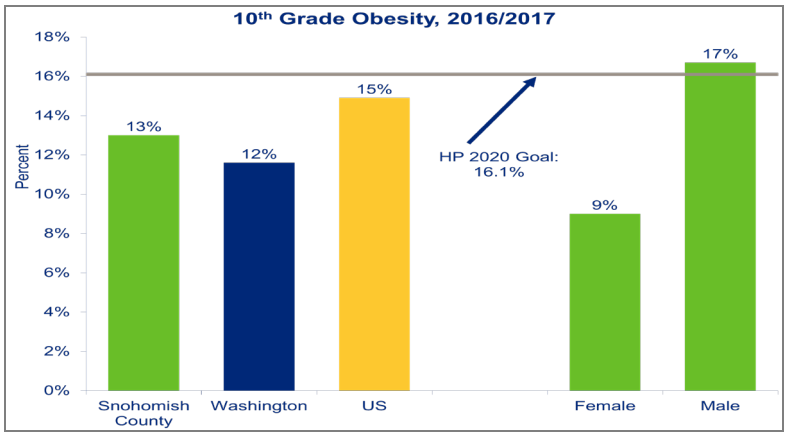
Area	2010	2015
Snohomish County	28.8%	28.6%
Washington State	27.4%	27.4%
United States	27.3%	28.3%



Source: Centers for Disease Control & Prevention, Graph CARES Engagement Network

Obesity - Youth

The percentage of 10th grade youth who are obese in Snohomish County is 13%. This indicator has been increasing over time, although it is lower than the Healthy People 2020 goal of 16%. Children are classified as obese if their calculated BMI is in the 95th percentile or above for their age.



Source: Healthy Youth Survey, Graph Snohomish Health District

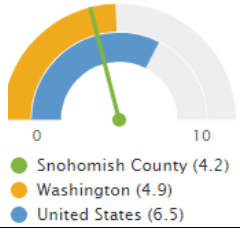
Figure 46. The percentage of 10th graders considered obese by gender

Infant Mortality

The Snohomish County rate of deaths for infants less than one year of age per 1,000 births has improved and is less than that of the state and national rates. High rates of infant mortality indicate the existence of broader issues pertaining to access to care and maternal and child health.

Table 28. Number of infant deaths than one year of age per 1,000 births

Area	2014	2012
Snohomish County	3.57	4.2
Washington State	4.54	4.9
United States	6.0	6.5



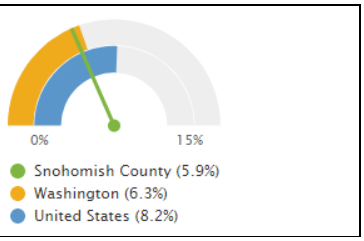
Source: US Department of Health & Human Services, *National Center for Health Statistics, Graph CARES Engagement Network

Low Birthweight

This indicator reports the percentage of total births that are low birthweight (under 2500g). Low birthweight infants are at high risk for health problems. Percentages for Snohomish County are lower in Washington State and the U.S. Non-Hispanic, black infants are disproportionately born low birthweight in comparison to other races.

Table 29. The percentage of low birthweight births

Area	2002 - 2008	2006 - 2012
Snohomish County	5.8%	5.9%
Washington State	6.2%	6.3%
United States	8.1%	8.2%



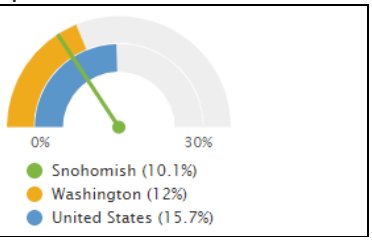
Source: US Department of Health & Human Services, Graph CARES Engagement Network

Poor Dental Health - Adult

The percentage of adults age 18 and older who self-report that six or more of their permanent teeth have been removed due to tooth decay, gum disease, or infection is 10% for Snohomish County, lower than state and national percentages.

Table 30. The percentage of adults age 18 and older who self-report poor dental health

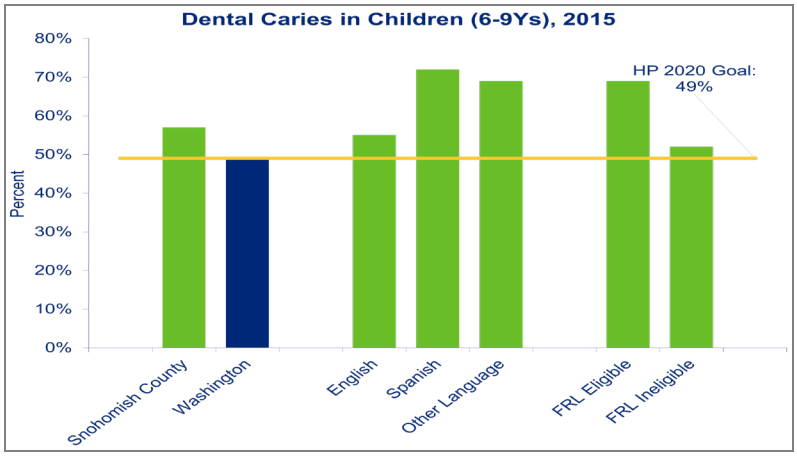
Area	2006-2010
Snohomish County	10.1%
Washington State	12%
United States	15.7%



Source: Centers for Disease Control & Prevention, Graph from CARES Engagement Network

Poor Dental Health - Youth

Children with dental caries, or cavities, in Snohomish County is at 57%, compared to 49% in Washington State. Disparities exist amongst non-English speaking residents.



Source: Snohomish County Smile Survey, Graph Snohomish Health District

Figure 47. The percentage of children between ages 6 and 9 years with dental caries

Emergency Department Visits

Some emergency department visits are preventable and may indicate inadequate access to care. Lowering inappropriate emergency department visits that are preventable or treatable in

a primary care or urgent care setting can lower overall costs and improve coordination of care for the patient. Common measures of preventable emergency department visits include diagnosis related to mental health, alcohol, substance abuse, asthma and dental conditions.[3] Approximately 19,000 of the 61,000 (31%) annual outpatient emergency department visits at PRMCE can be classified as potentially avoidable. Of those potentially avoidable emergency department visits, alcohol/drug abuse is the number one diagnosis grouping.

Table 31. Preventable emergency department visits ranked by number of cases at PRMCE May 2018 – April 2019

Rank	MSDRG Code Description / Reason for Visit	Cases
1	897 - ALCOHOL/DRUG ABUSE OR DEPENDENCE W/O REHABILITATION THERAPY W/O MCC	1,723
2	603 - CELLULITIS W/O MCC	1,536
3	153 - OTITIS MEDIA & URI W/O MCC	1,513
4	690 - KIDNEY & URINARY TRACT INFECTIONS W/O MCC	1,103
5	103 - HEADACHES W/O MCC	1,006
6	552 - MEDICAL BACK PROBLEMS W/O MCC	959
7	392 - ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS W/O MCC	861
8	951 - OTHER FACTORS INFLUENCING HEALTH STATUS	820
9	203 - BRONCHITIS & ASTHMA W/O CC/MCC	803
10	149 - DYSEQUILIBRIUM	740
11	885 - PSYCHOSES	726
12	556 - SIGNS & SYMPTOMS OF MUSCULOSKELETAL SYSTEM & CONN TISSUE W/O MCC	713
13	607 - MINOR SKIN DISORDERS W/O MCC	608
14	880 - ACUTE ADJUSTMENT REACTION & PSYCHOSOCIAL DYSFUNCTION	523
15	305 - HYPERTENSION W/O MCC	401

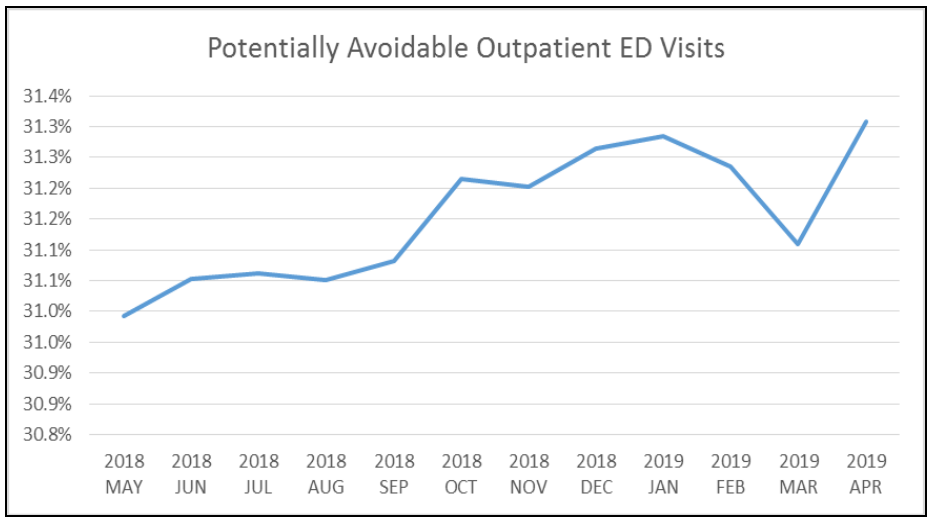


Figure 48. Percentage of potentially avoidable outpatient emergency department visits at PRMCE

[3] Agency for Healthcare Research & Quality

Hospital Visits – Suicide and Self-Harm

The number of suicide and self-harm events per 1,000 encounters for PRMCE emergency room and inpatient hospital stays has increased over the last three years. Additionally, PRMCE has substantially more emergency department visits for suicide/self-harm than other Providence facilities in Washington and Montana.

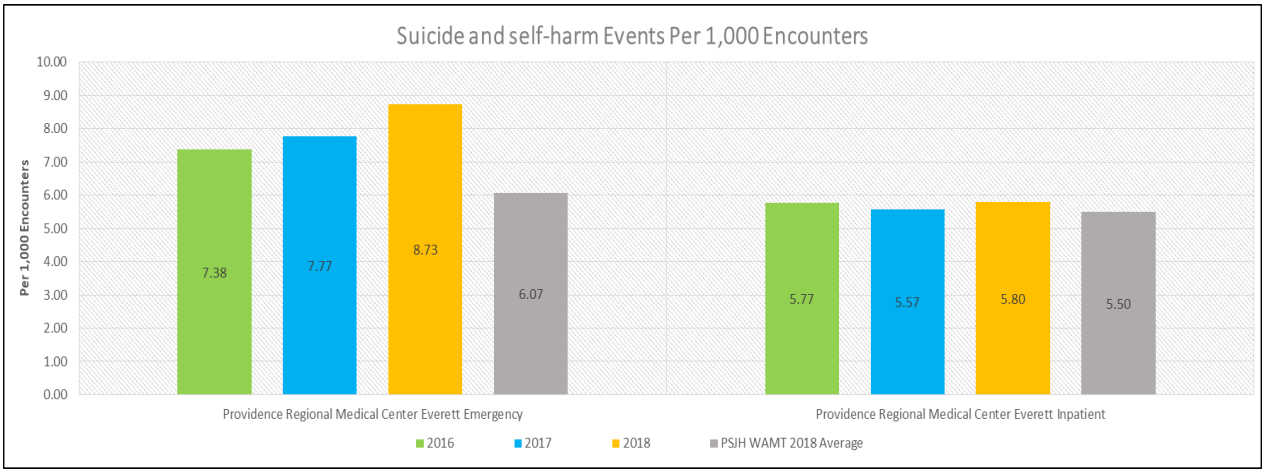


Figure 49. The number of suicide and self-harm events per 1,000 encounters at PRMCE, emergency and inpatient

COMMUNITY INPUT

PRMCE formed the Providence Institute for a Healthier Community (PIHC) as a partnership between business, government, healthcare providers, schools, and non-profits with the goal of encouraging residents of Snohomish County to make small but important behavioral changes to improve their health. Recognizing that health is more than healthcare, PIHC starts with a shared understanding of health as defined by our community and works together to create a healthier future. PIHC serves as the convener and facilitator by helping establish innovative community partnerships to support health and well-being.

To better understand the community's perspective, opinions, experiences, and knowledge, PIHC reaches out and listens to the community, letting them define what health and happiness mean to them. PIHC collects this feedback through various methods including the Health & Well-Being Monitor™, the Edge of Amazing Community Health Summit, PIHC Strategic Oversight Team, PIHC Strategic Planning Council, and the PIHC Sustainability, Inclusion and Co-Creation Task Force. In addition, feedback was obtained from the Mission and Healthier Communities Committee and the Snohomish Health District Community Health Assessment team. Through these forums, community members, nonprofit organizations, and government stakeholders provide input on the issues and opportunities of the people, neighborhoods and cities of Snohomish County. Below is a summary of these community groups, community forums and surveys. Please see Appendix 3 for a list of participants and dates.

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 develop a survey to get input on health and well-being from the point of view of Snohomish County residents. This survey is called the Health and Well-Being Monitor™. 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 more informed and compassionate conversations with community members around what it takes to improve health and well-being.

To develop the monitor, a sampling of nearly 600 Snohomish County adults over the age of 18 were contacted through a telephone and online survey. The central questions of the monitor include how residents define their health and well-being, factors that residents find important to health and well-being, and how satisfied residents are with their own health and well-being.

Participants are asked to measure 24 aspects of their health in six key areas identified as relevant by the community: 1) security and basic needs, 2) emotional and spiritual health, 3) work learning and growth, 4) physical health, 5) relationships and social connections, 6) and neighborhood and environment. To look at health from the point of view of the residents, 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 form the basis for the Snohomish County Health and Well-Being Index. (See Community Health & Well-Being beginning on page 11 for detailed findings of the HWBM).

In addition to the countywide Health & Well-Being Monitor™, in 2019 PIHC began working with diverse communities to build upon the infrastructure of the Health & Well-Being Monitor™ to crease a community version to assist organizations and community networks with measuring well-being, informing action steps, and tracking progress. The community level Health & Well-Being Monitor™ provides communities with a snapshot of the perceptions, satisfaction and behaviors related to the six dimensions of health. This method allows communities to become more active well-being partners based on what matters to them.

Edge of Amazing Community Health Summit

Now in its 5th year, the PIHC Edge of Amazing is an annual community health forum that brings together over 300 members of the community representing individuals, private and public organizations, educational institutions, government, youth, seniors and more to identify and develop ways to improve community health and well-being across Snohomish County. At each summit, participants review and give feedback on the current state of health in Snohomish County, set a vision and priorities, and share best practices.

An organization committee made up of community members reviews feedback from the previous Edge of Amazing summit and incorporates other emerging themes to identify conference topics that are identified as important to the community. At the 2019 forum, in addition to reviewing the current Health and Well-Being Monitor™ survey results, community members participated in discussions focused on 1) mental and emotional health including opioid abuse, mental health first aid, integrating behavioral health, and building trauma informed organizations; 2) security and basic needs, including housing and homelessness; and 3) relationships and social connections, including valuing diversity.

PIHC Strategic Oversight Team

The PIHC Strategic Oversight Team is a community group consisting of board and community members who meet monthly to review, provide feedback, and guidance into PIHC's key initiatives and processes.

PIHC Strategic Planning and Priority Council

This council is a community group, made up of community members, businesses, non-profits, schools, and other leaders who convened in a day-long forum to review and provide insight in the PIHC Strategic Plan and key initiatives. This established the strategic focus and priorities for the work over the next three years. The outcome of the community forum include the identification of three issues to be addressed: 1) human well-being is multi-dimensional, but our responses often are not; 2) culturally, we are reactive instead of proactive about our health, and 3) people don't have access to all of the things they need to be healthy.

PIHC Sustainability, Inclusion, and Co-Creation Task Force

The Sustainability, Inclusion, and Co-Creation Task Force is a community group that provided the guiding principles that PIHC used in the development, creation, and deployment of key community health initiatives. The guiding principles of community co-creation, inclusion and sustainability were recommendations from the task force that were used to shape the strategic planning retreat.

- Community Co-creation: Ensure shared, supportive practices and procedures are in place so that PIHC and current and future partners and constituents share a common understanding and vision to advance mutual benefits from projects undertaken by PIHC and community partners.

- Inclusion: Policies, practices, and procedures are equitable and transparent to ensure relationships contribute to decision making and governance. Specifically include people experiencing barriers to health equity.

- Sustainability: Policies that enable PIHC to make sustaining investments in initiatives and systems leverage community collaboration to empower healthy communities.

Snohomish Health District - Community Health Assessment Data Task Force and Community Data Walk

The task force was convened by the Snohomish Health District for a year-long review of the community health indicators and to seek input from the respective communities and organizations represented. In addition to the Data Task Force, several data walks were held within the community to get the feedback and perspective of Snohomish County community members. Participants were guided through a data analysis process and asked for input to better understand the health issues that the community is facing. Close to 50 people attended the data walks and provided feedback on health disparities, root causes and potential actions that may best address the top areas of concern. The Snohomish Health District anticipates releasing their final written report in December 2019. The outcome of this work formed the basis of the primary data indicators used in the PRMCE CHNA.

Providence Community Ministry Board – Mission & Healthier Communities

The Providence Northwest Washington Regional Community Ministry Board serves as the governing body for PRMCE. The Community Ministry Board delegates responsibility for the PRMCE CHNA/CHIP work to the Mission & Healthier Communities committee. The committee membership includes both Board and community members that represent a broad cross-section of the community. The committee helps to ensure that the Providence Mission, core values and vision are integrated throughout the northwest Washington region of Providence. The committee also participates in the development of the CHNA and ensures that programs are designed to enhance the health of our local community. The committee devotes time at each committee meeting to discuss community health needs and how PRMCE is contributing to a healthier community.

SIGNIFICANT HEALTH NEEDS

To conduct the assessment, quantitative and qualitative data about the community were analyzed to determine PRMCE's focus and plan to address the identified needs (see the Appendix 1 for a comprehensive list of 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.

Prioritization Process and Criteria

PRMCE utilized a three-step approach to identify the significant health needs that it will address in this cycle. 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.

In the first phase of the PRMCE assessment, over 150 indicators were evaluated. The Snohomish Health District convened a community task force to review the Health District's community health indicators and seek input from community members. The results of this work was used as the starting point for the PRMCE CHNA. In addition to the Snohomish Health District information, data other sources were used including the PIHC Health & Well-Being Monitor™, Robert Wood Johnson, Behavioral Risk Factor Surveillance System, community surveys and forums, and hospital level data. These indicators were prioritized using a methodology adopted from the Snohomish Health District process. Data were scored and prioritized by the PRMCE 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

For the second phase, indicators from the first phase were grouped by health behaviors, health outcomes and social determinants of health. These groupings were used to ensure that PRMCE was evaluating the community more broadly than clinical care. The data were then reviewed and scored by the Providence Northwest Washington Service Area Community Ministry Board, Mission and Healthier Communities to identify the areas of greatest need in our community based on the need for improvement, disproportionate impact on sub-populations, and level of community resources dedicated to improving the indicator.

The following needs were identified during the second phase. The top seven areas of greatest need closely mirror those that were identified through the Snohomish Health District community process.

Table 32. Comparison of prioritized health needs from Snohomish Health District and PRMCE

Snohomish Health District Community Data Walk	Providence Mission & Healthier Communities Committee
Mental Health – Youth	Mental Health - Access
Suicide – Adult	Opioid Use disorder
Opioid Use disorder	Housing / Homelessness
Dental Health – Children	Primary Care - Access
Primary Care - Access	Suicide
Housing / Homelessness	Obesity, Diet & Exercise
Obesity – Youth	Dental Health – Access for Youth

During the final phase, the CHNA Advisory Group completed an analysis of the second phase to select the significant health issues that PRMCE will focus on based on the linkage to the strategic plan, availability of resources relative to community need, and confidence in PRMCE's ability to have an impact

Table 33. PRMCE's prioritized significant health-related needs for the 2019 CHNA

Phase III Outcome
Access to Mental Health Care
Opioid Use Disorder
Housing / Homelessness
Access to Primary Care

Potential Resources Available to Address Significant Health Needs

PRMCE 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. Understanding the potential resources to address significant health needs is fundamental to determining current state capacity and gaps. In addition to PRMCE, the organized health care delivery systems include organizations such as the Snohomish Health District, Swedish Edmonds, Evergreen Health Monroe, Cascade Valley Hospital, Community Health Center of Snohomish County, SeaMar, The Everett Clinic and Western Washington Medical Group. In addition, there are numerous other social service agencies, non-profit agencies, and faith-based organizations that contribute resources to address these identified needs. Some of the organizations that PRMCE works closely with to address the significant health needs include Catholic Community Services, Clare's Place, and Everett Gospel Mission

PRMCE understands that local community resources and assets are vital to improving the health of the population. PIHC created an on-line search and collaboration resource tool called

LiveWellLocal™ which makes it easier to find and connect with the many community assets in Snohomish County that support health and healing. It provides a way for communities to work together to gather and share information, expanding the depth, usability and equity of available resources. The tool was created with three audiences in mind including the following:

1) Snohomish County health and social service providers who refer or support clients with well-being needs and goals
2) Individuals within the county who want to take action and improve their own well-being by engaging with supportive community resources
3) Organizations who want to promote well-being and improve population health.

For a list of potential resources available to address significant health needs, please see Appendix 6 or visit www.pihchub.org/livewell/.

2019 PRIORITY 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, PRMCE cannot directly address all needs identified in a CHNA. Based on the outcome of the evaluation from Phase III, PRMCE determine that we will address the following priority areas as part of the 2020 - 2022 Community Health Improvement Plan:

Table 34. Prioritized health needs with definition and justification for selection

Health Issue	Definition	Justification
Access to Mental Health Care	Access to mental health care includes the availability of quality, integrated care for individuals with a range of mental conditions. Due to the lack of access to mental health services, patients are either going without care, have long wait times to see a provider, or are cared for in facilities that are not equipped to care for them.	• Snohomish County has 305 mental health care providers per 100,000 population. • 17% of 65+ population has depression. • 54% report at least one poor mental health day, average of 5.2 days per month • 38% of individuals report at least one poor health day (day where health was not good or it kept them from doing usual activities) which includes physical and mental health. • 8.73 suicide encounters per 100,000 emergency department encounters, and 5.8 per 100,000 inpatient encounter.
Opioid Use Disorder	Opioid use disorder has a significant health and social impact on individuals and the community and is a serious problem in Snohomish County. Opioid use disorder include prescription opioids prescribed by doctors to treat moderate to severe pain such as morphine, oxycodone, hydrocodone or fentanyl, or illegal drugs such as heroin.	• 53% perceive opioid use as a crisis or significant problem in their community • 415,000 people in Snohomish County report knowing someone who is struggling with opioids. • Drug poisoning mortality is 16 people per 100,000 population. • The top diagnosis for avoidable outpatient emergency room visits is for alcohol and drug abuse.
Housing / Homelessness	Housing and homelessness issues encompasses affordability, availability, overcrowding, and quality of housing as well as the condition of homelessness, its prevention, and its impact on individuals and communities.	• 5% of individuals screened in TotalHealth report lack of stable housing. • 33% of households experience housing costs that exceed 30% of household income. • 599 unsheltered individuals, increased by 92%. • Everett School District high proportion of students experiencing homelessness. • 66% report homelessness as a crisis or significant problem in their community and 29% report it as a problem in their

Health Issue	Definition	Justification
		neighborhood • 42% know someone who is or has been homeless.
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. The supply and accessibility of facilities and physicians affect access. Rates of morbidity, mortality, and emergency hospitalizations can be reduced if residents access services such as health screenings, routine tests, and vaccinations.	• 51.8 primary care providers per 100,000 population • 1.26 FQHC's per 100,000 population. • 31% of outpatient emergency department visits at PRMCE may be avoidable. • 33% of adults did not have a routine checkup with their primary care provider in the past year • Much of the area around Everett, Marysville, and Mukilteo is designated as a Primary Care Health Professional Shortage Area. • Everett and Edmonds are designated as Medically Underserved Areas. • 38% of individuals report at least one poor health day (day where health was not good or it kept them from doing usual activities) which includes physical and mental health.

EVALUATION OF IMPACT ON 2017-2019 COMMUNITY HEALTH IMPROVEMENT PLAN (CHIP)

This report also evaluates results from our previous CHNA. During that time, the prioritized health needs that PRMCE focused on were access to primary care, opioid use disorder, and homelessness. PRMCE responded by making investments of time, resources, and funding in programs that were most likely to have an impact on these needs. Often there are organizations that provide services in Snohomish County that address community needs. As good stewards of our own and others' resources, PRMCE is careful not to duplicate services and instead partners with these organizations to ensure Snohomish County residents' needs are served. PRMCE makes community investments and offers funding support to non-profit organizations known to have ongoing, positive community outcomes.

Opioid Use Disorder

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

Trends:

- Drug poisoning mortality rate has increased
- Opioid related deaths are rising, heroin and synthetic opioid deaths have increased.
- Opioid overdose point in time count has increased
- Youth illegal drug use has increased
- Youth use of painkillers to get high has decreased

Table 35. Opioid misuse indicators from the previous CHNA compared to now

Indicator	Snohomish County		WA	US
	Current	Previous		
Drug Poisoning mortality rate	17	16	15	
Opioid related deaths (all opioids)	103	94		
Opioid overdose count per day	12	10		
Opioid overdose count per week	57	37		
Youth illegal drug (not marijuana, tobacco, alcohol) use	5.9%	4.7%	5.6%	4.5%
10th grade youth used painkiller to get high	4.0%	4.6%	4.4%	12.8%
Individuals who know someone who is or has been addicted to opioids	50%			

Strategies and Tactics: A few of the highlights of the programs/projects that PRMCE has lead, participated in, or funded to help reduce opioid use disorder are outlined in the tables below.

Strategy #1: Increase access to treatment options.

Table 36. Highlights of programs PRMCE led, participated in, or funded aimed at increasing access to treatment options.

Organization or Program	Lead Organization	Description
Providence Drug and Alcohol Addiction services	Providence	Inpatient and outpatient chemical dependency, detox, and stabilization services.
Medication Tack Back and Disposal Program	Snohomish Health District	Kiosks placed in PRMCE Colby Campus and PMG Monroe outpatient pharmacy locations, which allow residents to turn in expired/unwanted medicines for proper disposal.
Chronic Utilizer Alterative Response Team	City of Everett	Connecting chronic utilizers of social services (emergency departments, jails, social service agencies, etc.) with housing, transportation, and other social services. PRMCE assists with finding primary care, detox, or other health services for the clients of the program.
Police Assisted Addiction and Recovery Initiative	City of Everett Police	Individuals presenting to the Everett Police Department are connected to residential inpatient drug treatment programs both in and out of state. PRMCE provides short-term detox treatment.
Edge of Amazing	Providence	Providence Institute for Healthier Communities annual Edge of Amazing event break out session "A Community Response to the Opioid Crisis" pulled together community members to discuss ways in which the community can work together to address the opioid crisis.
Screening, Brief Intervention, and Referral to Treatment (SBIRT) Counselors	Washington State DSHS	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 having mental health issues.
Social Workers in Primary Care	Providence	Social workers/mental health professionals are now embedded into primary care at Providence Medical Group.
Compass Health	Compass Health	PRMCE provided funding support to Compass Health. Compass offers a wide-range of services including outpatient substance use disorder treatment for youth and adults, homeless support, and supportive housing

Strategy #2: Educate about opioid abuse.

Table 37. Highlights of programs PRMCE led, participated in, or funded to educate about opioid abuse.

Organization or Program	Lead Organization	Description
Prescription drug monitoring Program	Washington State Dept. of Health	Providence collects and shares dispensing records so the information is available to medical providers and pharmacists as a tool to reduce prescription drug misuse.
Emergency Department data	Snohomish Health District	PRMCE partners with the Snohomish Health District to collect and analyze data on patients in the emergency

Organization or Program	Lead Organization	Description
collection		department who have overdosed. PRMCE provides phone calls and follow-up to assist individuals seeking treatment/safer lifestyle choices to connect with local service providers. Data is also used to develop effective interventions and refer patients to community treatment options.
Providence Inside Out Program	Providence	Using real human organs, a PRMCE representative teaches youth and adults how substance use and other harmful habits and lifestyles can affect the brain, lungs and other organs.
Patient partnership agreement	Providence	PRMCE inpatient units developed a written partnership agreement with drug addicted infection patients to ensure disruptive behavior and possession/use of illicit drugs in the hospital is managed.
Caregiver education	Providence	Educational seminars offered to caregivers on the hidden dangers of prescription drug use and the risk for caregivers.

Strategy #3: Develop evidence-based community standards and protocols.

Table 38. Highlights of programs PRMCE led, participated in, or funded to develop evidence-based community standards and protocols.

Organization or Program	Lead Organization	Description
ED and Up	Institute for Healthcare Improvement	PRMCE participated in a pilot to integrate behavioral health in the emergency department and upstream. The goal is to improve patient outcomes, increase staff safety, and decrease avoidable emergency department visits for individuals with mental health and substance use issues.
Community Pathways	Providence	Committee of community medical providers whose primary purpose is to develop common community wide-protocols, check-list, and toolkits for prescribing opioids.
Neonatal Abstinence Syndrome	Providence	PRMCE initiated protocol changes for caring for babies born with prenatal opiate exposure, including 1) revised and simplified assessment, 2) trial one-time dose of morphine and 3) emphasize importance of non-pharmacological treatment options.
Pain Management Oversight Team	Providence	PRMCE developed a pain management oversight team to develop monitoring tools and safe opiate prescribing protocols.
Medication Assisted Treatment	Providence	Inpatient and emergency department initiated protocols are in place for medications (such as suboxone) to treat withdrawal symptoms and provide safe levels of the drug to combat cravings.

Access to Primary Care

Goal: Ensure individuals can access primary care at the right time, and in the right care setting.

Trends:

- Adults who did not see a health care provider due to cost decreased
- Adults with a personal doctor or healthcare provider decreased
- Primary care provider ratio is unchanged and well below state and national trends
- Adults with a check-up within last year unchanged

Table 39. Access to primary care indicators from the previous CHNA compare to now

Indicator	Snohomish County		WA	US
	Current	Previous		
Adults who did not see a health care provider because of cost	11.5%	15.5%	10.4%	13.5%
Adults with a personal doctor or health care provider	72.9%	82.5%	74.4%	76.7%
Primary care provider ratio	1960 to 1	1932 to 1	1200 to 1	1320 to 1
Visit to primary care physician within last year	77%	76%		

Strategies and Tactics: A few of the highlights of the programs/projects that PRMCE lead, participated in, or provided funding to in order to increase access and awareness about the importance of primary care are outlined in the tables below.

Strategy #1: Improve the patient experience with new access options, digital tools, and convenient access.

Table 40. Highlights of programs PRMCE led, participated in, or funded aimed at improving the patient experience

Organization or Program	Lead Organization	Description
Digital Technology	Providence	Increased digital platforms that allow patients to be more engaged in their primary healthcare. Patients can utilize MyChart to view their medical record and schedule appointments online. Interactive interactions through text messaging is available to schedule an appointment or request a referral.
ExpressCare	Providence	Implemented ExpressCare, primary care services for common conditions, in four convenient locations within Walgreen stores in Snohomish County.
Tele-health	Providence	Tele-health solutions are designed to make primary health care convenient and easy to access. PMG offers various applications for the community to download to a

Organization or Program	Lead Organization	Description
		smartphone, other mobile device, or a computer. One such product is Health eXpress which is live video or audio access to primary care services.
Premium Assistance Program	Project Access Northwest	PRMCE provided funding to assist uninsured and underinsured individuals with paying insurance premiums.
Amen Free Clinic	ASI Northwest	PRMCE provided funding for a free medical clinic that provided medical, dental, eyewear, and health education services to uninsured/underinsured individuals. Additionally, PRMCE provided assistance with coordinating the medical teams and community resources for the event.
Safe Harbor Free Clinic	Safe Harbor	PRMCE provided funding for Safe Harbor which provides free healthcare to patients who are underinsured and uninsured, including lab services, respiratory care, minor procedures, podiatry, and primary care.
PMG Expanded Operating Hours	Providence	All PMG primary care clinics in the community expanded operating hours so more appointment times are available to accommodate the increasing need for primary care.
Chronic Utilizer Alterative Response Team (CHART)	City of Everett	Connecting chronic utilizers of social services (emergency departments, jails, social service agencies, etc.) with housing, transportation and other social services. PRMCE works to obtain primary care, detox, or other health services for the clients of the program.

Strategy #2: Increase the number of primary care physicians per population.

Table 41. Highlights of programs PRMCE led, participated in, or funded aimed at increasing the number of primary care physicians per population.

Organization or Program	Lead Organization	Description
Providence Medical Group primary care services	Providence	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.
Medical students	Elson S. Floyd College of Medicine	PRMCE serves as a training site for new medical students enrolled at the WSU Everett campus.
Family Practice Residency Program	SeaMar	PRMCE serves as an inpatient training site in internal medicine and obstetrics for the family medicine residency program. SeaMar has a special focus on working with underserved populations.

Strategy #3: Increase awareness about the primary care services that are available.

Table 42. Highlights of programs PRMCE led, participated in, or funded aimed at increasing awareness about primary care services

Organization or Program	Lead Organization	Description
Live Well Local™	Providence	Searchable database for individuals, case managers, health coaches, etc. to find community resources.
Emergency department social work program for primary care	Providence	The emergency department social workers help patients who have multiple emergency department visits connect to primary care providers so that patients develop a relationship for continuing care and know what to expect from a primary care provider.
Right Care from the Right Place	Providence	PMG implemented a campaign to educate community on what care is the right care for ExpressCare, primary care, urgent care, and emergency room care.

Homelessness / Housing

Goal: 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.

Trends:

- Individuals worried about paying for power and water increased
- Individuals that did not have a permanent place to sleep increased
- Total unsheltered persons and persons in emergency shelters increased
- Increase in individuals in emergency shelters

Table 43. Homeless/housing indicators from the previous CHNA compare to now

Indicator	Snohomish County		WA	US
	Current	Previous		
Individuals screened in TotalHealth™ who are worried about paying for power and water	13.5%	8%		
Individuals screened in TotalHealth™ who lack stable housing	5%	5%		
Renters spending >30% of income on housing	33.2%		32.9%	32%
Persons that did not have a permanent place to sleep	1116	878		
Total unsheltered persons	599	312		
Total individuals in emergency shelters	364	345		
Total individuals in transitional housing	116			
10th grade students whose current living arrangements are the result of losing home because family cannot afford housing	6.2%	6.50%	5.70%	
Individuals who know someone that is or has been homeless	42%			

Strategy and Tactics: A few of the **h**ighlights of the programs/projects that PRMCE lead, participated in, or provided funding to in order to improve homelessness are outlined in the tables below.

Strategy #1: Improve the overall health and well-being of patients that are ready to be discharged from the hospital but do not have access to stable housing.

Table 44. Highlights of programs PRMCE led, participated in, or funded aimed at improving patients access to stable housing

Organization or Program	Lead Organization	Type of support / description
Live Well Local™	Providence	Searchable database for individuals, case managers, health coaches, etc. to find community resources.
Medical Respite	Everett Gospel Mission	Program provides medical respite for PRMCE inpatients that need a low-level of medical care (wound care, antibiotics), but do not have stable housing.
Medical Rest Beds	Everett Gospel Mission	Patients experiencing homelessness discharged from PRMCE that need medical rest are connected with the Everett Gospel Mission for assignment to one of eight medical rest beds.
Poverty simulation	United Way	PRMCE staff participated in a poverty simulation to learn about and understand the situations some of the most vulnerable in our community experience every day.

Strategy #2: Provide medical screening and other healthcare services for homeless individuals, including assessments to determine individual need.

Table 45. Highlights of programs PRMCE led, participated in, or funded aimed at screening homeless patients for social needs

Organization or Program	Lead Organization	Type of support / description
Emergency Department Social Workers	Providence	Social workers in the emergency department assist identified frequent use patients, including patients experiencing homelessness, with establishing primary care and a care plan so patients develop relationship for continuing care.
Total Health™	Providence	Screening patients seen in a primary care setting for social needs such as homelessness, nutrition, domestic violence, transportation, education, etc. A housing navigator is on-site to assist individuals with housing needs.
Medical Legal Pilot	Providence	Partnering with Northwest Justice Project, PRMCE assists patients that have extended hospital stays and complex social needs with access to legal services. Patients use these services for housing support, guardianships, and other legal needs.

Strategy #3: Expand participation in community efforts to directly address homelessness.

Table 46. Highlights of programs PRMCE led, participated in, or funded to directly address homelessness

Organization or Program	Lead Organization	Type of support / description
Chronic Utilizer Alterative Response Team	City of Everett	Connecting chronic utilizers of social services (emergency departments, jails, social service agencies, etc.) with housing, transportation, and other social services. PRMCE works to obtain primary care, detox, or other health services for the clients of the program.
Police Assisted Addiction and Recovery Initiative	City of Everett Police	Individuals presenting to the Everett Police Department, many experiencing homelessness, are connected to residential inpatient drug treatment programs both in and out of State. PRMCE provides short-term detox treatment.
Compass Health	Compass Health	PRMCE provided funding for Compass Health. They offer a wide-range of services including outpatient substance use disorder treatment for youth and adults, homeless support, and supportive housing.
Project Homeless Connect	United Way	PRMCE participated in Project Homeless Connect by providing an onsite medical team for blood glucose testing, nutrition education, blood pressure checks and other healthcare information.
Clare's Place	Catholic Community Services	PRMCE provided funding for operations of Clare's Place. Clare's Place is a permanent supportive housing facility that provides 65 units for chronically homeless, and vulnerable households in Snohomish County.
Volunteers of America	Volunteers of America	PRMCE provided funding to Volunteers of America which serves people with human services needs including a homeless services program which provides case management, rental assistant, and other supportive services to individuals and families experiencing homelessness.
Domestic Violence Services (DVS)	Domestic Violence Services	PRMCE provided funding. DVS provides support groups, education, and advocacy, as well as an emergency shelter for survivors of domestic violence.
Housing Hope	Housing Hope	PRMCE provided funding to Housing Hope. They provide a full range of housing services including emergency shelter, transitional housing, affordable rental apartments, and homeownership opportunities for low-income households.
Interfaith Family Shelter	Interfaith Association	PRMCE provided funding to Interfaith Family Shelter. They provide shelter and resources to individuals and families experiencing homelessness or at risk of losing their housing.
Cocoon House	Cocoon House	PRMCE provided funding to Cocoon House. They conduct outreach and provide short and long term housing for young people experiencing homelessness or at risk of being unsheltered.

2019 CHNA GOVERNANCE APPROVAL

This community health needs assessment was adopted on October 17, 2019 by the Community Ministry Board of the hospital. The final report was made widely available[4] by December 31, 2019.

Kim Williams 10-17-19

Kim Williams, RN, MS, FACHE — Date
Chief Executive Officer
Providence Regional Medical Center Everett
Northwest Washington Service Area

Rick Shea Oct. 17th 2019

Rick Shea — Date
Chair
Northwest Washington Service Area, Community Ministry Board

12/13/2019

Joel Gilbertson — Date
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To request a free copy or provide comments of current and previous community health needs assessments, contacting the individual above. You may also view electronic copies of current and previous community health needs assessments at http://www.psjhealth.org/community-benefit/washington.

[4] Per § 1.501(r)-3 IRS Requirements, posted on hospital website

APPENDICES

Appendix 1: Primary Data Collection

Category	Indicator	Snohomish		WA	US	Goal	Source*
		Current	Previous				
ACCESS TO HEALTH SERVICES							
Dental	10th grade youth have been to the dentist in the past year	77.6%	79.6%	77.1%	77.1%	HP 2020; 49%	HYS
Dental	Adults visited dentist or dental clinic in past year	68.2%	69.2%	67.9%	65.5%	HP 2020, 49%	BRFSS
Dental	Visit to Health Professional within last year - A dentist	69%	72%				HWBM
Dental	Dental Caries in elementary school children (6-9 years old)	57.3%	56%	49.0%		HP 2020, 49%	Smile Survey
Dental	Dentist ratio	1430 to 1	1577 to 1	1250 to 1	1480 to 1	RWJ 1280:1	RWJ CHR
Dental	Sealants in elementary school children (6-9 years old)	39.6%	45%	44.0%		HP 2020, 28.1%	Smile Survey
Hospital Visit	Number of hospital stays for ambulatory-care sensitive conditions per 1,000 Medicare enrollees	28%	28%		49%		Dartmouth Atlas of Health Care
Hospital Visit	Overall hospitalization rate	8788.8	8681.7	8462.2			CHARS, WSCHAT
Hospital Visit	Visits to Health Professional within last year - Emergency Room	18%	18%				HWBM
Primary Care	Adults who did not see a health care provider because of cost	11.5%	15.5%	10.4%	13.5%		BRFSS
Primary Care	Adults with a personal doctor or health care provider	72.9%	82.5%	74.4%	76.7%	HP 2020 83.9%	BRFSS
Primary Care	Primary care provider ratio	1960 to 1	1932 to 1	1200 to 1	1320 to 1	1030 to 1	RWJ CHR
Primary Care	Visit to Health Professional within last year, own primary care physician	77%	76%				HWBM
CANCER							
Breast	Female breast cancer incidence per 100,000 population	139	175.91	165.6	153.7		State Cancer Profile
Breast	Female breast cancer mortality	19.4	20.9	19.6	20.3	20.7	WACR
Breast	Mammogram last two years (F 50-74)	69.9%	78.6%	76.1%	78.4%	HP 2020, 73.7%	BRFSS
Colorectal	Colorectal cancer incidence per 100,000 population	38.1	41.07	34.0	39.0		State Cancer Profile
Colorectal	Colorectal cancer mortality	13.3	14.9	12.5	13.6	14.5	WACR
Colorectal	Colorectal cancer screening (50+)	65.6%	70.7%	69.9%	69.8%	HP 2020, 70.5%	BRFSS
General	Cancer mortality	156.0	168.5	151.0	155.8	HP 2020 161.4	WACR
Lung	Lung Cancer incidence per 100,000 population	60.3	56.14	53.4	55.6		WACR
Lung	Lung cancer mortality	33.7	41.1	35.0	38.3	45.5	WACR
Prostate	Prostate Cancer incidence per 100,000 population	106.8					WACR
Prostate	Prostate cancer mortality	22.9	17.3	20	18.9	21.8	WACR

Category	Indicator	Snohomish		WA	US	Goal	Source*
Skin	Melanomas of the skin incidence	68.2	70.1	51.1	40.3		State Cancer Profile
Skin	Melanomas of the skin mortality	3.6	3.04	2.7	2	2.4	WSCHAT
CHRONIC DISEASE							
Asthma	10th grade students ever told they have asthma	18.1%	19.1%	21.3%	22.9%		HYS
Asthma	Adults ever told they have asthma	14.3%	10.6%	15.0%	13.7%		BRFSS
Asthma	Asthma hospitalization	48.9	46	53.6			WSCHAT
Cholesterol	High cholesterol diagnosis	31.2%		30.4%	31.2%		BRFSS
Diabetes	Adults ever told they have diabetes	7.9%	9.8%	8.7%	10.7%		BRFSS
Diabetes	Diabetes hospitalization	106.2	106	112.2			BRFSS
Heart Disease	Adults ever told they have coronary heart disease/had an MI	4.6%	4.5%	5.1%	5.9%		BRFSS
Heart Disease	Cardiovascular Disease - hospitalizations per 1,000 Medicare Beneficiaries, 65+	97	50.1		122.8		CDC Atlas of Heart Disease & Stroke
Heart Disease	Cardiovascular Disease - mortality per 100,000 people 35+	357.1	373.7		426.2		CDC Atlas of Heart Disease & Stroke
Heart Disease	HBP diagnosis	28.6%	28.6%	28.1%	32.0%	HP 2020, 26.9	BRFSS
Pulmonary	COPD diagnosis	6.2%		5.5%	5.9%		BRFSS
Stroke	Stroke hospitalization rate per 1,000 Medicare beneficiaries 65+	16.7	10.6		16.9		CDC Atlas of Heart Disease & Stroke
Stroke	Stroke mortality per 100,000 people 35+	64.3	64.6		72.2		CDC Atlas of Heart Disease & Stroke
COMMUNICABLE DISEASE							
Chlamydia	Chlamydia rate – females age 15-24 years	2507.7	2155.4	2950.2	3437.5		WSCHAT
Gonorrhea	Gonorrhea rate	101.1	56.97	144.4	145.8		WSCHAT
Hepatitis	Acute Hepatitis B rate	0.9		0.7	1	HP 2020; 1.5	WSCHAT
Hepatitis	Acute Hepatitis C rate	0.9	0.43	1.4	0.8	HP 2020; 0.25	WSCHAT
Hepatitis	Hepatitis A rate	0.6		0.4	0.4	HP 2020; 0.3	WSCHAT
HIV	New HIV diagnosis rate	7.1	4.9	7.1	14.7		CDC NCHS
Immunizations	65+ with pneumonia shot	73.7%	73.7%	76.3%	72.0%	HP 2020 90%	BRFSS
Immunizations	Children complete for all immunizations—K-12	86.4%		87.3%			OSPI
Influenza	65+ with flu vaccination	58.6%	59.3%	59.7%	59.1%		WSCHAT
Influenza	Adults who had flu shot past 12 months	30.0%	36.8%	40.0%	37.8%	HP 2020; 70%	WSCHAT
Influenza	Influenza Hospitalizations (compared with 2016-2017 season)	512	460				Snohomish Health District Influenza Surveillance
Influenza	Influenza Mortality (compared with 2016-2017 season)	40	45				Snohomish Health District Influenza Surveillance
Pertussis	Pertussis rate	11.6	7.12	9.4	4.9		WSCHAT
Syphilis	Primary and secondary syphilis rate	6.6	3.51	9.3	8.7		WSCHAT
TB	Active Tuberculosis rate	3.4	3.54	2.8	2.9	HP 2020; 1.0	WSCHAT

Category	Indicator	Snohomish		WA	US	Goal	Source*
DIET & ACTIVITY							
Nutrition	10th grade students consuming 0 sugar-sweetened beverages per day	24.1%	25.3%	26.6%			HYS
Nutrition	10th grade students eating 5+ fruits and vegetables per day	17.2%	18.9%	17.5%			HYS
Nutrition	Adults with very low fruit intake	39.6%	32%	35.7%	40.6%		BRFSS
Nutrition	Adults with very low vegetable intake	16.3%	17.5%	16.6%	22.1%		BRFSS
Nutrition	Days in last week went without a meal due to lack of money	0.16	0.19				HWBM
Nutrition	Days in last week ate 5 servings of fruits and vegetables	4.1	3.99				HWBM
Obesity	10th grade students who are obese (>95th percentile)	15.1%	13.0%	13.7%	14.9%	HP 2020 16.1%	HYS
Obesity	10th grade students who are overweight (>85th percentile)	14.9%	14.4%	14.6%	16.2%		HYS
Obesity	Adults who are obese (BMI>/= 30.0)	28.6%	27.6%	28.6%	29.6%	HP 2020, 30.5%	BRFSS
Obesity	Adults who are overweight, but not obese (BMI=25-29.9)	35.3%	36.6%	34.5%	35.0%		BRFSS
Obesity	Percentage of adults that report BMI of 30 or more	29%	29.0%		28%		CDC Diabetes Interactive Atlas
Physical Activity	Days in last week exercised for at least 30 min.	3.9	3.92				HWBM
Physical activity	10th grade students physically active for > 60min.day	22.1%	22.0%	21.6%		HP 2020 31.6%	HYS
Physical activity	10th grade students, 2+ hours of video games on school day	44.4%	58.8%	45.4%		HP 2020 17.4%	HYS
Physical activity	Adults meeting aerobic and strength physical activity recommendations	21.4%	37.8%	22.9%	20.5%	HP 2020, 47.9%	BRFSS
Physical activity	Population with adequate access to locations for physical activity	87%	95%		83%		Business Analyst, ESRI, & US Census
GENERAL HEALTH							
Life Expectancy	Life expectancy at birth	80.5	80.3	80.4	78.8		RWJ CHR
Life Expectancy	Years of healthy life @ 20	52.2	60.8	51.9			WSCHAT
Mortality	Childhood mortality rate per 100,000 (1-14)	10.9	10.3	12.7	16.7	HP2020	WSCHAT
Mortality	Infant Mortality rate per 100,000	4.2	3	4.9	6.5	HP 2020, 6.0	CDC NCHS
Mortality	Overall mortality rate	675.1	708.14	676.5	728.8		WSCHAT
Quality of Life	Adult physical health 'not good' 14+ days a month	9.2%	14.1%	11.0%	11.5%	HP 2020, 20.2%	BRFSS
Quality of Life	Overall health and well-being index	7.51	7.71				HWBM
Quality of Life	Individuals reporting poor physical health days in the last month	57%	50%				HWBM
Quality of Life	Individuals reporting at least 6 days of poor satisfaction with physical health	26%	19%				HWBM
Quality of Life	Overall satisfaction with the way things are going in life	7.44	7.6				HWBM

Category	Indicator	Snohomish		WA	US	Goal	Source*
Quality of Life	Overall satisfaction with emotional well-being	7.81	7.98				HWBM
Quality of Life	Individuals reporting debilitating health days in the last month	39%	37%				HWBM
Quality of Life	Percentage of adults reporting fair or poor health (age adjusted)	12%	13%		16%		BRFSS
INJURY							
Falls	65+ Fall Hospitalization	1602.4		1626.2	1783.0		WSCHAT
Falls	65+ Fall Mortality	55.0		83.2	61.6	HP 2020 ; 47	WSCHAT
Falls	65+ hospitalized for hip fractures	458.6		465.2	664.9*		WSCHAT
Physical Abuse	10th graders hurt on purpose by an adult	24.5%	23.1%	25.2%			HYS
Physical Abuse	10th grade students made to feel unsafe by a boyfriend or girlfriend in the past year	4.9%	9.0%	5.3%			HYS
Transport	Motor Vehicle Collision mortality	7.7	7	7.5	12.7	12.4	WSCHAT
Transport	MVC hospitalization per 100,000 population	44.6	44.3	45.69			CDC NCHS
MATERNAL, INFANT AND CHILD HEALTH							
Birth	Number of births per 1,000 female population ages 15 – 19	16	19		27		CDC NCHS
Birth	Live births with low birth weight (weighing < 2,500 grams)	6.0%	5.9%	6.4%	8.2%	RWJ 6%	RWJ CHR
Birth	Premature births (<39 weeks)	8.6%	9.1%	9.4%	9.9%	HP 2020 9.4%	WSCHAT
Gynecology	Pap test last 3 years (F 21-65)	72.7%	80.6%	78.4%	80.1%	HP 2020, 93%	BRFSS
Pregnancy	Pregnant women diagnosed with gestational diabetes	10.0%	7.5%	8.7%	6.0%		PRAMS
Pregnancy	Pregnant women with no 1st trimester prenatal care	25.6%	19.6%	26.5%	22.9%	HP2020, 22.1%	WSCHAT
Pregnancy	Smoking during pregnancy	8.6%	9.0%	9.1%	7.2%	HP 2020 1.4%	PRAMS
Pregnancy	Teen pregnancy (15-19) (per 1,000 women)	21.7	16.6	24.4	22.3	RWJ 15%	WSCHAT
MENTAL HEALTH							
Access	Mental health professional ratio	350 to 1	379	330 to 1	470	RWJ 330:1	RWJ CHR
Access	Visit to health professional - Mental Health Provider	14%	12%				HWBM
Bullying	10th grade students bullied within the past month	19.3%	22.9%	19.3%			HYS
Bullying	10th grade students that feel safe at school	76.7%	81.7%	78.0%			HYS
Depression	10th grade depression symptoms	36.3%	36.3%	34.5%	32.5%	7.5% (12-17)	BRFSS
Depression	Post-partum depression	12.2%		11.3%	11.0%		PRAMS
Mental Health	Adult mental health 'not good' 14+ days a month	11.3%	13.8%	12.7%			BRFSS
Mental Health	Average number of days of poor mental or emotional health	5.2	8				HWBM
Mental Health	Individuals reporting poor mental health days in the last month	54%	52%				HWBM
Suicide	10th grade seriously considering suicide	22.5%	21.8%	20.6%	17.3%		HYS

Category	Indicator	Snohomish		WA	US	Goal	Source*
Suicide	Suicide mortality, per 100,000 population	14.39	14.6	14.89	13.4	10.2	WSCHAT
Youth	10th grade with adult to turn to	50.5%		49.2%		83.2% (12-17)	BRFSS
SUBSTANCE USE							
Alcohol	10th grade binge drinking	9.1%	9.4%	9.6%			HYS
Alcohol	10th grade current alcohol use	17.5%	18.6%	18.5%	27.0% (2017)		HYS
Alcohol	10th grade students that drove after drinking alcohol	3.6%	4.4%	4.8%			HYS
Alcohol	Adult binge drinking	16.6%	15.9%	16.4%		24.2%	BRFSS
Drug	Drug Poisoning mortality rate	17	16	15			RWJ CHR
Drug	Opioid overdoses taken to PRMCE ER	381					SC OPPIT
Drug	Opioid related deaths (all opioids)	103	94				SC OPPIT
Drug	Opioid overdose count per day	12	10				SC OPPIT
Drug	Opioid overdose count per week	57	37				SC OPPIT
Drug	Percent of Children removed by CPS due to parent drug abuse	48.8%		38.3%			Dept Social & Health Services
Drug	Youth illegal drug (not marijuana, tobacco, alcohol) use	5.9%	4.7%	5.6%	4.5%		HYS
Drug	10th Grade youth used painkiller to get high	4.0%	4.6%	4.4%	12.8%		HYS
Drug	Individuals that know someone that is or has been addicted to opioids	50%					HWBM
Smoking	10th grade current e-cigarette use	22.6%	16.6%	21.2%			HYS
Smoking	10th grade current marijuana use	17.3%	16.0%	17.9%	18.7%	6% (12-17)	HYS
Smoking	10th grade current smoking cigarettes	4.9%	6.7%	5.0%	7.6%	16% (9-12 combined)	HYS
Smoking	12th graders drove a vehicle after marijuana use	15.8%	17.5%	16.5%	18.3%		HYS
Smoking	Adult current e-cigarette use	4.24%		4.50%			BRFSS
Smoking	Adult Marijuana use	18.4%		16.6%			BRFSS
Smoking	Adults current smoking cigarettes	14.7%	17.3%	13.9%		HP 2020, 12%	BRFSS
Smoking	Adults who are current smokers	13%	16.7%		17%		BRFSS
Substance Use	Hospitalizations for Alcohol and other drugs per 100,000 population	1165.9	1025.6	1109	1121.7		Agency for Healthcare Research and Quality
SOCIAL & ECONOMIC							
Discrimination	Experienced discrimination in last 12 months due to race, ethnicity, gender, or sexual orientation	26%	12%				HWBM
Education	On-time graduation rate	79.5%	75.90%	79.3%	84.1% (2016)	87%	OSPI
Education	Residents who feel they need education and training	15.8%	14%				HWBM
Education	Adults ages 25-44 with some post-secondary education	69.1%	69%		69%		ACS
Education	Pop 25+ with bachelor's degree	30.6%		33.6%	30.3%		ACS
Employment	Population ages 16 and older unemployed but seeking work	3.1%	3.9%	4.2%	3.9%	3.2 (RWJ)	Bureau of Labor

Category	Indicator	Snohomish		WA	US	Goal	Source*
Housing	Residents screened who are worried about paying utilities	13.5%	8%				HWBM
Housing	Residents screened who feel they lack stable housing	5%	5%				HWBM
Housing	Renters spending >30% of income on housing	33.2%		32.9%	32%		ACS
Housing	Persons that did not have a permanent place to sleep	1116	878				SCPIT
Housing	Total Unsheltered persons	599	312				SCPIT
Housing	Individuals in emergency shelters	364	345				SCPIT
Housing	Individuals in transitional housing	116					SCPIT
Housing	10th grade students whose current living arrangements are the result of losing home because family cannot afford housing	6.2%	6.50%	5.70%			HYS
Housing	Individuals that know someone that is or has been homeless	42%					HWBM
Income	% Below FPL	8.8%	10.3%	12.2%	14.58%		ACS
Income	Children Below FPL	11.7%	14.0%	16.5%	21.2%	12% (RWJ)	ACS
Income	Free/Reduced Cost Lunch recipients	36%	31.2%	43.6%	49.2%	33% (RWJ)	CDC NCHS
Insurance	Uninsured adults 18-64	7.8%	16.6%	8.4%	12.4%	HP 2020; 0%	BRFSS
Transport	10th graders texting and driving	40.4%	37.2%	41.3%			HYS
Transport	Adult texting and driving	36.9%		32.23%			BRFSS
Transport	Residents screened who feel they have no transportation	5%	6%				HWBM

*Sources:

BRFSS – Behavioral Risk Factor Surveillance system
ACS – American Community Survey
HYS – Healthy Youth Survey
HWBM – PIHC Health & Well-Being Monitor™
SCPIT – Snohomish County Point in Time Survey
SC OPPIT - Snohomish County Overdose Prevention Point in Time Count
WSCHAT - Washington State Comm. Health Assessment Tool
RWJ CHR - Robert Wood Johnson County Health Rankings
CDC NCHS - CDC National Center for Health Statistics

Appendix 2: Snohomish County Demographics

Providence St.Joseph Health

Snohomish County, WA Demographics

Summary	Census 2010	2019	2024
Population	713,335	823,512	886,548
Households	268,325	306,587	329,624
Families	182,282	207,183	222,374
Average Household Size	2.62	2.65	2.66
Owner Occupied Housing Units	179,759	207,300	226,958
Renter Occupied Housing Units	88,566	99,287	102,666
Median Age	37.0	38.4	38.8

Trends: 2019 - 2024 Annual Rate	Area	State	National
Population	1.49%	1.31%	0.77%
Households	1.46%	1.29%	0.75%
Families	1.43%	1.24%	0.68%
Owner HHs	1.83%	1.56%	0.92%
Median Household Income	2.96%	2.91%	2.70%

	2019		2024	
Households by Income	Number	Percent	Number	Percent
<$15,000	17,276	5.6%	14,484	4.4%
$15,000 - $24,999	14,957	4.9%	12,040	3.7%
$25,000 - $34,999	16,356	5.3%	13,543	4.1%
$35,000 - $49,999	26,485	8.6%	23,327	7.1%
$50,000 - $74,999	54,744	17.9%	52,044	15.8%
$75,000 - $99,999	48,392	15.8%	51,532	15.6%
$100,000 - $149,999	67,746	22.1%	80,517	24.4%
$150,000 - $199,999	32,615	10.6%	46,144	14.0%
$200,000+	28,016	9.1%	35,993	10.9%
Median Household Income	$85,254		$98,632	
Average Household Income	$106,519		$122,389	
Per Capita Income	$39,758		$45,602	

	Census 2010		2019		2024	
Population by Age	Number	Percent	Number	Percent	Number	Percent
0 - 4	47,378	6.6%	50,046	6.1%	54,701	6.2%
5 - 9	47,064	6.6%	51,668	6.3%	54,155	6.1%
10 - 14	48,705	6.8%	53,281	6.5%	55,482	6.3%
15 - 19	49,561	6.9%	48,533	5.9%	51,889	5.9%
20 - 24	44,412	6.2%	49,173	6.0%	47,704	5.4%
25 - 34	99,203	13.9%	119,073	14.5%	129,257	14.6%
35 - 44	104,474	14.6%	112,200	13.6%	126,202	14.2%
45 - 54	114,411	16.0%	111,200	13.5%	109,244	12.3%
55 - 64	84,583	11.9%	111,788	13.6%	111,939	12.6%
65 - 74	41,019	5.8%	73,604	8.9%	89,394	10.1%
75 - 84	22,317	3.1%	30,272	3.7%	42,491	4.8%
85+	10,208	1.4%	12,674	1.5%	14,090	1.6%

	Census 2010		2019		2024	
Race and Ethnicity	Number	Percent	Number	Percent	Number	Percent
White Alone	559,011	78.4%	601,509	73.0%	647,551	73.0%
Black Alone	18,168	2.5%	29,712	3.6%	31,987	3.6%
American Indian Alone	9,793	1.4%	10,947	1.3%	11,785	1.3%
Asian Alone	63,385	8.9%	94,441	11.5%	101,670	11.5%
Pacific Islander Alone	3,135	0.4%	5,414	0.7%	5,829	0.7%
Some Other Race Alone	27,121	3.8%	36,713	4.5%	39,523	4.5%
Two or More Races	32,722	4.6%	44,776	5.4%	48,203	5.4%
Hispanic Origin (Any Race)	64,249	9.0%	87,379	10.6%	94,068	10.6%

Data Note: Income is expressed in current dollars.

Source: Esri, U.S. Census

Appendix 3: Community Input

Health & Well-Being Monitor™

Participants	Date(s)
Registered voter households, that is, households in which at least one member is registered to vote, which comprises 91% of households in the county. This list was supplemented by a commercial list of households which were non-voter households. Sample size: 2018: 666 adults (18+) in Snohomish County and 585 in 2018. Technique: Multi-mode data collection. • 312 telephone survey with live interviewers • 354 questionnaires completed online	June 19-24, 2019 Telephone survey June 21 – July 6, 2019 On-line survey July 1 – 8, 2018 Telephone survey June 30 – July 22, 2018, On-line survey

Edge of Amazing

Participants	Convening Dates
Due to the number of participants (300+) in the sessions, a full listing of attendees is not provided. Representative sectors of the community include housing, food/nutrition, education, low-income, social justice, transportation, Tribal populations, health advocacy, workforce, domestic violence, civic leadership, non-profit organizations, medically underserved areas, mental health, local and state government, health department, small businesses, healthcare providers, youth, seniors, etc. The Edge of Amazing utilizes a broad representation of the community, including public health, government and schools to set agendas and priorities for each of the sessions. Those members include: • Becky Ballbach, Everett Public Schools • Celine Anelone Brozovich, Dances with Foods • Alice Chao, Kaiser Permanente • Kevin Clay, MD, Chief of Ambulatory Medicine • Mary Cline-Stively, ChildStrive • Kathy Coffee, Leadership Snohomish County • Jim Dean, Interfaith Family Shelter • Bob Drewel, WSU North Puget Sound • Jimmy Grierson, MD, Safe Harbor Free Clinic • Elaine Hall, Edmonds Community College • Vicci Hillty, Domestic Violence Services • Marissa Ingalls, Coordinated Care • Hil Kaman, City of Everett • Melissa Kelii, TGB Architects • George Kosovich, Verdant Health Commission • Tyler Lawrence, SeaMar Community Health Center • Bob Leach, DA Davidson, Retired • Heather Logan, Cascade Valley Health Foundation • Sadi McHatton, Snohomish Health District • Erin Monroe, Workforce Snohomish	Oct 2, 2019 Oct 11, 2018 Oct 10, 2018 Sep 19, 2017

Participants	Convening Dates
• Nate Nehring, Snohomish County Council • Josh O'Connor, Sound Publishing • Sarah Olson, City of Lynnwood • Patrick Pierce, Economic Alliance of Snohomish County • Dan Rankin, City of Darrington • Mel Sheldon, Tulalip Tribes • Sally Shinstrom, Faith Community Nursing • Ramonda Sosa, Homage Senior Services • Mark Wakai, Providence • Alex Zitnik, Integrated Rehabilitation Group	

Snohomish Health District Community Health Assessment Data Task Force

Partnerships	Convening Dates
• Amy Beth Cook, Lake Stevens School District • Zinyao DeGraw, Snohomish Health District • Robin Fenn, Verdant Health Foundation • Gabriel Fraley, Snohomish Health District • Lisa George, Providence Regional Medical Center Everett • Nathan Marti, Snohomish County Human Services • Carrie McLachlan, Snohomish Health District • Alicia McQueen, Tulalip Tribes • Kevin O'Brien, Lake Stevens Fire Department • DeAnne Okazaki, Providence Regional Medical Center Everett • Martha Peppones, Homage Senior Services • Kevin Plemel, Snohomish Health District • Heather Thomas, Snohomish Health District • Victoria Adela Breckwich Vasquez, University of WA Bothell • Brant Wood, Snohomish County PUD • Patricia Yepassis-Zembrou, Snohomish Health District	Jan 25, 2018 Mar 7, 2018 May 2, 2018 Jun 6, 2018 July 11, 2018 Aug 1, 2018 Sept 12, 2018 Oct 10, 2019 Data Walks Nov. 27 – Everett Dec 4, 2018 – Lynnwood Dec 11, 2018 – Monroe

PIHC Strategic Oversight

Participants	Convening Dates
• Dora Alcorta – St. Mary Magdalen Parish, Latina/Latino community leader • Maribeth Carson, SP – Sister of Providence • Kevin Clay, MD - Chief of Ambulatory Medicine • Bob Drewel – WSU North Puget Sound • Van Dinh-Kuno – Refugee & Immigrant Services Northwest • Bob Leach – Retired D.A. Davidson & Co. • Barry Stueve - Providence VP Mission Integration • John Vandree, MD – Retired • Carol Whitehead - WA State Leadership Academy, Everett Public Schools • Kim Williams - Providence Northwest WA Service Area. • Julie Zarn - Providence Director Emergency Department	On-going monthly meetings

PIHC Strategic Planning Priority Council

Participants	Convening Date
• Sylvia Anderson – Everett Gospel Mission • Kevin Clay, MD - Chief of Ambulatory Medicine • Bob Drewel – WSU North Puget Sound • Van Dinh-Kuno – Refugee & Immigrant Services Northwest • Alessandra Durham – Snohomish County Executive Office • Tami Farber – Leadership Snohomish County Diversity, Equity and Inclusion • Janice Green – NAACP • Jimmy Grierson, MD – Safe Harbor Free Clinic • Lori Kloes – Providence General Foundation • Elizabeth Kohl – Housing Hope • Bob Leach – Retired D.A. Davidson & Co. • Heather Logan – Cascade Valley Health Foundation • Edgar Longoria – Everett Housing Authority • Mary O'Brien – Department of Social and Health Services • Jason Peterson – Providence Northwest WA Service Area • Rosario Reyes – Latino Educational Training Institute • Lisa Shumaker – Providence Health Educator • Reverend Paul Stoot – Greater Trinity Academy for Children • Mallory Taylor – Community Health Center of Snohomish County • Barbara Tolbert – City of Arlington • John Vandree, MD – Retired • Mark Wakai – Providence St. Joseph Health • Carol Whitehead - WA State Leadership Academy, Everett Public Schools • Kim Williams - Providence Northwest WA Service Area	March 2019

Sustainability, Inclusion and Co-Creation Task Force

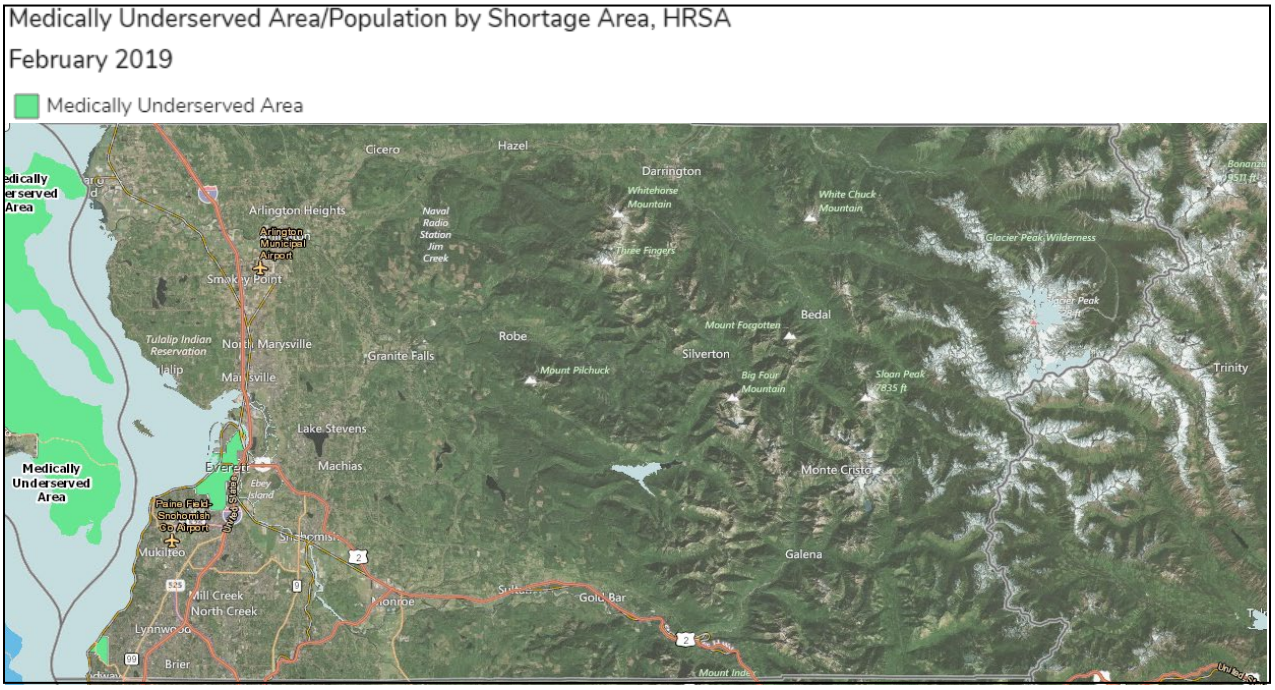
Participants	Convening Dates
• Dora Alcorta – St. Mary Magdalen Parish, Latina/Latino community leadership • Sylvia Anderson – Everett Gospel Mission • Jessica Burt – PIHC • Sr. Anita Butler – Sister of Providence • Kevin Clay, MD – Chief of Ambulatory Medicine • Van Dinh-Kuno- Refugee and Immigrant Services Northwest • Bob Drewel – WSU North Puget Sound • Alessandra Durham – Snohomish County Executive Office • Tami Farber – YMCA of Snohomish County • Janice Green – NAACP • Elizabeth Kohl – Housing Hope • Bob Leach – DA Davidson, retired • Liga Mezaraups – Nursing, PRMCE • Mary O'Brien – Department of Social and Health Services • Rosario Reyes – Latino Educational Training Institute	March 2019 Nov 14, 2018 Oct 29, 2018 July 10, 2018 June 25, 2018

Mission & Healthier Communities Committee

Membership	Convening Dates
Members of the Board Mission and Healthier Community committee include: • Dora Alcorta, St. Mary Magdalen Church • David Allen, UW Bothell School of Nursing • Sylvia Anderson, Everett Gospel Mission • Dana Riley-Black, Everett Public Schools • Susie Borovina, Providence Medical Group • Maribeth Carson, SP, Sisters of Providence • Van Dinh-Kuno, Refugee & Immigrant Services Northwest • Bob Drewel – WSU North Puget Sound • Scott Forslund, Providence Institute for a Healthier Community • Gail Larson, retired healthcare executive • Bob Leach, retired, D.A. Davison • DeAnne Okazaki, PRMCE • Susan Reis, MD, community member • Steve Schmutz, Archbishop Murphy High School • Ray Stephenson, retired City of Everett • Barry Stueve, PRMCE • Michael Sullivan, retired, community member • John Vandree, retired, physician • Carol Whitehead, WA State Leadership Academy, Everett Public Schools • Kim Williams, Providence NW Washington Service Area	Every other month, 2nd week of the month. Jan 9, 2019 Mar 13, 2019 May 8, 2019 July 10, 2019 Sept 11, 2019 Nov 13, 2019

Appendix 4: Medically Underserved Area/Medically Underserved Population and Health Profession Shortage Area

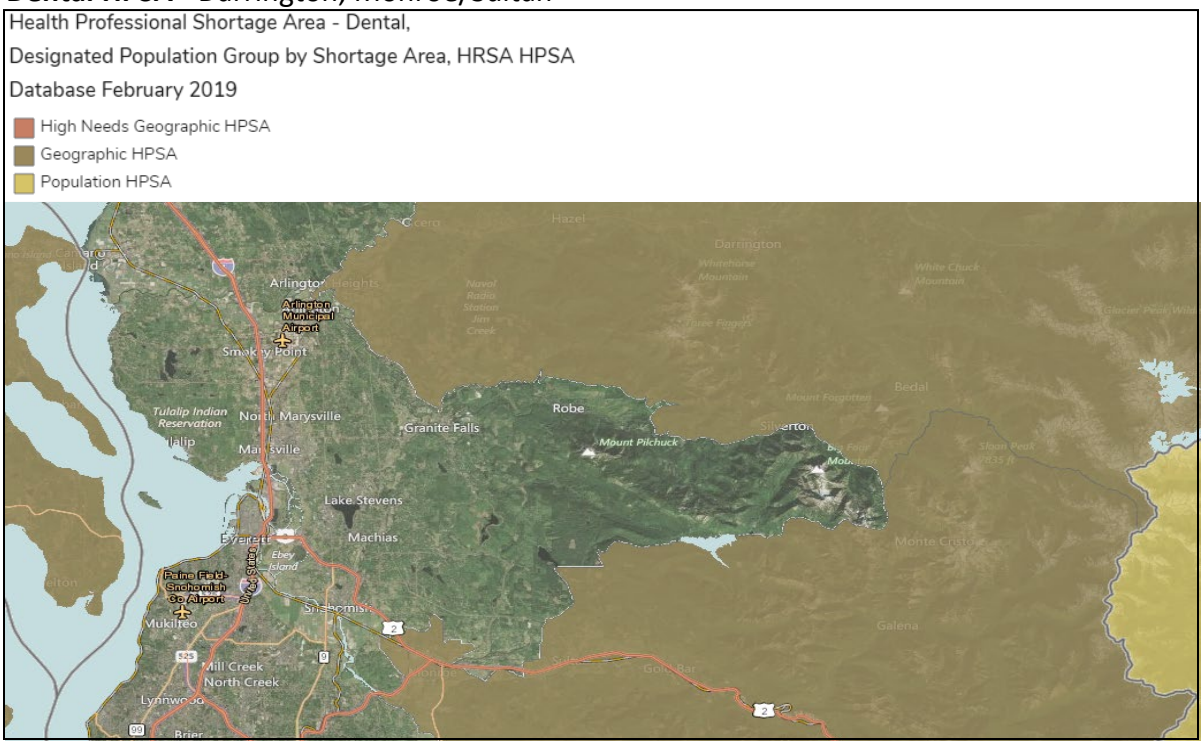
Medically Underserved Areas and Medically Underserved Populations are defined by the Federal Government to include areas or population groups that demonstrate a shortage of healthcare services (too few primary care providers, high infant mortality, high poverty or a high elderly population). This designation process was originally established to assist the government in allocating community health center grant funds to the areas of greatest need. Medically Underserved Populations are identified based on documentation of unusual local conditions that result in access barriers to medical services. Medically Underserved Areas and Medically Underserved Populations are permanently set. Snohomish County does not have a medically underserved population designation. The map below depicts the Medically Underserved Areas within Snohomish County which includes Central Everett and West Edmonds.



Source: Health Resource and Services Administration

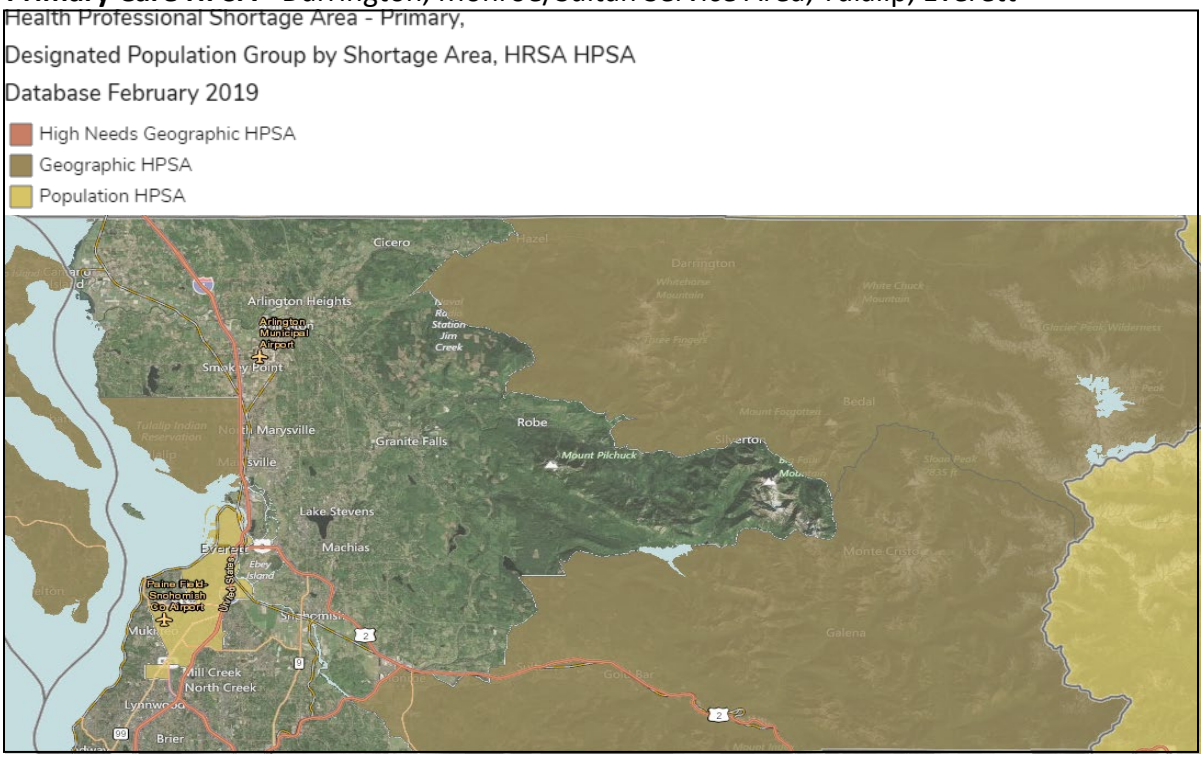
The Federal Health Resources and Services Administration designates Health Professional Shortage Areas as areas with a shortage of primary medical care, dental care, or mental health providers. They are designated according to geography (i.e., service area), demographics (i.e., low-income population), or institutions (i.e., comprehensive health centers). Snohomish County has several areas that are designated as a shortage area. This information can be used to understand access issues, state and local health care planning, placement of providers, and allocation of limited health care resources. The maps below depict these shortage areas.

Dental HPSA - Darrington, Monroe/Sultan



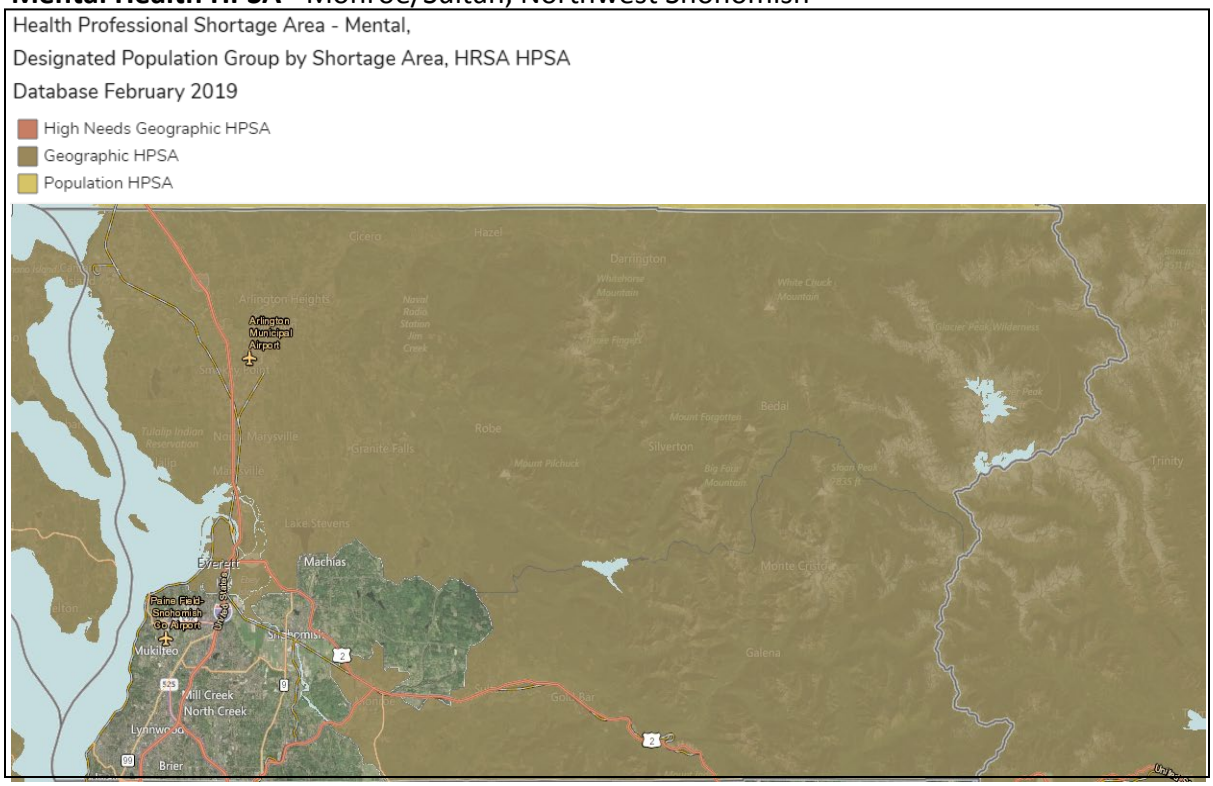
Source: Health Resource and Services Administration

Primary Care HPSA - Darrington, Monroe/Sultan Service Area, Tulalip, Everett



Source: Health Resource and Services Administration

Mental Health HPSA - Monroe/Sultan, Northwest Snohomish



Source: Health Resource and Services Administration

Appendix 5: Hospital Level Data

Suicide and self-harm events per 1,000 encounters at PRMCE by age, race, zip code and diagnosis code.

Suicide and Self-Harm Events				
Age	2016	2017	2018	Total
Under 18	208	225	239	672
18-44	386	369	341	1096
45-64	139	140	166	445
65+	28	22	29	79
Race	2016	2017	2018	Total
WHITE OR CAUCASIAN	618	595	594	1807
OTHER	61	68	73	202
BLACK OR AFRICAN AMERICAN	29	47	44	120
AMERICAN INDIAN OR ALASKA NATIVE	30	19	39	88
ASIAN	18	16	17	51
UNKNOWN	2	6	4	12
NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER	2	1	2	5
ICD-10	2016	2017	2018	Total
X78.9XXA - Intentional self-harm by unspecified sharp object, initial encounter	71	102	111	284
X78.1XXA - Intentional self-harm by knife, initial encounter	78	71	67	216
X83.8XXA - Intentional self-harm by other specified means, initial encounter	55	66	74	195
X78.8XXA - Intentional self-harm by other sharp object, initial encounter	67	60	67	194
T42.4X2A - Poisoning by benzodiazepines, intentional self-harm, initial encounter	66	58	57	181
Zip Code	2016	2017	2018	Total
98201	139	134	111	384
98270	117	90	85	292
98258	62	75	75	212
98271	61	58	74	193
98208	54	71	53	178

Prevention quality indicators per 1,000 admissions 2018

	PQI #01 Diabetes Short-term Complications Admission Rate	PQI #02 Perforated Appendix Admission Rate	PQI #03 Diabetes Long-Term Complications Admission Rate	PQI #05 Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate	PQI #07 Hypertension Admission Rate	PQI #08 Heart Failure Admission Rate	PQI #09 Low Birth Weight Rate	PQI #10 Dehydration Admission Rate	PQI #11 Community Acquired Pneumonia Admission Rate	PQI #12 Urinary Tract Infection Admission Rate	PQI #14 Uncontrolled Diabetes Admission Rate	PQI #15 Asthma in Younger Adults Admission Rate	PQI #16 Lower-Extremity Amputation Among Patients with Diabetes Rate
PRMCE	7.66	3.27	10.93	24.99	3.66	32.79	46.63	3.27	10.97	10.58	4.67	6.08	3.66
PSJH WAMT Avg	8.93	2.27	11.69	32.21	3.29	38.01	46.63	4.14	13.72	9.37	5.22	4.64	3.11
Age Group													
18 to 39 years	14.75	4.96	4.25	-	0.99	4.40	43.07	0.57	1.84	2.98	2.41	5.81	0.57
40 to 64 years	10.08	3.92	19.59	21.90	5.37	29.33	103.23	2.35	10.86	8.40	6.61	-	5.93
65 to 74 years	3.15	4.02	12.76	33.31	2.80	42.46	-	2.62	16.08	9.96	5.77	-	6.12
75+ years	1.15	0.14	5.04	22.06	4.90	58.09	-	6.49	16.00	21.76	3.60	-	1.87
	7.68	**3.28**	**10.93**	**24.97**	**3.67**	**32.78**	**44.99**	**2.97**	**10.93**	**10.61**	**4.68**	**5.81**	**3.67**
Gender													
FEMALE	6.53	2.7	6.35	30.9	3.71	26	50.07	3.29	9.65	10.84	4.61	4.4	17.37
MALE	9.29	4.1	17.32	18.98	3.6	42.26	43.25	2.51	12.72	10.29	4.77	12.23	63.59
	7.68	**3.28**	**10.93**	**24.97**	**3.67**	**32.78**	**46.63**	**2.97**	**10.93**	**10.61**	**4.68**	**5.81**	**36.66**
Payor													
CAPITATION	-	-	-	-	-	-	-	-	-	-	-	-	-
COMMERCIAL	6.00	6.11	8.23	13.70	2.67	12.45	43.68	1.78	5.89	4.00	2.56	3.21	2.00
MEDICAID	17.56	2.70	13.32	30.96	4.63	22.20	52.20	1.54	7.33	6.56	6.95	9.25	2.90
MEDICARE	4.75	1.56	11.87	28.28	4.00	50.20	-	4.97	15.80	16.83	5.04	8.97	5.19
OTHER	25.64	-	102.56	32.26	-	102.56	-	-	-	25.64	-	-	-
OTHER GOVERNMENT	5.76	1.44	4.32	28.20	1.44	30.26	33.33	2.88	14.41	7.20	5.76	4.29	2.88
SELF PAY	18.18	9.09	12.12	27.65	6.06	39.39	20.00	3.03	3.03	3.03	9.09	17.70	-
All Payors	**7.66**	**3.27**	**10.93**	**24.99**	**3.66**	**32.79**	**46.63**	**3.27**	**10.97**	**10.58**	**4.67**	**6.08**	**3.66**

Appendix 6: Resources Potentially Available to Address the Significant Health Needs

For a detailed list of community resources visit www.pihchub.org/livewell/.

Organization Type	Organization or Program	Description of services or program	Significant Health Need			
			Homeless	Opioid Use Disorder	Primary Care	Mental Health
Government	City of Everett - 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.	x	x	x	
Government	City of Everett - PAARI (Police Assisted Addiction and Recovery Initiative)	Individuals presenting to the Everett Police Department requesting assistance are connected to a residential inpatient program.		x		
Social Services	Catholic Community Services - Clare's Place	Chronically homes housing, child, youth and family services, addiction recovery, mental health, services for seniors and people with disabilities	X	X		X
Social services	Cocoon House	Provides short and long term housing to young people experiencing homelessness and their children.	x	X		X
Medical	Community Health Center of Snohomish County	Primary care providers playing a bigger role in opioid addiction treatment		X	X	
Social Services	Compass Health	Provides mental and chemical dependency services to all ages, income levels and ethnic cultures.	x	x		
Social Services	Cocoon House	Shelter for teens	X	X		X
Social Services	Everett Gospel Mission	Food, shelter for men, women and children who are experiencing homelessness	x			
Medical	Evergreen Recovery Services	26 bed detox facility		X		
Hospital	Fairfax	Inpatient facility in Everett, Monroe and Kirkland				X
Social Services	Housing Hope	Promotes and provides affordable housing and tailored services to reduce homelessness and poverty.	x			
Medical	Ideal Option	Comprehensive medication assisted treatment program.		X		
Church	Interfaith Association Family Shelter	Services for families experiencing poverty and homelessness.	x			
Social Services	Mercy Housing	Affordable housing and supportive services	x			
Medical	Project Access Northwest – Premium Assistance	Premium assistance program provides support to those that may need assistance with paying insurance premiums.			x	

Organization Type	Organization or Program	Description of services or program	Significant Health Need			
			Homeless	Opioid Use Disorder	Primary Care	Mental Health
Medical	SeaMar Marysville Family Medicine Residency	Primary care physician residency program to train and graduate family medicine providers who are committed to the underserved.			x	
Hospital	Smokey Point Behavioral Health	115 bed facility providing inpatient psychiatric care				X
Government	Snohomish County Human Services - 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.		x		
Public Health Government Sheriff	Snohomish County Health District, Sheriff's Office, County Government	Overdose Prevention Resource Guide to educate in preventing substance abuse, including content about addiction, treatment, recovery and prevention.		x		
Public Health	Snohomish Health District – Drug Overdose program	Connect emergency department patients that have been seen for drug overdose with education and referrals for drug treatment and other community resources.		x		
Medical	The Everett Clinic	Primary and specialty medical care			x	
Social Services	United Way -Project Homeless Connect	One-day community event to provide medical screening, dental care and other services for individuals experiencing homelessness.	x		x	
Educational	Washington State University	Medical school program located in Everett.			x	
Social Services	Washington Recovery Services	Help Line to assist individuals with finding appropriate services		X		
Medical	Western WA Medical Group	Primary and specialty medical care			X	

Appendix 7: PRMCE Community Health Needs Assessment governance

Name	Description	Name / Title / Organization	Sector
Providence Northwest WA 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, including oversight of the CHNA	Members of the Board Mission and Healthier Community committee include: • Dora Alcorta, St. Mary Magdalen Church • David Allen, UW Bothell School of Nursing • Sylvia Anderson, Everett Gospel Mission • Dana Riley Black, Everett Public Schools • Susie Borovina, PMG • Maribeth Carson, SP, Sisters of Providence, Mother Joseph Province • Van Dinh-Kuno, Refugee & Immigrant Services • Bob Drewel, retired Snohomish County executive • Scott Forslund, PIHC • Gail Larson, community member • Bob Leach, D.A. Davison • DeAnne Okazaki, PRMCE • Susan Reis, MD, community member • Steve Schmutz, Archbishop Murphy High School • Ray Stephenson, retired City of Everett • Barry Stueve, PRMCE • Michael Sullivan, community member • John Vandree, retired Physician • Carol Whitehead, Everett School District • Kim Williams, PRMCE	Faith based organization, churches, educational institutions, community social service organizations, hospital, Immigrant services, government, other healthcare organizations
NWSA Executive Committee	The Providence Northwest Washington Service Area Executive leadership team has accountability for the ongoing planning, budgeting, and implementation of community benefit activities, including the CHNA and CHIP.	• Barry Stueve, Mission • Casey Calamusa, Marketing & Communications • Darren Redick, Support Services • DeAnne Okazaki, Administrative programs • Janine Holbrook, Nursing • Jason Peterson, Strategy • Jay Cook MD, Medical Staff • Karin Larson-Pollock, Quality • Kathleen Groen, Human Resources • Kim Williams, Chief Executive • Lori Kloes, Foundation • Mitesh Parikh, Medical Group • Scott Combs, Finance • Steve Campbell MD, Medical Group	Hospital
CHNA Advisory Group	The advisory group has accountability for the development of the CHNA.	• Barry Stueve, Mission • DeAnne Okazaki, Administrative programs • Jason Peterson, Strategy • Scott Forslund, PIHC	Hospital

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PROVIDENCE ST. JOSEPH HEALTH

Providence St. Joseph Health is committed to improving the health of the communities it serves, especially those who are poor and vulnerable. With 51 hospitals, 829 physician clinics, senior services, supportive housing and many other health and educational services, the health system and its partners employ more than 119,000 caregivers (employees) serving communities across seven Western states – Alaska, California, Montana, New Mexico, Oregon, Texas and Washington. With system offices based in Renton, Wash., and Irvine, Calif., the Providence St. Joseph Health family of organizations works together to meet the needs of its communities, both today and into the future.