PROVIDENCE
Regional Medical Center
Everett

Community Health Improvement Plan

Providence Regional Medical Center Everett

2020 - 2022

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Executive Summary

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 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 to the northwest Washington community 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 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 the 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 including $13.5 million in free and low-cost care so the underinsured and uninsured could access health care.

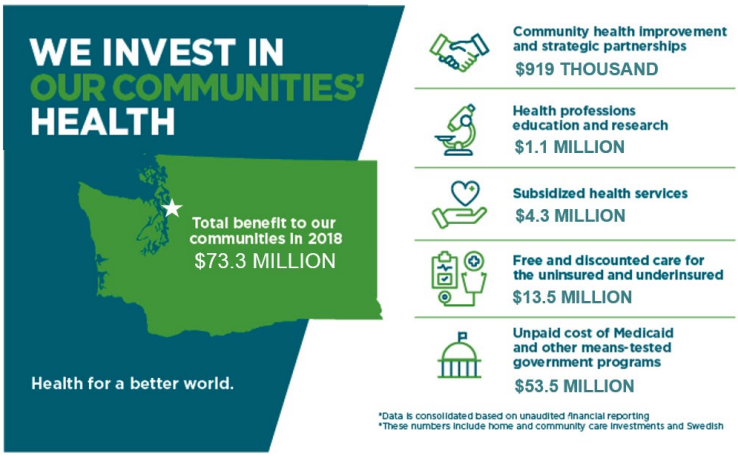

Figure 1. PRMCE Community Benefit

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).

Community Health Improvement Plan Priorities

As a result of the findings of our Community Health Needs Assessment (CHNA) and through a prioritization process aligned with our mission, resources and hospital strategic plan, PRMCE will focus on the following priority areas for its 2020-2022 community benefit efforts:

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

We are committed to focusing on these areas because they are core to our Mission of caring for those who are poor and vulnerable. Each of the health needs we have identified include a metric and measurable goal that will be used as an indicator of progress. We will also develop specific metrics to gauge the effectiveness of the tactics identified and review 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

Planning for the Uninsured/Underinsured

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

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

Definition of Community Served

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. 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 total population, 11% are Hispanic, and 5% report two or more races. 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.

According to the Robert Wood Johnson Foundation County Health Rankings, Snohomish County is ranked as the 3rd healthiest community in the State of Washington in both health outcomes and health behaviors. 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.

Community Health Needs Assessment

Assessment Process

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 need. In addition to the quantitative data, community 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.

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 the Strategic Oversight Team, Strategic Planning Council, Sustainability, Inclusion and Co-Creation Task Force, the Health & Well-Being Monitor™, the Edge of Amazing Community Health Summit, and TotalHealth™. 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.

Prioritization Process

PRMCE utilized a three-step approach to identify the significant health needs that PRMCE will address in this cycle. In the first phase of the PRMCE assessment, over 150 indicators were evaluated. Qualitative and quantitative data were evaluated from multiple sources including the Snohomish Health District, 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 County Health Assessment Data Task Force. Data were scored and prioritized by the PRMCE CHNA Advisory Group using the comparison to local, state and national data, whether the metric was trending up/down, comparison to goal, and the size or seriousness of the problem.

For the second phase, indicators from phase I 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 was 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 the level of community resources dedicated to improving the indicator. The following needs were identified during this phase. These areas of need closely mirror those that were identified by the Snohomish Health District community process.

1. Access to Mental Health
2. Opioid Use Disorder
3. Housing/Homelessness
4. Access to Primary Care
5. Suicide
6. Obesity, Diet & Exercise
7. Access to Dental Health for Youth

During the final phase, the Northwest Washington Service Area executive leadership team and CHNA advisory group completed an analysis of the data from Phase II 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. The following areas of greatest need will be the focus of the PRMCE 2020-2022 CHIP:

1. Access to Mental Health
2. Opioid Use Disorder
3. Housing/Homelessness
4. Access to Primary Care

Needs Not Being Addressed

Due to the lack of identified effective interventions, resource constraints, or absence of expertise, PRMCE will not address obesity/diet/exercise or access to youth dental care. Given the scope of care we provide to our community, we will have an indirect impact on these community needs through our ongoing work as engaged partners with other community-led collaborative efforts. Additionally, suicide will not be directly address by PRMCE. However, we anticipate that the focus on access to mental health will also have a positive impact on suicide.

Community Health Improvement Plan (CHIP)

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

The goal of this improvement plan is to measurably improve the health of individuals and families living in the Snohomish County community. The plan's target population includes the community as a whole, and specific population groups including the underserved.

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

The following section outlines PRMCE's plan to address the four priority areas over a three-year period. The target population for the improvement plan is the Snohomish County community, with emphasis on vulnerable populations.

Access to Mental Health Care

Mental health care is foundational to an individual's quality of life and physical health. Access to mental health care includes the availability of quality, integrated care for individuals with a range of mental disorders. Due to the lack of access to mental health care, 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.

Goal: The goal is to improve access to quality, timely mental health services in Snohomish County, and reduce the stigma and discrimination associated with mental illness.

Measures: The overall indicators that are used to measure access to mental health are below. Specific measures will be identified for each tactic as they are developed.

Table 1. Mental health care measurements

Indicator	Snohomish County		WA	US
	Current	Previous		
Mental health professional ratio	350 to 1	379	330 to 1	470
Visit to mental health provider	14%	12%		
Average number of days per month of poor mental or emotional health for an individual	5.2	8		
Individuals reporting poor mental health days in the last month	54%	52%		
10th grade seriously considering suicide	22.5%	21.8%	20.6%	17.3%
Suicide mortality, per 100,000 population	14.39	14.6	14.89	13.4

Strategies:

Table 2. Mental health care strategies and tactics

Strategy	Tactic
Improve whole person care by embedding mental health programs into primary care.	Integrate pediatric mental health into primary care. Expansion of Total Health™ to community partners.
Increase access to mental health services.	Develop inpatient mental health unit at PRMCE Review effectiveness of the mental health urgent care at PMG. Expansion of Fairfax Hospital at the PRMCE Pacific Campus.
Educate caregivers, providers and the community in order to decrease the stigma and discrimination associated with mental illness.	Expand mental health first aid training. Communicate and ensure caregivers are knowledgeable about and have access to resources such as the Behavioral Health Concierge service.
Collaborate with and support community partners.	Ensure sponsorship funding is aligned with organizations that support mental health. Identify actionable items from Edge of Amazing “Mental Health First Aid and Integrating Behavioral Health”.

Potential Key Community Partners:

Some of the organization and programs that PRMCE may partner with to increase access to mental health care include Catholic Community Services, Compass Health, North Sound Accountable Communities of Health, Fairfax Behavioral Health, Snohomish County Human Services, and Northwest Innovation Lab.

Opioid Use Disorder

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

Goal: The goal is to implement prevention and intervention strategies to reduce the morbidity and mortality caused by the abuse of opioid medications and illegal opioids in Snohomish County, and reduce the stigma and discrimination associated with substance use disorders.

Measures: The overall indicators that are used to measure opioid use disorder are below. Specific measures will be identified for each tactic as they are developed.

Table 3. Opioid use disorder measurements

Indicator	Snohomish County		WA	US
	Current	Previous		
Opioid related deaths	103	94		
Opioid overdose count per day	12	10		
Opioid overdose count per week	57	37		
Children removed by CPS due to parent drug abuse	48.8%		38.3%	
Youth illegal drug (not marijuana, tobacco, alcohol)	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:

Table 4. Opioid use disorder strategies and tactics

Strategy	Tactic
Increase access to treatment options.	Evaluate access to Providence Drug and Alcohol Addiction services.
Prevent inappropriate opioid prescribing to reduce opioid misuse.	Continue to provide/grow the medication assisted treatment for opioid use disorder in the emergency room.
Educate caregivers, providers and the community to decrease the stigma and discrimination associated with opioid use disorder.	Expand mental health first aid training expansion. Communicate and ensure caregivers are knowledgeable about and have access to resources for themselves and their families.
Provide screening/assessment for community members and patients to identify social determinants of health (e.g. drug abuse, homelessness, mental health).	Expansion of Total Health™ to community partners.
Collaborate with and support community partners.	Ensure sponsorship funding is aligned with organizations that support opioid use disorder.

Strategy	Tactic
	Identify actionable items from Edge of Amazing "A Community Response to the Opioid Crisis".

***Key Community Partners*:**

Some of the organization and programs that PRMCE may partner with to impact the goal of reducing opioid abuse include Community Health Center of Snohomish County, Compass Health, North Sound Emergency Medicine, Seamar Community Health Center, and Snohomish Health District.

Homelessness

Homelessness has a high negative impact on an individual's health status and homeless individuals are high users of medical systems. A homeless person is defined as an individual without permanent housing who may live on the streets, stay in a shelter, mission, single room occupancy facility, abandoned building or vehicle, or in any other unstable or non-permanent situation.

Goal: Reduce the number of individuals and families in Snohomish County experiencing homelessness, connect PRMCE patients to stable housing, and decrease the stigma and discrimination associated with homelessness.

Measures: The overall indicators that are used to measure homelessness are below. Specific measures will be identified for each tactic as they are developed.

Table 5. Homelessness measurements

Indicator	Snohomish County		WA	US
	Current	Previous		
Residents screened through TotalHealth™ who are worried about paying for power and water	13.5%	8%		
Residents screened through 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 loss of their home because family cannot afford housing	6.2%	6.50%	5.70%	
Individuals who know someone that is or has been homeless	42%			

Strategies:

Table 6. Homelessness strategies and tactics

Strategy	Tactic
Identify solutions to the health care needs of the homeless population post discharge.	Everett Gospel Mission medical respite operational support. Bethany/PRMCE Interim Care Unit collaboration.
Provide screening/assessment for community members and patients to identify social determinants of health with a specific focus on housing/homelessness.	Expansion of Total Health™ and housing navigator in clinics.
Educate caregivers, providers, and the community to decrease the stigma and discrimination associated with homelessness.	To be determined.
Collaborate with and support community partners to directly address homelessness.	Ensure sponsorship funding is aligned with organizations that support mental health. Evaluate Catholic Community Services low barrier housing and other housing projects. Identify actionable items from Edge of Amazing "Homeless Everywhere, What are we doing about it."

***Key Community Partners*:**

Some of the organization and programs that PRMCE may partner with to impact the goal of reducing homelessness include Catholic Community Services, Everett Gospel Mission, Cocoon House, Compass Health, Domestic Violence Services, Housing Hope, Snohomish County Human Services, United Way of Snohomish County, and the YMCA.

Access to Primary Care

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

Goal: Assist Snohomish County residence with accessing primary care at the right time and in

the right care setting.

Measures: The overall indicators that are used to measure access to primary care are below. Specific measures will be identified for each tactic as they are developed.

Table 7. Access to primary care measurements

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 Health Professional within last year	77%	76%		

Strategies:

Table 8. Access to primary care strategies and tactics

Strategy	Tactic
Improve the patient experience with new access options, digital tools, and convenient access.	Identify action items from NW Innovation Resource Center collaborative focusing on how the community makes decisions on healthcare choices
Collaborate with community partners to increase the available workforce and interest in the health care sector.	Evaluate implementation of an Internal Medicine Residency Program.
Recruit additional primary care providers to meet the needs of the community where it's convenient for the patient	Implement strategies at PMG for primary care recruitment. Expansion of PMG Marysville primary care clinic.

***Key Community Partners*:**

Some of the organization and programs that PRMCE may partner with to impact the goal of improving access to primary care include SeaMar Community Health Center, Washington State University, Archbishop Murphy High School, Everett Public Schools, and Northwest Innovation Resource Center.

Other Community Benefit Programs

In addition to projects that specifically focus on the CHNA priority needs, PRMCE offers community benefit programs and services that often operate at a financial loss. These services are provided because they meet community need and if the service was no longer offered, it would either be unavailable in the area, the community's capacity to provide the service would be below the community's need, or provision of the services would become the responsibility of government or another not-for-profit organization to provide. A list of some of these services is included in the table below.

Table 9. Subsidized services

Need Being Addressed	Program Name	Description	Target Population
Sexual abuse, human trafficking	Providence Intervention Center for Assault and Abuse	The program promotes emotional and physical healing for people victimized by sexual assault and child abuse.	Children and adults
Obesity and Diabetes	PRMCE Wound Ostomy	The program provides multidisciplinary, specialized wound and ostomy care for complex patients.	Adults, with focus on underinsured
Autism	Boyden Family Autism Center	Treatment program focused on teaching foundational skills needed for effective communication, adaptive skills and positive behavior management.	Children and their families
Drug and alcohol abuse	Providence Drug and Alcohol Addiction Treatment	Hospital-based inpatient, outpatient, and day treatment and detoxification, as well as rehabilitative treatment for alcoholism and other drug dependencies.	Adults
Diabetes, obesity and stroke	Providence Rehabilitation Therapy	Comprehensive rehabilitative care for physical, occupational and speech therapy.	Adults, with a focus on Medicare and Medicaid population
Neurodevelopment	Providence Children's Center	The program provides services for children with special health needs with a focus on early intervention.	High-risk children and their parents, with a focus on uninsured, underinsured.

Plan Approval

This community health improvement plan was adopted by the Community Ministry Board of the hospital on October 17, 2019. The final report was made widely available by December 31, 2019.

Kim E Williams 10-17-19

Kim Williams, RN, MS, FACHE — Date
Chief Executive Officer
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10-24-19

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

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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