Community Health Needs Assessment

Approved by the Grays Harbor County Public Hospital District No. 2 Board of Commissioners.
November 24th, 2020

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Introduction/Overview

Harbor Regional Health Community Hospital (HRHCH) is a 140-bed licensed acute care community hospital located in Aberdeen, Washington, the largest city in mostly rural Grays Harbor County. HRHCH is designated by Medicare as a Sole Community Hospital (SCH). The SCH program was created by Congress to support small rural hospitals which *"by reason of factors such as isolated location, weather conditions, travel conditions, or absence of other hospitals, is the sole source of inpatient hospital services reasonably available in a geographic area to Medicare beneficiaries"*.

HRHCH opened as Aberdeen General Hospital in 1897 and was renamed as HRHCH in 1945. In 1956, the hospital was found to no longer meet State licensing requirements, and the Board made the decision to build a replacement hospital. The project was financed through public donation (60 percent) and Hill-Burton Act funds (40 percent). The current hospital building opened in December 1959.

Well into the 1960s Grays Harbor County, named after the large estuarine bay near the County's southwestern corner, was largely dependent on the logging and fishing industries. In the 1960s, foreign mills began outbidding local timber companies based on price, and in the 1980s, threats to the spotted owl and salmon lead to Federal restrictions and high rates of unemployment. Fishing and clamming, once important to the county's economy, also deteriorated based on depleted stocks.

Today, charter fishing and ocean beaches bring considerable tourism to the area, and as a result, employment is largely in the lower-wage services sector. The County has consistently experienced higher rates of unemployment and poverty than the State.

Harbor Regional Health Community Hospital

Mission

To heal, comfort and serve our community with compassion.

Vision

To provide every patient superior service and safety, exceptional by any standard.

In addition to acute inpatient care (OB, intensive care and medical/surgical), HRHCH provides, among other services, a 24/7 emergency department, radiology, physical therapy, laboratory, imaging, rehabilitation, surgery, chemical dependency, cardiac, wound care, ambulatory infusion, and respiratory care. HRHCH, through its operating subsidiary, Harbor Regional Health Medical Group, also owns and operates primary care and specialty clinics, with a total of approximately 24 providers.

Nearly 80% of HRHCH patients have Medicare or Medicaid as their payer or are receiving charity care. Today, of Washington's 100+ hospitals, HRHCH ranks 5th highest in its patient's reliance on governmental payers (that do not typically pay cost) and patients requiring charity care. In August 2014, residents voted to create Grays Harbor Public Hospital District #2 (the District). The defined District boundaries largely parallel western Grays Harbor County, with a population of nearly 60,000. The purpose of establishing a public health district was, in part, to allow HRHCH to benefit from a revenue stream that the State Legislature appropriated for District hospitals that are also SCHs. In January of 2015, the District began operations with a board of seven elected commissioners; replacing the previous community citizen board.

While the addition of the District has helped financial viability, the challenges HRHCH faces daily remain: HRHCH has experienced an operating loss each year since conversion to a District. 2019 witnessed improvements associated with several factors, including ongoing administrative efforts to streamline operations, reduce inefficiencies, increase emphasis on prevention and outsource various administrative functions. It also resulted from the Legislature's willingness to further increase Medicaid reimbursement for two SCHs in the State, including HRHCH, which are now paid at 150% of the normal Medicaid reimbursement rate.

The financial impact of the COVID-19 Pandemic is still unknown, but hospitals in general have been hard hit. The statewide ban on elective cases and patient unease about seeking health care, even for emergencies has resulted in significant reductions in primary and specialty care visits, outpatient visits, ED visits and hospitalizations. Despite these ongoing challenges, HRHCH continues to be committed and hopeful that it will achieve financial stability, continue to find avenues to improve health and assure access for District residents.

When HRHCH's 2017 CHNA was developed, Robert Wood Johnson's County Health Rankings listed Grays Harbor County as the 35th lowest (out of Washington's 39 counties) for overall health outcomes. This ranking has worsened, with the County in 2020 now ranking 37th out of Washington's 39 counties. During the same timeframe, the County improved in health factors rankings, moving from 36th in 2017 to 33rd in 2020. Health outcomes represent how healthy an area is. It also reflects the physical and mental well-being of residents within a community through measures representing the length and quality of life. Health factors represent those things a community can modify to improve the length and quality of life for residents including health behaviors, clinical care, social and economic factors, and physical environment.

It is within this context that HRHCH's 2020-2022 Community Health Needs Assessment (CHNA) was undertaken. This assessment heavily relies on data from numerous community and public organizations throughout Grays Harbor County. Health Facilities Planning & Development, a consulting firm in Seattle, Washington with more than 30 years of experience working with Washington hospitals and data, facilitated the CHNA process and supported HRHCH in finalizing the CHNA and implementation plan.

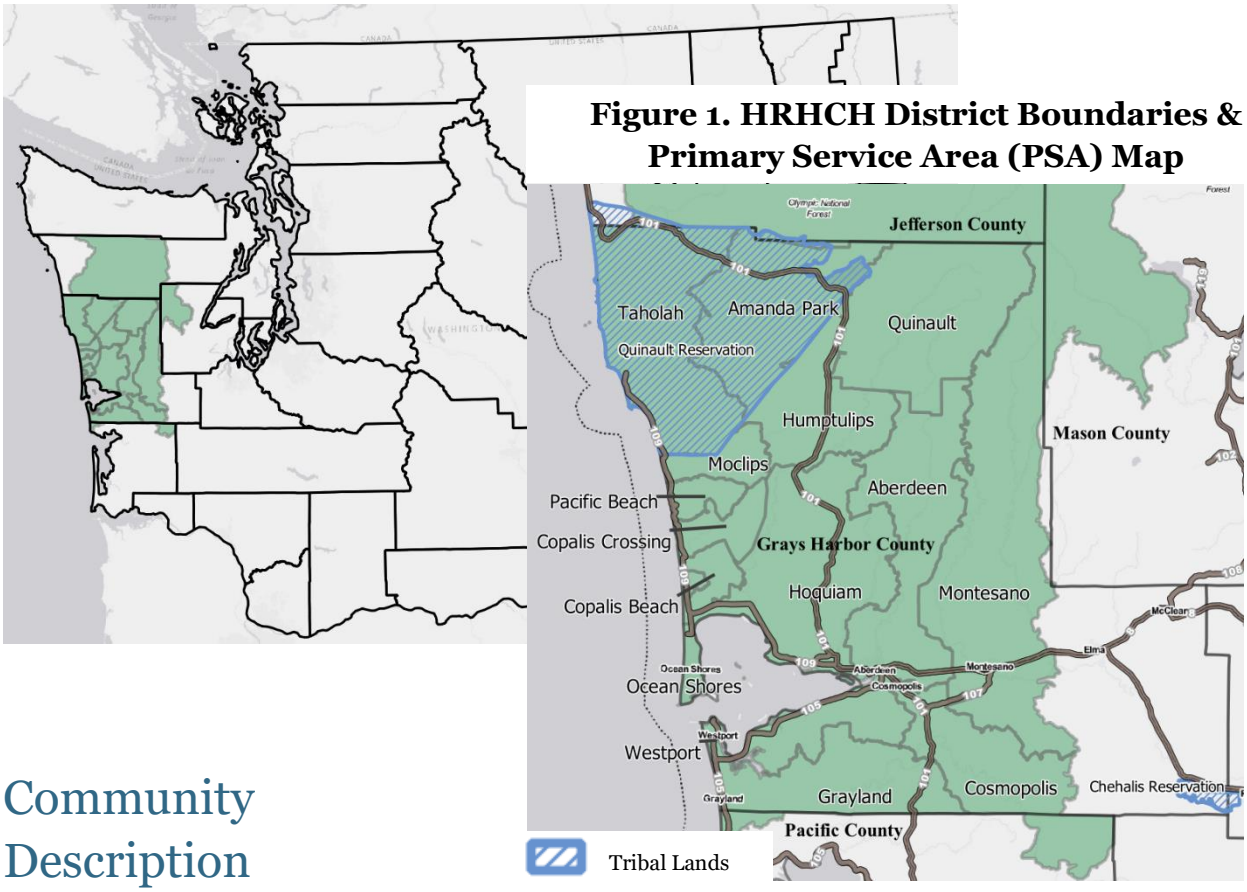


Figure 1. HRHCH District Boundaries & Primary Service Area (PSA) Map

Community Description

Grays Harbor County covers more than 1,900 square miles in western Washington State, and its western border is the Pacific Ocean. The County is as large as the State of Delaware and includes 76,627 residents. It is predominantly rural. The hospital itself is located in the city of Aberdeen, the largest city in the County. The population of Aberdeen was approximately 16,756 as of July 2019 estimates. The next largest city is Hoquiam (population 8,655).

The District is fully contained in the County and its geographic boundaries largely parallel the area commonly referred to as Western Grays Harbor County. The District includes about 77% of the total population of Grays Harbor County. Over 85% of HRHCH's inpatient discharges were generated by individuals residing within the District, and for these reasons, the District's boundaries are considered the primary service area (PSA) for this CHNA. The defined PSA is the same geography as used in the HRHCH's 2017 CHNA and can be seen in Figure 1. The District/PSA is defined as the following zip codes[1]:

98520 (Aberdeen)	98587 (Taholah)	98562(Moclips)
98550 (Hoquiam)	98547 (Grayland)	98566 (Neilton)
98569 (Ocean Shores)	98535 (Copalis Beach)	98536 (Copalis Crossing)
98563 (Montesano)	98571 (Pacific Beach)	98575 (Quinault)
98595 (Westport)	98526 (Amanda Park)	98583 (Satsop)
98537 (Cosmopolis)	98552 (Humptulips)	

The Quinault Indian Nation's home is embedded within the geography of the District, along the coastal areas of the County and consists of the Quinault and Queets tribes. Major highways in Grays Harbor County include State Route 101, which runs north/south along the coast, and Highways 12 and 8, which run east/west, and ultimately connects to Interstate Highway 5 in the east. The state highways converge in the cities of Aberdeen and Hoquiam. Driving time from the city of Aberdeen to the next largest city, Olympia, is roughly one hour. Driving time to either Seattle or Portland, Oregon is about two and a half hours. It takes about an hour to drive from Lake Quinault in the north end of the District/PSA to Aberdeen.

Throughout this CHNA, where possible, data was collected specific to the District/Service Area, and where not, County level data was used.

As depicted throughout this CHNA, the District/PSA and the County both face a number of health and socioeconomic challenges, including health care access being compromised by a low provider to population ratio, higher death rates than the State at large, higher rates of teen pregnancy, lower birth outcomes and higher rates of behavioral health concerns, including use of opioids, heroin and higher rates of suicide. The CHNA also depicts that the social and economic factors—the social determinants that can contribute to poorer health—are more of a burden within the boundaries of the District and Grays Harbor County than in most other areas of Washington State.

[1] For some zip codes, a portion of the geography and population are outside of the District boundaries. Population and demographic data was adjusted to account for only the percentage that resides within the District.

2017 CHNA and Accomplishments

HRHCH's 2017 CHNA identified significant health needs related to health care access, health status and health behaviors in the District/PSA as well as Grays Harbor County in general. The 2017 CHNA identified the following priorities and strategic actions:

Priority	Achievements
Behavioral Health **Action:** Advocate and secure adequate resources to improve access to behavioral health care by integrating into primary care and address the opiate crisis. **Strategies:** ▪ Evaluate Telemedicine ▪ Conduct Crisis intervention Training ▪ Continue evidence-based MAT Programs and Distribution of Naloxone kits ▪ Conduct Opioid Symposium	▪ HRHCH's inpatient and outpatient providers participate weekly in the UW Psychiatry and Addictions Case Conference Series and utilize the UW Psychiatry phone consultation service to expand their mental health and addiction care capacity. ▪ HRHCH is working with the UW to implement tele-Medication Assisted Treatment services. ▪ Crisis de-escalation training has been implemented in key departments. ▪ HRHCH now provides Medically Assisted Treatment (MAT) services through our Substance Use Disorder unit at HarborCrest. We have also worked in partnership with Grays Harbor Public Health to distribute Naloxone kits throughout the community and with the Harbor Strong Coalition to distribute opioid lock boxes in the community. ▪ HRHCH held an Opiate Symposium on November 8, 2017. We had 111 people attend the event and 67% of the attendees gave feedback on the event that have guided (and will continue to guide) services and program development.
Economic Development **Action:** Active participation in Economic Development, with specific interest in advocacy for more family wage jobs, more affordable housing and better transportation. **Strategies:** ▪ Commitment of Leadership time and Board level resources to actively advocate and support enhancements in community infrastructure	▪ HRHCH leadership participated in economic development committees with Greater Grays Harbor, served in board positions for the Greater Grays Harbor Economic Development board, and developed a partnership with the City of Hoquiam and the Washington State Department of Commerce to develop a prioritized list of economic development projects. ▪ HRHCH works collaboratively with CPAA to coordinate entry into their housing and shelter programs for those who are housing insecure and coordinate access to food and transit through community partnerships.

Priority	Achievements
Prevention and Management of Chronic Conditions **Action:** Manage chronic diseases by improving care coordination and self-management programs. **Strategies:** ▪ Implement Chronic Care Model: Stanford Chronic Disease Self-Management ▪ Evaluate feasibility of adding coordination staff or community health workers ▪ Provide phone call reminders and schedule follow-ups ▪ Educate about benefits of physical activity and eating healthy foods ▪ Advocate for more recreational spaces, and for policies to reduce tobacco use	▪ HRHCH participated in a train the trainer program. Two employees are now equipped to run health education classes. We are evaluating virtual options to implement during the COVID-19 Pandemic. ▪ Within the primary care clinics, specific measurable workflows were identified to manage diabetic patients. ▪ Also, within primary care, a Contact Center for primary care providers was established in an effort to offer more robust appointment and follow up services. ▪ A Prompt Care clinic was established to help those who use the ER for chronic health issues gain access to primary care. HRHCH is also reestablishing its EDIE program to establish comprehensive care plans to minimize ER visits for those with chronic disease. ▪ For patients with COPD who come to the ER for treatment, HRHCH works directly with Lincare, a respiratory therapy provider in the community, to ensure patients follow-up on their respiratory therapy appointments. ▪ HRHCH trained a number of employees to be Navigators to assist those with chronic care needs gain access to health insurance and access providers via Apple Care. ▪ HRHCH has also implemented community education and engagement opportunities including: Diabetes classes that also included a coupon for fresh vegetables at the end; and a smoking cessation program developed by HRHCH's Cardiopulmonary Director
Health Promotion and Education **Action:** Outreach that supports healthy living and self-management. **Strategies:** ▪ Speaker sessions on healthy eating and physical activity ▪ Further enhancements to website to make information accessible ▪ Care coordination to support chronic care self-management	▪ HRHCH coordinated a speaker series that covered several health promotion topics and coordinated an annual Health Fair including booths focused on exercise and healthy eating. ▪ The HRHCH Website has been completely rebuilt and is being updated weekly. Blogs are being established so that providers can educate the community. ▪ HRHCH is part of the Grays Harbor Partner Coalition which is headed by Grays Harbor Public Health. The group seeks to facilitate communication between community entities working to manage addiction services across the county.

Methodology

This CHNA builds off the HRHCH's 2017 CHNA. In addition, since the September 26, 2017 adoption of our CHNA, a number of other CHNAs were completed that include all or portions of the District as well as the County. These CHNAs were developed by the Cascade Pacific Action Alliance (CPAA), Grays Harbor Public Health, and Grays Harbor County Public Hospital District No. 1, dba Summit Pacific Medical Center. A brief description of each entity and a summary of its CHNA priorities follows.

Cascade Pacific Action Alliance: *CPAA exists to improve community health and safety while advancing the Triple Aim: improving the patient experience of care, including quality and satisfaction; improving the health of populations; and reducing per capita health care costs. It operates in a seven-county region of Central Western Washington, which includes Cowlitz, Grays Harbor, Lewis, Mason, Pacific, Thurston, and Wahkiakum counties. CPAA is also the Accountable Community of Health (ACH) for the seven counties, meaning that the State Health Care Authority (HCA) has named it the regional entity leading Medicaid transformation and pursuing projects aimed at transforming the Medicaid delivery system. Washington's transformation projects focus on health systems capacity building, care delivery redesign, prevention and health promotion, and increased use of value-based payment (VBP) models that reward providers for quality of care rather than the volume of services and procedures provided. HRHCH's CEO, Mr. Tom Jensen is on the Board of CPAA and is its immediate past chair.*

CPAA's Regional Health Improvement Goals are to improve health equity and health outcomes for all residents in the communities it serves, with a focus on addressing the social determinants of health; to keep residents healthy as long as possible and address all health needs with a focus on prevention and early interventions; and to reduce per-capita health care costs while improving the quality of care provided to residents in our communities. CPAA's regional priorities were developed through region-wide engagement. In developing these, each county hosted a local forum to identify local health priorities and then shared regional priorities and actions that align with the local action agenda were adopted. CPAA's current regional priorities include are depicted in Figure 2.

Figure 2. CPAA 2017 Priorities

Grays Harbor County Public Health and Social Services Department's (GHCPH) mission is to improve the health and well-being of the people of Grays Harbor. Its vision is of Grays Harbor as a place where all people can be healthy throughout their lives.

GHCPH's 2016 *Community Health Improvement Plan: Creating a Healthier Grays Harbor* used a collaborative county-wide process and gathered the community to detail the serious health challenges that exist, to describe the efforts underway and to create a vision for a healthier tomorrow. Its priorities are detailed in Figure 3.

Figure 3. Grays Harbor Public Health Priorities

Grays Harbor County Public Hospital District No. 1, dba Summit Pacific Medical Center is a public hospital district that operates a Critical Access Hospital with a level IV trauma designation, two rural healthcare clinics and a seven day a week urgent care clinic in Eastern Grays Harbor County. Its vision is 'to build the healthiest community in the Nation." Summit Pacific's 2020-2022 Community Needs Health Assessment (CHNA) was developed over several months, using internal and external data and community feedback. In the late fall of 2019, three community sessions were convened specifically to provide input on community health needs. At these sessions, health rankings and other related information were reviewed, priorities were discussed, and the community's input was solicited.

The priorities of each of these organizations as well as those contained in HRHCH's 2017-2020 CHNA are identified in Figure 4 on the next page.

Figure 4. Grays Harbor County Health Priorities from Recent Community Health Assessments

Cascade Pacific Action Alliance (2017)	Grays Harbor Public Health CHIP (2016) Forum	Summit Pacific Medical Center (2020)	Harbor Regional Health Community Hospital (2017)
Improve Healthcare Access	Children & Youth: Giving Kids a Healthy Start	Health Behaviors	Behavioral Health
Improve Care Coordination & Integration	Mental Illness and Substance Abuse: Recovering Hope	Clinical Care	Economic Development
Prevent & Manage Chronic Disease	Chronic Disease: Reducing the Burden	Social, Economic & Physical Environment	Prevention and Management of Chronic Conditions
Prevent & Mitigate Adverse Childhood Experiences (ACES)	Healthcare Access for Everyone: Right care, right time		Health Promotion and Education
Enhance Economic & Educational Opportunities			

In addition to consideration of these community priorities, both primary and secondary data was incorporated to create a comprehensive understanding of the District and County's health, health status and health care needs. Demographics, health behaviors, mortality and access to health care were among the indicators that were examined. As noted earlier, where possible, data was collected specific to the District, and where not, county level data was used.

Data sources include, but are not limited to the following:

- Behavioral Risk Factor Surveillance Survey
- American Community Survey (ACS), US Census Bureau
- OFM Public Hospital District Statistics and Chart Book
- Robert Wood Johnson County Health Rankings
- Department of Health and Human Services National Vital Statistics
- Grays Harbor 2019 Public Health Snapshots
- Washington Healthy Youth Survey 2018 Grays Harbor County
- Washington Health Care Authority
- HRSA Data Warehouse
- University of Washington Alcohol & Drug Abuse Institute
- Employment Security Department
- Washington State Department of Commerce

Demographics and Social Determinants of Health

Demographics:

The population is expected to grow much more slowly in the District/PSA and County than in the rest of the state between today and 2024 (2.2%, 2.6% and 6.2% respectively). Today, the percentage of the District and County's population that is 65+ is already higher than the state (22% compared to 15.9%). It is also the cohort expected to continue to grow through 2024. In fact, as shown in Table 1, the 0-64 age cohort is projected to decrease in the District and County (-0.8% and -4.8% respectively).

Table 1. District, County and State Population, by Age

	District		Grays Harbor County		Washington State	
Population	**2019**	**% Chg. 2019-2024**	**2019**	**%Chg. 2010-2024**	**2019**	**% Chg. 2010-2024**
Total Population	59,169	2.2%	76,627	2.6%	7,572,102	6.2%
% 0-64	78%	-0.8%	78.5%	-4.8%	84.1%	3.4%
% 65+	22%	11.5%	21.5%	13.6%	15.9%	21.1%

Source: Claritas 2019

Table 2 provides more detail on the District and demonstrates that the 0-64 cohort decreased by 6.0% between 2010-2019, with the most significant decrease (9%) in the 45-64 population. The 0-64 population is expected to decrease another 0.8% by 2024; again, led by a decrease in the 45-64 population (5.3%).

Table 2. The District Population

	2010	Pct of Tot Pop	2019 Est	Pct of Tot Pop	Pct Chg 2010-2019	2024 Proj	Pct of Tot Pop	Pct Chg 2019-2024
Tot. Pop.	**58,751**	**100%**	**59,169**	**100%**	**0.7%**	**60,502**	**100%**	**2.2%**
Pop. By Age								
0-17	12,222	21%	11,655	20%	**-4.9%**	11,748	19.4%	**0.8%**
18-44	18,886	32%	18,149	31%	**-4.1%**	18,507	30.6%	**1.9%**
45-64	17,739	30%	16,269	27%	**-9.0%**	15,452	25.5%	**-5.3%**
65-74	5,729	10%	8,299	14%	**31.0%**	9,670	16.0%	**14.2%**
75-84	2,951	5%	3,486	6%	**15.3%**	3,696	6.1%	**5.7%**
85+	1,223	2%	1,311	2%	**6.7%**	1,429	2.4%	**8.3%**
Tot. 0-64	48,848	83%	46,072	78%	**-6.0%**	45,707	75.5%	**-0.8%**
Tot. 65 +	9,903	17%	13,097	22%	**24.4%**	14,795	24.5%	**11.5%**

Source: Claritas 2019

Table 3 depicts that within the District, 73.1% of the population is white (a decrease of 4.2% since 2010). In comparison, at 11.1%, the Hispanic population has increased 23.2% since 2010.

The District is slightly more diverse than the County, but significantly less so than the state. For example, 64% of the population statewide is white, and 13% is Hispanic. The Asian population statewide is almost 8% compared to 1.2% in both the County and District. The only cohort that represents a higher percentage of the population in the County vs the State is American Indian, at 4.1% within the District, 4.5% in the County and only 1.3% statewide.

Table 3. District Population by Race and Ethnicity

	2010	Pct of Tot Pop	2019 Est	Pct of Tot Pop	Pct Chg 2010 -2019	2024 Proj	Pct of Tot Pop	Pct Chg 2019-2024
Tot. Pop.	**58,751**	**100%**	**59,169**	**100%**	**0.7%**	**60,502**	**100%**	**2.3%**
Pop. By Race								
American Indian/Alaskan Native Alone	2,356	4.0%	2,423	4.1%	2.8%	2,503	4.1%	3.3%
Asian Alone	789	1.3%	744	1.3%	-5.6%	729	1.2%	-2.0%
Black/African American Alone	688	1.2%	852	1.4%	23.8%	960	1.6%	12.7%
Native Hawaiian/ Pacific Islander Alone	140	0.2%	190	0.3%	35.8%	223	0.4%	17.7%
Some Other Race Alone	2,172	3.7%	2,579	4.4%	18.8%	2,860	4.7%	10.9%
Two or More Races	2,113	3.6%	2,535	4.3%	19.9%	2,823	4.7%	11.4%
White Alone	45,140	76.8%	43,253	73.1%	-4.2%	42,957	71.0%	-0.7%
Hispanic	5,354	9.1%	6,594	11.1%	23.2%	7,447	12.3%	12.9%

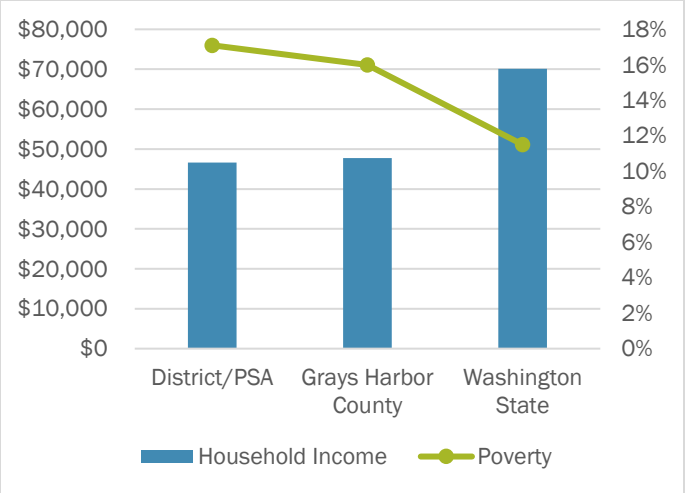
Source: Claritas 2019

Social Determinants of Health

Social determinants of health—the conditions under which people are born, grow, live, work and play—greatly influence the health of a community and its residents. Graduation rates, housing affordability, income/poverty and race are all social determinants. Figure 5 shows that social and economic factors are more of a burden in Grays Harbor County than in many other areas of Washington State. This includes poverty and unemployment.

The Median Household Income in the District is 66% of that of the State ($46,650 vs. $70,116). Rates of poverty in the District (17.1%) are also higher than the County (16.0%) and are significantly above the state's rate of 11.5%.

Figure 5. 2018 Income and Poverty



*Source: Social Explorer Tables: ACS 2018, Social Explorer; U.S. Census Bureau, Median Income Inflation Adjusted *Neilton and Moclips location data not available*

The United Ways of the Pacific Northwest's ALICE report provides county-level estimates of ALICE households and households in poverty. ALICE is an acronym for Asset Limited, Income Constrained, Employed – households that earn more than the Federal Poverty Level (FPL), but less than the basic cost of living for the county (the ALICE Threshold). Combined, the number of ALICE and poverty-level households equals the total population struggling to afford basic needs.

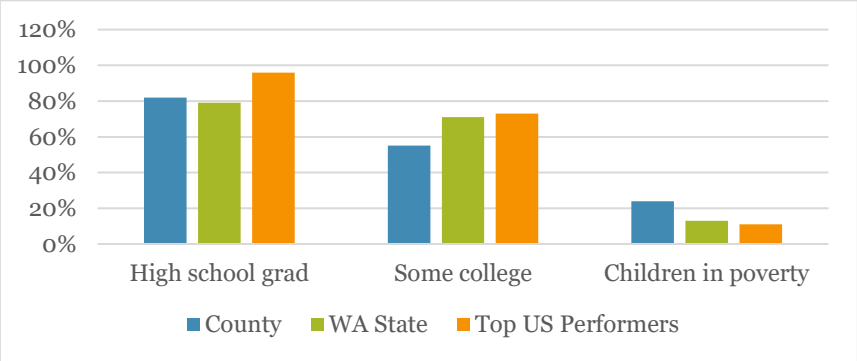
Table 4. ALICE Households, 2018

Area (Zipcode)	Total Households	% Below Alice Threshold
Aberdeen (98520)	8,310	47%
Copalis Beach (98535)	276	58%
Cosmopolis (98537)	834	38%
Grayland (98547)	579	49%
Hoquiam (98550)	4,738	48%
Humptulips (98552)	184	51%
Montesano (98563)	3,023	37%
Ocean Shores (98569)	3,074	49%
Pacific Beach (98571)	139	62%
Taholah (98587)	237	53%
Westport (98595)	1,249	51%
Grays Harbor County	27,674	46%
Washington State	2,767,682	37%

*Source: 2018 Alice Report *Not all locations available*

According to the 2018 United Way ALICE Report data, 46% of Grays Harbor County households were living below the ALICE threshold compared to 37% statewide. This includes 45% of households of families with children, and 50% of senior households (65 & older). Towns within the District ranged from 37% living below the threshold to 62%. Data by town is shown in Table 4.

Figure 6. Social & Economic Factors

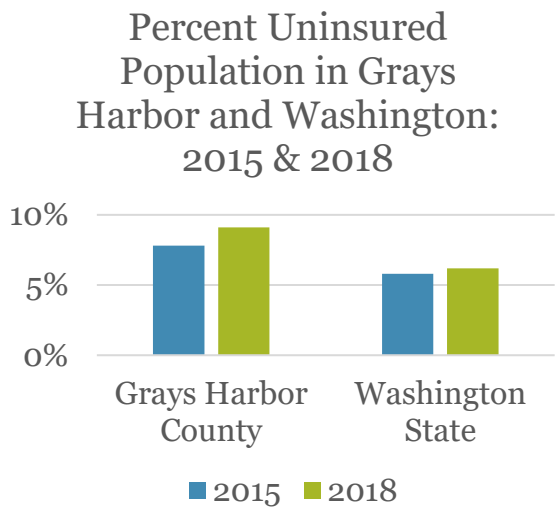


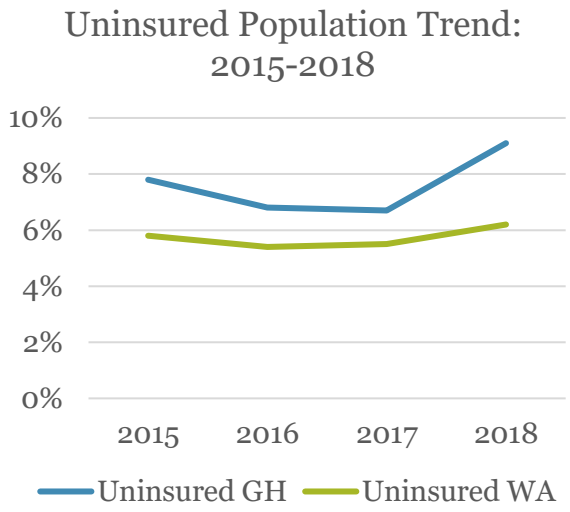
As can be identified in Figure 6, while the County fairs better than the state in terms of high school graduation rates, it fairs far worse than the state in terms of children in poverty (24% vs. 13%).

Source: County Health Rankings 2020

Figure 7 shows that while more than 10,000 residents have gained access to health insurance via Washington State's Medicaid expansion program, Grays Harbor County still has higher rates of uninsured than the state, and that number has been trending back up since 2017.

Figure 7. Percent Uninsured: Grays Harbor County and Washington State





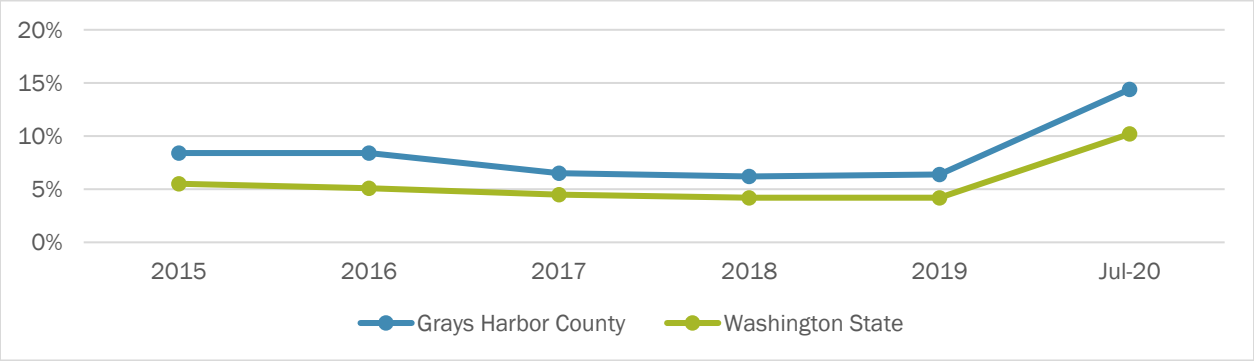
Source: OFM Chart Book 2020

A recent OFM report (August 2020) assessed the impact of COVID-19 on the state's uninsured rate, health coverage changes of newly unemployed workers, and changes in uninsured rates at the county level. COVID-19 altered the trajectory of a mild, slow rise in Washington's uninsured rate to a much sharper increase. At the start of 2020, the state uninsured rate was 6.7% (up from 6.6% in 2019). In May the rate peaked at 13% but has since declined to 8.3% in the week ending August 15, 2020. Similarly, Grays

Harbor County also saw a significant increase in uninsured due to COVID-19, and was at 10.8% in the week ending August 15, 2020, 30% higher than the state.

In the past several years, as can be identified in Figure 8, both the District/PSA and the County's unemployment rates have been in the range of 6.4% to 8.5%, about 50% higher than the state (4.2% to 5.5%). Like uninsured rates, unemployment rates across the state have also been significantly impacted by COVID-19, with Grays Harbor County currently experiencing an unemployment rate of 14%, second only to Pend Oreille County (14.4%) in the Northeastern most portion of the State.

Figure 8. Unemployment in Grays Harbor and Washington Over Time

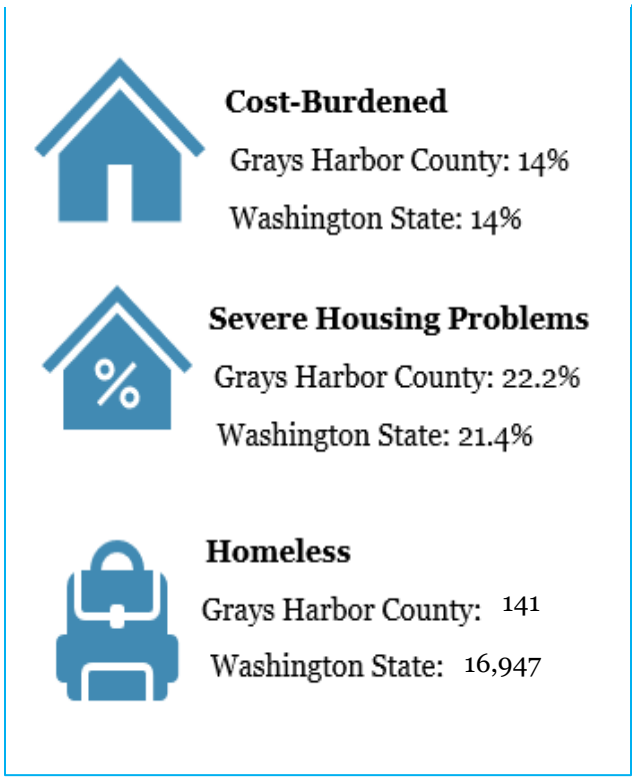


Source: Employment Security Department/LMEA; U.S. Bureau of Labor Statistics, Local Area Unemployment Statistics, July Non-Seasonally Adjusted

The Robert Wood Johnson County Health Rankings provide estimates of individuals who have 'severe housing problems,' meaning individuals who live with at least 1 of 4 conditions: overcrowding, high housing costs relative to income, lack of a kitchen, or lack of plumbing. Similarly, Robert Wood Johnson defines a "cost burdened" household as a household that spends 50% or more of their household income on housing.

Figure 9 identifies that while the County's cost-burdened households and severe housing problem rates are in-line with the State, the reality is that one fifth of Grays Harbor County residents do not have safe, affordable housing, and over 140 of community members are homeless, as measured by the Department of Commerce's Point in Time data. Being homeless puts an individual at increased risk of multiple health issues including psychiatric illness, substance use, chronic disease, musculoskeletal disorders, skin and foot problems, poor oral health, and infectious diseases such as tuberculosis, hepatitis C and HIV infection.

Figure 9. Housing and Homelessness 2019



Source: County Health Rankings, Washington State Department of Commerce

There is a strong and growing evidence base also linking stable and affordable housing to health. When too much of a paycheck goes toward the rent or mortgage, it makes it hard to afford to go to the doctor, cover the utility bills, or maintain reliable transportation to work or school. As identified in Table 5, when drilling down on cost burden households in the District by type (home ownership vs. rental costs), the District fairs worse than both the County and State in terms of percent income going towards either home ownership or rental costs. This is consistent with the higher rates of single parent households in the District (38.9%) as compared to the County (35.4%) and the state (25.6%). Children in single-parent households are often at-risk for social isolation, have an increased risk for illness, and mental health problems, and are more likely to engage in unhealthy behaviors than their counterparts.

Table 5. Affordable Housing Statistics

	PSA	Grays Harbor County	Washington State
Cost burdened households: Homeowners Who are Paying at Least 50% of Income for Ownership Costs	9.3%	8.8%	8.9%
Cost burdened households: Residents Paying More than 50% of Income on Rent	22.6%	22.2%	21.4%
Median Gross Rent	$766	$778	$1,194
Children Living with Single Parents	38.9%	35.4%	25.6%

Source: Social Explorer Tables: ACS 2018 (5-Year Estimates) (SE), ACS 2018 (5-Year Estimates), Social Explorer; U.S. Census Bureau

The District's Health Status

The Robert Wood Johnson Foundation's County Health Rankings compare counties within each state on more than 30 factors. Counties in each state are ranked according to summaries of a variety of health measures, and counties are ranked relative to the health of other counties in the same state. The 2017 and 2020 summary composite scores for Grays Harbor County are identified in Table 6. As the table shows, while there was improvement in the County's Overall Health Factors ranking and specifically in clinical care and health behaviors, Grays Harbor County still ranks in the lowest quartile of Washington's 39 total counties in both Overall Health Outcomes and Overall Health Factors and shows a worsening in length of life, quality of life and social and economic factors.

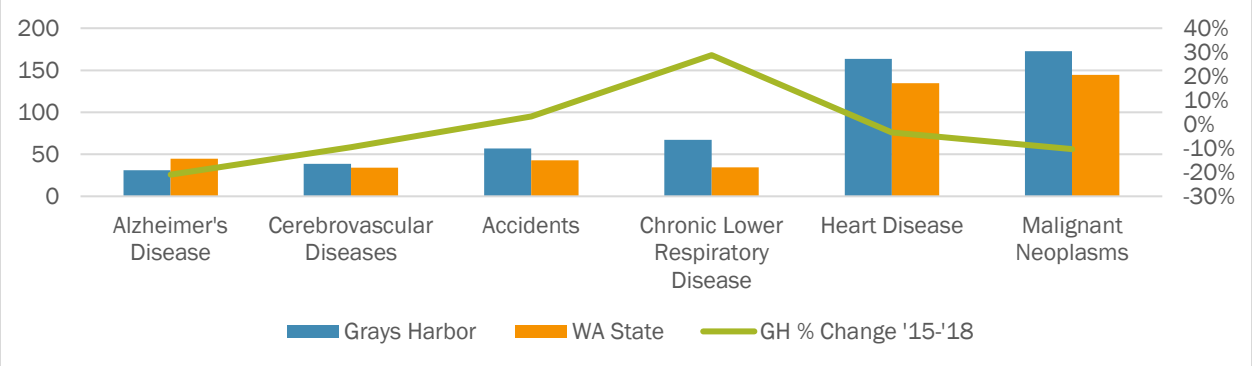
Table 6. County Health Rankings, Grays Harbor County 2017 vs. 2020

Composite Score	2017	2020
Overall Health Outcomes	**35**	**37**
Length of Life	35	37
Quality of Life	30	35
Overall Health Factors	**36**	**33**
Health Behaviors	34	32
Clinical Care	35	33
Social & Economic Factors	33	36
Physical Environment	7	7

Source: County Health Rankings, 2017 & 2020

In 2018, Grays Harbor had the second highest death rate (827.1 per 100,000) in the state, second only to Pacific County (838 deaths per 100,000). This compares to the state rate of 664.5 per 100,000. As depicted in Figure 10, and consistent with the state, the leading causes of death in Grays Harbor County are cancer and heart disease. However, both cancer and heart disease death rates are significantly higher in the County than the state.

Figure 10. Leading Causes of Death per 100,000



Source: 2018 Death rates from WA DOH and Vital Statistics Summary

Health Risk Behaviors and Outcomes

District residents experience a greater burden of chronic diseases than the rest of Washington. As can be seen in Table 7, the self-reported rates of diabetes among County and District residents are over 39% higher than Washington State residents and obesity is 29% higher in the District than the State.

Table 7. Self-Reported Chronic Health Conditions in Adults
% Answering Yes

Question	District	Grays Harbor County	WA State
(Ever told) you have diabetes?	16.22%	16.18%	11.62%
During the past month, other than your regular job, did you participate in any physical activities or exercises?	71.92%	72.10%	78.98%
(Ever told) you had angina or coronary heart disease?	6.55%	7.13%	5.40%
Calculated body mass index category (obese)	33.77%	32.10%	25.80%

Source: 2014-2018 CDC BRFSS

The most common behavioral contributors to chronic disease, morbidity or mortality include diet and activity patterns, the use of alcohol, drugs, tobacco, firearms, and motor vehicle accidents. Importantly, the social and economic costs related to these behaviors can all be greatly reduced by changes in an individual's behaviors. Table 8 shows that Grays Harbor generally ranks significantly worse on health behaviors. Of note are Physical Inactivity (41% higher than State) and Teen Births (55% higher than State).

Higher teen birth rates in the County are of concern. Younger mothers are less likely to get prenatal care early in their pregnancies and their pregnancies are more likely to result in premature births and low birth-weight babies.

According to the Washington State Department of Health Center for Health Statistics, in 2018 11.5% of mothers in Grays Harbor County received late or no prenatal care compared to 6.5% statewide. Additionally, 6.3% of births were low birthweight compared to 5.3% statewide, and 12.4% of births were premature compared to 9.4%. Both the lack of prenatal care and birthweight correlate to poorer overall health over a person's lifespan.

Table 8. Other Health Behaviors in Adults

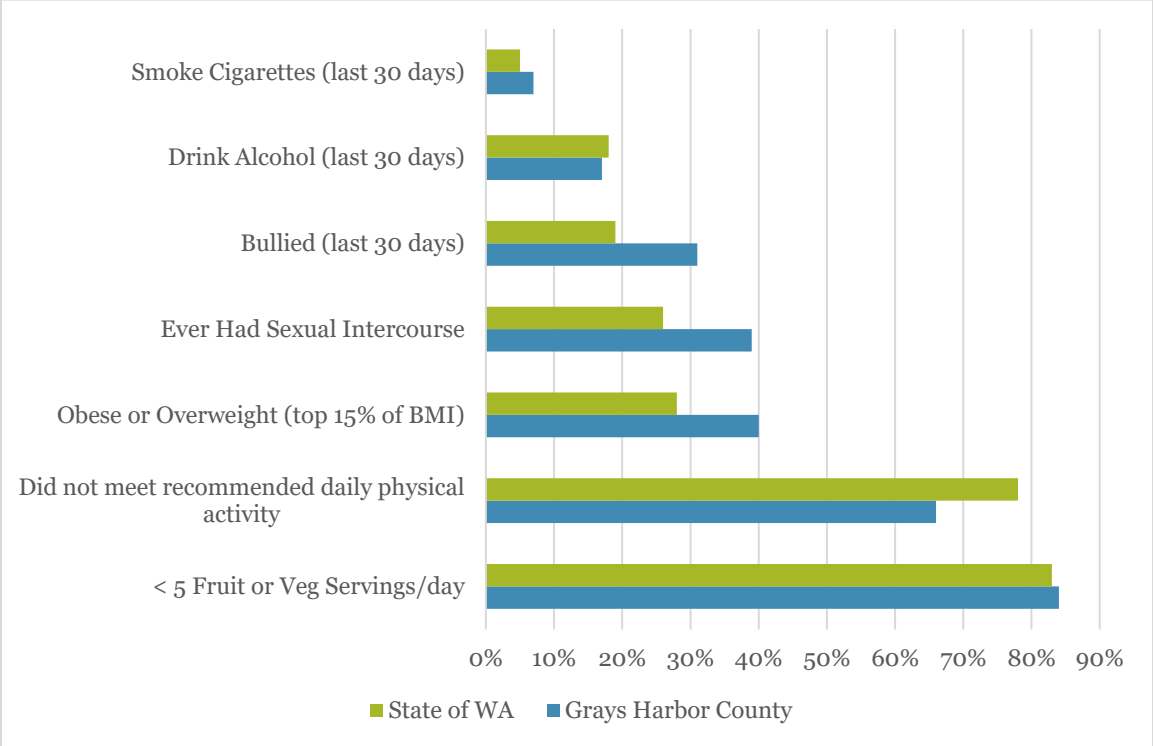
	County	Top U.S. Performers	WA State
Percentage of the adult population in a county who both report that they **currently smoke every day or most days** and have smoked at least 100 cigarettes in their lifetime.	15%	14%	13%
Access to healthy foods by considering the distance an individual lives from a grocery store or supermarket, locations for health food purchases in most communities, and the inability to access healthy food because of cost barriers.	7.0	8.6	8.1
Percentage of adults ages 20 and over reporting **no leisure-time physical activity in the past month.**	24%	20%	17%
Percentage of a county's adult population that reports **binge or heavy drinking in the past 30 days.**	18%	13%	17%
Percentage of **motor vehicle crash deaths with alcohol involvement.**	23%	11%	32%
Number of births per 1,000 female population ages 15-19 **(Teen Births).**	28	13	18

Source: County Health Rankings 2020

Specific to youth, Washington's Healthy Youth Survey (HYS), a collaborative effort of the Office of the Superintendent of Public Instruction, the Department of Health, the Department of Social and Health Service's Division of Behavioral Health and Recovery, and the Liquor and Cannabis Board, provides important information about youth. Students in each school district in grades 6, 8, 10, and 12 answer questions about safety and violence, physical activity and diet, alcohol, tobacco and other drug use, and related risk and protective factors.

As shown in Figure 11 Grays Harbor County 10th graders have significantly higher rates of being bullied in the last 30 days, of being obese or overweight, and having had sexual intercourse.

Figure 11. Grays Harbor County Healthy Youth Survey Results, 10th Grade



Source: Healthy Youth Survey, 2018, Grays Harbor County and Washington State, Grade 10

Behavioral Health and Substance Use

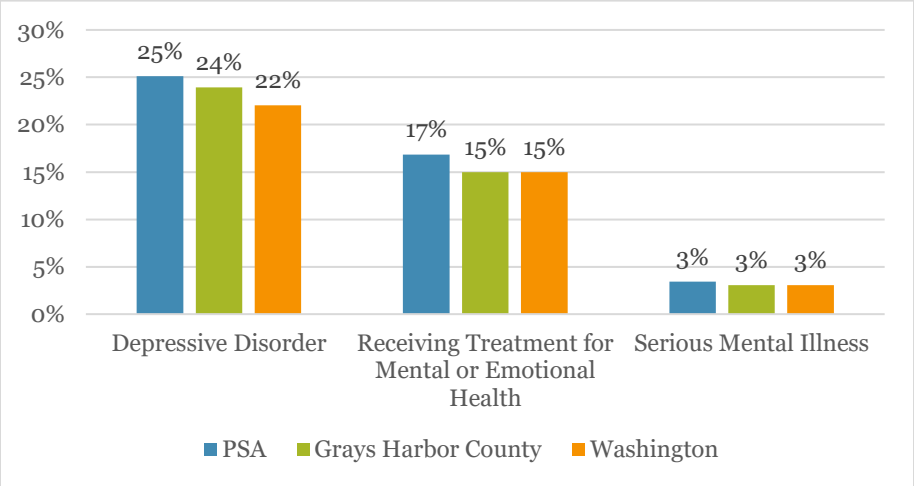
Figure 12. Self-Reported Poor Mental Health Days

Source: County Health Rankings

RWJ's County Health Rankings collects data on poor mental health days from CDC's BRFSS data. A 2014 study in the American Journal of Epidemiology suggests that counties with more poor mental health days are more likely to have higher unemployment, poverty, percentage of adults who did not complete high school, mortality rates, and prevalence of disabilities versus counties with less poor mental health days. As shown in Figure 12, Grays Harbor County residents self-report an average of 4.6 poor mental health days in the last 30 days, about 10% higher than the State rate.

Figure 13. Self-Reported Mental Health Conditions

As can be identified in Figure 13 on the right, the CDC's BRFSS 5-year 2014-2018 estimates show that 25.12% of the service area reported being told they have a depressive disorder (including depression, major depression, dysthymia, or minor depression), compared to 22.05% for the state.



Source: CDC BRFSS 2014-2018

According to the 2018 Healthy Youth Survey, 42% of Grays Harbor County 10th graders reported having depressive feelings, compared to 40% of 10th graders statewide.

Table 9. Rate of Suicide 2013-2017

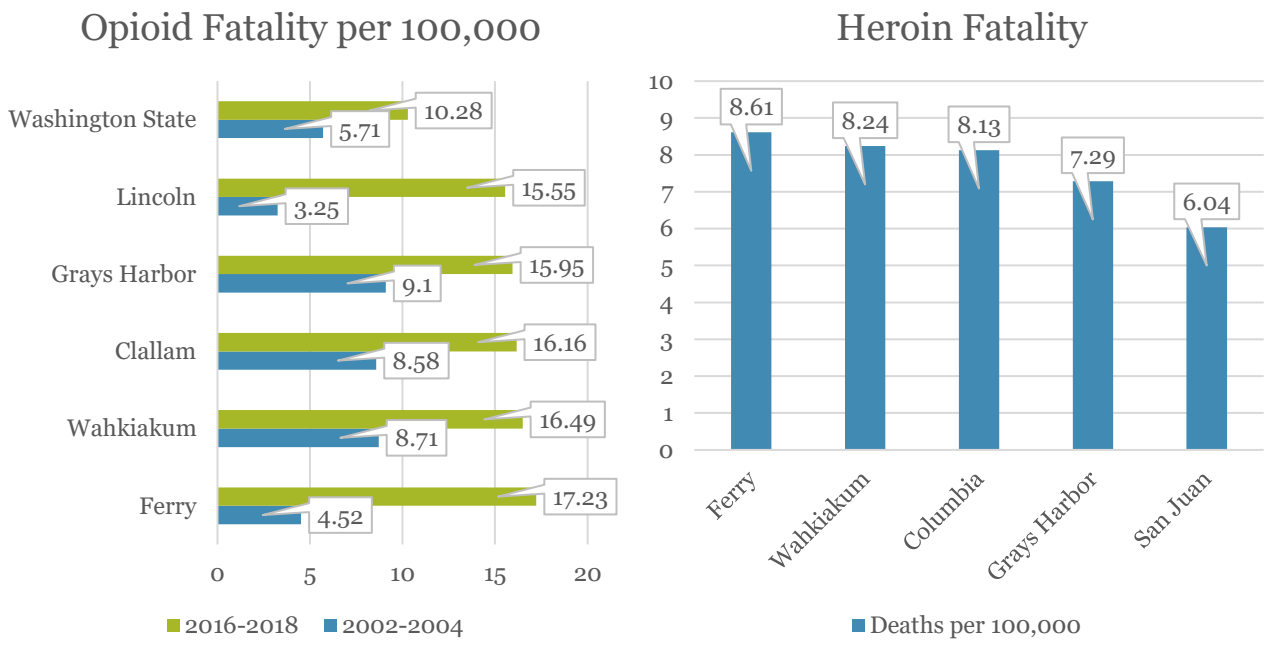
	Number of suicides	Age-adjusted rate (per 100,000)
Grays Harbor County	72	19.8
Washington State	5,669	15.4

Source: 2019 WA DOH Firearm Fatality and Suicide Prevention, A Public Health Approach

Grays Harbor County experienced an overall suicide rate more than 25% higher than the State average for the 2013-2017-time frame.

As identified in Figure 14, with a 75% increase between the 2002-2004 timeframe and 2016-2018 timeframe, Grays Harbor County now ranks fourth highest of all Washington Counties for all opioid fatalities, with a rate of 15.95 per 100,000 in 2016-2018, compared to 10.28 per 100,000 statewide. The County also ranks in the top 5 counties for heroin overdose deaths with a rate of 7.29 per 100,000 in 2016-2018.

Figure 14. Top 5 Opioid and Heroin Fatality Counties

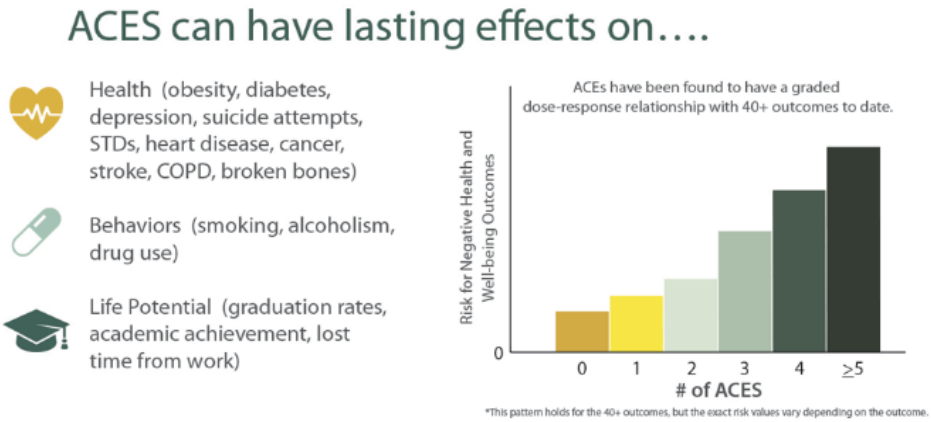


Source: University of Washington Alcohol & Drug Abuse Institute Interactive Database (2020), 2016-2018 University of Washington Alcohol & Drug Abuse Institute Interactive Database (2020)

Adverse Childhood Experiences (ACEs)

Adverse Childhood Experiences, or ACEs, are traumatic events that occur in childhood and cause stress that changes a child's brain development. Exposure to ACEs has been shown to have adverse health and social outcomes in adulthood, including but not limited to depression, heart disease, COPD, risk for intimate partner violence, and alcohol and drug abuse. ACEs include emotional, physical, or sexual abuse; emotional or physical neglect; seeing intimate partner violence inflicted on one's parent; having mental illness or substance abuse in a household; enduring a parental separation or divorce; and having an incarcerated member of the household.

Figure 15. Association between ACEs and Negative Health Outcomes



Source: Centers for Disease Control & Prevention, "Association Between ACEs and Negative Outcomes"

ACE burden is defined as the number of ACEs an adult was exposed to during childhood. The highest ACE score is 8. In Washington, 62% of adults 18-64 have at least one ACE; 26.5% have 3 or more; 5% have 6 or more. According to Grays Harbor Public Health Department 2019 Snapshots, 38% of Grays Harbor adults had three or more ACEs. 75% of 8th grade students believe they can discuss important things with the adults in their neighborhood or community.

Access to Care

Access to care when and where it is needed is impacted by income, health insurance, transportation, and the supply of providers, among other factors. While more than 10,000 County residents have gained access to health insurance via Medicaid expansion, the County still has higher rates of uninsured than the state, and that number has been trending back up since 2017.

The Federal Health Resources & Service Administration (HRSA) deems geographies and populations as Medically Underserved Areas (MUAs), Medically Underserved Populations (MUPs) and/or Health Professional Shortage Areas (HPSAs). MUAs and MUPs identify geographic areas and populations with a lack of access to primary care services. Similarly, a HPSA designation identifies a critical shortage of providers in one or more clinical areas.

There are also several types of HPSAs depending on whether shortages are wide spread or limited to specific groups of people or facilities including: a geographic HPSA wherein the entire population in a certain area has difficulty accessing healthcare providers and the available resources are considered overused; or a population HPSA wherein some groups of people in a certain area have difficulty accessing healthcare providers (e.g. low-income, migrant farmworkers, Native Americans).

Once designated, per Figure 16 below, HRSA scores HPSAs on a scale of 0-26, with higher scores indicating greater need. HPSA designations are available for three different areas of healthcare: primary medical care, primary dental care, and mental health care.

Figure 16 HPSA Scoring Criteria

Three scoring criteria are common across all disciplines of HPSA:

- *The population to provider ratio,*
- *The percentage of the population below 100% of the Federal Poverty Level (FPL), and*
- *The travel time to the nearest source of care (NSC) outside the HPSA designation.*

You can review the HPSA scoring methodology, differentiated by discipline, below:
The following figure provides a broad overview of the four components used in Primary Care HPSA scoring:

The entirety of Grays Harbor County has been designated as a HPSA for primary, dental, and mental health care. These designations are important as more than 30 federal programs depend on the shortage designation to determine eligibility or funding preference to increase the number of physicians and other health professionals who practice in those designated areas. Table 10 reflects Grays Harbor County's HPSA designations and scoring.

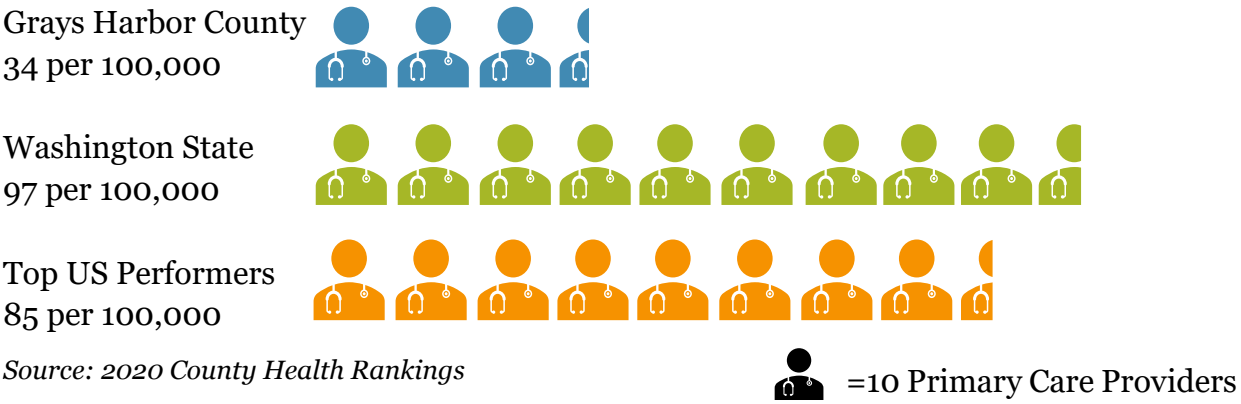
Table 10. Grays Harbor County HPSA Designations

HPSA	Designation Type	Designation Date	Score
Primary Care	Low-Income: Entire County	8/01/2017	16
Dental Care	Geographic: Entire County	8/24/2017	18
Mental Health	Geographic: Entire County	8/03/2017	17

Source: HRSA Data Warehouse – HPSA Find

Figure 17 demonstrates the number of Primary Care Physician FTEs per 100,000 is considerably lower than Washington State's at 34 versus 97 per 100,000 and U.S. Top Performers at 85 per 100,000.

Figure 17. Number of Primary Care Physician FTEs per 100,000 population



Source: 2020 County Health Rankings

For healthcare access, and as shown in Table 11, Grays Harbor ranks below the state on all 7 healthcare access measures developed and reported in 2020 by County Health Rankings. This includes an uninsured rate almost 30% higher and 31% more preventable hospital stays per 100,000 Medicare enrollees.

Table 11. Healthcare Access

	Grays Harbor County	Top U.S. Performers	WA State
Uninsured	9%	6%	7%
Primary care physicians	2,910:1	1,030:1	1,180:1
Dentists	2,000:1	1,240:1	1,230:1
Mental health providers	340:1	290:1	270:1
Preventable hospital stays	3,888	2,761	2,969
Mammography screening	36%	50%	39%
Flu vaccinations	42%	53%	46%

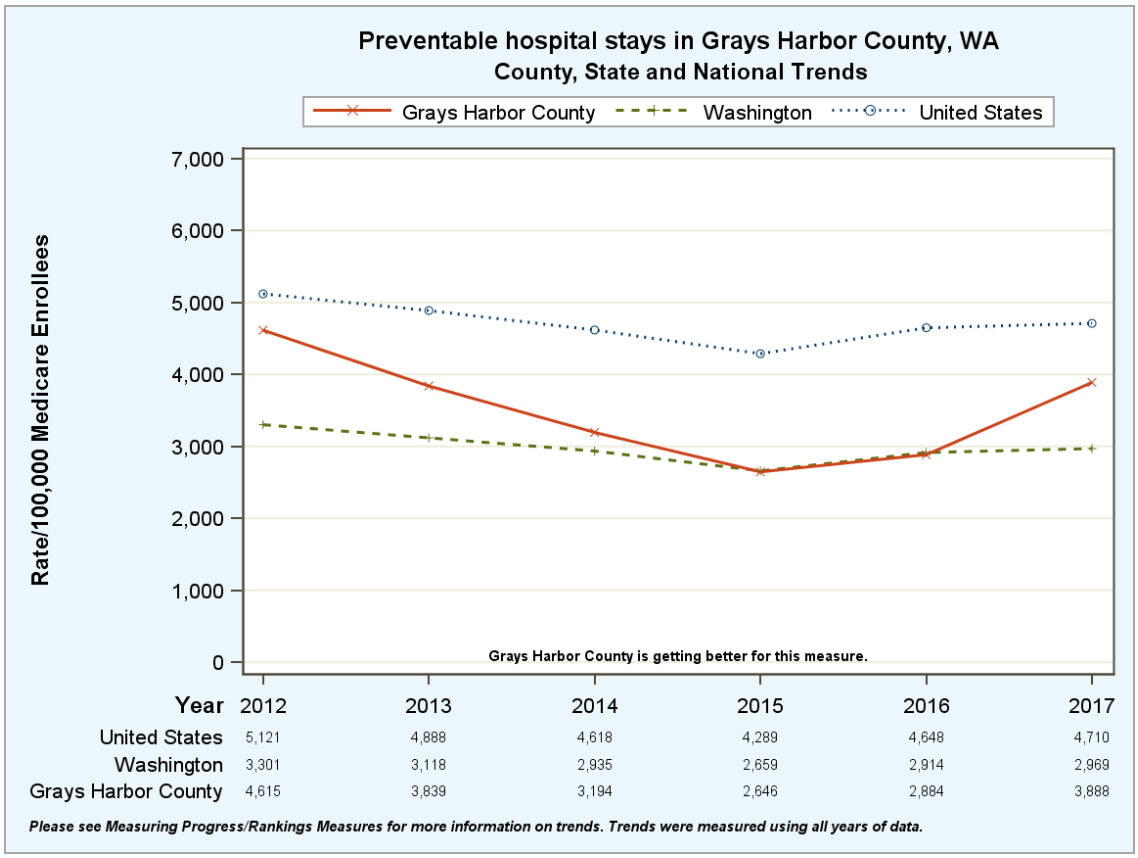
Source: County Health Rankings 2020

An ambulatory care—sensitive condition (ACSC) is defined as a condition for which timely and effective primary care or outpatient care can potentially reduce the risk of subsequent hospitalization. Hence, a hospitalization for an ACSC is also called a preventable hospitalization or avoidable hospitalization. Theoretically, as ACSC hospitalization is preventable with a proper supply of "ambulatory care", it is considered to be a negative index for primary care. In other words, Preventable Hospital Stays could be classified as both a quality and access measure, as some literature describes hospitalization rates for ambulatory care-sensitive conditions primarily as a proxy for access to primary health care.

Ambulatory care-sensitive conditions include convulsions, chronic obstructive pulmonary disease, bacterial pneumonia, asthma, congestive heart failure, hypertension, angina, cellulitis, diabetes, gastroenteritis, kidney/urinary infection, and dehydration. This measure is age-adjusted.

Lower numbers on this measure are the goal. Grays Harbor County ranks well below the nation but is higher than the Washington State average but demonstrated improvement between 2016 and 2107. In 2019, County Health Rankings reported preventable hospital stays by race.

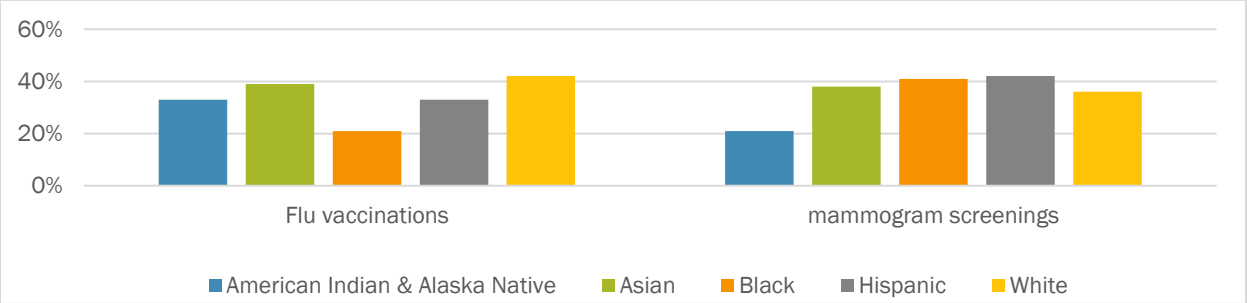
Figure 18. Preventable Hospital Stays Over Time



Source: County Health Rankings, 2013-2019

Though Grays Harbor's overall rates for mammogram screenings and flu vaccinations are generally better than the state, 2017 rates are lower for specific racial and ethnic minority populations as depicted in Figure 19. Data for the American Indian/Alaska Native and Black populations in Grays Harbor County were higher than the overall County rates (9,950 American Indian/Alaskan Native, 6,523 for Black, and 3,762 for White.

Figure 19. Flu Vaccinations and Mammogram Screenings by Race



Source: County Health Rankings 2020

Data from the Arcora Foundation indicate potential dental health access issues in Grays Harbor County. For example, the percent of adults who have seen a dentist in the last year in the County is significantly lower than the percent statewide (51% vs. 69%). Importantly, and as can be identified in Figure 20, data also demonstrates that adults have worse dental outcomes than the State with 17% of residents over the age of 65 having all permanent teeth extracted compared to only 9% statewide.

Figure 20. % Who Had All Permanent Teeth Extracted 65 and older (2018)

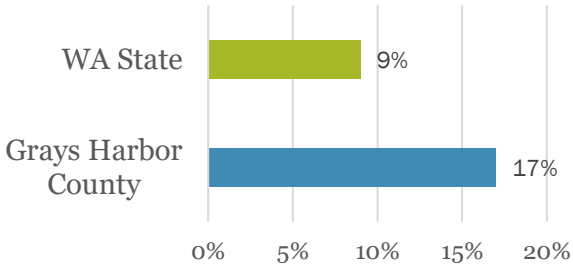
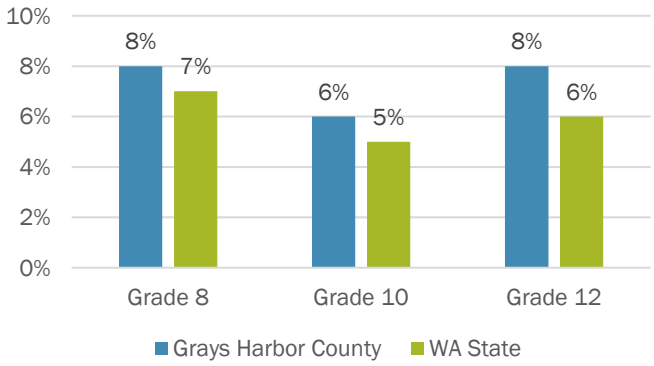


Figure 21. Missed School Days due to a Toothache (2018)



The situation is slightly better for school age youth in the County. While fewer Grays Harbor 8th grade students have seen the dentist in the last year than students statewide (82% vs. 87%), as seen in Figure 21, by 12th grade Grays Harbor is doing better than the state (81% compared to 79%). However, more students in 8th- 12th grade in the County are missing school due to a toothache than students statewide.

Community Convening

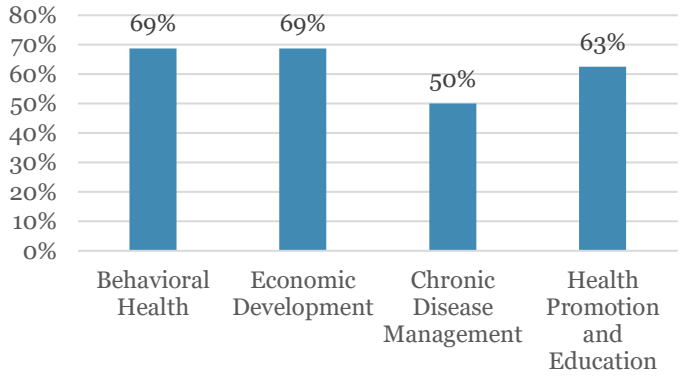
In prior CHNAs, GCHC undertook robust in-person community convenings to assess, identify, and prioritize community needs. After much discussion, this year, due to COVID, we chose to distribute an online survey to District/PSA and County leaders as well as to organizations that serve the vulnerable, including the following organizations listed in Table 12 below:

Table 12. Survey Recipients and Their Target Populations/Communities

	**City Government Officials** Aberdeen, Cosmopolis, Westport, Montesano, and Hoquiam		**Grays Harbor County Emergency Management** Countywide
	**HRHCH Foundation** District Low Income/vulnerable populations		**Port of Grays Harbor** Countywide
	**School Districts** Students, Teachers and Families in Aberdeen, North Beach, Ocosta		**Behavioral Health Resources** Countywide. Behavioral health focus
	**Grays Harbor County Public Health** Countywide, Low Income and Vulnerable Populations, Homeless		**Law Enforcement/Chief of Police** Residents of Aberdeen, Hoquiam, Montesano
	**Quinault Nation** Quinault and Queets tribes and descendants of five other coastal tribes: Quileute, Hoh, Chehalis, Chinook, and Cowlitz.		**First Responders (Ocean Shores and Grays Harbor County Fire)** Countywide and community specific
	**Grays Harbor Community Foundation** Youth, families, vulnerable populations, homeless		**YMCA of Grays Harbor** Low Income/vulnerable populations. Focus on equity.
	**HRHCH Foundation** Low income/vulnerable populations		**State and Federal Representatives** Residents of the 24th Legislative and 6th Congressional Districts

36 surveys were sent, with a response rate of nearly 50%. Given that many recipients were working remotely during this timeframe and given the alignment of the responses from those we received, we are confident that we received valid input.

Figure 22. 2017 CHNA Priorities. Little to no Improvement (Ranked 1-2 out of 5)



The survey was designed to solicit feedback on perceived improvements in the areas prioritized in HRHCH's 2017 CHNA. It also requested input on other or new health needs and gaps of the community. Specifically, the survey posed questions related to the four HRHCH 2017 CHNA Priorities, restated below:

- **Behavioral Health:** Advocate and secure adequate resources to improve access to behavioral health care by integrating with primary care, and address the opiate crisis
- **Economic Development:** Active participation in Economic Development, with specific interest in advocacy for more family wage jobs, more affordable housing and better transportation
- **Prevention and Management of Chronic Conditions:** Manage chronic diseases by improving care coordination and self-management programs
- **Health Promotion and Education:** Outreach that supports healthy living and self-management

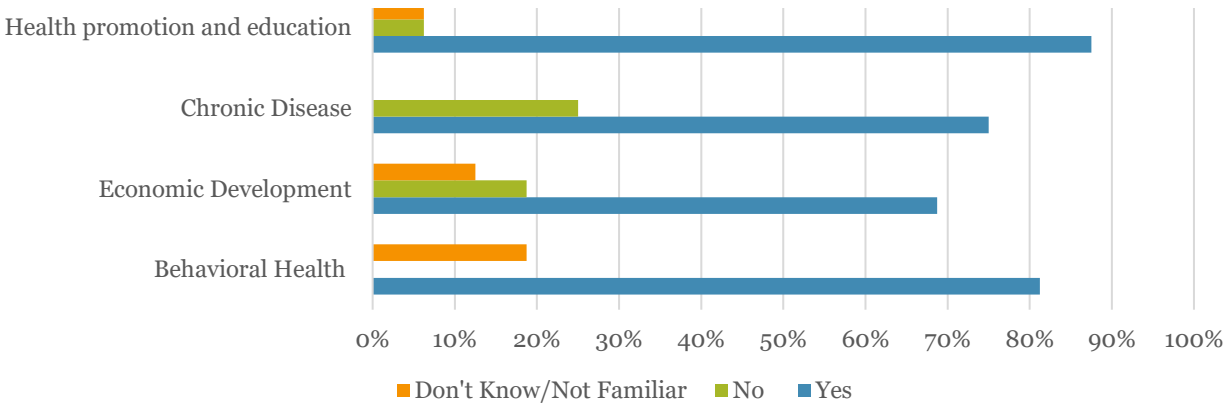
The questions specifically asked were:

> *On a scale from 1 (no improvement) to 5 (great improvement), please indicate the improvement you have experienced either personally or within the community over the past three years in relationship to the priority.*
>
> *Do you think the priority should continue to be a CHNA priority action in the coming years?*

As shown in Figure 22, respondents generally indicated that they—either personally or in their profession--- experienced little to no improvement in the last three years in areas including behavioral health access/opioid crisis, economic development and health promotion and education. Half of the respondents also indicated that they experienced little to no improvement related to chronic disease management.
As identified in Figure 21, the vast majority of respondents also concluded that HRHCH's 2017 priorities should continue to be priorities in the upcoming years with health promotion and education receiving the highest rating (88%) and economic development the lowest (but still at nearly 70% of respondents).

Based on the data collected in preparation for the 2020 CHNA, and after participation in, and/or close review of the Community Needs Assessment and Health Improvement Plans produced by Public Health, CPAA and Summit Pacific Medical Center, the survey also asked respondents to prioritize an additional priority that rose to the top in those Reports; that priority was health care access. 94% of respondents thought health care access should be a priority.

Figure 23. 2017 Priorities – Should the Priority Continue to be a Focus?

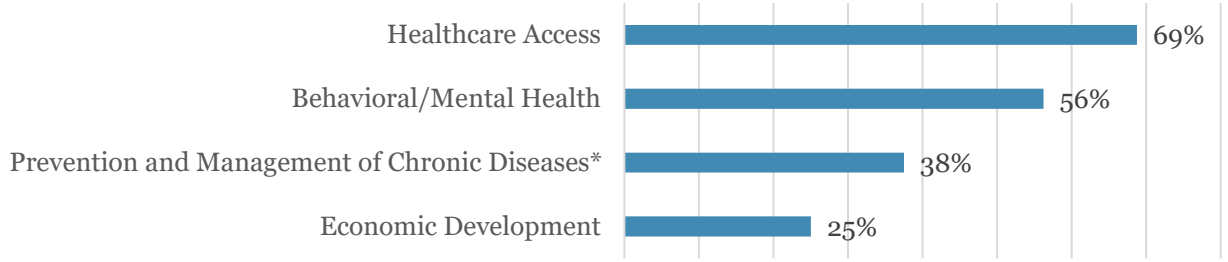


The Community Convening process ultimately asked respondents to rank each of the 2017 CHNA priorities as well as the additional health care access priority, specifically asking:

> *Of the priorities referenced in this survey: Behavioral/Mental Health, Prevention and Management of Chronic Diseases (this is a combination of the current CHNA priorities: chronic conditions and health promotion/education), Economic Development, and Healthcare Access, which two do you identify as the top priorities?*

The responses are depicted in Figure 23. When ranked compared to other priorities, Healthcare Access (69%) and Behavioral Health (56%) rose to the top, with Prevention and Management of Chronic Disease ranking in the top two for only 37.5% of respondents. Economic development ranked in the top two for only 25% of respondents.

Figure 24. Respondents' Top Priorities



Respondents were also asked if there were other areas of health needs that were not addressed in earlier questions. One respondent provided a particularly in-depth response, as follows:

> *Diet and lifestyle are a major component of health care and addressing the needs of other indicators such as Mental and Behavioral Illness and Chronic Disease. The Blue Zones initiative at Summit Pacific is a huge undertaking and HRHCH should consider the work that goes into creating partnerships with grocery stores, school districts, gyms, and area businesses to support a community that is health conscious. Changing human behavior is difficult if the environment does not change. But if you change the environment (the community) and make health the focus at work, school, church, etc, we begin to change the environment and thus the behaviors are easier to change.*

Other areas of health needs identified by community respondents included early intervention programs, satellite clinics and facilities, and more training for clinical staff. Access to care specific to the underinsured/uninsured and more recruitment of providers, another access issue, were also noted.

2020-2022 CHNA Priorities

Based on the health needs in Grays Harbor County and the District, and after consideration of: 1) our resources and expertise, and 2) other community agencies and providers and their respective areas of expertise, resources and programming, HRHCH adopted the following CHNA priorities for 2020-2023:

1. Healthcare Access
2. Behavioral/Mental Health
3. Prevention and Management of Chronic Diseases
4. Economic Development

We are confident that we can lead our selected initiatives and demonstrate quantifiable improvements over time. While we will not lead in certain areas, we still intend to actively support, partner and advocate in other initiatives, especially those around housing insecurity and programs for residents living on the margins wherein we improve mental and physical wellbeing.

2020-2022 CHNA Implementation Strategies

Our 2020 selected Implementation Strategies include:

Priority: Healthcare Access

Implementation Strategy 1: ***Increase primary care access, reduce unnecessary emergency department and hospital use, and reduce unnecessary outmigration.***

Our intended actions include:

- Recruit and retain additional primary care providers and continue to build health care delivery teams in the primary care clinics.
- Provide more flexible options for accessing care through continued expansion of Prompt Care Clinics locations and hours.
- Evaluate the feasibility of a satellite primary care clinic at the new HRHCH Ocean Shores Prompt Care Clinic.
- Integrate specialty care into the primary care clinics, particularly cardiology care, to reduce outmigration.
- Continue to improve care coordination efforts to assure seamless care transitions for patients within our care.

Anticipated Impacts: Increased local access to care, reduced barriers to care and inequities, reduction in unnecessary ED visits and hospitalizations, increased preventive care measures, and improved outcomes.

Implementation Strategy 2: ***Improve access to and availability of preventive dental health services for children and dental treatment for underserved adults.***

Our intended actions include:

- Evaluate integration of dental services into the primary care clinics with a focus on preventive services for children and treatment for low-income adult, including consideration of a rural health clinic change in scope.
- Identify grant funding to assist with the planning of the appropriate dental clinic model for our community and to help with any necessary capital and operational costs.
- Pursue short-term solutions including visiting dentists and free mobile services.

Anticipated Impacts: Improved access to dental services for the underserved, improved adherence to recommended preventive dental care schedules, improved dental outcomes, reduced health risks, missed school days, ED visits and primary care visits associated with dental pain/decay.

Priority: Behavioral/Mental Health

Implementation Strategy 3: ***Evaluate telemedicine opportunities to increase access to behavioral health and substance use disorder services throughout the community.***

Our intended actions include:

- Expand work with the University of Washington to implement tele-psych services and psychiatric consultation services for primary care providers.
- To assure sustainability, advocate for continuation of the COVID exemptions for the provision of telehealth services by rural health clinics and for authorizing reimbursement changes to allow telehealth visits to be billed as an RHC visit.
- Pursue additional telehealth options.

Implementation Strategy 4: ***Increase behavioral health partnerships and service and increase integration with primary care.***

Our intended actions include:

- Identify and secure additional behavioral health partnerships to support further integration of behavioral health, substance use disorder and primary care services.
- Continue focus on de-escalation training for HRHCH providers and staff.
- Continue evidence-based MAT Programs and Distribution of Naloxone kits.
- Increase the number of MAT providers in the primary care clinics.

Anticipated Impacts: Increased access to behavioral health and substance use services, increased availability for those unable/unwilling to travel, enhanced care coordination and integration of behavioral health and primary care, reduced wait times for behavioral health services. Reduced hospitalizations associated with behavioral health crises, and reduced substance abuse hospitalizations and deaths.

Priority: Prevention and Management of Chronic Diseases

Implementation Strategy 5: ***Consistent with the Cascade Pacific Action Alliance (CPAA) Medicaid Transformation Project, standardize care coordination service delivery for individuals with complex needs to support early detection and patient self-management.***

Our intended actions include:

- Engage patients and encourage participation in the CPAA's Chronic Disease Self-Management Program's educational workshops designed to help people gain self-confidence in their ability to control their symptoms and learn how their health problems affect their lives.
- More fully implement the Chronic Care Model approach to caring for people with chronic diseases in the primary care setting, focusing on the development of proactive health care teams, care coordination and patient, family, and provider engagement.
- Evaluate need for, and ability to secure additional care coordination staff or community health workers. Identify grant funding to test the feasibility.
- Continue community education to provide information on healthy lifestyle choices and reduce the risk of injury and disease progression.

Anticipated Impacts: Reduced burden associated with preventable infection and diseases, and community empowerment to manage their own health disparities.

Priority: Economic Development

Implementation Strategy 6: ***Commit HRHCH Leadership time and Board level resources to advocate and support efforts to enhance community infrastructure.***

Our intended actions include:

- Support community efforts designed to create more family wage jobs, more affordable housing and better transportation.
- Continue to work collaboratively with CPAA to coordinate entry into their housing and shelter programs.

Anticipated Impacts: Improvement in the social and economic status of HRHCH service are residents, enhanced community engagement.