Confluence Health

Central Washington Hospital & Wenatchee Valley Hospital 2019

Joint Community Health Implementation Plan

A Collaborative Approach to Impacting Population Health in North Central Washington

Prepared by Action Health Partners, Chelan-Douglas Health District, Confluence Health Central Washington Hospital & Wenatchee Valley Hospital

2019 North Central Washington Community Health Implementation Plan

Executive Summary

Background

Every three years, a regional Community Health Needs Assessment (CHNA) is performed in North Central Washington in an effort to understand the health needs of the region and to provide direction for healthcare organizations, critical access and community hospitals, public health districts and community organizations to focus their efforts on improving the health and well-being of the community; working to make North Central Washington the best place to grow, learn, work and receive care.

There are many reasons for this assessment process. A CHNA is a federal requirement for not-for-profit hospitals under the Patient Protection Act and Affordable Care Act. It is an accreditation requirement for public health departments under the National Public Health Accreditation Program. It is also a community resource for organizations when writing grants or identifying issues for action in North Central Washington.

Confluence Health

The origins of Central Washington Hospital date to the early 1900s with the establishment of Central Washington Deaconess Hospital and St. Anthony's Hospital. The two organizations merged in 1974 to form Central Washington Health Services Association. The St. Anthony's facility was renamed Rosewood Hospital in 1974 and the facilities combined their operations at the remodeled and expanded Rosewood Hospital site under the name Central Washington Hospital.

Dr. L.M. Mares, Dr. A.G. Haug and Dr. L.S. Smith founded the Wenatchee Valley Clinic in 1940. Their philosophy was that patients were best served when they had easy access to other specialists under the same roof.

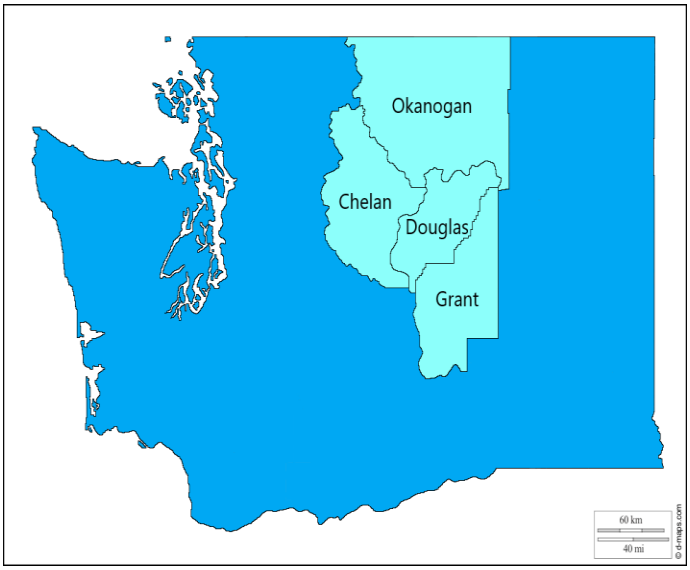
In 2012, the two organizations began the process of affiliating, which was finalized in July 2013. Collectively known as Confluence Health, our affiliation allows us to offer a full range of inpatient and outpatient health care services and cutting-edge technology.

Today Confluence Health still has the best interest of our patients at heart; we're just larger and able to take care of more of them. In fact, with a full range of healthcare services and cutting-edge technology, we've got North Central Washington covered with a rural healthcare delivery system second to none.

Our founders recognized that a regional patient base was required to support specialty care in a rural environment, but even they didn't envision a comprehensive healthcare delivery system encompassing a region of roughly 12,000 square miles. Today over 60 percent of our business comes from outside the greater Wenatchee area, and our specialists drive over 130,000 miles annually to provide outreach to clinics in North Central Washington communities.

Physician recruitment and retention have always been among our strengths. Our doctors were recruited not only because they bring knowledge from some of the nation's best medical training programs, but because of their values. They came for the quality of life, the beauty of the land and professionalism that fosters the physician-patient relationship. This ability to recruit has paid off in steady growth, and today Confluence Health has over 270 physicians and 150 advanced practice providers.

Confluence Health is a strong believer in being a corporate good neighbor and is generous in its contributions to local community organizations.



Community Profile

The North Central region of Washington State includes Chelan, Douglas, Grant and Okanogan counties. These four counties include approximately 12,686.08 square miles of total land in the north central part of the state.[1]

The population size of each of the four counties has increased and is estimated to be 250,520 for the region.[2] The greatest proportion of the population resides in Chelan and Douglas Counties, which includes the greater Wenatchee area. Moses Lake in Grant County follows in size of population. In addition to those two cities, there are other rural cities and towns of varying sizes scattered throughout the region. The population density for the region, estimated at 19.75 persons per square mile, is less than the state (107.9 persons per square mile) and national (90.88 persons per square mile) average population densities.[3]

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[1] University of Missouri Extension, CARES Engagement Network, Health Indicators Report from the U.S. Census Bureau, American Community Survey, 2013-2017

[2] University of Missouri Extension, CARES Engagement Network, Health Indicators Report from the U.S. Census Bureau, American Community Survey, 2013-2017

Source: University of Missouri Extension, CARES Engagement Network, Health Indicators Report; Data Source: U.S. Census Bureau, American Community Survey, 2013-2017

Data Source: Office of Financial Management, Forecasting & Research Division, 2019 Population Trends, August 2019

[3] University of Missouri Extension, CARES Engagement Network, Health Indicators Report from the U.S. Census Bureau, American Community Survey, 2013-2017

CHNA Methodology

Assessment Process and Methods

Information for the assessment was gathered through four data collection methods: health indicators; a community survey; focus groups; and other community assessments. Data was collected for over 100 health indicators used to identify trends and changes from the previous two CHNAs as well as to better inform the assessment process. A community survey, called the Community Voice Survey, was used to capture the voice of the community, regarding important health needs. Focus groups were performed in each of the counties; resulting in an overview of strengths, weaknesses, opportunities and threats affecting health of the communities in the region. Finally, assessments completed by organizations or coalitions throughout the region over the past three years were gathered, reviewed and collated to help identify community health priorities and themes of needs. The data collection process has benefited from in-person input from over 85 people and survey data collected from 5,010 North Central Washington residents.

Summary of Prioritization Process

In August 2019, the CHNA co-authors came together and reviewed the data from the four data collection methods, which culminated in the identification of 10 potential health needs of the region. During the August 2019 CHNA Steering Committee meeting, members reviewed and confirmed the 10 potential health needs.

In September 2019, a diverse group of community stakeholders from across North Central Washington gathered together to review the 10 potential needs and prioritize the health needs for the region. Through a multi-voting technique, the group prioritized five health needs that will be the focus of the region.

Priority Health Needs Identified by the Health Department

The prioritized health needs for the 2019 CHNA are (as ranked by stakeholders):

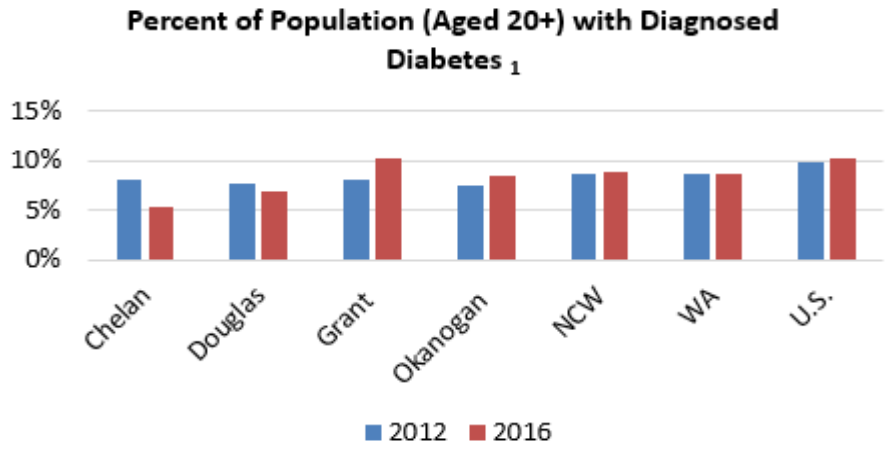
- Chronic Disease
- Access to Care (Behavioral and Physical Health)
- Education
- Substance Use
- Affordable Housing

This CHNA report was adopted by the Confluence Health Board on December 10, 2019. This Implementation Plan is applicable to both Central Washington Hospital and Wenatchee Valley Hospital.

Central Washington Hospital & Wenatchee Valley Hospital
2019 Joint Community Health Implementation Plan

Priority – Chronic Disease

Chronic Disease - Diabetes

Summary of Issues
According to the CDC estimates, 30.3 million people have diabetes in the U.S. and 23.6 percent of these individuals have not been diagnosed.[1] Data from our CHNA shows a declining rate of patients diagnosed with diabetes in Chelan and Douglas Counties, but an increase in rates for Grant and Okanogan Counties.    Focus at Confluence Health has been on completing the Diabetic Perfect Process on patients, measuring the percentage of patients age 18 to 75 achieving the perfect process. To complete the process, patients must be on a statin therapy if not allergic, have an annual foot exam, complete an annual urine screening and achieve an A1c measure of < 8%. Through 2019, Confluence is achieving this result on 44.35% of patients.
Goal
Improve the health and quality of life for those living with diabetes
Objectives
Confluence Health works towards achieving the following objectives: • Improving completion of 4/5 components of the Diabetes Perfect Process in patients. • Empowering patients with Diabetes to improve education and self-management of their condition. • Improving care delivery models to identify high risk patients, screening patients effectively and treating patients through consistent algorithms to deliver the best outcomes.
Approach & Action Plans
Confluence Health (consisting of Central Washington Hospital and Wenatchee Valley Hospital) continues to invest and participate in programs that are community based and which target diabetics and those patients at risk of developing diabetes. CH staff will continue to engage in education and outreach in the community setting (e.g. Cooking Classes at Pybus Market, Group Education Courses, School Outreach) to promote education and empower patients to learn ways to self-manage their diabetes.

Confluence Health will also continue to invest in developing sustainable care models for delivery of care to patients diagnosed with, or at risk of developing, diabetes. Weight Management initiatives will continue to include emotional and behavioral health education to address motivation as well as diabetes-related distress (i.e. emotional responses related to the disease). This support includes intervention strategies to promote patient engagement and self-management.

Confluence Health will continue to refine processes for identifying patients seen in the practice who are at high risk according to ADA recommendations. Screening will occur in all patient care areas and appropriate follow up will be provided. To deliver this care, the organization will continue to develop and educate on the consistent use of treatment algorithms for patients with diabetes. Care teams and patients will determine mutually agreed-upon treatment plans and goals will be individualized to each patient's needs.[2]

Intended Outcomes and Key Metrics

Long Term Outcomes: Adults self-manage their diabetes and related care with support from the care team.

When possible, Confluence Health will integrate metrics aligning with established framework to assess program impacts. These may include the following:

- Number of adults diagnosed with diabetes or prediabetes who completed Confluence education series.
- Percentage of patients achieving 4/5 components of the diabetes perfect process (statin therapy if not allergic, annual foot exam, annual urine screening, achieve an A1c measure of < 8% and appropriate retinal eye exam)
- Number of community events provided annually to help empower patients to improve self-management.

Key Programs and Collaborations

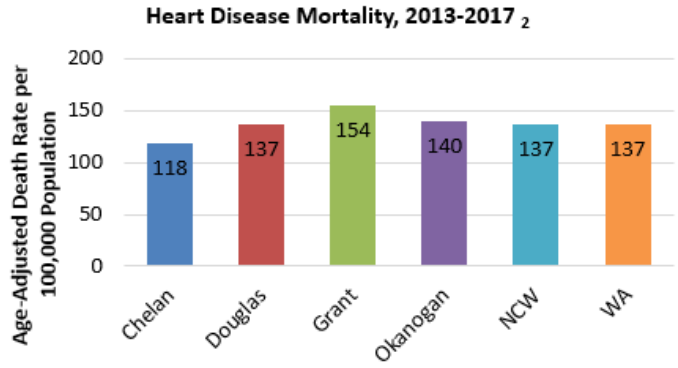
- Nutrition Therapy –
- Pharmacy Events –
- Endocrine Program –

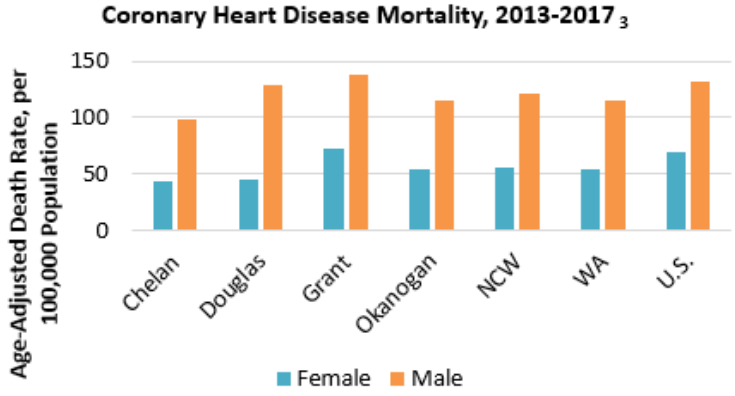
References

1. Centers for Disease Control (CDC). https://www.cdc.gov/daibetes/pdfs/data/statistics/national-diabetes-statistics-report.pdf
2. Together2Goal. http://www.together2goal.org/assets/PDF/planks.pdf

Chronic Disease – Hypertension

Summary of Issues
High blood pressure (hypertension) is one of the most important risk factors for heart disease, stroke, kidney failure, and diabetes complications. Nearly one of three American adults has high blood pressure, and the costs, including healthcare services, medications and missed days of work are estimated at a staggering $156 billion.[1] The Confluence Health CHNA sites the following statistics around heart disease for our community:





Strategic goals within the organization have been focused on controlling blood pressure for patients diagnosed with HTN who are aged 18-75. For each of these patient populations, control values are set, and adherence measured to the goal. Confluence has achieved blood pressure control in these patients at a rate of 68.11%.

Goal
Improve the health and quality of life for those living with hypertension

Objectives
Confluence Health works towards achieving the following objectives: • Improving blood pressure control below 140/90 in patients diagnosed with HTN. • Empowering patients with Hypertension to improve education and self-management of their condition. • Improving care delivery models to identify high risk patients, screening patients effectively and treating patients through consistent algorithms to deliver the best outcomes.

Approach & Action Plans

Confluence Health (consisting of Central Washington Hospital and Wenatchee Valley Hospital) continues to invest in training care team members who should, through training, be aware of the importance of hypertension management and blood pressure goals. Team members should be encouraged to comment to patients on their progress and on the importance of medications and medication adherence, especially when patients are not at goal. This focus will ensure appropriate measurement of a patient's blood pressure and improve provider decisions when delivering treatment.

Ensuring consistent measurement of a patient's condition at all visits throughout the system is key. Through this measurement, appropriate categorization and assessment of patients leads to better care delivery. Although patients with hypertension may visit a primary care physician or specialist for non-hypertension chief complaint, standardized processes are in place to assure hypertension is evaluated and/or treated at every visit.

Confluence Health continues to refine guidelines and recommendations that are based on evidence from a rigorous systematic review and synthesis of the published medical literature. Guidelines help clinicians and patients make appropriate decisions about health care, by:

- Describing a range of generally accepted approaches for the diagnosis, management, or prevention of specific diseases or conditions; and
- Defining practices that meet the needs of most patients in most circumstances.

These recommendations are not fixed protocols that must be followed. For individual patients, the judgment of responsible clinicians remains paramount. Clinicians and patients need to develop individualized treatment plans, tailored to the specific needs and circumstances of the patient. Patients will continue to be encouraged to be active participants in their own health and do what they can to more effectively manage their blood pressure at home.[2]

Intended Outcomes and Key Metrics

Long Term Outcomes: Adults self-manage their hypertension and related care with support from the care team.

When possible, Confluence Health will integrate metrics aligning with established framework to assess program impacts. These may include the following:

- Number of adults diagnosed with hypertension who completed Confluence education programs.
- Percentage of patients achieving goal blood pressure measurements of < 140/90.
- Number of community events provided annually to help empower patients to improve self-management.

Key Programs and Collaborations

Pharmacy Services play a key role in how we provide services to our hypertension patients as well. Some of these services include the following:

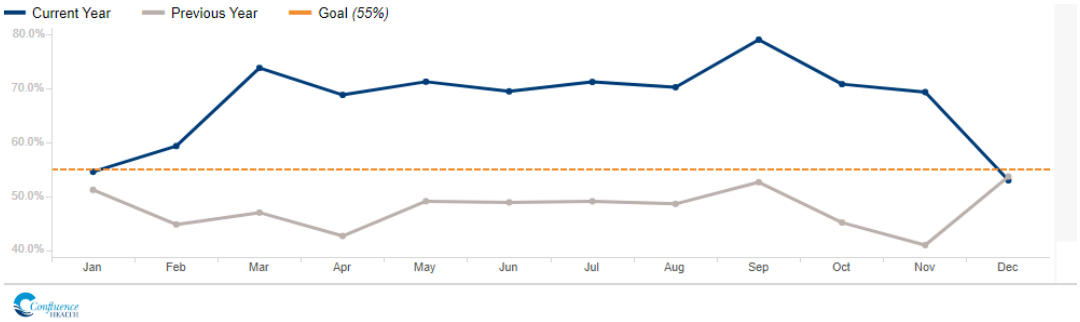
- East Wenatchee Primary Care Integrated Pharmacist Provider: This advanced practice pharmacist provider, with prescribing privileges, sees patients in office for chronic disease state medication management based on referrals from primary care providers. The pharmacist provider most commonly sees patients with hypertension. This pharmacist provider supports patients with disease state education, medication management, and aligning care goals with the established hypertension goals.
- The refill and prior authorization department ensures medication adherence is high for patients and access to medications are a priority.
- The refill and prior authorization department currently refers patients to scheduling for proper follow up with primary care for hypertension care based on disease state control assessed when refilling hypertension related medications.

References

1. American Medical Group Foundation. Measure Up Pressure Down: Provider Toolkit To Improve Hypertension Control. www.measureuppressuredown.com. 2013.
2. Centers for Disease Control and Prevention. Hypertension Control Change Package for Clinicians. Atlanta, GA: Centers for Disease Control and Prevention, US Dept of Health and Human Services; 2015.

Priority – Access to Healthcare Including Behavioral Health

Access to Care - Behavioral Health

Summary of Issues
Making sure that individuals have access to mental healthcare can improve lives and communities. For many it can dramatically reduce or eliminate the risk of suicide, legal issues, family conflict, employment issues, substance abuse, and further mental and physical health problems. The below data shows an increase of access to mental health care from 2018-2019 but we still have room to improve.    To improve access to mental healthcare, Confluence Health has focused on increasing the number of mental health care experts. From 2015 to 2019 we have gone from 7 mental health experts to 39 mental health experts within our organization. We have also focused our efforts on identifying mental health issues in primary care.
Goal
Improve the health and quality of life for those living with mental health issues by providing increased access to mental health care.
Objectives
Confluence Health works towards achieving the following objectives: • Expand existing medication management services via telehealth to our remote North Country clinics. • Add psychotherapy services via telehealth to North Country clinics. • Implement the Collaborative Care model in Omak • Improve access to psychotherapy treatment by offering 5 diverse group treatment options.
Approach & Action Plans
Confluence Health (consisting of Central Washington Hospital and Wenatchee Valley Hospital) will continue to provide medication management services to our remote sites in North Country. Currently this program is not taking any new patients due to the demand exceeding our capacity. In the coming years, we are committed to improving access via telehealth and plan to not only expand this program but also offer psychotherapy services to that area. Confluence Health will implement the Collaborative Care model in our Omak. The **Collaborative Care Model** has the most evidence among integration **models** to demonstrate its effective and efficient integration in terms of controlling costs, improving access, improving clinical outcomes, and increasing patient satisfaction in rural primary care settings.[1]

Confluence Health stays committed to offering group therapy as a treatment option. Groups can offer many benefits to the patient including increased access to care. A therapy group provides an opportunity for people to share with each other personal experiences and feelings, coping strategies or firsthand information about diseases or treatments.[2]

Intended Outcomes and Key Metrics

Long Term Outcomes: 100% of patients requesting mental health care would have an appointment within 10 days of their request.

When possible, Confluence Health will integrate metrics aligning with established framework to assess program impacts. These may include the following:

- New patient appointments within 10 days of request.
- Number of therapy groups provided to patients annually to improve access to mental health care.

Key Programs and Collaborations

Need to list out all the collaboration points we have and programs:

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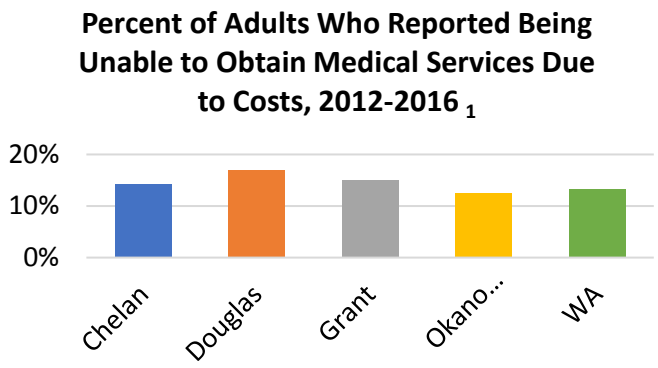
References

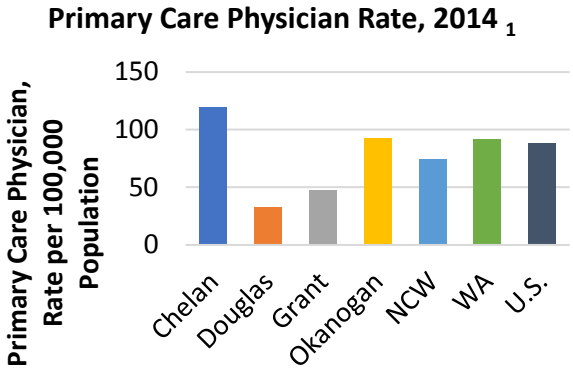
3. American Psychiatric Association. https://www.psychiatry.org/psychiatrists/practice/professional-interests/integrated-care/learn
4. Mayo Clinic. https://www.mayoclinic.org/healthy-lifestyle/stress-management/in-depth/support-groups/art-20044655

Access to Care – Primary Care

Summary of Issues

Access to Care remains a significant issue across all health care facilities. Some of the major challenges with access are shortages in numbers of primary care providers nationally, rising health care costs, lack of insurance or underinsurance, long distances to clinics or hospitals, and long waits for specialty appointments in certain areas.





Strategic goals within the organization have been focused on improving number of open appointments in primary care practices within 24 hours, and of ensuring patients can be seen in specialty practices within 10 days. In addition, we focus significant efforts on recruiting new primary care physicians.

Goal

Ensure that all patients have access to needed health care services

Principles and Objectives

Confluence is committed to the following principles:

- All patients will be seen at Confluence health regardless of their ability to pay
- All patients will be treated equally regardless of their ethnicity, religion, socioeconomic status, sexual orientation or other identifying features

Confluence works towards achieving the following objectives:

- Primary care practices aim to have more than 40% of their appointments available within 24 hours
- Specialty care practices aim to see new referrals within 10 business days 60% of the time.

Approach & Action Plans

Confluence Health (consisting of Central Washington Hospital and Wenatchee Valley Hospital) is committed to providing care to all patients in a timely manner. One of the most important features of this commitment is our Compassionate Care Program, in which we work with patients to cover some or all costs. In 2019 we provided $15,000,000 of care through this program, which equate to about 25,000 patient accounts. There is clear evidence that lower income patients have lower rates of health care usage, according to the CDC, and we want to ensure that all patients receive appropriate care regardless of cost.

In addition, we want to ensure that all patients are treated equally and feel welcome to receive care across all sites in Confluence Health. In 2016, we started a Health, Equity, Diversity and Inclusion program which now works to address and improve issues of diversity and inclusion for patients and staff. This robust program will continue to grow and help care for all patients.

Availability of primary care providers remains an ongoing issue, and Confluence continues to commit significant efforts to recruiting more providers. In 2019, we hired 29 new primary care providers at Confluence Health and continue our recruiting efforts across our system.

Confluence health is also continuing to improve the availability of appointments in primary care clinics. Several of our providers have transitioned to open access models where virtually all appointments are booked within 24 hours. We are committed to expanding this model to additional practices. Furthermore, we offer virtual (phone) visits and are working to expand these options as well. Finally, we will explore telehealth as an option for primary care visits which is particularly important for patients who travel long distances for care.

As we move forward, we aim to continue to develop community partnerships that will expand our care delivery options and services provided. Sometimes access to care may include exercise prescriptions, dietary counseling, or medication management which can all be provided by care teams. Furthermore, we understand that online scheduling and appointment availability thought online portals can help with access as well. We will continue to improve these options as well.

Intended Outcomes and Key Metrics

Long Term Outcomes: Patients will have access to care when they need it, regardless of ability to pay.

When possible, Confluence Health will integrate metrics aligning with established framework to assess program impacts. These may include the following:

- Percentage of appointments available in primary care practices within 24 hours
- Number of primary care practices at any given time open to new patients
- Number of virtual or telehealth visits provided monthly

Key Programs and Collaborations

Patient Access plays a key role in our access strategies. These services include:

- Continuing to improve and identify patients for our compassionate care program.
- Improving our MyChart patient portal activation rate to improve communication with our care teams.

References

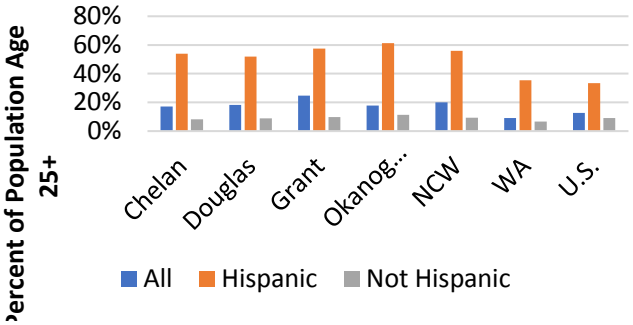
1. Health Care Access and Utilization Among Adults Ages 18-64, by Poverty Level: United States 2013: 2015 **https://www.cdc.gov/nchs/products/databriefs/db262.htm**

Priority – Education

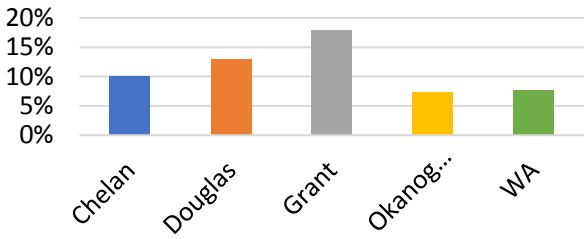
Summary of Issues

Limited education levels and literacy, which includes health literacy, was identified as a weakness in the focus groups. Education affects health as it can create opportunities for better health (e.g. better jobs, higher earnings, and resources for good health).[1] High School graduation rates, language, literacy, and health literacy are key issues that influence the health of the community.[2]

Percent of Population with No High School Diploma, 2013-2017 [3]



Population Age 5+ Speaking English Less than Very Well, 2012-2016 [5]



Goal

Improve the health and quality of life for those in North Central Washington with health related education

Principles and Objectives

Confluence works towards achieving the following objectives:

- Expand nutritional education opportunities
- Expand education opportunities with MD's and APP's (e.g. Cardiac education, Obesity education)
- Continue current education opportunities (e.g. childbirth education, health promotion and wellness programs, Suicide Prevention etc)

Approach & Action Plans

Confluence Health (consisting of Central Washington Hospital and Wenatchee Valley Hospital) continues to invest and participate in educational programs that are community based, which target specific health related conditions. Confluence Health staff will continue to engage the community in education and outreach in the community setting (e.g. Cooking Classes at Pybus Market, Group Education Courses, School Outreach) to promote education and empower patients to learn ways to self-manage their health.

Intended Outcomes and Key Metrics

Long Term Outcomes: Confluence Health patients will self-manage their health through the education and support received from the care teams.

When possible, Confluence Health will integrate metrics aligning with established framework to assess program impacts. These may include the following:

- Number of adults diagnosed with diabetes or prediabetes who completed Confluence Health education series.
- Number of community events provided annually to help empower patients to improve self-management

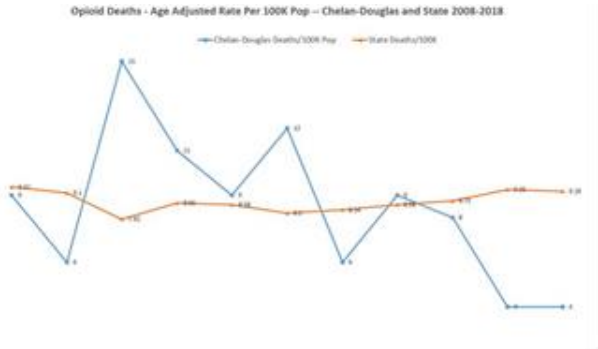
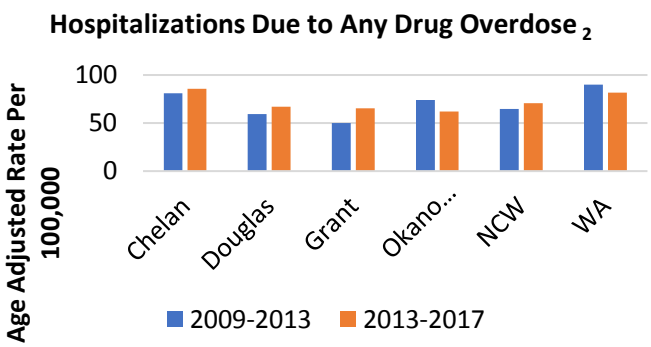
Key Programs and Collaborations

- Nutrition Educators
- Service Line opportunities (e.g. Cardiology)
- Community partnership with local advocacy groups to provide public education opportunities or identify opportunities for additional education opportunities.
- Suicide Prevention Community Committee

[1] Virginia Commonwealth University, Center on Society and Health, Why Education Matters to Health, Exploring the Causes, 2019.

[2] Healthy People 2020, Social Determinants of Health, 2019

Priority – Substance Abuse

Summary of Issues
"Opiods" was identified as one of the most important health problems that impacts the community in the 2019 Community Voice Survey. • 32.42% (N=1,624) of respondents identified opioids as a top health problem. "Drug abuse" was identified as the highest unhealthy behavior (59.76%) while "alcohol abuse" was identified as the next most important unhealthy behaviors (45.75%) within the community.      
Goal
The goal of Confluence Health is to provide educational opportunities, and programs, which will provide communities tools and resources to reduce the prevalence of opioid and alcohol abuse.
Principles and Objectives
Confluence is committed to the following principles: • All community members will have access to tools and resources to address opioid and alcohol abuse Confluence works towards achieving the following objectives: • Expand the opioid take back program • Empower community members to use tools and resources available to them
Approach & Action Plans

Confluence Health (consisting of Central Washington Hospital and Wenatchee Valley Hospital) continues to invest and participate in programs that are community based which will target patients, and community members, currently, or at risk of, opioid or alcohol abuse.

Intended Outcomes and Key Metrics

- Increase the number of opioid take back sites within Confluence Health
- Increase the number of education and community events provided annually to empower patients and community members, to address opioid or alcohol abuse.

Key Programs and Collaborations

- Confluence Health Pharmacy
- Community partnership with local advocacy groups to provide public education opportunities or identify opportunities for additional education opportunities.

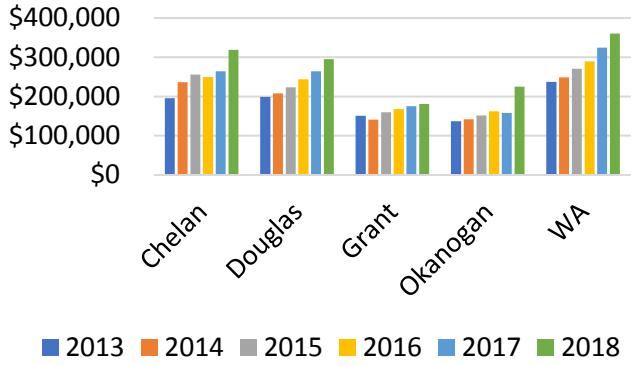
Priority – Affordable Housing

Summary of Issues

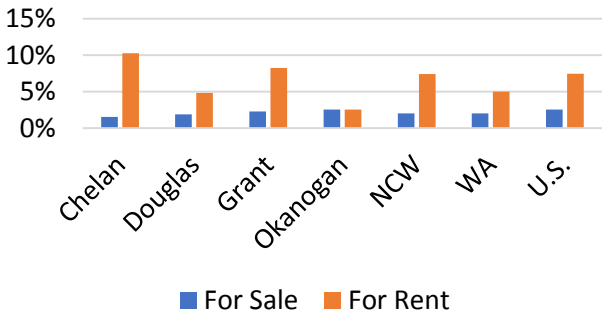
Affordable housing was identified as the most important factor that will improve the quality of life in the community in the 2019 Community Voice Survey (51.04%). Lack of affordable housing was identified as a weakness in the focus groups. Affordable housing was identified as an opportunity in the focus groups. Affordable housing affects health as greater residential stability can reduce stress and related adverse health outcomes.[2] Housing and stability and quality of housing are key issues that influence the health of the community.[3]

Barriers to housing in Chelan and Douglas County have been challenging and difficult to overcome. According to the Chelan-Douglas Trends website, produced and sponsored by Eastern Washington University, the current median price of a home in the two county area is $360,143. This compares to the median family income of $61,714. The current mortgage denial rate is 8% for Caucasians and nearly double for non-Caucasians. The rental market is equally as tight at 1.93% vacancy rate. Currently, the cost of a one-bedroom rental requires an income of $27,800 and a two-bedroom rental is $36,960.

Median Resale Price, 2013-2018 [4]



Vacant Housing Units, 2013-2017 [5]



A convenience sample of homeless patients admitted to Central Washington Hospital was reviewed to determine the cost of homelessness to Confluence Health. In reviewing one year of data, for patients who were determined to be homeless and all medical visits. Of the sample 76% were men and most had coverage from either Medicaid or self-pay.

- 48% visited ED more than 5 times in one year
- 4 patients were responsible for 57% of the clinical visits sample
- 8 patients had inpatient admissions. Of those 8, 5 had multiple inpatient admissions.
- Total unreimbursed charges totaled $1,002,169

Goal

To collaborate with local advocacy groups to address affordable housing.

Principles and Objectives
Confluence works towards achieving the following objectives: • Continue to participate with local advocacy groups, and community partnerships, to address affordable housing. • Coordinate with the Confluence Health Foundation to identify potential grant opportunities for affordable housing for Confluence Health patients.
Approach & Action Plans
Confluence Health (consisting of Central Washington Hospital and Wenatchee Valley Hospital) will continue to partner with local advocacy groups to address affordable housing. These partnerships may take various forms including, but not limited to, housing task forces within the communities Confluence Health serves, coordinating with local hotels to offer discounted rates for patients, and family members. Confluence Health will also continue to ensure active leadership representation on housing task forces and/or advocacy groups.
Intended Outcomes and Key Metrics
• Participation in community led housing initiatives • In coordination with the Confluence Health Foundation identify and submit at least two grant proposals, which would include components for affordable housing. • Monitor metrics of homeless population to determine whether community led initiatives and/or grant opportunities reduce the financial metrics identified in the sample above.
Key Programs and Collaborations
• Local community housing task forces • Local housing advocacy groups • Confluence Health Foundation

[2] Center for Housing Policy, The Impact of Affordable Housing on Health: A Research Study, 2015.
[3] Healthy People 2020, Social Determinants of Health, 2019

Following is a summary of the Joint Implementation Strategy as it relates to each Hospital Facility (Central Washington Hospital (CWH) and Wenatchee Valley Hospital (WVH)):

Significant Health Need	Goal	Objectives	Approach & Action Plans	Intended Outcomes and Key Metrics	Key Programs and Collaborations
Chronic Disease	CWH & WVH	CWH & WVH	CWH & WVH	CWH & WVH	CWH & WVH
Access to Care	CWH & WVH	CWH & WVH	CWH & WVH	CWH & WVH	CWH & WVH
Education	CWH & WVH	CWH & WVH	CWH & WVH	CWH & WVH	CWH & WVH
Substance Abuse	CWH & WVH	CWH & WVH	CWH & WVH	CWH & WVH	CWH & WVH
Affordable Housing	CWH & WVH	CWH & WVH	CWH & WVH	CWH & WVH	CWH & WVH