COMMUNITY HEALTH NEEDS ASSESSMENT
2023-2025

CASCADE MEDICAL
PARTNERS IN YOUR HEALTH

Adopted by the Commissioners of Chelan County Public Hospital District No. 1, December 20, 2022

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Executive Summary

Background

With the enactment of the Federal Patient Protection and Affordable Care Act in 2010, not-for-profit hospitals were required to develop a Community Health Needs Assessment (CHNA) once every three years. This report presents Chelan County Public Hospital District No. 1, Cascade Medical Center's (Cascade) fourth CHNA.

The CHNA process is designed to collect data and engage the community in order to better understand its health needs and to provide direction for providers, social service organizations, public health, and the general community as they focus collaborative efforts to increase overall health. Cascade sees great value in the CHNA process and is pleased to present our findings and priorities in this document.

Cascade's first two CHNAs were conducted in partnership with the North Central Accountable Community of Health (NCACH). NCACH's mission is to advance whole-person health and health equity in North Central Washington by unifying stakeholders, supporting collaboration, and driving systemic change, with particular attention to the social determinants of health. The process for the first two CHNAs included evaluation of the health status and health needs of NCACH's four county region of Okanogan, Chelan, Douglas, and Grant Counties.

In 2019, Cascade elected to conduct its own CHNA in order to focus more closely on our local community and residents. After assessing our community and identifying disparities, priorities were established for the 2020-2022 time period (**Exhibit 1**). As with the 2019 process, this new CHNA included an in-depth evaluation of the local community's health status and health outcomes; engagement with the community on issues of health care importance and gaps; and culminated with the development of priorities for the period 2023-2025.

Cascade Medical Center

Cascade is a federally designated Critical Access Hospital (CAH). The CAH designation means that the hospital is rural and was classified by Washington State as an essential provider. The CAH Program was designed to reduce financial vulnerability of rural hospitals and improve access to health care by keeping essential services in rural communities.

Mission Statement

Cascade Medical is an exceptional rural health care facility. We are a team of compassionate and dedicated professionals who provide quality primary care, services, and resources to our patients and their families.

Cascade is dedicated to caring for the health and well-being of our community. We are owned and operated by Chelan County Public Hospital District No. 1, which covers more than 1,200 square miles in North Central Washington, including the towns of Plain, Leavenworth, Peshastin, and Dryden. The District includes approximately 10,000 residents living primarily in three zip codes in Chelan County: 98826 (Leavenworth/Plain), 98821 (Dryden), and 98847 (Peshastin). It also encompasses a small portion of 98815 (Cashmere). In addition to those who reside within the District, Cascade supports the urgent medical needs of the nearly two million tourists that visit our community each year.

The District also owns and operates the Emergency Medical Services for the community and provides approximately 800 transports annually.

2020-2022 CHNA Accomplishments

The Impact of COVID

Like most communities across the nation, our community, and therefore Cascade, was significantly impacted by COVID-19. At the time of this writing, there have been over 1.8 million total cases of COVID-19 in Washington State, and over 23,000 in Chelan County.

The State's Stay-at-Home Order, issued in March 2020, required that Cascade quickly transition in-person primary care visits to virtual visits and develop innovative processes and procedures to keep the

Exhibit 1: 2020-2022 CHNA Priorities and Identified Needs

Child and Family Wellness:

- *Adult and youth mental health, including substance abuse and opioid prescribing*
- *Childhood food insecurity*
- *Lack of affordable housing*
- *Barriers with access to care, including around language, insurance, and service location*
- *Improved care coordination*
- *Lack of local pre- and postnatal care*
- *Limited childcare options*

Aging in Place:

- *District population is aging*
- *Challenges of active living for older adults, especially during winter months*
- *Disparities affecting the older adult population: high poverty rates in Leavenworth, and many seniors struggling to make ends*
- *Lack of community-based services for elderly needing additional support*

Equity for Neighbors in Poverty and the Working Poor:

- *Lack of affordable housing*
- *Food insecurity*
- *Lack of adequate childcare options*
- *Lack of a robust public transportation system*
- *Barriers to access other public*

Cascade team, patients, and community safe. Beyond primary care, this included transitioning other outpatient services from face-to-face to a virtual/telemedicine focus.

In addition, a respiratory clinic space in the hospital was deployed to accommodate increases in patient volume and to enhance infection control and patient and staff safety. This space provided separation of patients with potential COVID from other patients. It also included the development of "virtual" waiting rooms that allowed patients to check-in and communicate with staff and providers while waiting safely in their cars.

Cascade made investments in necessary equipment and supplies to establish drive-through testing and vaccination programs, and as of the writing of this CHNA, Cascade has administered almost 8,000 COVID tests and more than 6,300 vaccinations. **Exhibit 2** highlights some of the key COVID-19 response strategies undertaken by Cascade. Despite the numerous challenges presented by COVID, Cascade was able to make real progress on our 2020-2022 CHNA priorities.

Exhibit 2: Cascade COVID-19 Mitigation Strategies

- Deployed a respiratory clinic in the hospital to provide enhanced infection control and patient and staff safety.
- Installed plexiglass barriers throughout the hospital and clinics to enhance infection control.
- Altered existing spaces to create additional waiting areas to allow for social distancing.
- Adjusted seating in all waiting rooms and created a system for "virtual waiting rooms" that allowed patients to remain in their cars for safety.
- Hired 1.0 FTE to check patient and visitor temperatures.
- Added per diem staff to run and staff vaccine clinics.
- Designated a Cascade employee to manage vaccine process.
- Invested in lab equipment to be able to run rapid tests.
- Hosted a number of vaccine clinics, including partnering with the local schools.
- Established drive-through COVID-19 testing and vaccine program.
- Performed telephone, video, and curbside visits for all COVID-symptomatic patients.
- Redeployed staff to other areas/jobs, ensuring no one was furloughed or did not receive pay.

COVID-19 Tests	COVID-19 Vaccinations
▪ 2020: 2,564	▪ 2020: 103
▪ 2021: 3,366	▪ 2021: 5,476
▪ 2022 YTD: 1,739	▪ 2022 YTD: 787

Exhibit 3 summarizes the accomplishments in our three key focus areas: *Child and Family Wellness, Aging in Place, and Poverty and the Working Poor.*

Exhibit 3: Cascade Medical 2020-2022 Accomplishments
Child and Family Wellness:
Offered health care services within the school system
Partnered with the school district on suicide awareness training
Cascade's employed Psychologist received certification to diagnose autism
Deployed mobile clinic, telehealth, and tele-behavioral health services outreach to outlying areas in the District; in process of implementing mobile integrated health visits
Used new Electronic Health Record (EHR) conversion to ensure all patient forms are dual-language; created additional dual-language communications
Prioritized hiring dual-language speakers in key areas, including financial counseling; hired bilingual practitioners for mobile clinic; implemented premium pay for Spanish speakers
Implemented drive-through flu shot clinic and offered free sports physical events
Achieved 95% coverage with childhood vaccines and won the Bronze Immunize WA award
Advocated for legislative changes to allow the county to utilize existing tax funds for housing
Attended community development and regional housing meetings and workshops
Implemented pediatric occupation and speech therapy programs
Aging in Place:
Cascade Medical has all structures and training in place and began offering a tele-stroke program with UW Harborview in Fall 2022
Agreement in place to ensure Cascade is properly contracted to care for veterans
Added podiatry to local services at Cascade
More standardization of coagulation patient prescriptions
Implemented program to help patients and their families understand when cognitive decline is occurring and connect with resources
Attended city council meetings regarding the topic of the Osborne property, responded to community surveys, raised the topic at the OVOF strategy meetings, wrote letter of support for city for federal funding to make pool accessible year-round
Poverty and the Working Poor:
Began serving outlying areas via a mobile clinic in Fall 2022
Patient navigator participated in school district migrant fair, is connected with mobile clinic outreach; additional charity care outreach implemented in Fall 2022
Established collaborative relationship with MEND free clinic to connect people with charity care
Educated community leaders about the high level of poverty and working poor in our community through local clubs, in our public meetings, and during an open-forum panel
Moved all wage scales so no base wage started below $15/hour; increased all hourly wage scales by $1.50/hour in 2021; continuing to update wage scales annually to match market

Methodology

Cascade's CHNA process included both primary and secondary data collection. Primary data, collected directly from the source, was captured by soliciting the community voice. In the Fall of 2022, Cascade designed a comprehensive community survey. The survey was distributed to community organizations and their members throughout the District and was sent directly to the homes of all District residents through an outreach postcard mailed via U.S. Postal Service. To date, more nearly 240 households responded to the survey.

Secondary data, including data from federal, state, and regional-level sources, was also used to better understand the demographics, health behaviors, social and economic factors, physical environment, and clinical care characteristics of the District. Key data sources included:

- The Behavioral Risk Factor Surveillance Survey (BRFSS)
- U.S. Census and the American Community Survey (ACS)
- Washington Healthy Youth Survey
- Robert Wood Johnson Foundation's County Health Rankings and Community Commons' Health Indicator Reports
- Washington State Report Card, Office of Superintendent of Public Instruction
- County Health Assessment Tool, Washington Department of Health
- Drug Overdose Dashboard, Washington Department of Health

Whenever possible, the secondary data was gathered at the District level. When not available, County data was used as a proxy.

Healthy People 2030

The Healthy People Federal Initiative began in 1979 when the Surgeon General issued a landmark report titled *Healthy People: The Surgeon General's Report on Health Promotion and Disease Prevention*. Healthy People 2030 is the fifth iteration of the initiative. It builds on knowledge gained and lessons learned to address the latest public health priorities. It provides 10-year, measurable public health objectives—and tools to help track progress toward achieving those objectives. Cascade reviewed the 2030 initiatives and considered the 2030 overarching goals in this CHNA.

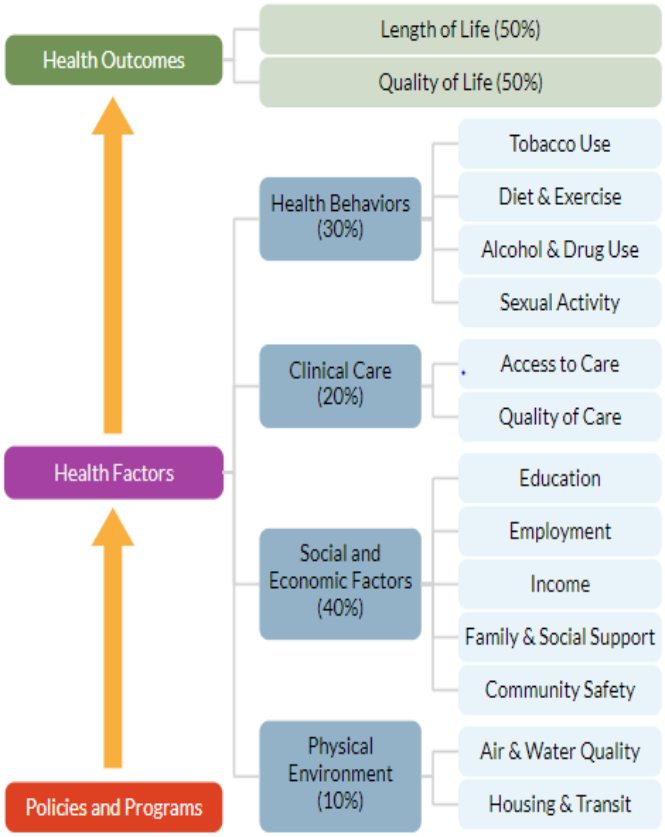
The overarching goals of Healthy People 2030 include:

- Attain healthy, thriving lives and well-being free of preventable disease, disability, injury, and premature death.
- Eliminate health disparities, achieve health equity, and attain health literacy to improve the health and well-being of all.
- Create social, physical, and economic environments that promote attaining the full potential for health and well-being for all.
- Promote healthy development, healthy behaviors, and well-being across all life stages.
- Engage leadership, key constituents, and the public across multiple sectors to take action and design policies that improve the health and well-being of all.

Robert Wood Johnson's County Health Rankings

Cascade organized the data collection and analysis consistent with Robert Wood Johnson Foundation's (RWJF) Health Model (**Exhibit 4**), which recognizes that clinical care is only one element impacting a person's health. The RWJF publishes an annual report and health data for every county in the United States. The RWJF model demonstrates that clinical care comprises only 20% of the factors influencing health outcomes. The other health factors impacting length and quality of life include health behaviors, social and economic factors, and physical environment. It is critical to evaluate and work to influence each of these modifiable health factors.

Exhibit 4: RWJF Health Model

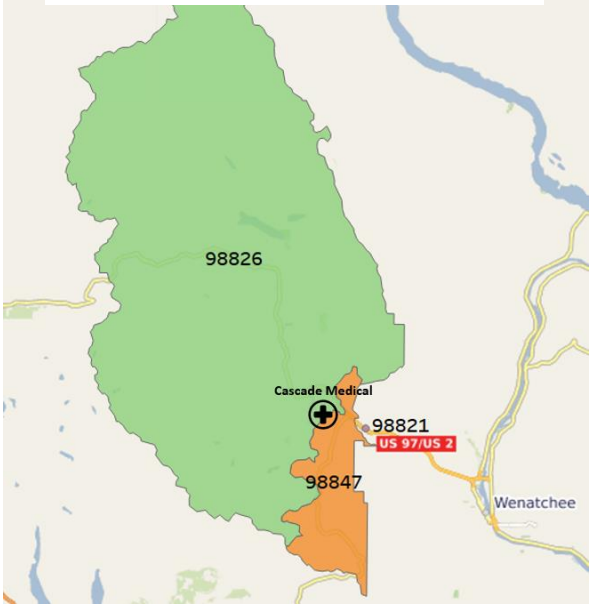


A Profile of Our Community

Service Area Definition

As shown in **Exhibit 5**, the Chelan County Public Hospital District is comprised of three distinct communities/zip codes: 98826 (Leavenworth/Plain), 98821 (Dryden), and 98847 (Peshastin), as well as a small portion of 98815 (Cashmere).

Exhibit 5: The District



Demographic Overview

As identified in **Exhibit 6**, the District continues to grow, and its overall population is aging. Between 2010 and 2022, the District grew by over 1,000 residents, with the biggest gains in those aged 65 and older (56.0% increase). Approximately 12% of the District's population is Hispanic/ Latino, and this cohort is projected to grow faster than the District at large over the next five years (8.9% vs 5.2%). Over the same period, the District's population growth is projected to come almost exclusively from those aged 65 and older (18.4%), compared to a nearly flat increase in residents 0 to 64 years old (0.4%).

Exhibit 6: Hospital District Demographic Changes Over Time, 2010-2027

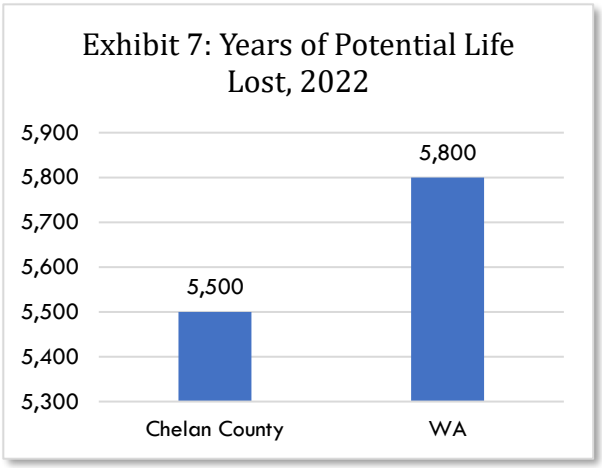
	2010	% of Pop.	2022 Est.	% of Pop.	% Chg 2010–2022	2027 Proj.	% of Pop.	% Chg 2022 – 2027
Tot. Pop.	**9,114**	**100%**	**10,095**	**100%**	**10.8%**	**10,617**	**100%**	**5.2%**
Pop. By Age								
0-17	1,858	20.4%	1,771	17.5%	-4.7%	1,789	16.9%	1.0%
18-44	2,527	27.7%	2,883	28.6%	14.1%	3,070	28.9%	6.5%
45-64	3,015	33.1%	2,767	27.4%	-8.2%	2,591	24.4%	-6.4%
65-74	1,019	11.2%	1,705	16.9%	67.4%	2,123	20.0%	24.5%
75-84	493	5.4%	742	7.3%	50.4%	770	7.3%	3.9%
85+	202	2.2%	228	2.3%	12.4%	274	2.6%	20.3%
Tot. 0-64	7,400	81.2%	7,421	73.5%	0.3%	7,450	70.2%	0.4%
Tot. 65 +	1,714	18.8%	2,674	26.5%	56.0%	3,167	29.8%	18.4%
Hispanic	1,027	11.3%	1,223	12.1%	19.1%	1,308	12.3%	6.9%
Fem. 15-44	1,416	15.5%	1,573	15.6%	11.1%	1,656	15.6%	5.2%

Source: Nielsen Claritas, zip codes 98826, 98847, 98821, and part of 98815

Health Outcomes

Length of Life

Measuring how long people in a community live demonstrates whether people are dying prematurely, and it prompts evaluation of what is driving premature deaths. By exploring a County's data related to length of life, important indicators about a community's health can be highlighted.



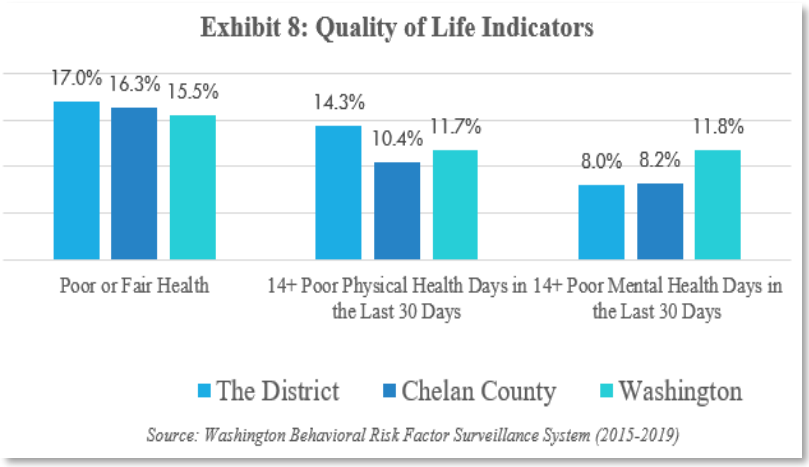
Years of Potential Life Lost (YPLL) and Life Expectancy

YPLL is a widely-used measure of the rate and distribution of premature mortality. Measuring premature mortality, rather than overall mortality, focuses attention on deaths that might have been prevented. This measure calculates the years of potential life lost for those under age 75 per 100,000 people. As identified in **Exhibit 7**, Chelan County has a premature death rate lower (better) than the State (5,500 per 100,000 vs. 5,800 Statewide).

Life expectancy measures the average number of years from birth a person can expect to live, according to the current mortality experience (age-specific death rates) of the population. Life expectancy calculations are based on the number of deaths in a given time period and the average number of people at risk of dying during that period, allowing comparison across counties with different population sizes. Life expectancy in Chelan County is aligned with that of the State (80.3 vs. 80.4, respectively).

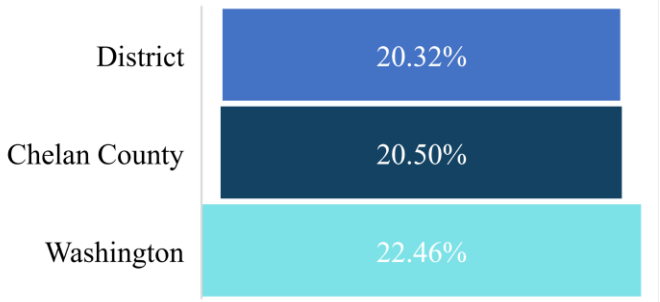
Quality of Life

In addition to measuring how long people live, it is important to also include measures that consider how well people live. Quality of life refers to how healthy people feel while alive. It represents the well-being of a community, and underscores the importance of physical, mental, social, and emotional health from birth to adulthood.



RWJF's County Health Rankings: Quality of Life measures look at indicators including the percentage of adults reporting fair or poor health (age-adjusted), the percentage of individuals reporting 14 or more physically unhealthy or 14 or more poor mental health days in the past 30 days. As seen in **Exhibit 8**, the District fares worse than the County and State in terms of physical health indicators but is in line with the County and better than the State in terms of self-reported mental health. Though the percentage of District residents that report being diagnosed with a depressive disorder is also consistent with the County (and slightly better than the State), the data still indicates that one in five District residents report being diagnosed with a depressive disorder (**Exhibit 9**).

Exhibit 9: Percentage Reporting Being Diagnosed with a Depressive Disorder



And of concern is the fact that, according to the Healthy Youth Survey, the percentage of 10th graders that reported considering suicide in the past 12 months was higher in the District than the County (24% vs. 18%).

Risk Factors

Risk factors are causal determinants of increased rates of disease that also impact quality of life. Lifestyle, including diet, eating well, and exercise, can help people avoid certain diseases, but when they are not enough, diabetes and obesity often result, and they are both significant risk factors for developing other chronic conditions that can lower quality of life and overall life expectancy.

As shown in **Exhibit 10**, the District fares slightly better than the County and State in terms of the percentage of adults reported being obese. The District is aligned with the County and State with regard to diabetes and high blood pressure, with almost one-third of District residents reporting high blood pressure.

Exhibit 10: Risk Factors

Risk Factors	%	Geography	Better than WA	Equal to WA	Worse than WA
Adult Obesity	24%	District	●		
	28%	Chelan County		●	
Diabetes	9%	District		●	
	10%	Chelan County		●	
High Blood Pressure	28%	District		●	
	30%	Chelan County		●	

Sources: Washington Behavioral Risk Factor Surveillance System (2015-2019)

Health Factors

There are many things that influence how well and how long we live. Everything, from our education to our environment, impacts our health. Health factors represent those things we can modify to improve the length and quality of life for residents. There is no one factor that dictates the overall health of an individual or community. A combination of multiple modifiable factors, from clean air and water to stable and affordable housing, need to be considered to ensure community health for all.

Social and Economic Factors

Social and economic factors, such as income, education, employment, community safety, and social supports, significantly affect how well and how long we live. These factors affect our ability to make healthy choices and to afford medical care and housing.

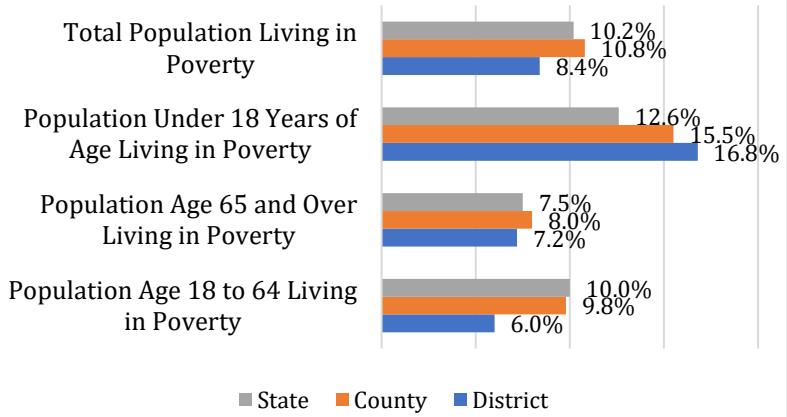
Our basic social and economic supports—good schools, stable family-wage jobs, and strong social networks—are foundational to achieving long and healthy lives. For example, employment provides income that shapes opportunities around housing, education, childcare, food, medical care, and more. In contrast, unemployment limits these choices and the ability to accumulate the savings and assets that can help cushion in times of economic distress.

Social and economic factors are not commonly considered when it comes to health, yet, as demonstrated by RWJF, strategies to improve these factors can have an even greater impact on health than many strategies traditionally associated with health improvement.

Poverty

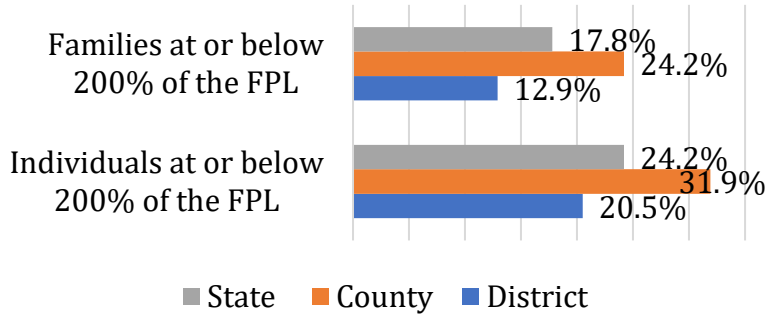
Poverty is defined by family size and income and is th e primary measure of financial stability. When evaluating populations living at or below the federal poverty level (FPL) by different age cohorts (**Exhibit 11**), the District has higher rates of children living in poverty than does the County or the State. For seniors, the District is faring better than the County and is in line with the State.

Exhibit 11: Poverty Rates, 2020



Importantly, many families living above the poverty line still struggle to make ends meet. When looking at District data for those individuals or families that are at or below 200% of the poverty line, the District is faring better than the County or the State. It is still important to note that one in five District residents are at or below this level and likely struggle to make ends meet (**Exhibit 12**).

Exhibit 12: Individuals and Families At or Below 200% of FPL, 2020



ALICE Households

As identified in **Exhibit 13**, the United Way produces data to help understand and define the struggles of households that earn above the FPL but earn below a basic cost of living threshold. These are known as ALICE households. In Chelan County, nearly half of the households are below the ALICE threshold, meaning they are both below the FPL and below the basic cost of living threshold established by United Way. In Leavenworth (the only area in the District with sufficient data to be included), 40% of households are below the ALICE threshold. This is in line with the State (39%) and Nation (41%).

Chelan County
- 45% ALICE & Poverty
- Poverty – 20%
- ALICE – 25%

Washington State
- 39% ALICE & Poverty
- Poverty – 12%
- ALICE – 27%

Leavenworth (98826)
- 40% ALICE & Poverty
- Poverty – 18%
- ALICE – 22%

U.S. Average
- 41% ALICE & Poverty

Exhibit 13: What is an ALICE Household?

ALICE is an acronym for Asset Limited, Income Constrained, Employed.

ALICE is a way of defining and understanding the struggles of households that earn above the Federal Poverty Level (FPL), but not enough to afford a bare-bones household budget.

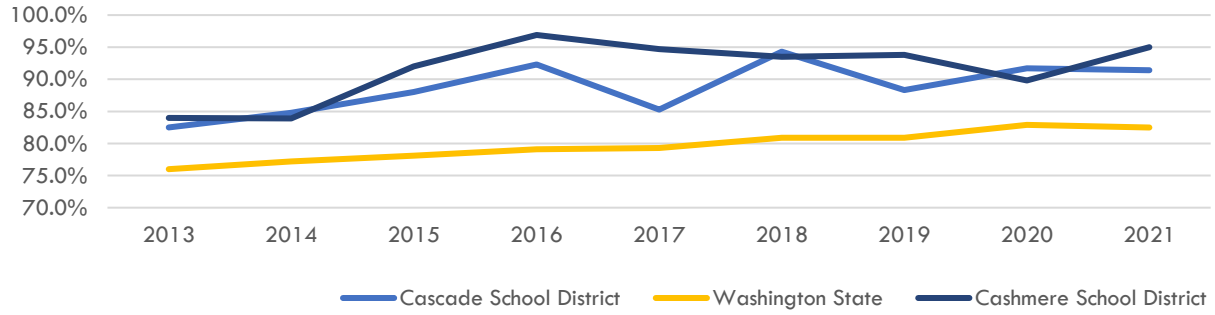
For far too many families, the cost of living outpaces what they earn. These households struggle to manage even their most basic needs: housing, food, transportation, childcare, health care, and necessary technology.

When funds run short, cash-strapped households are forced to make impossible choices, such as deciding between quality childcare or paying the rent, filling a prescription, or fixing the car.

Education

High school graduation rates in the District have consistently been higher than the State average (**Exhibit 14**). Despite the overall strong graduation rates, there are disparities within the District: of the population age 25 and older, nearly one in five Dryden and Peshastin residents do not have a high school diploma or equivalent. Leavenworth has the highest rate of individuals with some college or a college degree.

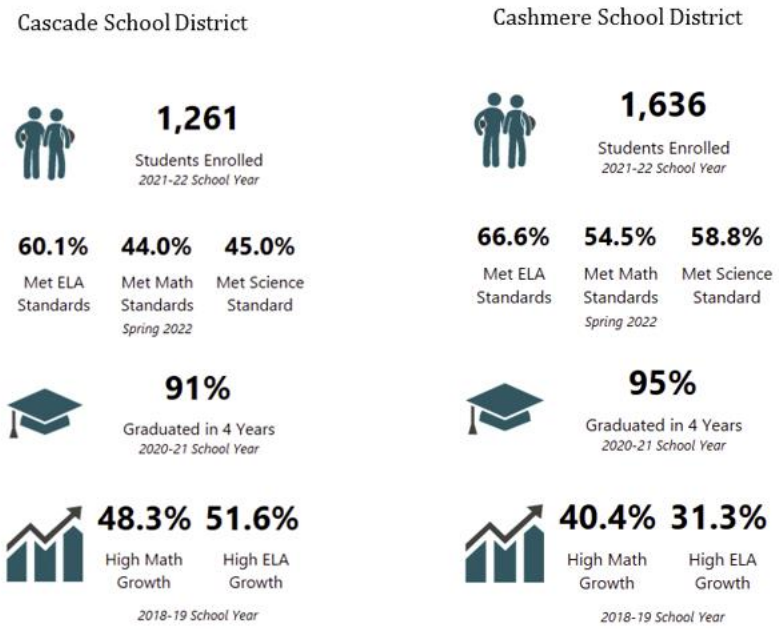
Exhibit 14: Four-Year Graduation Rates, Cascade School District, Cashmere School District, and Washington State



Source: Washington State Office of Superintendent of Public Instruction

While graduation rates have been higher in the District, students are having difficulty meeting ELA, math, and science standards. There were over 1,200 students enrolled in the Cascade School District and over 1,600 in the Cashmere School District in the 2021-2022 school year (**Exhibit 15**).

Exhibit 15: School District "Report Card"



Source: Washington State Office of Superintendent of Public Instruction

Childcare

While data sources have been updated since the last CHNA, it is important to recognize how critical childcare access is to families across the District. In the last updated data, 75% of families reported both parents in the labor force. This means the need for childcare is great, however, it is not always available. Large swaths of Washington State are childcare deserts. A childcare desert is any area with more than 50 children under age 5 that contains either no childcare providers or so few options that there are more than three times as many children as licensed childcare slots available (**Exhibit 16**). Across Washington State, 63% of people live in a childcare desert, and the District qualifies as a childcare desert as well. This lack of resource causes financial and personal strain on households. Families often have to resort to non-licensed childcare options, which leave children more vulnerable to poor care. The childcare capacity in the Leavenworth/Plain area can only accommodate 24 children, and the Peshastin and Dryden area can only accommodate 60. This leaves large numbers of children unable to access safe, quality childcare.

Exhibit 16: Childcare Indicators

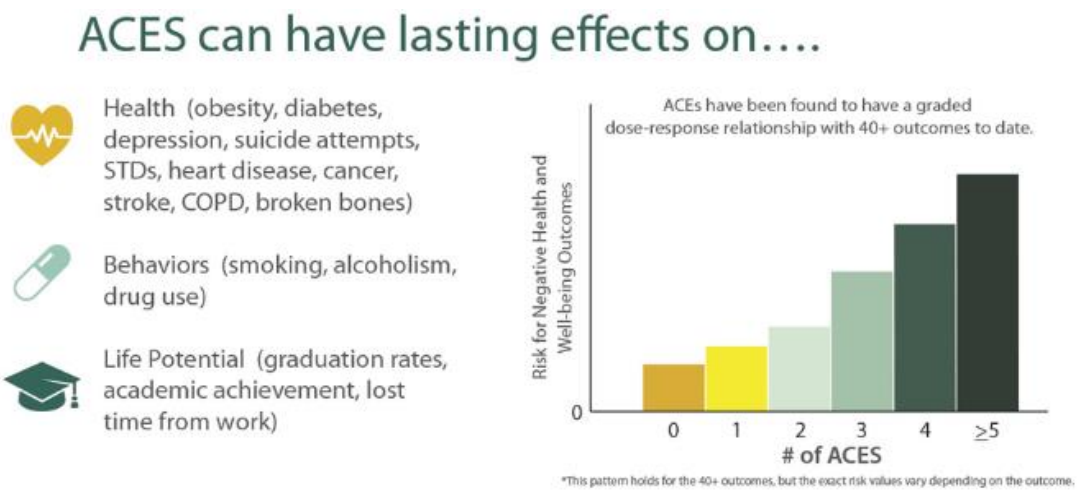
	Leavenworth/Plain	Peshastin, Dryden, and areas around Wenatchee
Percentage of children with both parents in the labor force	78%	74%
Licensed childcare providers	2	3
Family childcare homes	1	2
Total childcare capacity	24	60
Population under age 5	248	472

Source: Center for American Progress, 2020

Adverse Childhood Experiences (ACEs) and Trauma

Adverse childhood experiences, or ACEs, are traumatic events that occur in childhood and cause stress that changes a child's brain development (**Exhibit 17**). 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; or having an incarcerated member of the household.

Exhibit 17: Association between ACEs and Negative Health Outcomes



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

Exhibit 18 indicates that the percentage of District residents who report having three or more ACEs has increased since 2011 (15.2% to 20.9%), compared to the State which has remained relatively stable. While absent in 2011 data, District residents are now reporting six or more ACEs in 2019 data.

Exhibit 18: ACE Scores

	2011		2019	
Score	**District**	**WA State**	**District**	**WA State**
One to Two	36.4%	35.6%	27.9%	35.0%
Three to Five	15.2%	19.7%	20.9%	20.1%
Six or More	0.0%	4.8%	2.3%	5.8%

Source: BRFSS 2011, 2019 Data

Social and Economic Factors by Select Communities

As part of the CHNA process, additional analysis was done to evaluate differences within the District. As **Exhibit 19** demonstrates, the Leavenworth area makes up nearly 30% of the District's population. The data also suggests that the defined southeast region (Peshastin-Dryden) is younger, has a larger percentage of Hispanic/Latino population, has lower levels of owner-occupied homes, and has higher rates of people who own no vehicles.

Exhibit 19: Selected Socioeconomics for District Communities

	SW Leavenworth (Icicle Valley)	Lake Wenatchee	Leavenworth	NE Leavenworth (Chumstick Highway)	Peshastin	Dryden	District Total
Total Population	**1,466**	**916**	**3,803**	**2,042**	**1,325**	**3,343**	**12,895**
Hispanic or Latino	5%	1%	7%	2%	4%	20%	9%
Age 65 and over	41%	41%	17%	39%	20%	20%	26%
% Below Federal Poverty Level	7%	16%	5%	4%	31%	4%	8%
% of Population 25+ without High School Diploma	4%	3%	5%	8%	42%	14%	9%
% of Population with Bachelor's Degree or Higher	43%	34%	44%	32%	16%	18%	33%
% Low Income (Less than 200% of FPL)	14%	20%	24%	20%	29%	18%	21%
Owner Occupied	67%	91%	64%	80%	72%	82%	74%
Renter Occupied	33%	9%	36%	20%	28%	18%	26%
% Households with Single Female Householder	2%	0%	14%	0%	26%	18%	11%

Source: American Community Survey 5-Year Estimates 2016-2020, census block groups

Health Behaviors

Health behaviors are actions individuals take that affect their health. These include actions that lead to improved health, such as eating well and being physically active, and actions that increase one's risk of disease, such as smoking, excessive alcohol intake, and risky sexual behavior. In the United States, many of the leading causes of death and disease are attributed to unhealthy behaviors. For example, poor nutrition and low levels of physical activity are associated with higher risk of cardiovascular disease. Tobacco use is associated with heart disease and cancer. Excessive alcohol use is associated with injuries, certain types of cancers, and cirrhosis.

Addressing health behaviors at the community level requires considering strategies to ensure that all neighbors, regardless of income, can access nutritious food, safe spaces to be physically active, and supports for healthy choices.

Food Insecurity

Lacking consistent access to a sufficient amount of nutritious, balanced food is called "food insecurity," and it is related to negative health outcomes such as weight gain and premature mortality. In addition to measuring consistent food availability in the past year, the food insecurity metric also assesses intake of balanced meals with adequate macronutrient variety.

In Chelan County and Washington State (**Exhibit 20**), approximately one in six children are food insecure. Much of the District's geography is defined as a food desert, where it is inconvenient and difficult to access groceries and other foods. Lack of convenient, timely, and affordable access to balanced and healthy foods carries many mental and physical health risks, particularly for children. The United States Department of Agriculture measures food deserts, or areas with poor access to groceries, in terms of distance from the nearest supermarket. The District is categorized as "low access," meaning that at least 500 people live farther than 10 miles from the nearest supermarket. This issue is then compounded by the District being categorized as a low vehicle-access area. This designation means that at least 100 people have no access to a vehicle and live more than a half-mile from the nearest supermarket.

Exhibit 20: Food-Related Indicators

	Chelan County	Washington State
Child Food Insecurity Rate	16%	14%
Overall Food Insecurity Rate	11%	10%
Food Environment Index	8.2	8.3

Many Chelan County families live above the poverty line but are unable to afford a basic household budget. Children in these families are particularly vulnerable to the negative effects of hunger and poor school outcomes from hunger-related stress and discomfort.

Substance Use

District residents report double the rate of heavy drinking than both the County and State (**Exhibit 21**). This indicates that District residents are drinking enough to negatively impact their health and well-being and are at risk for alcohol dependence. Fewer adults in the District reported smoking (9%) than the County (11%) or the State (14%). While drug overdose data is not available for the District, data shows that the rate in Chelan County is slightly less than the State (12 per 100,000 as compared to 15 per 100,000 Statewide).

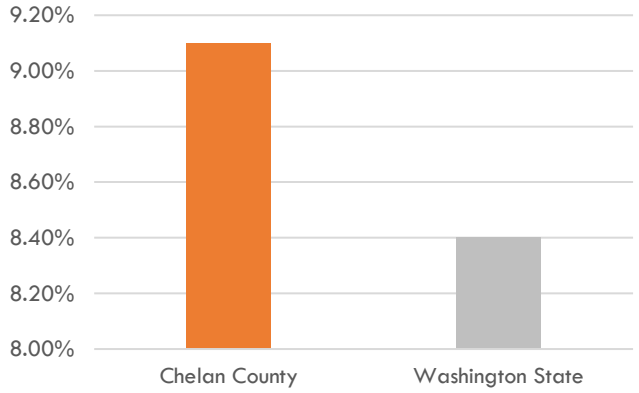
Exhibit 21: Smoking, Substance Use, and Overdose Data

	The District	Chelan County	Washington State
Heavy Drinking (% of adults reporting 8 or more drinks per week for a woman; 15 or more drinks for a man)	10.2%	7.2%	6.4%
Drug Overdose Deaths (per 100,000 population)	N/A	12	15
Smoking (% of Adults reporting smoking every day or most days)	9.0%	11.0%	13.5%

Sources: Washington Behavioral Risk Factor Surveillance System (2015-2019); WA State DOH 2018-2020

The Healthy Youth Survey (HYS) is 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. According to data from the Healthy Youth Survey, a higher percentage of 10th graders in the County report having consumed alcohol in the past 30 days than in the State (**Exhibit 22**).

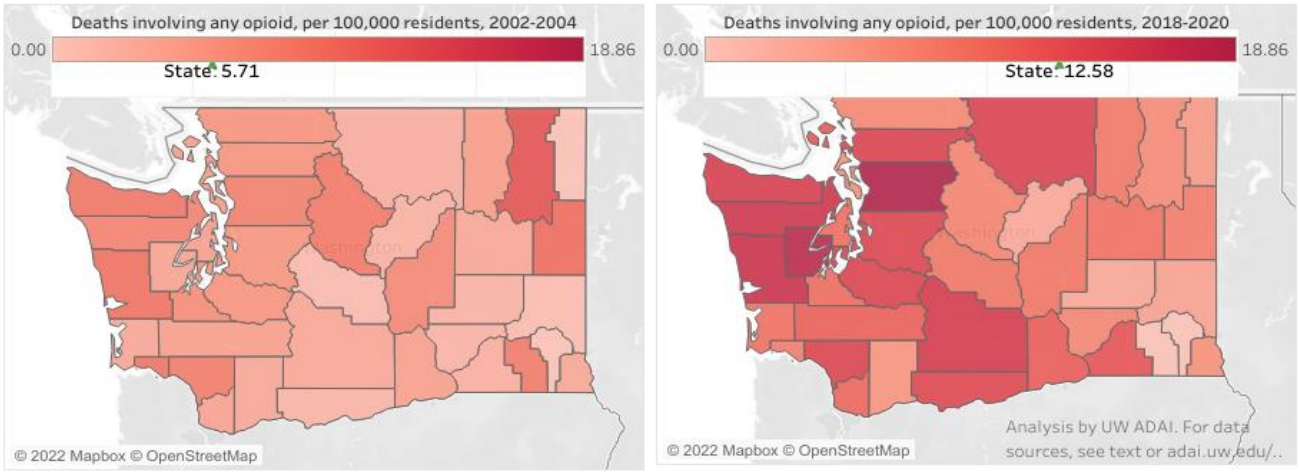
Exhibit 22: Youth Who Report Having Consumed Alcohol in the Past 30 Days (10th Grade)



Opioid Epidemic

In Washington State, deaths involving any opioid was at 12.58 per 100,000 residents in 2018-2020: a 120% increase over the 2002-2004 timeframe. The trend in Chelan County is reversed, however, and the County experienced a decrease in opioid-related deaths by 14.0% in the same time period. **Exhibit 23** shows rates by county.

Exhibit 23: Rate of Death Attributed to Opiates, by County



Source: University of Washington Alcohol & Drug Abuse Institute

While Chelan County has benefited from the decline in opioid-related mortality, the County consistently had a higher opioid prescription rate than the State overall. Between 2011 and Q4 of 2021, Chelan County had a 45% reduction in the opioid prescription rate and now has a similar prescribing rate as Washington. In 2018, Chelan County had an opioid prescription rate 5.1% higher than the State.

Clinical Care

Access to affordable, quality, and timely health care can prevent disease by detecting and addressing health concerns early. Understanding clinical care in our community helps us understand how we might improve the health of our neighbors. Advances in clinical care over the last century, including vaccinations and preventive screenings, have led to significant increases in life expectancy. Clinical care and practice continue to evolve, with advances in care coordination leading to improved quality and availability of care.

Despite these advances, many individuals across the country do not have access to a primary care provider. In Washington State, the Affordable Care Act (ACA) initially led to sharp declines in the percentage of uninsured people. However, the latest report on health care coverage (February 2021) from the Washington State Office of Financial Management (OFM) indicates that there was a slight increase in uninsured rates between 2016 and 2019, with rates going from 5.4% to 6.1% Statewide. The same report shows the increase in Chelan County, moving from 6.2% to 10.4%. The national rate slightly increased from 8.6% to 9.2% over the same period. This data does not include impacts of the COVID-19 pandemic on these rates. The current reports from OFM do not include data beyond 2019 at the time of writing this CHNA.

Even among individuals with health insurance, there are many barriers to accessing health care: high deductible costs, language barriers, long distance to a provider, or lack of specialists in their geographic area or health network. Those without regular access to quality providers and care are often diagnosed at later, less treatable stages of a disease than those with insurance, and, overall, have worse health outcomes, lower quality of life, and higher mortality rates.

Clinical care includes what people view as traditional medicine: primary care providers, vaccines, screenings, etc. Access to these services means making sure all people can get these services in convenient, timely, and affordable ways. There are many barriers to accessing health services, from financial to geographic limitations. In order to understand access to clinical care, there is a wide range of factors to consider: health of the community, provider ratios, health insurance rates, and socioeconomic factors.

Uninsured

According to **Exhibit 24**, Chelan County continues to lag slightly behind the State in health insurance rates, while the District looks slightly better than the State. With medical costs contributing to roughly two-thirds of all personal bankruptcy cases in the U.S., being uninsured puts additional strain on low-income households.

Exhibit 24: Uninsurance Rates by Subgroups

	The District	Chelan County	Washington State
Uninsured	5.7%	9.1%	6.2%
Uninsured Children (under 19 years)	1.4%	3.0%	2.8%
Uninsured Adults (19 – 64)	10.1%	14.3%	8.9%
Uninsured Seniors (65+)	0.0%	2.1%	0.7%
White (Non-Hispanic/Latino) Uninsured	5.9%	4.9%	4.3%
Hispanic/Latino Uninsured	6.9%	19.7%	16.4%

Sources: BRFSS 2015-2019 and American Community Survey, 2016-2020 5-Year Estimates

Maternal Health

Between 2016 and 2021, an annual average of approximately 142 babies were born to District residents each year (**Exhibit 25**). Of total births to District residents, preterm births (babies born < 37 weeks of gestation) had a low of 6.5% in 2019 and a high of 13.5% in 2018. On average, 9.4% of births between 2016 and 2021 were preterm.

Exhibit 25: District Births

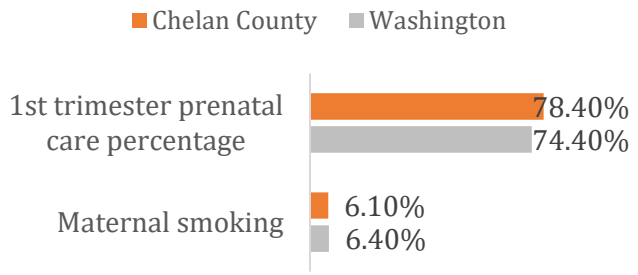
	2016	2017	2018	2019	2020	2021
Preterm Births: babies born at less than 37 weeks of gestation (% of total)	9 (6.7%)	18 (12.0%)	20 (13.5%)	10 (6.5%)	11 (9.2%)	13 (8.7%)
Underweight at Birth: babies weighing less than 2,5000 grams (% of total)	0	1	0	1	0	0
Total Births	134	150	148	153	120	149

Source: Washington State Department of Health CHARS Database, 2016-2021

Over the 2017-2021 period, a greater proportion of County residents sought prenatal care in the 1st trimester than other Washingtonians (**Exhibit 26**). Local access to prenatal services reduces out-of-pocket costs and transportation barriers for rural patients. When care is not local, travel to services can and does result in delayed initial prenatal care visits, missed return visits, and late identification of obstetric complications.

A focus on increasing the number of providers able to manage prenatal and postnatal care locally will result in improved outcomes and reduced stress, financial costs, and transportation barriers.

Exhibit 26: Maternal Health Indicators



Source: Washington State Department of Health Tracking Network (2017-2021).

Health Care Provider Supply

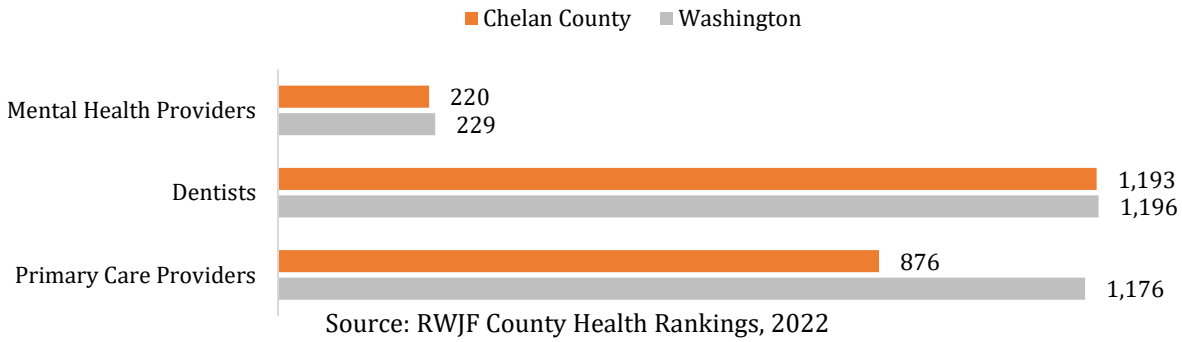
While uninsured rates are higher in Chelan County, the County does score well in a key component of access to health care: the ratio of primary care physicians to population. Having more physicians per capita improves access to primary care and lessens a community's reliance on emergency services.

As shown in **Exhibit 27**, Washington has a ratio of 1,176:1, Chelan County has a ratio of 876:1, meaning there are more primary care physicians in Chelan County per capita than in the State. However, this is a result of there being a large physician presence in Wenatchee and not necessarily in the more rural areas of the County, including the communities that Cascade serves.

In fact, there has been a recent loss of providers in Leavenworth, impacting access and availability. In the community convening, the majority of respondents felt there has been a decrease in access to primary care over the last few years, and nearly 80% of respondents thought the ability to recruit and retain a quality health care workforce was one of the most important factors to improving health and quality of life in the District.

Exhibit 27 also shows that Chelan County is on par with the State in regard to its mental health provider and dentist ratios.

Exhibit 27: Ratio of Population to Health Care Providers

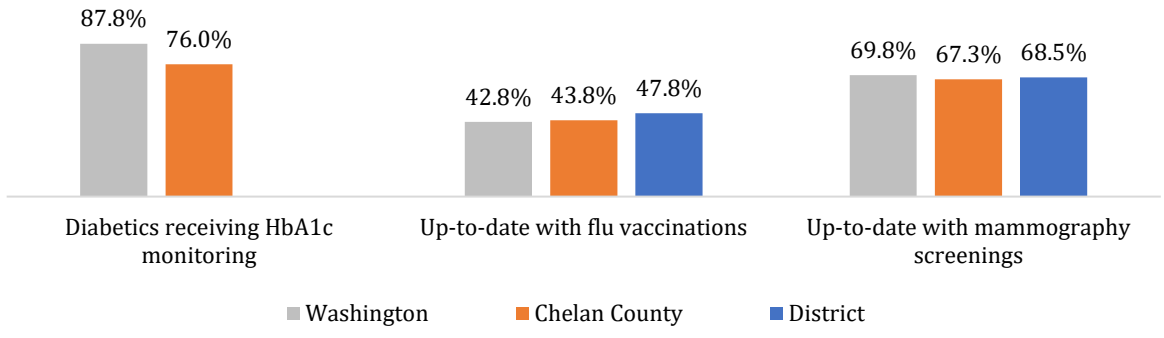


Source: RWJF County Health Rankings, 2022

Preventive Care

Key markers of access to health care in a community are the rates of preventive screenings and vaccines. Getting vaccinated prevents many life-threatening illnesses from ever occurring, and preventive screenings catch disease processes early so that treatments are more effective. **Exhibit 28** shows that the District has similar rates to both the County and State for mammography screenings (approximately 68%).

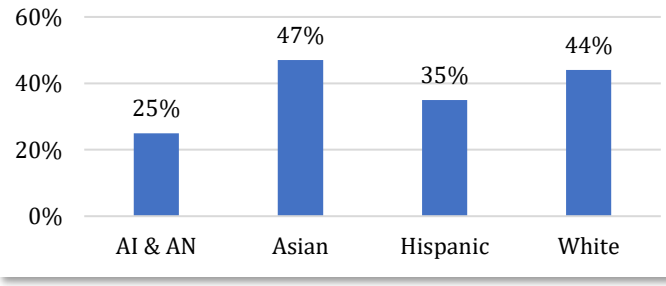
Exhibit 28: Proportion of Medicare Enrollees Receiving Appropriate Preventive Care



Source: BRFSS. Data for diabetic District residents receiving HbA1c monitoring is unavailable as the n is too small.

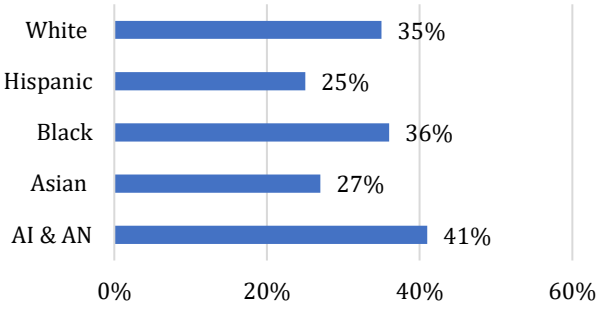
However, racial disparities exist in access to many different types of preventive care (**Exhibit 29**). Since the last CHNA, the gap has widened among Medicare recipients in Chelan County, with White residents being 25% more likely than Hispanic/Latino residents to have an up-to-date mammogram (44% vs. 35%). For the AI/AN population, the discrepancy is even larger, with only 25% of this group having had a mammography screening.

Exhibit 29: Percentage of Female Medicare Enrollees (Ages 65-74) Who Received an Annual Mammography Screening, Chelan County



Yearly influenza outbreaks can prove deadly to seniors, children, pregnant women, and people with asthma or who are immunocompromised. Vaccines help prevent people from getting severe flu. Despite the importance of the flu vaccine, especially in an area with many seniors, less than a half of Chelan County's fee-for-service Medicare recipients are vaccinated against the flu. However, District rates (47.8%) are higher than both the State (42.8%) and County (43.8%). Much like mammography screenings, significant racial/ethnic disparities in flu vaccination exist, with only a quarter of Chelan County's Hispanic/Latino residents receiving a flu vaccine, compared with 35% of White residents (**Exhibit 30**).

Exhibit 30: Percentage of Medicare Enrollees Who Received an Annual Flu Vaccination, Chelan County

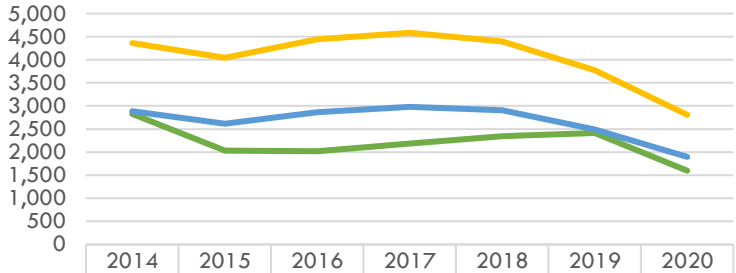


Per Washington State Department of Health data, 67.3% of residents 18–35-months are up-to-date on immunizations in 2021, compared to 57.4% of residents age 18-35-months in Washington State overall. The State and national goal is 80% for this population. Increasing efforts to improve immunization compliance at all ages will help safeguard Chelan County's most vulnerable members.

Preventable Hospital Stays

Preventable hospital stays are often measured by assessing Prevention Quality Indicators, or PQIs, which track ambulatory care sensitive conditions (ACSC). ACSCs are conditions that, with good outpatient care, should not require hospitalization. For all PQIs, Chelan County is below both the State and national levels in 2020, meaning that it performs better and has fewer hospitalizations for ambulatory care sensitive conditions (ACSC) than the rate at the State and national level. The 2020 data (**Exhibit 31**) shows that the long-term trend across all geographies is getting better for this measure. However, between 2017 and 2019, Chelan County's trend worsened, coming more in line with the State rate. Chelan County's rate has since improved and is again ahead of the State.

Exhibit 31: Preventive Quality Indicators (per 100,000 Medicare beneficiaries, per year)



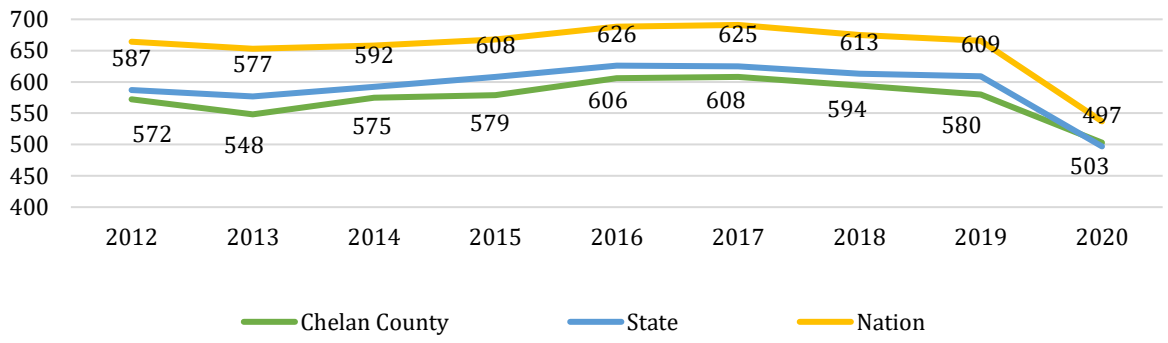
	2014	2015	2016	2017	2018	2019	2020
Chelan County	2,827	2,031	2,021	2,187	2,343	2,412	1,597
State	2,884	2,612	2,862	2,980	2,904	2,491	1,897
Nation	4,358	4,040	4,447	4,583	4,398	3,770	2,807

Source: Centers for Medicare & Medicaid Services Mapping Medicare Disparities

Emergency Department Visits

Emergency department (ED) visit rates is another measure that sheds light on the health care utilization of an area. Many people use the emergency department as a means of primary care. Per the CDC, 12.5% of nationwide ED visits in 2018 resulted in a hospital admission.

Exhibit 32: Emergency Department Visit Rate (per 1,000 beneficiaries, per year)



Source: Centers for Medicare & Medicaid Services "Mapping Medicare Disparities" Tool

Among Medicare recipients in 2020, Chelan County residents have a lower rate of ED visits than the nation and a similar rate to the State, suggesting that Chelan residents receive appropriate outpatient care (**Exhibit 32'**). This remains true for several age cohorts among older adults (<64, 65-74), but not for the age groups of 75-84 and 85+. Chelan County's ED visit rate for residents aged 85+ is higher than both the State and national rates, suggesting that injury (e.g., falls) prevention services for the very elderly may be lacking in Chelan County.

Physical Environment

The physical environment is where individuals live, learn, work, and play. People interact with their physical environment through the air they breathe, water they drink, houses they live in, and the transportation they access to travel around the community. Poor physical environments can affect the ability of our families and neighbors to live long and healthy lives.

Our collective health and well-being depend on equitable opportunities for everyone, yet across and within counties there are stark differences in the opportunities to live in safe, affordable homes, especially for people with low incomes and people of color.

Housing

Stable, affordable housing can provide a safe environment for families to live, learn, grow, and form social bonds. Housing is often the single largest expense for a family, and when a large proportion of a paycheck goes to paying the rent or mortgage, the housing cost burden can force people to choose between keeping a roof over their head or paying for other essentials such as utilities, food, transportation, or medical care.

What is a cost-burden household?

HUD defines cost-burdened families as those who pay more than 30 percent of their income for housing.

What is a severe cost-burdened household?

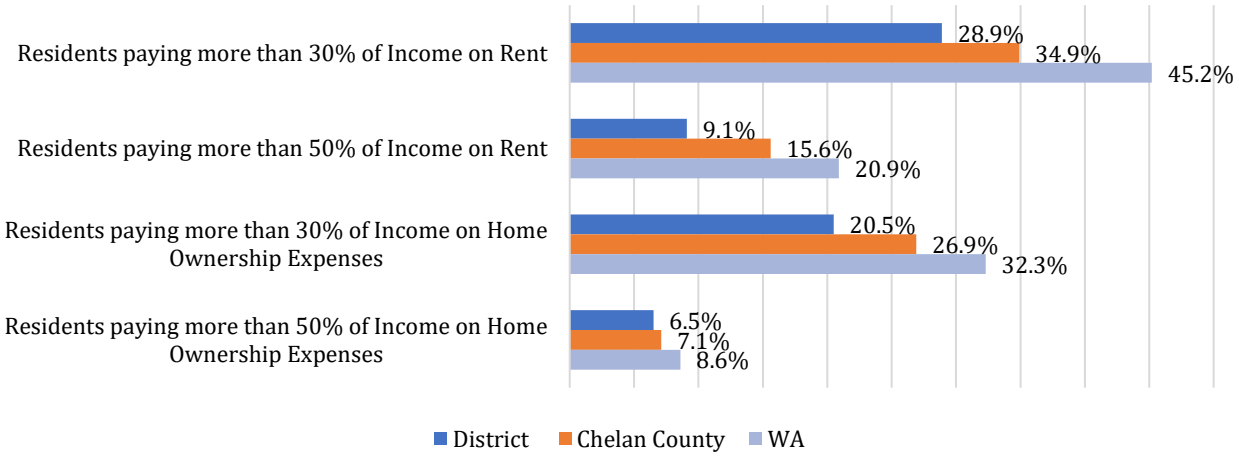
HUD defines severe cost-burdened families as those who pay more than 50 percent of their income for housing.

What is a household with severe housing problems?

A household that faces at least 1 of 4 major problems: overcrowding, lack of plumbing, lack of kitchen facilities, severe housing cost burden [50% or more of income to housing] is considered to have a severe housing problem.

The percentage of households with severe housing problems is lower in the County than the State. Similarly, while both the County and the District have a lower percentage of cost-burdened and severe cost-burdened households than the State, almost 30% of renters in the District are paying more than 30% of their income on rent and one in five residents are paying more than 30% of their income on homeownership costs (**Exhibit 33**).

Exhibit 33: Housing Cost-Burdened and Severe Cost-Burdened Households



There continues to be an urgent lack of home health aides for older adults in the community, and a lack of assisted-living facilities for those who need additional help with their activities of daily living. The single assisted-living facility in the District has only 41 rooms, and only three adult family homes exist, with a total of 18 beds. There is no home health agency physically based in the District, although there are several in Wenatchee that provide services. Finally, there are no adult daycare options in the District.

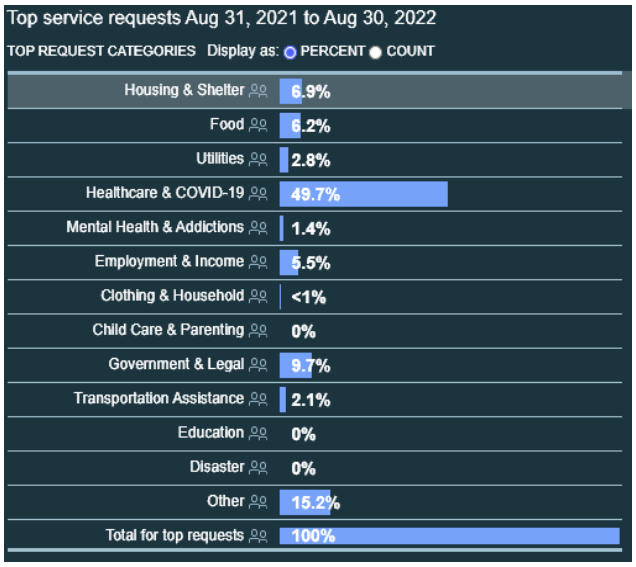
Homelessness

Point-in-time counts are done every year to better understand the population of individuals who are experiencing chronic and acute homelessness. Up until 2019, the counties of Chelan and Douglas did a joint point-in-time count, and they resumed a joint count in 2022. In the 2020 measure, Chelan County had 94% of the total sheltered and unsheltered homeless individuals and 100% of the chronically homeless individuals. The 2022 combined data shows 398 sheltered and unsheltered homeless individuals in the Chelan and Douglas counties and 121 chronically homeless individuals.

2-1-1 Counts

Washington 2-1-1 is the State's "go to" system for Washingtonians in need of accurate community health and human service information and referrals. 2-1-1 is a free, confidential community service and one-stop connection to the local services residents need, such as utility assistance, food, housing, health care, childcare, after-school programs, elder care, crisis intervention, and more. The pandemic has radically changed the system given the increase in calls for vaccination appointments. **Exhibit 34** shows that between August 2021 and August 2022, nearly half of the 145 requests coming from Leavenworth/Plain were related to health care and COVID-19 (49.7%). The same data shows that of the 6.9% of housing and shelter requests, over half were for rent assistance, highlighting the economic impact of the COVID-19 pandemic. Similar rates of requests exist across the District.

Exhibit 34: Leavenworth/Plain 2-1-1 Count

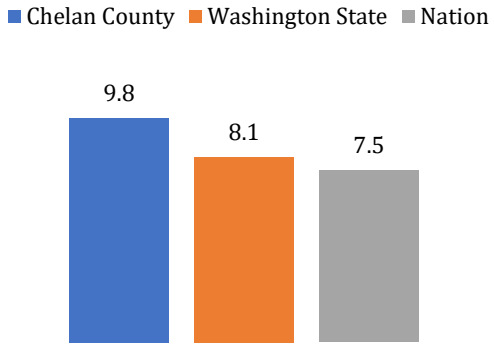


Source: Washington State 2-1-1 Counts, 2022

Air and Water Quality

Clean air and safe water are necessary for good health. Air pollution (especially fine particulate matter) is associated with increased asthma rates and lung diseases, and an increase in the risk of premature death from heart or lung disease. Air Pollution – Particulate Matter is a measure of the fine particulate matter in the air. It is reported as the average daily density of fine particulate matter in micrograms per cubic meter. Chelan County has a higher average density of fine particulate matter in the air than Washington or the Nation (**Exhibit 35**).

Exhibit 35: Air Pollution – Particulate Matter



Source: RWJF County Health Rankings, 2022

Water contaminated with chemicals, pesticides, or other contaminants can lead to illness, infection, and increased risks of cancer. An increase in drinking water violations has also been shown to increase health care expenditures. Between 3-10% of community water systems experience a violation each year. At least one community water system in Chelan County reported a health-based drinking water violation in 2020.

Community Convening

Cascade's CHNA process involved engaging the community to provide input regarding unmet health needs and priorities. In the Fall of 2022, Cascade sent out electronic surveys to gather feedback from the community. To date, nearly 240 responses have been received. 44% of respondents were 65+, 87% were from Leavenworth, and 9% identified as Hispanic/Latino or spoke a language other than English at home.

Because the survey over-sampled the 65+ age group (44% of survey respondents, compared to 27% in the District population), survey results compare respondents under the age of 65 and those 65 and older.

The first part of the survey focused on assessing respondents' insights on the priorities Cascade established in the 2020-2022 CHNA, including:

- Child and Family Wellness
- Aging in Place
- Poverty and the Working Poor

Exhibit 36: On a scale from 1 (no improvement/progress) to 5 (much improvement/progress), have you seen or experienced any positive change in the CHNA focus areas? Under 65

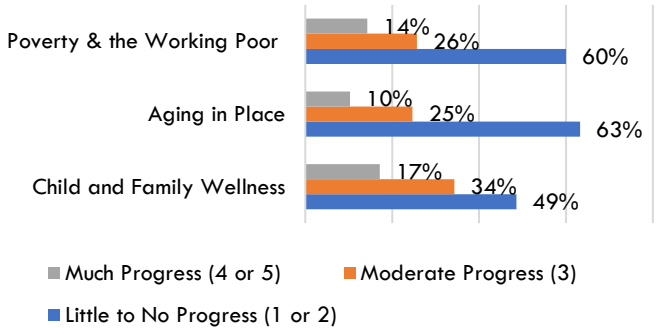
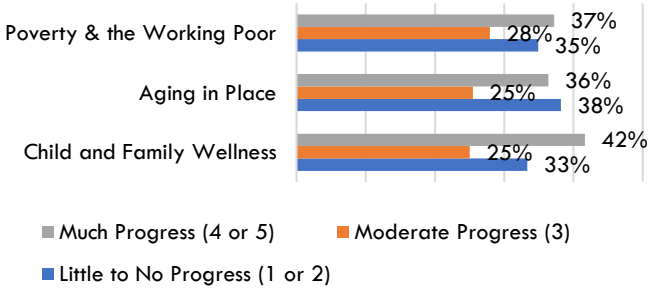


Exhibit 37: On a scale from 1 (no improvement/progress) to 5 (much improvement/progress), have you seen or experienced any positive change in the CHNA focus areas? 65+



Of respondents who had an opinion, those under 65 (**Exhibit 36**) identified significantly less progress in the CHNA priorities than those 65 and over (**Exhibit 37**). Related to poverty and the working poor, 60% of those under 65 saw little to no progress, compared to just 35% of those 65+. Similarly, 63% of those under 65 saw little to no progress related to aging in place, compared to 38% in the 65+ age group. While those under 65 also saw less improvement in child and family wellness, the discrepancy between the groups was not as significant. 49% saw little to no improvement in the under 65 group, compared to 33% in the 65 and older group. It is also important to note that over 30% of those under 65 responded "Do not know/Prefer not to answer," and 40-50% in the 65+ age group responded as such.

As seen in **Exhibits 38** and **39**, the overwhelming majority of respondents from both age cohorts agreed that these same focus areas should continue to be made priorities for the next three years.

Exhibit 38: Which of these focus areas should continue to be priorities over the next three years? Under 65

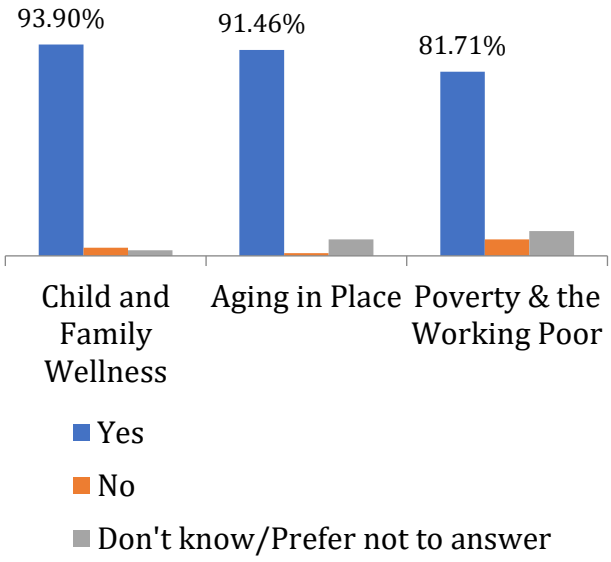
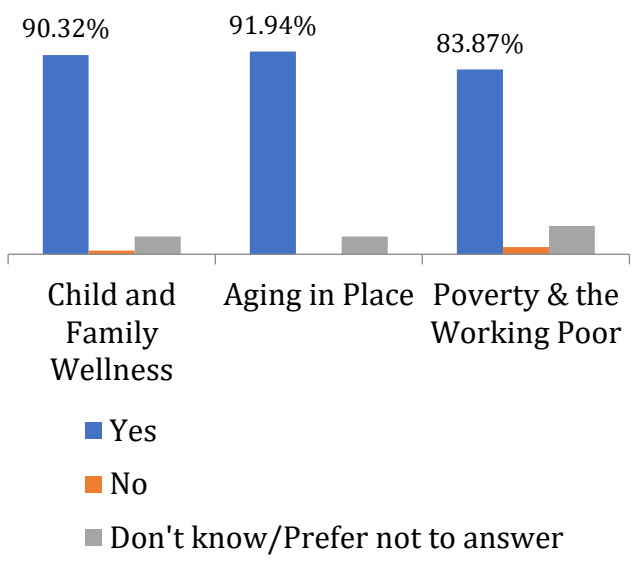


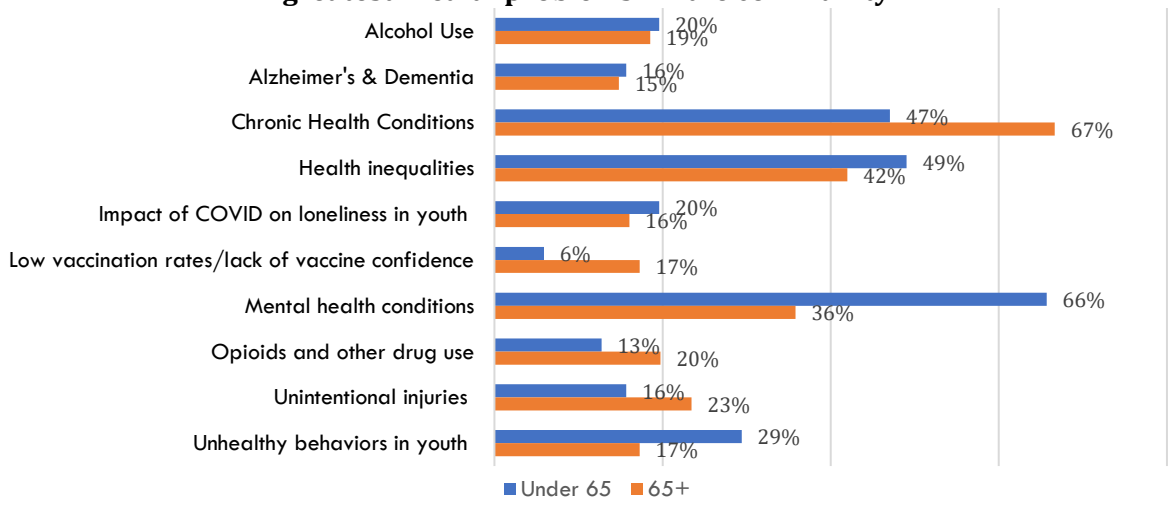
Exhibit 39: Which of these focus areas should continue to be priorities over the next three years? 65+



Respondents were then asked to rate the overall health of the communities served by Cascade. Those 65+ thought the community was healthier than the under 65 cohort. 55% rating the community as healthy or very healthy while 39% of respondents under 65 rating the community as healthy or very healthy.

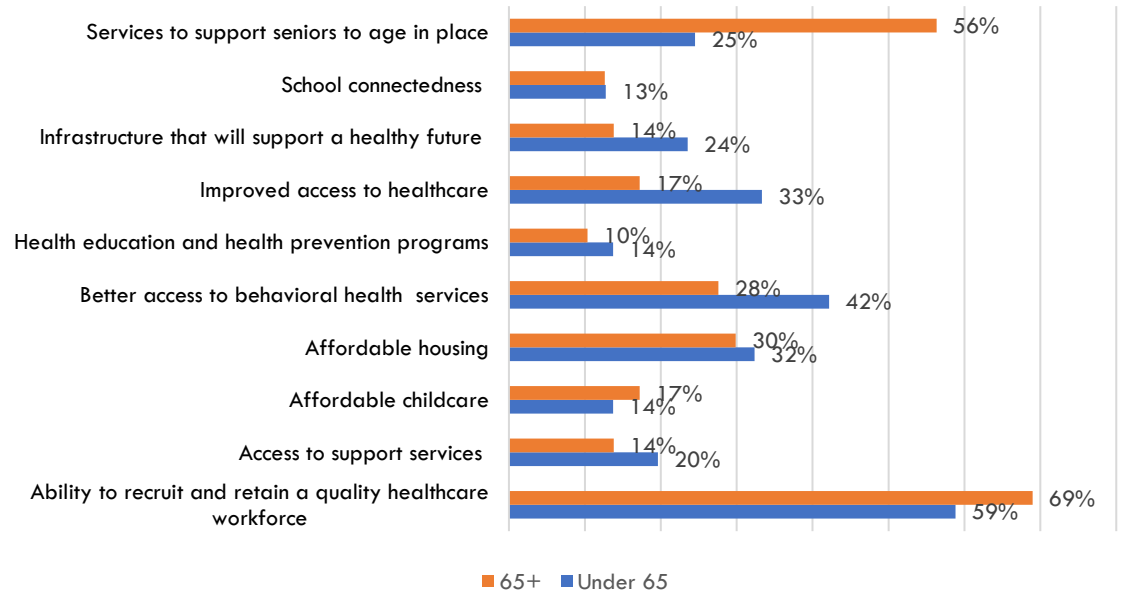
In order to understand the factors that go into the respondents' beliefs about the health of the community, they were given a list of 12 factors and asked to "*identify the three greatest health problems in the community*". **Exhibit 40** shows that both cohorts identified mental health, chronic conditions, and health inequities as the top three priorities. Mental health was identified as the #1 problem in the under 65 cohort, followed by chronic health conditions and health inequities. In the 65+ population, chronic health conditions were identified as #1, followed by health inequalities and mental health.

Exhibit 40: In the following list, what do you think are the three greatest "health problems" in the community?



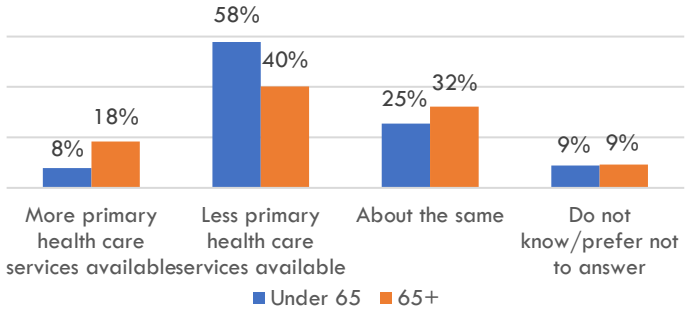
Respondents were then provided a list of factors and were asked to "*Identify the top three most important factors that will improve the health and quality of life in the Community?*" **Exhibit 41** shows that for both age cohorts, the ability to recruit and retain a quality healthcare workforce rose to the top, with 59% of the population under 65 and 69% of the population 65 and older identifying it as the number one factor. Coming in second place for the under-65 population is behavioral health; the second choice for the 65+ group is support for aging in place.

Exhibit 41: Please identify the top three most important factors that will improve the health and quality of life in the community.



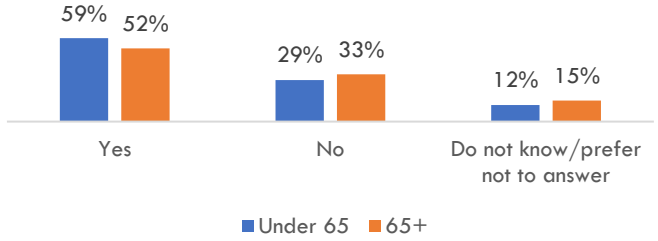
In terms of primary care access, those under 65, thought there was less primary care access over the last few years (58%) than the 65+ population. Nearly 20% of the 65+ population thought there was more primary care services available, compared to under 10% of the under 65 cohort (Exhibit 42).

Exhibit 42: In the last few years, in terms of primary health care access in our community, do you think there are:



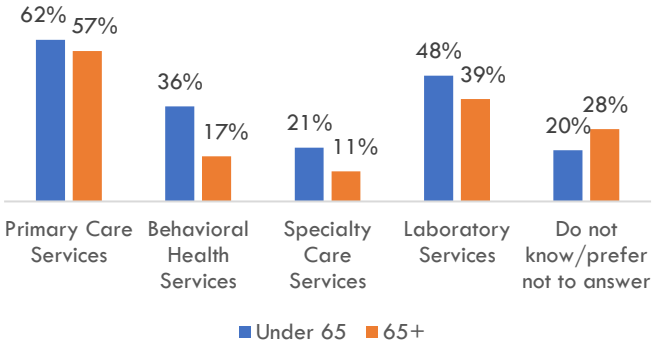
Similarly, almost 90% of respondents 65+ reported having a primary care provider, compared to 68% of those under 65. About half of both cohorts are waiting longer than a week, but less than a month, for non-urgent health visits. However, the 65+ population tends to be seen earlier and have fewer wait times that are over one month. While more members of the under 65 group report finding the wait times unreasonable), both cohorts acknowledge that wait times have changed and are now longer.

Exhibit 43: Do you think having a mobile or travelling clinic that would provide services closer to your community, home, school, or workplace would help improve access to care?



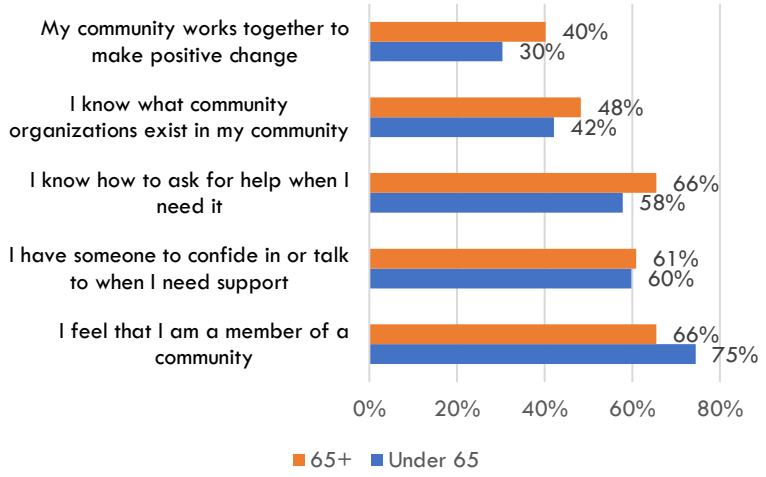
When asked if they faced challenges finding transportation or otherwise getting to existing primary clinics, only around 7% said yes. However, as identified in **Exhibit 43,** the majority of respondents thought that a mobile or travelling clinic would improve access to care (59% of those under 65 and 52% of those 65 and older). Both cohorts report a desire to see primary care and lab services offered in a mobile clinic (**Exhibits 44**). The under 65 population is also more interested in behavioral health services offered via mobile van.

Exhibit 44: Which services would need to be provided in a mobile clinic to make it most useful/available to you?



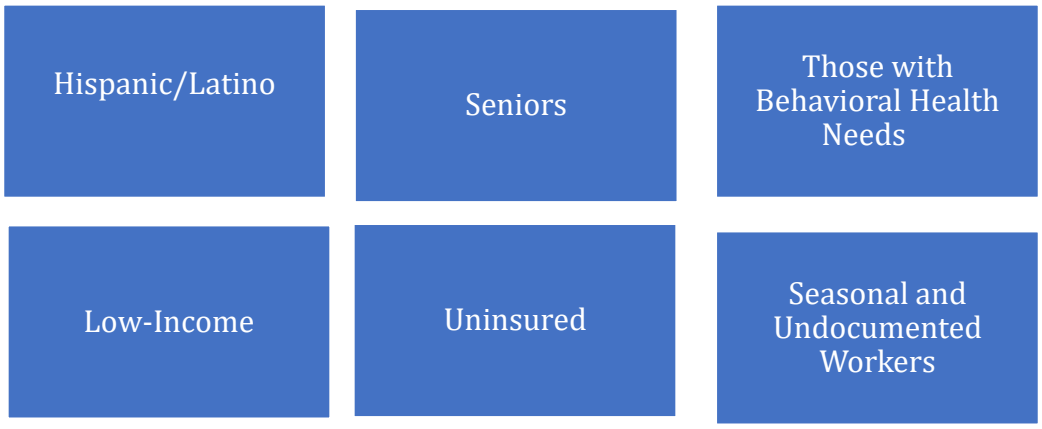
Both cohorts feel that they are connected to the community, but those under 65 feel that the community "works together to make positive change" at only 60% the rate of the 65+ population **(Exhibit 45).**

Exhibit 45: Which of the following statements reflect your sense of community connectedness?



Finally, respondents were asked if they were aware of any specific populations in the community who are less healthy or are experiencing greater inequalities. Consistently, respondents identified the populations in **Exhibit 46**. The top three groups identified were: the Hispanic/Latino population, Seniors, those with behavioral health needs, and the low-income population.

Exhibit 46: Are you aware of any specific populations in the community that are less health or are experiencing greater inequalities?



Prioritized Community Health Needs

The data presented in this CHNA identifies a relatively heathy community with pockets of disparities, including those living in poverty, ALICE households and other traditionally underserved groups. The data suggest behavioral health needs persist and recently, what has emerged for many community residents, is lack of timely access to primary care. The community convening confirmed these results, and importantly identified that the community served by Cascade has slightly differing perceptions of needs and gaps based on age. While both cohorts believe that the priorities established in the 2020-2022 CHNA should continue, the under 65 cohort identifies mental health as the top gap, while the 65+ identifies chronic health conditions as the top gap. Both cohorts believe that the number one priority for improving the community's health is the ability to recruit and retain a quality healthcare workforce. In second place for the under 65 population is behavioral health. The second choice for the 65+ group is support for aging in place.

Concurrent with this CHNA process, Cascade was also undertaking a strategic plan update. In that process the need to provide accessible, equitable, quality, and safe care was identified as a concern and highlighted as a top issue to address. To do so, Cascade has aligned the CHNA priorities and the strategic plan with a laser focus on attracting, engaging, developing, and supporting wellbeing in our workforce and on innovations and workflows to increase efficiencies in primary care so that providers are unencumbered and can see more patients per day. We expect this to be accomplished by addressing coverage of the ED, hospital, and clinics, by implementing team-based care and by optimizing existing systems and workflows. To further enhance access, Cascade proposes to explore off-campus delivery strategies and actively work to build trust in traditionally underserved communities.

At this time, Cascade has built off and refined the 2020-2022 priorities with more focused strategies. The strategies will be further vetted during the Implementation Plan development process. Consistent with CHNA federal requirements, for needs identified that Cascade cannot lead, we will note why, and identify and engage with other organizations in the communities that may be better positioned to address those needs.

The 2023-2025 Priorities and strategies to be further developed during implementation planning include:

1. **Child and Family Wellness, with Particular Focus on Primary Care Access and Youth Behavioral Health:**
   - *Innovations to increase access to primary care, including mitigating lack of providers, language, trust, and service locations; and by focusing on recruiting and retaining staff*
   - *Continuing growth in behavioral health programming, including substance abuse and opioid prescribing*
   - *Continuing outreach and partnership with the schools*

2. **Aging in Place:**
   - *Innovations to increase access to care*
   - *Increasing use of mobile clinic and mobile integrated care*
   - *Focus on management of chronic diseases*
   - *Advocating for more community-based services for elderly needing additional support*

3. **Equity, and Building Trust in Traditionally Underserved Communities**
   - *Primary care that is accessible and available*
   - *Building trust and recognition that all are welcome at Cascade*
   - *Continuing existing and growing new partnerships to support our traditionally underserved*
   - *Development of a Patient and Family Engagement Council that actively seeks the voice of these communities*

Implementation Plan

Consistent with 26 CFR § 1.501(r)-3, Cascade must adopt an Implementation Strategy on or before the 15th day of the fifth month after the end the taxable year in which the CHNA is adopted, or by May 15, 2023.

Prior to this date, the Implementation Plan will be presented to the Board of Commissioners for review. Once approved, the Implementation Plan will be appended to this CHNA and widely disseminated. It will serve as Cascade Medical's guidance for the next three years in prioritizing and decision-making regarding resources and will guide the development of an annual plan that operationalizes each initiative.

The Implementation Plan, which has been informed by community stakeholders, partners, our Board of Commissioners, and employees, including medical staff, dovetails and supports Cascade Medical's three-year organizational strategic plan.

CASCADE MEDICAL
PARTNERS IN YOUR HEALTH

Community Health Needs Assessment
Implementation Plan
2023 – 2025

The Board of Commissioners of Chelan County Public Hospital District No 1, dba Cascade Medical, adopted its 2023-2025 Community Health Needs Assessment (CHNA) in December of 2022. This Implementation Plan is in support of the CHNA and was informed by community stakeholders, partners, the Board of Commissioners, and employees, including medical staff. It has also been integrated into Cascade Medical's three-year organizational strategic plan.

The data presented in the CHNA identified a relatively heathy community with pockets of disparities, including those living in poverty and other traditionally underserved groups. The data suggest behavioral health needs persist and recently, what has emerged for many community residents, is lack of timely access to primary care. The community convening confirmed these results, and importantly identified that the community served by Cascade has slightly differing perceptions of needs and gaps based on age and race or ethnicity.

Between the adoption of the CHNA and the development of the Implementation Plan, Cascade Medical continued outreach with a specific focus on those traditionally underserved residents of our communities. By the end of January 2023, we had more robust engagement with those who report their primary language to be Spanish. Cascade Medical used this additional information as it developed the below strategies.

The adopted CHNA priorities and focus areas include:

1. **Child and Family Wellness, with Particular Focus on Primary Care Access and Youth Behavioral Health:**
    a) *Innovations to increase access to primary care, including mitigating lack of providers, language, trust, and service locations; and by focusing on recruiting and retaining staff.*
    b) *Continuing growth in behavioral health programming, including substance abuse and opioid prescribing.*
    c) *Continuing outreach and partnership with the schools.*

2. **Aging in Place:**
    a) *Innovations to increase access to care.*
    b) *Increasing use of mobile clinic and mobile integrated care.*
    c) *Focus on management of chronic diseases.*
    d) *Advocating for more community-based services for elderly needing additional support.*

3. **Equity, and Building Trust in Traditionally Underserved Communities:**
    a) *Primary care that is accessible and available.*
    b) *Building trust and recognition that all are welcome at Cascade.*
    c) *Continuing existing and growing new partnerships to support our traditionally underserved.*
    d) *Development of a Patient and Family Engagement Council that actively seeks the voice of these communities.*

The table below delineates Cascade Medical's planned implementation tactics to address these three priorities and focus areas during the 2023–2025 period. Progress and completion will be tracked through a combination of standard quarterly strategic plan dashboarding as well as other methods of regular monitoring.

Tactic / Initiative	Timeline	Focus Area
Implement Team-based Care	By end of 2023	1a, 2a, 3a
Implement Hospitalist Program	By end of 2023	1a, 2a, 3a
Develop and Implement a Living Well Program	Fully implemented by end of 2025	1a
Continue MA Apprenticeship Program	Continue through 2025	1a, 2a, 3a
Implement CNA Apprenticeship Program	By end of 2023	1a
Continue Robust Student Preceptorship Programs	Continue through 2025	1a, 1c, 3a
Build and Implement Robust Education Program Across the Organization	Fully implemented by end of 2025	1a
Utilize Consulting Pharmacy Resources for Prescription Refills	Implemented by end of 2023	1a, 3a
Expand Telepsychiatry Referral Options	Continue through 2025	1b
Explore Restarting School-Based Clinic	By end of 2024	1a, 1c, 3a, 3c
Explore Certification for Swing Bed Program	By end of 2023	2a

Tactic / Initiative	Timeline	Focus Area
Certify Telestroke Program	By end of 2023	2a
Implement Cardiac Rehab program	By end of 2023	2a
Optimize Utilization of Mobile Clinic	By end of 2023 & continuing	1a, 2a, 2b, 3a, 3b, 3c
Finalize Mobile Integrated Health Needs Assessment and Implement Program	By end of 2023 & continuing	1a, 2a, 2b, 2c, 3a
Restart Chronic Care Management Program	By end of 2023	2c
Continue to Conduct and Grow Chronic Disease Group Classes	Continue through 2025	2c
Develop and Implement Gender-Affirming Care Program	By end of 2024	3a, 3b
Continue Focused DEI Work and Participation in WSHA DEI Collaborative	Continue through 2025	3a, 3b, 3c
Continue Partnership with UV MEND for Free Clinic	Continue through 2025	3a, 3b, 3c
Expand Opportunities for Employment for Disabled Adults	By end of 2023 & continuing	3b, 3c
Implement Patient & Family Advisory Council	By end of 2023 & continuing	3d
Explore Options to Replace Translation Services Provider	By end of 2023	3a, 3b, 3c
Initiate Full External Communication Plan	By end of 2023	3a, 3b, 3c, 3d
Continued Focus on Dual Language Recruitment	Continue through 2025	1a, 3a, 3b
Continue Free Sports Physicals Night with Vaccination Support	Continue through 2025	1a, 1c
Continue to Offer Drive Through Flu Shot Clinics	Continue through 2025	1a, 2a
Explore IHI's Concept of an Age Friendly Health System	By end of 2024	2a, 2b, 2c, 2d
Develop Expanded Hours for Clinic/Urgent Care Services	By end of 2024	1a, 3a, 3b
Explore Additional Service Line Expansion including for Wound Care, Infusion Services, and Outpatient Ultrasound	By end of 2023 & continuing	2a, 2c, 3a
Implement OTAGO (Community Fall Prevention Program)	By end of 2023	2a, 2d, 1a
Continue working with North Central Region Fall Prevention Coalition and host fall prevention education event	By end of 2023 & continuing	2a, 2d, 1a

Tactic / Initiative	Timeline	Focus Area
Explore transportation options, including whether DART expansion is possible and understand possibilities about being able to bill for wheelchair van service	By end of 2025	1a, 2a, 2d, 3a, 3c
Continue peer support work	Continue through 2025	1b
Provide behavioral health education to partner organizations' teams, to support their staff working through behavioral health emergencies	By end of 2023 & continuing	1a, 1b, 3c
Provide Cognitive Pyramid training to Mountain Meadows	By end of 2023	2a, 2d
Broaden community events offerings	By end of 2025	3b, 3c
Explore offering behavioral health services in conjunction with the Mobile Clinic	By end of 2025	1a, 1b, 2a, 2b, 3b