Because Your Health Matters

HARBOR REGIONAL HEALTH
2024-2026
COMMUNITY HEALTH NEEDS ASSESSMENT

Approved by the Grays Harbor County Public Hospital District No. 2
Board of Commissioners, December 26, 2023

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Introduction/Overview

Grays Harbor County Public Hospital District No. 2, dba Harbor Regional Health (HRH), is a regional healthcare network providing a broad range of services, including inpatient hospital, emergency, primary care, and specialty services. HRH is licensed for 140 beds on its main campus in Aberdeen, the largest city in the mostly rural Grays Harbor County. It is designated by Medicare as a Sole Community Hospital (SCH), a program created by Congress to support smaller, rural hospitals.

HRH opened as Aberdeen General Hospital in 1897; it was renamed Grays Harbor Community Hospital in 1945, and then rebranded to HRH in 2021. In 1956, the Board made the decision to build a replacement hospital. The project was financed through public donation (60%) and Hill-Burton Act funds (40%). The current hospital building opened in December 1959. In August 2014, the community voted to form the Public Hospital District (PHD).

Harbor Regional Health

Mission

To heal, comfort, and serve everyone with dignity and compassion.

Vision

To be the unified healthcare network of choice, partnering with our community to provide exceptional care with an inspired team.

Today, HRH operates a 24/7 emergency department with a Level 3 trauma designation and provides inpatient hospitalization, including critical care, obstetrics and newborn services, chemical dependency, and medical surgical care. HRH also provides primary and specialty care, and outpatient services like diagnostic imaging and laboratory procedures. With healthcare services provided in Aberdeen, Montesano, Hoquiam, and Westport, HRH sees over 300 patients per day and is one of the region's economic leaders, employing over 500 people and working with partners across the region to ensure that everyone has access to high-quality, compassionate care.

As a PHD, approximately $5,000,000 is assessed and collected annually to benefit hospital operations. This amount represents roughly 5% of the hospital's operating budget. In 2022, HRH provided more than $1.2 million dollars in charity care. Nearly 80% of HRH's patients rely on governmental payers, which typically pay below cost. Many of these patients also receive charity care or some other form of financial assistance.

Harbor Regional Health's Values

Respect: *We embrace diversity and honor the rights and privacy of everyone with dignity and empathy.*

Integrity: *We are fair, honest, ethical, and do the right thing for those we serve.*

Compassion: *We are kind, caring, and respectful to everyone we encounter.*

Responsiveness: *We think creatively and uphold the highest standards of quality, safety, and service, expecting accountability to each other.*

HRH is committed to continued collaboration with our community, employees, and medical professionals to create the path that will best support our District in moving forward. This includes being actively engaged in addressing inequities, reducing disparities, and increasing opportunities for diversity and inclusion to strengthen our connection to all the communities and populations we serve.

Health Facilities Planning & Development, a consulting firm based in Seattle with more than 30 years of experience working with Washington hospitals, facilitated the CHNA process and supported HRH in finalizing this assessment. This CHNA relies on data, and, importantly, input from numerous community members and organizations throughout Grays Harbor County, as well as from our employees and medical professionals. This assessment provides a comprehensive summary and analysis of the quantitative data we collected, the results of our community engagement process, and selected health priorities of focus as we move forward.

Community Description

Well into the 1960s, Grays Harbor County, named after its discoverer, Captain Robert Gray, was largely dependent on the logging and fishing industries. From the 1960s through the 1980s, a combination of increased competition from foreign lumber mills and federal environmental restrictions on timber and fishing led to high rates of unemployment in the area. Today, in addition to wood and timber manufacturing and food production, charter fishing and ocean beaches bring considerable tourism to the area. However, the county consistently experiences higher rates of unemployment and poverty than Washington State as a whole.

Grays Harbor County covers more than 2,000 square miles in western Washington, and its western border is the Pacific Ocean. The county is as large as the state of Delaware and includes 79,741 residents. It is predominantly rural. The hospital itself is located in the city of Aberdeen, the largest city in Grays Harbor County. The population of Aberdeen was 17,191 as of July 2021 census estimates. The next largest city is Hoquiam, with a population of 8,798.

The District is fully contained in the county and its geographic boundaries largely parallel the area commonly referred to as Western Grays Harbor County. The District includes about 78% of the total population of Grays Harbor County. Over 85% of HRH's inpatient discharges were generated by individuals residing within the District, and for these reasons, the District's boundaries are considered the Service Area for this CHNA.

Exhibit 1: HRH District Boundaries & Service Area Map

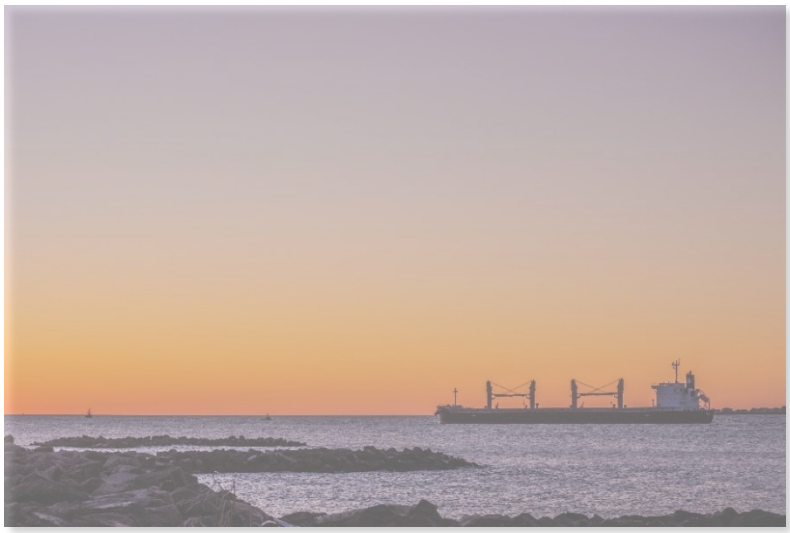
The defined Service Area is the same geography as that used in the HRH's 2021-2023 CHNA, and includes the following zip codes[1]:

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

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

The tribal lands of the Quinault Indian Nation are located within the District, along the coastal areas of the county, and consist of the Quinault and Queets tribes and descendants of five other coastal tribes: Quileute, Hoh, Chehalis, Chinook, and Cowlitz. Major highways in Grays Harbor County include State Route 101, which runs north/south along the coast, and Highways 12 and 8, running east/west and ultimately connecting to Interstate Highway 5 in the east. The state highways converge in the cities of Aberdeen and Hoquiam. Driving time from the city of Aberdeen to the next largest city, Olympia, is roughly one hour. Driving time to either Seattle or Portland, Oregon, is about two and a half hours. It takes about an hour to drive from Lake Quinault in the north end of the District to Aberdeen.

As depicted throughout this CHNA, the District and the county both face a number of health and socioeconomic challenges, including healthcare access being compromised by health professional shortages; higher death rates than the state at large; higher rates of behavioral health concerns, including use of opioids; and higher rates of suicide. The CHNA also depicts that social and economic factors—the social determinants that can contribute to poorer health—are more of a burden within the boundaries of the District and Grays Harbor County than in most other areas of Washington State.



2021-23 CHNA and Accomplishments

HRH's 2021-2023 CHNA identified significant health needs related to healthcare access, behavioral health, health conditions, and social determinants of health in the District, as well as Grays Harbor County in general. **Exhibit 2** summarizes HRH's 2021-2023 priorities and its accomplishments over the last three years related to each of the previously identified priorities.

Exhibit 2: HRH Accomplishments

Priority: Healthcare Access	
Implementation Strategy 1: ***Increase primary care access, reduce unnecessary emergency department and hospital use, and reduce unnecessary outmigration.***	
Action Items	**Accomplishments**
Recruit and retain additional primary care physicians and advanced practice personnel; build healthcare delivery teams in the primary care clinics.	▪ With the assistance of the University of Washington and Premera, developed a Nurse Practitioner (NP) Fellowship program in September 2021. ▪ Hired four Family Medicine NPs to the RHC clinics.
Provide more flexible options for accessing care.	▪ As of October 2023, transitioned the Prompt Care Clinic into a walk-in clinic available to the public. ▪ Added Pediatric services to the Prompt Care Clinic. ▪ Increased availability of same-day appointments.
Evaluate the feasibility of satellite primary care clinics in Ocean Shores/North Beach and Westport.	▪ Developed pro forma and collaborated with interested parties regarding satellite clinics. ▪ Conducted a feasibility study for a mobile health clinic that would be able to serve additional outlying areas.
Integrate specialty care into the primary care clinics, particularly cardiology care, to reduce outmigration**.**	▪ Began offering cardiology clinic services in the Aberdeen Internal Medicine Clinic through partnership with Pulse Heart Institute four days a week.
Continue to improve care coordination efforts to assure seamless care transitions for patients.	▪ Implemented the Enterprise Data Dissemination Informatics Exchange (EDDIE) program to identify frequent users of the ED. ▪ Developing program to connect frequent ED users to Prompt Care Clinic to coordinate and manage their care.
Implementation Strategy 2: ***Improve access to and availability of preventive dental health services for children and dental treatment for underserved adults.***	
Action Items	**Accomplishments**
Evaluate integration of dental services in primary care, with a focus on children and low-income adults.	▪ Engaged with financial consulting company to build the pro forma for the program. ▪ Developing a dental program based on best practices in Washington, including pursuing a rural health clinic (RHC) change in scope to allow cost-based reimbursement for dental services.
Identify grant funding for planning of the appropriate dental clinic model for our community and to help with any necessary capital and operational costs.	▪ Submitted grant application to the Arcora Foundation. A meeting is scheduled with the Foundation to discuss grant application and next steps.

Priority: Behavioral/Mental Health	
Implementation Strategy 3: ***Evaluate telemedicine opportunities to increase access to behavioral health and substance use disorder services throughout the community.***	
Action Items	**Accomplishments**
Expand work with the University of Washington to implement tele-psych services and psychiatric consultation services for primary care physicians and advanced practice personnel.	▪ Weekly communications to primary care physicians and advanced practice personnel through the University of Washington Psychiatry and Addictions Case Conference regarding how to implement a tele-psych program.
Advocate for continuation of the COVID exemptions for the provision of telehealth services by RHCs and enhanced reimbursement for telehealth visits.	▪ Collaborated with the Washington State Hospital Association (WSHA) to advocate for the legislative extension of telehealth reimbursement after the end of the COVID-19 Federal Public Health Emergency.
Implementation Strategy 4: ***Increase behavioral health partnerships and services and increase integration with primary care.***	
Action Items	**Accomplishments**
Continue focus on de-escalation training for HRH healthcare personnel and staff.	▪ Offering the AVADE (Awareness-Vigilance-Avoidance-Defense-Escape/Environment) workplace violence prevention course to healthcare personnel and staff. ▪ As of January 2023, HRH enrolls new employees into the next available AVADE class upon employment.
Continue evidence-based MAT programs and distribution of naloxone kits.	▪ Employees from the hospital and clinics participate in annual Overdose Awareness Day and naloxone kit distribution.
Increase the number of MAT-trained healthcare personnel in primary care clinics.	▪ With the removal of the MAT waiver requirement, all primary care clinic physicians and advanced practice personnel have been educated on the importance of providing MAT services. ▪ Developing policies and procedures to support delivery of MAT services in our Family Medicine clinics.

Priority: Prevention and Management of Chronic Diseases	
Implementation Strategy 5: ***Consistent with the Cascade Pacific Action Alliance (CPAA) Medicaid Transformation Project, standardize care coordination service delivery for individuals with complex needs to support early detection and patient self-management.***	
Action Items	Accomplishments
Engage patients and encourage participation in the CPAA's Chronic Disease Self-Management Program's (CDSMP) educational workshops designed to help people gain self-confidence in their ability to control their symptoms.	▪ Two representatives from the organization received training to provide chronic disease self-management classes virtually. ▪ Three lay leaders completed training in the CDSMP in February 2023. ▪ Opened CDSM 6-week workshops to the public.
Fully implement the Chronic Care Model in the primary care setting, focusing on the development of proactive healthcare teams; care coordination; and patient, family, and healthcare personnel engagement.	▪ Developed a standard workflow in the clinics with appropriate Electronic Health Record (EHR) templates and materials to support care coordination activities. ▪ Built standard reports to collect data on the performance of Diabetes Core Care Measures. ▪ Providing training to all new nurse practitioners or medical assistants on workflows.
Evaluate need for, and ability to secure, additional care coordination staff or resources.	▪ Adopted a screening tool for social determinants of health that has been added to the EHR. ▪ Began utilizing screening tool in the Nurse Practitioner Fellowship clinic with plans to expand to other clinics.
Priority: Economic Development	
Implementation Strategy 6: ***Commit HRH Leadership time and Board-level resources to advocate and support efforts to enhance community infrastructure.***	
Action Items	**Accomplishments**
Support community efforts designed to create more family-wage jobs, more affordable housing, and better transportation.	▪ HRH leadership is collaborating with Greater Grays Harbor Chamber of Commerce and Economic Development Council to cultivate the necessary conditions for business success and community prosperity in Grays Harbor, including collaboration in the Federal Opportunity Zone business tax incentive programs in Aberdeen, Hoquiam, and Pacific Beach. ▪ HRH Administration partners with local high schools and Grays Harbor College to train the next generation of healthcare workforce.

Methodology

The Robert Wood Johnson Foundation's (RWJ) Health Rankings Model emphasizes the many factors in population health that, if improved, can help make communities healthier places to live, learn, work, and play. In the Health Rankings Model, the current health of a community is referred to as "health outcomes" and is calculated by rates of mortality (premature death) and morbidity (chronic diseases). In turn, these health outcomes are influenced by "health factors" in a community, ranked by a calculation of various health behaviors, clinical care, social and economic factors, and physical environment measures. Health factors represent what will influence the future health of a community, while health outcomes represent how healthy a community is today.

Exhibit 3: RWJ County Health Rankings, 2020 vs. 2023

Composite Scores	Grays Harbor County 2020	2023	
Overall Health Outcomes	37	37	
Length of Life	37	37	
Quality of Life	35	38	↓
Overall Health Factors	33	35	↓
Health Behaviors	32	36	↓
Clinical Care	33	33	
Social & Economic Factors	36	35	↑
Physical Environment	7	8	↓

The RWJ County Health Rankings compares counties within each state on more than 30 factors. Washington's 39 counties are ranked according to a variety of health measures, and counties are ranked relative to the health of other counties in the state. The 2020 and 2023 summary composite scores for Grays Harbor County identified in **Exhibit 3** show that Grays Harbor County ranks in the lower quartile of Washington's 39 counties in both Overall Health Outcomes (rank of 37) and Overall Health Factors (rank of 35), with the Health Factors ranking decreasing between 2020 and 2023.

It is within this context that HRH's 2024-2026 Community Health Needs Assessment (CHNA) was undertaken. This CHNA builds off the HRH's 2021-2023 CHNA and includes both primary and secondary data to create a comprehensive understanding of the District and county's health, health status, and healthcare needs. Demographics and multiple indicators of both health outcomes and health factors were examined. Where possible, data was collected specific to the District, and where not, county-level data was used.

Demographics and Social Determinants of Health

As identified in **Exhibit 4**, the District and Grays Harbor County are expected to grow at a slower rate (3.7% and 3.8%, respectively) than Washington State (4.3%) between 2024-2029. The percentage of the population that is 65+ remains higher in the District and county (over 25%) than the state (15%) and is expected to continue to grow through 2029. In fact, the 0-64 age cohort is projected to decrease slightly in the District and county (-0.5% and -0.1%, respectively) while growing slightly statewide (1.9%).

Exhibit 4: District, County, and State Population, by Age

	District		Grays Harbor County		Washington State	
Population	**2024 Est.**	**% Chg. 2024-2029**	**2024 Est.**	**% Chg. 2024-2029**	**2024 Est.**	**% Chg. 2024-2029**
Total Population	**61,792**	3.7%	**79,741**	3.8%	**7,904,020**	4.3%
% 0-64	**73.6%**	-0.5%	**74.6%**	-0.1%	**82.0%**	1.9%
% 65+	**26.4%**	15.4%	**25.4%**	15.2%	**18.0%**	15.3%

Source: Claritas, 2022

Exhibit 5 provides more detail on the District's population and demonstrates that the 0-64 cohort decreased slightly between 2020-2024 (2.1%), with the most significant decrease (5.6%) in the 45-64 population. The 0-64 population is expected to decrease another 0.5% by 2029, relative to the state's 2% growth in that population. Meanwhile, the 65+ population grew 14.8% between 2020-2024, and is expected to grow another 15.4% by 2029, increasing to account for nearly 30% of the total population.

Exhibit 5: The District Population

	2020	% of Tot. Pop.	2024 Est.	% of Tot. Pop.	% Chg. 2020-2024	2029 Proj.	% of Tot. Pop.	% Chg. 2024-2029
Tot. Pop.	***60,685***	***100.0%***	***61,792***	***100.0%***	***1.8%***	***64,088***	***100.0%***	***3.7%***
Pop. by Age								
0-17	*11,670*	*19.2%*	*11,296*	*18.3%*	*-3.2%*	*11,148*	*17.4%*	*-1.3%*
18-44	*18,292*	*30.1%*	*18,600*	*30.1%*	*1.7%*	*19,389*	*30.3%*	*4.2%*
45-64	*16,517*	*27.2%*	*15,584*	*25.2%*	*-5.6%*	*14,724*	*23.0%*	*-5.5%*
65-74	*9,140*	*15.1%*	*10,342*	*16.7%*	*13.2%*	*11,585*	*18.1%*	*12.0%*
75-84	*3,880*	*6.4%*	*4,669*	*7.6%*	*20.3%*	*5,761*	*9.0%*	*23.4%*
85+	*1,186*	*2.0%*	*1,301*	*2.1%*	*9.7%*	*1,481*	*2.3%*	*13.8%*
Tot. 0-64	*46,479*	*76.6%*	*45,480*	*73.6%*	*-2.1%*	*45,261*	*70.6%*	*-0.5%*
Tot. 65 +	*14,206*	*23.4%*	*16,312*	*26.4%*	*14.8%*	*18,827*	*29.4%*	*15.4%*
AN/AI	*3,188*	*5.3%*	*3,030*	*4.9%*	*-5.0%*	*2,851*	*4.4%*	*-5.9%*
Hispanic	*6,552*	*10.8%*	*7,208*	*11.7%*	*10.0%*	*8,218*	*12.8%*	*14.0%*
Fem. 15-44	*9,310*	*15.3%*	*9,525*	*15.4%*	*2.3%*	*9,831*	*15.3%*	*3.2%*

Source: Nielsen Claritas, 2022

The District is significantly less diverse than Washington State, with 67% of the statewide population identifying as White, compared to 77% for the District. The only cohort that represents a higher percentage of the population in the District versus the state is the American Indian/Alaska Native (AI/AN) population, at 3.6% versus 0.9% statewide; this despite the District's AI/AN population decreasing in size since 2020 and expected continued decline through 2029. Importantly, while the percentage of the population that is Hispanic is below that of the state, the Hispanic population is expected to grow through 2029 and currently accounts for 12% of the population.

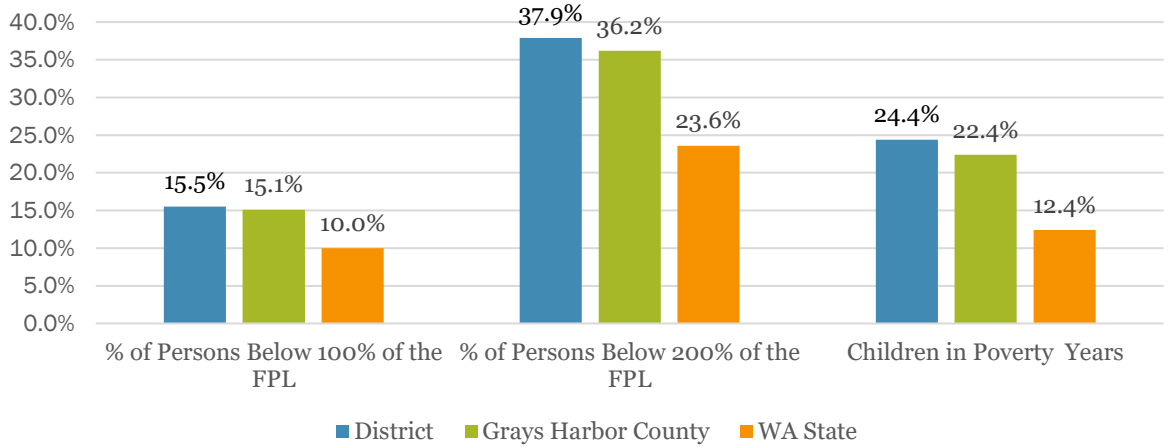
Social Determinants of Health

Social determinants of health—the conditions under which people are born, grow, live, work, and play—greatly influence the health of a community and its residents. Income, poverty, education, and graduation rates are all examples of social determinants of health.

Exhibit 6 demonstrates that District and Grays Harbor County residents are burdened by higher rates of poverty than the state, with over 15% of District and county residents at or below 100% of the Federal Poverty Level (FPL), compared to 10% statewide, and nearly 40% of District and county residents struggling to make ends meet (at or below 200% of the FPL), compared to 24% statewide.

Importantly, the rates of children living in poverty in the District (those under the age of 18 in households at or below 100% of the FPL) are double that of the state. Poverty can result in an increased risk of mortality, prevalence of medical conditions and disease incidence, depression, intimate partner violence, and poor health behaviors. A 1990 study found that if poverty were considered a cause of death in the U.S., it would rank among the top 10 causes.

Exhibit 6: District, County, and State Poverty Statistics



The median household income in the District is also 60% lower than that of the state ($51,349 versus $82,400). **Exhibit 7** additionally demonstrates the significant racial and ethnic disparities in income levels that exist within the District and the state. The median household incomes for the American Indian/Alaska Native population ($32,538) and the Hispanic/Latino population ($45,822) are significantly less than that of the Non-Hispanic White population ($52,172) in the District. These disparities are significant because individuals with lower incomes have less money to spend taking care of themselves and their families, affecting such decisions as paying for visits to the doctor, medicine, or purchasing healthy food.

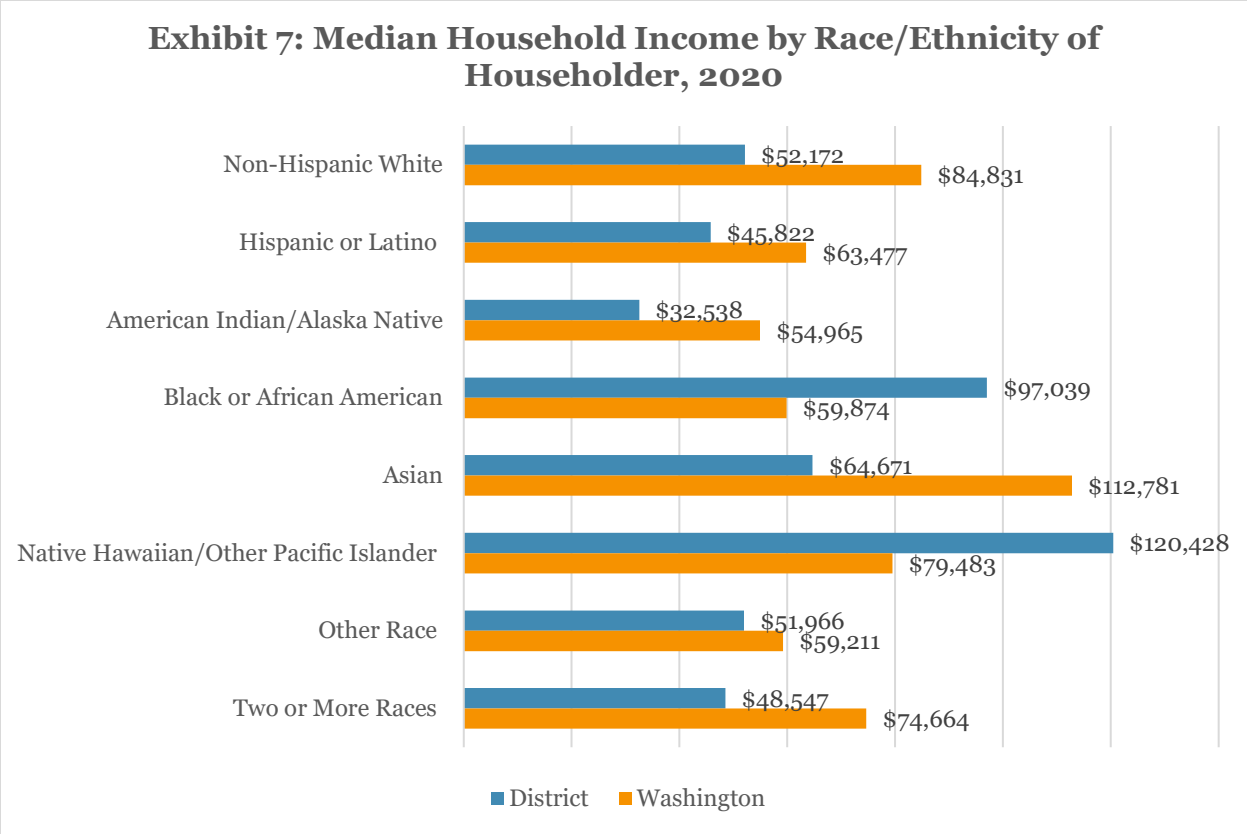


Exhibit 8 identifies that while the county fares well in terms of those residents aged 25 or older graduating from high school, the percentage of adults age 24-44 who have completed some post-secondary education is well below state and national averages. Higher educational attainment is linked to higher future income. Individuals who have not earned a high school diploma have a median income 25% less than those who have graduated high school, half that of those with a college degree, and two-thirds less than those with a graduate or professional degree. Not only does one's education level affect their health, but education can have multigenerational implications that also make it an important measure for the health of future generations.

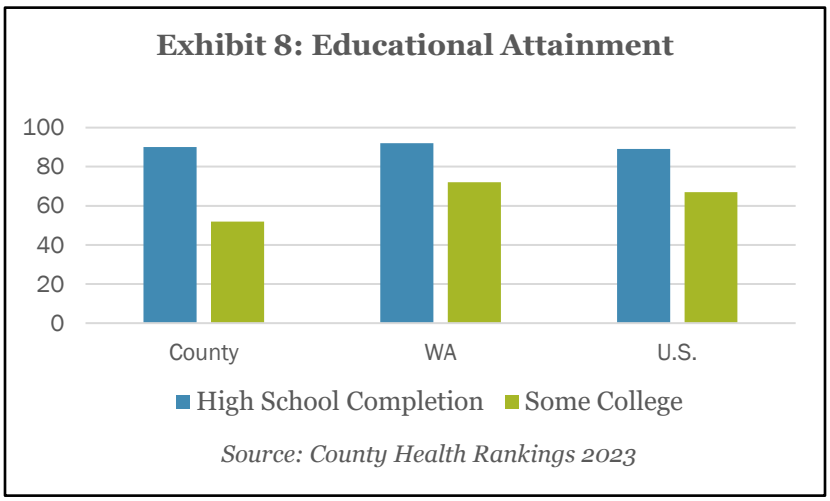


Exhibit 9 shows that the District also has a higher uninsured rate (7.7%) than the county (7.2%) or state (6.4%). The District and county also have significantly higher rates of public health insurance coverage than the state.

Exhibit 9: Health Insurance Rates			
	District	**County**	**State**
No Health Insurance Coverage	**7.7%**	**7.2%**	**6.4%**
With Health Insurance Coverage:	92.4%	92.8%	93.6%
Public Health Coverage	53.5%	51.3%	35.4%
Private Health Insurance	56.9%	59.0%	71.2%
Source: U.S. Census, American Community Survey 5-Year Estimates, 2021			

Stable, affordable housing can provide a safe environment for families to live, learn, and grow. However, housing is often a family's largest expense. When rent or mortgage payments are too high, families are forced to make difficult choices between paying for shelter and paying for other essentials such as utilities, food, transportation, or medical care.

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

Exhibit 10: Housing and Homelessness, 2023	
	**Cost-Burdened Households** Grays Harbor County: 12% Washington State: 14%
	**Severe Housing Problems** Grays Harbor County: 14% Washington State: 15%
	**Homeless** Grays Harbor County: 202 Washington State: 20,399
Source: County Health Rankings, Washington State Department of Commerce	

There is a strong and growing evidence base also linking stable and affordable housing to health. When too much of a paycheck goes toward the rent or mortgage, it makes it hard to afford to go to the doctor, cover the utility bills, or maintain reliable transportation to work or school.

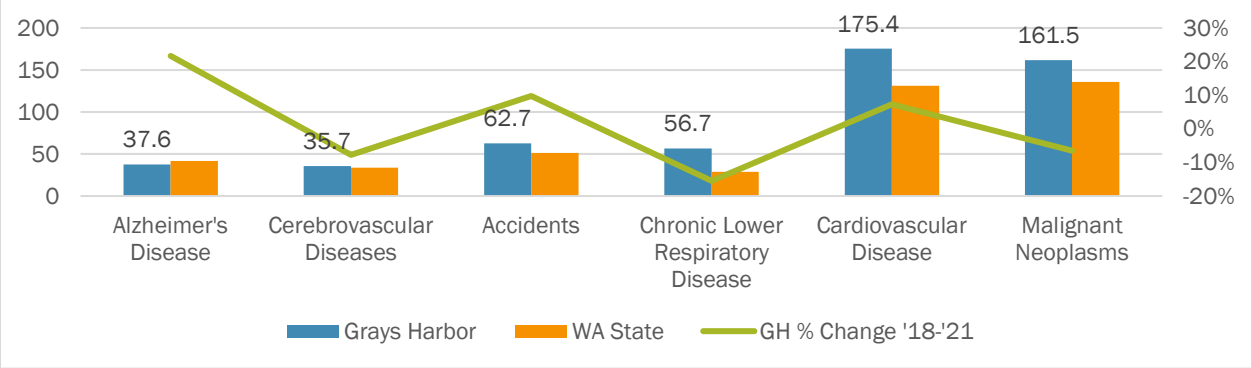
Exhibit 10 identifies the county's cost-burdened households and those with severe housing problems. Both are in line with the state and both measures have improved since 2019, with cost-burdened households down 2% and those experiencing severe housing problems down 8%.

That said, almost one-fifth of Grays Harbor County residents do not have safe, affordable housing, and 202 community members are homeless, as measured by the Department of Commerce's Point in Time data. This is up over 40% since 2019. Being homeless puts an individual at increased risk of multiple health issues, including psychiatric illness, substance use, chronic disease, musculoskeletal disorders, skin and foot problems, poor oral health, and infectious diseases such as tuberculosis, hepatitis C, and HIV infection.

The District's Health Status

In 2021, Grays Harbor County had the fourth highest death rate (1,000.8 per 100,000) in Washington State. This compares to the state rate of 757.4 per 100,000. As depicted in **Exhibit 11**, and consistent with the state, the leading causes of death in Grays Harbor County are cancer and heart disease. However, both cancer and heart disease death rates are significantly higher in the county than the state. The county also experienced a 21% increase in deaths from Alzheimer's disease and an over 10% growth in deaths caused by accidents.

Exhibit 11: Leading Causes of Death per 100,000 Residents



Source: 2021 Death Rates from WA DOH and Vital Statistics Summary

District residents also experience a greater burden of chronic diseases than the rest of Washington. As **Exhibit 12** illustrates, the self-reported rates of diabetes among county and District residents are double that of Washington State residents, and obesity is 7% higher in the District than the state.

Exhibit 12: Self-Reported Chronic Health Conditions in Adults			
	District	**County**	**State**
Have you ever been told you have diabetes?	18%	18%	9%
Calculated body mass index category (obese)	31%	32%	29%
Source 2021 CDC BRFSS			

Health Risk Behaviors and Outcomes

The most common behavioral contributors to chronic disease, morbidity, or mortality include diet and activity patterns; the use of alcohol, drugs, and tobacco; firearms; and motor vehicle accidents. Importantly, the social and economic costs related to these behaviors can all be greatly reduced by changes in an individual's behaviors.

Exhibit 13 shows that the District ranks significantly below Washington State on many health behaviors that lead to worse health outcomes. For example, the CDC has identified that insufficient sleep is associated with serious adverse health and social outcomes and is linked to seven of the fifteen leading causes of death. It also plays a significant role in determining cognitive performance and workplace productivity. Likewise, physical inactivity can lead to heart disease—even for people who have no other risk factors. It can also increase the likelihood of developing other heart disease risk factors, including obesity, high blood pressure, high blood cholesterol, and type 2 diabetes.

Exhibit 13: Health Behaviors in Adults and Children		
	District	**WA State**
Insufficient sleep **(Less than 7 hours per night)**	**36%**	**30%**
Physical inactivity (Percentage of adults age 18+ reporting no leisure-time physical activity)	**23%***	**19%**
Food insecure people (Percentage of population who lack adequate access to food)	**15%***	**10%**
Food insecure children (Percentage of children under age 18 who lack adequate access to food)	**23%***	**12%**
Teen births* (Number of births per 1,000 female population ages 15-19)	**23**	**15**
Smoking (Percentage of adults who are current smokers)	**15%**	**11%**
Source: CDC BRFFS 2022; County Health Rankings 2022 **** Represents Grays Harbor County data***		

Higher teen birth rates in Grays Harbor County are also of concern. Younger mothers are less likely to get prenatal care early in their pregnancies, and their pregnancies are more likely to result in premature births and low birth-weight babies. Food insecurity is also a major concern in the county, affecting 15% of adults (20% more than the state) and 23% of children (30% more than the state).

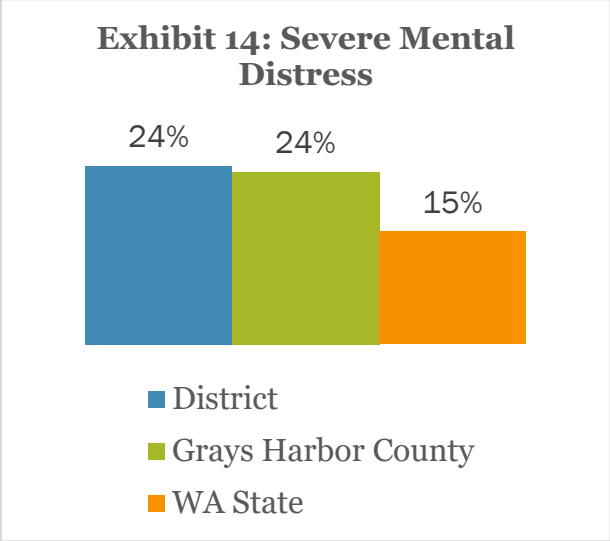
Importantly, the District also has a higher percentage of residents who are current smokers than the state, and, according to the CDC, cigarette smoking harms nearly every organ of the body, causes multiple diseases, and reduces the health of smokers in general. Smokers are more likely than nonsmokers to develop heart disease, stroke, and lung cancer, and smoking diminishes overall health, increases absenteeism from work, and increases healthcare utilization and cost.

Behavioral Health

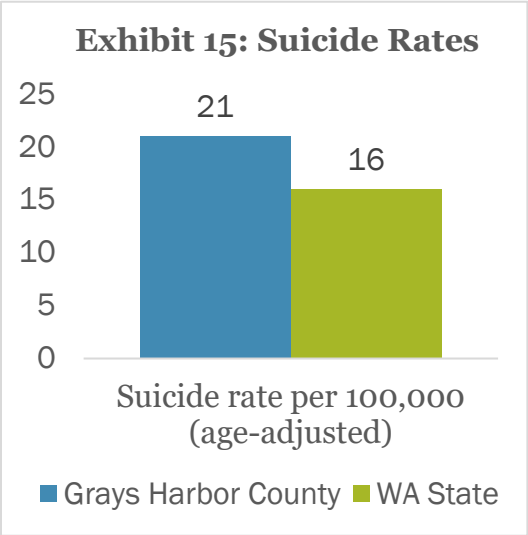
Mental Health

A 2014 study in the American Journal of Epidemiology suggests that regions with more poor mental health days are more likely to have higher unemployment, poverty, percentage of adults who did not complete high school, mortality rates, and prevalence of disabilities versus areas with fewer poor mental health days.

As shown in **Exhibit 14**, 24% of District and county residents reported severe mental distress (defined as 14 or more poor mental health days in the last 30 days), compared to 15% in Washington. County residents also self-reported an average of 5.5 poor mental health days within the last 30 days, about 10% higher than the state rate.



According to data from the National Institutes for Health, the Centers for Disease Control and Prevention, and as outlined in the Washington State Department of Health's 2019 Firearm Fatality and Suicide Prevention Report:



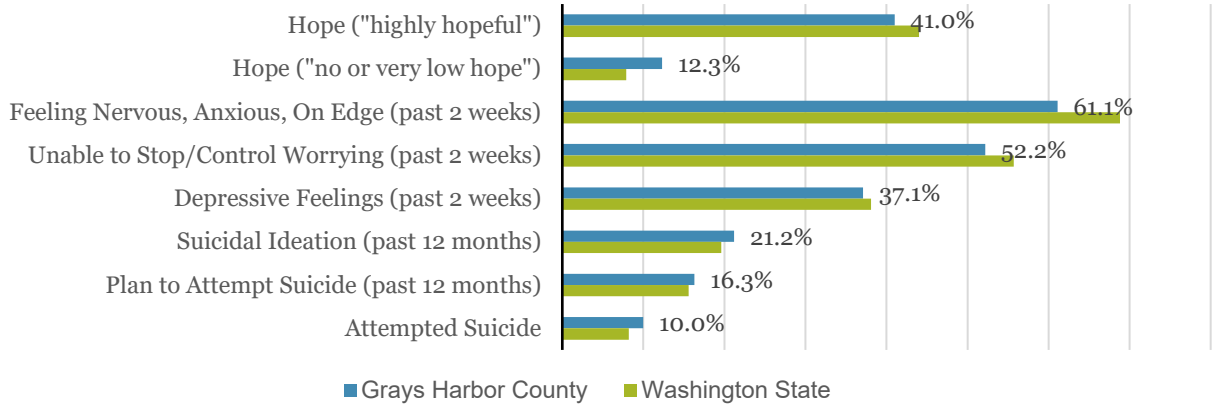
- Washington State's suicide rate is 10% higher than that of the nation.
- In Washington and nationally, suicide rates are higher in rural areas.
- In Washington, the age-adjusted suicide rate in small towns/isolated rural areas was 21.2 per 100,000 people in 2018 (24% higher than the state rate).

Exhibit 15 demonstrates that this is consistent with the experience for Grays Harbor County, with a suicide rate of 21 per 100,000 in 2020 (the last year of reliable data).

Specific to youth, Washington's Healthy Youth Survey (HYS), a collaborative effort of the Office of the Superintendent of Public Instruction, the Department of Health, the Department of Social and Health Service's Division of Behavioral Health and Recovery, and the Liquor and Cannabis Board, provides important information about youth health. Students in grades 6, 8, 10, and 12 in each school district answer questions about safety and violence; physical activity and diet; alcohol, tobacco, and other drug use; and related risk and protective factors. The 2021 survey was the 17th statewide survey and 200,000 youth across all 39 counties participated.

The COVID-19 pandemic created profound disruptions across all aspects of personal, familial, social, economic, and health domains. These disruptions and their impacts are still being measured and felt. As shown in **Exhibit 16**, Grays Harbor County tenth graders are experiencing those impacts acutely. Between 2018 and 2021, the number of county youth who reported feeling "no, or very low hope" grew 140%, and at a rate 43% higher than state peers. Youth in the county are also experiencing suicidal ideation, planning, and attempts at a higher rate than their peers across Washington State.

Exhibit 16: Grays Harbor County Healthy Youth Survey Resulsts, 10th Grade (Mental Health Indicators)



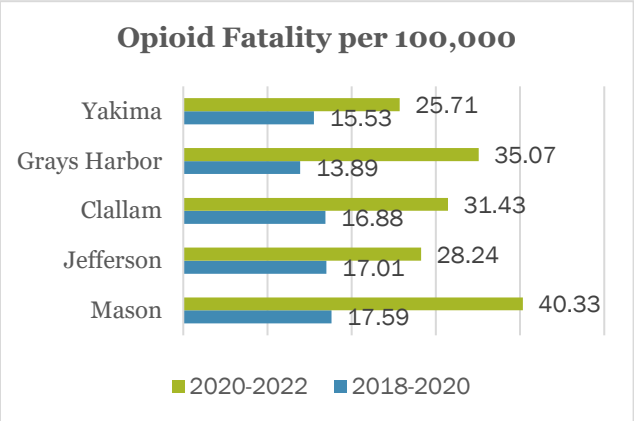
Source: Healthy Youth Survey, 2021, Grays Harbor County and Washington State

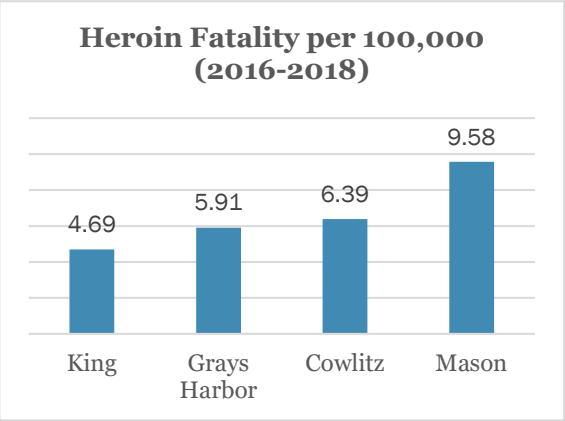
Substance Use

While the county has only slightly higher rates of reported binge or heavy drinking (19% compared to 18% statewide) and alcohol-impaired driving deaths (35% compared to 33%), the county's number of deaths related to drug overdose were 10% higher than the state, with 47% of all injury deaths from overdoses. Importantly, 11% of all injury hospitalizations were also overdose-related for Q4, 2022.

As shown in **Exhibit 17**, Grays Harbor County now ranks second highest of all Washington counties for opioid fatalities, with a rate of 35.07 per 100,000 in 2020-2022, compared to 20.44 per 100,000 statewide. The county also ranks in the top five counties for heroin overdose deaths, with a rate of 5.91 per 100,000 in 2020-2022.

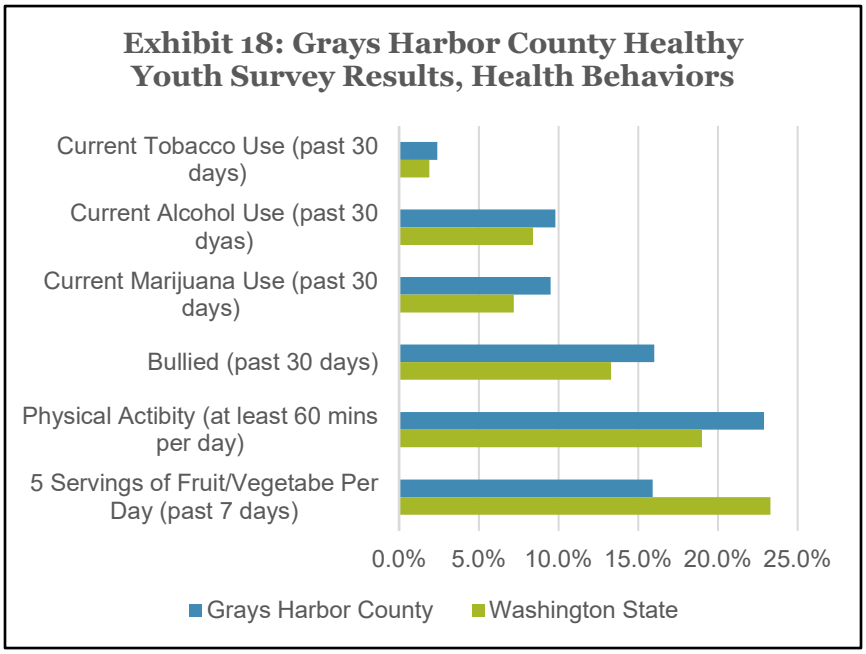
Exhibit 17: Top Five Opioid and Heroin Fatality Counties





Source: University of Washington Alcohol & Drug Abuse Institute Interactive Database, 2018-2020
University of Washington Alcohol & Drug Abuse Institute Interactive Database, 2020-2022

Exhibit 18 further shows that Grays Harbor County youth are reporting significantly higher rates of drug and alcohol use and bullying than their peers across the state.

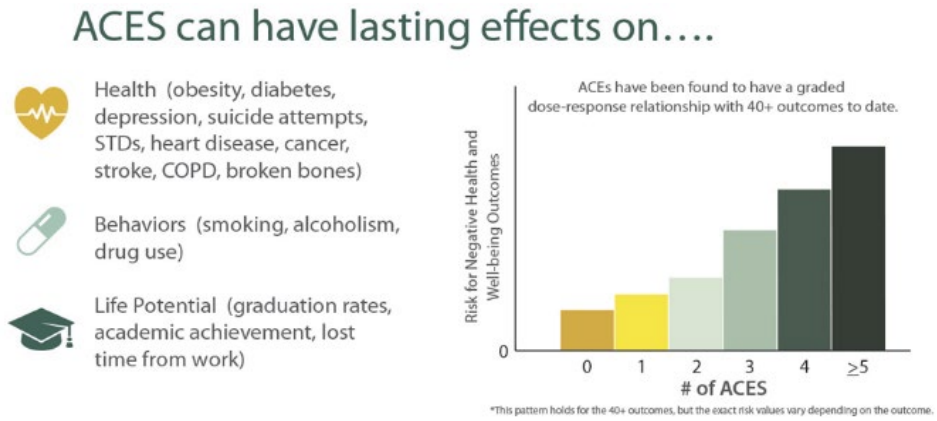


Substance use among teens has been shown to lead to higher rates of physical and mental illness, diminished overall health and well-being, risky sexual health behaviors, experience of violence, and other social, emotional, physical health impacts. Likewise, being a victim of bullying can lead to longer-term impacts including interpersonal violence, substance use, sexual violence, poor social functioning, and poor performance. Even witnessing bullying can impact well-being.

Adverse Childhood Experiences (ACEs)

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

Exhibit 19: Association Between ACEs and Negative Health Outcomes



An ACE burden is defined as the number of ACEs an adult was exposed to during childhood. The highest ACE score is 8. **Exhibit 20** compares District and state ACE scores between 2011 and 2021. Comparison across the decade shows the District consistently having higher percentages of residents experiencing three or more ACEs during childhood than residents statewide. Importantly, the number of District adults who recorded six or more ACEs has increased significantly since 2011 and is now 40% higher than the state.

Exhibit 20: Adverse Childhood Experiences (District vs. State)

ACE Score	2011		2021	
	District	WA State	District	WA State
1 – 2	33.87%	35.98%	30.40%	35.48%
3 – 5	27.91%	21.47%	24.91%	22.12%
6+	1.09%	7.17%	10.26%	7.31%

Source: Washington Behavioral Risk Factor Surveillance System, 2011-2021

Access to Care

Access to care when and where it is needed is impacted by income, health insurance, transportation, and the supply of healthcare personnel, among other factors. The Federal Health Resources & Service Administration (HRSA) deems geographies and populations as Medically Underserved Areas (MUAs), Medically Underserved Populations (MUPs), and/or Health Professional Shortage Areas (HPSAs). MUAs and MUPs identify geographic areas and populations with a lack of access to primary care services. Similarly, a HPSA designation identifies a critical shortage of healthcare personnel in one or more clinical areas.

Exhibit 21: HPSA Scoring Criteria

Three scoring criteria are common across all disciplines of HPSA:

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

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

There are also several types of HPSAs, depending on whether shortages are widespread or limited to specific groups of people or facilities. These include a geographic HPSA wherein the entire population in a certain area has difficulty accessing healthcare personnel and the available resources are considered overused, or a population HPSA wherein some groups of people in a certain area have difficulty accessing healthcare personnel (e.g., low-income, migrant farmworkers, Native Americans). Once designated, per **Exhibit 21**, HRSA scores HPSAs on a scale of 0-25, with higher scores indicating greater need. HPSA designations are available for three different areas of healthcare: primary medical care, primary dental care, and mental health care.

Exhibit 22 reflects Grays Harbor County's HPSA designations and scoring. The entirety of Grays Harbor County has been designated as a HPSA for primary, dental, and mental health care. These designations are important as more than 30 federal programs depend on the shortage designation to determine eligibility or funding preference to increase the number of physicians and other health professionals who practice in those designated areas.

Exhibit 22: Grays Harbor County HPSA Designations

HPSA	Designation Type	Designation Date	Score (as of 9/20/21)
Primary Care	Low-Income: Entire County	8/01/2017	14
Dental Care	Geographic: Entire County	8/24/2017	14
Mental Health	Geographic: Entire County	8/03/2017	16

Source: HRSA Data Warehouse – HPSA Find

Exhibit 23 demonstrates the ratio of population to primary care physicians. The ratio represents the number of individuals per one primary care physician. Grays Harbor County's ratio of primary care physicians, dentists, and mental health providers is considerably higher (worse) than Washington State and the top U.S. performers.

Exhibit 23: Healthcare Personnel Ratios

	Primary Care	Dentists	Mental Health
Grays Harbor County	3,040:1	1,920:1	240:1
Washington	1,180:1	1,200:1	220:1
Top U.S. Performers	1,010:1	1,210:1	340:1:1

In terms of healthcare access, Grays Harbor County ranks below Washington State on multiple other access measures developed and reported in 2023 by RWJ County Health Rankings. An ambulatory care-sensitive condition (ACSC) is defined as a condition for which timely and effective primary care or outpatient care can potentially reduce the risk of subsequent hospitalization. Hence, a hospitalization for an ACSC is also called a preventable hospitalization or an avoidable hospitalization. In other words, preventable hospital stays could be classified as both a quality and access measure, as some literature describes hospitalization rates for ambulatory care-sensitive conditions primarily as a proxy for access to primary healthcare.

As shown in **Exhibit 24**, Grays Harbor County experiences 20% more preventable hospital stays per 100,000 Medicare enrollees versus the state. Other select access to care measures provided in **Exhibit 24** include the percentage of the population receiving timely mammography screenings and receiving an annual flu vaccine. The county is performing worse than the state in terms of both mammography screenings and flu vaccinations. Influenza is a potentially serious disease that can lead to hospitalization and even death. Every year there are millions of influenza infections, hundreds of thousands of flu-related hospitalizations, and thousands of flu-related deaths. An annual flu vaccine is the best way to help protect against influenza and may reduce the risk of flu illness, flu-related hospitalizations, and even flu-related death.

Data from the Arcora Foundation indicates there is also a lack of dental health access in Grays Harbor County. For example, the percentage of adult county residents who have seen a dentist in the last year is significantly lower than the statewide percentage (51% versus 69%). Importantly, and as shown in **Exhibit 25**, data also demonstrates that Grays Harbor County adults have worse dental outcomes than adults in the state, with 17% of county residents over the age of 65 having all permanent teeth extracted compared to only 9% statewide.

Exhibit 25: Percentage of Residents 65+ Who Have Had All Permanent Teeth Extracted (2022)

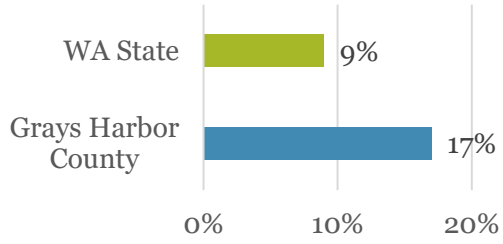
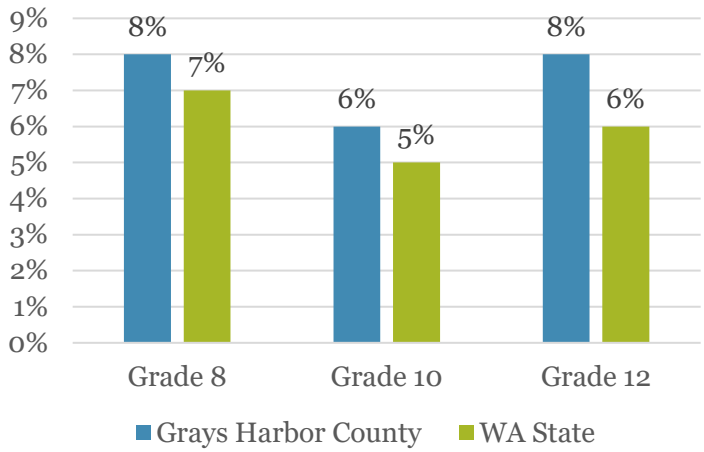


Exhibit 26: Missed School Days Due to a Toothache (2022)



The situation is slightly better for school-age youth in the county. While fewer Grays Harbor County 8th grade students have seen the dentist in the last year than students statewide (82% versus 87%), by 12th grade, Grays Harbor County is doing better than the state (81% compared to 79%). However, as seen in **Exhibit 26**, more students in 8th- 12th grade in the county are missing school due to toothaches than students statewide.

Community Engagement

To gather an active community voice in the CHNA process, HRH distributed an online survey in collaboration with its community partners, social media, staff, and healthcare personnel. The survey was designed to receive community insights on health needs, gaps, and priorities of the community. With low initial responses from the Hispanic population, on-site surveying was also conducted in Spanish and in English, in addition to the online survey.

There were 470 respondents to the 2023 survey, 39 of which were completed by Hispanic residents. Where the Hispanic population's responses were significantly different than total respondents' answers, it has been noted below.

Exhibit 27 shows that over 50% of respondents were in the 35-64 age range, and almost 40% of respondents were 65 or older. As seen in **Exhibit 28**, Hispanic respondents were younger, with nearly 90% of respondents under the age of 65, and 35% of those between 18-34 years of age (compared to only 6 % of total respondents). Nearly 70% of total respondents and 54% of Hispanic respondents self-reported living in Gray's Harbor County for six or more years.

Exhibit 27: Total Respondents: What age group do you fall within?

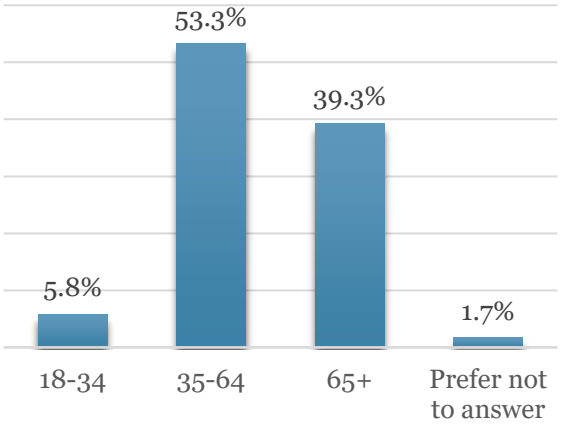
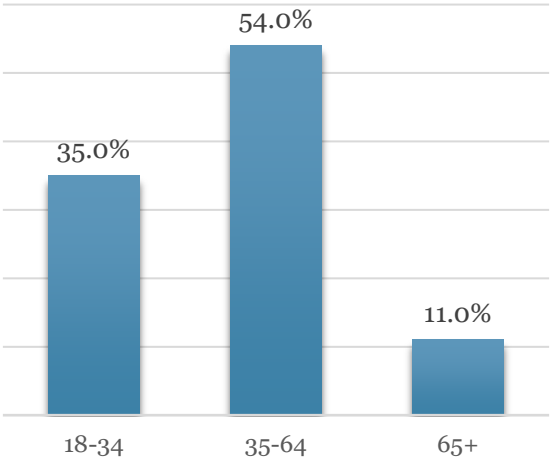


Exhibit 28: Hispanics: What age group do you fall within?

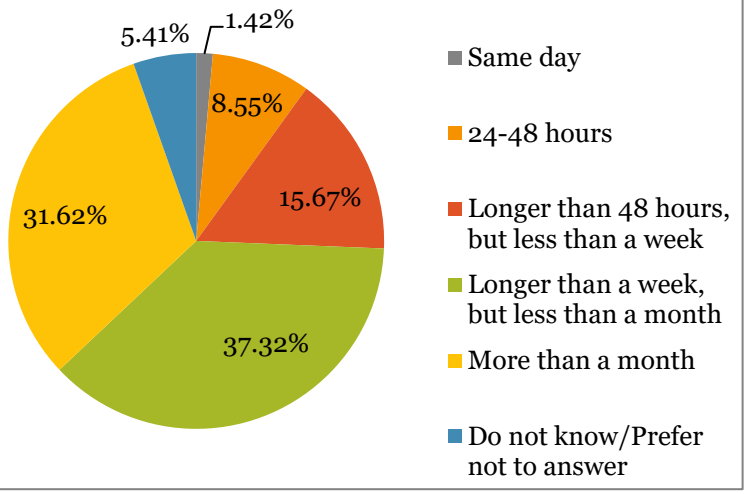


Primary Care Access

Survey respondents were asked specific questions related to primary care provision in the community. Nearly 87% of total respondents reported having a regular healthcare provider or clinic, compared to less than 60% of Hispanic respondents.

Exhibit 29 identifies respondents' perceptions of wait times for non-urgent care, with 37% indicating more than a week wait time and 32% indicating more than a month wait time. When asked, "Is this wait reasonable to you?," 50% of respondents answered "no." When asked about perceived changes in wait time over the past few years, 50% of respondents also answered "yes, it is worse/longer," while 33% answered, "it is about the same."

Exhibit 29: On average, if you called your healthcare provider or clinic to schedule a non-urgent appointment (e.g., a routine wellness exam), how long would you have to wait to see them?



As identified in **Exhibit 30,** when asked about general primary care access in the community, 73% of total respondents felt there was less primary healthcare access available, with 15% thinking it was about the same. Only 33% of Hispanic respondents reported less primary care access available and another 33% thought it was about the same; although 22% of Hispanic respondents stated they did not know or preferred not to answer.

Exhibit 30: In the last few years, in terms of primary healthcare access in general in our community, do you think there are:		
	Total Respondents	**Hispanic Respondents**
More primary healthcare services available	4.0%	11.12%
Less primary healthcare services available	73.3%	33.3%
About the same	14.5%	33.3%
Do not know/Prefer not to answer	8.2%	22.2%

Mobile Clinic

When survey respondents were asked if it was often challenging to find transportation or to otherwise get to healthcare appointments, only 20% of total respondents responded "yes," compared to 50% of Hispanic respondents. When asked if a mobile clinic would improve access to care, 68% of total respondents answered "yes," while 100% of Hispanic respondents answered in the affirmative. **Exhibit 31** reflects which services respondents thought would make a mobile clinic most useful to them. Primary care and laboratory services rose to the top for total respondents and the Hispanic population, with behavioral health and specialty care also listed for nearly one-third of respondents.

Exhibit 31: Which services would need to be provided in a mobile clinic to make it most useful/available to you?		
	Total	Hispanic
Primary Care Services	72.3%	77.1%
Behavioral Health Services	27.7%	31.4%
Specialty Care Services	27.2%	31.4%
Laboratory Services	47.5%	40.0%
Do not know/Prefer not to answer	9.2%	2.8%
Other	11.9%	8.5%

Community Health

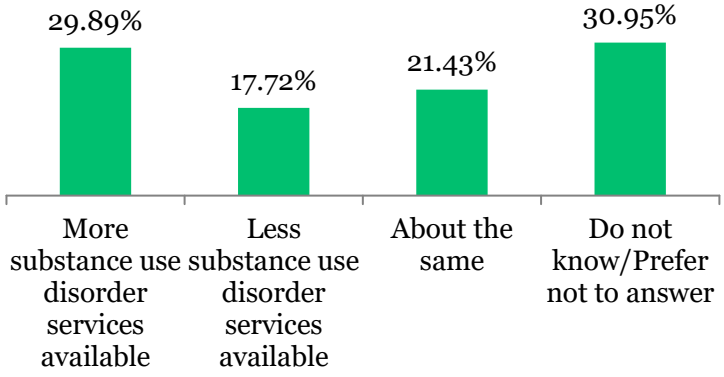
When asked to rate the overall health of the communities of Grays Harbor County, 58% of respondents ranked them "Unhealthy" to "Very Unhealthy," while 33% ranked them as "Somewhat Healthy," and only 2% ranked the county "Healthy."

When asked if they were aware of any specific populations in the community that are less healthy or are experiencing greater inequalities, respondents overwhelmingly identified four main groups: the homeless, the elderly, those struggling with behavioral health issues (mental health or substance use), and the low-income population.

Substance Use Disorder

Substance use disorder (SUD) continues to be a driving concern for the community. Over 77% of respondents think that substance use has increased among youth and adults over the last few years. As identified in **Exhibit 32**, when asked if they think there are more or less SUD services in the community, about one-third of respondents reported more services available, with 18/5 thinking there were less. It is important to note that over 30% did not know or preferred not to answer.

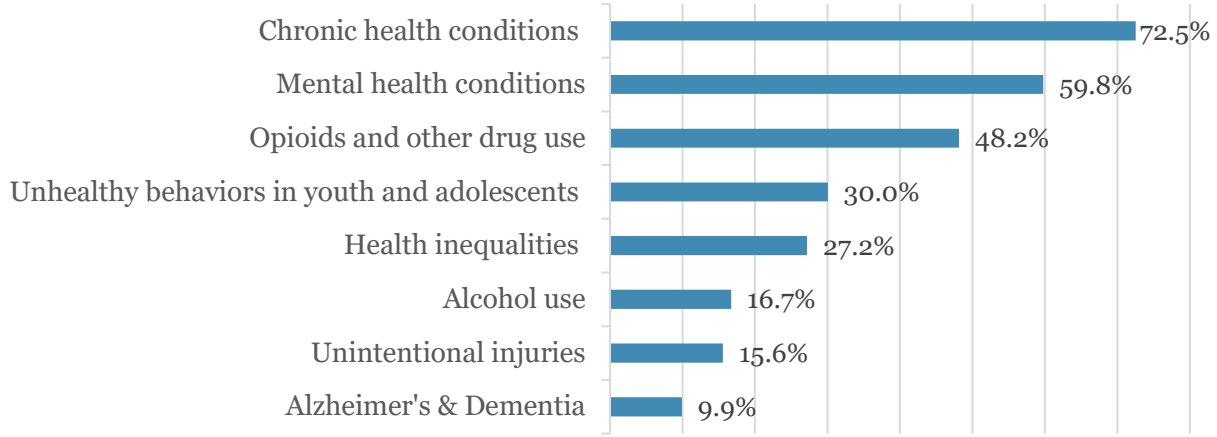
Exhibit 32: In the last few years, in terms of substance use disorder services in the community, do you think there are:



As identified in **Exhibit 33**, when asked to prioritize the "three greatest health problems" facing the community, 73% of respondents identified chronic health conditions as one of the top three health problems in the community.

Several behavioral health-related health problems also ranked high: 60% of total respondents identified mental health conditions, 48% opioids and other drugs, and 17% alcohol use as top health problems. Hispanic respondents placed similar weight on chronic health conditions and behavioral health issues, but with a larger emphasis on alcohol use; 60% of Hispanic respondents identified alcohol use as one of the top three health problems facing the community.

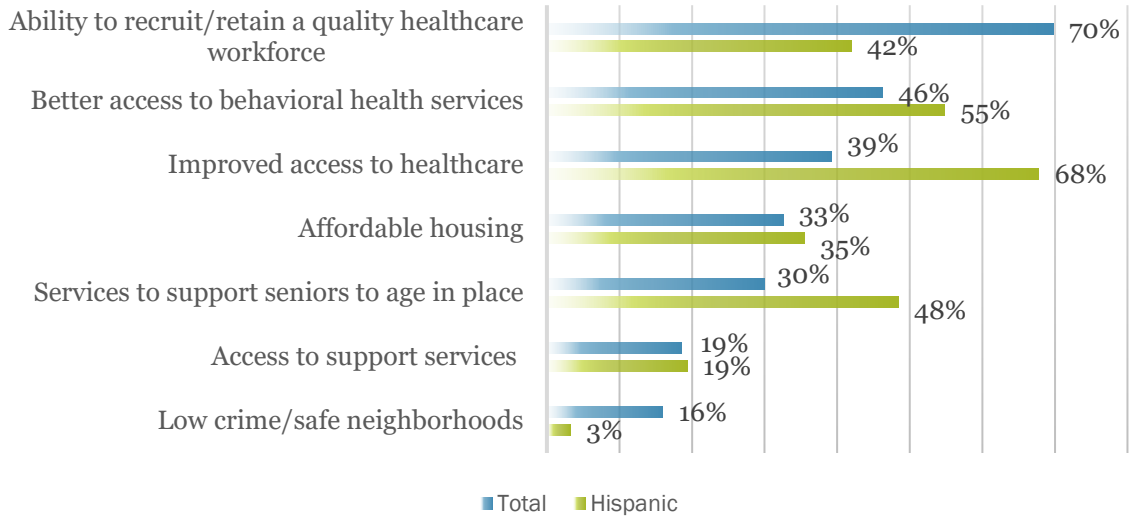
Exhibit 33: From the following list, what do you think are the three greatest "health problems" in the community?



When asked to rank the most important factors that will improve the health and quality of life in the community, **Exhibit 34** shows that issues around access to care dominate the selections. “The ability to recruit/retain a quality healthcare workforce,” “better access to behavioral/mental health,” and “improved access to healthcare” all rose to the top. “Affordable housing,” and “services to support seniors to age in place” were also seen as key factors. This was true for Hispanic respondents as well, but with a stronger emphasis on improved access to healthcare and better access to behavioral health services over workforce recruitment and retention.

Importantly, when survey respondents were asked separately about the importance of workforce development in the county in comparison to other healthcare needs, nearly 90% of respondents reported that it was very or critically important to focus on workforce development.

Exhibit 34:From the following list, please identify the top three most important factors that will improve the health and quality of life in the community.



American Indians/Alaska Natives (AI/AN) comprise about 5% of the primary service area, the AI/AN response to the community survey was just under 2% (n=9). Such a low sample rate makes extrapolation of data-driven themes difficult, but qualitatively there were some differences of note that require further exploration.

While many of the responses by AI/AN residents were similar to overall survey respondents, more AI/AN residents identified opioids and other drug use as one of the key health problems in the community. The AI/AN population also identified affordable housing, childcare, and access to support services, including transportation, as key factors for improving the health of the community. AI/AN respondents were also very focused on community-based workforce development, naming both early career-connected learning opportunities in high school and creating and tying scholarships for community residents to serving in the local healthcare industry.

These themes are aligned and reflected in the 2024-2026 CHNA Priorities and Implementation Plan and represent an opportunity for further alignment and collaboration across the greater HRH community.

2024-2026 Priorities

A Laser Focus on Health Equity

Together, the data and community convening process fully suggest that the priorities established in the 2021-2023 CHNA should, with refinement and additional focus, continue. The 2021-2023 priorities included: healthcare access; behavioral health; prevention and management of chronic diseases; and economic development. The data and community convening also clearly demonstrated a need for all priorities to have a laser focus on health equity.

In the community survey, nearly 30% of respondents identified health inequalities as the greatest health problem facing the community. Health inequalities were defined as: *some groups of people are less healthy than others because of avoidable, unfair, and systemic differences in health care between groups of people.*

As is evidenced throughout this report, disparities in health outcomes and the social determinants of health, fall particularly hard on populations on the basis of race, socioeconomic status, and geography.

- According to the Centers for Disease Control (CDC), racial and ethnic minorities, and individuals from low-income backgrounds, experience higher rates of chronic disease and more barriers to accessing quality healthcare.

- Studies aggregated by the CDC also consistently show disparities in mortality rates based on race, ethnicity, and socioeconomic status.

- The Robert Wood Johnson Foundation's County Health Rankings (RWJ) and the World Health Organization (WHO) have both studied and identified significant disparities in life expectancy based on factors of race, income, and education.

- As shown directly in this report, chronic disease prevalence and access to, and utilization of, health care differs within the community along lines of race, ethnicity, socioeconomic status, and geography.

As the CHNA above reports, there are significant racial and ethnic disparities in income levels within the county. The median household incomes for the AI/AN population ($32,538) and the Hispanic/Latino population ($45,822) are significantly less than that of the Non-Hispanic White population ($52,172) in the District. These disparities are significant because individuals with lower incomes have less money to spend taking care of themselves and their families, affecting such decisions as paying for visits to the doctor, medicine, or purchasing healthy food.

Poverty can result in an increased risk of mortality, prevalence of medical conditions and disease incidence, depression, intimate partner violence, and poor health behaviors. A 1990 study found that if poverty were considered a cause of death in the U.S., it would rank among the top 10 causes.

When drilling down further on these specific populations, health disparities particularly among the AI/AN population became evident. HRH examined data specific to the Quinault Reservation subcounty division and the specific zip codes of the Quinault Reservation (98587, Taholah, WA and 98526, Amanda Park, WA) that are within the Harbor Regional Health Primary Service Area. As can be identified in **Exhibit 35,** on all measures of poverty the AI/AN population experiences significant disparities in comparison to the Service Area, County, or State.

Exhibit 35: Poverty Status in 2020 (by Age & FPL)

	Quinault Reservation	HR PSA	Grays Harbor County	WA State
Population Under 18 Years of Age for Whom Poverty Status Is Determined	**31.8%**	22.1%	22.1%	11.9%
Population Age 18 to 64 for Whom Poverty Status Is Determined	**25.4%**	14.9%	15.2%	9.7%
Population Age 65 and Over for Whom Poverty Status Is Determined	**20.7%**	7.3%	7.7%	8.1%
Individuals with Income Less than 200% of the FPL	**45.6%**	35.6%	34.1%	23.0%
Families with Income Less than 200% of the FPL	**42.1%**	25.9%	24.6%	16.9%

Importantly, County data also demonstrates significant disparities in health outcomes and health factors for the AI/AN population (**Exhibit 36**). It is important to note that it also demonstrates disparities among the Hispanic population on specific preventative healthcare access measures.

Exhibit 36: Key Health Outcomes and Health Factors By Race/Ethnicity				
	Non - Hispanic American Indian and Alaskan Native	**Hispanic (all races)**	**Grays Harbor County**	**WA State**
Premature Death (Years of Potential Lost Life)	17,900	8,900	10,000	6,300
Premature Age-Adjusted Mortality Number of deaths among residents under age 75 per 100,000 population(age-adjusted).	880	350	500	320
Life Expectancy	70.6	81.2	75.5	79.4
Health Factors				
Teen Births Number of births per 1,000 female population ages 15-19.	43	28	20	13
Drug Overdose Deaths Number of drug poisoning deaths per 100,000 population.	116	-	36	23
Preventable Hospital Stays Rate of hospital stays for ambulatory-care sensitive conditions per 100,00 Medicare enrollees.	3,176	716	1,868	1,791
Mammography Screening Percentage of female Medicare enrollees ages 65-74 who received an annual mammography screening.	11%	18%	33%	39%
Flu Vaccinations Percentage of fee-for-service Medicare enrollees who had an annual flu vaccination.	23%	28%	37%	44%
Injury Deaths Number of deaths due to injury per 100,000 population.	152	82	101	74

Research indicates that reducing health inequalities can lead to significant economic benefits, increased productivity, and decreased healthcare costs. Mitigating health inequities and reducing systemic barriers to community health are a key focus of Harbor's 2024-2026 Priorities and subsequent Implementation Plan.

Priorities

The updated data and community input included in this CHNA show an increasing reality and recognition that:

- Specific strategies and partnerships to recruit and retain a quality healthcare workforce are key to increasing healthcare access, as are addressing barriers to access, including cost and lack of support services such as transportation.
- The Service Area continues to face a significant chronic disease burden, and there needs to be an emphasis on supporting healthy aging and management of chronic conditions, with a specific focus on the AI/AN population.
- There needs to be a continued focus to support prevention and treatment of mental health conditions and substance use for all segments of the community.
- Poverty, homelessness, and housing affordability continue to impact health equity, access, and outcomes in the community.

Based on the above, the 2024-2026 CHNA priorities will include an overall focus on reducing health disparities and specifically include:

- Increase access to healthcare services, with a special emphasis on healthcare workforce recruitment, development, and retention.
- Prevention and management of chronic conditions, with an emphasis on services and supports for healthy aging in place.
- Partner, advocate, educate, and directly provide services to address the community's growing behavioral health needs, including substance use.
- Collaborate with community partners to focus on economic development of the community, with a renewed focus on addressing housing affordability, homelessness, and supports for those struggling to make ends meet.

2024-2026 CHNA Implementation Plan

This 2024-2026 Community Health Needs Assessment (CHNA), highlighted crucial health challenges and opportunities within our Service Area, emphasizing the need for strategic initiatives tailored to our unique community demographics and needs. The following strategies included in HRH's Implementation Plan are meticulously designed to address these priorities, focusing on enhancing healthcare access through workforce development, advancing chronic disease management, bolstering mental health and substance use interventions, and tackling the socioeconomic factors affecting health equity.

This Implementation Plan builds on the priorities identified in the CHNA, committing to a comprehensive approach that not only seeks to reduce health disparities but also strengthens community resilience. Importantly, the plan includes targeted efforts to involve and support the AI/AN population in Grays Harbor, ensuring that our strategies are inclusive and responsive to the needs of all community segments. Moreover, in collaboration with our partners, we aim to address broader social determinants of health such as housing affordability and economic stability, ensuring a holistic improvement in health outcomes for all community members.

The HRH 2024-2026 Implementation Strategies include:

Implementation Strategy 1: Increase access to healthcare services, with a special emphasis on healthcare workforce recruitment, development, and retention.
Strategies:
Expand Primary Care to Westport ○ Collaborators: City of Westport ○ Resources: Financial, Administrative, Staffing
Expand Primary Care to Pacific Beach ○ Collaborators: Seabrook and Seabrook Foundation ○ Resources: Financial, Administrative, Staffing
Expand Primary Care to Ocean Shores ○ Collaborators: City of Ocean Shores, Ocean Shores Community Groups ○ Resources: Financial, Administrative, Staffing
Expand Cardiac Service Elective Procedures including PCIs ○ Collaborators: VitalSolutions and Pulse Heart Institute ○ Resources: Administrative, Staffing
Medical Assistant Apprenticeship – Train Medical Assistants to Fill Internal Needs ○ Collaborators: Washington Association for Community Health ○ Resources: Administration, Staff time to support and coach during training
ARNP Rural Health Fellowship – Train ARNPs who want to focus on rural health with the goal that the fellows will continue to practice with HRH, but either way we are supporting the training and development of the next generation. ○ Collaborators: University of Washington, Premera Rural Health Nursing Initiative ○ Resources: Administrative, Staff time to train and support, Reporting, Accreditation
Medical Assistant Student Clinical Rotations – MA students from the local college get their required experience within HRH with the goal that they will continue to practice in our community. ○ Collaborators: Grays Harbor College ○ Resources: Biannual Medical Assistant Advisory Committee meetings

Implementation Strategy 1: Increase access to healthcare services, with a special emphasis on healthcare workforce recruitment, development, and retention.
High School NA-C Program – Students from the local high schools get their required nursing assistant experience with our organization with the hope that they will continue to practice in our community. o Twin Harbors Skills Center (Participating School Districts in Twin Harbors Consortium: Aberdeen, Hoquiam, Lake Quinault, Montesano, North Beach, Ocosta, Raymond, South Bend, Taholah, Willapa Valley, Wishkah Valley) o Resources: Administration and Staff time
Resumption of Job Shadowing – After being shut down due to the pandemic, HRH has resumed job shadowing for high school students interested in healthcare. o Collaborators: Grays Harbor County High Schools o Resources: Administrative, Staffing
NA-C Residency - Education department has developed a Certified Nursing Assistant Residency program which supports newly graduated and licensed NA-Cs to transition from school to the working world. o Collaborators: Local High Schools and GH College o Resources: Administrative, Staffing
Mid-Contract Nursing Pay Scale Increases – In order to remain competitive in the fast paced and changing compensation for this position the administration has opened the opportunity for mid-contract negotiations. o Collaborators: Washington State Nurses Association o Resources: Administrative time, and Financial Investment
Professional Development Pathways for the AI/AN and Hispanic Workforce - Ensure career pipeline/ladders are culturally relevant and attractive to our diverse community, including the AI/AN and Hispanic community members. o Collaborators: Quinault Tribal Nation, Greater Grays Harbor, Grays Harbor Work Source
AMA Organizational Biopsy – The American Medical Association's (AMA) Organizational Biopsy is a core component that includes the 10-item Mini-Z burnout assessment. The Mini-Z is a validated tool that measures job satisfaction, stress, burnout, work control, work chaos, values alignment, documentation time, and EHR proficiency. We will analyze the survey data that pinpointed opportunities to reduce burnout and boost job satisfaction to create targeted plans to enhance job satisfaction and minimize burnout among the medical staff. Over the next few years, we plan to conduct follow-up surveys to refine these key organizational strategies with a focus on improving staff engagement and retention. o Collaborators: American Medical Association o Resources: Administrative time, and Financial Investment to support change
Biannual Employee Engagement Surveys –Providing essential insights that help identify areas of improvement and strengths in staff morale and satisfaction. By addressing these areas, HRH can enhance working conditions, thereby boosting retention, and creating a more positive, productive workplace. o Collaborators: Survey Monkey o Resources: Administrative time, and Financial Investment in survey software

Implementation Strategy 2: Prevention and management of chronic conditions, with an emphasis on services and supports for healthy aging in place.
Strategies:
Expand Primary Care – By expanding primary care to underserved communities in our district, we make getting care closer to home much more viable. This expansion may take the form of actual clinics, but we are also exploring the idea of a mobile clinic to bring healthcare to wherever it is needed. ○ Collaborators: Funding partners such as the Murdock Charitable Trust and the Roots and Wings Foundation ○ Resources: Financial, Administrative, Staffing
Self-Measured Blood Pressure Home Monitoring Program – Family Medicine patients are referred and enrolled in a self-measured blood pressure program meeting with Medical Assistant and NP, receive orientation to the program and a blood pressure cuff to monitor their BP at home. ○ Collaborators: Comagine Health ○ Resources: Administrative and Staff time
Community Health Fairs – By actively participating in these events, Harbor Regional Health is able to directly reach community members, offering education to community members about how to prevent and manage chronic conditions, while emphasizing the importance of sustainable practices that allow seniors to live healthily and independently in their own homes for as long as possible. ○ Collaborators: City of Ocean Shores, YMCA of Grays Harbor, Quinault Tribal Nation ○ Resources: Administrative and Staff time
Blue Zones – Blue Zones are regions identified as having higher than usual concentrations of people living significantly longer and healthier lives, largely due to lifestyle factors such as diet, physical activity, and strong community engagement. HRH's participation in Blue Zone initiatives supports the prevention and management of chronic conditions by promoting these evidence-based lifestyle practices, specifically tailored towards aging populations. This involvement facilitates services and supports that empower seniors to age in place healthily, leveraging community resources and preventive health strategies to enhance longevity and quality of life. ○ Collaborators: CHOICE Regional Health Network, Blue Zones Activate ○ Resources: Administrative time
Equitable Strategies for Addressing the Health Disparities in the AI/AN Community - Engage with local tribal nations and organizations to partner to provide increased and more equitable access to healthcare services. The Patient Experience Workgroup, Diversity, Equity, and Inclusion Team will outreach to local tribes with the goal of improved collaboration and a reduction in health disparities. ○ Collaborators: Quinault Indian Nation, Shoalwater Bay Indian Tribe, and The Confederated Tribes of the Chehalis Reservation ○ Resources: The Patient Experience Workgroup: DEI Team time

Implementation Strategy 3: Partner, advocate, educate, and directly provide services to address the community's growing behavioral health needs, including substance use.
Strategies:
Explore Viability of an EmPATH (Emergency Psychiatric Assessment, Treatment, and Healing) Unit – a specialized facility tailored for immediate care of individuals in mental health crises, providing a calm, therapeutic environment distinct from traditional emergency rooms. Staffed by a multidisciplinary team, these units focus on rapid assessment, treatment initiation, and connecting patients to ongoing care. o Collaborators: Grays Harbor County Public Health o Resources: Administration time, significant construction costs
Transition SUD treatment to Primary Care in Rural Health Clinics – The goal is to expand services in terms of both volume and location. o Collaborators: HarborCrest Behavioral Health (HCBH) o Resources: SUDP Physicians, Staff, and Administration
Medications for Opioid Use Disorder (MOUD) in Jails Program - Launched under the Rural Response to the Opioid Epidemic, this program creates and refines processes and services for individuals involved in the criminal justice system who have opioid use disorder. o Collaborators: GH County Public Health, WA State Health Care Authority, Coastal Community Action Program, GH Law Enforcement Agencies o Resources: SUDP Staff, and Administration
International Overdose Awareness Day – Overdose awareness is spread through the organization by email, social media, posters, fundraising, special events, education at both campuses, and participation with GH County's event in Hoquiam. o Collaborators: HCBH, HRH, WA DOH, and Grays Habor County Public Health o Resources: Staff, and Administration time.
Narcan Training – HCBH staff offers community training for overdose response to community members and provides Narcan at the time of training no questions asked. o Collaborators: HCBH, WA DOH, Quinault Tribal Nation o Resources: Staff time
Beds for Native Population with SUD – Partner with Quinault Wellness Center to ensure SUD treatment participants can find local inpatient services. o Collaborators: HCBH, Quinault Wellness Center o Resources: SUDPs, Physicians, Staff, and Administration
Narcan deployment in Emergency Department (ED) and HCBH – Continue the use of the HCAs guidelines to distribute Narcan to those seeking help with SUD. Continue partnership with Aberdeen Healthmart pharmacy to ensure HRH patients leave with Narcan in hand when they depart the ED to meet SB5195 requirements. o Collaborators: HCBH, HRH ED, Aberdeen Healthmart o Resources: Staff and Administration time, cost of Narcan
Drug Use Surveillance Group – Participate with community partners sharing current trends on the street as well as the availability of resources, and options within our communities to help support individuals living with SUD and seeking help. o Collaborators: HCBH, Grays Harbor Law Enforcement Agencies, Community Groups o Resources: Staff and Administration
Quinault Tribal Wellness Court – HCBH provides support and resources including same day bed availability when able for their participants. o Collaborators: HCBH, Quinault Tribal Nation o Resources: Staff and Administration

Implementation Strategy 4: Collaborate with community partners to focus on economic development of the community, with a renewed focus on addressing housing affordability, homelessness, and supports for those struggling to make ends meet.
Strategies:
Social Determinants of Health Surveys - The Centers for Medicare & Medicaid Services (CMS) will require healthcare organizations to screen patients for five social risk drivers (SDOH) domains: food insecurity, interpersonal safety, housing insecurity, transportation insecurity, and utilities. Screening provides Harbor Regional Health with crucial data to understand and address community needs effectively. This insight enables targeted collaboration with community partners to develop interventions that improve housing affordability, tackle homelessness, and support those struggling economically, enhancing overall community development. o Collaborators: CMS, Community Partner yet to be determined o Resources: Staff and Administration time
Greater Grays Harbor – HRH belongs to GGHI who works to build and strengthen business and industry within the community, with specific initiatives aimed at business retention and expansion, entrepreneurial development, and business recruitment. These efforts help create a thriving economic environment that can address broader social issues like housing and homelessness by fostering job creation, stabilizing the economy, and improving overall community well-being. o Collaborators: GGHI o Resources: Staff and Administration time, annual dues
Community Partnerships – Our Care Transitions Department actively collaborates with various community partners focused on supporting economically disadvantaged community members, especially those addressing issues related to housing affordability, homelessness, and essential support services. We coordinate efforts with organizations such as the Coastal Community Action Program, Union Gospel Mission, Friendship House, Destination Hope and Recovery, and Home and Community Services, among others, to ensure comprehensive support for those in need within our community. o Collaborators: Coastal Community Action Program, Union Gospel Mission, Friendship House, Destination Hope and Recovery, and Home and Community Services, Quinault Tribal Nation o Resources: Staff and Administration time
Grays Harbor Crisis Partners – Our Care Transitions Department is actively engaged in Crisis Partners meetings coordinated by Grays Harbor County Public Health, which also involve law enforcement and behavioral health services. These meetings focus on developing macro solutions to issues like housing affordability, homelessness, and resource allocation, ensuring a collaborative and strategic approach to addressing these community challenges. o Collaborators: GHC Public Health, local law enforcement, behavioral health community partners, Quinault Tribal Nation o Resources: Staff and Administration time