**Our Mission**

We provide hope, care and cures to help every child live the healthiest and most fulfilling life possible.

**Our Vision**

Seattle Children’s will be an innovative leader in pediatric health and wellness through our unsurpassed quality, clinical care, relentless spirit of inquiry, and compassion for children and their families.

Our founding promise to the community is as valid today as it was over a century ago. We will care for all children in our region, regardless of their family’s ability to pay.

We will:

- Practice the safest, most ethical and effective medical care possible
- Discover new treatments and cures through breakthrough research
- Promote healthy communities while reducing health disparities
- Empower our team members to reach their highest potential in a respectful work environment
- Educate and inspire the next generation of faculty, staff and leaders
- Build on a culture of philanthropy for patient care and research

**Our Values**

- Compassion
- Excellence
- Integrity
- Collaboration
- Equity
- Innovation

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**Introduction**

At Seattle Children’s, our commitment to caring for children, teens and young adults is our passion, our duty and our privilege. We conduct a Community Health Assessment (CHA) every three years to identify the most significant needs impacting the health of our communities and ways to address those needs. The Patient Protection and Affordable Care Act (ACA) requires nonprofit hospitals to conduct Community Health Needs Assessments (CHNA), but we do not include the word “needs” in our CHA because we believe that the communities we serve offer more than just a list of needs. These communities have their own unique set of assets and challenges, and are places that actively develop and harness their own capabilities and strengths.

In 2018/2019, Seattle Children’s joined Public Health – Seattle & King County, the Washington State Hospital Association and 10 other hospitals and health systems in King County, Washington, on a collaborative initiative to publish our second comprehensive and jointly authored CHNA, which contains data describing the King County community, life expectancy, leading causes of death and chronic illnesses. This collaborative, known as the King County Hospitals for a Healthier Community, also published an LGBTQ community spotlight report focusing primarily on youth. These two reports laid the groundwork for our 2019 pediatric CHA and reflect the communities we care for beyond King County. Seattle Children’s serves as the medical center for the largest landmass of any children’s hospital in the country, covering the Washington, Alaska, Montana and Idaho (WAMI) region.

Our CHA pulls data from various sources and provides insights into several factors impacting the health and well-being of the communities we serve. This includes the diversity of the population, health status, health behaviors, access to healthcare and preventive services, environments, and social and economic forces that shape the health status of our children and youth in the region.

Our assessment also highlights some of the assets and resources already available in the region to address the health of the community, as well as opportunities for improvement. The CHA helps lay the groundwork for community partnerships and strategies that will build on strengths and succeed in responding to the identified needs. We hope this will provide useful information for hospitals, public agencies and local organizations interested in improving the health and safety of communities. We also hope it leads to enriching conversations across the WAMI region and gets us one step closer to eradicating some of the health inequities that our communities experience. This assessment is intended to guide Seattle Children’s community benefit priorities and subsequent Community Health Implementation Strategies (CHIS) from 2020 to 2023.
Methodology

Data included in our CHA were compiled from local, state and national sources such as the U.S. Census Bureau, U.S. Centers for Disease Control and Prevention, Public Health – Seattle & King County, state health departments and youth risk behavior surveys conducted in the WAMI region.

Our CHA and the jointly authored 2018/19 King County Health Needs Assessment use a data collection approach that includes primary data, such as interviews with stakeholder coalitions and community leaders, and listening groups with youth, parents, caregivers and experts on specific topics. Secondary data gathering includes epidemiologic data on health outcomes, as well as demographic, behavioral and environmental data. Data for Alaska, Idaho and Montana were compiled using publicly available data sources or data sets supplied by the departments of health in those states.

To identify community health needs and assets, we used a population-based community health framework informed by the socio-ecological model and a mixed-method data collection approach that included:

• feedback from stakeholder coalitions and individual organizations and key informants
• listening groups with children/youth, parents and caregivers, and experts in specific topics
• input from Seattle Children’s leaders, faculty and staff members
• a review of recent reports, including broad community health assessments, strategic plans or reports on specific health needs
• needs assessments focusing on the health status, strengths and needs of families in cities, suburbs, towns and villages throughout the WAMI region
• demographic, behavioral and environmental data from local, state and national sources

For our qualitative data collection, we identified coalitions that have expertise addressing health needs, have diverse membership, and have a regional or sub-regional focus. Other stakeholders included those representing the broad interests of the community; representatives of medically under-resourced, low-income populations, people of color, and/or populations with chronic diseases, including representatives from local health departments. Additionally, we hosted listening sessions with youth, parents, caregivers and experts on specific topics; and reviewed recent reports on local health needs. To identify community concerns and assets, Seattle Children’s worked with pediatricians in their second year of residency who, as a part of their training, take a month-long rotation in the Community Health and Benefit division of the External Affairs and Guest Services Department at Seattle Children’s. These residents interviewed stakeholders, consulted recent community-based reports and pulled information from previous hospital CHNAs.

Between 2016 and 2019, these pediatricians and the community health and benefit team members at Seattle Children’s who trained them conducted 26 listening sessions across the WAMI region with parents or caregivers of children ages 0 to 21. We conducted all of our listening sessions in English, and provided Spanish translation at three events, Somali translation at five events, Amharic translation at five events, Oromo translation at one event and Vietnamese translation at one event. Additionally, the residents visited eight communities that were urban, suburban or rural, including villages, to learn about community health challenges. They also interviewed 172 key informants in the WAMI region.
Limitations

Although we gathered a great deal of community input from a wide range of stakeholders, limited resources hindered our ability to learn about and hear from families throughout the entire WAMI region equally. While our qualitative results are intended to provide insight into the assets, needs and ideas of the communities, we acknowledge that they may not represent the views of all sectors of our community.

Other limitations of our report include incomplete or inadequate quantitative data on some topics of interest and our inability to comprehensively summarize every asset throughout the region. For example, although we report data on fruit and vegetable consumption, comprehensive population-based data on healthy eating are simply not available. Additionally, inconsistent age groupings in epidemiological and outcome data; inconsistent life-stage categories, such as when a child is considered an adult; and inconsistent definitions of certain terms such as “Hispanic” and “community” made it difficult to make side-by-side comparisons. Throughout this report, we have used the designations of ethnic and national groups that are used in the data cited.

Our Community

Seattle Children’s serves as the pediatric and adolescent medical center for Washington, Alaska, Montana and Idaho (WAMI region). Most of our patients are from the state of Washington, with 51% of patients residing in King County. For the purposes of this CHA, we defined our community as the children and youth in the WAMI region, with a deeper focus on Seattle, King County and Washington. Specifically, about 18% of Seattle Children’s patients come from Seattle, 33% from other places in King County, 45% from other locations in Washington, 3% from Alaska, Montana and Idaho, and 1% from other locations.

Community, Social and Economic Context

CHA research yielded the following demographics:

Population

From 2013 to 2018, the population of Washington was 7.4 million; Alaska was 738,000; Montana was 1.03 million; and Idaho was 1.7 million. About one-quarter of each state’s population was under age 20 during this time. Children and teens under age 18 represented 20% of the King County, Washington population in 2017.
Racial/ethnic breakdown
In 2018 (among youth under age 18):
- **Washington**: 55% were white; 22% were Hispanic/Latino; 9% were multiracial; 8% were Asian; 4% were Black/African American; 1% were American Indian/Alaska Native; and 1% were Native Hawaiian/Pacific Islander.

On average from 2013 to 2017 (among total population):
- **Alaska**: 65% were white; 14% were American Indian/Alaska Native; 9% were multiracial; 6% were Asian; 3% were Black/African American; 2% identified as “Other”; and 1% were Native Hawaiian/Pacific Islander.
- **Montana**: 89% were white; 7% were American Indian/Alaska Native; 3% were multiracial; and 1% were Asian.
- **Idaho**: 90% were white; 3% were multiracial; 3% identified as “Other”; 1% were Asian; 1% were American Indian/Alaska Native; 1% were Black/African American; and 1% were Native Hawaiian/Pacific Islander.

Foreign-born population and language spoken at home
From 2013 to 2017 an average of 2% to 8% of the populations in the WAMI region were foreign-born; and 4% to 19% of people ages 5 and older spoke a language other than English at home.

People experiencing homelessness/housing insecurity
- **Washington**: 11.2 out of every 10,000 families were homeless in 2017 — the sixth highest rate of homelessness among families with children in the nation. During the 2017 to 2018 school year, 40,365 students were homeless — about 3.4% of the overall student population. In King County in 2018, 1,518 youth were homeless or unstably housed (11% under the age of 18).
- **Alaska**: 10.1 out of every 10,000 families were homeless in 2017 — the eighth highest rate of homelessness among families with children in the nation. During the 2016 to 2017 school year, 4,041 youth enrolled in public schools were homeless at some point during the year (21.6% were unaccompanied youth).
- **Montana**: 6.6 out of every 10,000 families were homeless in 2017. During the 2016 to 2017 school year, 3,606 youth enrolled in public schools were homeless at some point during the year — a 20% increase over the previous school year.
- **Idaho**: 5.1 out of every 10,000 families were homeless in 2017. During the 2016 to 2017 school year, 7,143 youth enrolled in public schools were homeless at some point during the year (12% were unaccompanied youth).

Unemployment rates
As of June 2019, Washington state had an average unemployment rate of 4.6% (seasonally adjusted) across the state and in King County the rate was 2.9% (not seasonally adjusted). The King County rate was the lowest unemployment rate in the state. In Alaska, the rate was 6.4% (not seasonally adjusted) in April 2019 — nearly twice the U.S. rate. Montana's rate was 3.6% (seasonally adjusted) in April 2019 whereas Idaho's was 2.8% (seasonally adjusted) in April 2019.

Poverty rates
As of September 2019, the median household income was $63,179 (2018 figures) in the WAMI region and the official poverty rate was 11.8%, a decrease of 0.5% from the 2017 rate and the fourth annual decline. However, in Washington state, the child poverty rate was 13.2%. In Alaska, the child poverty rate was 13.8%, Montana was 14.8% and Idaho was 17.2%. Meaning, 11.8% of families in the WAMI region live with incomes below the federal poverty threshold and don’t have enough means to meet their basic needs.
Key Findings: What the Data Tells Us By Priority Area

Across the WAMI region, many of these rates vary by race, ethnicity, and gender, geography, being in a rural or urban area, socioeconomic status, environmental factors, health literacy and disability.

Mental and Behavioral Health

Poor mental or behavioral health can limit productivity at school or at home; can impact a child’s ability to learn; and can contribute to or exacerbate poor physical health.

Adverse Childhood Experiences (ACEs)

A growing body of research has made it increasingly apparent that adverse childhood experiences are a critical pediatric health issue. ACEs are potentially traumatic experiences and events, ranging from abuse and neglect to witnessing domestic violence. They can have negative, lasting effects on health and well-being in childhood and later in life. However, more important than exposure to any specific event of this type is the accumulation of multiple adversities during childhood; the more adversity a child faces, the more likely they are to experience negative health effects. Montana and then Alaska had the highest percentage of youth experiencing three or more ACEs in a pediatric population in 2017.

Anxiety

In 2018, between 55% and 68% of 8th, 10th, and 12th graders in Washington reported feeling nervous, anxious or over the edge in the past two weeks, while between 45% and 59% reported that they were unable to stop or control worrying in the past two weeks. This trend has increased since 2016 in the WAMI region. In Montana, 32% of adolescents struggle with an anxiety disorder. Data was not available for Alaska and Idaho.

Bullying

- **Washington**: In 2018, 31% of 6th graders, 27% of 8th graders, 19% of 10th graders and 17% of 12th graders reported that they were bullied, and between 12% and 16% of students reported being cyberbullied (bullied using technology) within the past month. Bullying and cyberbullying rates in King County were slightly lower than the state averages.
- **Alaska**: 21.6% of high school students were bullied on school property and nearly 20% of high school students were cyberbullied in the past year in 2017.
- **Montana**: 21.6% of high school students reported that they were bullied on school property in the past year — down from 25.3% in 2015. In 2017, 17.6% of high school students were cyberbullied in the past year, down from 18.5% in 2015.
- **Idaho**: 25.8% of high school students reported that they were bullied on school property in the past year in 2017 — up from 22.3% in 2009. About one in five high school students were cyberbullied in the past year — up from 17% in 2011.

Depression

Over the last decade, rates of depressive feelings among youth across the WAMI region have increased by 17% to 30%, depending on the community. Having depressive feelings means feeling so sad or hopeless for two weeks or more that they stopped doing some of their usual activities. Between 2017 and 2018 between 31% and 41% of high school students in the WAMI region reported depressive feelings and one in three 10th and 12th graders in Washington state experienced
depressive feelings in 2018. The proportion of youth with depressive feelings has increased across King County, WA since 2016. Rates were higher than the county average for female and LGBTQ students, as well as those who live in the South King County Region and those who were Hispanic, Native Hawaiian/Pacific Islander, American Indian/Alaska Native and multiple-race.

**Alcohol, drug and tobacco use**

Across the WAMI region, cigarette smoking rates have decreased among high school students while electronic vapor product use has increased or stayed consistent over the last few years. Alcohol, marijuana and other drug use trends vary across the region.

**Alcohol use**

Across the WAMI region anywhere from 18% to 28% of students in traditional high schools self-reported that they had at least one drink of alcohol in the past 30 days and of the same cohort of students in the WAMI region 11% to 18% reported problem or heavy drinking (drinking three or more days in the past month and/or one or more binge-drinking episodes).

**Electronic vapor product use**

In Washington, 21% of 10th graders and 30% of 12th graders reported using vapor products within the previous 30 days in 2018. Nearly four times as many 12th graders used vapor products compared to cigarettes. In Alaska, 16% of youth in traditional high schools reported that they currently used electronic vapor products. In Montana, 22.5% of high school students reported that they used electronic vapor products in the previous month in 2017. The rate of current electronic vapor product use has declined since 2015. In Idaho, about 14% of high school students reported that they used electronic vapor products in the previous month.

**Marijuana use**

High school aged students reported using marijuana in the past 30 days at the following rates: Washington — 18% of 10th graders and 26% of 12th graders; Alaska — 21.5% of students in traditional high schools; Montana — 21.1% of high school students; Idaho — 16.2% of high school students.

**Prescription medication use**

In Washington in 2018, 7% of 10th and 12th graders reported taking a prescription medication without a doctor’s prescription within the past month. For Alaskan students, 7.2% of reported taking a prescription medication without a prescription, while 13.7% of Montana students and 13.9% of Idaho students reported taking a prescription medication without a prescription in the past month.

**Tobacco use**

In Washington, 5% of 10th and 8% of 12th graders reported having smoked cigarettes in the previous month in 2018. In Alaska, 6.7% of youth in traditional high schools reported smoking cigarettes at least once in the previous month in 2017 — nearly half the rate as 10 years prior. In Montana, 12.1% of high school students reported smoking cigarettes at least once in the previous month in 2017 — a 20% decline from 2007. And in Idaho, 9.1% of high school students reported smoking cigarettes at least once in the past 30 days — down 20% from 2007.

**Suicide and Injury Prevention**

Suicide by firearm, drowning, poisoning and motor vehicle crashes among adolescents are leading causes of death and injury across the WAMI region. Suicide rates continue to rise and firearms account for over half of all suicide deaths. Poisons include medicines, cleaning products and liquid nicotine. Drownings can unexpectedly occur while swimming, boating or playing in or near water. Correctly used child safety seats can reduce the risk of death by 71% yet more than half of car seats are used incorrectly. These injuries and deaths are preventable.
Suicide

The use of a firearm is the most lethal method of suicide. The presence of a household firearm is linked with an increased risk of adolescents using a firearm to attempt suicide. Securing or removing a firearm from the home reduces the chances that youth and adults at risk for suicide will use it to harm themselves.

- **Washington:** Suicide was the leading cause of death among youth ages 10 to 24 from 2013 through 2017. An average of three youth ages 10 to 24 died by suicide each week between 2015 and 2017. The most common method of suicide was by firearm. In 2018, 10% of 8th and 10th graders and 9% of 12th graders reported that they attempted suicide.

- **Alaska:** Alaska has the second highest rate of suicide nationwide for all ages. More than half of all deaths by suicide involve using firearms at a rate of 16.6 deaths per 100,000 population. About 21% of high school students had seriously considered suicide, nearly 18% had made a suicide plan and more than 10% of students attempted suicide during the past year in 2017.

- **Montana:** One in 10 Montana high school students and one in seven middle school students reported attempting suicide in 2018. About 65% of suicide deaths in 2014 were by firearm. Montana has the second highest rate of suicide by firearm in the country at 14.6 deaths per 100,000 population.

- **Idaho:** Between 2012 and 2016, 105 school-age children and 169 college-age youth (ages 19 to 24) died by suicide. About 60% of the deaths by suicide were by firearm. Nearly 22% of high schoolers had seriously considered suicide — up from 17.1% in 2007 — and 10% of students attempted suicide during the past year in 2017. Idaho had the eighth highest rate of suicide by firearm at 11.1 deaths per 100,000 population.

Drowning

In Washington, between 2013 and 2017, an average of 25 children and youth under the age of 24 died due to drowning each year. Between 2012 and 2016, 65% of drowning deaths occurred in open water. In Alaska, between 2016 and 2018, there were 7 accidental drowning deaths for children ages 0 to 18. In Montana, between 2014 and 2017, there were at least 17 unintentional drowning deaths per 100,000 people between the ages of 0 and 21. In Idaho in 2016, 12 children and youth under the age of 24 died by drowning.

Motor Vehicle Crash Deaths

In Washington, between 2013 and 2017, 629 unintentional motor vehicle crash deaths among children and youth occurred — an average of 126 per year. In Alaska, between 2016 and 2018, there were 31 unintentional motor vehicle crash deaths for children ages 0 to 18. In Montana, between 2014 and 2017, there were at least 134 unintentional motor vehicle deaths per 100,000 people between the ages of 0 and 21. In Idaho in 2016, 65 children and youth under the age of 24 died in motor vehicle accidents.

Poisoning

In Washington in 2017, the Washington Poison Center responded to 62,987 calls (18% involved children under age 6). From 2013 to 2017, nine children under the age of 9 and 339 youth ages 15 to 24 died from unintentional poisoning. In Alaska, between 2016 and 2018, there were 7 deaths due to accidental poisoning or exposure to noxious substances in children ages 0 to 18. In Montana, between 2014 and 2017, there were at least 18 unintentional poisoning deaths per 100,000 people between the ages of 0 and 21. In Idaho in 2016, 34 children and youth died from poisoning.
Healthy Lifestyles

Poor diet and physical activity are risk factors for becoming overweight or obese. Eating fewer meals at home, increased availability and affordability of unhealthy food, and increased food portion sizes can all contribute to poor diet among youth. Food insecurity and obesity can affect the same youth since food insecurity is largely attributed to low income, and under-resourced communities often lack locations that promote healthy exercise such as parks. Additionally, when people eat less or skip meals to stretch food budgets, they may overeat when food is available, or fill up on affordable meals high in fat, but low in nutritional value.

Fruit and vegetable consumption

Fewer than one in five high school students in Washington ate five or more servings of fruits or vegetables per day during the previous week in 2018. In Alaska, Montana and Idaho, less than 13% of students ate vegetables three or more times per day in 2017.

Weight-related health and behavior

In Idaho and Montana approximately 26% of high school students were overweight or obese in 2017; and three out of 10 students in traditional high schools in Alaska were overweight or obese. In Washington, 26% of eighth graders, 28% of 10th graders and 32% of 12th graders were overweight or obese in 2018.

Physical activity

About half of students in Idaho and Montana reported that they were physically active on five or more of the past seven days in 2017. In Alaska about 18% met the daily 60-minute physical activity recommendation in 2017. Approximately one-quarter of school-age children in Washington met the daily 60-minute physical activity recommendation in 2018.

Food insecurity

Food insecurity is defined as an uncertainty of having or an inability to acquire enough food for all household members because of insufficient money or other resources. The national food insecurity rate among children in 2017 was 17%.

In 2017, upwards of 18.7% of children in the WAMI region lived in food insecure households and over half of those children were eligible for federal nutrition programs.

Coordinated care for children and youth with special healthcare needs and chronic conditions

The percentage of children and youth with special healthcare needs in Washington and Montana in 2016 and 2017 was the same as the national rate (19%). The rates in Alaska and Idaho were lower than the national rate at 17% and 18%, respectively.

Other pediatric health indicators

Asthma

Asthma is one of the most common chronic diseases nationwide affecting nearly one in every 12 children (8.1%). From 2016 to 2017, approximately 5% to 7.3% of children in WAMI region had asthma.

Health insurance coverage

Without health insurance coverage, many people find healthcare unaffordable and forgo care even when they may need it. In 2017, 5% of children in the United States had no health insurance coverage.
In 2017:

- **Washington**: 2.7% of children were uninsured — a substantially lower rate than before 2015. In King County, less than 2% of children under age 18 were uninsured.
- **Alaska**: 10% of children were uninsured — down from 14% in 2008 and 2009. Alaska tied for the second highest percentage of children who were uninsured in 2017.
- **Montana**: 6% of children were uninsured — down from 16% in 2008.
- **Idaho**: 5% of children were uninsured — down from 13% in 2008.

**Immunization rates**

The Centers for Disease Control and Prevention recommends that children ages 19 to 35 months complete the 4:3:1:3:1:4 immunization series. The Healthy People 2020 goal is 80% immunization coverage for children ages 19 to 35 months. In 2017 and 2018 the immunization coverage for children in the WAMI region ranged from 59% to 69.5%.

**Infant mortality**

Infant mortality refers to the rate of infant deaths before their first birthday. The infant mortality rate in the United States in 2017 was 5.9 deaths per 1,000 live births.

The infant mortality rates in Alaska, Montana and Idaho ranged from 5.4 and 6.1 deaths per 1,000 live births in 2016. The Washington infant mortality rate was 3.9 deaths per 1,000 live births in 2017 (3.6 deaths per 1,000 live births in King County in 2015).

**Community Assets and Programs**

Our CHA highlights a few of the many dedicated government, nonprofit and private organizations serving our community’s most under-resourced populations. Several organizations and providers offer education, advocacy, clinical care, research or direct services to help children, youth and families get the healthcare and preventive services they need. State and local public health departments across the WAMI region offer essential data to help foster evidence-based program, policy and system environment changes. This assessment also highlights the diversity of children, youth and families in our region, which is a strength. Families and community stakeholders specifically mentioned community centers, community health clinics, racially and ethnically specific organizations as assets as well.

**What the community tells us**

Since epidemiological and quantitative data only provide a partial snapshot of health indicators in the community, we gather qualitative data from families and community stakeholders for a more complete picture of assets and needs.

Parents, caregivers, youth and community leaders shared many strengths they noticed in their communities at listening sessions throughout the WAMI region over a three-year period. These strengths included:

- A strong sense of culture and tight-knit communities at gathering places, such as community centers and community- and faith-based organizations.
- Existing, culturally and linguistically appropriate programs and resources that support families and individuals.
- Schools and primary care offices that serve as supportive environments for children and youth with mental and behavioral health needs.
- Traditions of health passed down within families and communities through foods, cultural activities, storytelling and generational knowledge.
• In-person and online support groups that provide an outlet for families to share resources and connect to others who have a child or children experiencing similar medical or behavioral health issues. Families discussed a need to expand these groups to non-English speakers.

• Private support of programs to tackle important issues within a community, such as programs to address food insecurity.

• Integrated and coordinated care to minimize the need to visit multiple providers.

Community members also shared the following concerns:

• **Mental and behavioral healthcare**: Time and again, regardless of community or setting, families told us that mental and behavioral health care is still an unmet need in our schools and communities. Families reported a lack of access to specialized mental health care close to home, including insufficient resources for youth with developmental disorders or substance abuse issues. They expressed a need for more integration with primary care and earlier intervention as well as improved community mental health capacity in their own cities, villages, or towns.

  Families expressed how children needing mental and behavioral health care services often “fall through the cracks” because there is a shortage of services available and because the mental health care system is prohibitively challenging to navigate. In almost every conversation, families shared concerns about long waitlists and lack of pediatric mental health providers. They described care as “reactive,” and oftentimes having to wait until crisis occurs before treatment is accessible.

  Stigma, racism, and poverty were emphasized as barriers to improving child health and pediatric mental and behavioral health. Almost every family shared an experience of facing mental health stigma or a financial barrier to care. Families expressed desire for more awareness, education, and caregiver support.

• **Economic security and basic needs**: Meeting children’s basic needs is critical to provide a foundation for life-long health. The community addressed several needs including affordable housing, childcare and healthy foods as well as an increase in public transportation, public safety and living wages. Some families also discussed the cost of healthcare services and travel for care, and how it impacted their ability to afford other basic needs.

• **Care closer to home**: Parents discussed a lack of local pediatric subspecialty services and/or waitlists to access those services that were prohibitively long. In some communities, families requested more telemedicine offerings to avoid having to travel to bigger cities for care.

• **Healthy lifestyles**: A lack of education around proper nutrition and access to healthy and affordable foods were cited as challenges to living a healthy lifestyle. Many low-income families and listening group participants reported difficulties being physically active because of public safety issues, lack of exercise-related information in their own language, body image stigma, cost and lack of time. Other barriers to a healthy lifestyle included transportation issues, winter weather conditions and a lack of opportunities to participate in physical activities in rural locations.

• **Care coordination**: Listening session participants desire better connections between primary care providers, schools, specialty care and community services, as well as greater availability of these resources closer to home. They would like care coordinated through a medical home (or medical neighborhoods), especially for children and youth with special healthcare needs, and access to more patient navigators that can assist with language and/or cultural barriers.

• **Preventable injuries**: Community members were concerned about firearm safety, water safety and risk-taking behaviors among teens (especially while driving). In some communities, families discussed worries over child abuse rates and teen suicide rates, especially suicides by firearm. They requested better access to lock boxes and firearm safety education.
Prioritizing the Needs

Our CHA helps us determine the focus of our work and how we prioritize the needs based on our finite resources. As detailed below, we have chosen to prioritize the areas with the greatest need and those where we believe we can make the biggest difference to improve health outcomes and reduce health disparities through our unique position as a children’s hospital. We believe that by working in partnership with others, our efforts will have ripple effects throughout the community.

Based upon the findings in our 2019 CHA, Seattle Children’s Community Benefit priority areas for 2020 through 2023 are:
Primary community benefit priority:
• Mental and Behavioral Health

Other community benefit priorities:
• Healthy Lifestyles
• Suicide and Injury Prevention
• Economic Security

Sustaining community benefit programs:
• Access and Care Coordination
• Adolescent Health
• Programs and Services for Children with Special Needs
• Family Education and Resources

Our priorities have been approved by the Seattle Children’s Hospital Board of Trustees (the ultimate governing board of the organization) and will be incorporated into the hospital’s operating, community outreach and strategic initiatives as well as the 2020-2023 community health implementation strategies.

Evaluation

Measuring the impact of our community health and benefit efforts is critical as we embrace our mission to provide hope, care and cures to help every child live the healthiest and most fulfilling life possible. Beginning in 2019, the federal government updated the community benefit requirements for tax-exempt hospitals to include evaluating the impact of the actions taken to address the significant health needs identified in their prior community health assessment. Our goal is to demonstrate results that include process, impact and outcome measures.

Together with public health, providers, community-based organizations and families, we made significant progress in each of the four priority areas from our 2016-2019 Community Health Improvement Strategies, developed in response to the most urgent health and safety needs of the children, teens and families in Washington state and King County, Washington and as identified through our second Community Health Assessment in 2016. From 2016 to 2019, we sought to make an impact in four priority areas by embarking on 16 strategies and 70 tactics. In total, we proudly made significant progress on 59, finalized 3, and are reevaluating the remaining 8. While there is still much work to be done, we are proud of the progress we’ve made the past three years. To see our full evaluation chapter, please read Appendix C in our 2019 CHA.

Moving Forward

As a children’s hospital, we recognize that the health of our community directly impacts the health and well-being of the patients we serve. Mutually beneficial partnerships and community efforts will further enhance our mission to help every child live the healthiest and most fulfilling life possible.

To tackle our community benefit priorities that were determined based on the results of our CHA, we will build on the assets in the communities we serve and will implement, support and measure the impact of our community health programs and systems to respond to the most pressing needs. We will maintain our commitment to improving the health of the community by working with stakeholders, partners and families to enhance strengths and address concerns. We believe that a collaborative approach to improving community health will yield stronger, more effective strategies that will make the greatest impact in the areas identified by epidemiological data, youth, community leaders and families.
In developing our community health implementation strategy, we aim to:

• Engage stakeholders and community members in program planning implementation and evaluation.
• Continue and strengthen Seattle Children’s advocacy efforts and work with partners at the neighborhood, city, state and federal levels to ensure policies and practices benefit all children and families with a focus on health equity.
• Approach health concerns in a holistic, comprehensive manner.
• Support existing community efforts to avoid duplication, preserve essential resources and ensure that the most under-resourced populations can access services. We will also work to improve population health by utilizing some important cross-cutting themes in our work, such as access, care coordination, equity, population health, prevention and social justice.
• Include a rigorous evaluation component to our implementation strategies in order to employ effective, evidence-based practices in our efforts to improve community health.

Visit [www.seattlechildrens.org/communityhealthassessment](http://www.seattlechildrens.org/communityhealthassessment) to read our complete 2019 Community Health Assessment.