Public Hospital District No. 4, King County
www.snoqualmiehospital.org

Snoqualmie Valley Hospital
9801 Frontier Ave. SE
Snoqualmie, WA 98065
425.831.2300

Snoqualmie Valley Hospital Clinic
(Specialty & Primary Care)
9801 Frontier Ave. SE
Snoqualmie, WA 98065
425.831.2313

Snoqualmie Hospital Rehabilitation Clinic
9801 Frontier Ave. SE
Snoqualmie, WA 98065
425.831.2376

Snoqualmie Ridge Medical Clinic
35020 SE Kinsey Street
Snoqualmie, WA 98065
425.396.7682

October 6, 2016

Board of Commissioners
Snoqualmie Valley Hospital

Dear Commissioners:

You the Board of Commissioners along with the Executive Team worked together to produce a new strategic plan to guide us for the next two years. We completed a SWOT, took into account community needs, and considered industry trends. We confirmed our Mission, cast a new Vision, and developed strategies around four strategic focus areas of Viability, Quality, Relationships and Growth. I present to you this document containing summary and detail of our work. As I considered our efforts I felt I should convey to you my gratitude for the work you did not only during our planning sessions but in advance of them and between them. Thank you!

I also thought you should know that our work has been consistent with the purposes of Snoqualmie Valley Hospital upon the inception of the District. In 1972 the petition to the King County Council for the formation of the District included these aspirational words for the impact to individuals of the District, "...the establishment of said district will be conducive to public health, convenience and welfare, and will be a benefit to the property hereinafter described..." Our plan includes strategies designed to connect in new ways with other area healthcare organizations and reach out to the community to better serve its residents, all while maintaining high quality and efficient operations that assure that medical and wellness services will always be provided locally.

I am proud of the planning work we have done and look forward now to implementing the tactics that support this plan and providing you with quarterly reports on our progress at work/study sessions.

Sincerely,

Tom Parker
CEO
Snoqualmie Valley Hospital

SNOQUALMIE VALLEY HOSPITAL

STRATEGIC PLAN 2017-2018

Snoqualmie Valley
HOSPITAL
Dedicated to quality. Devoted to community.

STRATEGIC PLAN 2017-2018

TABLE OF CONTENTS

INTRODUCTION AND PROCESS

Hospital District #4 King County d.b.a. Snoqualmie Valley Hospital (SVH) developed a new Strategic Plan for 2017 and 2018. The plan includes reaffirmation of the Mission, a new Vision statement, updated Strategic Focus Areas and related Definitions, and Strategies in each of the Strategic Focus Areas.

SVH Commissioners and Executive Team developed the plan together with facilitation provided by Andrew Ballard of Marketing Solutions of Millcreek, WA. Each of the participants provided initial input through a SWOT exercise and received planning support information: Industry Analysis Report, Community Health Data Report, and a Community Survey Report. Common themes from the SWOT were:

- STRENTHS: High quality staff, care, and infrastructure
- WEAKNESSES: Capacity size and services, lack of community engagement, and debt
- OPPORTUNITIES: Increase collaboration, partnerships, and promotion of services
- THREATS: Competition, and not being able to meet community needs

Two sessions were conducted. The first session focused on affirmation and changes as needed to the Mission Statement, Vision Statement and the Strategic Focus Areas. Following the first session participants were assigned to one of four groups, each one tasked with development of a draft definition of the four Strategic Focus Areas:

- VIABILITY: David Speikers, Emma Herron, Steve Daniel
- QUALITY: Joan Young, Kim Witkop, MD
- RELATIONSHIPS: Dariel Norris, Tom Parker, Kim Witkop, MD, Steve Daniel, Jay Rodne
- GROWTH: Gene Pollard, Jay Rodne

The draft definitions were then sent to the other commissioners and executives for their suggested edits. Each group then reviewed the input and produced the final definition.

The second session included a review of the new definitions and a process for developing strategies under each of the Strategic Focus Areas. Two workgroups were formed, each one tasked to develop a prioritized list of strategies for two of the Strategic Focus Areas.

Workgroup assignments:

- VIABILITY & RELATIONSHIPS: Dariel Norris, David Speikers, Kim Witkop, MD, Steve Daniel
- QUALITY & GROWTH: Joan Young, Gene Pollard, Emma Herron, Jay Rodne

After the work groups produced their strategies, the commissioners and executives had an opportunity to assign point values to the strategies that were developed by the other group. Tom Parker did not sit on either of the work groups but offered input while they were developing the strategies and was able to assign point values to all the strategies.

The strategies were then prioritized based on both the prioritization given by the work group and the assigned points given by others outside the work group.

For each of the Strategies there are three columns of scores:

1. Workgroup Priority: This is the priority that was given by the workgroup who was assigned to that Strategy's Strategic Focus Area.

2. Non-Workgroup Members' Scoring: These are the total points attributed to each Strategy through the "dot scoring system". Each participant had three dots valued at 3, 2, and 1, with 3 being this highest score, and placed their dots on the strategies of the other workgroup.

3. Combined Score Priority: This is a prioritization that combines both the Workgroup Priority and the Non-Workgroup Member's Scoring. The Non-Workgroup Members' Scoring has been converted into a prioritization, the highest score given a priority of 1, the next highest score a priority of 2 and so on. These priorities were then averaged with the priorities from the Workgroup to get a combined priority score.

Following the establishment of the strategies, management was tasked with developing tactics that will accomplish each of the strategies. Executive management will first develop tactics that are expected to have significant impact and the 2017 operational and capital budgets. Executive management will also engage each of the department heads (Operations Team) in the development of department-based tactics that support the accomplishment of the strategies.

Tactics expected to have significant impact on the 2017 operational and capital budgets will be presented with the proposed 2017 budget. Departmental tactics will be developed by department heads by year end 2016. Executive management will report to the board of commissioners quarterly during Work/Study Sessions the organization's progress on implementation of the strategic plan.

SUMMARY OF OUTCOME

The following is a summary of the outcome of the strategic planning sessions which includes the new Mission and Vision statements, the four Strategic Focus Areas, their Definitions, the Strategies and the prioritization scoring as described above.

MISSION

Promote and improve the health and wellbeing of people in our community by providing quality care in a collaborative environment.

VISION

Our Community will become the healthiest in the Nation.

STRATEGIES

Strategy	***Workgroup Priority***	***Non-Workgroup Members' Score/ Priority***	***Combined Score Priority***
STRATEGIC FOCUS AREA: VIABILITY *The previous financial history of the district and the current amount of debt makes financial viability a priority. We are defining financial viability as a balanced budget, positive cash flow, debt repayment and positive financial returns on District investments.*			
Balance budget to generate capital for future growth and investments.	2	15 / 1	1.5
Challenge our present independent and swing bed-centric model to determine options that allow sustainability considering new payment models and the changing healthcare landscape.	1	3 / 4	2.5
Offer services consistent with community needs and payment models to support them considering industry trends.	3	7 / 2	2.5
Reduce debt and use a standardized method for self-assessment of progress toward goal.	4	5 / 3	3.5

STRATEGIC FOCUS AREA: QUALITY *The commitment and continuing efforts to use measurable interventions to propel and sustain improvement that contributes to better patient outcomes, better system performance, and more satisfying experiences.*			
Transform services from episodic and transactional to longitudinal and preventative.	1	13 / 1	1.0
Reduce hospital re-admission rate and average length of stay.	2	4 / 3	2.5
Increase patient and family satisfaction scores.	4	11 / 2	3.0
Increase designated stroke and cardiac levels of care.	3	2 / 4	3.5
Increase percentage of Q.I. reporting metric scores.	5	0 / 5	5.0
STRATEGIC FOCUS AREA: RELATIONSHIPS *Relationships are at the core of our existence. Relationships, based on mutual respect and trust, are interactions that will make us better as individuals and an organization.*			
Develop strategic approach to seeking new, strengthening current, or returning to historical relationships both in realms of business and community.	2	15 / 1	1.5
Develop a method of valuating relations and the value of our contribution to relations.	1	7 / 3	2.0
Expand employee development and recognition program.	3	8 / 2	2.5
STRATEGIC FOCUS AREA: GROWTH *Growth initiatives must be measurable, consistent with our mission, financially sustainable, and responsive to the health needs of those we serve.*			
Identify potential affiliation partners.	1	9 / 1	1.0
Conduct a comprehensive asset mapping process.	2	8 / 2	2.0
Focus growth marketing on outpatient services.	3	4 / 4	3.5
Reduce outmigration.	4	7 / 3	3.5
Increase outreach to make the Hospital a community gathering place.	5	2 / 5	5.0

SUPPORT RESOURCES

The following is a summary of the support resources that were provided to participants in the strategic planning sessions. Full reports are found in the Appendix.

The *Hospital Industry Analysis Report* Key Findings:

- Outpatient revenue in hospitals is 45% of total revenue
- Public vs. Private insurance in hospitals is split 40%/60% respectively
- US personal consumption expenditures at hospitals are forecast to grow at an annual rate of 6% between 2016 and 2020.
- Average hourly was increased from 2015 to 2016 by 15%
- Industry drivers for change are technology innovation and new government regulations including the Affordable Care Act
- Business challenges:
    - Capital need for aging facilities and new technology
    - High cost of hospital care
    - Medical errors
    - Staff shortages
    - Aging workforce and increases in workplace injuries
- Trends:
    - Mergers and consolidations
    - Growth in Healthcare IT
    - Reduction in inpatient length of stay
    - Medical tourism
    - Shift from inpatient to outpatient services
    - Growth of the ACO model

The *Community Health Needs Assessment Report* produced for SVH showed that much like Washington State, and King County, residents of the SVH service area had the following significant healthcare and health needs:

- Access to health care
- Preventive practices (vaccines and screenings)
- Cancer
- Heart disease

- Lung disease
- Mental health
- Overweight and obesity
- Smoking

Obesity was found to be the one condition for which residents of the SVH service area had a significantly higher incidence rate than the Washington State and King County.

The *Community Survey Report* had only 36 participants. As such it was not relied upon to guide the strategic plan. A copy of the results are contained in the Appendix.

Tactical Planning / Implementation

Following the establishment of the strategic plan, Executive Management identified initial tactics that support the Strategic Plan including those that are expected to have significant impact on the 2017 operational and capital budget. These tactics are shown below and are incorporated into the 2017 budgets recommended to the board by management.

Additionally, departmental tactics are being developed by department heads and will be added to executive management's report to the board regarding implementation of the strategic plan.

Initial Tactics Including Those with Significant Impact on 2017 Budgets

STRATEGIC FOCUS AREA: VIABILITY			
BUDGET IMPACT TACTICS FOR VIABILITY STRATEGIES	**Revenue**	**Expense**	**Capital**
Challenge our present independent and swing bed-centric model to determine options that allow sustainability considering new payment models and the changing healthcare landscape.			
Brand the Clinics and ED with area hospital partner to grow acute care admissions. (Note: Revenue is expected to be impacted by branding. Given that the timeline for affiliation is not yet known, it is premature to include a revenue increase in the 2017 budget. It is estimated though that volumes will increase from branding. Evergreen Monroe Hospital experienced an 18% increase in Emergency Department volume and revenue following its affiliation with Evergreen Health. An 18% increase in gross revenue at SVH would be $1,018,000 based on 12 months of ED revenue from Aug '15 through Jul '16.			
Balance budget to generate capital for future growth and investments.			
Achieve staffing productivity at 50th percentile per Truven benchmark report		($250,000)	
Discontinue use of Xenex		($60,000)	
Eide Baily Benchmarking Implementation – ED		($197,000)	
Eide Baily Benchmarking Implementation – MedSurg		($769,000)	
Shared Fiber connection with City and School District (savings occur each year for 5 years)		($56,000)	$130,000
Increase Medicare Days			
Offer services consistent with community needs and payment models to support them considering industry trends.			
Identify or develop program of employee wellness to set example for the community. (re: obesity issue identified in Community Health Needs Assessment.) (AHA, 20/20, 30/10, Weight Watchers, etc.)		$50,000	
Bring area hospitals' CHE programs here			
Reduce debt and use a standardized method for self-assessment of progress toward goal.			
Create bond retirement dashboard			

STRATEGIC FOCUS AREA: QUALITY			
BUDGET IMPACT TACTICS FOR QUALITY STRATEGIES	**Revenue**	**Expense**	**Capital**
Strategy: Transform services from episodic and transactional to longitudinal and preventative.			
Continue Clinic practice transformation			
Participate in at least one type-one (shared savings) value-based care arrangement			
Modify clinic provider contracts to reflect value-based care			
Value-based care education and management			
Include quality incentive in physician contracts			
Strategy: Reduce hospital re-admission rate and average length of stay.			
Maintain average Swing Bed Medicaid census of 2 or less – Assumes replacement with 2 Medicare SB patients	$2,391480		

Implement telemedicine service (focus on access to specialists to reduce readmission rate)			
Continue Social Work's use of Advance Care Planning to reduce length of stay with particular focus on reducing outlier length of stay.			
Implement new Curaspan module for discharge planning.		$2,400	
Strategy: Increase designated stroke and cardiac levels of care.			
Increase designations as allowed by State Cardiac/Stroke Program.			
Conduct feasibility assessment and pro forma or increasing levels			
Gain entrance into State Trauma System			
Strategy: Increase patient and family satisfaction scores.			
Launch Patient and Family Engagement Program to include plan for connecting with Senior Centers, Community Centers, EMS, and other Health and Human Services Organizations.		$25,000	
Strategy: Increase percentage of Q.I. reporting metric scores.			
Improve scores for those below the midpoint of benchmarks.			

STRATEGIC FOCUS AREA: RELATIONSHIPS			
BUDGET IMPACT TACTICS FOR RELATIONSHIPS STRATEGIES	**Revenue**	**Expense**	**Capital**
Develop a method of valuating relations and the value of our contribution to relations.			
Implement vendor assessment tool.		$12,000	
Develop relationship evaluation tool to assess the value of external relationships (WSHA, AWPHD, WRHC, NW Council, SnoValley Tribe, SVCN). Include evaluation of dues.			
Develop strategic approach to seeking new, strengthening current, or returning to historical relationships both in realms of business and community.			
Develop RFP for potential affiliation partners. Engage Merger and Acquisition consultant to guide RFP process.		$50,000	
Develop plan for connecting with non-employed providers within the District			
Shared Fiber connection with City and School District (savings occur each year for 5 years) NOTE: THIS IS A DUPLICATE TACTIC			
Expand employee development and recognition program.			
Develop education program to help employees optimize their utilization of the Employee Benefits Program			

STRATEGIC FOCUS AREA: GROWTH			
BUDGET IMPACT TACTICS FOR GROWTH STRATEGIES	**Revenue**	**Expense**	**Capital**
Identify potential affiliation partners.			
Develop RFP for potential affiliation partners. Engage Merger and Acquisition consultant to guide RFP process. NOTE: THIS IS A DUPLICATE TACTIC			
Conduct a comprehensive asset mapping process.			
Map internal assets and skills			
Develop integrated service offering asset map with community partners			

Focus growth marketing on outpatient services.			
Continue work of Program Development Teams: ED, Clinics, Imaging, Outpatient Rehab, Endo, Swing Bed			
Reduce outmigration.			
Brand the Clinics and ED with area hospital partner to grow acute care admissions.			
Implement telemedicine service to include virtual clinic in Carnation and Snoqualmie Pass.. NOTE: THIS IS A DUPLICATE TACTIC			
Add second van to increase capacity for transporting patients for outpatient services.			$25,000
Increase outreach to make the Hospital a community gathering place.			
Conduct annual Family Health Fair and mini-health fairs		$20,000	
Become highly credible voice for community wellness (P&F Engagement, EE Wellness, L&L, presence at other health fairs, cooking demos, Door to Door Community Awareness Campaign)		$2,800	

Departmental Tactics **[TEMPLATE]**

STRATEGIC FOCUS AREA: VIABILITY			
BUDGET IMPACT TACTICS FOR VIABILITY STRATEGIES	**Revenue**	**Expense**	**Capital**
Challenge our present independent and swing bed-centric model to determine options that allow sustainability considering new payment models and the changing healthcare landscape.			
Balance budget to generate capital for future growth and investments.			
Offer services consistent with community needs and payment models to support them considering industry trends.			
Reduce debt and use a standardized method for self-assessment of progress toward goal.			

STRATEGIC FOCUS AREA: QUALITY			
BUDGET IMPACT TACTICS FOR QUALITY STRATEGIES	**Revenue**	**Expense**	**Capital**
Strategy: Transform services from episodic and transactional to longitudinal and preventative.			
Strategy: Reduce hospital re-admission rate and average length of stay.			
Strategy: Increase designated stroke and cardiac levels of care.			
Strategy: Increase patient and family satisfaction scores.			
Strategy: Increase percentage of Q.I. reporting metric scores.			

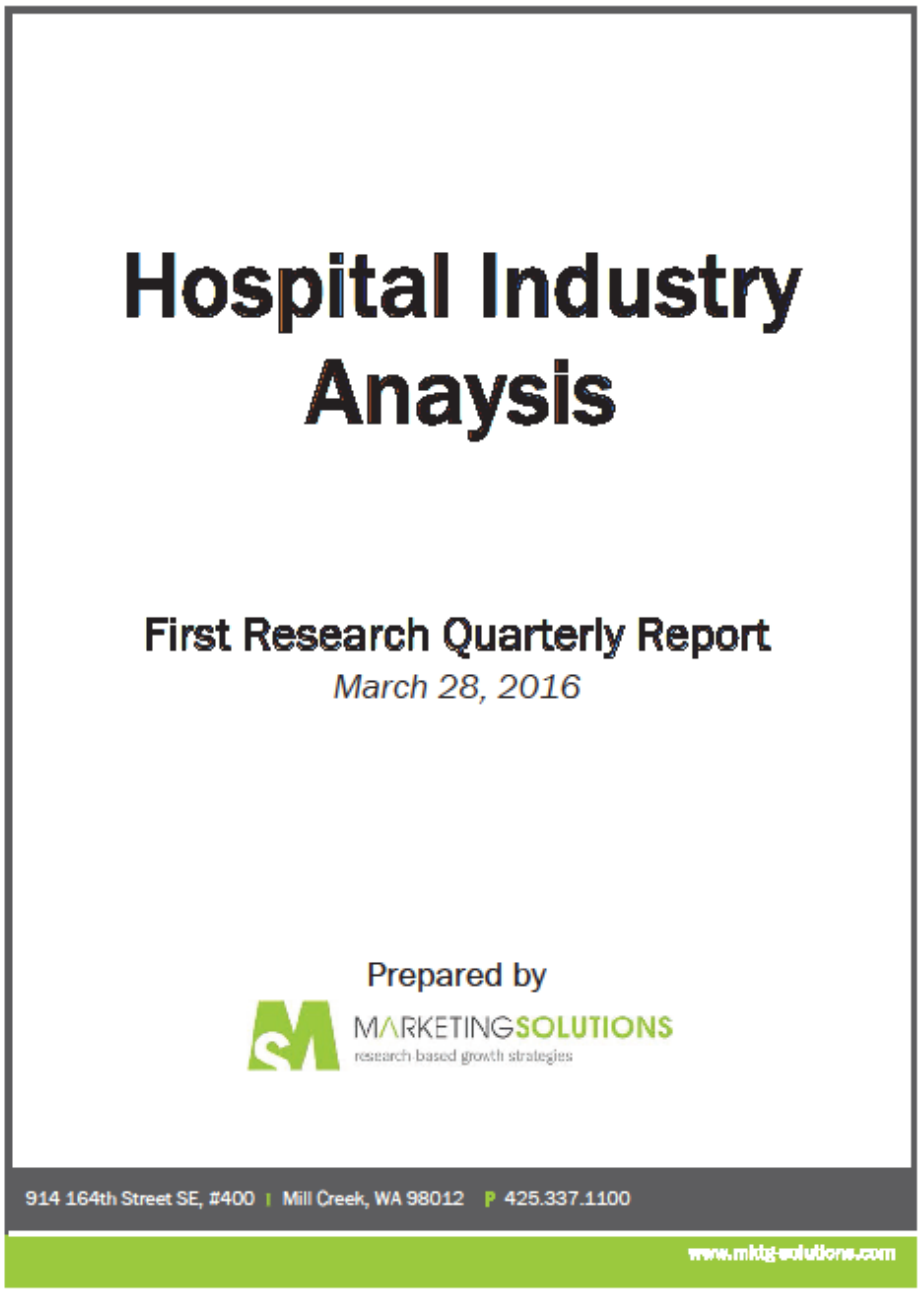
STRATEGIC FOCUS AREA: RELATIONSHIPS			
BUDGET IMPACT TACTICS FOR RELATIONSHIPS STRATEGIES	**Revenue**	**Expense**	**Capital**
Develop a method of valuating relations and the value of our contribution to relations.			
Develop strategic approach to seeking new, strengthening current, or returning to historical relationships both in realms of business and community.			
Expand employee development and recognition program.			

STRATEGIC FOCUS AREA: GROWTH			
BUDGET IMPACT TACTICS FOR GROWTH STRATEGIES	**Revenue**	**Expense**	**Capital**
Identify potential affiliation partners.			
Conduct a comprehensive asset mapping process.			
Focus growth marketing on outpatient services.			
Reduce outmigration.			
Increase outreach to make the Hospital a community gathering place.			

SNOQUALMIE VALLEY HOSPITAL
2017-2018 STRATEGIC PLAN

Appendix

Appendix 1: Hospital Industry Analysis Report



Industry Overview

Companies in this industry provide medical, diagnostic, and treatment services to people on an inpatient and outpatient basis at specialized medical, surgery, emergency, and other health care facilities. Major companies include Community Health Systems (CHS), HCA (Hospital Corporation of America), and Tenet Healthcare (all based in the US), as well as Apollo Hospitals (India), Générale de Santé (France), and Ramsay Health Care (Australia).

The world has about 17,000 hospitals. Regions with the most hospital beds per 10,000 people include Europe, the Western Pacific, and the Americas, according to the World Health Organization.

The US has about 7,100 hospitals with combined annual revenue of about $1 trillion. The industry doesn't include residential care facilities or outpatient care centers, which are covered in separate industry profiles.

Competitive Landscape

Demand for hospital services is driven by demographics, illness and injury rates, and advances in medical care and technology. The profitability of individual companies depends on **efficient operations**, since many hospitals offer similar services, and customer perception, since in many cities hospitals compete for patients.

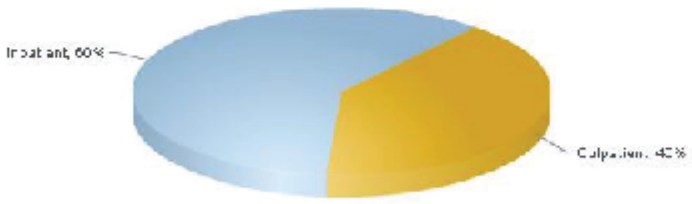
Hospitals also compete for physicians, and seek to attract doctors with state-of-the-art equipment and an attractive work environment. Large companies have advantages in buying supplies, sharing best practices, and negotiating contracts with health insurers. Large hospitals may offer a wider variety of services. Small hospitals can compete successfully by serving a limited geographical area or offering specialized services. About 75% of the 7,100 US hospitals are nonprofits, affiliated with churches, charities, or local governments.

The US industry is fragmented: the top 50 organizations generate about 30% of revenue.

Products, Operations & Technology

Major services include inpatient hospital care, which accounts for about 55% of industry revenue, and outpatient services (those that typically don't require an overnight stay), which account for about 45%, according to the American Hospital Association. The average hospital has about 150 beds.

Revenue by Service - American Hospital Association



Hospitals can be government- or privately run, either by a charitable organization or a for-profit corporation. Most US hospitals, including **teaching hospitals** and other institutions, are exempt from federal income tax. Around 75% of US hospitals are general medical and surgical hospitals. These institutions account for more than 90% of industry revenue. About 1,700 US hospitals provide psychiatric, substance abuse, and other specialized services, such as obstetrics, pediatrics, orthopedics, and cancer care; these facilities generate about 7% of industry revenue.

Hospitals provide an efficient way for doctors to use facilities, equipment, and services too expensive to buy for private practices. Hospital **operations** revolve around routine patient care such as feeding and hygiene; treatment procedures (including medications); record-keeping; personnel management; purchasing; and billing.

Hospitals pay close attention to **costs**, because they usually receive a fixed amount of revenue per patient and must bear actual costs themselves. There are some **economies of scale**: a 50-bed hospital often needs the same expensive equipment (such as an MRI machine) as a 200-bed hospital. Hospitals usually need to keep a nursing staff in proportion to the number of **"licensed" beds**. Occupancy rates are typically around 65% of beds. The average inpatient hospital stay for short-stay hospitals is just under five days.

Labor is the largest single operating cost item, often equal to more than 45% of revenue. Nurses, aides, and technicians comprise the majority of the workforce. While hospitals may employ their own doctors, most doctors who use their facilities have **independent practices** and use the hospital under contract. Doctors may be affiliated with several hospitals within the same area. Some hospitals are affiliated with **medical schools** to provide student training, and many others host **research facilities**.

Technology

Information technology systems are essential to hospital management; **computer systems** manage complex patient records and billings. Many hospitals also have computerized purchasing systems to keep inventories low. Recent technological advances include medical information systems that help doctors with diagnoses and treatment, and prescription systems that help prevent drug interactions and medication mistakes. Some hospitals use wireless technologies that doctors and nurses can use at bedside.

Recent health reform mandates aimed at improving efficiencies are rewarding hospitals for implementing **electronic health records (EHRs)**, which manage patient profiles, physician orders, test results, and decision support tools and allow for sharing of data among care providers. Adoption of EHRs increased from 10% in 2008 to 76% in 2014, and more than 90% of eligible hospitals have received government incentives for taking steps towards meaningful use of EHRs.

Hospital equipment is often expensive and may have a short useful life because of rapid technological advances. Recent innovations include **robotic surgery**, laser surgery, MRI imaging, handheld ultrasound, and telemedicine (remote patient monitoring) systems.

Sales & Marketing

Typical **customers** are individuals requiring immediate urgent care, scheduled surgeries with extended recovery time, and individuals needing routine outpatient services such as blood work, wellness checks, diagnosis, treatment, and rehabilitation.

Major types of marketing include TV ads, newspapers, and radio. Most marketing is for general branding and name recognition. Hospitals directly market and sell services to **doctors** (who refer patients) and to **insurers** (who pay for most services) rather than to the individuals who actually receive the services. Hospitals attract referrals from doctors by offering a wide array of facilities and equipment and hosting specialists on their staff. Contracts with health insurers, another important resource for patient referrals, typically specify the variety and costs of services provided to insured individuals.

The **Internet** plays an increasingly important role in marketing, particularly in urban areas where patients have choices in the type of care. Some hospitals use online screening forms to collect basic information about a patient's need, guiding the patient to an appropriate division or specialist. Hospitals regularly tout their expertise in online newsletters, publications, and public seminars.

Prices vary depending on the service, length of patient stay, and the patient's insurance policy. Hospitals routinely negotiate rates with a patient's insurance provider or managed care organization (MCO). Payment terms to hospitals are much more standardized in federal programs like Medicaid (intended for low-income families) and Medicare (those 65 or over).

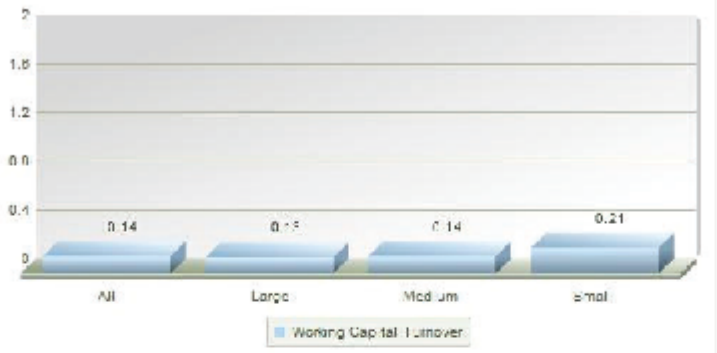
Finance & Regulation

The quality of **accounts receivable** in US hospitals is often poor, because of the large number of uninsured who use hospitals as their only source of health care. Receivables are typically about 60 days, although so-called government-run "providers of last resort" can have much higher receivables. Hospitals can lower the amount of write-offs from uncollected bills by working with federal or state government-run insurance programs to increase the number of patients covered. **Public health insurance programs,** including Medicare and Medicaid, on average account for 30% to 40% of hospital revenue. Private health insurance plans account for about 50% to 60%.

The average **working capital turnover** ratio for the industry in the US is about 20%. Cash flow is usually high, with a large number of small payments. Because of the high cost of medical equipment and buildings, hospitals typically have large capital investments. Employee expenses are also high, and operating margins are slim.

Working Capital Turnover by Company Size

The working capital turnover ratio, also known as working capital to sales, is a measure of how efficiently a company uses its capital to generate sales. Companies should be compared to others in their industry.



Financial industry data provided by MicroBit Corporation collected from 32 different data sources and represents financial performance of over 4.5 million privately held businesses and detailed industry financial benchmarks of companies in over 900 industries (SIC and NAICS). More data available by subscription or single report purchase at www.microbit.com/firstresearch.

Regulation

Hospitals are heavily regulated at the federal, state, and local level. Participants in federal **Medicare** and **Medicaid** must abide by a large number of regulations concerning their operating, accounting, and billing procedures. **Medicare** has a major influence on the payments hospitals receive, as many other payers use Medicare payment schedules as their benchmark, and legislation has tried to address the rapid growth in national health care costs. Legislation related to health reform includes the **Affordable Care Act (ACA)** of 2010, the American Recovery and Reinvestment Act (ARRA) of 2009, the Health Insurance Portability and Accountability Act (HIPAA) of 1996, and the Health Information Technology for Economic and Clinical Health (HITECH) Act of 2009.

State regulations can vary widely. Some states mandate a specific level of staffing per patient, some require a certificate of need before a hospital can buy a large piece of equipment such as an MRI machine, and some don't allow for-profit hospitals to employ doctors directly. Most states manage a network of state health regulators to inspect hospitals for quality of care, the risk of infectious disease, and working conditions.

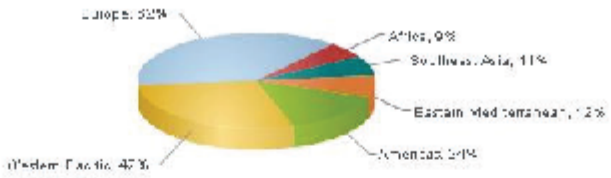
Insurance can be complicated by state programs, offered as a benefit to state employees or provided to individuals without coverage. Hospitals must work within complex state and federal insurance programs and regulations to ensure both proper care and pay for services.

International Insights

The world has about 17,000 hospitals. Regions with the most hospital beds per 10,000 people include Europe, the Western Pacific, and the Americas, according to the World Health Organization. Among countries, Belarus, Japan, North Korea, South Korea, and Russia have the most hospital beds per 10,000 people. Top hospital systems based outside the US include Apollo Hospitals (India), Générale de Santé (France), and Ramsay Health Care (Australia).

Hospitals typically account for 40% to 70% of **national health care expenditures** in European Union countries. In the EU access to health care and hospitals across country borders is a complicated issue, compounded by politics, laws, and patients' rights. EU member countries operate different health care systems, and varying **perceptions of care** have resulted in patients seeking care in other countries. In addition, doctors often move from their home country to practice in another. Due to country-of-origin laws, nations could lose control over hospitals within their borders. The benefits of cross-border health care include standardization of care and better use of resources.

Hospital beds per 10,000 pop. - WHO



Significant portions of EU health care budgets are dedicated to chronic and long-term illnesses such as diabetes care. Countries and regions are looking for ways to reduce the burden of **chronic illness** on cash-strapped health systems. Health care technology such as health care IT, eHealth, and mHealth (mobile technology) all have the potential to make caring for chronically ill patients less expensive and more effective. The use of mobile and wireless technology could save as much as 99 billion euros by 2017, according to PricewaterhouseCoopers and the Groupe Speciale Mobile (GSM) Association.

Improving hospital care worldwide is challenging, but WHO is attempting to **standardize care**. The Safe Surgery Checklist is a WHO initiative aimed at **reducing injuries** to hospital patients wherever they are treated. Some 3,900 hospitals have endorsed the initiative, which could save at least 500,000 lives per year, according to WHO. The checklist works best when hospitals incorporate it as part of procedural changes that emphasize communication among surgical team members and as part of an increased emphasis on patient safety. Another campaign, the Safe Childbirth Checklist, aims to reduce some 6 million child and maternal deaths that occur each year.

Hospital-acquired infections and antibiotic-resistant strains of bacteria are serious issues for many hospitals. Infection rates range from 7% in developed nations to 10% in developing countries. Since antibiotics are not a moneymaker for pharmaceutical companies, research into more effective drugs has not been at the forefront of drug development. Also of concern are some completely resistant bacteria that are no longer confined to hospitals, but have been identified in outside communities, such as antibiotic-resistant tuberculosis, gonorrhea, and E. Coli strains.

Other **global health concerns** include child mortality rates, malnutrition, obesity, and infectious disease. The largest obstacle in many developing nations is access to care.

Regional Highlights

In the US, demand for hospital services is greatest in areas with a large older population, such as Florida, and states that large or high-growth populations, such as Texas, California, Pennsylvania, and New York.

States with high Hispanic populations (Arizona, California, and Texas) often require doctors and staff to speak basic Spanish. Signs, disclosures, and forms are often printed in both English and Spanish. As the population of the US becomes **increasingly diverse**, doctors and nurses must be aware of the range in cultural attitudes toward the physician-patient relationship and the differing rates of disease among various ethnicities.

Human Resources

Although the majority of hospital employees earn low to modest pay, the high income of doctors and other specialists contributes to higher overall earnings. Average hourly wages of workers in general medical and surgical hospitals are significantly higher than the national average.

Injury rates for hospitals are twice as high as the national average. Common injuries include back strains and sprains from moving patients or from falls.

Hospital employees require training on a broad range of issues, including government regulations, insurance, limiting workplace injuries and medical mishaps, reducing liability, and overcoming language and cultural barriers. HR executives regularly schedule seminars and presentations to maintain a highly educated staff. Initial training and orientation can last several weeks. Attrition can be costly, and turnover a problem in lower-wage positions.

Industry Employment Growth

Bureau of Labor Statistics

Average Hourly Earnings & Annual Wage Increase
Bureau of Labor Statistics

Industry Growth Rating

Demand: Driven by medical advances and demographics
Need efficient use of labor and equipment
Risk: Healthcare reform changes business operations and insurers limit payments

Quarterly Industry Update

3.28.2016

Challenge: Hospital Emergency Rooms Experience Worsening Drug Shortages - US emergency rooms are experiencing shortages of critical lifesaving medicines, impacting hospitals' abilities to provide efficient critical care services. The number of drug shortages increased 435% between 2008 and 2014, according to a recent study published in *Academic Emergency Medicine*. Of some 1,800 shortages reported since 2001, more than half were lifesaving drugs, about one-third were drugs used in emergency rooms, and 10% were drugs that had no substitute. Shortages are attributed to manufacturing delays, supply and demand, and raw materials availability; in nearly half of cases, the manufacturer gives no reason. The majority of drugs on shortage in ERs are sterile injectable medicines with low profit margins. Increased regulatory requirements might influence manufacturers to stop producing an unprofitable drug, according to *The Washington Post*. The FDA has issued a long-term plan to mitigate shortages, but the agency cannot require manufacturers to make medically necessary drugs. The Government Accountability Office is concerned that shortages may lead to care rationing or substitution of less effective alternatives, according to *FierceHealthcare*.

Industry Impact - Hospitals must instruct staff on alternative care regimens when a drug shortage occurs. In

some cases there is no acceptable substitute for an unavailable medication, potentially damaging quality of care. Hospital administrators must exert pressure on regulatory and industry organizations to thoroughly explore causes and solutions to the crisis.

Industry Indicators

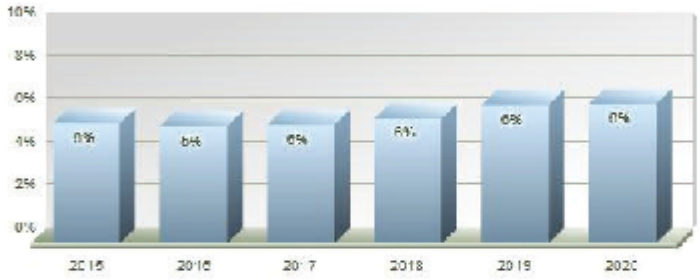
US consumer prices for medical care commodities, which may impact hospitals' operational costs for equipment and supplies, increased 2.4% in March 2016 compared to the same period in 2015.

US consumer prices for medical care services, an indicator of profitability for hospital services, rose 3.6% in March 2016 compared to the same month in 2015.

Total US revenue for hospitals rose 2.9% in the fourth quarter of 2015 compared to the previous year.

Industry Forecast

US personal consumption expenditures at hospitals are forecast to grow at an annual compounded rate of 6% between 2016 and 2020. Data Published: February 2016



First Research forecasts are based on INFORUM forecasts that are licensed from the Interindustry Economic Research Fund, Inc. (IERF) in College Park, MD. INFORUM's "interindustry-macro" approach to modeling the economy captures the links between industries and the aggregate economy. Forecast FAQs

Industry Drivers

Changes in the economic environment that may positively or negatively affect industry growth.

Data provided by First Research analysts and reviewed annually

Technology Innovation Advances in science and technology, including information technology

Government Regulations Changes in federal, state, or local government regulations or business-related policies

Critical Issues

Affordable Care Act - The ACA is changing the way hospitals function. In particular, the law calls for an emphasis on patient outcomes and overall patient care, which influences how hospitals are reimbursed for services. Hospitals with high readmission rates are reimbursed by Medicare at a lower rate, for example. Also as a result of the law, hospitals are also seeing an influx of newly insured patients. Hospitals must carefully manage capacity and workflow to effectively absorb and treat these patients.

Managed Care - Although hospitals treat patients, their largest customers are managed care companies. Large hospital organizations such as Tenet deal with thousands of managed care contracts, which can make it difficult to efficiently bill and process accounts. On the local level, just a handful of MCOs may dominate most health markets, giving hospitals less bargaining leverage. In some areas, a single health insurer is so dominant that it holds a market share in excess of 50%. In the hospital industry's favor is that MCOs try to attract the best health care providers for their networks as possible to serve their enrollees.

Business Challenges

Capital Spending Required - To compete locally, hospitals require large capital investments in facilities and equipment, which can result in significant debt. Investments in computer IT systems have been especially important to comply with the records regulations of the Health Insurance Portability and Accountability Act (HIPAA) and to improve clinical information flow. During the recession of the late 2000s, when credit was tight, many hospitals had to scale back on capital improvements or cancel projects entirely.

Rising Cost of Hospital Care - Hospital prices rose at an annual rate of 8% between 2008 and 2010, according to America's Health Insurance Plans (AHIP). The AHIP said that hospital consolidation was a factor in rising prices. Costs were also affected by growth in utilization and increases in labor and medical technology costs, according to the AHA. At the same time, hospital margins did not increase, indicating the pressure on hospitals to keep prices low.

Medical Errors - Medical errors are estimated to cause hundreds of thousands of deaths and result in billions of dollars in extra costs annually, taking into account additional expensive care, lost income, and malpractice suits. Hospitals try to prevent mistakes with staff training and incentives to increase handwashing, procedures such as marking body parts to be operated on, and the adoption of checklists akin to pilot checklists.

Staffing Shortages - Demand for health care workers is increasing, but the available labor pool is inadequate, especially in nursing. General practice physicians and certain specialists are also experiencing high demand. The current shortage of nurses and physicians is expected to grow as older generations retire. Experts predict a shortage of up to 260,000 nurses and 90,000 doctors by 2025.

High Risk of Employee Injury - Health care workers have a very high percentage of illness and injuries because they work in close proximity to ill patients, handle dangerous equipment, and often must do work that involves physical exertion, such as lifting. Hospital workers have an average illness and injury rate that is double the national average for all US industries.

Ban on New Physician-owned Hospitals - The ACA bars the formation of new physician-owned hospitals and limits the activities of existing ones, effectively reversing a key industry trend. As a result, many physician groups have halted plans for new construction. Existing physician-owned hospitals grandfathered under the law will have to inform patients of the doctor's stake in the hospital so they may choose to be treated there or elsewhere. They must also make their ownership status known on the Web and in other public areas.

Business Trends

Consolidation - Provisions of the ACA, especially changing reimbursement modalities, have spurred unprecedented consolidation in the hospital industry, altering the competitive landscape. Hospitals have been buying competitors, independent physician groups, and insurance companies, all to get a better handle on cost containment, patient care data, and revenue streams. Critics say that the consolidation of large hospital systems and the acquisition of physician practices have caused the cost of care to rise. The FTC has investigated some proposed mergers due to antitrust concerns.

Health Care IT - Health care IT is the most pressing technology issue facing hospitals. Developing electronic health records (EHRs) is a priority for many companies to improve quality and efficiency of care and reduce medical errors and redundancies. Government regulations and incentives are pushing hospitals to come up with EHR systems that protect privacy while allowing doctors and hospitals to transfer health care information between facilities.

Reduced Patient Hospital Stay - In response to cost and revenue pressures, the medical industry has reduced

the average time patients spend in hospitals. Surgical patients who can be treated and released quickly are more profitable for hospitals than medical cases that involve lengthy hospital stays. The average hospital stay dropped from 7 days in 1980 to 4.8 in 2010.

Medical Tourism - US hospitals face competition from medical providers in other nations. Hospitals in India, Malaysia, Singapore, and other nations are marketing routine medical procedures, elective surgery, cancer care, and other treatments to American "tourists" who want to avoid the high cost of US health care. Some 1.2 million Americans received medical care in foreign countries in 2014, up from 900,000 in 2013, according to Patients Beyond Borders.

Growth of Outpatient Services - Outpatient services comprise a growing portion of hospital revenue, more than 40 percent industrywide. Since patients are sent home after surgery or other procedures, outpatient care is less expensive than inpatient care. Hospitals and managed care organizations see outpatient care as a way to cut costs while still providing quality care.

Growth of Accountable Care Organizations - Participation by US hospitals in accountable care organizations (ACOs) is growing, with 89 new Medicare ACOs formed in 2014, according to *Health Affairs*. Created by the Affordable Care Act, ACOs are networks of hospitals, physicians, and other providers that coordinate patient care, ideally eliminating unnecessary tests and hospital readmissions and consolidate technology and staffing expenses. Medicare and private insurers reimburse ACOs, with the fee amount split between the network providers. Providers in ACOs are incentivized if they cooperate care and reduce medical costs.

Industry Opportunities

Aging Population, Increasing Demand - The aging of the US population is expected to continue to drive increases in health care expenditures. The number of US residents 65 and over, the fastest-growing segment of the population, is projected to increase 38% between 2015 and 2025.

IT Development - Hospitals were slow to adopt IT tools because of the expense in implementation and difficulty in managing complex medical information. However, with the federal government offering incentives for implementing health information technology tools, that is changing. Electronic medical records, extranets, portals, and medical research sites allow hospitals a freedom of information access never before experienced in the industry. Electronic information management can help eliminate errors and many of the hours nurses spend charting patient data.

Alternative Medical Services - A growing number of hospitals offer patients some form of alternative medicine, according to the American Hospital Association (AHA). With a market estimated at just over $30 billion and affluent customers who can pay high prices upfront for these services, more hospitals provide alternative medicine such as acupuncture. However, hospitals often consider these services loss leaders, and chiefly offer them in the effort to attract affluent patients who are more likely to have insurance that will pay for additional, conventional medical services.

Expansion of Insured Patient Population - The Affordable Care Act is making health insurance available to more and more Americans following the implementation of coverage provisions in 2014. As a result, the pressures of treating uninsured patients, who often seek expensive emergency room care, could decrease. Hospitals will still be required to offer discounted and charity care for low-income patients, but the effect of the law could be a net positive.

Specialist Services - Many hospitals are expanding their presence in existing markets by adding specialist service lines including obstetrics, oncology, cardiology, and orthopedics. Hospitals can also enhance revenue by adding outpatient surgery centers and clinics.

Consulting and Management - Large hospital chains are taking advantage of health federal reform challenges by offering outsourced revenue cycle management, patient engagement, and technology services to smaller community hospitals that don't have the benefit of scale.

Executive Insight

Chief Executive Officer - CEO

Navigating the ACA
The federal Affordable Care Act (ACA) has had a significant impact on hospital operations and revenues. Medicare reimbursement changes (such as penalties for high readmission rates) have put pressure on hospitals

to maintain and improve quality of care while keeping costs under control. Consolidation and mergers also add pressure to the industry, as hospitals are acquiring competitors, physician groups, and even insurers. To maintain margins and to make changes required by the ACA, hospitals are implementing system-wide performance improvement initiatives focused on cost reduction and revenue enhancement.

Reducing Hospital Errors
Errors in patient treatment by hospitals cost lives and unnecessary expenses. Hundreds of thousands of deaths and injuries costing billions of dollars overall occur annually as a result of medical errors and hospital-induced infections. Hospitals seek to improve patient safety by implementing new procedures and information systems aimed at preventing errors, and enforcing preventative processes, such as strict handwashing routines and checklists.

Chief Financial Officer - CFO

Updating Billing Systems
New initiatives to improve the quality of patient care and make bills easier for consumers to understand will force changes in hospital billing systems. As consumers bear a higher portion of health care costs, they want more explanation of hospital charges in "plain English." Hospitals must update billing systems to accommodate these changes while maintaining or improving billing accuracy.

Funding Capital Investments
Hospitals are concerned with their ability to address future capital needs. Some hospitals operate in states that require certificates of need for permission to expand their facilities and services, which may prevent expansion and thus curb revenue growth. Hospitals may rely on traditional capital sources, such as bonds, bank loans, and philanthropy. Others are selling non-core real estate assets, like medical office buildings and outpatient centers, to raise funds and de-leverage balance sheets.

Chief Information Officer - CIO

Implementing Electronic Medical Records
Electronic health records (EHRs) hold great promise for hospitals to control costs and improve quality of care. As a result, the federal government has made widespread adoption of EHRs a national priority. However, a survey by the American Hospital Association on EHR use finds that most hospitals fall into the "getting started" or "low usage" groups. The most frequently cited barriers to adopting EHRs: initial and ongoing costs, interoperability with current systems, acceptance by clinical staff, and availability of well-trained IT staff.

Integrating IT Systems
Given the cost and impact on work processes of large-scale systems, many hospitals are taking an incremental approach to IT adoption: they're implementing IT systems within individual departments, with plans to connect them over time. Without proper planning, integrating these department "silos" into an enterprise-wide IT system will challenge hospitals. They also face challenges sharing clinical data with physician offices, labs, and health insurers. Adoption of industry standards by IT vendors can reduce the integration effort, but such standards are still evolving. As a first step toward systems integration, many hospitals are installing a redundant communication infrastructure with the bandwidth to support sharing voice, data, and images across the enterprise.

Human Resources - HR

Hiring and Retaining Skilled Nurses
Demand for RNs will continue to rise with the growing health care needs of aging baby boomers. The American Association of Colleges of Nursing cites a projected shortage of 260,000 nurses in the US by 2025. To address this, hospitals support expanding nursing education programs and increasing the number of visas (H-1B, H1C, and TN) for foreign nurses. They're also exploring ways to provide more attractive working conditions and persuade older RNs to remain in the workforce past retirement.

Controlling Rising Pension Costs
Hospitals have historically had generous benefit and retirement programs. These programs, combined with an aging workforce and reduced investment returns, have contributed to higher pension costs and related funding requirements, particularly for nonprofit hospitals. A recent study by S&P's Rating Services finds that during the past two to three years, pension costs have risen at double-digit rates for hospitals with defined benefit programs. Hospitals are being forced to carefully analyze the financial impact of supporting defined-benefit and retirement programs.

VP Sales/Marketing - Sales

Growing Outpatient Services
Hospitals want to grow patient volumes to make up for cuts in reimbursement rates from health insurers. However, because their hospital bed use is often at capacity, they're focusing instead on growing outpatient services. Due to advances in medical technology, many procedures that once required a hospital stay can now

be done on an outpatient basis. The emergence of freestanding ambulatory surgical centers, often owned by doctors, has given consumers more choices for outpatient services. Hospitals are responding with more aggressive print and TV ads touting their medical expertise and focus on patient care.

Improving Public Perceptions
Public perceptions of hospitals have been declining in recent years as reports of errors, negligence, and other issues make the news. To counter this, hospitals are conducting PR campaigns to communicate what they're doing to improve the quality of care and are being more transparent in reporting quality and costs.

Executive Conversation Starters

Chief Executive Officer - CEO

How has the company reconfigured its operations to navigate the new rules of the ACA?
To maintain margins and to make changes required by the federal Affordable Care Act, hospitals are implementing system-wide performance improvement initiatives focused on cost reduction and revenue enhancement.

How is the hospital reducing its staff error rate?
Hospitals are improving patient safety by implementing new procedures and information systems aimed at preventing errors.

Chief Financial Officer - CFO

What plans does the hospital have to update billing systems?
Hospitals update billing systems to accommodate insurers' "pay for performance" metrics, while maintaining or improving billing accuracy.

How does the hospital typically finance capital projects?
Hospitals rely on traditional sources, like bonds, bank loans, and philanthropy, and also sell non-core real estate assets.

Chief Information Officer - CIO

What challenges or benefits does the hospital see in moving to EHRs?
The government has made adopting EHRs a national priority and is considering incentive programs to speed adoption.

How extensive are the hospital's plans to integrate IT systems across departments?
Many hospitals are installing communication infrastructure with the bandwidth to support sharing voice, data, and images across the enterprise.

Human Resources - HR

How is the hospital addressing the nursing shortage?
Hospitals expand nursing education benefits, increase visas for foreign nurses, and develop retention programs.

What concerns does the hospital have about rising pension costs?
Due to rapidly increasing pension rates, hospitals carefully analyze the financial impact of supporting defined-benefit and retirement programs.

VP Sales/Marketing - Sales

What marketing strategy works best to promote the hospital's outpatient facilities?
Hospitals typically use print and TV advertising to tout their medical expertise and patient care.

How does the hospital address the public perception that the quality of care has gone down?
Hospitals conduct PR campaigns to communicate quality of care improvements, and are more transparent in reporting quality and costs.

Call Prep Questions

Conversation Starters

How has the ACA impacted the company's operations?
The ACA is changing the way hospitals function.

How does the company manage its relationship with health insurers?
Although hospitals treat patients, their largest customers are managed care companies.

How much does the hospital invest in capital improvements?
To compete locally, hospitals require large capital investments in facilities and equipment, which can result in significant debt.

What opportunities does the hospital see in serving the aging population?
The aging of the US population is expected to continue to drive increases in health care expenditures.

How is the hospital benefiting from new IT systems?
Hospitals were slow to adopt IT tools because of the expense in implementation and difficulty in managing complex medical information.

What are the company's plans to offer alternative medical services for patients?
A growing number of hospitals offer patients some form of alternative medicine, according to the American Hospital Association (AHA).

Quarterly Industry Update

How does the company ensure that it maintains adequate supplies of medicines?
US emergency rooms are experiencing shortages of critical lifesaving medicines, impacting hospitals' abilities to provide efficient critical care services.

Operations, Products, and Facilities

How many hospitals does the company operate?
Many for-profit hospitals belong to chains.

Is the hospital for-profit, nonprofit, government-owned?
About 75% of the 7,100 US hospitals are nonprofits, affiliated with churches, charities, or local governments.

How many licensed beds does the company have?
A typical large hospital may have 300 beds; community hospitals generally have fewer than 100 beds.

Is the hospital associated with a medical school or research facility?
Some hospitals are affiliated with medical schools to provide student training; others have associated research facilities.

In which, if any, particular areas of medicine does the company specialize?
Many hospitals now specialize in areas such as cardiac or cancer treatment.

What is the average patient stay in number of days?
The average hospital state is four to five days.

What is the company's typical occupancy rate?
Around 65% of licensed beds are usually occupied.

To what extent does the company participate in Medicare and Medicaid programs?
Together, these programs provide around 30% to 40% of hospital revenues, but payments are often lower than from other payers.

How have increased costs for malpractice insurance affected the services the hospital offers?
Some doctors have stopped offering higher risk health care services altogether, which may affect hospitals' abilities to offer those surgeries or procedures.

Customers, Marketing, Pricing, Competition

How does the hospital compete for patients and doctors with new physician-owned specialty hospitals?
Hospitals are concerned that the physician-owned specialty facilities will steal many profitable patients.

Does the hospital have relationships with several MCOs or insurance providers or is there a dominant player?
Many hospitals depend highly on one insurance provider.

How does the company attract and approve doctor affiliations?
Some companies have special marketing programs.

What other hospitals, clinics, outpatient surgery centers, or diagnostic labs compete in the same area?

Independent clinics that provide specialized services, such as lab services, outpatient surgery, or imaging services like CAT scans, often deliver superior service at lower cost.

Regulations, R&D, Imports and Exports

How does the company operate within the framework of state and federal regulations?
Hospitals are among the most tightly regulated industries in the US.

How has the hospital financed necessary regulatory changes regarding medical coding, patient privacy, and financial transactions?
In addition to patient privacy rules, hospitals must implement new accounting and financial rules.

Organization and Management

If a nonprofit, how much control does the sponsor exercise over hospital administration?
In response to financial challenges, many nonprofits have hired professional hospital administrators.

How will shorter medical resident hours affect the hospital?
New work rules limit residents to 80 hours per week.

How would a state nurse-to-patient ratio requirement impact the hospital?
California has the nation's first nurse-to-patient ratio requirement for hospitals.

Financial Analysis

What is the average inpatient bill?
The average inpatient bill is more than $10,000.

What is the revenue mix between Medicare, Medicaid, managed care companies, and out-of-pocket payments?
Government programs provide about 30% to 40% of hospital revenue, private insurers about 50% to 60%.

Have labor costs been increasing faster than revenues?
Labor costs typically equal more than 45 percent of revenues.

Business and Technology Strategies

What is the hospital's strategy for reducing costs?
Before health care costs exploded, many hospitals were managed without regard for cost containment. New federal regulations and pressure from managed care companies have forced hospitals to become more cost-efficient.

How has the company managed its expansion and other capital investment plans?
Cost/revenue pressures have caused many hospitals, both non- and for-profit, to merge with competing institutions to provide more cost-effective care by eliminating duplicate services, administrative costs, and excess beds; adopting "best practices"; and improving purchasing efficiencies. Some companies have seen opportunities in serving smaller communities with less competition.

How has the mix of inpatient and outpatient services changed over the last several years?
Outpatient services are a growing source of revenue.

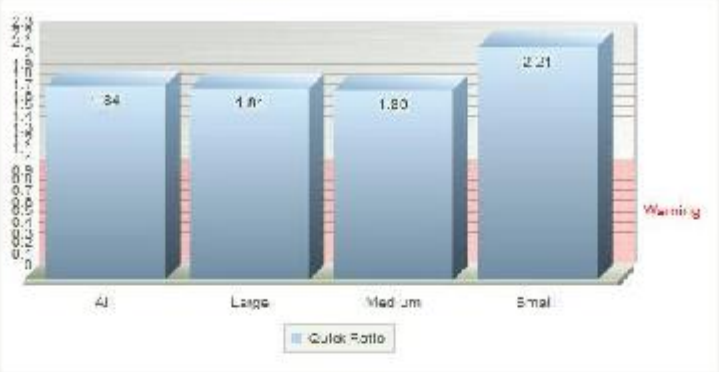
How does the company plan to fund the acquisition of increasingly expensive diagnostic and treatment equipment?
Advances in medical knowledge and technology are producing sophisticated, but expensive, new equipment that rapidly becomes obsolete.

Financial Information

COMPANY BENCHMARK TRENDS

Quick Ratio by Company Size

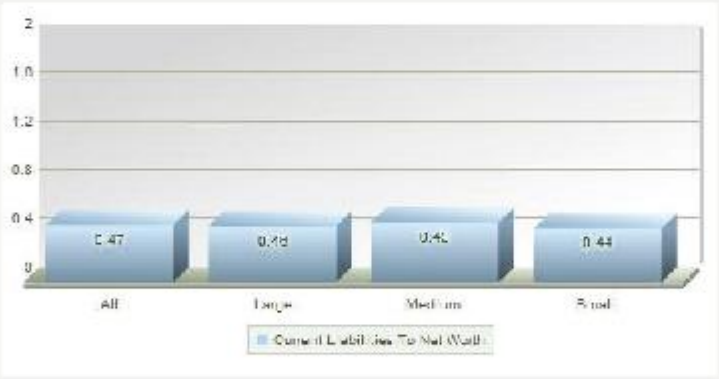
The quick ratio, also known as the acid test ratio, measures a company's ability to meet short-term obligations with liquid assets. The higher the ratio, the better; a number below 1 signals financial distress. Use the quick ratio to determine if companies in an industry are typically able to pay off their current liabilities.



Financial industry data provided by MicroBilt Corporation collected from 32 different data sources and represents financial performance of over 4.5 million privately held businesses and detailed industry financial benchmarks of companies in over 900 industries (SIC and NAICS). More data available by subscription or single report purchase at www.microbilt.com/fistresearch.

Current Liabilities to Net Worth by Company Size

The ratio of current liabilities to net worth, also called current liabilities to equity, indicates the amount due creditors within a year as a percentage of stockholders' equity in a company. A high ratio (above 80 percent) can indicate trouble.



Financial industry data provided by MicroBilt Corporation collected from 32 different data sources and represents financial performance of over 4.5 million privately held businesses and detailed industry financial benchmarks of companies in over 900 industries (SIC and NAICS). More data available by subscription or single report purchase at www.microbilt.com/fistresearch.

COMPANY BENCHMARK INFORMATION

NAICS: 622

Data Period: 2014	Last Update April 2016
Table Data Format	Mean

Company Size	All	Large	Medium	Small

Size by Revenue		Over $50M	$5M - $50M	Under $5M
Company Count	4688	124	679	3885

Income Statement				
Net Sales	100%	100%	100%	100%
Gross Margin	93.2%	93.4%	92.9%	93.3%
Officer Compensation	1.2%	1.1%	1.1%	2.5%
Advertising & Sales	0.3%	0.3%	0.3%	0.3%
Other Operating Expenses	90.1%	90.5%	89.9%	88.1%
Operating Expenses	91.6%	91.9%	91.3%	90.9%
Operating Income	1.6%	1.5%	1.6%	2.4%
Net Income	0.7%	0.6%	0.7%	1.0%

Balance Sheet				
Cash	13.4%	12.9%	13.3%	17.0%
Accounts Receivable	20.9%	20.2%	21.4%	22.9%
Inventory	0.4%	0.3%	0.4%	0.7%
Total Current Assets	44.4%	42.7%	45.0%	51.9%
Property, Plant & Equipment	35.7%	37.4%	35.5%	26.7%
Other Non-Current Assets	19.9%	19.9%	19.5%	21.4%
Total Assets	100.0%	100.0%	100.0%	100.0%
Accounts Payable	5.4%	5.3%	5.8%	4.3%
Total Current Liabilities	20.3%	19.9%	21.1%	19.8%
Total Long Term Liabilities	36.2%	36.7%	35.8%	35.0%
Net Worth	43.5%	43.4%	43.2%	45.2%

Financial Ratios				
Quick Ratio	1.84	1.81	1.80	2.21
Current Ratio	2.19	2.15	2.14	2.62
Current Liabilities to Net Worth	46.7%	45.8%	48.8%	43.9%
Current Liabilities to Inventory	x50.72	x56.78	x51.39	x27.93
Total Debt to Net Worth	x1.30	x1.30	x1.32	x1.21
Fixed Assets to Net Worth	x0.82	x0.86	x0.82	x0.59
Days Accounts Receivable	44	41	45	54
Inventory Turnover	x29.56	x33.77	x29.88	x14.53
Total Assets to Sales	58.5%	56.9%	59.2%	65.8%
Working Capital to Sales	14.1%	13.0%	14.2%	21.1%

Accounts Payable to Sales	3.1%	3.0%	3.3%	2.8%
Pre-Tax Return on Sales	1.1%	0.9%	1.2%	1.7%
Pre-Tax Return on Assets	1.8%	1.7%	1.9%	2.6%
Pre-Tax Return on Net Worth	4.2%	3.8%	4.5%	5.7%
Interest Coverage	x2.10	x1.86	x2.34	x2.84
EBITDA to Sales	4.8%	4.4%	4.8%	6.9%
Capital Expenditures to Sales	4.1%	3.9%	4.2%	5.3%

Financial industry data provided by MicroBilt Corporation collected from 32 different data sources and represents financial performance of over 4.5 million privately held businesses and detailed industry financial benchmarks of companies in over 900 industries (SIC and NAICS). More data available by subscription or single report purchase at www.microbilt.com/fistresearch.

ECONOMIC STATISTICS AND INFORMATION

Annual Construction Put into Place - Census Bureau

Change in Producer Prices - Bureau of Labor Statistics

Change in Consumer Prices - Bureau of Labor Statistics

VALUATION MULTIPLES

No valuation multiples available for this industry.

Industry Websites

Agency for Healthcare Research and Quality
News and announcements on the health care industry.

America's Health Insurance Plans
National trade association for the health insurance industry.

American College of Healthcare Executives
Virtual link to Congress, education, FAQs, Health Administration press, and career services.

American Health Information Management Association
Professional organization specializing in health information management education for health care professionals. Hot topics, career information, certification, products, events, and specialty group links.

American Hospital Association
National organization formed in 1906 that represents and serves hospitals, health care networks and patients. Provides advocacy, campaigns for coverage, compliance assistance, press releases, health forums, and research and education.

American Medical Association
Hundreds of links, news, and information about many physician specialties.

Canadian Healthcare Association
Issues, news, reports, advocacy, events, education resources.

Canadian Medical Association
News and information.

Healthcare IT News
Articles on health care information technology.

HospitalConnect
News links.

Modern Healthcare
Weekly business news related to the health care industry.

Thomson Reuters 100 Top Hospitals
Annual survey of top US hospitals.

US Department of Health & Human Services
News on public affairs, research, policies, administrative tools, search engines.

World Health Organization
International health care issues, reports, statistics, and news.

Glossary of Acronyms

ACA - Affordable Care Act of 2010

ACO - accountable care organization

AHA - American Hospital Association

AHIP - America's Health Insurance Plans

CDCP - Centers for Disease Control and Prevention

CON - certificate of need

DRG - diagnosis-related group

EMR - electronic medical records

HCA - Hospital Corporation of America

HCFA - Health Care Financing Administration

HIPAA - Health Insurance Portability and Accountability Act

MCO - managed care organization

NCHS - National Center for Health Statistics

PPO - Preferred provider organizations

PPS - prospective payment systems

RFID - radio frequency identification

SCHIP - State Children's Health Insurance Program

WHO - World Health Organization

Appendix 2: Community Health Data Report

Community Health Data Report

2016

Snoqualmie Valley Hospital

Table of Contents

Background

Snoqualmie Valley Hospital is a critical access hospital, which is a part of the Snoqualmie Valley Hospital District. Public hospital districts were authorized by Washington State legislature in 1945 to deliver services to help people stay healthy physically, socially, and mentally. Snoqualmie Valley Hospital District is King County Public Hospital District #4. It was voted into existence by the community in 1972. The Hospital District includes a full-service hospital and three clinics. Its mission is to promote the health and well-being of people in our community by providing quality care in a collaborative environment. The original hospital was built in 1983. To appropriately address the needs of a growing community, a new 70,000 square feet hospital facility was built and opened in April 2015.

Service Area

Snoqualmie Valley Hospital is located at 9801 Frontier Ave. SE, Snoqualmie, Washington 98065. The hospital serves the communities of Carnation, Fall City, North Bend, Preston, Snoqualmie, and Snoqualmie Pass.

Snoqualmie Valley Hospital Service Area

City	ZIP Code
Carnation	98014
Fall City	98024
North Bend	98045
Preston	98050
Snoqualmie	98065
Snoqualmie Pass	98068

Secondary Data Collection

Secondary data were collected from a variety of local, county, and state sources to present a community profile, birth indicators, leading causes of death, health care access, chronic disease, communicable disease, health behaviors, social issues and school and student characteristics. When available, these data sets are presented in the context of King County and Washington, framing the scope of an issue as it relates to the broader community.

Analyses were conducted at the most local level possible for the hospital service area, given the availability of the data. For example, many data sets are based on Health Reporting Areas (HRAs) and places/cities. Other data are only available by county or county regions.

Health Reporting Areas

For the purpose of creating City Health Reports, King County Public Health divided the county into twenty-five Health Reporting Areas (HRAs) made up in some cases of smaller HRAs, grouped for statistical validity. The Snoqualmie / North Bend / Skykomish HRA was used to report data for this report. The cities within this HRA are Snoqualmie, North Bend, Skykomish, Klahanie, Riverbend, Tanner, and Baring. It is important to note that while the HRA does not conform exactly with the hospital service area, it fits most closely with the availability of data. Sources of data for this report include the U.S. Census American Community Survey, Washington State Department of Health, Seattle and King County Public Health, Uniform Data System, Centers for Disease Control, Seattle/King County Coalition on Homelessness, Washington State Office of the Superintendent of Public Instruction and others.

Secondary data for the service area were collected and documented in data tables with narrative explanation. The tables present the data indicator, the geographic area represented, the data measurement (e.g. rate, number, or percent), county and state comparisons (when available), the data source, data year and an electronic link to the data source. Analysis of secondary data included an examination and reporting of health disparities for some health indicators. The report includes benchmark comparison data that measures data findings as compared to Healthy People 2020 objectives. Healthy People 2020 objectives are a national initiative to improve the public's health by providing measurable objectives and goals that are applicable at national, state, and local levels.

Significant Health Needs

Health needs were identified from secondary data using the size of the problem (relative portion of population afflicted by the problem) and the seriousness of the problem

(impact at individual, family, and community levels). To determine size or seriousness of the problem, the health need indicators identified in the secondary data were measured against benchmark data, specifically county rates, state rates and/or Healthy People 2020 objectives. Indicators related to the health needs that performed poorly against one or more of these benchmarks met this criterion to be considered a health need.

The analysis of secondary data yielded a preliminary list of significant health needs:

- Access to health care
- Cancer
- Heart disease
- Lung disease
- Mental health
- Overweight and obesity
- Preventive practices (vaccines and screenings)
- Smoking

Community Profile

Population

The population of the Snoqualmie Valley Hospital service area is 41,183. The population grew by 6.8% in the periods from 2007-2011 to 2010-2014.

Total Population, 2007-2011 Compared to 2010-2014

	Zip Code	2007-2011	2010-2014	Percent Change
Carnation	98014	6,922	6,902	-0.3%
Fall City	98024	5,705	5,988	5.0%
North Bend	98045	13,415	14,643	9.2%
Preston	98050	208	208	0.0%
Snoqualmie	98065	12,007	13,202	10.0%
Snoqualmie Pass	98068	292	240	-17.8%
Snoqualmie Valley Service Area		**38,549**	**41,183**	**6.8%**
King County		**1,908,379**	**2,008,997**	**5.3%**
Washington		**6,652,845**	**6,899,123**	**3.7%**

Source: U.S. Census Bureau, American Community Survey, 2007-2011 and 2010-2014, DP05. http://factfinder.census.gov

Population by Age

Children and youth, ages 0-17, make up over one-fourth (28.3%) of the population of the service area; 4.3% are 18-24 years of age; 29.3% are 25-44, 30.3% are 40-64; and 7.8% of the population are seniors, 65 years of age and older. The area has higher rates of children under age 18 and adults 45 to 64, and fewer seniors and adults 18 to 24, when compared to the county and the state. Preston has the highest percentage of youth under age 18 (25.5%), although percentages from areas with very low populations, such as Preston and Snoqualmie Pass, should be viewed with caution. Fall City has the highest percentage of seniors (10.1%) within the service area.

Population by Age

	Zip Code	Age 0-4	Age 5-17	Age 18-24	Age 25-44	Age 45-64	Age 65+
Carnation	98014	8.4%	16.1%	5.7%	27.2%	34.3%	8.3%
Fall City	98024	5.4%	18.3%	5.9%	25.7%	34.6%	10.1%
North Bend	98045	6.9%	19.7%	4.8%	27.3%	31.9%	9.4%
Preston	98050	0.0%	25.5%	0.0%	32.7%	41.8%	0.0%
Snoqualmie	98065	12.6%	21.9%	2.5%	34.2%	23.9%	4.9%
Snoqualmie Pass	98068	0.8%	2.1%	11.7%	25.4%	50.4%	9.6%
Snoqualmie Valley Service Area		**8.7%**	**19.6%**	**4.3%**	**29.3%**	**30.3%**	**7.8%**
King County		**6.2%**	**14.9%**	**9.0%**	**31.7%**	**26.6%**	**11.6%**
Washington		**6.4%**	**16.6%**	**9.6%**	**27.4%**	**26.8%**	**13.2%**

Source: U.S. Census Bureau, American Community Survey, 2010-2014, DP05. http://factfinder.census.gov

Comparing the age of the population from the 2007-2011 period to 2010-2014, there was a slight increase in the percentage of young children and seniors, with a slight decrease in the population between the ages of 5 and 64.

Population of Service Area, by Age, Five-Year Comparison

	2007-2011	2010-2014
Age 0-4	8.2%	8.7%
Age 5-17	20.3%	19.6%
Age 18-24	4.4%	4.3%
Age 25-64	60.1%	59.6%
Age 65+	7.0%	7.8%
Total	100%	100%

Source: U.S. Census Bureau, American Community Survey, 2007-2011 and 2010-2014, DP05. http://factfinder.census.gov

Race/Ethnicity

The majority population in the service area is comprised of Whites (85.5%). Hispanics or Latinos make up 5.0% of the population, and Asians are 4.7%. The area has a larger percentage of Whites and smaller percentages of all other races when compared to the county and the state. In the service area, Carnation has the largest percentage of Hispanics or Latinos (7.5%), Blacks/African Americans (0.7%), Native Hawaiians/Pacific Islanders (0.4%), and Other Race or Mixed Race (6.6%). Snoqualmie has the highest percentage of Asians (2.9%) in the service area. The largest percentage of American Indians / Alaskan Natives (2.0%) in the service area is found in Fall City.

Population by Race and Ethnicity

	White	Asian	Hispanic or Latino	Black/ African American	American Indian/ Alaska Native	Native Hawaiian/ Pacific Islander	Other / Mixed
Carnation	81.9%	2.9%	7.5%	0.7%	0.1%	0.4%	6.6%
Fall City	86.9%	5.3%	3.9%	0.0%	2.0%	0.0%	1.9%
North Bend	88.6%	1.1%	6.7%	0.5%	0.1%	0.0%	3.0%
Preston	100%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Snoqualmie	83.0%	9.4%	2.4%	0.2%	0.3%	0.0%	4.6%
Snoqualmie Pass	92.5%	0.0%	2.5%	0.8%	0.0%	0.0%	4.2%
SVH Service Area	**85.5%**	**4.7%**	**5.0%**	**0.3%**	**0.4%**	**0.1%**	**4.0%**
King County	**63.5%**	**7.4%**	**9.2%**	**6.0%**	**0.6%**	**0.6%**	**4.8%**
Washington	**71.3%**	**15.2%**	**11.7%**	**3.5%**	**1.2%**	**0.7%**	**4.2%**

Source: U.S. Census Bureau, American Community Survey, 2010-2014, DP05. http://factfinder.census.gov

Unemployment

During the period of 2010-2014, unemployment in King County was 7.2% and for Washington it was 8.8%. In the service area, the unemployment rate was 5.1%, lower than the county and state.

Employment Status for the Population 16 and Over, 2010-2014

	Zip Codes	Civilian Labor Force	Unemployed	Unemployment Rate
Carnation	98014	4,032	233	5.8%
Fall City	98024	3,262	176	5.4%
North Bend	98045	8,247	395	4.8%
Preston	98050	116	0	0.0%
Snoqualmie	98065	6,975	324	4.6%
Snoqualmie Pass	98068	178	40	22.5%
Snoqualmie Valley Hosp. Service Area		**22,810**	**1,168**	**5.1%**
King County		**1,131,947**	**81,761**	**7.2%**
Washington		**3,503,337**	**308,955**	**8.8%**

Source: U.S. Census Bureau, American Community Survey, 2010-2014, DP03. http://factfinder.census.gov

Income

The median household income in the Snoqualmie Valley service area is $102,085. This is a higher median income than found in the county ($73,035) or the state ($60,294). Preston has a median income of $247,188. Snoqualmie Pass has the lowest median household income ($53,864) in the service area.

Median Household Income

	Zip Codes	Median Household Income
Carnation	98014	$97,806
Fall City	98024	$99,257
North Bend	98045	$87,470
Preston	98050	$247,188
Snoqualmie	98065	$123,548
Snoqualmie Pass	98068	$53,864
Snoqualmie Valley Service Area		**$102,085**
King County		**$73,035**
Washington		**$60,294**

Source: U.S. Census Bureau, American Community Survey, 2010-2014, DP03. http://factfinder.census.gov

Poverty

Poverty thresholds are used for calculating all official poverty population statistics and are updated each year by the Census Bureau. For 2014, the federal poverty level (FPL) for one person was $11,670 and for a family of four $23,850. In the Snoqualmie Valley service area, 6.1% of the population was living at or below 100% of the Federal Poverty Level (FPL) and 13.4% were considered low-income (living at or below 200% FPL). However, this overall rate masks the disparities in the population when viewed by community. North Bend has the highest rate of poverty (9.9%) followed by Fall City (7.1%) and Carnation (6.4%). However, the poverty rates in the Snoqualmie Valley service area are considerably lower than found in the county (11.8%) and state (13.5%). There were no low-income households reported for Preston.

Ratio of Income to Poverty Level

	Zip Codes	Below 100% Poverty		Below 200% Poverty	
		Number	Percent	Number	Percent
Carnation	98014	439	6.4%	1,103	16.0%
Fall City	98024	424	7.1%	913	15.3%
North Bend	98045	1,440	9.9%	2,688	18.4%
Preston	98050	0	0.0%	0	0.0%
Snoqualmie	98065	166	1.3%	731	5.7%
Snoqualmie Pass	98068	12	5.0%	42	17.6%
Snoqualmie Valley Service Area		**2,481**	**6.1%**	**5,477**	**13.4%**
King County		**6,133**	**11.8%**	**483,335**	**24.4%**
Washington		**13,006**	**13.5%**	**2,052,229**	**30.3%**

Source: U.S. Census Bureau, American Community Survey, 2010-2014, S1701. http://factfinder.census.gov

Families in Poverty

North Bend has the largest percentage of families living in poverty (13.5% of families living with related children under the age of 18), while Preston has none, and Snoqualmie less than one percent (0.6%).

Families Living in Poverty

	Zip Codes	Percent
Carnation	98014	4.9%
Fall City	98024	7.5%
North Bend	98045	13.5%
Preston	98050	0.0%
Snoqualmie	98065	0.6%
Snoqualmie Pass	98068	42.9%
Snoqualmie Valley Service Area		**7.5%**
King County		**11.6%**
Washington		**14.8%**

Source: U.S. Census Bureau, American Community Survey, 2010-2014, DP03. http://factfinder.census.gov

Families where the female is the head of household (HOH) are households where a female maintains a household with related children under the age of 18 with no husband present. Almost a quarter (23.1%) of all families in the county that have a female HOH, live in poverty, which is less than the state rate of 28.3%.

Female HOH with Children Living in Poverty

	Zip Codes	Percent
Carnation	98014	18.9%
Fall City	98024	0.0%
North Bend	98045	32.2%
Preston	98050	0.0%
Snoqualmie	98065	6.2%
Snoqualmie Pass	98068	100%
Snoqualmie Valley Service Area		**18.1%**
King County		**23.1%**
Washington State		**28.3%**

Source: U.S. Census Bureau, American Community Survey, 2010-2014, DP03. http://factfinder.census.gov

Housing

More than three quarters of the housing units in the service area are owner-occupied. From 2007-2011 to 2010-2014, owner-occupied housing decreased slightly, from 81.4% to 78.6%; renter-occupied housing increased from 18.6% to 21.4%, and housing vacancies decreased slightly, while they remained the same for the county. Home ownership and rental rates are similar across all service area cities, with Preston being the exception; Preston shows all 60 of its housing units as owner-occupied.

Housing Units

	Housing Units	Owner Occupied		Renter Occupied		Vacant	
		2011	2014	2011	2014	2011	2014
Carnation	2,706	88.1%	80.2%	11.9%	19.8%	10.6%	9.1%
Fall City	2,180	85.6%	80.7%	14.4%	19.3%	5.4%	7.7%
North Bend	5,811	79.4%	76.7%	20.6%	23.3%	8.9%	5.6%
Preston	60	100%	100%	0.0%	0.0%	0.0%	0.0%
Snoqualmie	4,507	82.6%	78.9%	17.4%	21.1%	7.5%	5.7%
Snoqualmie Pass	658	48.1%	78.0%	51.9%	22.0%	76.3%	81.5%
Snoqualmie Valley Service Area		**81.4%**	**78.6%**	**18.6%**	**21.4%**	**11.1%**	**9.8%**
King County		**59.6%**	**57.5%**	**40.4%**	**42.5%**	**6.4%**	**6.4%**
Washington State		**64.4%**	**62.7%**	**35.6%**	**37.3%**	**9.1%**	**9.4%**

Source: U.S. Census Bureau, American Community Survey, 2010-2014, DP04. http://factfinder.census.gov

Language

In the service area, English is the dominant language spoken in the home. In those homes where other languages are spoken, only 2.7% do not speak English very well.

Language Spoken at Home, Ability to Speak English, Population 5 Years and Over

	Zip Codes	Speaks Only English	Speaks a Language Other than English	
			Speaks English "Very Well"	Speaks English Less Than "Very Well"
Carnation	98014	87.8%	97.9%	2.1%
Fall City	98024	89.9%	94.4%	5.6%
North Bend	98045	90.1%	97.9%	2.1%
Preston	98050	100%	N/A	N/A
Snoqualmie	98065	88.5%	97.7%	2.3%
Snoqualmie Pass	98068	79.8%	95.4%	4.6%
Snoqualmie Valley Service Area		**89.2%**	**97.3%**	**2.7%**
King County		**73.6%**	**89.3%**	**10.7%**
Washington		**81.2%**	**92.2%**	**7.8%**

Source: U.S. Census Bureau, American Community Survey, 2010-2014, DP05. http://factfinder.census.gov

In the service area, 4.1% speak Spanish at home, 3.4% speak some other Indo-European language, and 3.2% speak an Asian or Pacific Islander language; in each case, it is a smaller percentage than found in the county or the state. The highest number of Spanish speakers is found in Carnation (6.3%), the highest number of Indo-European language speakers (other than Spanish) is found in Snoqualmie Pass

(15.5%), but the population is small so this percentage should be interpreted with caution. The highest percentages of Asian / Pacific Islander language speakers is found in Snoqualmie (5.2%), followed closely by Fall City (5.1%).

Language Spoken at Home for the Population 5 Years and Over

	Zip Codes	English Only	Spanish	Other Indo-European	Asian / Pac. Islander
Carnation	98014	87.8%	6.3%	4.1%	1.8%
Fall City	98024	89.9%	3.4%	1.7%	5.1%
North Bend	98045	90.1%	5.8%	2.5%	1.5%
Preston	98050	100%	0.0%	0.0%	0.0%
Snoqualmie	98065	88.5%	1.3%	4.8%	5.2%
Snoqualmie Pass	98068	79.8%	4.6%	15.5%	0.0%
Snoqualmie Valley Service Area		**89.2%**	**4.1%**	**3.4%**	**3.2%**
King County		**73.6%**	**6.7%**	**6.4%**	**11.1%**
Washington		**81.2%**	**8.3%**	**3.9%**	**5.6%**

Source: U.S. Census Bureau, American Community Survey, 2010-2014, DP02. http://factfinder.census.gov

Education

The population of the Snoqualmie Valley service area is highly educated; 54.4% hold a college degree, which exceeds the state rate (42.0%) but is slightly lower than the county rate (55.2%). Only 5.5% of the population, age 25 and over, have less than a high school degree.

Educational Attainment, Percent of Population Age 25+

	Less Than 9th Grade	9th to 12th Grade	High School Graduate	Some College, No Degree	AA Degree	BS Degree	Graduate Degree
Carnation	1.4%	6.4%	18.8%	22.5%	9.0%	27.8%	14.1%
Fall City	3.3%	3.0%	18.5%	19.2%	10.1%	33.3%	12.7%
North Bend	1.9%	5.0%	20.1%	26.5%	9.6%	27.2%	9.7%
Preston	0.0%	11.6%	13.5%	42.6%	0.0%	24.5%	7.7%
Snoqualmie	0.4%	1.5%	10.5%	21.9%	8.7%	38.7%	18.2%
Snoqualmie Pass	0.5%	1.5%	31.2%	21.5%	2.4%	42.4%	0.5%
Snoqualmie Valley Service Area	**1.6%**	**3.9%**	**16.8%**	**23.4%**	**9.2%**	**31.8%**	**13.4%**
King County	**3.6%**	**4.3%**	**16.7%**	**20.1%**	**8.2%**	**29.2%**	**17.8%**
Washington	**4.1%**	**5.8%**	**23.3%**	**24.9%**	**9.7%**	**20.6%**	**11.7%**

Source: U.S. Census Bureau, American Community Survey, 2010-2014, DP02. http://factfinder.census.gov

Birth Indicators

Births

The Washington State Department of Health and the Seattle & King County Department of Health do not provide access to birth data at the zip code level. None of the cities in the service area are included in the relatively short list of cities for which birth data is made available. Data from a 2008-2012 breastfeeding report suggest that the average number of births for the Snoqualmie / North Bend / Skykomish HRA during that time period was 561 per year.

Total Births and Birth Rate, Five-Year Average, 2010-2014

	Number	Rate per 1,000 persons
King County	24,887	12.4
Washington	87,191	12.6

Source: Washington State Department of Health, 2010-2014, http://www.doh.wa.gov/DataandStatisticalReports/VitalStatisticsData/Birth/BirthTablesbyYear

Teen Births

Teen birth rates in the Snoqualmie / North Bend / Skykomish HRA occurred at a five-year average rate of 1.7 per 1,000 teen females between the ages of 15 and 17. This is less than that of King County (6.3) and the state (10.5 births per 1,000 teen females, ages 15 to 17).

Births to Teenage Mothers, Ages 15-17, Five-Year Average, 2010-2014

	Births to Teen Mothers	Rate per 1,000 Females, Ages 15-17
Snoqualmie / North Bend / Skykomish HRA	8	1.7
King County	**213**	**6.3**
Washington	**1,370**	**10.5**

Source: Washington State Department of Health, per Seattle & King County Public Health's City Health / HRA Profiles for 2016, 2010-2014. http://www.kingcounty.gov/healthservices/health/data/CityProfiles.aspx

Prenatal Care

In the Snoqualmie / North Bend / Skykomish HRA, 4.1% of women who gave birth received prenatal care late (after the first trimester) or received no prenatal care, which is a better rate of accessing care than the county (5.5%) or state (6.1%).

Late Entry into Prenatal Care (After First Trimester), Five-Year Average, 2010-2014

	Births with Late Prenatal Care	Percent
Snoqualmie / North Bend / Skykomish HRA	81	4.1%
King County	**4,125**	**5.5%**
Washington	**16,005**	**6.1%**

Source: Washington State Department of Health, per Seattle & King County Public Health's City Health / HRA Profiles for 2016, 2010-2014. http://www.kingcounty.gov/healthservices/health/data/CityProfiles.aspx

Low Birth Weight

Low birth weight is a negative birth indicator. Babies born at a low birth weight are at higher risk for disease, disability and possibly death. The service area has a lower rate of low birth weight babies (5.5%) when compared to the county (6.5%) and state (6.3%). The Healthy People 2020 objective for low birth weight infants is 7.8% of live births. The percentage of low birth weight infants in the Snoqualmie Valley service area favorably exceeds this benchmark.

Low Birth Weight (Under 2,500 g), Five-Year Average, 2010-2014

	Low Weight Births	Percent
Snoqualmie / North Bend / Skykomish HRA	114	5.5%
King County	**1,617**	**6.5%**
Washington	**5,484**	**6.3%**

Source: Washington State Department of Health, per Seattle & King County Public Health's City Health / HRA Profiles for 2016, 2010-2014. http://www.kingcounty.gov/healthservices/health/data/CityProfiles.aspx

Infant Mortality

The infant death rate in the Snoqualmie / North Bend / Skykomish HRA was not calculated because the number of deaths was fewer than 5. The infant death rate in the county was 4.2 deaths per 1,000 live births, which are less than the Healthy People 2020 objective of 6.0 infant deaths per 1,000 live births.

Infant Mortality Rate, Five-Year Average, 2010-2014

	Infant Deaths	Rate per 1,000 Live Births
Snoqualmie / North Bend / Skykomish HRA	< 5	N/A
King County	**520**	**4.2**
Washington	**2,002**	**4.6**

Source: Washington State Department of Health, per Seattle & King County Public Health's City Health / HRA Profiles for 2016, 2010-2014. http://www.kingcounty.gov/healthservices/health/data/CityProfiles.aspx

Breastfeeding

Breastfeeding has been proven to have considerable benefits to baby and mother. The American Academy of Pediatrics recommends babies be fed only breast milk for the first six months of life. Only limited data is available at the county and HRA levels; the Snoqualmie / North Bend / Skykomish HRA compares favorably with the county, with 96.1% of all mothers of newborns initiating breastfeeding.

Breastfeeding Initiation, Five-Year Average, 2008-2012

	Number	Percent
Snoqualmie / North Bend / Skykomish HRA	539	96.1%
King County	**23,503**	**95.5%**

Source: Washington State Department of Health, per Seattle & King County Public Health's City Health / HRA Profiles for 2016, 2010-2014. http://www.kingcounty.gov/healthservices/health/data/CityProfiles.aspx

Leading Causes of Death

Age-Adjusted Death Rate

Age-adjusted death rates are an important factor to examine when comparing mortality data. The crude death rate is a ratio of the number of deaths to the entire population. Age-adjusted death rates eliminate the bias of age in the makeup of the populations being compared. When adjusted for age, the death rate in the Snoqualmie / North Bend / Skykomish HRA is 610.1 per 100,000 persons, lower than the county (628.1).

Age-Adjusted Death Rate, Five-Year Average, 2008-2012

	Rate per 100,000 Persons
Snoqualmie / North Bend / Skykomish HRA	610.1
King County	**628.1**

Source: Seattle & King County Public Health, King County Health Profile, 2014. http://www.kingcounty.gov/healthservices/health/data.aspx

The top three causes of death in the Snoqualmie / North Bend / Skykomish HRA are cancer, heart disease and chronic lower respiratory disease (CLRD). Rates of death from heart disease, lower respiratory disease, and suicide are all higher than county levels, and deaths by heart disease and suicide exceed Healthy People 2020 goals.

Death Rates for Top 10 Causes of Death, Five-Year Average, 2010-2014

	Snoqualmie / North Bend / Skykomish HRA		King County	Washington	Healthy People 2020
	5-Year Total	Age-Adjusted	Age-Adjusted	Age-Adjusted	Age-Adjusted
All Cancers	214	148.1	150.5	162.5	161.4
Heart Disease	169	128.5	127.2	142.3	103.4
Chronic Lower Respiratory Disease (CLRD)	48	40.9	29.7	40.8	N/A
Accidents and external causes	46	23.8	30.7	38.4	36.4
Alzheimer's Disease	37	34.9	41.1	44.0	N/A
Suicide	32	14.9	12.1	14.4	10.2
Stroke	26	24.5	31.4	35.5	33.8
Diabetes Mellitus	21	16.8	18.3	21.9	N/A
Chronic Liver Disease and Cirrhosis	15	7.4	9.3	11.0	8.2
Essential Hypertenstion	9	6.6	7.4	7.5	N/A

Source: Washington State Department of Health, per Seattle & King County Public Health's City Health / HRA Profiles for 2016, 2010-2014. http://www.kingcounty.gov/healthservices/health/data/CityProfiles.aspx

Breast and Colon Cancer Mortality

The cancer death rate in the service area for female breast cancer is 22.8 per 100,000 women. This rate is higher than the county (20.9 per 100,000 females), and higher than the Healthy People 2020 objective of 20.7 deaths from breast cancer per 100,000 persons. When examining the rate of death due to colorectal cancer, the age-adjusted, five-year average is 13.3 per 100,000 persons for both the HRA and the county. This is better than the Healthy People 2020 objective of 14.5 deaths per 100,000 persons as a result of colorectal cancer.

Cancer Age-Adjusted Death Rate per 100,000 Persons, Five-Year Average, 2008-2012

	Breast Cancer		Colorectal Cancer	
	Number	Age-Adjusted	Number	Age-Adjusted
Snoqualmie / North Bend / Skykomish HRA	4	22.8	4	13.3
King County	**222**	**20.9**	**252**	**13.3**

Source: Seattle & King County Public Health, King County Community Health Indicators, 2008-2012. http://www.kingcounty.gov/healthservices/health/data/indicators.aspx

Drug Dependence and Abuse

The rate of death due to drug use is 6.3 per 100,000 persons in the Snoqualmie / North Bend / Skykomish HRA, which is lower than the county (12.0) and the Healthy People 2020 objective of 11.3 per 100,000 persons.

Drug-Related Age-Adjusted Death Rate per 100,000 Persons, Five-Year Average

	Drug Dependence and Abuse	
	Number	Age-Adjusted
Snoqualmie / North Bend / Skykomish HRA	3	6.3
King County	**252**	**12.0**

Source: Seattle & King County Public Health, King County Community Health Indicators, 2008-2012. http://www.kingcounty.gov/healthservices/health/data/indicators.aspx

Alcohol Dependence and Abuse

The rate of death in the service area due to alcohol use is 8.0 per 100,000 persons, which is lower than the rate of death found in the county (8.9).

Alcohol-Related Age-Adjusted Death Rate per 100,000 Persons, Five-Year Average

	Alcohol Dependence and Abuse	
	Number	Age-Adjusted
Snoqualmie / North Bend / Skykomish HRA	4	8.0
King County	**188**	**8.9**

Source: Seattle & King County Public Health, King County Community Health Indicators, 2008-2012. http://www.kingcounty.gov/healthservices/health/data/indicators.aspx

HIV/AIDS Mortality

The rate of death due to HIV/AIDS is small and, therefore, the service area HRA did not meet statistical validity requirements for an average annual count or an age-adjusted death rate. The county (1.7 per 100,000 persons) and state (1.0 per 100,000) rates are below the Healthy People 2020 objective (3.3 per 100,000 persons).

HIV/AIDS Age-Adjusted Death Rate per 100,000 Persons, Five-Year Average

	HIV/AIDS	
	Number	Age-Adjusted
King County	36	1.7
Washington	323	1.0

Source: Seattle & King County Public Health, King County Community Health Indicators, 2008-2012, http://www.kingcounty.gov/healthservices/health/data/indicators.aspx; and Washington State Department of Health, HIV Surveillance Reports, 2008-2012. http://www.doh.wa.gov/DataandStatisticalReports/DiseasesandChronicConditions/HIVAIDSData/SurveillanceReports

Access to Health Care

Health Insurance

Health insurance coverage is considered a key component to accessing health care. Among the adult population, 93.1% has health insurance, a higher rate than the county or the state. The majority of residents have private health insurance (85.3%). Snoqualmie Pass has the highest rates of uninsured (27.9%) in the area, although this percentage is based on a very low population; Fall City, with a larger population, has 11.8% uninsured. Preston has no residents who are without insurance.

Types of Health Insurance Coverage, Ages 18-64

	Zip Codes	No Health Insurance Coverage	Private and/or Public Health Coverage	Public Health Coverage	Private Health Coverage
Carnation	98014	7.0%	93.0%	8.5%	84.5%
Fall City	98024	11.8%	88.2%	9.3%	78.9%
North Bend	98045	7.9%	92.1%	10.3%	81.8%
Preston	98050	0.0%	100%	10.1%	89.9%
Snoqualmie	98065	3.1%	96.9%	3.9%	93.0%
Snoqualmie Pass	98068	27.9%	72.1%	2.5%	69.6%
Snoqualmie Valley Service Area		**6.9%**	**93.1%**	**7.8%**	**85.3%**
King County		**11.1%**	**88.9%**	**13.7%**	**75.2%**
Washington		**12.9%**	**87.1%**	**17.7%**	**69.4%**

Source: U.S. Census Bureau, American Community Survey, 2010-2014, S2701. http://factfinder.census.gov

Among children in the service area, 1.4% are uninsured (98.6% insured), compared to 4.3% for King County (95.7% insured), and 5.6% who are uninsured (94.4% insured) in Washington state.

Uninsured Children, Ages 0-17

	Zip Codes	Number	Percent
Carnation	98014	39	2.3%
Fall City	98024	68	4.8%
North Bend	98045	7	0.2%
Preston	98050	0	0.0%
Snoqualmie	98065	47	1.1%
Snoqualmie Pass	98068	2	28.6%
Snoqualmie Valley Service Area		**163**	**1.4%**
King County		**18,261**	**4.3%**
Washington		**88,903**	**5.6%**

Source: U.S. Census Bureau, American Community Survey, 2010-2014, S2701. http://factfinder.census.gov

Barriers to Care

From 2010-2014, 10% of adults, 18 and over, did not see a doctor at least once in the previous year due to cost. This was lower than county (14%) and state (15%) rates.

Adults with Unmet Medical Need Due to Cost, Five-Year Average

	Percent
Snoqualmie / North Bend / Skykomish HRA	10%
King County	**14%**
Washington State	**15%**

Source: Behavioral Risk Factor Surveillance Survey (BRFSS), Washington State Department of Health, per Seattle & King County Public Health's City Health / HRA Profiles for 2016, 2010-2014.
http://www.kingcounty.gov/healthservices/health/data/CityProfiles.aspx

Dental Care

From 2010-2014, 19% of adults in the Snoqualmie / North Bend / Skykomish HRA did not access dental care in the past year. 29% of adults in King County, and 33% of Washington State adults did not obtain dental care.

Adults Who Did Not Access Dental Care, Five-Year Average

	Percent
Snoqualmie / North Bend / Skykomish HRA	19%
King County	**29%**
Washington State	**33%**

Source: Behavioral Risk Factor Surveillance Survey (BRFSS), Washington State Department of Health, per Seattle & King County Public Health's City Health / HRA Profiles for 2016, 2010-2014.
http://www.kingcounty.gov/healthservices/health/data/CityProfiles.aspx

Access to Primary Care Community Clinics

Community clinics provide primary care (including medical, dental and mental health services) for uninsured and medically underserved populations. There are a number of Section 330 funded grantees (Federally Qualified Health Centers – FQHCs) serving the Snoqualmie Valley Hospital service area, including: Sea Mar Community Health Centers, HealthPoint Community Health Centers, Neighborcare Health, Country Doctor Community Clinic and King County Public Health Centers. HealthPoint is the dominant FQHC for Carnation and Fall City, while in North Bend and Snoqualmie it is Sea Mar.

Using ZCTA (ZIP Code Tabulation Area) data for the service area and information from the Uniform Data System (UDS)[1], 13.4% of the population in the Snoqualmie Valley service area is categorized as low-income (200% of Federal Poverty Level) and 5.9% are at or below the Federal Poverty Level. Even with Section 330 funded Community Health Center providers in the area, there are a majority of low-income residents who are not served by a clinic provider. The FQHCs have a total of 628 patients in the

[1] The UDS is an annual reporting requirement for grantees of HRSA primary care programs:
• Community Health Center, Section 330 (e)
• Migrant Health Center, Section 330 (g)
• Health Care for the Homeless, Section 330 (h)
• Public Housing Primary Care, Section 330 (i)

service area, however, there remain 4,849 low-income residents, approximately 88.5% of the population at or below 200% FPL that are not served by a Section 330-funded grantee.

Low-Income Patients Served and Not Served by FQHCs

Patients served by Section 330 Grantees	Penetration among Low-Income Patients	Penetration of Total Population	Low-Income Not Served	
			Number	Percent
628	11.5%	1.5%	4,849	88.5%

Source: UDS Mapper, 2014. http://www.udsmapper.org

Chronic Disease

Diabetes

The percent of adults, 18 and older, who reported being diagnosed with diabetes, was 9% in the service area, which is the same as the state rate, and higher than the 7% county rate.

Adult Diabetes Prevalence, Five-Year Average

	Percent
Snoqualmie / North Bend / Skykomish HRA	9%
King County	**7%**
Washington State	**9%**

Source: Behavioral Risk Factor Surveillance Survey (BRFSS), Washington State Department of Health, per Seattle & King County Public Health's City Health / HRA Profiles for 2016, 2010-2014.
http://www.kingcounty.gov/healthservices/health/data/CityProfiles.aspx

Asthma

The percent of children, ages 0-17, with asthma is 7% in King County and 6% in East King County. At the county level, African Americans and Asians, males, and very low income households (under $15,000 per year) have the highest prevalence of childhood asthma.

Child (0-17) Asthma Prevalence, Five-Year Average

	Percent
East County	6%
King County	**7%**

Source: Seattle & King County Public Health, Health Indicators 2009-2013.
http://www.kingcounty.gov/healthservices/health/data/indicators.aspx

9% of adults in the Snoqualmie / North Bend / Skykomish HRA and in King County have asthma, which is less than the 10% state rate. Among county adults with asthma, females, Native Americans, and low-income populations have the highest prevalence.

Adult Asthma Prevalence, Five-Year Average

	Percent
Snoqualmie / North Bend / Skykomish HRA	9%
King County	**9%**
Washington State	**10%**

Source: Behavioral Risk Factor Surveillance Survey (BRFSS), Washington State Department of Health, per Seattle & King County Public Health's City Health / HRA Profiles for 2016, 2010-2014.
http://www.kingcounty.gov/healthservices/health/data/CityProfiles.aspx

Asthma Hospitalization

Asthma hospitalizations in children (0-17) occurred at a rate of 137.0 per 100,000 persons in King County. The East King County rate of childhood asthma hospitalizations is 93.6 per 100,000 persons, which is lower than the King County rate. County children who are 0-4 years old, male and at high levels of poverty, have the highest rates of asthma hospitalization.

Adults are hospitalized for asthma at much lower rates than children. Averaged over five years, adults in King County were hospitalized for asthma at a rate of 47.7 per 100,000 persons. In East King County, the adult asthma hospitalization rate is 28.6 per 100,000 persons. At the county level, senior adults, females, and those at high levels of poverty have the highest rates of asthma hospitalization.

Asthma Hospitalization, per 100,000 Persons, Five-Year Average

	Childhood Asthma	Adult Asthma
East County	93.6	28.6
King County	**137.0**	**47.7**

Source: Seattle & King County Public Health, Health Indicators 2008-2012.
http://www.kingcounty.gov/healthservices/health/data/indicators.aspx

Colorectal and Breast Cancer

The incidence of colorectal cancer, averaged over three years, is 35.5 per 100,000 persons for King County, which is lower than the state rate of 37.5 per 100,000 persons. Seniors, Native Americans and Hawaiian / Pacific Islanders, and males have higher rates of colorectal cancer.

In King County, breast cancer rates in women occur at a rate of 189.8 per 100,000 persons, which is higher than the state rate of 170.0 per 100,000 persons. Black females and senior females in the county have the highest rates of breast cancer.

Colorectal and Breast Cancer Incidence, per 100,000 Persons, 2010-2012

	King County	Washington
Colorectal cancer	35.5	37.5
Breast cancer	189.8	170.0

Source: Washington State Department of Health Cancer Registry, 2010-2012.
https://fortress.wa.gov/doh/wscr/WSCR/Query.mvc/Query

Communicable Disease

Tuberculosis

The rate of tuberculosis in King County, averaged over five years, is 5.3 per 100,000 persons, which is higher than the state rate of 2.9 per 100,000 persons. King County has the highest rate of TB of all Washington State counties.

While the rate of new TB cases diagnosed has been on the decline in King County in the past few years, males, the homeless, and residents 65 and older still suffer with higher rates of TB. Foreign-born residents are at particularly high risk for TB; 87% of newly diagnosed cases in 2014 were among individuals born outside the U.S., with half of all those coming from five countries: China, India, Mexico, Philippines, and Vietnam.

New Diagnoses of TB, per 100,000 Persons, Five-Year Average, 2011-2015

	Tuberculosis	
	Number of New Diagnoses	Rate per 100,000 persons
King County	105.4	5.3
Washington State	199.4	2.9

Source: Washington State Department of Health TB Program, 2015 TB Cases by County, 2011-2015
http://www.doh.wa.gov/YouandYourFamily/IllnessandDisease/Tuberculosis/DataReports

Sexually Transmitted Diseases

Chlamydia rates continue to rise, occurring at a rate of 363.5 per 100,000 persons in King County, though this is lower than for Washington State (376.7). Chlamydia occurs at the highest rates among females, ages 20-24, and girls 15-19. The rate of Gonorrhea is also on the rise, with 110.0 cases per 100,000 persons for King County, which is higher than the state rate of 88.1 per 100,000 persons. Males, ages 20-24 have the highest rates of Gonorrhea, followed closely by males 25-29. Syphilis rates have been dropping slightly, occurring at a rate of 8.6 per 100,000 persons in King County, which is much higher than the state rate of 4.8 per 100,000 persons. Syphilis occurs at much higher rates among males and most frequently among males, ages 20-44, with the highest rate in 2014 among 20-24 year olds. Rates of new diagnoses of genital herpes are also dropping, with a county level of 19.1 per 100,000 persons, which is lower than the state (29.9 new diagnoses per 100,000 persons). It is diagnosed more often in women than in men, and most often in women 20-24 years of age.

Sexually Transmitted Diseases, per 100,000 Persons, 2014

	King County	Washington
Chlamydia	363.5	376.7
Gonorrhea	110.0	88.1
P&S Syphilis	8.6	4.8
Genital Herpes	19.1	29.9

Source: Washington State Department of Health, Sexually Transmitted Disease Profile, King County 2014.
http://www.doh.wa.gov/YouandYourFamily/IllnessandDisease/SexuallyTransmittedDisease/CountyProfiles

HIV/AIDS

HIV incidence is the number of persons newly diagnosed with HIV each year, including those also diagnosed with AIDS. The incidence rate of new HIV/AIDS diagnoses, averaged over five years, was 14.5 per 100,000 persons in King County, which is about double the state rate of 7.3. While the number of new and existing HIV/AIDS cases is highest among Whites, the highest rates of new diagnosis are typically among males, ages 25-44, non-Hispanic Blacks (particularly immigrants), and those living in poverty.

HIV prevalence is the number of persons who are seropositive for the human immunodeficiency virus per 100,000 persons. The rate of HIV/AIDS prevalence in King County is 346.0 per 100,000 persons, almost double the state rate. Males, ages 45-54 and non-Hispanic Blacks have the highest rates of HIV/AIDS prevalence.

HIV/AIDS Incidence and Prevalence, per 100,000 Persons, Five-Year Average, 2010-2014

	New Diagnoses	Prevalence
King County*	14.5	346.0
Washington State*	7.3	182.1

Source: Seattle & King County Public Health, HIV / AIDS Epidemiology Annual Report, 2015.
http://www.kingcounty.gov/healthservices/health/communicable/hiv/epi/reports.aspx

Health Behaviors

Health screenings and immunizations are widely accepted methods to help identify and prevent disease.

Child Immunizations

The rate of childhood immunizations among children, ages 19-35 months is 67.4% in Washington state (the CDC divided the state into two divisions only through 2010; it has not polled King County separately since 2006), which is lower than the U.S. rate of 71.6.

Child Immunizations, Age 19-35 Months, 4:3:1:3:3:1, 2014

	Percent
Washington State	67.4%
United States	71.6%

Source: Centers for Disease Control, National Immunization Survey, 2014. http://www.cdc.gov/vaccines/imz-managers/coverage/nis/child/index.html

The rate of school-required immunizations among Kindergarten-aged children is 90.8% in the Snoqualmie Valley School District, which is higher than the King County and the state rate of 85%.

Kindergarten Immunization Completion, 2015-2016 School Year

	Complete	Out of Compliance	Exempt	Exempt Due to Personal / Philosophical Beliefs
Snoqualmie Valley School District	90.8%	4.4%	4.2%	3.0%
King County	**85.0%**	**9.0%**	**4.1%**	**3.2%**
Washington State	**85.0%**	**8.6%**	**4.5%**	**3.3%**

Source: Washington Department of Health, School Immunization Data Tables, 2015-2016. http://www.doh.wa.gov/DataandStatisticalReports/HealthBehaviors/Immunization/SchoolReports/DataTables

Flu Shots

It is recommended that all adults receive flu shots every year, particularly those at high risk of complications, such as the elderly. In the Snoqualmie / North Bend / Skykomish HRA, 38% of adults got the flu shot, which is slightly higher than the 37% state rate but below the county rate of 40%.

Reports on flu shots were only broken down by age, ethnicity and income at the county level. Hispanics are the least likely to have gotten the flu shot, while women and upper-income residents obtained flu shots at higher rates than other segments of the population. Flu shot use also increased with age; 66% of seniors 65 and older in King

County received the flu shot. This is still lower, however, than the Healthy People objective of 70% of persons receiving a flu shot.

Flu Shots, Adults 18+, Five-Year Average, 2010-2014

	Percent
Snoqualmie / North Bend / Skykomish HRA	38%
King County	**40%**
Washington	**37%**

Source: Washington State Department of Health, per Seattle & King County Public Health's City Health / HRA Profiles for 2016, 2010-2014. http://www.kingcounty.gov/healthservices/health/data/CityProfiles.aspx

Pneumonia Vaccination

The pneumonia vaccination rate among seniors in the HRA is 74%, which is comparable to the county and state rates but well below the Healthy People 2020 objective of 90%. Whites and women in the county were most likely to have gotten the pneumonia vaccine.

Pneumonia Vaccine, Adults 65+, Five-Year Average

	Percent
Snoqualmie / North Bend / Skykomish HRA	74%
King County	**72%**
Washington	**73%**

Source: Washington State Department of Health, per Seattle & King County Public Health's City Health / HRA Profiles for 2016, 2010-2014. http://www.kingcounty.gov/healthservices/health/data/CityProfiles.aspx

Mammograms

80% of women, 50 to 74 years of age, in the HRA have had a mammogram in the past two years. This exceeds the county and state rates, but falls short of the Healthy People 2020 objective of 81.1%. At the county level, white and Asian women, women ages 65-74, and women in high-income households tend to obtain screening mammograms at rates higher than other segments of the female population.

Mammogram in Last Two Years, Women 50-74, Five-Year Average

	Percent
Snoqualmie / North Bend / Skykomish HRA	80%
King County	**72%**
Washington	**71%**

Source: Washington State Department of Health, per Seattle & King County Public Health's City Health / HRA Profiles for 2016, 2010-2014. http://www.kingcounty.gov/healthservices/health/data/CityProfiles.aspx

Colorectal Cancer Screening

In East King County, 65% of adults 50 years and older have been screened for

colorectal cancer. This rate is slightly higher than the county (64%), but below the Healthy People 2020 objective of 70.5%. Hispanics/Latinos and lower-income households tend to get colorectal cancer screenings at a lower rate than other segments of the population; screening rates rise consistently with income.

Colorectal Cancer Screening, Adults 50-75, Two-Year Average

	Percent
East County	65%
King County	**64%**

Source: Seattle & King County Public Health, Health Indicators 2009-2013. http://www.kingcounty.gov/healthservices/health/data/indicators.aspx

Smoking

The percentage of adults in the HRA who smoke cigarettes is 14%, which is the same as the county rate and lower than the state rate (17%). Higher rates of smoking in the county are seen in males, African Americans, Native Americans, residents ages 25-44, and those whose household incomes are below $25,000 annually. The Healthy People 2020 objective is 12%.

Adult Smokers, Five-Year Average, 2010-2014

	Percent
Snoqualmie / North Bend / Skykomish HRA	14%
King County	**14%**
Washington	**17%**

Source: Washington State Department of Health, per Seattle & King County Public Health's City Health / HRA Profiles for 2016, 2010-2014. http://www.kingcounty.gov/healthservices/health/data/CityProfiles.aspx

Youth Smoking

8% of school-aged youth in grades 8, 10 and 12 in East King County indicated they had smoked cigarettes one or more times in the past 30 days. The highest percentage of smoking occurred in 12th graders, males, and among Native American and Hawaiian / Pacific Islander students in the county.

Youth Smokers, Grades 8, 10, and 12; 2010 & 2012 averaged

	Percent
East County	8%
King County	**9%**

Source: Seattle & King County Public Health, Health Indicators 2010 & 2012. http://www.kingcounty.gov/healthservices/health/data/indicators.aspx

Adults Overweight and Obese

In the East County area, half the adult population (50%) is overweight or obese, having a Body Mass Index (BMI) greater than or equal to 25. Almost one-third of the population (32%) is overweight and almost one-fifth (18%) is obese (having a BMI of 30 or more). At the HRA level, obesity is even higher, with 29% of Snoqualmie / North Bend / Skykomish HRA residents having a BMI >= 30. Males and adults, ages 45-64, and Native Americans and African Americans, have the highest levels of obesity in the county.

Adult Overweight and Obese, Five-Year Average, 2009-2013

	Overweight	Obese	Overweight and Obese
East County	32%	18%	50%
King County	**33%**	**22%**	**55%**

Source: Seattle & King County Public Health, Health Indicators 2009-2013.
http://www.kingcounty.gov/healthservices/health/data/indicators.aspx

Adult Obesity, Five-Year Average, 2010-2014

	Percent
Snoqualmie / North Bend / Skykomish HRA	29%
King County	**22%**
Washington	**18%**

Source: Behavioral Risk Factor Surveillance Survey (BRFSS), Washington State Department of Health, per Seattle & King County Public Health's City Health / HRA Profiles for 2016, 2010-2014.
http://www.kingcounty.gov/healthservices/health/data/CityProfiles.aspx

Youth Overweight and Obese

In East King County, 16% of youth in grades 8, 10 and 12 are overweight or obese (top 15% BMI for age and gender), with 6% considered obese (the top 5% of BMI for age and gender). These numbers are lower than King County. Rates of obesity are higher for boys (11%) than girls (6%), and particularly high for Native Hawaiian or Pacific Islander children (23%), Hispanic/Latino (14%) and Native American and African American children (12%), and lowest for Asian and White children (6%).

Youth Overweight, Grades 8, 10, and 12; 2010 & 2012 averaged

	Overweight	Obese	Overweight and Obese
East County	10%	6%	16%
King County	**12%**	**8%**	**20%**

Source: Seattle & King County Public Health, Health Indicators 2010 & 2012.
http://www.kingcounty.gov/healthservices/health/data/indicators.aspx

Adult Physical Activity

The CDC recommendation for adult physical activity is moderate activity equal to or greater than 150 minutes in a week or vigorous activity equal to or greater than 75 minutes a week. In East King County, in the most-recent data available, only one-quarter (25%) of adults met the physical activity recommendation. Younger adults (28%) and Whites (23%) had higher rates of physical activity, and rates of physical activity increased with income. The lowest levels of physical activity in King County were seen in African Americans (17%), and Hispanics/Latinos (19%).

Physical Activity, Adults, 2011 & 2013 averaged

	Percent
East County	25%
King County	**22%**

Source: Seattle & King County Public Health, Health Indicators 2011 & 2013.
http://www.kingcounty.gov/healthservices/health/data/indicators.aspx

The percentage of adults in the Snoqualmie / North Bend / Skykomish HRA who are sedentary and do not participate in any leisure time physical activity is 11%, which is better than the county (16%) and state (20%). County seniors tend to be more sedentary, as do Hispanic / Latino and African American residents. Leisure-time physical activity increases with income.

Sedentary Adults: No Leisure Time Physical Activity, Five-Year Average, 2010-2014

	Percent
Snoqualmie / North Bend / Skykomish HRA	11%
King County	**16%**
Washington	**20%**

Source: Behavioral Risk Factor Surveillance Survey (BRFSS), Washington State Department of Health, per Seattle & King County Public Health's City Health / HRA Profiles for 2016, 2010-2014.
http://www.kingcounty.gov/healthservices/health/data/CityProfiles.aspx

Youth Physical Activity

The CDC recommendation for youth physical activity is 60 minutes or more each day. 25% of East County youth in grades 8, 10, and 12 meet this activity recommendation, which is slightly higher than for King County (24%). At the county level, younger youth and males have higher rates of activity compared to other students, as do Native American and African American children. Hispanic / Latino children (21%) and Asian children (18%) are the least active.

Youth Physical Activity, Grades 8, 10, and 12; 2010 & 2012 averaged

	Percent
East County	25%
King County	**24%**

Source: Seattle & King County Public Health, Health Indicators 2010 & 2012.
http://www.kingcounty.gov/healthservices/health/data/indicators.aspx

Social Issues

Years of Healthy Life and Life Expectancy

Life expectancy in the Snoqualmie / North Bend / Skykomish HRA is 82.3 years, which is higher than the county (81.8 years) and the state (80.3). Life expectancy in the county tends to be highest for Asians (86.4) and Hispanics/Latinos (86.9), as well as women, and rises with income.

Life Expectancy, Five-Year Average

	Life Expectancy
Snoqualmie / North Bend / Skykomish HRA	82.3
King County	**81.8**
Washington State	**80.3**

Source: Behavioral Risk Factor Surveillance Survey (BRFSS), Washington State Department of Health, per Seattle & King County Public Health's City Health / HRA Profiles for 2016, 2010-2014.
http://www.kingcounty.gov/healthservices/health/data/CityProfiles.aspx

Years of healthy life are the number of years a newborn can expect to live with good or excellent health if current life expectancy and health rates stay the same for his/her entire life. For residents of East King County, years of healthy life are expected to be 76.8 years. The gap between this and life expectancy, are years of fair or poor health. Poverty correlates highly with the number of years of ill health at the end of life.

Years of Healthy Life, Five-Year Average, 2008-2012

	Healthy Life	Life Expectancy
East County	76.8	83.8
King County	**72.4**	**81.6**

Source: Washington State Department of Health, Center for Health Statistics, per Seattle & King County Public Health, Health Indicators 2008-2012. http://www.kingcounty.gov/healthservices/health/data/indicators.aspx

Fair or Poor Health

When asked to self-report on health status, 12% of adults in the HRA indicated they were in fair or poor health. This is the same as the rate found in the county, but lower than found in the state (16%). At the county level, the highest levels of fair or poor health were reported by seniors, Native Americans, Hispanics/Latinos and African Americans, and the poor. Perceived or actual levels of ill health decreased with rising income.

Fair or Poor Health, Adults, Five-Year Average

	Percent
Snoqualmie / North Bend / Skykomish HRA	12%
King County	**12%**
Washington	**16%**

Source: Behavioral Risk Factor Surveillance Survey (BRFSS), Washington State Department of Health, per Seattle & King County Public Health's City Health / HRA Profiles for 2016, 2010-2014.
http://www.kingcounty.gov/healthservices/health/data/CityProfiles.aspx

Activity Limitation

Among adults in the HRA, 22% have limited activity as a result of physical, mental or emotional problems. In the county, limited activity rises with age: 11% for 18-24 year olds rising to 36% for those 65 and older. Activity limitation also rises with decreasing income: 16% among households earning $75,000 or more, to 42% among those earning $15,000 or less. Rates are highest among Native Americans (33%), Whites (24%) and African-Americans (21%), with Hispanics/Latinos at 17% and Asians at 10%.

Activity Limitation, Adults, Five-Year Average

	Percent
Snoqualmie / North Bend / Skykomish HRA	22%
King County	**22%**
Washington	**25%**

Source: Behavioral Risk Factor Surveillance Survey (BRFSS), Washington State Department of Health, per Seattle & King County Public Health's City Health / HRA Profiles for 2016, 2010-2014.
http://www.kingcounty.gov/healthservices/health/data/CityProfiles.aspx

Physical or Mental Unhealthy Days

The average number of physical and mental unhealthy days experienced by adults in the HRA in the last 30 days was three days. At the county level, adults 45 to 64 have higher numbers of unhealthy days, and there is a direct correlation with income (number of unhealthy days increases rapidly as income decreases).

Physical and Mental Health Unhealthy Days

	Average Number of Days in the Past 30	
	Mental Health Not Good	Physical Health Not Good
Snoqualmie / North Bend / Skykomish HRA	3	3
King County	**4**	**3**
Washington	**4**	**4**

Source: Behavioral Risk Factor Surveillance Survey (BRFSS), Washington State Department of Health, per Seattle & King County Public Health's City Health / HRA Profiles for 2016, 2010-2014.
http://www.kingcounty.gov/healthservices/health/data/CityProfiles.aspx

Frequent Mental Distress

Frequent mental distress is defined as 14 or more poor mental health days in the last month. In the Snoqualmie / North Bend / Skykomish HRA, 9% of the adult population experienced frequent mental distress. Females, Hispanics/Latinos, and African Americans at the county level experienced higher rates of mental distress compared to other segments of the population. Mental distress also correlates closely with income, rising steeply as income falls: 6% in households earning $75,000 or more, and 24% in those earning $15,000 or less. Rates of mental distress fall as age rises, with only 5% of seniors reporting mental distress as compared to 13% of young adults.

Frequent Mental Distress

	Percent
Snoqualmie / North Bend / Skykomish HRA	9%
King County	**11%**
Washington	**11%**

Source: Behavioral Risk Factor Surveillance Survey (BRFSS), Washington State Department of Health, per Seattle & King County Public Health's City Health / HRA Profiles for 2016, 2010-2014.
http://www.kingcounty.gov/healthservices/health/data/CityProfiles.aspx

Adult Alcohol Use

Excessive drinking is defined as greater than 60 drinks per month for men and greater than 30 drinks a month for women, or binge drinking, which is five or more drinks on one occasion for men and four or more for women. In the HRA, 20% of adults engaged in excessive drinking over the past year, which is less than the county (22%) but higher than the state rate (19%). The highest rates of binge drinking at the county level are among males, 18-44 year olds, Native Americans and Whites.

Adult Alcohol Use

	Percent
Snoqualmie / North Bend / Skykomish HRA	20%
King County	**22%**
Washington	**19%**

Source: Behavioral Risk Factor Surveillance Survey (BRFSS), Washington State Department of Health, per Seattle & King County Public Health's City Health / HRA Profiles for 2016, 2010-2014.
http://www.kingcounty.gov/healthservices/health/data/CityProfiles.aspx

Homelessness

As part of the Seattle/King County Coalition on Homelessness's annual Unsheltered Homeless Count, 3,772 individuals were counted on January 23rd, 2015 One Night Count. This represents a 21% increase over the number of homeless counted in 2014, which was a 14% increase over 2013.

It is understood that there may be many more homeless individuals throughout Seattle and King County who were not counted on the night of the count either because they were hidden from volunteer counters, are living unsheltered in areas of the county not included in the count, or were temporarily homeless but staying with friends and family.

Unsheltered Homeless in King County, 2015

	Number	Percent
East Side	48	1.3 %
King County	**3,772**	**100 %**

Source: Seattle/King County Coalition on Homelessness, One Night Count, 2015.
http://www.homelessinfo.org/what_we_do/one_night_count/

Crime

Washington State Sheriff and Police Departments are in the process of migrating from the Uniform Crime Reporting System to the National Incident Based Reporting System, which affected statistical reporting starting in 2012. While most of the migration is complete, the Carnation Police Department and the King County Sheriff's Department are among those yet to be integrated, and accessing accurate data and comparisons are still impaired. As such, the data reported should be considered estimates and comparisons viewed with caution. Data suggest that crime rates are generally lower for the service area than for the state.

Crime Rates per 1,000 Persons, 2015

	Violent Crimes		Property Crimes		Larceny-Theft	
	Number	Rate per 1,000 Persons	Number	Rate per 1,000 Persons	Number	Rate per 1,000 Persons
Carnation Police Department	1	0.6	50	27.9	27	15.1
North Bend Police Department	3	0.5	246	38.0	217	33.5
Snoqualmie Police Department	2	0.2	168	13.1	136	10.6
King County Sheriff's Department	369	1.5	4,695	18.4	2,376	9.4
Washington State, Total	**18,935**	**3.2**	**285,827**	**47.9**	**139,002**	**23.3**

Source: Washington Association of Sheriffs and Police Chiefs' Crime in Washington 2015 Annual Report.
http://www.waspc.org/crime-statistics-reports

Domestic Violence

Domestic violence offenses in Washington State occur at a rate of 730.3, with the rate of injury from domestic violence being 255.4 per 100,000 persons. Information on domestic violence injuries, but not offenses, was available for the North Bend and Snoqualmie Police Departments; North Bend shows a higher rate of domestic violence

injuries. No data was available for either the Carnation Police Department or the King County Sheriff's Department.

Domestic Violence Offences, 2015

	Number	Number of Injuries	Rate of Injury per 100,000 persons
Carnation Police Dept.	N/A	N/A	N/A
North Bend Police Dept.	N/A	21	324.3
Snoqualmie Police Dept.	N/A	28	217.9
King County Sheriff's Dept.	N/A	N/A	N/A
Washington State, Total	**51,582**	**18,038**	**255.4**

Source: Washington Association of Sheriffs and Police Chiefs' Crime in Washington 2015 Annual Report. http://www.waspc.org/crime-statistics-reports

School and Student Characteristics

The Snoqualmie Valley school district was examined for selected demographic and performance characteristics.

School Enrollment

School enrollment for the school district in 2014-2015 was 6,657 students.

Total Student Enrollment, 2014-2015

	Total Enrollment
Snoqualmie Valley School District	6,657
King County	**287,145**
Washington	**1,075,107**

Source: Office of Superintendent of Public Instruction, Washington State; For District and State data: 2014-2015 Report Card. http://reportcard.ospi.k12.wa.us/ For King County: October 2016 Enrollment Report: http://www.k12.wa.us/dataadmin/

Student Race/Ethnicity

The student population of the area district schools is primarily White (83.1%). Hispanics are the next most prevalent race (6.5%), with Asians comprising 4.8% of the student population. All other races total 5.6% of the student population.

Enrollment by Race/Ethnicity

	Caucasian		Asian		Hispanic	
	Number	Percent	Number	Percent	Number	Percent
Snoqualmie Valley School District	5,533	83.1%	322	4.8%	432	6.5%
King County	**133,557**	**46.5%**	**49,782**	**17.3%**	**48,856**	**17.0%**
Washington	**233,616**	**57.0%**	**77,421**	**7.2%**	**612,625**	**21.7%**

Source: Office of Superintendent of Public Instruction, Washington State; For District and State data: 2014-2015 Report Card. http://reportcard.ospi.k12.wa.us/ For King County: October 2016 Enrollment Report: http://www.k12.wa.us/dataadmin/

Enrollment by Race/Ethnicity

	African American		Native American		Pacific Islander		Multiracial/Other	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Snoqualmie Valley School District	55	0.8%	35	0.5%	12	0.2%	271	4.1%
King County	**24,376**	**8.5%**	**1,943**	**0.7%**	**4,060**	**1.4%**	**24,545**	**8.5%**
Washington	**48,248**	**4.5%**	**16,221**	**1.5%**	**10,680**	**1.0%**	**76,274**	**7.1%**

Source: Office of Superintendent of Public Instruction, Washington State; For District and State data: 2014-2015 Report Card. http://reportcard.ospi.k12.wa.us/ For King County: October 2016 Enrollment Report: http://www.k12.wa.us/dataadmin/

Free or Reduced Price Lunch Program

The number of students eligible for the free or reduced price meal program is an indicator of the socioeconomic status of a school district's student population. It is important to note, that while examining district totals provides an overview of the student population, this is an average among all the schools. Within the district there are a number of schools with higher and lower rates of eligible low-income children.

In the Snoqualmie Valley School District, 12.4% of students qualify for free or reduced price meals; this is lower than the percentage found at the county (35.6%) and state (45%) levels.

Free or Reduced Meal Program, 2014-2015

	Number	Percent
Snoqualmie Valley School District	828	12.4%
King County	**98,637**	**35.6%**
Washington	**482,024**	**45.0%**

Source: Office of Superintendent of Public Instruction, Washington State; For District and State data: 2014-2015 Report Card. http://reportcard.ospi.k12.wa.us/ For King County: Free and Reduced Price Meals Eligibility Count, October 2015: http://www.k12.wa.us/ChildNutrition/Reports.aspx

English Learners

The percentage of students who are English Learners in the Snoqualmie Valley School District is 2.3%, which is less than the rate of English Learners in the state (10.4%).

Transitional Bilingual, 2014-2015

	Number	Percent
Snoqualmie Valley School District	156	2.3%
Washington	**111,325**	**10.4%**

Source: Office of Superintendent of Public Instruction, Washington State, 2014-2015 Report Card. http://reportcard.ospi.k12.wa.us/

High School Graduation Rate

In the Snoqualmie Valley School District, 84.8% of students eligible for graduation with their cohort (four years after starting high school). This is higher than the county and state graduation rates.

High School Four-Year Cohort Graduation, 2014

	Rate
Snoqualmie Valley School District	84.8%
King County	**79.8%**
Washington	**77.2%**

Source: Office of Superintendent of Public Instruction, Washington State; For District and State data: 2014-2015 Report Card. http://reportcard.ospi.k12.wa.us/ For King County: Graduation and Dropout Statistics, 2014-2015 Appendix B. http://www.k12.wa.us/dataadmin/

Appendix 3: Community Survey Report

Snoqualmie Valley Hospital Survey Report

Below are the tabulated responses from a July – August 2016 Community Survey regarding preferences and perception about the hospital and clinics. Following the attitudinal data below are demographics of the respondents. The total sample size of the survey is 36.

Aggregate Responses

Value most

> Local location	(28)	78%
> Staff	(10)	28%
> Range of services	(7)	19%

Want improved

> More services	(8)	22%
> More specialists	(5)	14%

Would add

> Patient education	(3)	8%
> Mammogram	(3)	8%
> OB/GYN	(2)	6%

Have experienced the Hospital in past year. N=20

1. **What about the hospital do you value most?**

> Location	(11)	55%
> Caring staff	(4)	20%
> Services	(2)	10%

2. **If you could have the hospital improve one thing, what would that be?**

> More specialists	(5)	25%
> Improve traffic access	(3)	15%
> Don't know	(3)	15%

- Better management (2) 10%
- Better scheduling (2) 10%

3. **If you could have the hospital add one service or program, what would that be?**
   - Don't know (4) 20%
   - Mammography (3) 15%

Have not experienced the Hospital in past year. N=16

4. **What about the hospital do you think provides our community with the most value?**
   - Location (6) 38%
   - Range of services (3) 19%
   - Being a community leader (2) 13%

5. **If you could have the hospital improve one thing what would increase their value to the community, what would that be?**
   - Don't know or nothing (6) 38%
   - More services (4) 25%
   - Improve health of the community (3) 19%

6. **If you could have the hospital add one service or program, what would that be?**
   - Don't know (4) 25%
   - Patient education (3) 19%

Have experienced a Clinic in past year. N=14

7. **What about the clinic do you value the most?**
   - Staff (6) 43%
   - Location (5) 36%
   - Services (2) 14%

8. **If you could have the clinic improve one thing, what would that be?**
   - More services (4) 29%
   - Improve computer system (3) 19%
   - Communication with patients (2) 14%

- Improve scheduling (2) 14%

9. If you could have the clinic add one service or program, what would that be?

- Don't know or NA (5) 38%
- OB/GYN (2) 14%

Have not experienced a Clinic in past year. N=22

10. What about the clinic do you think provides the community with the most value?

- Don't know or NA (11) 50%
- Location (6) 27%
- Ease of seeing PCP (2) 9%

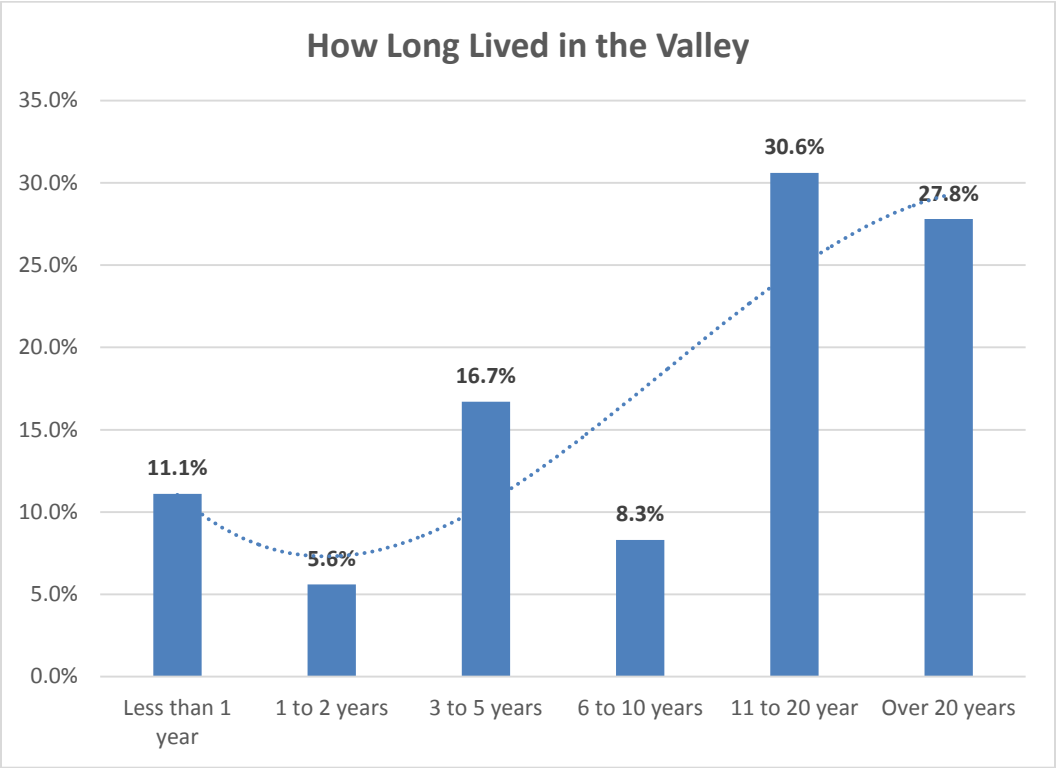
11. If you could have the clinic improve one thing that would increase their value to the community, what would that be?

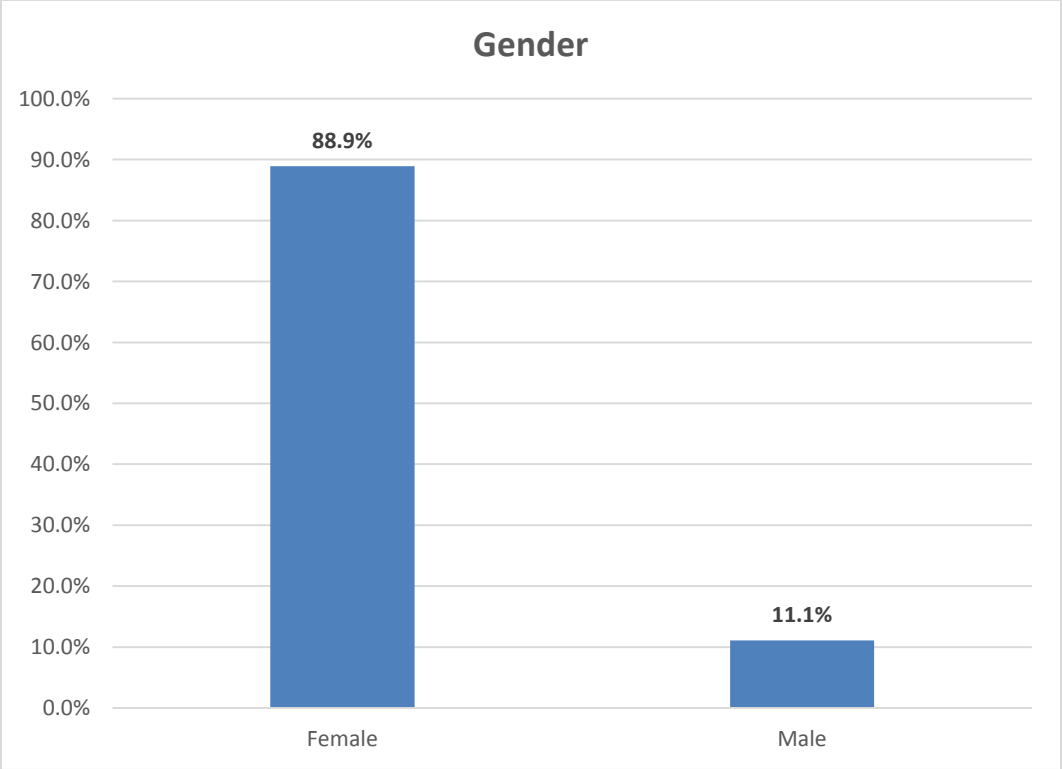
- Don't know or NA (17) 77%

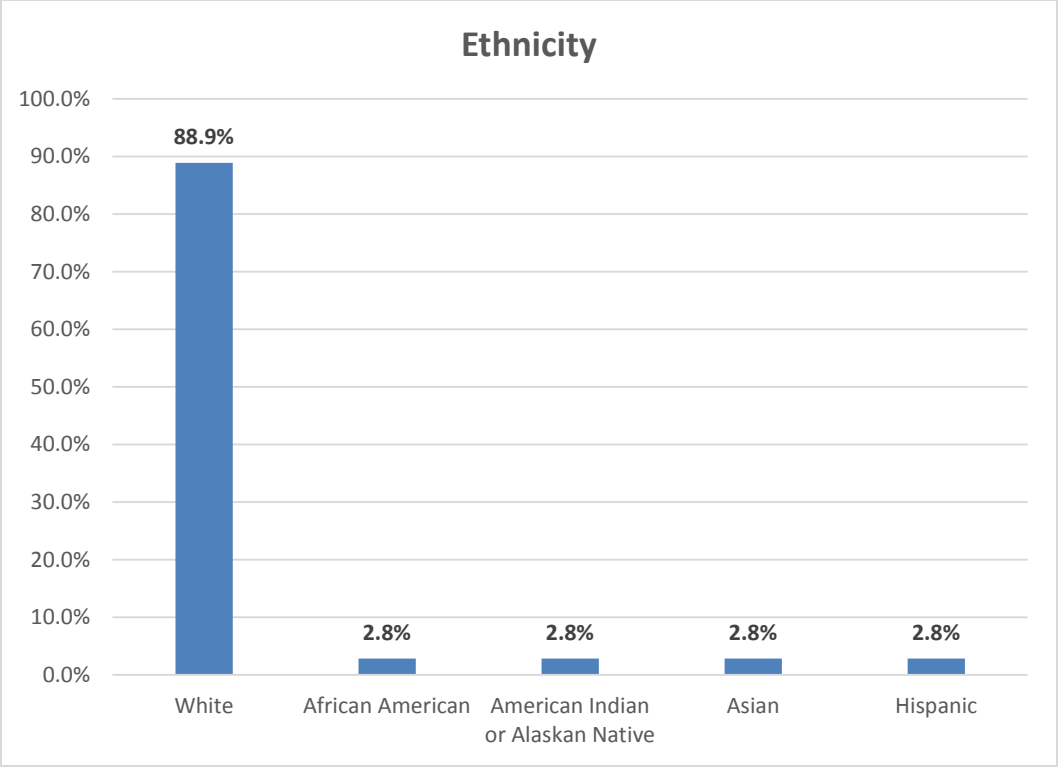
12. If you could have the clinic add one service or program, what would that be?

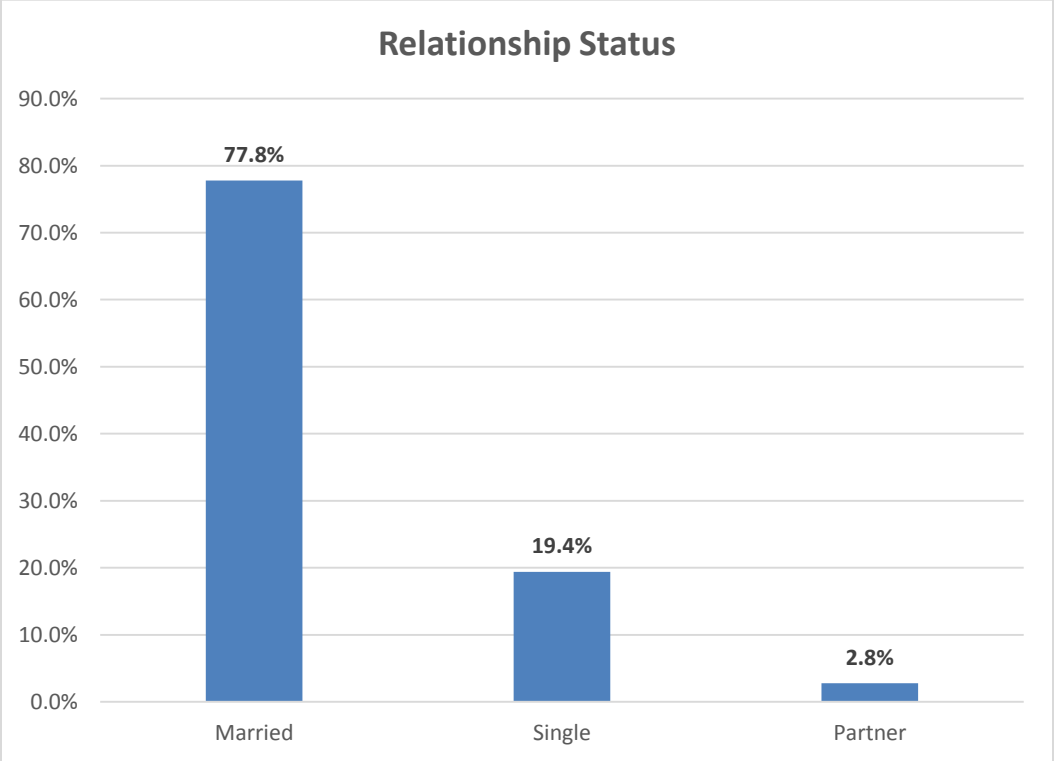
- Don't know, nothing, NA (18) 41%

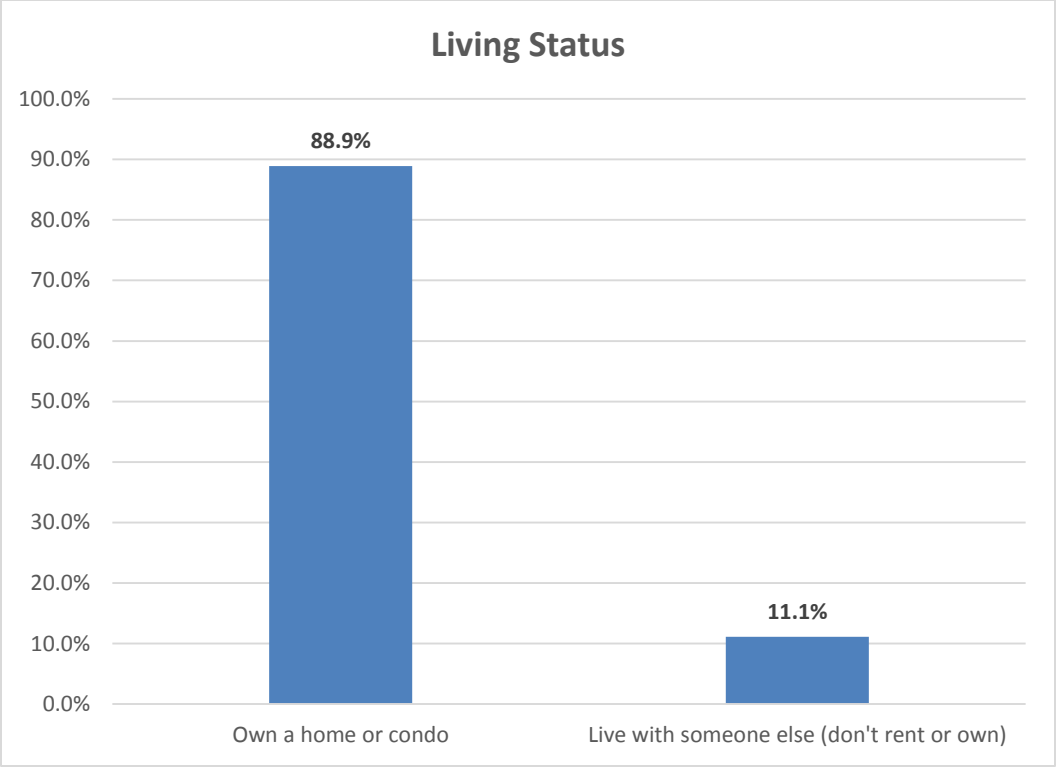
Demographics

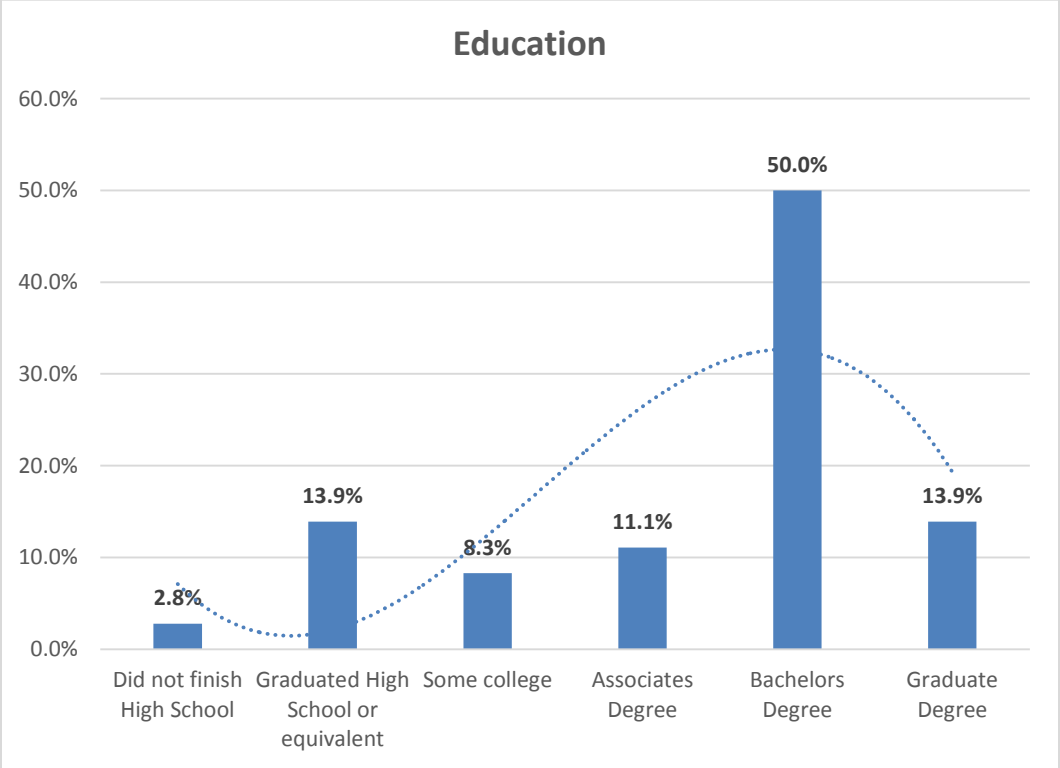


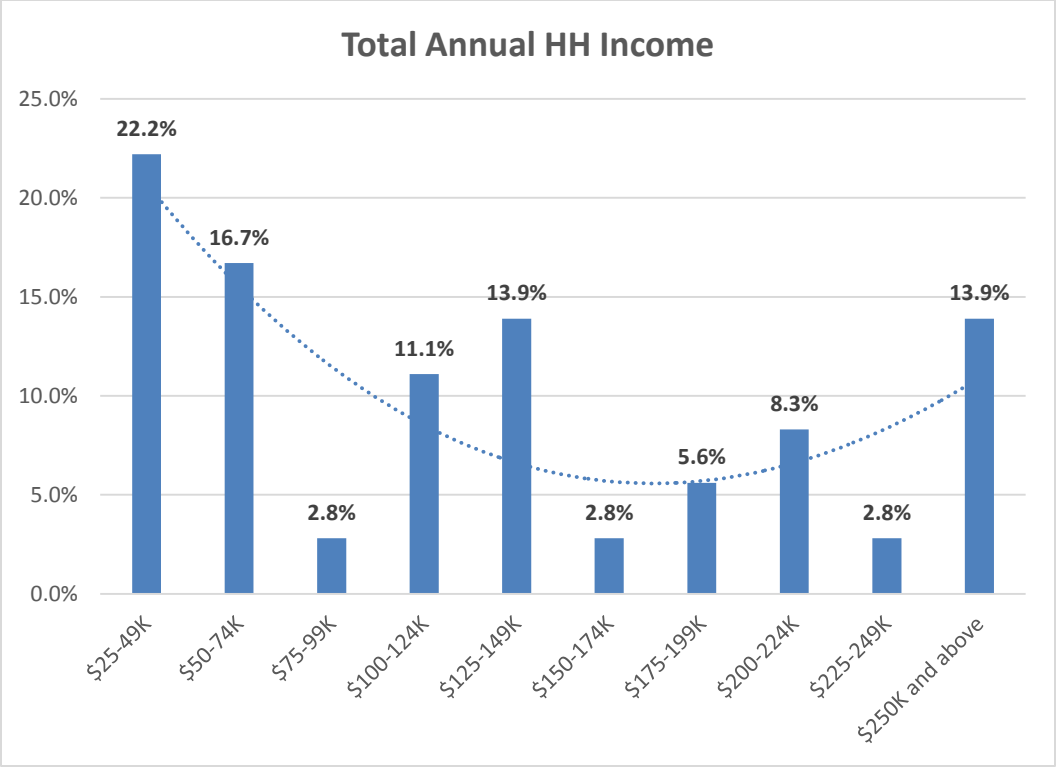


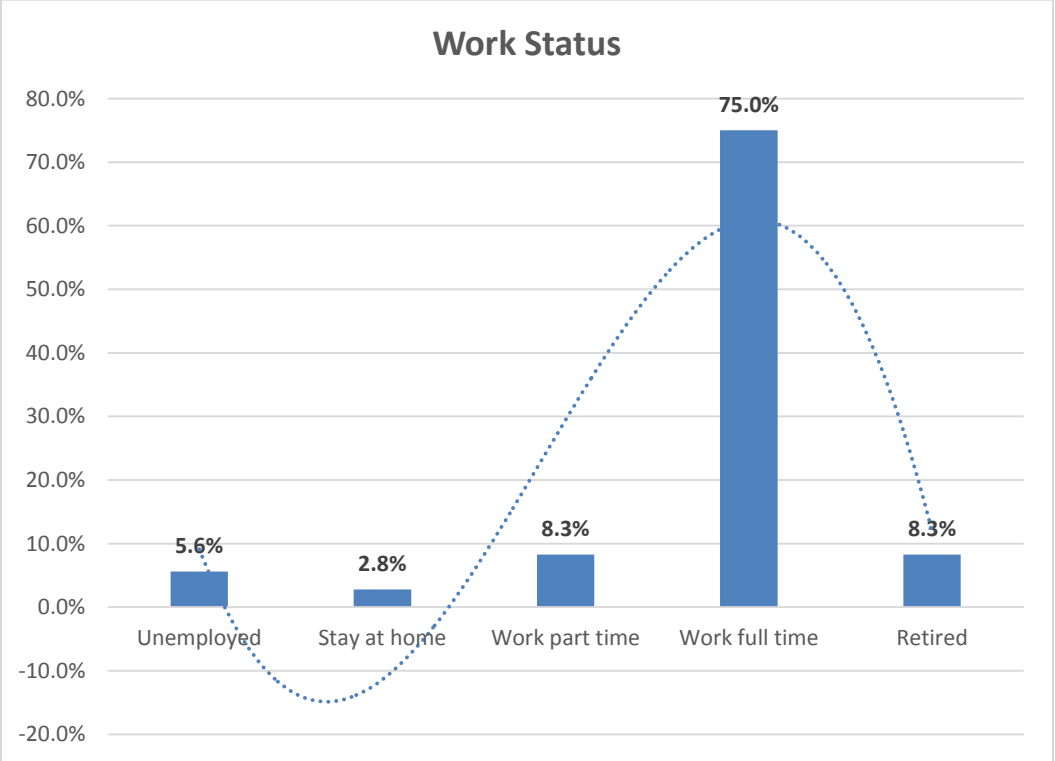

Ethnicity
100.0%
90.0%
80.0%
70.0%
60.0%
50.0%
40.0%
30.0%
20.0%
10.0%
0.0%
88.9%
2.8%
2.8%
2.8%
2.8%
White
African American
American Indian or Alaskan Native
Asian
Hispanic

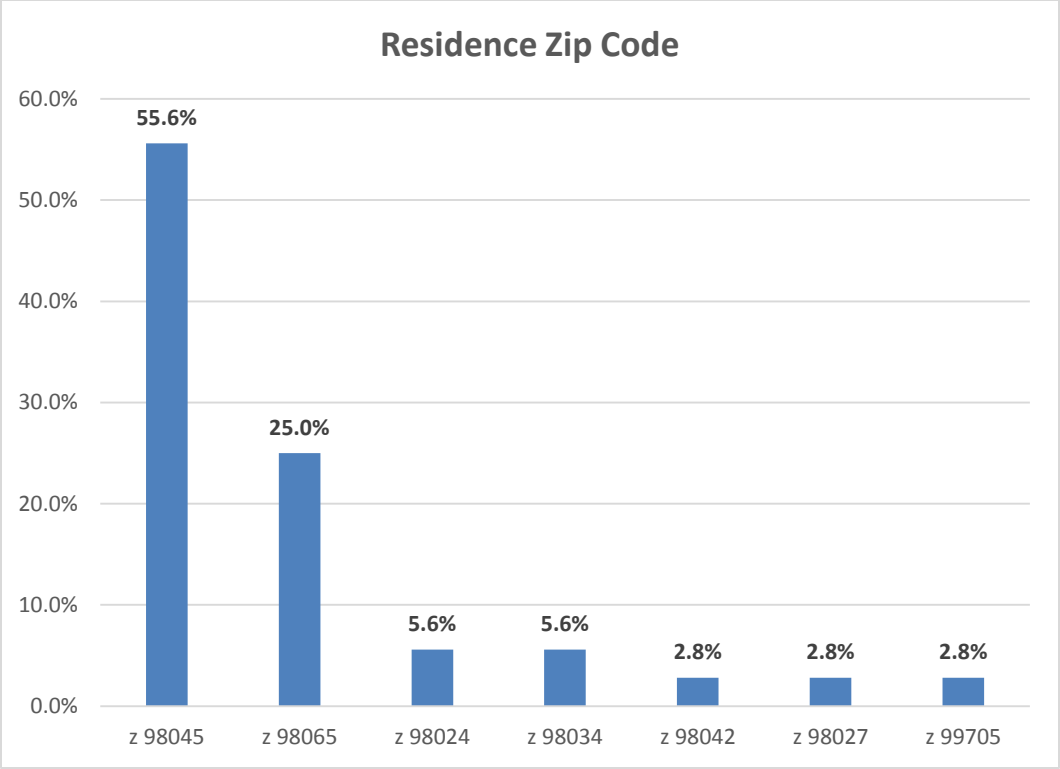

Relationship Status
90.0%
80.0%
70.0%
60.0%
50.0%
40.0%
30.0%
20.0%
10.0%
0.0%
77.8%
19.4%
2.8%
Married
Single
Partner

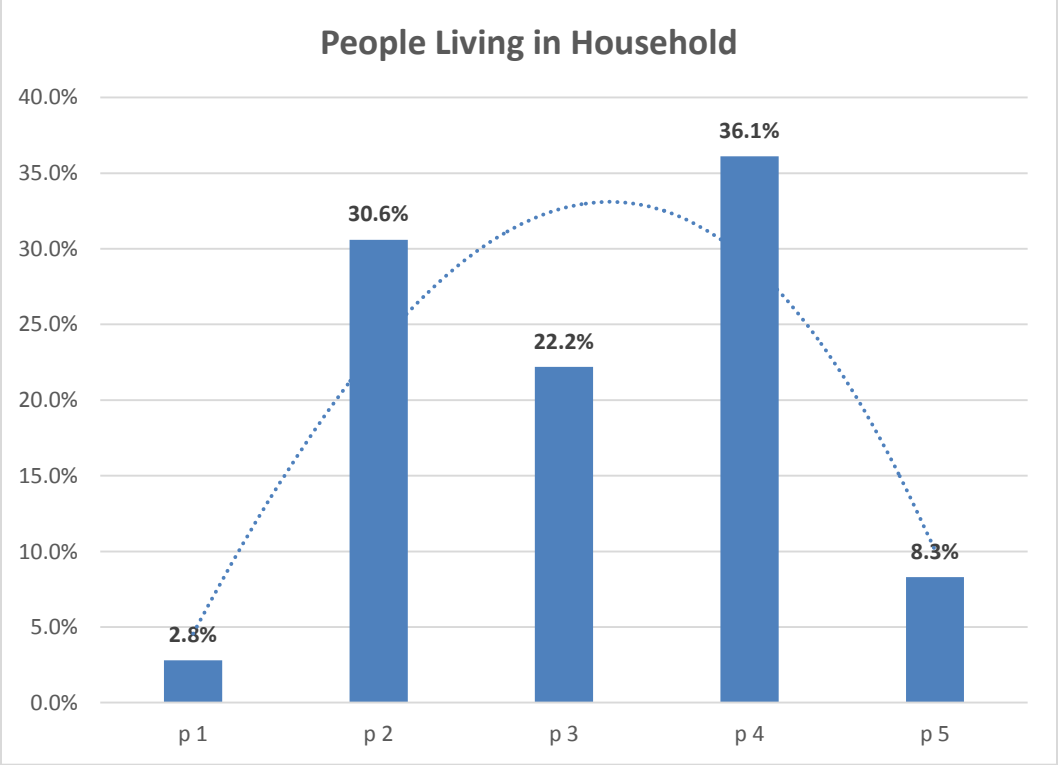

Living Status
100.0%
90.0%
80.0%
70.0%
60.0%
50.0%
40.0%
30.0%
20.0%
10.0%
0.0%
88.9%
11.1%
Own a home or condo
Live with someone else (don't rent or own)

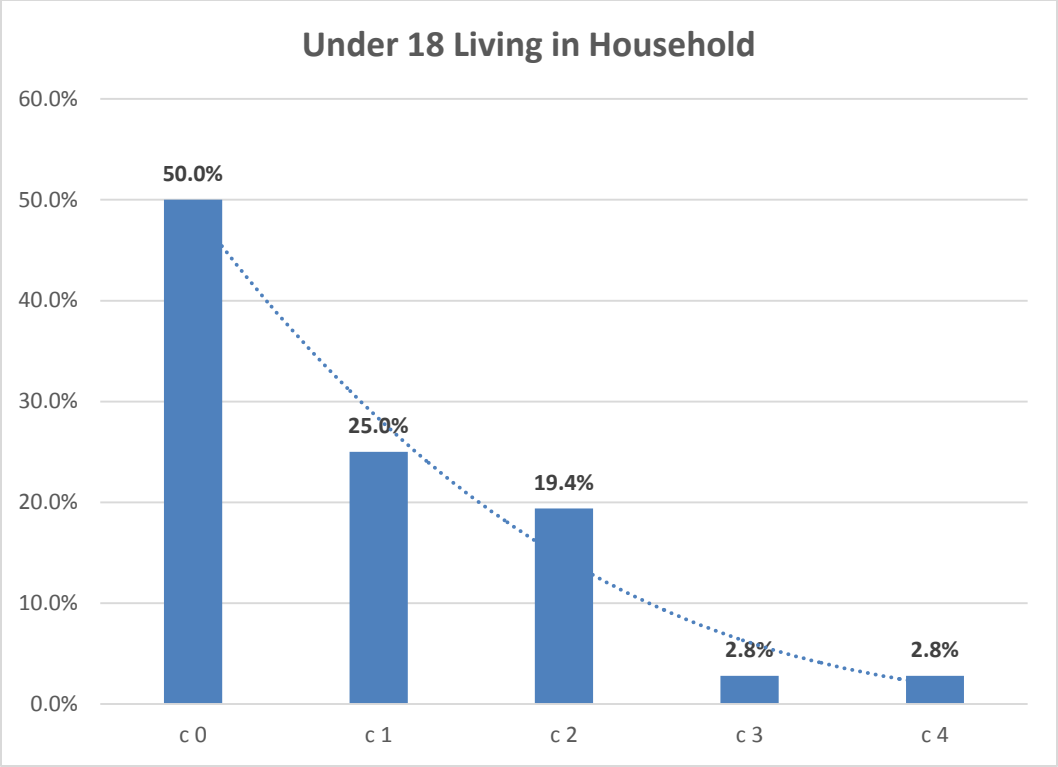

Education
60.0%
50.0%
40.0%
30.0%
20.0%
10.0%
0.0%
2.8%
13.9%
8.3%
11.1%
50.0%
13.9%
Did not finish High School
Graduated High School or equivalent
Some college
Associates Degree
Bachelors Degree
Graduate Degree


Total Annual HH Income
25.0%
20.0%
15.0%
10.0%
5.0%
0.0%
22.2%
16.7%
2.8%
11.1%
13.9%
2.8%
5.6%
8.3%
2.8%
13.9%
$25-49K
$50-74K
$75-99K
$100-124K
$125-149K
$150-174K
$175-199K
$200-224K
$225-249K
$250K and above


Work Status
80.0%
70.0%
60.0%
50.0%
40.0%
30.0%
20.0%
10.0%
0.0%
-10.0%
-20.0%
5.6%
2.8%
8.3%
75.0%
8.3%
Unemployed
Stay at home
Work part time
Work full time
Retired


Residence Zip Code
60.0%
50.0%
40.0%
30.0%
20.0%
10.0%
0.0%
55.6%
25.0%
5.6%
5.6%
2.8%
2.8%
2.8%
z 98045
z 98065
z 98024
z 98034
z 98042
z 98027
z 99705


People Living in Household
40.0%
35.0%
30.0%
25.0%
20.0%
15.0%
10.0%
5.0%
0.0%
2.8%
30.6%
22.2%
36.1%
8.3%
p 1
p 2
p 3
p 4
p 5


Under 18 Living in Household
60.0%
50.0%
40.0%
30.0%
20.0%
10.0%
0.0%
50.0%
25.0%
19.4%
2.8%
2.8%
c 0
c 1
c 2
c 3
c 4

Appendix 4: Strategic Planning Summary Report

Mission

Promote and improve the health and wellbeing of people in our community by providing quality care in a collaborative environment.

Vision

Our Community will become the healthiest in the Nation.

Strategy	***Workgroup Priority***	***Non-Workgroup Members' Score*/ Priority****	***Combined Score Priority****
STRATEGIC FOCUS AREA: VIABILITY *The previous financial history of the district and the current amount of debt makes financial viability a priority. We are defining financial viability as a balanced budget, positive cash flow, debt repayment and positive financial returns on District investments.*			
Balance budget to generate capital for future growth and investments.	2	15 / 1	1.5
Challenge our present independent and swing bed-centric model to determine options that allow sustainability considering new payment models and the changing healthcare landscape.	1	3 / 4	2.5
Offer services consistent with community needs and payment models to support them considering industry trends.	3	7 / 2	2.5
Reduce debt and use a standardized method for self-assessment of progress toward goal.	4	5 / 3	3.5
STRATEGIC FOCUS AREA: QUALITY *The commitment and continuing efforts to use measurable interventions to propel and sustain improvement that contributes to better patient outcomes, better system performance, and more satisfying experiences.*			
Transform services from episodic and transactional to longitudinal and preventative.	1	13 / 1	1.0
Reduce hospital re-admission rate and average length of stay.	2	4 / 3	2.5
Increase patient and family satisfaction scores.	4	11 / 2	3.0
Increase designated stroke and cardiac levels of care.	3	2 / 4	3.5
Increase percentage of Q.I. reporting metric scores.	5	0 / 5	5.0

Strategy	*Workgroup Priority*	*Non-Workgroup Members' Score*/ Priority***	*Combined Score Priority***
STRATEGIC FOCUS AREA: RELATIONSHIPS *Relationships are at the core of our existence. Relationships, based on mutual respect and trust, are interactions that will make us better as individuals and an organization.*			
Develop strategic approach to seeking new, strengthening current, or returning to historical relationships both in realms of business and community.	2	15 / 1	1.5
Develop a method of valuating relations and the value of our contribution to relations.	1	7 / 3	2.0
Expand employee development and recognition program.	3	8 / 2	2.5
STRATEGIC FOCUS AREA: GROWTH *Growth initiatives must be measurable, consistent with our mission, financially sustainable, and responsive to the health needs of those we serve.*			
Identify potential affiliation partners.	1	9 / 1	1.0
Conduct a comprehensive asset mapping process.	2	8 / 2	2.0
Focus growth marketing on outpatient services.	3	4 / 4	3.5
Reduce outmigration.	4	7 / 3	3.5
Increase outreach to make the Hospital a community gathering place.	5	2 / 5	5.0

** These scores are the result of the "dot" scoring system used to provide input from those who where not in the workgroup assigned to that specific strategic focus area.*

*** Non-workgroup Member's Scoring was converted to a prioritization, the highest score given a priority of 1. For each strategy these Priority scores were averaged with the priority score from the workgroup to get a combined priority score.*