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Allenmore Hospital

# 2025 COMMUNITY HEALTH IMPROVEMENT PLAN

*Implementation Strategies*
*2026–2028*

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# Allenmore Hospital

## 2025 Community Health Improvement Plan (CHIP)

Implementation Strategy Narrative for 2026–2028

### Organizational Commitment

MultiCare Allenmore Hospital is committed to improving the health and well-being of the communities it serves through strategic, measurable, and equity-focused community benefit investments. This Community Health Improvement Plan (CHIP) translates findings from the 2025 Community Health Needs Assessment (CHNA) into actionable implementation strategies designed to address identified priority health needs across Pierce County.

This CHIP reflects both hospital-specific accountability and coordinated system alignment within MultiCare Health System. While Allenmore and Tacoma General Hospitals will maintain distinct implementation plans, strategies are intentionally aligned to maximize impact, reduce duplication, and leverage shared clinical, operational, and community partnerships.

### Community Health Needs Assessment Foundation

The 2025 CHNA identified significant health priorities across the Pierce County service area through quantitative data analysis and sustained community engagement. Priority health needs selected for focused action during this CHIP cycle include:

- Mental Health (youth and adult depression; poisoning/overdose)
- Access to Care (inadequate prenatal care; lack of insurance coverage; transportation barriers)
- Chronic Disease (asthma-related emergency department utilization; adult obesity)

These priorities reflect both the magnitude of need and documented disparities in outcomes across race, ethnicity, geography, and socioeconomic status.

The CHIP builds directly upon this assessment and is designed to meet federal community benefit requirements while advancing MultiCare's mission and long-term strategic objectives.

### Health Equity Framework

Advancing health equity is central to Allenmore Hospital's implementation strategy. Data from the CHNA demonstrates persistent disparities in life expectancy, maternal health outcomes, chronic disease burden, and behavioral health indicators among historically underserved populations.

This CHIP incorporates an equity lens through:

- Stratified data monitoring by socio-demographic characteristics such as race, ethnicity, language, disability, gender identity, veteran status, payer, and geography
- Culturally responsive and developmentally appropriate clinical programming
- Expanded language access services and bilingual workforce support

- Partnerships with trusted community-based organizations
- Investment in upstream social drivers of health

By integrating clinical care delivery with community-based interventions, Allenmore Hospital aims not only to improve outcomes but to reduce inequities that contribute to preventable morbidity and mortality.

### Strategic Implementation Approach

The CHIP organizes implementation across a phased planning horizon:

- Now (2026) – Immediate actions and infrastructure strengthening
- Near (2027) – Program expansion and partnership scaling
- Far (2028) – Sustainable systems change and long-term impact

Across all priority areas, implementation strategies emphasize:

- Early identification and screening
- Improved timeliness and coordination of care
- Workforce development and provider recruitment
- Community partnership investment (cash and in-kind)
- Policy advocacy aligned with community health priorities
- Integration of social determinants of health screening and referral workflows

Strategies will be operationalized through multidisciplinary collaboration across Women's Services, Behavioral Health, Primary Care, Emergency Services, Population Health, Care Management, Government Relations, Community Partnerships, Center for Health Equity and Wellness, and system-level leadership teams.

### Behavioral Health Strategy Overview

Allenmore Hospital will strengthen early identification, reduce stigma, and expand timely access to behavioral health services across the care continuum. Interventions include universal screening efforts, enhanced suicide risk assessment, culturally informed care training, provider recruitment, and strengthened referral pathways.

Recognizing the impact of substance use and overdose in the region, the hospital will expand access to harm-reduction tools, community partnerships, and policy advocacy that support prevention and recovery. These efforts aim to build a coordinated ecosystem of care that improves patient trust, engagement, and outcomes.

### Access to Care Strategy Overview

Improving access to care remains foundational to community health improvement. Allenmore Hospital will focus on expanding ambulatory access, strengthening benefit enrollment support, addressing transportation barriers, and improving prenatal and postpartum continuity of care.

Implementation strategies include telehealth expansion, community-based enrollment partnerships, navigation services embedded within clinical settings, and collaboration with external partners to reduce structural barriers such as insurance coverage gaps and transportation limitations.

Special attention will be given to improving early prenatal care initiation, postpartum visit completion, and infant health outcomes, recognizing maternal-child health as a critical upstream driver of long-term population health.

### Chronic Disease Strategy Overview

To address asthma-related emergency department utilization and adult obesity, Allenmore Hospital will implement a coordinated strategy that integrates clinical management with upstream prevention efforts.

Key focus areas include:

- Standardized asthma action planning and patient education
- Universal screening for food insecurity
- Strengthening referral pathways to nutrition support programs
- Development of medically tailored meal and food access initiatives
- Partnerships promoting physical activity and healthy living environments

By combining clinical care management with community-based prevention and policy engagement, the hospital seeks to reduce avoidable utilization and improve long-term chronic disease outcomes.

### Community Partnerships & Cross-Sector Alignment

Allenmore Hospital recognizes that sustainable community health improvement requires cross-sector collaboration. The CHIP prioritizes partnerships with:

- Public health agencies
- Federally Qualified Health Centers
- Behavioral health providers
- Community-based organizations
- Workforce development initiatives
- Transportation and policy stakeholders

Grant making, sponsorships, in-kind support, volunteer engagement, and advocacy efforts will align with identified priority health needs and measurable objectives.

### Evaluation, Accountability & Reporting

Allenmore Hospital will monitor implementation progress through defined process and outcome metrics associated with each priority area. Metrics will include screening rates, referral completion rates, utilization trends, and health outcome indicators such as early prenatal care initiation and asthma-related emergency department visits.

Performance will be reviewed regularly by leadership and reported to the Regional Board. Mid-cycle adjustments will be made as needed to ensure effective resource allocation and measurable community impact.

Annual reporting related to community benefit activities will be completed in compliance with Internal Revenue Service (IRS) guidelines, including the required Schedule H reporting associated with Form 990.

## Governance & Board Oversight

The Regional Board provides governance oversight for the Community Health Improvement Plan and affirms its commitment to addressing identified priority needs. Board feedback will inform prioritization, sequencing, and resource allocation as strategies move from planning to implementation.

Through this CHIP, MultiCare Allenmore Hospital demonstrates its commitment to measurable, equity-centered, and community-informed action designed to improve health outcomes across Pierce County.

## Board Approval

This Implementation Strategy was reviewed and formally adopted by the Board of Directors of MultiCare Allenmore Hospital on April 20, 2026.

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# Implementation Grids

Initiatives Legend (Implementation Year)

- Now (2026)
- Near (2027)
- Far (2028)

*All initiatives are considered Now (2026) unless otherwise labeled as Near (2027) or Far (2028).*

## Behavioral Health

**Health Need:** BEHAVIORAL HEALTH (Youth and Adult Depression, Poisoning (Overdose))

**Goals:** Improve youth and adult depression, reduce substance use risk and overdose. Improve timely access to care, strengthen trust, and ensure coordinated support for patients and community.

| Strategy or Program | Initiatives (Now, Near, Far) |
|---|---|
| Enhance Screening and Early Identification | • Administer the "5 P Questionnaire" for pregnant people<br>• Administer universal mental health screening in primary care settings.<br>• Suicide Screening for patients presenting with Behavioral Health needs |
| Deliver Culturally and Developmentally Responsive Clinical Care | • Offer Culturally Informed Care 1.0 to all new employees and trauma-informed care training to all behavioral health providers<br>• Provide language access services<br>• Support Qualified Bilingual staff<br>• Support MASH camp, workforce development pathways<br>• Provide evidence informed training around reducing stigma for substance use disorders to MHS staff and the wider community through the HOPE forum and Health Equity Speaker Series.<br>• Near (2027): Explore methods to increase MHS staff trauma-informed care training beyond behavioral health.<br>• Near (2027): Explore methods to expand trauma-informed care training to community partners and first responders<br>• Near (2027): Explore methods to expand community education for substance use treatment programs via the SUD taskforce |
| Provide timely access and support | • Continue Homeless Outreach program in Pierce County<br>• Continue to integrate collaborative care into primary care<br>• Pilot collaborative care in select Women's Health clinics<br>• Continue partnership with Bridge Beds and explore how to effectively refer patients<br>• Near (2027): Explore methods to provide Naloxone kits for patients and guests requesting, as well as local small businesses |
| Provide advocacy, grants and in-kind support | • Support policies expanding access for patients with behavioral health needs and substance use disorder<br>• Support initiatives that provide more public transportation resources to reduce barriers to care |

| | |
|---|---|
| | • Offer in-kind and volunteer support to additional community partners with shared goals<br>• Offer grants and/ or sponsorship contributions to selected community partners with shared goals |

| Anticipated Impacts (Objectives) |
|---|
| • Increase early identification of mental health and substance use concerns<br>• Strengthen ecosystem for patient and community with behavioral health and substance use disorder |
| **Objective Metrics** |
| • Depression, suicide risk and substance use screening rates by demographic groups.<br>• # of positive screens<br>• # of referrals to providers<br>• # of individuals receiving specialized training<br>• # of Naloxone Kits distributed and # sites of distribution established<br>• # of individuals served in MHS Community Partnership grant funded programs<br>• # of related policies supported or opposed |
| **External Collaborators & Community Partners** |
| WSHA, community partners, Wellfound Behavioral Health Hospitals, community partners, small business groups, Chamber of Commerce, first responder groups, public health |
| **MHS Responsible Parties & Internal Partners** |
| Behavioral Health Network, Women's Services, Primary Care, ED, Marketing/ Communications/ Community Relations, Center for Health Equity and Wellness, Medical Academics, Government Relations |

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# Access to Care

**Health Need:** ACCESS TO CARE (Inadequate Prenatal Care, Lack of Insurance Coverage, Transportation Barriers)

**Goal:** Improve timely access to care.

| Strategy or Program | Initiatives (Now, Near, Far) |
|---|---|
| Increase access through growth and partnerships | • Improve ambulatory access in clinics through both recruitment and efficiencies<br>• Expand utilization of virtual care<br>• Grow Hepatobiliary access and capabilities<br>• Ensure patient communication needs are met through community engagement, staff training<br>• Develop partnerships and maintain MASH camp to introduce youth to healthcare careers<br>• Improve access to acute care services close to home (trauma, cardiac, cancer, etc.) |
| Improve benefit enrollment | • Partner with FQHC for service enrollment at community events- Medicaid patient navigation<br>• Continue participation in Project Access<br>• Offer benefit enrollment assistance to patients<br>• Support patients with transportation, housing, medical equipment, and other needs<br>• Near (2027): Explore expansion of the MHS Veteran's Advocacy Program to Pierce County |
| Support Community Clinics and Partnerships | • Near (2027): Explore ways to promote vaccine education and provide more access to underserved communities<br>• Residents and Staff from Tacoma Family Medicine volunteer at Neighborhood Clinic<br>• Medical Academics provide clinical services at Mount Tahoma High School, school-based health clinic<br>• Continue Dental Outreach program and partnerships and expand into Key Peninsula service area<br>• Develop MOU and bring health services to Oakland High School<br>• Near (2027): Explore Partnering further with Elevate Health (Accountable Community of Health)- for patient care coordination services<br>• Near (2027): Explore contracting with DOH Mobile Access Clinics- Care-A-Van |
| Expand Access for prenatal care and Improve Continuity of Care post pregnancy | • Pilot telehealth early care prenatal visits to reduce access barriers - launch in Pierce County in partnership with Quilted Health |
| Provide WIC Resources | • Pilot automated WIC referrals in select clinics<br>• Continue providing supplemental nutrition support for low-income pregnant people and families at MHS WIC clinics<br>• Provide culturally relevant breastfeeding support |

| | |
|---|---|
| Provide advocacy, grants and in-kind support | • Support policies expanding Medicaid enrollment / insurance coverage<br>• Support initiatives that provide more public transportation resources to reduce barriers to care<br>• Offer in-kind and volunteer support to additional community partners with shared access goals<br>• Offer grants and/ or sponsorship contributions to selected community partners with shared goals<br>• Continue partnerships with Pierce Transit, Para Transit, and other transportation services |

| Anticipated Impacts (Objectives) |
|---|
| • Increase Access and Availability<br>• Provide all infants with a health start at birth<br>• Strengthen the health care ecosystem for patient and community |
| **Objective Metrics** |
| • Early prenatal care initiation rate.<br>• Preterm birth rates and low birthweight rates<br>• Inpatient admission rates for asthma<br>• ED utilization for dental emergencies<br>• # of patients assisted with benefit enrollment<br>• Flu Vaccination Rates<br>• WIC enrollment rates<br>• # of individuals served in MHS Community Partnership grant funded programs<br>• # of related policies supported or opposed |
| **External Collaborators & Community Partners** |
| Project Access, Neighborhood Clinic, schools, Step by Step, public health, Quilted Health, FQHC, Veteran's Administration, Elevate Health |
| **MHS Responsible Parties & Internal Partners** |
| MultiCare Medical Partners, Tacoma General & Allenmore, Language Access Services, Workforce Development, Center for Health Equity and Wellness, Pop Health, Marketing/ Communications/Community Relations, Financial Services, Care Management/Social Work, Mary Bridge, Quilted Health, Women's Services, Bessler Center, WIC, NICU, Government Relations |

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# Chronic Disease

**Health Need:** CHRONIC DISEASE (Youth and Adult Asthma Related ED Visits, Obesity in Adults)

**Goals:** Reduce ED Utilization for Asthma. Reduce Risk for Obesity for Adults.

| Strategy or Program | Initiatives (Now, Near, Far) |
|---|---|
| Provide patients with Asthma Action Plan | • Create Asthma Action Plan for patients where needed |
| Increase Community Education on Community Risk Factors | • Near (2027): Partner with public health on notifications for air quality |
| Universal Screening for Food Insecurity | • Continue universal screening during inpatient admission process<br>• Explore ways to standardize universal screening in ED and primary care<br>• Research tools with automated bi-directional referral capabilities to community resources; consider using z-codes for tracking and coding SDOH needs |
| Provide Immediate Support to nutritious food for high-risk patients | • Refer to WIC and other food resources<br>• Provide free Summer Meals program on TG/ MBCH main campus<br>• Near (2027): Develop proformas and seek funding medically tailored meals for patients with chronic conditions (diabetes, CHF, CKD). Additionally, Create "food boxes" for discharge planning, especially for high-risk patients.<br>• Near (2027): Develop proforma and seek funding to provide on-site food pantries or "food pharmacies" offering fresh produce and culturally appropriate staples |
| Promote community events, community programs and partnerships | • Engage community in Sound to Narrows and other events that promote physical activity<br>• Engage youth in the Fit for Sound to Narrows, partner with the YMCA and co-lead this initiative<br>• Increase YMCA 101 referrals to YMCA health promotion programs |
| Provide advocacy, grants and in-kind support | • Support tobacco/vaping legislation and clean air related policies<br>• Support initiatives that provide more access to healthy foods and safe spaces for outdoor activities<br>• Offer in-kind and volunteer support to additional community partners with shared access goals<br>• Offer cash and sponsorship contributions to additional community partners with shared access goals |

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| Anticipated Impacts (Objectives) |
| --- |
| • Improve management of care for patients with Asthma<br>• Increase identification of food-insecure and housing insecure patients.<br>• Expand access to nutritious food for high-risk patients.<br>• Expand access to physical activity<br>• Increase identification of food-insecure and housing insecure patients.<br>• Strengthen the health care ecosystem for patient and community |
| **Objective Metrics** |
| • Universal Screening for Food Insecurity:<br>  o Screening rate (% of patients screened).<br>  o Number and % of positive screens.<br>  o Referral completion rate.<br>  o Utilization rates (i.e. Food Locker, Pantry utilization (visits/month).<br>• Well visit completion rates<br>• Preventative health screening completion rates<br>• # of patients referred to YMCA programs<br>• # of individuals served in MHS Community Partnership grant funded programs<br>• # of related policies supported or opposed |
| **External Collaborators & Community Partners** |
| YMCA, local food systems and food providers, schools, public health, United Way, Elevate Health, parks, City of Tacoma, Pierce County |
| **MHS Responsible Parties & Internal Partners** |
| Government Relations, Marketing/ Communications/ Community Relations/ Center for Health Equity and Wellness, Primary Care, Inpatient, ED, Care Navigators, Clinics, WIC, MBCH Pediatric Wellness |