MultiCare
Capital Medical Center

2025

2025 Community Health Improvement Plan

Implementation Strategies
2026–2028

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2025 Community Health Improvement Plan (CHIP)

Implementation Strategy Narrative for 2026–2028

Organizational Commitment

MultiCare Capital Medical Center 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 Thurston County.

This CHIP reflects both hospital-specific accountability and coordinated system alignment within MultiCare Health System. While Capital Medical Center maintains its own implementation strategy, its approaches are intentionally aligned with broader MultiCare initiatives and informed by the collaborative CHNA conducted with Providence Swedish and Thurston County Public Health and Social Services. This alignment helps maximize community impact, reduce duplication of efforts, and strengthen shared clinical, operational, and community partnerships

Community Health Needs Assessment Foundation

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

- Behavioral Health (Mental Health Crisis & Culturally Responsive Services; Substance Use & Prevention)
- Chronic Disease Management & Prevention (Obesity; Diabetes)
- Social Determinants of Health (Housing Instability & Homelessness; Food Security & Access to Healthy Food)
- Maternal & Child Health (Maternal Health Disparities; Childcare Access)
- Injury & Violence (Youth & School Safety; Domestic and Community Violence & Injury)

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 Capital Medical Center's implementation strategy. Data from the CHNA demonstrate 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, Capital Medical Center 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

Capital Medical Center will strengthen early identification of mental health needs, reduce stigma, and expand timely access to behavioral health services across the care continuum. Interventions include universal screening efforts, enhanced suicide risk assessment protocols, culturally responsive care training, provider recruitment, and strengthened referral pathways to community-based behavioral health services.

Recognizing the significant impact of substance use in the region, the hospital will support prevention, treatment, and recovery through expanded harm-reduction resources, coordinated

referral partnerships, and community education initiatives. These efforts aim to improve access to culturally responsive mental health care while supporting individuals and families impacted by substance use.

Chronic Disease Management & Prevention Strategy Overview

Capital Medical Center will implement coordinated clinical and community-based strategies to prevent and manage chronic conditions, with a focus on obesity and diabetes. Efforts will emphasize early detection, patient education, and lifestyle interventions that support long-term disease management.

Key focus areas include:

- Evidence-based diabetes management and prevention programs
- Community education and clinical counseling focused on nutrition and physical activity
- Partnerships that support healthy lifestyle environments
- Integration of screening and referral pathways that address barriers to disease prevention and management

Through these efforts, Capital Medical Center aims to reduce preventable complications, improve quality of life, and promote healthier communities.

Social Determinants of Health Strategy Overview

Recognizing that social and economic conditions significantly influence health outcomes, Capital Medical Center will strengthen efforts to address key social determinants of health, particularly housing instability, homelessness, and food insecurity.

Implementation strategies include expanded screening for social needs, strengthened referral pathways to community-based organizations, and partnerships that increase access to housing support services and nutritious food resources. The hospital will collaborate with regional partners to connect patients with programs that address basic needs while supporting long-term stability and wellbeing.

Maternal & Child Health Strategy Overview

Capital Medical Center will prioritize improving maternal and child health outcomes by expanding access to prenatal, postpartum, and early childhood services while addressing disparities that affect maternal health.

Key strategies include improving early prenatal care initiation, strengthening postpartum care continuity, and expanding partnerships that support maternal health education and family resources. The hospital will also collaborate with community organizations to improve access to childcare support and services that promote healthy development for infants and young children.

These efforts aim to improve birth outcomes, reduce disparities in maternal health, and support families during critical stages of early life.

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Injury & Violence Prevention Strategy Overview

Capital Medical Center will work with community partners to reduce injuries and violence affecting residents, with a focus on youth safety, school safety, and prevention of domestic and community violence.

Strategies include supporting community-based prevention initiatives, strengthening referral pathways for individuals affected by violence, and partnering with local organizations that promote safe environments for youth and families. The hospital will also support education and outreach efforts aimed at preventing injury and promoting community safety.

Community Partnerships & Cross-Sector Alignment

Capital Medical Center 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

Capital Medical Center 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 chronic disease management.

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 Capital Medical Center demonstrates its commitment to measurable, equity-centered, and community-informed action designed to improve health outcomes across Thurston County.

Board Approval

This Implementation Strategy was reviewed and formally adopted by the Board of Directors of MultiCare Capital Medical Center on March 18, 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 (Substance Use and Prevention, Mental Health Crisis, Culturally Responsive Services)

Goals: Improve depression, reduce substance use risk and overdose.

Strategy or Program	Initiatives (Now, Near, Far)
Enhance Screening and Early Identification	• Administer the "5 P Questionnaire" for pregnant people • Administer universal mental health screening in primary care settings. • Administer Suicide Screening for patients presenting with Behavioral Health needs
Meet individuals where they are to deliver behavioral health care through the Providence Swedish Mobile Clinic in Thurston County, in collaboration with MultiCare Capital Medical Center and other community partners	• Provide financial support to the Providence Swedish Mobile Clinic to serve people experiencing homelessness or housing instability who are in need of health care services
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 • Provide language access services • Support Qualified Bilingual staff • Support MASH camp • Provide evidence-informed training around reducing stigma for substance use disorders to MHS staff and the wider community through the HOPE forum and the Health Equity Speaker Series
Provide timely access and support	• Implement the PACT program (Program of Assisted Community Treatment) for Thurston County • Continue to integrate collaborative care into primary care • Pilot collaborative care in select Women's Health clinics, with imbedded LICSW behavioral health social worker • Near (2027): Explore methods to provide Naloxone kits at no charge for patients and guests requesting

Provide advocacy, grants, sponsorships and in-kind support	• Support policies expanding access for patients with behavioral health needs and substance use disorder • Align community partnership grants with Providence Health System to build capacity in partner organizations and deepen community impact in Thurston County

Anticipated Impacts (Objectives)
• Increase early identification of mental health and substance use concerns • 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 • Number of positive screens • Number of referrals to providers • Provide services through the mobile clinic to 65% of unhoused individuals based on each year's U.S. Department of Housing and Urban Development Point-in-Time count • 30% of patients served through the mobile clinic engage in follow up services
External Collaborators & Community Partners
WSHA, community partners, Providence Swedish, behavioral health hospitals
MHS Responsible Parties & Internal Partners
Behavioral Health Network, Women's Services, Primary Care, ED, Marketing/ Communications/ Community Relations, Center for Health Equity and Wellness, Government Relations

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Injury and Violence

Health Need: INJURY AND VIOLENCE (Youth and School Safety, Domestic and Community Violence and Injury)

Goals: Reduce Injury and Violence

Strategy or Program	Initiatives (Now, Near, Far)
Enhance Screening and Early Identification	• Screen for Intimate Partner Violence/ Domestic Violence
Provide timely access and support	• Refer patients to support services
Provide advocacy, grants, sponsorships and in-kind support	• Support policies that reduce injury and violence • Offer grants and/ or sponsorship contributions to selected community partners with shared goals

Anticipated Impacts (Objectives)
• Increase early identification of safety and violence concerns • Strengthen ecosystem for patient and community with safety needs
Objective Metrics
• Intimate partner violence/ domestic violence screening rates • Number of positive screens • Number of referrals to resources
External Collaborators & Community Partners
Community partners, domestic violence services, youth engagement services, children's advocacy center
MHS Responsible Parties & Internal Partners
Inpatient Services, Behavioral Health Network, Women's Services, Primary Care, ED, Marketing/ Communications/Community Relations, Center for Health Equity and Wellness, Government Relations

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Chronic Disease

Health Need: CHRONIC DISEASE (Obesity and Diabetes)

Goals: Reduce Risk for Obesity and Diabetes

Strategy or Program	Initiatives (Now, Near, Far)
Identify patients with early risk for diabetes	• Offer a metabolic program for pre-diabetic patients
Increase identification of food-insecure patients	• Continue universal screening for food security during inpatient admission process • Near (2027): Explore ways to implement / standardize universal screening in ED and primary care • Far (2028): Research tools with automated 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 • 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. • Far (2028): 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 events that promote physical activity, such as partnership with 23 Kitchens for the South Sound Slam Pickleball 3-day tournament • Increase YMCA 101 referrals to YMCA health promotion programs
Provide advocacy, grants, sponsorships and in-kind support	• Support initiatives that provide more access to healthy foods and safe spaces for outdoor activities • Offer grants and/ or sponsorship contributions to selected community partners with shared goals

Anticipated Impacts (Objectives)
• Improve management of care for patients with diabetes • Increase identification of food-insecure and housing insecure patients • Expand access to nutritious food for high-risk patients • Expand access to physical activity • Increase identification of food-insecure patients • Strengthen the health care ecosystem for patient and community
Objective Metrics
• Universal Screening for Food Insecurity: o Screening rate (% of patients screened).

○ Number and % of positive screens. ○ Referral completion rate. • Utilization rates (Food Locker, Pantry utilization (visits/month) if/ when programs are implemented • Referral rates to YMCA programs and other diabetes education services
External Collaborators & Community Partners
YMCA, local food systems and food providers, parks and recreation, WIC
MHS Responsible Parties & Internal Partners
Government Relations, Marketing/Communications/Community Relations/Center for Health Equity and Wellness, Inpatient, Care Navigators, Clinics

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Maternal and Child Health

Health Need: Infant and Birth Outcomes Prenatal and Maternal Care

Goals: Improve birth outcomes, strengthen caregiver capacity and enhance postpartum support

Strategy or Program	Initiatives
Strengthen parent and caregiver support	• Continue to implement the Centering Program • Train community-based Doulas in the hospital setting • Employ midwives as part of the maternal health care team • Partner with Quilted Health to increase access to doulas and midwives
Provide advocacy, grants, sponsorships and in-kind support	• Support policies expanding insurance coverage for pregnant and postpartum individuals • Offer grants and sponsorship contributions to selected community partners with shared goals • Offer in-kind and volunteer support to additional community partners with shared goals

Anticipated Impacts (Objectives)
• Strengthen the ecosystem around pregnant people, infants, and caregivers • Address drivers of poor maternal and child outcomes
Objective Metrics
• Early prenatal care initiation rates • Preterm birth rates, and low birthweight rates
External Collaborators & Community Partners
Community based doulas, Quilted Health, community based organizations that enhance birth outcomes and provide caregiver support
MHS Responsible Parties & Internal Partners
Women's Services, Marketing/Communications/Community Relations, Care Management/Social Work, Government Relations

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Social Determinants of Health

Health Need: Housing Instability, Food Security & Access to Healthy Food Environments

Goals: Reduce the impact of food insecurity and housing instability on health outcomes in Thurston County

Strategy or Program	Initiatives
Increase identification of food-insecure and housing insecure patients	• Continue universal screening during inpatient admission process • Near (2027): Explore ways to implement / standardize universal screening in ED and primary care • Near (2027): Research tools with automated referral capabilities to community resources; consider using z-codes for tracking and coding SDOH needs
Provide Immediate Support to nutritious food and housing support for high-risk patients	• Refer to WIC and other food resources • Refer to housing resources • Continue partnership with Bridge Beds and explore how to effectively refer patients • 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. • Near (2027): Develop proforma and seek funding to provide on-site food pantries or "food pharmacies" offering fresh produce and culturally appropriate staples
Provide Advocacy and In-kind Support	• Advocate for local policies that increase SNAP/WIC access, expand school meal programs, incentivize grocery development or address housing instability. • Partner with housing and food system agencies through in-kind volunteer contributions of time and effort • Partner with Local Food Systems (Collaborate with food banks, farmers markets, tribal food programs, and community gardens) through sponsorships and community partnership funds • Sponsor or partner with food access programs (i.e.: Mobile Food trucks; Farmer's markets) on hospital or clinical campus

Anticipated Impacts (Objectives)
• Increase identification of food-insecure and housing insecure patients • Expand access to nutritious food for high-risk patients • Strengthen community food and housing access • Empower patients and families to make healthy, affordable food choices
Objective Metrics
• Universal Screening for Food Insecurity and Housing Insecurity: • Screening rate (% of patients screened)

• Number and % of positive screens • Referral completion rate • Utilization rates (Food Locker, Pantry utilization (visits/month) if/ when programs are implemented
External Collaborators & Community Partners
YMCA, local food systems and food providers, housing resources
MHS Responsible Parties & Internal Partners
Center for Health Equity and Wellness, Community Partnerships, Pop Health, Marketing/ Communications/Community Relations, Care Management/Social Work, Clinics, Inpatient, ED