MultiCare

Covington Medical Center

2025

2025 Community Health Improvement Plan

Implementation Strategies 2026–2028

Covington Medical Center

2025 Community Health Improvement Plan (CHIP)

Implementation Strategy Narrative for 2026–2028

Organizational Commitment

MultiCare Covington 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 South King County.

This CHIP reflects both hospital-specific accountability and coordinated system alignment within MultiCare Health System. While MultiCare Covington Medical Center maintains its own implementation strategy, its approaches are intentionally aligned with broader MultiCare initiatives and informed by the 2024–2025 King County Community Health Needs Assessment. Although the assessment examines health conditions across the entire county, Covington Medical Center's community health efforts are primarily focused on South King County, the region where the hospital serves a large and diverse patient population. The CHNA incorporates community input, public health data, and demographic trends to better understand the factors influencing health and wellbeing across the region. Through this coordinated approach, Covington Medical Center seeks to maximize community impact, reduce duplication of efforts, and strengthen partnerships that support improved health outcomes and reduced disparities for individuals and families in South King County.

Community Health Needs Assessment Foundation

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

- Healthcare Access and Delivery (Mental Health and Substance Use; Access to Healthcare and Preventative Services)
- Equity and Social Determinants of Health (Socioeconomic barriers; Violence and Injury Prevention)
- Food Insecurity and Access
- Support for Children and Youth (Maternal and Child Health; Youth Mental Health and Substance Use)

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 MultiCare Covington Medical Center'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, MultiCare Covington 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, and system-level leadership teams.

Healthcare Access and Delivery Strategy Overview

MultiCare Covington Medical Center will focus on improving access to timely, high-quality healthcare services for residents across South King County. Recognizing the growing demand for behavioral health care and preventive services, the hospital will strengthen efforts to address mental health and substance use while expanding access to primary and preventive care.

Strategies include strengthening screening and early identification for mental health and substance use disorders, improving referral pathways to behavioral health treatment and recovery services, and expanding partnerships with community providers that support coordinated care. Covington Medical Center will also work to reduce barriers to preventive services by strengthening care navigation, improving access to primary care and screenings, and collaborating with community organizations that support health education and outreach.

Through these efforts, the hospital aims to improve access to care, promote early intervention, and support better health outcomes for individuals and families throughout South King County.

Support for Children and Youth Strategy Overview

Supporting the health and wellbeing of children and youth is a critical component of Covington Medical Center's community health strategy. Efforts will focus on improving maternal and child health outcomes while addressing growing concerns related to youth mental health and substance use.

Strategies include strengthening partnerships that support healthy pregnancies and early childhood development, improving access to maternal and pediatric care, and connecting families with community-based resources that support parenting and child wellbeing. Covington Medical Center will also collaborate with schools and community organizations to promote early identification of youth mental health needs, support prevention programs, and expand access to behavioral health services for children and adolescents.

Through these coordinated efforts, the hospital aims to promote healthy development, support families, and improve long-term health outcomes for children and youth across South King County.

Equity and Social Determinants of Health Strategy Overview

MultiCare Covington Medical Center recognizes that health outcomes are strongly influenced by social and economic conditions such as income, education, housing stability, and exposure to violence. In South King County, many families face persistent socioeconomic barriers that affect their ability to access healthcare and maintain overall wellbeing.

To address these challenges, the hospital will strengthen screening for social needs within clinical settings and expand partnerships with community organizations that provide support services. Efforts will focus on connecting patients with resources that address socioeconomic barriers, promoting culturally responsive care, and supporting initiatives aimed at violence and injury prevention.

By addressing the social drivers of health and supporting community-based solutions, Covington Medical Center seeks to reduce disparities and improve long-term health outcomes across the communities it serves.

Food Insecurity and Access Strategy Overview

Food insecurity remains a significant concern in South King County and can contribute to poor health outcomes, particularly for children, older adults, and low-income families. Limited access to affordable and nutritious food can increase the risk of chronic disease, worsen existing health conditions, and create additional stress for families.

MultiCare Covington Medical Center will work to identify and address food insecurity through screening within healthcare settings and strengthening referral pathways to community food resources. The hospital will collaborate with local organizations and regional partners to support programs that increase access to nutritious food and promote healthier food environments.

These efforts aim to improve nutrition security, support disease prevention, and strengthen the overall health and wellbeing of families across the region.

Community Partnerships & Cross-Sector Alignment

MultiCare Covington 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

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

Board Approval

This Implementation Strategy was reviewed and formally adopted by the Board of Directors of MultiCare Covington Medical Center on March 30, 2026.

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).

Healthcare Access and Delivery

Health Need: Healthcare Access and Delivery (Mental Health and Substance Use, Access to Healthcare and Preventative Services)

Goals: Reduce the prevalence of mental health and substance use disorders in the community and increase access to preventive and early-intervention health services

Strategy or Program	Initiatives (Now, Near, Far)
Enhance Screening and Early Identification for Mental Health status and Substance Use	• MHS Women's Clinics will administer the "5 P Questionnaire" for pregnant people in select pilot sites • MHS Primary Care Clinics will administer universal mental health screenings. • MHS Emergency Departments will implement Suicide Screening for patients presenting with Behavioral Health needs
Strengthen Trauma-Informed Care Across the System	• Provide trauma-informed care training to all behavioral health providers • 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. • Near (2027): Explore methods to expand trauma-informed care training beyond behavioral health staff.
Provide Timely Access and Support	• MHS will continue to integrate collaborative care into primary care • MHS will pilot collaborative care in select Women's Health clinics • MHS will continue partnership with Bridge Beds and explore how to effectively refer patients • Near (2027): Embed pharmacist support in multidisciplinary care models, grow to 9 providers • Near (2027): Explore models to expand distribution of Naloxone kits within MHS, as well as explore partnerships with local small businesses • Expand access to primary care in Kent/ Lake Meridian site • Evaluate services in outpatient buildings, explore partnerships with FQHCs
Provide advocacy, grants and in-kind support	• Support policies expanding access for patients with behavioral health needs and substance use disorder

	• Provide cash and sponsorship contributions to selected community partners with shared goals

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: King County MHS data. • Number of positive screens: King County MHS data • Number of referrals to providers: King County MHS data • # of Narcan kits distributed • # of collaborative care visits • # of staff and community members trained Stratify by socio-demographic characteristics such as: • Geography • Race/ethnicity • Insurance type (Medicaid vs commercial) • Language preference
Potential External Collaborators & Community Partners
WSHA, community partners, other Behavioral Health Hospitals, first responder groups, public health, Health Care Authority, King County, Substance Use Treatment Programs and Community Providers
MHS Responsible Parties & Internal Partners
Hospital staff and providers, Behavioral Health Network, Women's Services, Primary Care, ED, Marketing/ Communications/ Community Relations, Government Relations, Pharmacy

Equity and Social Determinants of Health

Health Need: Social Determinants of Health (Socioeconomic barriers, Violence and Injury Prevention)

Goal: Identify Health-Related Social Needs, Improve Benefit Enrollment and Reduce Violence

Strategy or Program	Initiatives (Now, Near, Far)
Increase identification of patients with social needs that create barriers to accessing health care	• Continue universal screening for health-related social needs and Intimate Partner Violence/ Domestic Violence during inpatient admission process • Near (2027): Explore ways to standardize universal screening in ED and primary care • Near (2027): Research additional tools with automated referral capabilities to community resources; consider using z-codes for tracking and coding SDOH needs
Improve benefit enrollment and refer to support services	• Offer benefit enrollment assistance to patients • Refer to support services • Near (2027): Explore expansion of MHS Veteran's Advocacy Program to King County • Near (2027): Explore implementation of a Medical/ Legal Partnership • Near (2027): Develop MOU with local Accountable Communities of Health (ACH) agency for resource navigation assistance
Provide advocacy, grants and in-kind support	• Support policies expanding Medicaid enrollment / insurance coverage and violence prevention strategies • Offer grants and sponsorship contributions to selected community partners with shared goals

Anticipated Impacts (Objectives)
• Reduction in unmet social needs • Reduction in rates of violence
Objective Metrics
Universal Screening for health-related social needs and intimate partner violence: • Screening rate (% of patients screened) • Number and % of positive screens • Referral completion rate Stratify by socio-demographic characteristics such as: • Geography • Race/ethnicity • Insurance type (Medicaid vs commercial) • Language preference

External Collaborators & Community Partners
Health Care Authority, King County, Veteran's Administration, legal aid agencies, additional community-based organizations
MHS Responsible Parties & Internal Partners
Hospital staff and providers, Behavioral Health Network, clinic staff and providers, Financial Services, Marketing/ Communications/Community Relations, Center for Health Equity and Wellness, Government Relations

Food Security and Accessibility

Health Need: Food Security and Accessibility

Goal: Improve Food Security and Access to Nutritious Foods

Strategy or Program	Initiatives (Now, Near, Far)
Increase identification of food-insecure patients.	• Implement universal screening during inpatient admission process • Near (2027): Explore ways to standardize universal screening in ED and primary care • Near (2027): Research additional tools with automated referral capabilities to community resources; consider using z-codes for tracking and coding SDOH needs
Provide Support to Navigate Nutritious Food Resources	• Refer to food and housing resources • Near (2027): Explore implementation of a free Summer Meals program for Children funded via USDA on hospital campus and selected community sites • Near (2027): Develop proformas and seek funding medically tailored meals for patients with chronic conditions (diabetes, CHF, CKD). Additionally, create proposal to provide "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 lockers" offering fresh produce and culturally appropriate staples • Near (2027): Create MOU with Elevate Health and other Accountable Communities of Health (ACH) in communities where MBCH has a presence for resource navigation assistance
Provide advocacy, grants and in-kind support	• Support initiatives that provide more access to healthy foods and safe spaces for outdoor activities • Participate in regional food policy and councils to influence long-term system planning • Offer grants and/ or sponsorship contributions to selected community partners with shared goals

Anticipated Impacts (Objectives)
• Reduction in food insecurity
Objective Metrics
Universal Screening for Food Insecurity: • Screening rate (% of patients screened) • Number and % of positive screens • Referral completion rate • Numbers served in food access programs

Stratify by socio-demographic characteristics such as: • Geography • Race/ethnicity • Insurance type (Medicaid vs commercial) • Language preference
External Collaborators & Community Partners
Health Care Authority, King County, food access agencies, additional community-based organizations
MHS Responsible Parties & Internal Partners
Hospital staff and providers, Behavioral Health Network, clinic staff and providers, Financial Services, Marketing/ Communications/Community Relations, Government Relations, Center for Health Equity and Wellness

Support for Children and Youth

Health Need: Support for Children and Youth (Youth Mental Health, Maternal/ Child Health)

Goal: Improve youth mental health as well as maternal/ child health outcomes.

Strategy or Program	Initiatives (Now, Near, Far)
Enhance Screening and Early Identification of Youth Behavioral Health Needs	• Provide universal depression screening in pediatric primary care settings. • Assess suicide risk for youth in the Emergency Department • Near (2027): Explore administration of the CRAFFT screening tool for substance use risk in Primary Care • Near (2027): Consider models for community-based training for identified populations, in collaboration with youth SUD providers
Improve Access and Engagement through Innovative Care Delivery Models	• Near (2027): Expand Behavioral Health Network's mental health department for children and teens that specializes in work with youth experiencing developmental or medical complexity • Near (2027): Expand telehealth prenatal visits to reduce access barriers - launch in partnership with Quilted Health • Continue to expand and support collaborative care models in primary care • Provide Behavioral Support Team (BeST) services in King County (partnership with DDA and King Co.) • Near (2027): Explore models to provide Naloxone kits for patients and guests requesting, as well as explore partnerships with local businesses for distribution sites
Provide Advocacy, Grants, Sponsorships and In-kind Support	• Support policies expanding access for youth with behavioral health needs and substance use disorder • Advocate for expanded access to midwives and doulas • Provide grants and/or sponsorships to selected community partners with shared goals

Anticipated Impacts (Objectives)
• Increase early identification of mental health and substance use concerns in youth • Strengthen the ecosystem around pregnant people and youth • Address drivers of poor maternal and child outcomes
Objective Metrics
• Depression, suicide risk and substance use screening rates • Number of positive screens • Number of referrals to providers • # of Narcan kits distributed • # of collaborative care visits in primary care or schools • Early prenatal care initiation rates

• Preterm birth rates, and low birthweight rates Stratify by socio-demographic characteristics such as: • Geography • Race/ethnicity • Insurance type (Medicaid vs commercial) • Language preference
Potential External Collaborators & Community Partners
WSHA, community partners, public health, Health Care Authority, schools, Substance Use Treatment Programs and Community Providers
MHS Responsible Parties & Internal Partners
Hospital staff and providers, Behavioral Health Network, Primary Care, ED, Marketing/ Communications/ Community Relations, Government Relations, Quilted Health, Women's Services, Mary Bridge Children's staff and providers