

2025 Community Health Improvement Plan



Implementation Strategies 2026–2028



Mary Bridge Children's Hospital

2025 Community Health Improvement Plan (CHIP)

Implementation Strategy Narrative for 2026–2028

Organizational Commitment

MultiCare Mary Bridge Children's 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 the service area.

This CHIP reflects both hospital-specific accountability and coordinated system alignment within MultiCare Health System. While Mary Bridge Children's Hospital maintains its own implementation strategy focused on improving the health and wellbeing of children and youth, its approaches are intentionally aligned with broader MultiCare initiatives and informed by the 2025 Mary Bridge Children's Community Health Needs Assessment. The assessment examined health needs across the hospital's multi-county service area, including Pierce, King, Thurston, and Kitsap counties, and incorporated input from public health data, community partners, and families. Through this coordinated approach, Mary Bridge seeks to maximize community impact, reduce duplication of efforts, and strengthen partnerships that support the health and development of children and families.

Community Health Needs Assessment Foundation

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

- Behavioral Health (Youth Substance Use & Prevention; Youth Mental Health Crisis & Culturally Responsive Services)
- Maternal & Child Health (Preterm Births & Low Birth Weight; New Parent & Caregiver Support; Promoting Safety & Injury Prevention for Children & Youth)
- Social Determinants of Health (Housing Instability & Youth Homelessness; Food Security & Access to Healthy Food Environments)
- Access to Care (Healthcare Access Disparities; Enhancing Culturally Responsive & Trustworthy Care; Navigation & Coordination of Care for Children with Special Health Needs)

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 Mary Bridge Children's Hospital's implementation strategy. Data from the CHNA demonstrates persistent disparities in access to care, birth outcomes, behavioral health and social needs.

This CHIP incorporates an equity lens through:

- Stratified data monitoring by socio-demographic characteristics such as race, ethnicity, language, disability, gender, 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, Mary Bridge 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.

Behavioral Health Strategy Overview

Mary Bridge Children's Hospital will focus on strengthening prevention, early identification, and treatment of behavioral health conditions affecting children and youth. Recognizing the growing impact of youth mental health challenges and substance use across the region, the hospital will work to expand timely access to behavioral health services while supporting prevention efforts that address underlying risk factors.

Key strategies include strengthening partnerships with schools, community organizations, and healthcare providers to improve early identification of mental health needs, expanding access to crisis response and stabilization services, and supporting youth substance use prevention and education initiatives. Mary Bridge will also prioritize culturally responsive care approaches to ensure behavioral health services are accessible, trusted, and effective for the diverse children and families served across the region.

Maternal and Child Health Strategy Overview

Mary Bridge Children's Hospital will advance maternal and child health by focusing on early life conditions that influence lifelong health outcomes. Efforts will prioritize reducing preterm births and low birth weight, strengthening support systems for new parents and caregivers, and promoting safe environments that prevent childhood injuries.

Strategies include expanding education and care coordination for expectant parents, strengthening postpartum support services, and partnering with community organizations to provide resources that support healthy pregnancies and early childhood development. The hospital will also support injury prevention initiatives that promote safe home, school, and community environments for children and youth.

Through these efforts, Mary Bridge aims to improve birth outcomes, strengthen family support systems, and promote the healthy development and safety of children throughout the region.

Social Determinants of Health Strategy Overview

Mary Bridge Children's Hospital recognizes that many health outcomes for children are shaped by the environments in which they live, learn, and grow. Housing instability, youth homelessness, and limited access to nutritious food can significantly affect the physical and emotional wellbeing of children and families.

To address these challenges, the hospital will strengthen screening and referral processes that identify social needs within clinical settings and connect families with community-based resources. Mary Bridge will also collaborate with regional partners to support housing stability initiatives, improve access to healthy food environments, and promote programs that help families meet basic needs. By addressing these social drivers of health, the hospital seeks to improve long-term health outcomes and support stable, healthy environments for children and youth.

Access to Care Strategy Overview

Ensuring equitable access to high-quality pediatric care remains a central priority for Mary Bridge Children's Hospital. The hospital will focus on reducing healthcare access disparities, strengthening culturally responsive care practices, and improving navigation and coordination of care for children with complex or special health needs.

Strategies include expanding care coordination services, improving referral pathways across pediatric specialty services, and strengthening partnerships with community providers to ensure children

receive timely and appropriate care. Mary Bridge will also prioritize culturally responsive communication and care delivery practices that build trust with families from diverse backgrounds.

These efforts aim to improve continuity of care, reduce barriers to pediatric services, and ensure that all children in the service area have access to the care and support they need to thrive.

Community Partnerships & Cross-Sector Alignment

Mary Bridge 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

Mary Bridge Children's 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 depression rates among youth.

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, Mary Bridge Children's Hospital demonstrates its commitment to measurable, equity-centered, and community-informed action designed to improve health outcomes across its service area.



Board Approval

This Implementation Strategy was reviewed and formally adopted by the Board of Directors of MultiCare Mary Bridge Children's Hospital on March 25, 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).

Behavioral Health

Health Need: Behavioral Health (Youth Substance Abuse and Prevention, Youth Mental Health, Culturally Responsive Services)

Goal: Improve youth mental health, reduce substance use risk, and expand culturally responsive services.

Strategy or Program	Initiatives (Now, Near, Far)
Enhance Screening and Early Identification	<ul style="list-style-type: none"> • Provide universal depression screening in pediatric primary care settings. • Assess suicide risk 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 • Near (2027): Track referrals and outcomes through the MAT Admission Program at Mary Bridge
Improve Access and Engagement through Innovative Care Delivery Models	<ul style="list-style-type: none"> • Seek continuation funding for the Tacoma School program YES! (Youth Engagement Services) • Provide support for grieving children through BRIDGES • Identify and address non-accidental trauma through the CAC of Pierce County and Mary Bridge Child Abuse Intervention Department • Expand Behavioral Health Network's mental health department for children and teens that specializes in work with youth experiencing developmental or medical complexity • Continue to expand and support collaborative care models in primary care and school-based health centers • Provide Behavioral Support Team (BeST) services in King County (partnership with DDA and King Co.) • Near (2027): Explore additional models of school-based behavioral health services • Near (2027): Open new Mary Bridge Children's Mental Health Urgent Care • Near (2027): Implement Mary Bridge/Behavioral Health Network Steering Committee to solidify strategies for improving internal processes and streamline referrals.

	<ul style="list-style-type: none"> Near (2027): Explore models to provide Naloxone kits for patients and guests requesting, as well as explore partnerships with local businesses for distribution sites
Strengthen Trauma-Informed Care and Behavioral Health Education Across the System	<ul style="list-style-type: none"> Provide trauma-informed care training to all behavioral health providers Implement 12 annual skills labs Provide “Introduction to Developmental Differences” Training which focuses on how to recognize the presence of developmental complexity in our patients, particularly within the populations of individuals with Intellectual Disability, Autism Spectrum, and the Highly Capable population. Provide monthly “Developmental Differences” consults to behavioral health and Mary Bridge providers
Provide Advocacy, Grants, Sponsorships and In-kind Support	<ul style="list-style-type: none"> 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)
<ul style="list-style-type: none"> Increase early identification of mental health and substance use concerns Improve access to care Strengthen the ecosystem for patients and community with behavioral health and substance use disorder
Objective Metrics
<ul style="list-style-type: none"> Depression, suicide risk and substance use screening rates by demographic groups Number of positive screens Number of referrals to providers # of Narcan kits distributed # of collaborative care visits in primary care or schools # of visits to new behavioral health urgent care # of staff and community members trained <p>Stratify by socio-demographic characteristics such as:</p> <ul style="list-style-type: none"> Geography Race/ethnicity Insurance type (Medicaid vs commercial) Language preference
Potential External Collaborators & Community Partners
WSHA, Children’s Hospital Association, community partners, first responder groups, public health, Health Care Authority, schools, Substance Use Treatment Programs and Community Providers
Responsible Parties & Internal Partners
Mary Bridge staff and providers, Behavioral Health Network, Primary Care, ED, Marketing/ Communications/ Community Relations, Government Relations, Pharmacy

Access to Care

Health Need: Access to Care (Healthcare Access Disparities, Enhancing Culturally Responsive and Trustworthy Care, Navigation and Coordination of Care for Children with Special Health Needs)

Goal: Improve timely access to pediatric care and provide coordinated support for children with complex needs.

Strategy or Program	Initiatives (Now, Near, Far)
Increase Access & Availability	<ul style="list-style-type: none"> Near (2027): Open new, free-standing children's hospital Near (2027): Develop and execute Children's Heart Center/ increase regional capacity through outreach clinics Near (2027): Expand specialty programs and expertise for multiple specialties (GI, Neuro, HemOnc, Endo, Ortho, Surgical) Near (2027): Expand hours to meet needs for patients and working families Near (2027): Expand digital care options Near (2027): Develop methods to evaluate percentage of children without a medical home
Provide Support for Children With Special Health Care Needs	<ul style="list-style-type: none"> Support school nurses by providing specialty education Provide support to a regional Maxillofacial Review Board, expand care provided to patients Provide Parenting Partnership home visiting services to qualified NICU families
Bring Pediatric care closer to where children and families live, play and gather	<ul style="list-style-type: none"> Increase regional access through outreach clinics Provide clinical services to students at Mt Tahoma High School via MultiCare Medical Academics Provide outreach programs at Oakland High School Coordinate community-based pediatric dental clinics Continue community-based immunization clinics Explore additional school health models
Provide Advocacy, Grants, Sponsorships and In-kind Support	<ul style="list-style-type: none"> Advocate for expanded pediatric Medicaid coverage, including behavioral health and specialty services. Support policies that fund school-based health centers and early intervention programs. Provide grants and/ or sponsorship contributions to selected community partners with shared goals

Anticipated Impacts (Objectives)
<ul style="list-style-type: none"> Increased access to care- with focused improvement in primary care access, medical home
Objective Metrics
<ul style="list-style-type: none"> % of children 12–24 months with recommended well-child visits % of children 24+ months with annual preventive visit Third next available new pediatric patient appointment (days) % of new pediatric patients seen within 14 days

- % of children with a medical home

Stratify by socio-demographic characteristics such as:

- Geography
- Race/ethnicity
- Insurance type (Medicaid vs commercial)
- Language preference

Potential External Collaborators & Community Partners

Community providers, schools and school nurses, public health, community-based organizations, FQHCs, Elevate Health

Responsible Parties & Internal Partners

Mary Bridge staff and providers, Bessler Center, ED, Behavioral Health, Primary Care, hospital leaders, Center for Health Equity and Wellness, Language Access Services, Workforce Development, Pop Health, Marketing/ Communications/Community Relations, Financial Services, Care Management/Social Work, Government Relations

Maternal and Child Health

Health Need: Maternal & Child Health (Preterm Births & Low Birth Weight; New Parent & Caregiver Support; Promoting Safety & Injury Prevention for Children & Youth)

Goal: Improve birth outcomes, postpartum health, and child safety.

Strategy or Program	Initiatives (Now, Near, Far)
Expand Access and Improve Continuity of Care	<ul style="list-style-type: none"> Provide telehealth prenatal visits to reduce access barriers - launch in Pierce County in partnership with Quilted Health
Expand WIC Resources	<ul style="list-style-type: none"> Pilot automated WIC referrals in select clinics Expand WIC Pop-Up Clinics in Pierce Co Identify food insecure NICU infants and enroll in WIC Provide culturally relevant breastfeeding support
Provide Child Safety Education and Support	<ul style="list-style-type: none"> Offer car seat installation checks and free/low-cost seats. Distribute home safety items (lock boxes, cribs, window fall prevention devices, etc.) Provide hands-on training for car seat installation, window fall prevention, safe sleep practices to parents and caregivers Expand injury prevention training to primary care providers Near (2027): Make injury prevention devices available in outpatient clinics and community settings Near (2027): Integrate injury-prevention counseling into well-child visits (safe sleep, car seats, poison prevention).
Strengthen Parent and Caregiver Support	<ul style="list-style-type: none"> Provide Parenting Partnership home visiting program to qualified NICU infants Near (2027): Develop MOU with Elevate Health and other ACHs in WA to assist with care coordination and use of Community Health Workers
Provide Advocacy, Grants, Sponsorships and In-kind Support	<ul style="list-style-type: none"> Support policies expanding access Advocate for expanded access to midwives and doulas Provide grants and/or sponsorships to selected 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
- WIC reach and enrollment
- ED/ Trauma data for child injury
- # of injury prevention devices distributed
- # of individuals educated on injury prevention best practices

- # of home visits

Stratify by socio-demographic characteristics such as:

- Geography
- Race/ethnicity
- Insurance type (Medicaid vs commercial)
- Language preference

Potential External Collaborators & Community Partners

Elevate Health, public health, perinatal collaborative, community providers, external WIC providers, fire and rescue services, maternal/ child home visiting programs, libraries, YMCA, community-based organizations

Responsible Parties & Internal Partners

Bessler Center, Quilted Health, WIC, Center for Childhood Safety, Women's Services, Parenting Partnership

Social Determinants of Health

Health Need: SOCIAL DETERMINANTS OF HEALTH (Food Security and Access to Healthy Food Environments, Housing Instability and Youth Homelessness)

Goals: Improve early identification of social needs and expand access to nutrition and housing-related support.

Strategy or Program	Initiatives (Now, Near, Far)
Enhance Screening and Early Identification of Food and Housing Insecurity	<ul style="list-style-type: none"> Continue universal screening during inpatient admission process Near (2027): Explore ways to standardize universal screening in ED and primary care Far (2028): 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 and Housing Resources	<ul style="list-style-type: none"> Refer to food and housing resources Provide free Summer Meals program on TG/ MBCH main 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. Far (2028): Develop proforma and seek funding to provide on-site food pantries or “food lockers” offering fresh produce and culturally appropriate staples Near (2027): Pilot implementation of a “food locker” on the Mary Bridge Hospital campus 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 Education and Nutrition Literacy Support to Parents and Caregivers	<ul style="list-style-type: none"> Integrate nutrition education into primary care—an approach aligned with USDA’s emphasis on nutrition promotion Provide Pediatric Wellness educational classes virtually Near (2027): Explore providing culturally tailored meal education in partnership with community-based organizations Near (2027): Explore methods/ digital tools (apps, text reminders) to share recipes, budgeting tips, and local food resources
Provide Advocacy, Grants, Sponsorships and In-kind Support	<ul style="list-style-type: none"> Support tobacco/vaping legislation and clean air related policies Support initiatives that provide more access to healthy foods and safe spaces for outdoor activities Participate in regional food policy and housing councils to influence long-term system planning.

	<ul style="list-style-type: none"> • Examine relationship between oral health access and free and reduced school lunch program eligibility rates for further partnership opportunities • Offer in-kind and volunteer support to additional community partners with shared goals • Offer grants and/or sponsorship contributions to selected community partners with shared goals
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Anticipated Impacts (Objectives)
<ul style="list-style-type: none"> • Increase identification of food-insecure and housing insecure patients • Expand access to nutritious food and housing for high-risk patients. • Strengthen the health care ecosystem for patient and community
Objective Metrics
<ul style="list-style-type: none"> • Universal Screening for Food and Housing Insecurity: <ul style="list-style-type: none"> ○ Screening rate (% of patients screened). ○ Number and % of positive screens. ○ Referral completion rate. • Utilization rates (Summer Meal, Food Locker, Pantry utilization (visits/month)). <p>Stratify by socio-demographic characteristics such as:</p> <ul style="list-style-type: none"> • Geography • Race/ethnicity • Insurance type (Medicaid vs commercial) • Language preference
Potential External Collaborators & Community Partners
<p>YMCA, local food systems and food providers, schools, libraries, public health, United Way, Elevate Health, Good Roots, housing supports, 211</p>
Responsible Parties & Internal Partners
<p>Bessler Center, Government Relations, Marketing/ Communications/ Community Relations/ Center for Health Equity and Wellness, Primary Care, Inpatient, ED, Care Navigators/ Social Work, Clinics, WIC, MBCH Pediatric Wellness</p>