MultiCare
Yakima Memorial Hospital

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 Yakima Memorial 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 Yakima County.

This CHIP reflects both hospital-specific accountability and coordinated system alignment within MultiCare Health System, designed to maximize community impact through shared clinical, operational, and community partnerships.

Community Health Needs Assessment Foundation

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

- Behavioral Health (substance use and prevention; mental health crisis and culturally responsive services)
- Access to Care (availability and accessibility of services; financial and systemic barriers)
- Social Determinants of Health (housing instability and homelessness; food security and healthy food environments)
- Maternal and Child Health (infant and birth outcomes; prenatal and maternal care)

These priorities reflect both the magnitude of need and documented disparities in health outcomes across race, ethnicity, geography, language, and socioeconomic status in Yakima County. This Community Health Improvement Plan builds directly upon the assessment and is designed to meet federal community benefit requirements while advancing MultiCare's mission and long-term strategic objectives.

Addressing Priority Needs: 2026 Board-Approved Initiatives and Continued Strategies

The 2026–2028 implementation strategies reflect both new strategic direction approved by the MultiCare Yakima Memorial Hospital Board of Directors and the continuation of strategies from the prior 2022–2025 Community Health Improvement Plan that remain responsive to identified community health needs.

New initiatives approved by the Board in 2026

Following adoption of the 2025 Community Health Needs Assessment, the Board approved two new priority initiatives for the 2026–2028 cycle.

The Board selected a school-based intervention program as its top priority new initiative. This initiative will endeavor to establish partnerships with Yakima County school districts and explore various models to provide health related programming in the school setting, with particular attention to culturally appropriate approaches for Hispanic/Latino youth and families. The board emphasized interest in approaches that reach larger volumes of youth that also demonstrate high impact.

The Board further directed the hospital to seek partnership with Astria Health and work to strengthen relationships with the Yakama Nation. This effort will focus on identifying access gaps and exploring culturally appropriate care models for tribal communities, including coordination with traditional healing practices where appropriate. This represents an exploratory phase of engagement to co-design strategies.

Strategies continued from the 2022–2025 Community Health Improvement Plan

The 2022–2025 Community Health Improvement Plan identified three priority areas — Access to Care, Behavioral Health, and Health Equity — and the hospital made measurable progress across all three. A number of strategies from that cycle continue to directly address needs identified in the 2025 CHNA and are carried forward in this plan.

Continued strategies include: reducing avoidable emergency department utilization; reducing readmissions; increasing preventive cancer screening rates; maximizing use of inpatient behavioral health capacity; integrating behavioral health into all primary care clinics; standardizing evidence-based behavioral health screenings; and reporting quality metrics by race, ethnicity, and language to monitor and reduce health disparities.

These continued strategies provide coverage across all four 2025 CHNA priority areas and complement the two new board-approved initiatives.

Health Equity Framework

Advancing health equity is central to Yakima Memorial Hospital's implementation strategy. Data from the 2025 CHNA demonstrates persistent disparities in behavioral health outcomes, maternal and infant health, chronic disease burden, and access to care among historically underserved populations in Yakima County, including Hispanic/Latino residents, Yakama Nation tribal members, agricultural workers, and rural and low-income families.

This Community Health Improvement Plan incorporates an equity lens through:

- Stratified data monitoring by race, ethnicity, and 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 Yakima Memorial Hospital aims not only to improve outcomes but to reduce the inequities that contribute to preventable morbidity and mortality across Yakima County.

Strategic Implementation Approach

Across all priority areas, implementation strategies emphasize:

- Early identification, screening, and prevention
- Improved timeliness and coordination of care
- Workforce development and cultural competency
- Community partnership investment through grants, in-kind support, and collaborative programming
- Policy advocacy aligned with community health priorities
- Integration of social determinants of health screening and referral into clinical workflows

Strategies will be operationalized through multidisciplinary collaboration across Behavioral Health, Primary Care, Emergency Services, Maternal and Newborn Services, Population Health, Care Management, Community Health Partnerships, the Center for Health Equity and Wellness, and system-level leadership teams.

Behavioral Health Strategy Overview

Yakima Memorial Hospital will strengthen early identification of behavioral health needs and substance use, expand mental health access, and build culturally responsive behavioral health services across the care continuum. Exploration of a school-based program will serve as the centerpiece of this work, complemented by continued integration of behavioral health into primary care settings, standardized screening practices, and optimizing inpatient behavioral health capacity. Recognizing the disproportionate impact of fentanyl and polysubstance use in Yakima County, the hospital will continue to seek partnerships to build a coordinated ecosystem of care.

Access to Care Strategy Overview

Improving equitable access to care remains foundational to community health improvement in Yakima County. Yakima Memorial Hospital will continue reduction of avoidable emergency department utilization, expand preventive screening, and reduced readmission rates. Relationship-building with the Yakama Nation, in partnership with Astria Health, will extend access efforts into tribal and rural communities where geographic isolation and transportation barriers create significant gaps.

Social Determinants of Health Strategy Overview

Yakima Memorial Hospital recognizes that stable housing, food security, and economic opportunity are foundational to health. The hospital will maintain its investment in community partnerships that address housing instability and food insecurity, and will continue connecting patients to food assistance and social support resources through clinical encounters and community-based programs.

Maternal and Child Health Strategy Overview

Maternal and child health remains a core public health priority for Yakima County, where rates of preterm birth, low birthweight, and late prenatal care continue to exceed state averages. Yakima Memorial Hospital will sustain partnerships that support prenatal access, postpartum care continuity, and infant health outcomes, and continuity of support for caregivers and children through Children's Village.

Community Partnerships & Cross-Sector Alignment

Yakima Memorial Hospital recognizes that sustainable community health improvement requires cross-sector collaboration. This Community Health Improvement Plan prioritizes partnerships with public health agencies, community clinics, behavioral health providers, tribal health systems, community-based organizations, educational institutions, and housing and social service organizations. Grants, sponsorships, in-kind support, volunteer engagement, and advocacy efforts will align with identified priority health needs and measurable objectives.

Evaluation, Accountability & Reporting

Yakima Memorial Hospital will monitor implementation progress through defined process and outcome metrics associated with each priority area, aligned with the hospital's existing CHNA tracking framework. Performance will be reviewed quarterly by leadership and reported to the Regional Board. 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 this Community Health Improvement Plan and affirms its commitment to addressing identified priority needs. Through these implementation strategies, MultiCare Yakima Memorial Hospital demonstrates its commitment to measurable, equity-centered, and community-informed action designed to improve health outcomes across Yakima County.

Board Approval

This Community Health Improvement Plan was reviewed and formally adopted by the Board of Directors of MultiCare Yakima Memorial Hospital on April 27, 2026.

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Implementation Strategies

Behavioral Health

Health Need: BEHAVIORAL HEALTH (Substance Use & Prevention; Mental Health Crisis & Culturally Responsive Services)

Goal: Expand access to behavioral health prevention, treatment, and recovery services. Strengthen culturally and linguistically responsive care across the community.

Color key: Teal = new board-approved initiative | Blue = continued from 2022–2025 Community Health Improvement Plan

Strategy or Program	Initiatives
Evaluate School-Based Clinical and Educational Program Models	• Endeavor to establish partnerships with Yakima County school districts to co-design and embed behavioral health programming • Partner with MultiCare Behavioral Health Network as subject matter experts in school based programs to research existing evidence-based practices targeting gaps in services • Integrate culturally appropriate prevention materials for Hispanic/Latino youth and families • Identify funding sources and community co-sponsors to sustain the program
Continue to Expand Inpatient Behavioral Health Access	• Continue to maintain behavioral health staffed bed capacity • Continue partnership with MultiCare Behavioral Health Network and Comprehensive Healthcare
Continue to Integrate Behavioral Health in Primary Care	• Continue to maintain integrated behavioral health staff across all five primary care clinics • Continue warm hand-off processes for patients with behavioral health needs
Continue to Standardize Evidence-Based Behavioral Health Screenings	• Continue standardized depression screening in all primary care settings • Continue Columbia Suicide Screening for patients presenting with behavioral health needs • Continue Screening, Brief Intervention and Referral to Treatment (SBIRT) in ED and hospital units
Objective Metrics	
• Target/ actual encounters of youth reached through school-based clinical and educational programming • Average daily census — behavioral health inpatient unit • # of collaborative care visits # and % Depression screening rates	

• # and % of positive screens • Pursue data sharing agreements with FQHC partners for more complete screening rate data Stratify data, when available, by socio-demographic characteristics such as: • Geography • Race/ethnicity • Language preference • Insurance type (Medicaid vs commercial) • Veteran status
Potential External Collaborators & Community Partners
Yakima Health District, Education Service District 105, Yakima school districts, Nuestra Casa, Triumph Treatment Services, Comprehensive Healthcare, Yakama Nation Tribal Health, Astria Health, Yakima Union Gospel Mission, community clinics, FQHCs
MHS Responsible Parties & Internal Partners
Behavioral Health Network, Primary Care, Emergency Services, Center for Health Equity and Wellness, Community Health Partnerships, Government Relations

Access to Care

Health Need: ACCESS TO CARE (Availability & Accessibility of Services; Financial & Systemic Barriers)

Goal: Increase equitable access to primary, specialty, and behavioral health services across Yakima County.

Color key: Teal = new board-approved initiative | Blue = continued from 2022–2025 Community Health Improvement Plan

Strategy or Program	Initiatives
Endeavor to strengthen Relationship with Yakama Nation (Access to Care)	• Initiate joint conversations with Astria Health and Yakama Nation tribal health to identify opportunities to address access gaps. • Explore culturally appropriate care models, including coordination with traditional healing practices
Continue to Reduce Avoidable Emergency Department Utilization and Readmissions	• Continue to strengthen care transitions and ensure patients have a primary care home • Continue partnership with Yakima Union Gospel Mission to provide services at their campus • Continue partnership with La Clinica Gratuita to provide services at their campus

Continue to Increase Preventive Cancer Screenings	• Expand cancer screening through targeted outreach and evidence-based interventions • Improve screening workflows and follow-up coordination across care settings • Use data to identify and reduce disparities in cancer screening rates • Strengthen community partnerships to increase access to preventive cancer screening services • Evaluate and address barriers to cancer screening across Yakima County

Objective Metrics

- Number of Yakama Nation engagement meetings or formal partnership milestones reached
- Pursue data sharing agreements with FQHC partners for more complete screening rate data
- Mammography screening rate for eligible patients
- Colorectal Screening Rates for eligible patients
- Readmission rates by patient language and transportation needs
- # served by Union Gospel Mission through partnership agreement
- # served by La Clinica Gratuita through partnership agreegment

Stratify data, when available, by socio-demographic characteristics such as:

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

Potential External Collaborators & Community Partners

Yakima Valley Farmworkers Clinic, Yakima Neighborhood Health Services, Community Health Center of Washington, Yakima Union Gospel Mission, Yakama Nation Tribal Health, Astria Health, Greater Health Now, Yakima Clinica Gratuita

MHS Responsible Parties & Internal Partners

Primary Care, Specialty Services, Emergency Services, Community Health Partnerships, MultiCare Medical Group Recruitment, Care Management, Government Relations

Social Determinants of Health

Health Need: SOCIAL DETERMINANTS OF HEALTH (Housing Instability & Homelessness; Food Security & Healthy Food Environments)

Goal: Strengthen hospital partnerships and community investments that address housing instability and food insecurity as drivers of poor health outcomes.

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Color key: Teal = new board-approved initiative | Blue = continued from 2022–2025 Community Health Improvement Plan

Strategy or Program	Initiatives
Continue Relationship-Building with Yakama Nation (Social Determinants of Health)	• Include food security, housing instability, and environmental health in joint Yakama Nation engagement conversations
Continue to Support Community Partnerships Addressing Housing and Food Insecurity	• Continue to provide grants through the MultiCare Community Partnership Fund supporting social determinants of health priorities • Continue to support partner organizations serving individuals experiencing homelessness through in-kind and service partnerships • Continue to connect patients to food assistance resources through clinical encounters
Continue to Support Community Nutrition and Healthy Living Education Programs through partner organizations	• Establish partnerships to support low- or no-cost community health education classes including cooking, nutrition, and healthy lifestyle programs • Establish partnerships to support WIC clinics providing supplemental nutrition for low-income pregnant people and families

Objective Metrics

- Number of Yakama Nation engagement meetings or formal partnership milestones reached
- Inpatient universal screening for food security and housing needs:
    - Screening rate (% of patients screened).
    - Number and % of positive screens.
    - Bridge Bed utilization
    - # of new housing units created in the local area
- Number of individuals served through MultiCare Community Partnership Fund grant-funded programs

Stratify data, when available, by socio-demographic characteristics such as:

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

Potential External Collaborators & Community Partners

Catholic Charities Housing Services, Camp Hope, Yakima Union Gospel Mission, Yakima County Human Services, Yakima Valley Farmworkers Clinic, WIC, Nuestra Casa, La Casa Hogar, Yakama Nation, Greater Health Now, YMCA

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MHS Responsible Parties & Internal Partners
Community Health Partnerships, Care Management and Social Work, Center for Health Equity and Wellness, Primary Care, WIC, Government Relations

Maternal & Child Health

Health Need: MATERNAL & CHILD HEALTH (Infant & Birth Outcomes; Prenatal & Maternal Care)

Goal: Reduce disparities in maternal and infant health outcomes through expanded prenatal access, culturally responsive care, and continuity of support for caregivers and families.

Color key: *Teal = new board-approved initiative | Blue = continued from 2022–2025 Community Health Improvement Plan*

Strategy or Program	Initiatives
Continue the NICU to Home Program	• Continue the NICU to Home program to reduce wait times for in-home therapy for vulnerable infants following discharge
Continue to Advance Health Equity in Maternal and Child Care	• Continue to track and report maternal and infant health metrics by race, ethnicity, and language (REaL) • Provide support for caregivers and families through Children's Village services (such as developmental services. and home visiting models – nurse family partnership, parent to parent, parents as teachers)

Objective Metrics

- Birth outcomes
- # served in NICU to Home program
- # served in Children's Village developmental therapy programs
- # served in Children's Village home visitation programs

Stratify data, when available, by socio-demographic characteristics such as:

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

Potential External Collaborators & Community Partners
Yakima Valley Farmworkers Clinic, WIC, Healthy Start, Yakima Health District, Greater Health Now, Education Service District 101

MHS Responsible Parties & Internal Partners
Maternal and Newborn Services, NICU, Pediatrics, Primary Care, Community Health Partnerships, Center for Health Equity and Wellness, Care Management, WIC