



Community Health Needs Assessment

2026-2028

Table of Contents



Who We Are	03
Methodology	05
Primary Service Area	06
Community at-a-Glance: PSA Population	07
Community at-a-Glance: PSA Socioeconomic Characteristics	08
Health & Wellbeing	09
Community Conditions	11
Prior Community Health Needs Assessment Accomplishments	13
Other Regional Community Health Needs Assessments & Community Convening	14
2026-2028 Strategic Priorities and Implementation Planning	16
Appendix 1 – Data Collection Methodology, District Population Tables, and Source Data Tables	
Appendix 2 – Snoqualmie Valley Health 2026-2028 Strategic Plan Road Map	

Who We Are

Snoqualmie Valley Health (SVH), located in Snoqualmie, WA, is an independent public health system dedicated to providing expert, compassionate care. SVH is owned and operated by King County Public Hospital District No. 4 (the District), which was established by voters in 1972. In the 1980s and early 1990s, the hospital was leased to a third party and operated as a general acute care hospital. Following the end of that lease, the District faced several years of physical plant challenges and financial instability. SVH gained federal designation as a Critical Access Hospital (CAH) in November 2005. The original hospital—with only 14 patient rooms and increasingly constrained by limited capacity and changing regional transportation patterns—was relocated and replaced in 2015 with a 70,000-square-foot facility at the intersection of I-90 and State Route 18.

OUR MISSION

Empower individuals to live boldly, offering innovative, accessible healthcare that prioritizes wellness, fosters community, and fuels adventure.

OUR VISION

Inspiring wellness for life's great adventures.

Today, SVH is a 25-bed licensed hospital that provides emergency and trauma care, acute inpatient care, lab, diagnostic imaging, and a swing bed program. SVH is designated by the state as a Level 5 Trauma Center, a Level 2 Cardiac Facility, and a Level 3 Stroke Facility.

Over the last two years, SVH has greatly expanded local access to care, introducing new services and providers for pediatrics, gastroenterology, nephrology, allergy/immunology, neurology/epilepsy, rheumatology, sexual assault treatment, infectious disease, 3D mammography, and travel medicine. In 2025, SVH also celebrated the opening of its North Bend Medical Clinic. Starting with primary care services, the clinic will expand to include rotating specialty services, expanding access to care and reducing travel barriers in the Snoqualmie Valley. In total, SVH now operates three rural health clinics (RHCs) with primary care access and provides specialty services including cardiology, wound care, podiatry, behavioral health, and inpatient and outpatient rehabilitation.

In 2024, SVH served 16,149 patients, providing:



22,547 Clinic Visits



7,216 Urgent Care Visits



6,013 Emergency Visits



540 Inpatient Days



\$1,799,663 Financial Assistance Provided (Charity Care)

\$2,859,573 Unfunded Care Provided

Guided by a commitment to care that goes beyond clinical services, SVH participated in more than 15 community events in 2024, contributing 134 volunteer hours and connecting with over 4,000 community members across the Valley.

Recent strategic planning highlighted the need for improved access to outpatient services, including surgery, ambulatory rehabilitation, and diagnostic imaging. To meet this need, SVH is building The Hub, an 80,000-square-foot ambulatory services expansion under construction and scheduled to open in Fall 2026.



The Hub will significantly expand access to care, with four operating rooms, 33 exam rooms, pharmacy and infusion services, enhanced specialty care, and outpatient rehab for adults and children, creating 225 new jobs and adding more than 30 new medical providers. Designed as a community gathering space, The Hub includes a rock-climbing gym, restaurant, and gathering areas designed to strengthen social connection for a growing and aging population.

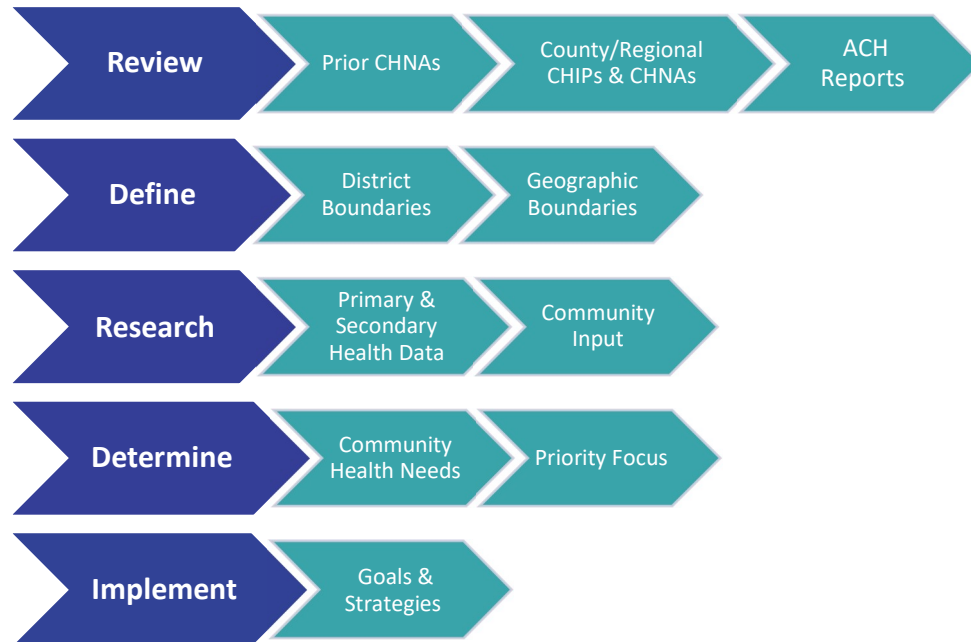
Community Benefit Programs
• Care Coordination & Transitions
• Chronic Disease Management
• Diabetes Education
• Health Benefits Education
• Immunizations/Flu Shot Clinics
• Smoking Prevention & Cessation
• Weight Loss Classes

Awards and Accreditations

Becker's 2025 Great Community Hospitals	Critical Access Hospital Achievement of Excellence (WSHA)	Quality Award for Pediatric Care	Excellence in Skilled Nursing
 <p>SVH was named one of Becker's Hospital Review's 2025 Great Community Hospitals, a national recognition honoring healthcare organizations that deliver exceptional care, foster deep community ties, and lead with innovation in non-urban settings.</p>	 <p>Snoqualmie Valley Health received the Critical Access Hospital Achievement of Excellence distinction from the Washington State Hospital Association (WSHA). The silver-level recognition honors hospitals demonstrating strong performance across 14 quality measures over a 12-month period.</p>	 <p>Recognized by Premera Blue Cross, the Quality Program supports Premera's mission of providing peace of mind to members about their healthcare coverage.</p>	 <p>SVH is proud to be recognized by Assisted Living Magazine for Excellence in Skilled Nursing in the Snoqualmie Valley and surrounding communities.</p>

Methodology

Snoqualmie Valley Health engaged Health Facilities Planning & Development, Seattle, to conduct its 2026-2028 CHNA using the following framework:



Data Collection

Primary and secondary data was collected to assess the overall health status of King County and the subset that comprises the District's primary service area (PSA). This data informed the identification and analysis of unmet health needs, as well as the development of key themes and priorities related to community well-being.

Because each Washington Public Hospital District serves a distinct geographic area, data was analyzed at the District and/or PSA level when available. Where sub-county data was not available, county-level data was used, and relevant findings are presented throughout the report. A detailed description of data sources, collection methods, analytic approach, and supporting data tables is provided in **Appendix 1**.

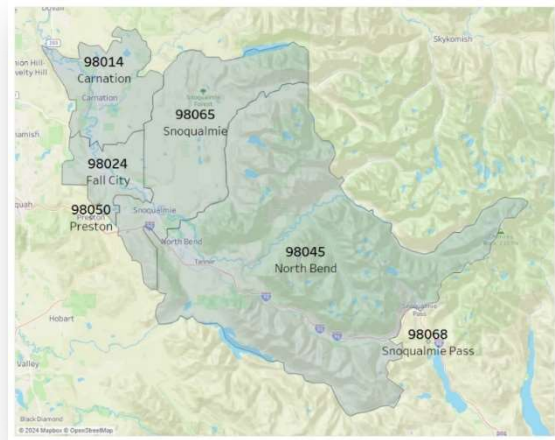


Primary Service Area

The legal boundaries of King County Public Health District No. 4, dba Snoqualmie Valley Health, are comprised of the following communities:

- Snoqualmie – 98065
- North Bend – 98045
- Fall City – 98024
- Carnation – 98014
- Preston – 98050

The headquarters and ancestral lands of the Snoqualmie Indian Tribe are also within the District boundary. Additionally, the community of Snoqualmie Pass (98068), while not within the District boundary, is identified as part of Snoqualmie Valley Health's primary service area (PSA), defined as the communities accounting for 85% or more of SVH's total patient volume.



According to the U.S. Census Bureau, the District is in the Seattle-Tacoma-Bellevue Metropolitan Core Based Statistical Area (CBSA), a census-designated Urban Area. The District is still considered rural and eligible for the Rural Health Clinic (RHC) Program, as it fell outside of Urbanized Areas in the 2010 Census. Per Center for Medicare and Medicaid Services interim guidance, a location meets RHC requirements if it was outside an urbanized area in either the 2010 or 2020 Census Bureau data.



Community at-a-Glance: PSA Population

- In 2025, the PSA had a population of almost 47,000 residents.
- Five-percent (5%) growth in the PSA communities is expected by 2030.
- Growth is focused in the 65+ cohort—which grew 126% between 2010 and 2025—and is expected to grow an additional 27% by 2030, while the 0-64 population is expected to remain relatively flat.

Primary Service Area Population:
46,919 (2025 est.)

5-Year Growth:
+2,365 (Percent Growth: 5%)

Growth and aging in the PSA, coupled with a defined shortage of both primary and specialty care, demand for healthcare services is expected to increase.

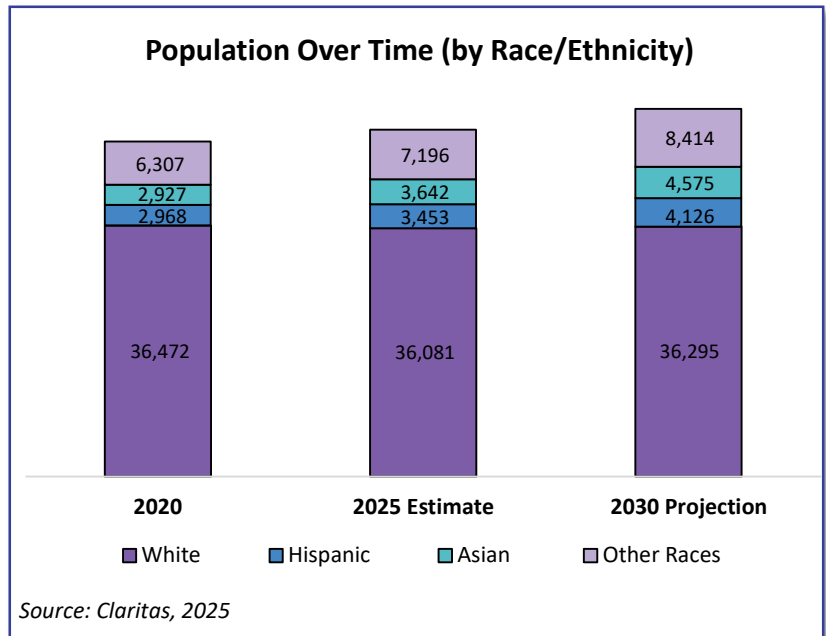
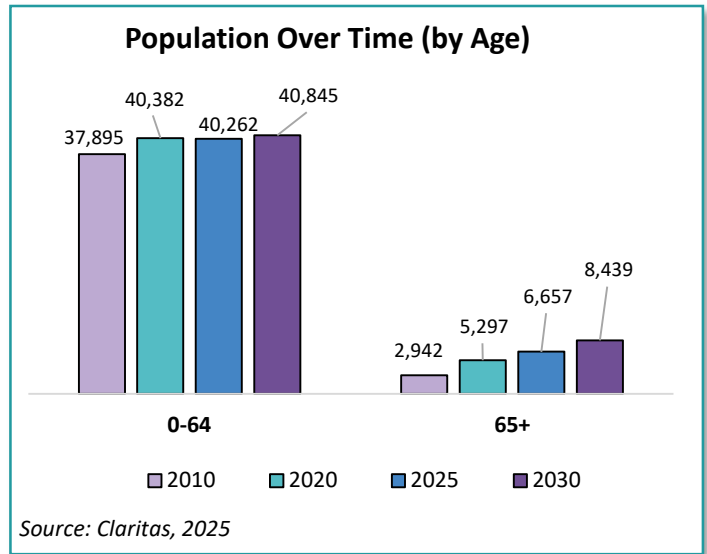
The PSA is less diverse relative to King County, though it is diversifying. Between 2020-2025:

- The Hispanic population grew 16% and is currently 7% of the population.
- The Asian population grew 24% and currently accounts for more than 8% of the population.
- The White population declined just over -1% in the same period.

By 2030:

- The Hispanic population is projected to be over 8% of the population (20% growth)
- The Asian population is projected to be over 9% of the population (26% growth)
- The White population is projected to remain flat (less than 1% growth)

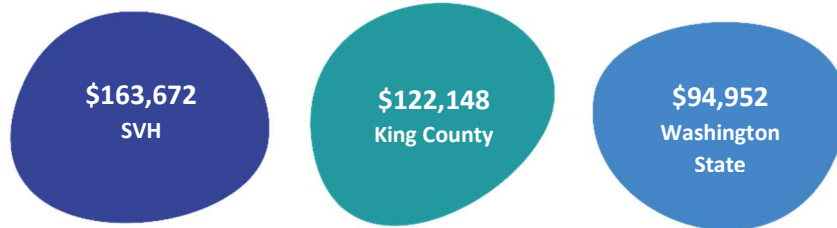
The American Indian population remains a consistent 0.8% of the PSA population, versus just 0.4% in King County.



Community at-a-Glance: PSA Socioeconomic Characteristics

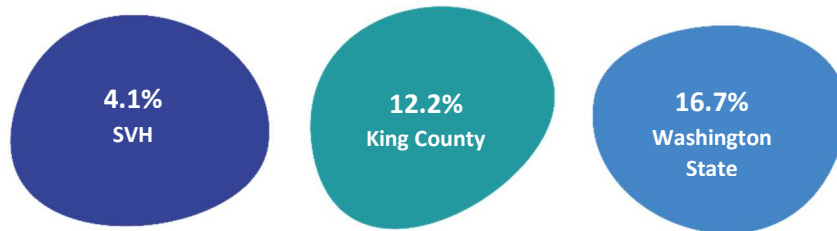
Median Household Income

Source: ACS, 2019-2023 5-Year Estimates



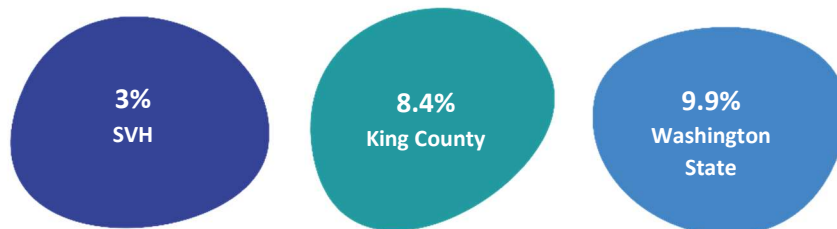
Poverty: Families Earning < 200% FPL

Source: ACS, 2019-2023 5-Year Estimates

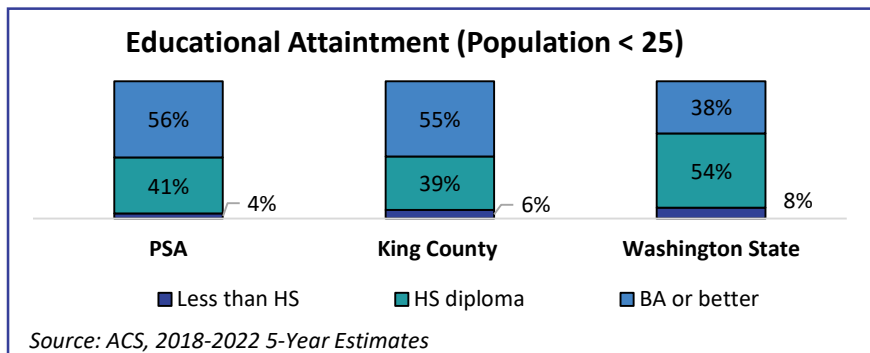


Poverty: Population Earning < 100% FPL

Source: ACS, 2019-2023 5-Year Estimates



In a region (King County) already considered highly educated, the PSA's rate of high school graduation (96.5%) and advanced educational attainment (56%) is higher than the county or state averages.



Health and Well-being

Prior to 2024, the RWJ County Health Rankings compared and ranked counties on more than 30 factors relative to the health of other counties. Beginning in 2024, RWJ County Health Rankings shifted away from numerical rankings to a scaled approach. Counties in a state are now represented by a dot, shaded a certain color, and placed on a decile scale from least healthy to most healthy in the state and nation. The darker colored areas indicate populations with healthier rankings. The RWJ County Health Rankings does not provide data below the county level.

Health and well-being data tells us how long people live, on average, within a community, and how much physical and mental health people experience in a community while they are alive.

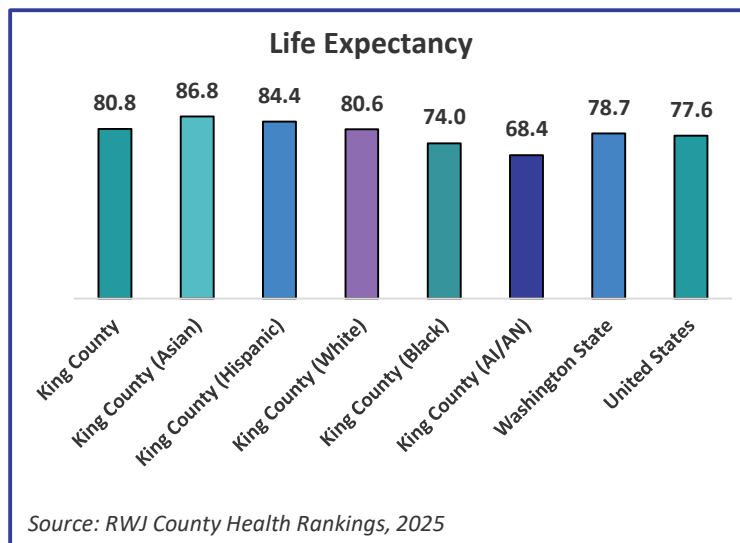


King County is faring better than the average county in Washington and the nation for population health and well-being.

Length of Life

Measuring how long people in a community live demonstrates whether people are dying prematurely, and it prompts evaluation of what is driving those premature deaths.

Life expectancy measures the average number of years from birth a person can expect to live, according to the current mortality experience (age-specific death rates) of the population. Life expectancy calculations are based on the number of deaths in a given period and the average number of people at risk of dying during that period, allowing comparison across counties with different population sizes.



King County (data not available below the county level) fares better than Washington State and the nation on life expectancy, and when disaggregated by race and ethnicity, Asian and Hispanic residents fare better still, averaging over four more years of life than the county as a whole. In contrast, both Black and American Indian residents fare significantly worse than the county, state, or nation.

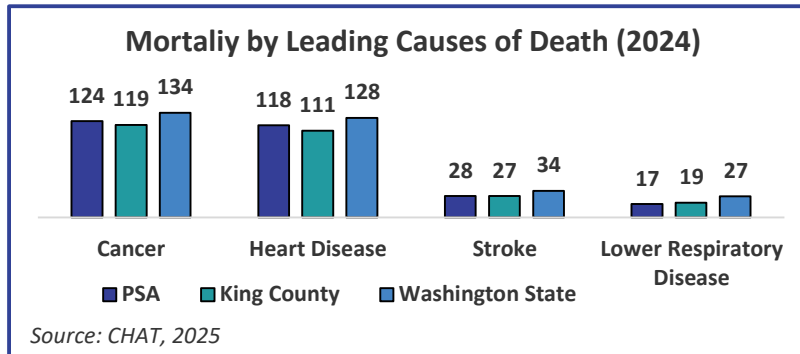
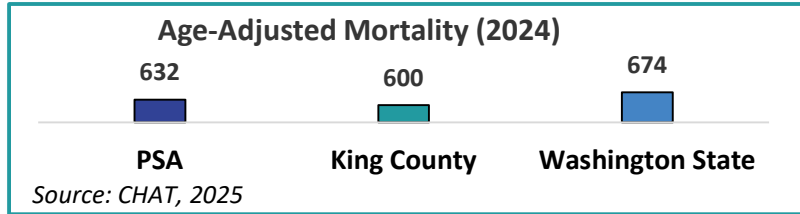
The PSA’s rate of overall age-adjusted mortality per 100,000 population (632) is higher than the county (600), but lower than the state (674).

When examining the leading causes of death, the PSA has lower rates of mortality for cancer, heart disease, and stroke relative to the state, but slightly higher rates relative to the county.

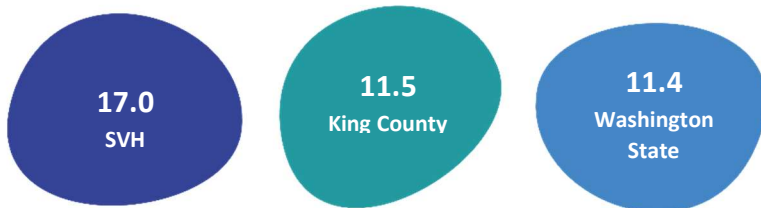
Other Health Outcomes

While generally faring better on measures of health relative to the state, the PSA’s health outcomes data also reveals areas of improvement relative to King County averages.

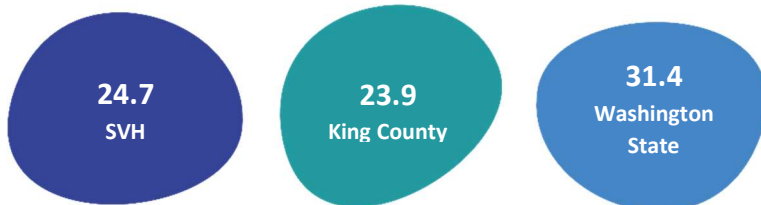
- The rate of mortality by suicide in the PSA is almost 50% higher relative to the county and state.
- Rates of obesity and high blood pressure are largely in line with the county and lower than that the state.



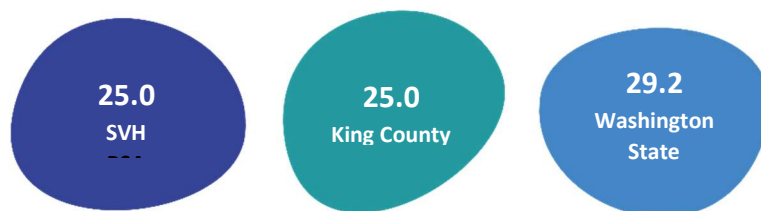
Age-Adjusted Death Rate by Suicide per 100,000. (2023)



Percentage of Obesity in Adults. (2022)



Percentage of Adults with High Blood Pressure. (2021)



Sources: DOH CHAT, 2025; HRSA GeoCare Navigator, 2022

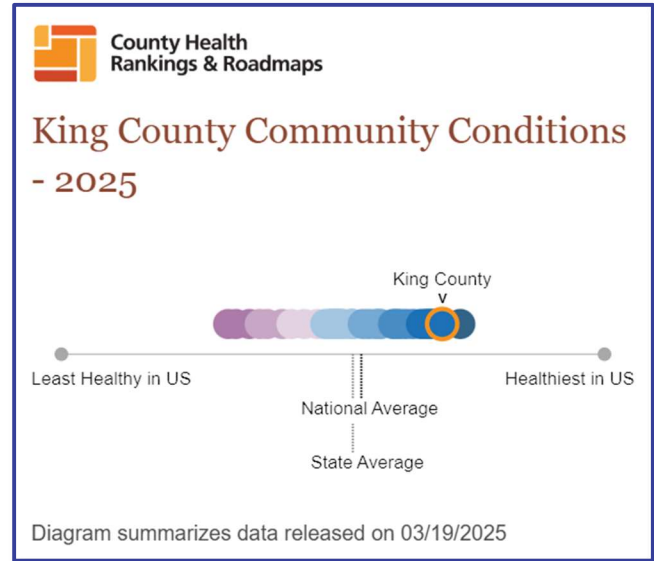
Community Conditions

As with Health and Well-being data, the RWJ County Health Rankings uses a scaled approach to rank counties on a decile scale from least healthy to most healthy in the state and nation on select health factors. The darker colored areas indicate populations with healthier rankings.

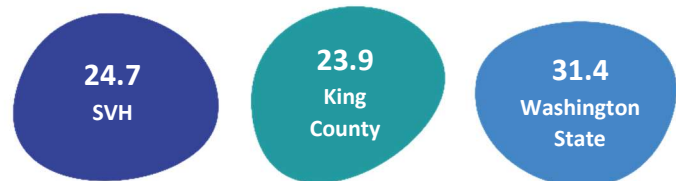
Community Conditions represent those things we can improve to live longer and healthier lives and are indicators of the future health of our communities. **King County is faring better than the average county in Washington and the nation for Community Conditions.**

While generally faring better on measures of health behavior relative to the state (i.e., physical activity, tobacco use, opioid deaths), the data suggests areas of focus related to mental health and substance use relative to King County.

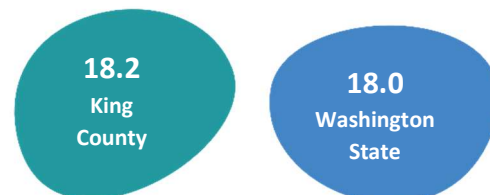
- The county's adult marijuana use (18.2%) and binge drinking rates, adult (24.7%) and youth (5.5%), are higher, relative to the county.



Percentage of Adults Who Binge Drink. (2023)



Percentage of Adults Who Use Marijuana. (2023)



Sources: DOH CHAT, 2025; HRSA GeoCare Navigator, 2022

The **Washington Healthy Youth Survey (HYS)** is a statewide, school-based survey administered every two years to students in grades 6, 8, 10, and 12 to measure health behaviors, risk factors, and protective factors among youth. It provides data used by schools, communities, and policymakers to guide youth prevention programs.

HYS data shows that King County 10th graders:

- Use marijuana less (5.5%) compared to their state peers (8.4%)
- Use alcohol less (7.8%) compared to state peers (9.1%)
- Have higher (worse) rates of binge drinking (5.5%) compared to state peers (4.2%)
- Have lower rates of depression (23.6%) compared to state peers (29.9%)
- Have lower rates of suicidality (12.3%) compared to state peers (14.5%)

Clinical Care

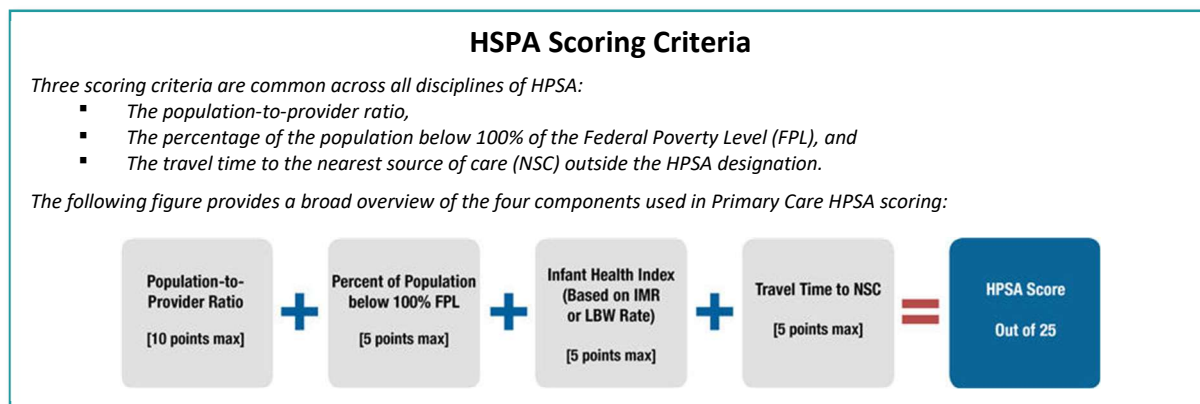
Access to affordable, high-quality, and timely healthcare is a primary driver of reduced morbidity and mortality, enabling earlier detection and effective management of disease. Expanded coverage and improved access are consistently associated with increased use of preventive services and measurable reductions in avoidable illness. Conversely, individuals without regular access to quality providers are more likely to be diagnosed at later, less treatable stages of disease and consequently experience poorer outcomes, lower quality of life, and higher mortality, along with greater financial burden.

SVH's 2025 *PSA Resident Services Demand Study* identified substantial shortages in locally-based primary and specialty care. Quantitative indicators such as physician-to-population ratios, along with direct outreach to practices revealed long wait times, limited new patient availability, and frequent referrals outside the PSA. Roughly half (50%) of non-SVH primary care providers are closed to new patients. SVH currently employs all specialty care staff in the Valley and the study found concerning levels of specialty practices in the area adjacent to the PSA closed to new patients and/or with wait times between 4-9 months. Referrals commonly extend to downtown Seattle, where delays are similar.

Interestingly, and relative to both the county and the state, the PSA generally fares better on access and preventative care measures, supported by the PSA's overall economic security and low rates of the uninsured. Nonetheless, both the data and community feedback suggest expanding provider supply is a top priority.

- Seven percent (7%) of adults report not having a primary care provider (relative to 15% in the county and state).
- Twenty-five percent (25%) of adults report not having a dental exam in the past year (relative to 30% in the county and 34% in the state).
- Relative to the state, PSA residents have higher rates of flu vaccination (68%), and pneumonia vaccination (65%).

Health Professional Shortages



The Federal Health Resources and Services Administration (HRSA) designates certain geographies and populations as Medically Underserved Areas (MUAs), Medically Underserved Populations (MUPs), and Health Professional Shortage Areas (HPSAs). HPSA designations indicate critical shortages of healthcare providers and may apply broadly to a geographic area or specifically to certain populations or facilities. Geographic HPSAs reflect provider shortages affecting the entire population within a defined area, while

population HPSAs identify access challenges among specific groups, such as low-income individuals, migrant farmworkers, or American Indian communities.

Once an area is designated as an HPSA, HRSA assigns a score ranging from 0 to 26, with higher scores reflecting greater shortages and need. Scores are calculated separately for three areas of care: primary medical, dental, and mental health services. These designations and scores are significant because they influence eligibility for more than 30 federal programs that support funding, loan repayment, and other incentives to attract and retain healthcare professionals in underserved communities.

King County has more favorable provider-to-population ratios than state and national averages, indicating relatively strong access to healthcare providers at the county level.

However, **the PSA is located within two geographic HPSAs for primary care and mental health services, and the 2025 SVH Resident Services Demand Study confirms ongoing shortages of primary care and select specialty providers within the PSA, reflecting localized access challenges despite broader county trends.**

King County Population to Provide Ratios

Provider Type	King County	Washington State	United States
Primary Care Physicians	820:1	1,170:1	1,310:1
Dentists	850:1	1,130:1	1,340:1
Mental Health Providers	150:1	180:1	290:1

Source: County Health Rankings 2024

King County HPSA Designations – 2025 Update

Category	Designation Type	Score
Primary Care	Geographic: Snoqualmie-North Bend	16
Mental Health	Geographic: East King County	15

Source: HRSA Data Warehouse, HPSA Find

Prior CHNA Accomplishments

SVH's 2023-2025 Strategic Plan employed best practices in strategic planning by fully integrating its 2023-2025 CHNA community priorities within an organizational framework for advancing innovation, strengthening community partnerships, and delivering high-quality care. With a clear focus on *access to care, behavioral health services, quality workforce, services and support for the elderly, and affordable housing*, SVH's Strategic Planning identified the targeted priorities and performance indicators detailed below.

Snoqualmie Valley Health 2023-2025 Priorities and Accomplishments		
2023-2025 CHNA Priorities	2023-2025 Strategic Plan KPIs	KPI Results
Build essential infrastructure to support a healthy future.	Successful implementation of new CT and MRI units by December 2024.	Early in 2024, SVH installed a new CT scanner and acquired a state-of-the-art MRI scanner, further enhancing our diagnostic capabilities. Both CT and MRI volumes increased dramatically during the fourth quarter.
Recruit and retain the highest caliber staff.	First-year turnover rates will be reduced from 39% to 32% or less.	First-year turnover was successfully reduced to 31%. While this figure may initially appear high, it aligns with industry standards and demonstrates meaningful progress in our retention efforts. This remains an area we are committed to focusing on for continued improvement.
Develop programs and infrastructure to meet and support health care needs of the community.	Increase the annual number of outpatient visits across the District by 2%, from 53,292 in 2023 to 54,357 in 2024.	There were 56,417 outpatient visits in 2024, exceeding our target. Additionally, clinic volume increased by 40% compared to last year.
Develop a brand of the future and define the "New SVH."	"Likelihood to Recommend" scores for the SVH system combined will be 4.6 or above.	We achieved a district-wide score of 4.83. This noteworthy outcome reflects the dedication of our team to delivering exceptional care and fostering trust within our community.
Ensure the financial resources to support our vision.	Positive 1.25% profit margin.	We exceeded expectations with a positive margin of 7.3%. The District has not seen financial results this strong in organizational history.

Other Regional CHNAs and Community Convening

2024-2025 King County CHNA¹

King County, in partnership with Hospitals for a Healthier Community—a collaborative of 10 county hospital systems—conducted a county-wide Community Health Needs Assessment (CHNA) in 2024-2025. While SVH was not a direct participant in the collaborative, the King County CHNA provides relevant context for understanding health needs across the broader King County community.

As part of the 2024/2025 King County CHNA, nine listening sessions were held with residents from communities of color across the county who experience disproportionate barriers to access for food, health, and mental health services. Led by community-based organizations with deep knowledge of local needs, the sessions offered translation and interpretation and explored key themes including food access, nutrition information, culturally responsive mental and behavioral health services, and climate-related health impacts. Key findings from King County listening sessions include:

1. Access to Healthy Food and Nutrition Information
2. Access to Mental and Behavioral Health Services
3. Climate Change Impacts on Food Security and Mental Health
4. Community Protective Factors (community networks, community strengths)
5. Emerging Priorities (overdose deaths, firearm violence, homelessness and housing instability, climate-related health impacts, limited access to care—particularly behavioral health—and food insecurity as persistent and worsening concerns)

2024 Overlake Medical Center & Clinics CHNA²

Overlake Medical Center is a non-profit health system located within King County, whose local service area overlaps and includes the SVH PSA. As part of its 2024 CHNA process, Overlake conducted thirteen interviews with community stakeholders from agencies and organizations that represent medically underserved, low-income, and/or minority populations. Interviews included a preliminary survey and were conducted via phone, with stakeholders asked to share their experience and perspective on the issues, challenges, and barriers relative to the identified health needs and known resources to address them. Interviewees were also asked to prioritize the health needs according to the highest level of importance in the community.

¹ King County Department of Public Health. (2025). *Healthy housing coalition community health needs assessment, 2024–2025*. <https://cdn.kingcounty.gov/-/media/king-county/depts/dph/documents/reports/chna/2024-2025-hhc-chna-report.pdf>

² Overlake Medical Center & Clinics. (2024). *FY24 community health needs assessment*. https://www.overlakehospital.org/sites/default/files/2025-07/Overlake%20Medical%20Center%20FY24%20CHNA_FINAL.pdf

Access to care, mental health, chronic disease, preventative practices, and substance use were ranked as the top five priority needs of the service area:

1. Access to health care
2. Mental health
3. Chronic disease
4. Preventive practices (health education, screenings, vaccines)
5. Substance use
6. Housing and homelessness
7. Healthy eating and active living
8. Sexually transmitted infections

Community Convening

To inform the identification of community health needs and priorities for SVH's primary service area, this CHNA incorporates community input collected through the 2024-2025 King County CHNA listening sessions and the 2024 Overlake CHNA community stakeholder surveys and interviews. Perspectives shared by community organizations and residents—particularly those serving, or living in, communities experiencing disproportionate barriers to care—provide relevant qualitative insight into the challenges and priorities that are also present within the SVH primary service area, outlined below under the 2026-2028 Strategic Community Priorities.



2026-2028 Community Priorities & Implementation Planning

Following an analysis of themes identified through national, state, and regional data—as well as insights gathered through community convenings—priority areas were developed using a synthesis of established strategic planning frameworks:



After review and adoption by the Board of Commissioners of King County Public Hospital District No.4, identified community priorities will be integrated into SVH’s 2025–2028 Strategic Planning. Alignment of community priorities to strategic planning reflects established best practice in community health improvement, ensuring that CHNA findings directly inform organizational strategy, resource allocation, and align organizational action with community-identified needs. This creates a continuous planning cycle in which community-identified needs guide decision-making and long-term system investments. A copy of SVH’s current 2025-2028 Strategic Plan Road Map is shown in **Appendix 2**.

2026-2028 Community Priorities:

1. Primary and Specialty Healthcare Access

SVH’s 2025 *PSA Resident Services Demand Study* found significant shortages of locally-based primary and specialty care, including long wait times and 50% of non-SVH primary care providers closed to new patients, reflecting localized access challenges despite broader county trends.

- The PSA falls within two King County geographic Health Professional Shortage Areas for primary care and mental health care.
- The 2025 *Resident Demand Study* conducted by SVH found that a significant shortage of primary care and select specialty providers exists in the PSA:
 - By 2031, the PSA is expected to generate over 80,000 total primary care visits.
 - Practice outreach found reasonable access to SVH’s primary care providers but long wait times at other clinics, with about 50% of providers at the other clinics (system-owned) not currently accepting new patients.
 - There are currently no specialty providers in the PSA other than those employed by SVH. Practice calling to specialty clinics in the surrounding region found concerning levels of practices closed to new patients and long wait times for those that are accepting new patients, typically between 4-9 months.
 - More urgent care can be supported simply by virtue of the shortage of primary care. In the longer term, an expanded urgent care/walk-in/virtual alternative appears to be an attractive option to residents of the PSA.

2. Behavioral Healthcare Access

The PSA's community conditions (health behaviors) data suggests areas of focus related to behavioral health relative to King County.

- The PSA records slightly higher rates of marijuana use in adults and binge drinking in both adults and youth relative to the county, and the PSA's rate of mortality by suicide is almost 50% higher relative to the county.
- The 2024-2025 King County CHNA also outlined priorities related to behavioral healthcare and access, including timeliness and availability: long wait-times, limited appointment slots, or providers not offering flexible hours make access difficult.

3. Prevention and Management of Chronic Disease

Health outcomes data and the need for expanded primary and specialty care access suggest areas of focus that are related to the prevention and management of chronic disease. Strategies could include expansion of services, best practices in care coordination, and patient outreach around screening and testing are indicated.

- The PSA's rate of overall age-adjusted mortality per 100,000 population (632) is higher than the county (600) and the PSA has slightly higher rates of mortality for cancer, heart disease, and stroke relative to the county, suggesting a focus on strategies such as patient education, increased prevention measures, protective health behaviors, and the management of chronic disease.
- The PSA's health outcomes data also reveals areas of improvement relative to King County averages, with the PSA's rates of obesity and high blood pressure in line with or higher than the county.



**APPENDIX 1 – Data Collection Methodology, District/Primary Service Area
Population Table, and Source Data Tables**

Methodology

Snoqualmie Valley Health engaged Health Facilities Planning & Development, Seattle, to conduct its 2026-2028 CHNA using the following framework:



Data Collection

Primary and secondary data was collected to assess the overall health status of the county and the District's primary service area (PSA). This data informed the identification and analysis of unmet health needs, as well as the development of key themes and priorities related to community well-being.

Because each Public Hospital District serves a distinct geographic region, data was analyzed at the District and/or primary service area level when available. Where sub-county data was not available, county-level data was used, and key findings are presented throughout the report.

Primary Data

King County, in partnership with Hospitals for a Healthier Community (a collaborative of 10 King County hospital/health systems) conducted a county-wide CHNA in 2024/2025. Primary data capturing the direct experiences and perspectives of District residents was compiled from the 2024/2025 King County CHNA.

Secondary Data

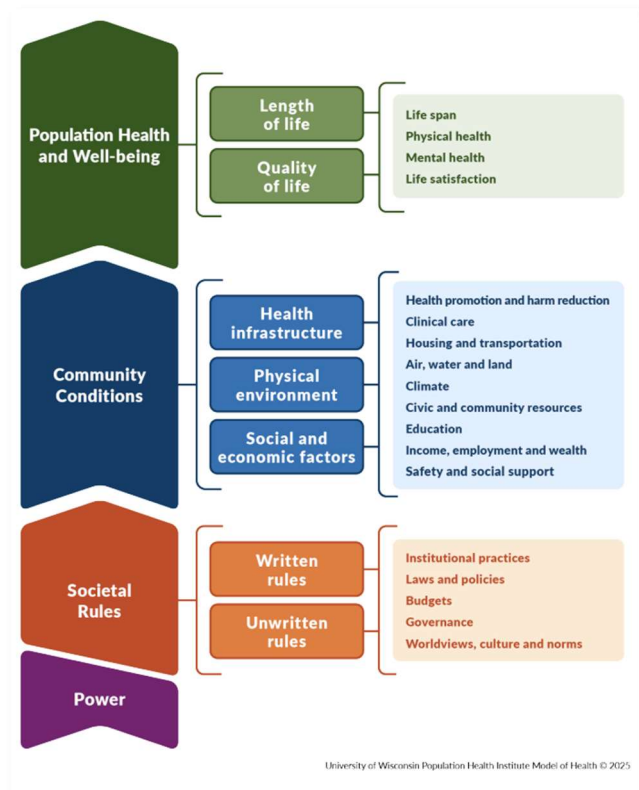
Secondary data was sourced from national, state, and regional/local databases to provide insight into demographics, health behaviors, socioeconomic factors, environmental conditions, and clinical care across the county and primary service area. Specific data sources include, but were not limited to:

- Claritas Population Data
- Snoqualmie Valley Health *Resident Services Demand Study* (2025)
- Community Health Assessment Tool (CHAT), Washington State Department of Health
- Washington Tracking Network (WTN), Washington State Department of Health

- Washington State Healthcare Authority
- Health Resources & Services Administration (GeoCare Navigator)
- American Community Survey (ACS)
- Robert Wood Johnson (RWJ) County Health Rankings
- Centers for Disease Control (Places)
- Washington State Healthy Youth Survey
- Washington State Office of Financial Management, Small Area Estimates
- Behavioral Risk Factor Surveillance System
- U.S. Census Bureau

After gathering and analyzing primary and secondary source data and information, several frameworks were applied to identify themes and determine priorities from the data—foremost, the Robert Wood Johnson Foundation’s (RWJ) Health Rankings Model.

In the Health Rankings Model, **Population Health and Well-being** represents how well and how long we live, including our physical, mental, and social well-being. **Community Conditions** encompass where we live, learn, work, and play, including affordable housing, clean water, and socioeconomic factors. **Societal rules** are set and held by people who wield power, shape the conditions that affect our health, and are formalized in policies and laws. **Power** is the ability to create change. People and groups who hold power influence societal rules and determine how they are applied.³



³ 2025 County Health Rankings & Roadmaps Report

District/Primary Service Area Population									
	2010	2020	Pct. Chg. 2010-2020	2025 Est.	Pct. of Tot. Pop.	Pct. Chg. 2020-2025	2030 Proj.	Pct. of Tot. Pop.	Pct. Chg. 2025-2030
Tot. Pop.	40,837	45,679	11.9%	46,919	100.0%	2.7%	49,284	100.0%	5.0%
Population by Age									
0-17	11,525	11,995	4.1%	11,021	23.5%	-8.1%	10,875	22.1%	-1.3%
18-44	14,290	14,804	3.6%	15,276	32.6%	3.2%	15,187	30.8%	-0.6%
45-64	12,080	13,583	12.4%	13,965	29.8%	2.8%	14,783	30.0%	5.9%
65-74	1,855	3,644	96.4%	4,343	9.3%	19.2%	5,203	10.6%	19.8%
75-84	767	1,295	68.8%	1,876	4.0%	44.9%	2,631	5.3%	40.2%
85+	320	358	11.9%	438	0.9%	22.3%	605	1.2%	38.1%
Population by Race/Ethnicity									
Tot. 0-64	37,895	40,382	6.6%	40,262	85.8%	-0.3%	40,845	82.9%	1.4%
Tot. 65 +	2,942	5,297	80.0%	6,657	14.2%	25.7%	8,439	17.1%	26.8%
Fem. 15-44	8,008	8,407	5.0%	8,423	18.0%	0.2%	8,375	17.0%	-0.6%
Hispanic	2,029	2,968	46.3%	3,453	7.4%	16.3%	4,126	8.4%	19.5%
American Indian/ Alaskan Native	329	367	11.6%	385	0.8%	4.9%	415	0.8%	7.8%
Asian	2,115	2,927	38.4%	3,642	7.8%	24.4%	4,575	9.3%	25.6%
Black/ African American	255	399	56.5%	488	1.0%	22.3%	606	1.2%	24.2%
Multiple Race/ Some Other Race	2,197	5,541	152.2%	6,323	13.5%	14.1%	7,393	15.0%	16.9%
White - Alone	35,964	36,472	1.4%	36,081	76.9%	-1.1%	36,295	73.6%	0.6%

Health & Wellbeing (Health Outcomes)

Indicator	Definition / Source	Snoqualmie Valley Health	King County	Washington State
Health Conditions				
Disability	Percentage of population with a disability, 2018-2022; HRSA GeoCare Navigator	7.0	10.1	13.0
Obesity	Percentage of adults (18+) with a BMI of 30 kg/m2 or greater, 2022; HRSA GeoCare Navigator	24.7	23.9	31.4
Obesity (Youth)	Percentage of 10th grade youth with a BMI of 30 kg/m2 or greater; 2023 Heathy Youth Survey		5.9	9.4
High Blood Pressure	Percentage of adults (18+) with high blood pressure, 2021; HRSA GeoCare Navigator	25.0	25.0	29.2
Diabetes	Percentage of adults (18+) with Diabetes, 2022; HRSA GeoCare Navigator	6.7	7.5	9.6
Mortality	Age-adjusted mortality rate (per 100,000), 2024; DOH CHAT	632	600	674
Cancer	Rate of deaths due to malignant neoplasms per 100,000, age-adjusted, 2024; DOH CHAT	123.7	118.7	134.4
Heart Disease	Rate of deaths due to diseases of the heart per 100,000, age-adjusted, 2024; DOH CHAT	118.1	111.4	127.7
Stroke	Rate of deaths due to cerebrovascular disease per 100,000, age-adjusted, 2024; DOH CHAT	27.6	27.3	33.8
Respiratory Disease	Rate of deaths due to cerebrovasculare disease per 100,000, age-adjusted, 2024; DOH CHAT	17.3	19.0	27.0
Accident Deaths	Rate of deaths due to accident per 100,000, age-adjusted, 2024; DOH CHAT	27.1	55	67.0
Life Expectancy	Average number of years people are expected to live, 2021-2023; RWJ County Health Ranking (National average = 77.6)		80.8	78.7
Pregnancy & Childbirth				
Prenatal Care	Percentage of women who received pre-natal care in the first trimester, 2024; DOH CHAT	88.5	79.5	79.3
Low Birth Weight	Percentage of Low birth weight (<2500 grams) per 100 total live births, 2024; DOH CHAT	4.7	7.0	7.0
School-required Immunizations	Percentage of Kindergarteners out of compliance with required immunizations (excludes exemptions), 2024-2025; DOH Washington Tracking Network	92.8 Snoqualmie Valley SD	88.3	87.2
Mental Health				
Frequent Mental Distress	Percentage of adults reported experiencing poor mental health for 14 or more of last 30 days, 2022; DOH CHAT (BRFSS)		14.6	17.2
Suicide	Age-adjusted rate of deaths by suicide (self-injury) per 100,000, 2023; DOH CHAT	17	11.5	14.4
Depression (Youth)	Percentage of 10th grade youth who report feeling sad or hopeless almost every day for 2 weeks or more in the last year; 2023 Heathy Youth Survey		23.6	29.9
Hope Scale (Youth)	Percentage of 10th grade youth who report no or very low hope on the Children's Hope Scale; 2023 Heathy Youth Survey		5.0	7.8
Suicide (Youth)	Percentage of 10th grade youth who report seriously considering attempting suicide in the past year; 2023 Heathy Youth Survey		12.3	14.5
Suicide (Youth)	Percentage of 10th grade youth who report attempting suicide in the past year; 2023 Heathy Youth Survey		5.0	7.1
Prevention				
No Primary Care	Percentage of adults (18+) with no usual source of care, 2023; HRSA GeoCare Navigator	6.9	15.4	15.1
Delayed Care	Percentage of Adults Who Delayed/ Not Sought Care Due to High Cost; 2022; DOH CHAT (BRFSS)		9.0	10.2
Physical Exam (Adult)	Percentage of adults (18+) reporting a routine check-up within the past year, 2022; BRFSS via DOH CHAT		70.6	69.4
No Physical Exam (Youth)	Percentage of 10th grade youth reporting no annual check-up or physical exam in the past 24 months; 2023 Heathy Youth Survey		18.5	21.1
No Dental Exam	Percentage of adults (18+) with no dental visit in past year, 2022; HRSA GeoCare Navigator	24.8	29.9	33.9
Dental Exam (Adult)	Percentage of adults (18+) reporting a dental visit in the past year, 2022; BRFSS via DOH CHAT		72.3	67.5
No Dental Exam (Youth)	Percentage of 10th grade youth reporting no annual dental check-up or exam in the past 24 months; 2023 Heathy Youth Survey		12.0	12.6
No Flu Vaccine	Percentage of adults (18+) reporting no flu vaccine, 2023; BRFSS via HRSA GeoCare Navigator	68.0	53.4	48.9
No Pneumonia Vaccine	Percentage of adults (18+) reporting no pneumonia vaccine, 2023; BRFSS via HRSA GeoCare Navigator	64.6	35.7	36.3
Breast Cancer Screening	Percentage of female residents, ages 50-74, who report receiving a mammogram in the past two years, 2022; DOH CHAT (BRFSS)		77.4	75.0
Colorectal Screening	Percentage of adult residents, ages 50-75, who had appropriate screening for colorectal cancer in the past year, 2018; BRFSS via DOH CHAT		60.6	58.3

Health Factors (Community Conditions)

Indicator	Definition / Source	Snoqualmie Valley Health	King County	Washington State
Health Behaviors				
Physical Inactivity	Percentage of adults reporting no leisure-time physical activity, 2022; DOH CHAT		13.3	17.1
Physical Activity (Youth)	Percentage of 10th grader youth reporting no physical activity in the past week; 2023 Heathy Youth Survey		10.4	10.9
Tobacco Use	Percentage of adults who are current smokers lage-adjusted) 2022; HRSA GeoCare Navigator	8.3	8.4	11.2
Tobacco Use (Youth)	Percentage of youth (10th grade) who report using smoking in the last 30 days; 2023 Heathy Youth Survey		1.7	2.2
Marijuana Use	Percentage of adults who report using marijuana in the past 30 days; 2021; DOH CHAT		18.2	18.0
Marijuana Use (Youth)	Percentage of 10th grade youth who report using marijuana in the past 30 days; 2023 Heathy Youth Survey		5.5	8.4
Binge Drinking	Percentage of adults (18+) who report binge drinking (5 drinks for men, 4 drinks for women) in the past 30 days, 2022; HRSA GeoCare Navigator	20.5	18.5	17.3
Alcohol Use (Youth)	Percentage of 10th grade youth who report alcohol consumption in past 30 days; 2023 Heathy Youth Survey		7.8	9.1
Binge Drinking (Youth)	Percentage of 10th grade youth who report drinking 5 or more drinks in a row in the past 2 weeks; 2023 Heathy Youth Survey		5.5	4.2
Opioid Deaths	Rate of opioid deaths per 100,000, 2024; DOH Washington Tracking Network		29.2	30.3
Health Infrastructure and Access				
Health Insurance	Uninsured rate, 2023; OFM (Hospital District data is 2019-2023 5-Year Estimate; ACS)	3.8	5.2	6.4
Primary Care Physician	Ratio of one primary care physician per people, 2021; RWJ County Health Rankings		820:1	1,170:1
Other Primary Care Providers	Ratio of one primary care provider (NP, PA, etc.) per people, 2021; RWJ County Health Rankings		700:1	800:1
Mental Health Provider	Ratio of one mental health provider per people, 2024; RWJ County Health Rankings		150:1	180:1
Dentists	Ratio of one dentist per people, 2022; RWJ County Health Rankings		850:1	1,130:1
Socioeconomic Factors				
High School Graduation	Percentage of adults (25+) with a high school degree of equivalent, 2019-2023 5-Year Estimate; ACS	96.5	93.8	92.2
Income	Median household income (2023 inflation adusted dollars), 2019-2023 5-Year Estimate; ACS	\$163,672	\$122,148	\$94,952
Unemployment	Unemployment rate for civilian workforce 16 years and over, 2019-2023 5-Year Estimate; ACS	2.3	4.6	5.0
Poverty	Children in poverty (<18) , 2019-2023 5-Year Estimate; ACS	1.9	9.2	11.9
Poverty	Adults in poverty (18-64) ,2019-2023 5-Year Estimate; ACS	3.1	8.0	9.6
Poverty	Senior in poverty (65+), 2019-2023 5-Year Estimate; ACS	4.3	9.1	8.5
Poverty	Population earning less than 200% of FPL, 2019-2023 5-Year Estimate; ACS	6.8	17.6	22.8
Poverty	Families earning less than 200% of FPL,2019-2023 5-Year Estimate; ACS	4.1	12.2	16.7
Physical Environment				
Childcare Cost Burden	Childcare costs for a 2-child household as a percent of median income, 2023-2024; RWF County Health Rankings (National average = 28%)		37.0	37.0
Food Insecurity	Percentage of people who did not have a reliable source of good, nutritious food / Average meal cost, 2023; Map the Meal Gap, feedingamerica.org		11.2 / \$4.84	13.3 / \$3.83
Rent Cost Burden	Cost Burdened Renters (those spending 30%-49% of income on rent), 2019-2023 5-Year Estimate; ACS	24.7	23.7	24.8
Severe Rent Cost Burdent	Severe Cost Burdened Renters (those spending more than 50% of income on rent), 2019-2023 5-Year Estimate; ACS	19.1	21.0	22.1
Ownership Cost Burden	Cost Burdened Homeowners (those spending between 30%-49% of income on homeownership expenses), 2019-2023 5-Year Estimate; ACS	23.1	24.2	23.8
Severe Ownership Cost Burden	Severe Cost Burdened Homeowners (those spending more than 30% of income on homeownership expenses), 2019-2023 5-Year Estimate; ACS	8.9	9.8	9.3
Traffic Volume	Average traffic volume per meter of major roadway in the county, 2020; RWJ County Health Ranking (National average = 108)		333	176
Acess to Parks	Percentage of population living within a half mile of apart, 2020 & 2024, RWJ County Health Rankings (National average = 51%)		88	57
Air Pollution	Particulate matter (micrograms/cubic meter) relative to EPA 12mg standard, 2020; RWJ County Health Rankings (National average = 7.3)		10.2	10.3
Drinking Water Violations	Drinking Water Violations, 2023; RWF County Health Rankings		At least one community water system in King County reported a health-based drinking water violation.	
Broadband Access	Percentage of households with broadband internet connection, 2019- 2023; RWJ County Health Rankings; DOH CHAT (National average = 90%)	RWJ data...	95.0	93.0

Health Centers, Rurality, & Shortage Areas

Indicator	Definition / Source	Snoqualmie Valley Health	King County	Washington State
Federally Qualified Health Centers				
Dominant FQHCs	2023; HRSA GeoCare Navigator	HealthPoint, Sea Mar		
Utilization (all)	Percentage Penetration of Total Population, 2023; HRSA GeoCare Navigator	1.3	11.7	14.9
Utilization (low-income)	Percentage Penetration of Low-Income, 2023; HRSA GeoCare Navigator	17.5	67.3	66.0
Rurality				
Rural	Am I Rural, Federal Office of Rural Health Policy; Rural Health Information Hub, 2025	No		
Rural	Percent of county population that is rural; Rural Health Information Hub, 2025	0.3		
CMS Eligible	Location eligible for Rural Health Clinic Program; Rural Health Information Hub, 2025	Yes		
Health Professional Shortage Areas				
Primary Care	Designation: Geographic (Snoqualmie-North Bend); Rural Health Information Hub, 2025	Yes		
Dental Care	Designation: Geographic; Rural Health Information Hub, 2025	No		
Mental Health	Designation: Geographic (East King County); Rural Health Information Hub, 2025	Yes		
Medically Underserved	Medically underserved populaton; Rural Health Information Hub, 2025	No		

APPENDIX 2 – 2026-2028 Snoqualmie Valley Health Strategic Plan Road Map

FOUNDATIONAL ELEMENTS

2025 Objective: Successfully establish an outpatient clinic in the North Bend community.

STRATEGIES

- Develop SVH culture
- Create opportunities for SVH Board
- Invest in Primary Care practices
- Energize the Hospital Foundation
- Improve IT/IS infrastructure org-wide
- Create master facilities plan to support future growth
- Ensure org-wide compliance with all governmental agencies
- Leverage AI to enhance, expand and create efficiencies
- Leverage Medical Staff engagement
- Streamline contracting processes
- Enhance Supply Chain functionality
- Optimize MS Suite for better integration
- Expand use of Telehealth across the district

HEALTH SYSTEM OF CHOICE

2025 Objective: "Likelihood to Recommend"/ Top Box scores will be maintained at 85% or above.

STRATEGIES

- Improve our physical spaces
- Create a special and unique customer service experience, creating emotional bonds with each patient, visitor and customer
- Focus on the ease of use by our customers
- Create a widely recognized boutique SVH Health Brand
- Create a health system recognized regionally & nationally
- Showcase food services and use as an engagement tool
- Leverage patient feedback to enhance experience and outcomes
- Community education services
- Community sponsorship and engagement

OUR TEAM

2025 Objective: Average Turnover rates will be reduced to 32% or less.

STRATEGIES

- Enhance, refine and improve HR related practices
- Create a robust, strategic approach to New Hires to improve retention and culture adoption
- HAVE MORE FUN!!! Find creative & meaningful ways to recognize, engage and appreciate our staff
- Implement a robust introduction to the culture of SVH upon hire & ongoing culture training
- Invest in workforce development activities
- Create workforce retention program
- Develop a fresh new employee recognition program

COMMUNITY HEALTH

2025 Objective: Increase the annual number of Outpatient visits across the District by 1% from 56,417 to 56,981.

STRATEGIES

- Redesign the Quality Improvement Program
- Med Aesthetics & Wellness program
- Assess specialty and NEW services
- Optimize Acute Care services
- Optimize Rehab department
- Establish and nurture strategic partnerships to support long-term vision
- Optimize the SwingBed program to generate improved revenue/savings
- Design and build a high functioning utilization review program
- Implementation of breast health program to include mammography

FINANCIAL STEWARDSHIP

2025 Objective: Achieve Budget with a break even bottom line.

STRATEGIES

- Capture opportunities for program growth
- Maximize program expense reductions for annual savings
- Implement strategic supply chain initiatives
- Optimize charge captures and billing practices org-wide
- Develop a strategic approach to cost reporting, budgeting and operational decisions
- Add point-of-service payment options