2022

COMMUNITY HEALTH NEEDS ASSESSMENT

Providence Regional Medical Center Everett

Everett, Washington

Photo courtesy of Wendy Fagan

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Providence SWEDISH

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MESSAGE TO THE COMMUNITY

To our community:

Providence Regional Medical Center Everett (PRMCE) is proud to be our community's health partner and, as a not-for-profit Catholic health care ministry, we embrace our responsibilities to provide for the needs of the communities we serve. We extend this work through our Community Health Needs Assessment (CHNA) efforts. A healthy community relies on many people and many resources. When the Sisters of Providence began our tradition of caring over 160 years ago, our ministry greatly depended on partnering with others in the community who were committed to doing good, and we continue similar partnerships today.

Providence's vision of "Health for a Better World" starts with our commitment to understanding and serving the needs of the community, especially those who are poor and vulnerable. With each investment we make and partnership we develop, we find ways to best address and prioritize our region's most challenging needs as identified through our CHNA. In 2021, driven by our Mission to care for our community, Providence Regional Medical Center Everett invested more than $89 million in community benefit. Together with our partners, we are building communities that promote and transform health and well-being.

With input and guidance from many of our community partners, including the Providence Community Mission Board and the Providence Institute for Healthier Communities (PIHC), we complete a CHNA every three years to identify the greatest unmet needs among the communities we serve. The objectives of the CHNA are to understand the greatest needs in the community, determine how PRMCE is best positioned to respond to those needs, and develop a community health improvement plan (CHIP) to identify implementation strategies that will lead to health improvement. In the coming year, we will focus our efforts on supporting and growing programs that address behavioral health, access to health care, housing instability and homelessness, and equity.

Our goal is to identify solutions that transform the health of our communities and collectively work with our partners to achieve Health for a Better World. A special thank you to the PIHC Strategic Oversight Committee members who served as the CHNA Advisory Committee and provided invaluable input to this important work.

We invite you to learn more about how we are working to meet community needs and help people live their healthiest lives.

Sincerely,

Kristy Carrington
Chief Executive
Providence Regional Medical Center Everett
Providence Swedish North Puget Sound Service Area

EXECUTIVE SUMMARY

Understanding and Responding to Community Needs

The Community Health Needs Assessment (CHNA) is an opportunity for Providence Regional Medical Center Everett to engage the community every three years with the goal of better understanding community strengths and needs. At Providence, this process informs our partnerships, programs, and investments. Improving the health of our communities is fundamental to our Mission and deeply rooted in our heritage and purpose. Our Mission calls us to be steadfast in serving all, especially our neighbors who are poor and vulnerable.

The 2022 CHNA was approved by the Providence Northwest Community Mission Board on October 20, 2022 and made publicly available by December 28, 2022.

Gathering Community Health Data and Community Input

We collected quantitative information from various sources including the U.S. Census Bureau, American Community Survey data, Behavioral Risk Factor Surveillance System, Washington State Department of Health, PRMCE emergency department utilization data, and the Health & Well-Being Monitor™. To obtain qualitative data we actively engage the community by conducting listening sessions with people who are from diverse communities, have low-incomes, and/or are medically underserved. We also conducted stakeholder interviews with representatives from organizations that serve these populations, specifically seeking to gain deeper understanding of community strengths and opportunities. Some key findings include the following:

- Mental health is a critical component of people's overall health.
- Housing is a foundational need.
- Navigating the health care system can be challenging.
- Effects of racism and discrimination contributes to poor physical and mental health.

While care was taken to select and gather data that would tell the story of the hospital's service area, it is important to recognize that limitations and gaps in information naturally occur. For example, not all data are available to be analyzed by zip code, race/ethnicity, or other socio-economic factors. Data may have a time lag and therefore may be several years old. Additionally, some data may not be available for trend analysis due to changes in definition or data collection methods.

Identifying Top Health Priorities

The CHNA was developed through a collaborative process engaging our many partners and community members, including the Providence Institute for Healthier Community (PIHC) Strategic Oversight Council, which represents the broad interest and demographics of the community. The PIHC Strategic Oversight Council served as the CHNA Advisory Committee leading the effort to identify the significant health needs of the community.

PRMCE utilized a multi-step approach to identify the significant health needs of the community and those that PRMCE will address in this CHNA cycle. The process started with listening to the voice of the community through key stakeholder interviews, group listening sessions, and a community survey. These findings were used to frame the discussion of the top health needs. A review of the quantitative data was then conducted to validate and enrich the outcomes of the qualitative information provided by the community. The data was compiled using a methodology adopted from the Snohomish Health District's 2018 community health needs assessment comparing local data to state and national data, identifying trends, and evaluating the size and seriousness of the problem. The next phase included scoring the significant needs based on the size, seriousness, trend, and disproportionate impact on sub-populations. The final phase included an evaluation based on the linkage to the strategic plan, the number of resources required relative to community need, and confidence in our ability to have a positive impact. Through this evaluation process, the following ranked priority areas were identified as those that PRMCE will focus on in the next three years:

1. Behavioral health (mental health and substance use)
2. Access to health care
3. Housing Instability and homelessness
4. Health equity, racism, and discrimination

PRMCE will develop a three-year Community Health Improvement Plan (CHIP) to respond to these prioritized needs in collaboration with community partners, considering resources and community strengths and capacity. The 2023-2025 CHIP will be approved and made publicly available no later than May 15, 2023.

Measuring Our Success: Results from the 2020-2022 CHIP

This report evaluates the impact of the 2020-2022 CHIP. PRMCE responded to community needs by making investments of direct funding, time, and resources to internal and external programs dedicated to addressing the prioritized needs using evidence-based and leading practices. In addition, we invited written comments on the 2019 CHNA and 2020-2022 CHIP. No written comments were received. A few of the key outcomes from the previous CHIP are listed below:

- Opened a 24-bed inpatient behavioral health unit at PRMCE.
- Partnered with the Everett Gospel Mission to provide medical respite beds for men experiencing homelessness who need a place to recover and heal following hospital discharge.
- Partnered with WSU Elson. S. Floyd College of Medicine's Internal Medicine Residency program and Sea Mar Marysville Family Medicine Residency program to serve as a training site for new physicians, with a special focus on working with underserved populations.

INTRODUCTION

Who We Are

Our Mission As expressions of God's healing love, witnessed through the ministry of Jesus, we are steadfast in serving all, especially those who are poor and vulnerable.

Our Vision Health for a Better World.

Our Values Compassion — Dignity — Justice — Excellence — Integrity

Providence has a long history of serving the community, beginning when the Sisters of Providence established a hospital in Everett in 1905. Today, Providence cares for the community through a comprehensive network of facilities and services from the beginning to the end of life, including primary and specialty care, hospital care, home care and hospice. By working with our team of compassionate caregivers, we strive to deliver the best in quality and affordable care to our patients and their families. Major programs and services offered in northwest Washington include inpatient acute care, an emergency department serving as a Level II trauma center, behavioral health, cancer services, women's services, rehabilitation, clinical research, chemical dependency, primary care, and specialty care. In northwest Washington, Providence includes:

- **Providence Regional Medical Center Everett (PRMCE)** is a 595-bed acute care tertiary hospital serving patients who reside in Snohomish County as well as from the surrounding region of Skagit, Whatcom, Island, and San Juan counties. It is the only Level II trauma center in Snohomish County and has a large and busy emergency department. PRMCE is split into two campuses: the smaller Pacific Campus includes the Pavilion for Women and Children, and the larger Colby Campus includes an emergency department and a cancer center. PRMCE serves as a teaching institute for many health professions and has a medical staff of more than 1,350 providers, and professional relationships with many medical groups in the community.

- **Providence Medical Group Northwest (PMG)** is a network of primary care, specialty care, and walk-in services providing care to children and adults in 15 locations throughout Snohomish County.

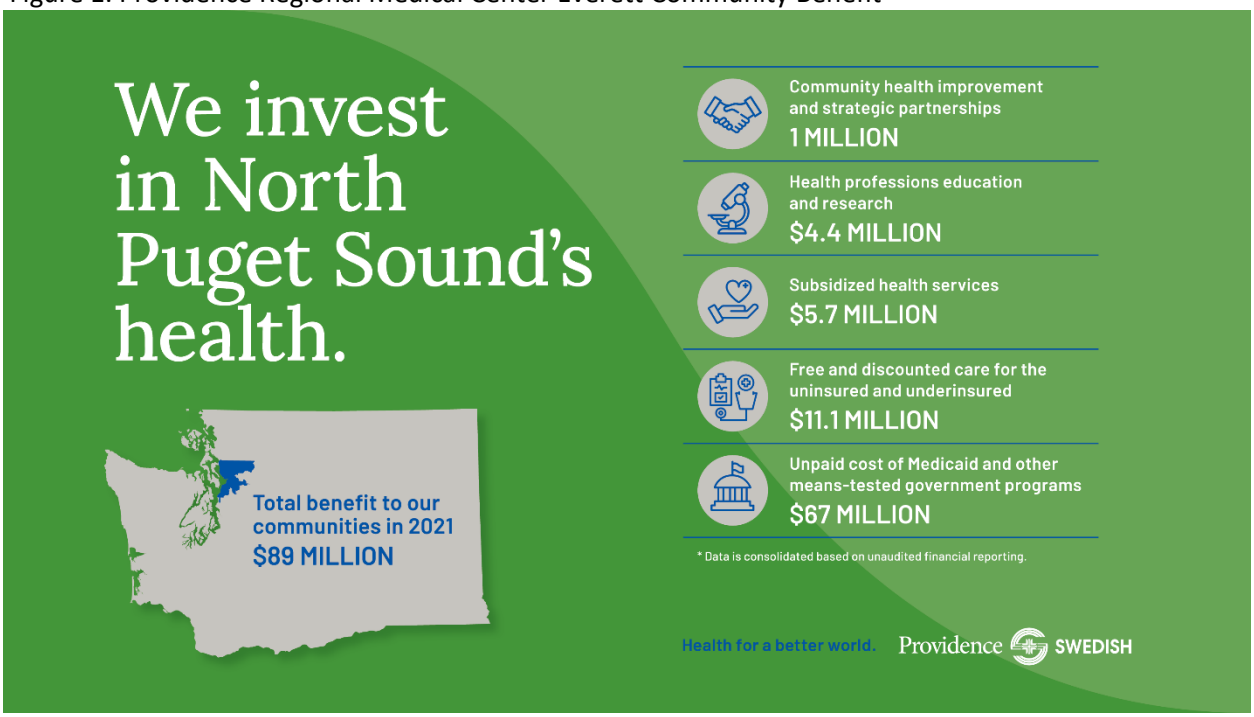
- **Providence Hospice and Home Care of Snohomish County (PH&HC)** provides home care and inpatient hospice services in Snohomish County.

- **Providence Institute for a Healthier Community (PIHC)** is a partnership between Providence, businesses, government, health care providers, social service agencies, and other non-profits aimed at encouraging residents of Snohomish County to make behavioral changes to improve their overall health. Recognizing that health is more than health care, PIHC starts with a shared understanding of health as defined by our community and works together to create a healthier future. PIHC serves as the convener and facilitator by helping establish innovative community partnerships to support health and well-being.

Our Commitment to Community

PRMCE dedicates resources to improve the health and quality of life for the communities we serve. During 2021, PRMCE and PMG provided $89 million in Community Benefit[1] in response to unmet needs and to improve the health and well-being of those we serve in Snohomish County. Community benefit includes $11.1 million in free and low-cost care for people who are underinsured or uninsured.

Figure 1. Providence Regional Medical Center Everett Community Benefit



PRMCE further demonstrates organizational commitment to community health through the allocation of staff time, financial resources, participation, and collaboration to address community-identified needs. The PRMCE chief executive is responsible for ensuring the compliance of state and federal 501r requirements as well as ensuring community and hospital leaders, providers, and others work together to plan and implement the resulting Community Health Improvement Plan (CHIP).

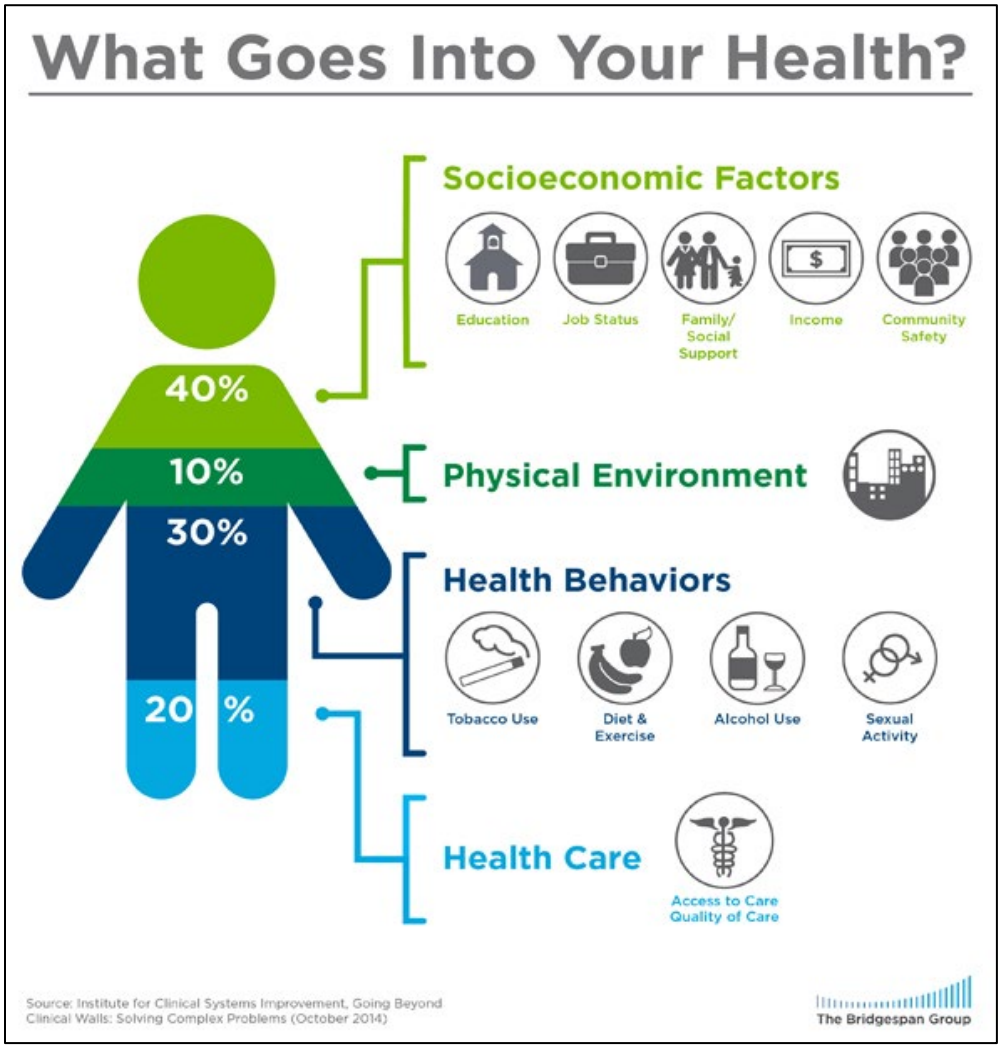
Health Equity

At Providence, we acknowledge that all people do not have equal opportunities and access to living their fullest, healthiest lives due to systems of oppression and inequities. We are committed to ensuring health equity for all by addressing the underlying causes of racial and economic inequities and health disparities. Our Vision is "Health for a Better World," and to achieve that we believe we must address not only the clinical care factors that determine a person's length and quality of life, but also the social

[1] Per federal reporting and guidelines from the Catholic Health Association.

and economic factors, the physical environment, and the health behaviors that all play an active role in determining health outcomes (see Figure 2[2]).

Figure 2. Factors contributing to overall health and well-being



The CHNA is an important tool we use to better understand health disparities and inequities within the communities we serve, as well as the community strengths and assets (see Figure 3 for definition of terms[3]). Through the literature and our community partners, we know that racism and discrimination have detrimental effects on community health and well-being. We recognize that racism and discrimination prevent equitable access to opportunities and the ability of all community members

[2] Institute for Clinical Systems Improvement, Going Beyond Clinical Walls: Solving Complex Problems (October 2013)

[3] Braveman P, Arkin E, Orleans T, Proctor D, and Plough A. *What is Health Equity? And what Difference Does a Definition Make?* Princeton, NJ: Robert Wood Johnson Foundation, 2017.

to thrive. We name racism as contributing to the inequitable access to all the determinants of health that help people live their best lives, such as safe housing, nutritious food, responsive health care, and more.

Figure 3. Definitions of key terms

Health Equity

A principle meaning that "everyone has a fair and just opportunity to be as healthy as possible. This requires removing obstacles to health such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care. For the purposes of measurement, health equity means reducing and ultimately eliminating disparities in health and its determinants that adversely affect excluded or marginalized groups." (Braverman, et al., 2017)

Health Disparities

Preventable differences in the burden of disease or health outcomes as a result of systemic inequities.

To ensure that equity is foundational to our CHNA, we have developed an equity framework that outlines the best practices that the hospital will implement when completing a CHNA. These practices include, but are not limited to the following:

Approach

Explicitly name our commitment to equity

Take an asset-based approach, highlighting community strengths

Use people first and non-stigmatizing language

Community Engagement

Actively seek input from the communities we serve using multiple methods

Implement equitable practices for community participation

Report findings back to communities

Quantitative Data

Report data at the block group level where available to address masking of needs at county level

Disaggregate data when responsible and appropriate

Acknowledge inherent bias in data and screening tools

Efforts taken to center equity in community engagement included interviewing stakeholders who represent organizations serving various demographic groups that are historically marginalized. Some of the populations intentionally included were refugee and immigrant community members, Spanish-speaking communities, and Black, Brown, Indigenous, and People of Color (BBIPOC). Listening sessions were designed to include participants from under-represented groups. Those sessions were conducted by appointed leaders of those groups to ensure participants felt safe to share their opinions. Efforts were made to conduct the sessions in the language that was most fluent for the group.

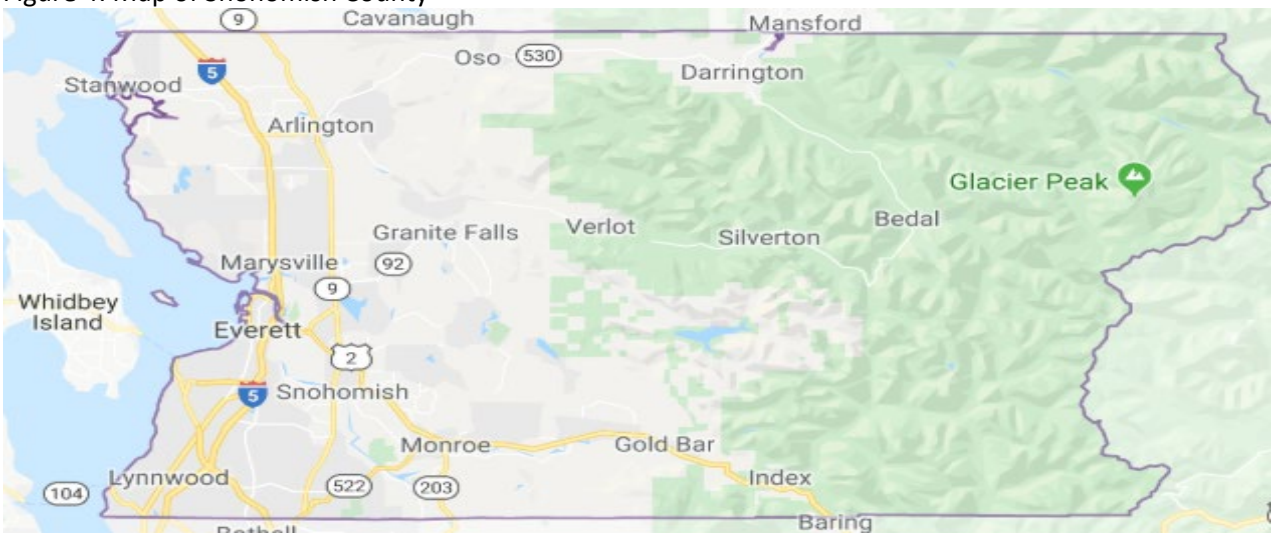
OUR COMMUNITY

Hospital Service Area and Community Served

The community served by the hospital is defined based on the primary geographic area in which the majority of PRMCE's inpatient population resides. As a tertiary referral center, PRMCE serves patients from the surrounding region consisting of Skagit, Whatcom, Island, San Juan, and Snohomish Counties. However, more than 75 percent of PRMCE's patient population resides in Snohomish County and for this reason, the geographic definition for the CHNA is Snohomish County.

Snohomish County is located in northwest Washington State with boundaries extending from Skagit County in the north, King County in the south, the Cascade Mountains in the east, and the Puget Sound in the west.

Figure 4. Map of Snohomish County



Community Demographics

The tables and graphs below provide basic demographic and socioeconomic information about Snohomish County, including identification of high-need areas compared to the broader service area. For the socioeconomic indicators, the broader service area and high-need service area values are calculated based on the average of the census tracts within each service area classification. Providence developed a dashboard that maps many of the CHNA indicators at the census tract level. A summary follows and additional quantitative results are available in Appendix 1. The high-need area and indicators dashboard can be found here NWWA - Data Hub 2022 (arcgis.com) [4].

[4] https://experience.arcgis.com/experience/16b7732724854eafbd3dc5d65d67faa6/

Additionally, Providence conducts an annual community survey called the Community Health & Well-Being Monitor™ to provide a snapshot of the community's health and well-being perceptions, satisfaction, and behaviors. The full report and methodology are available in Appendix 5.

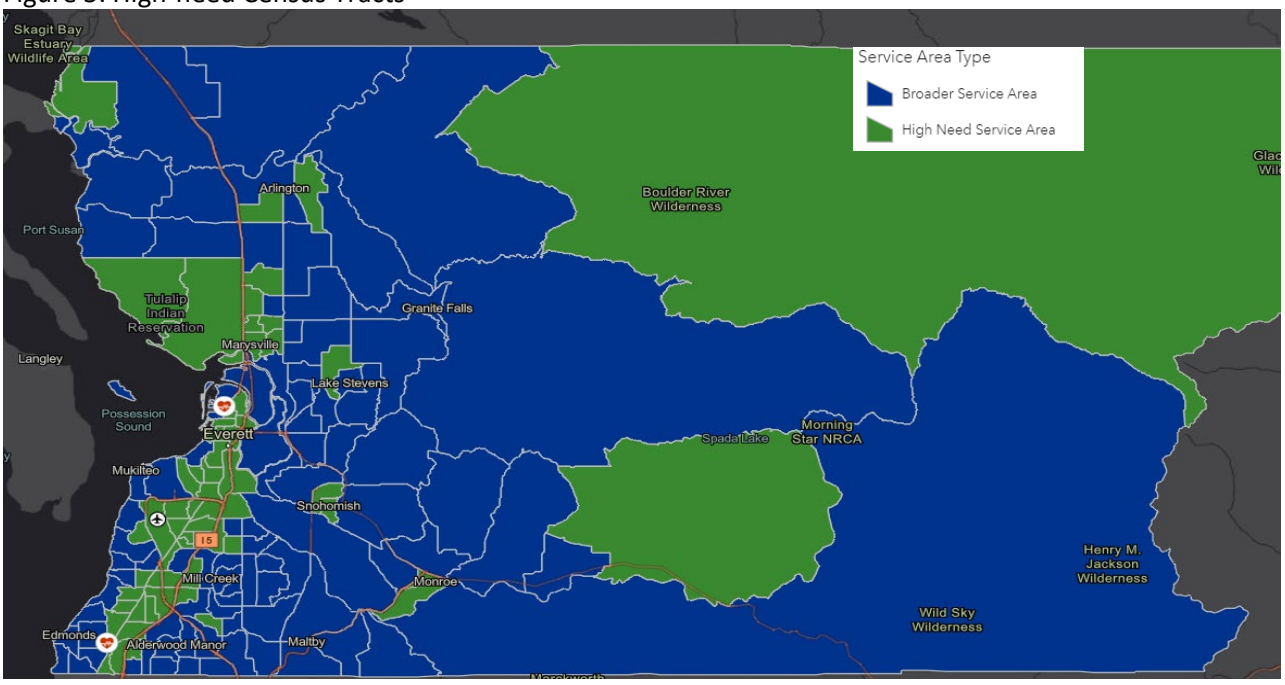
HIGH-NEED AREA – PROVIDENCE NEED INDEX

Within a hospital's service area is a high-need service area that is based on social determinants of health related to the inhabitants of that census tract. Based on a methodology developed by the Public Health Alliance of Southern California and their Healthy Planet[5] tool, Providence utilized the following variables to calculate a high-need census tract:

1. Population below 200% of the federal poverty level
2. Percent of population with at least a high school education
3. Percent of population age 5 years and over in limited-English speaking households
4. Life expectancy at birth

All variables were weighted equally, and the average value of the population was assigned to census tracts that did not have an estimated life expectancy at birth. Ultimately, a census tract was given a score between 0 and 100 where 0 represents the best-performing census tract and 100 the worst performing according to criteria. Census tracts that scored higher than the average is classified as high-need service area and are depicted in green (see Figure 5). There are 149 census tracts in the Snohomish County community, with 61 identified as high-need areas scoring above the average of 36.2. Of the 800,000 residents of Snohomish County, 40% live in the high-need area.

Figure 5. High-need Census Tracts



[5] https://www.healthyplacesindex.org/

POPULATION DEMOGRAPHICS

In 2021, the total population of Snohomish County was 798,808, with 479,796 residents in the broader service area and 319,012 in the high-need area. The total population represents a slight decline from the 2019 assessment. The largest proportion of residents are in the 30-39 age group compared to other age groups. The largest racial groups include White (75.4%), Asian (10.8%), and Black/African American (3.1%) with residents reporting two or more races at 6.3%. The Hispanic population represents 10% of the total population and 14.6% of the high-need service area.

Table 1. Population by Age

Indicator	Snohomish County	Broader Service Area	High-need Service Area
Total Population	798,808	479,796	319,012
Population Ages 0 - 9	99,912 (12.5%)	60,965 (12.7%)	38,947 (12.2%)
Population Ages 10 - 19	98,033 (12.3%)	61,493 (12.8%)	36,540 (11.5%)
Population Ages 20 - 29	104,015 (13.0%)	54,438 (11.3%)	49,577 (15.5%)
Population Ages 30 - 39	120,061 (15.0%)	69,454 (14.5%)	50,607 (15.9%)
Population Ages 40 - 49	108,599 (13.6%)	66,423 (13.8%)	42,176 (13.2%)
Population Ages 50 - 59	112,854 (14.1%)	71,905 (15.0%)	40,949 (12.8%)
Population Ages 60 - 69	88,805 (11.1%)	55,536 (11.6%)	33,269 (10.4%)
Population Ages 70 - 79	43,813 (5.5%)	27,151 (5.7%)	16,662 (5.2%)
Population Ages 80+	22,716 (2.8%)	12,431 (2.6%)	10,285 (3.2%)

Source: 2019 American Community Survey 5-year estimates.

Graph 1. Percent of Population by Age Group

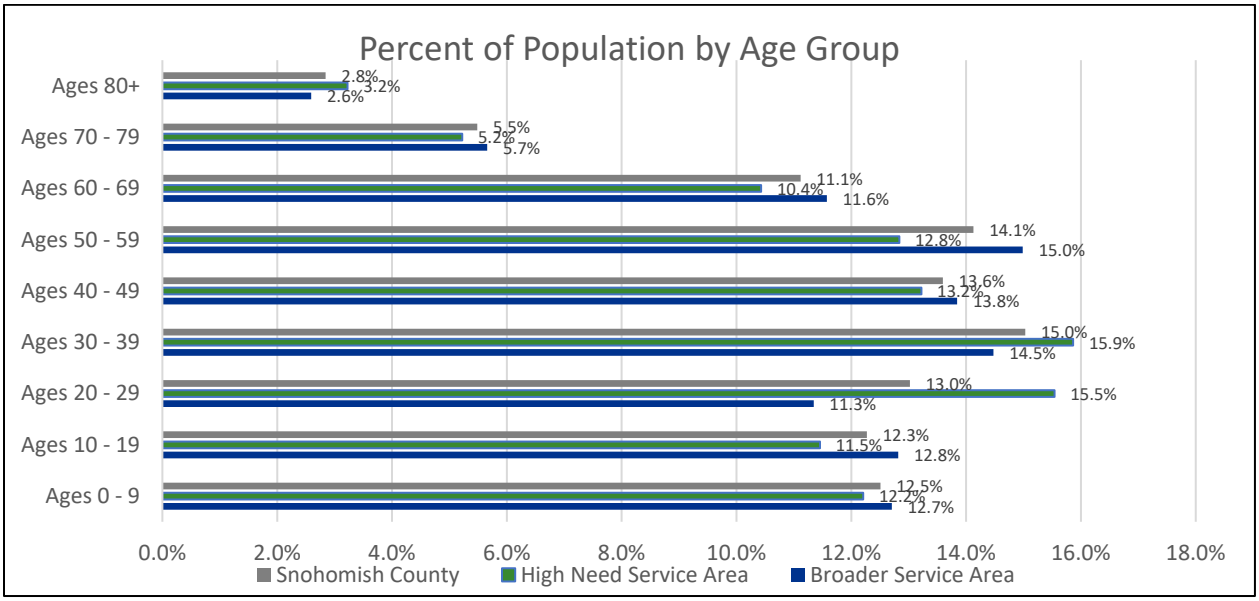


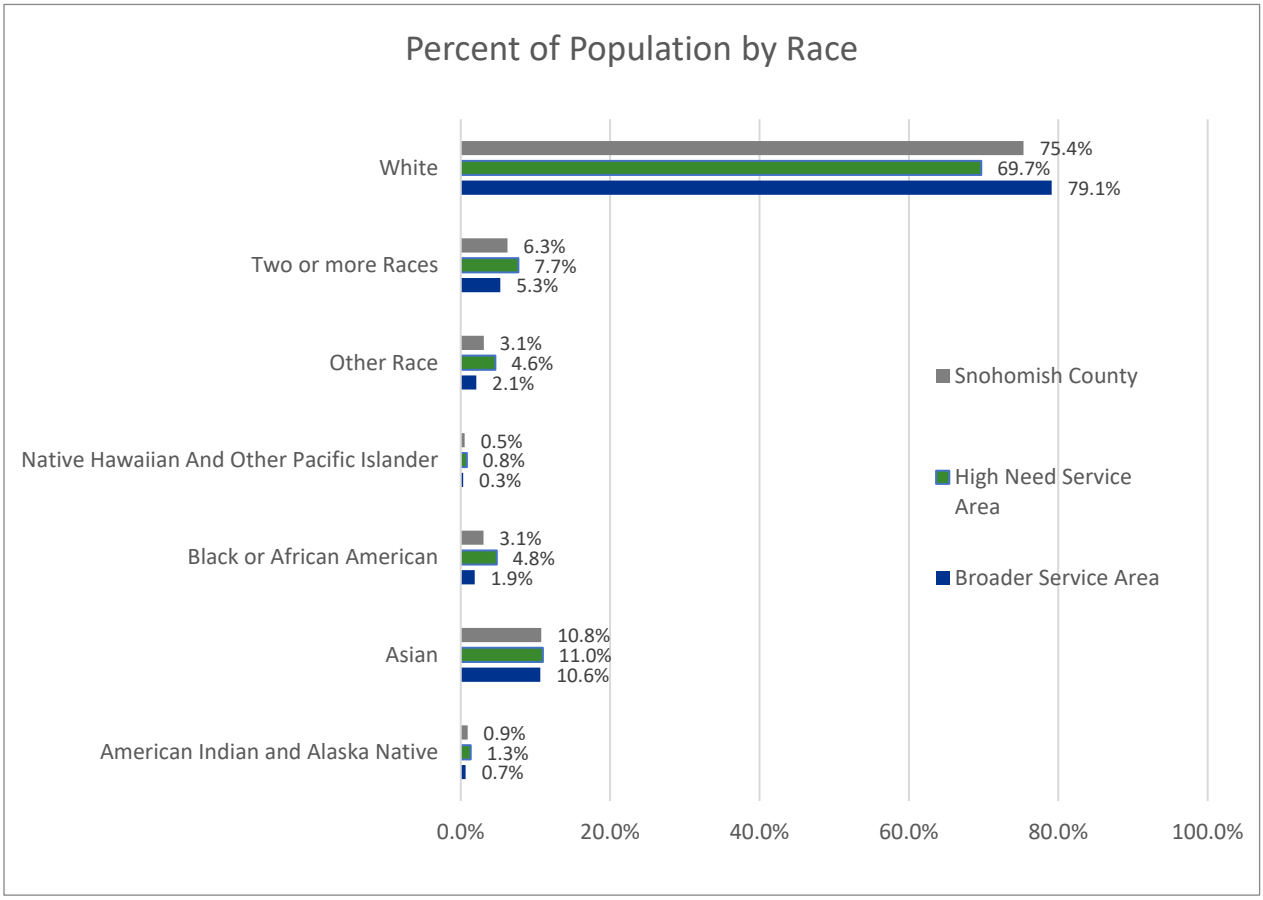
Table 2. Population By Race & Ethnicity

Indicator	Snohomish County	Broader Service Area	High-need Service Area
American Indian and Alaska Native	7,353 (0.9%)	3,128 (0.7%)	4,225 (1.3%)
Asian	86,121 (10.8%)	51,074 (10.6%)	35,047 (11.0%)
Black or African American	24,369 (3.1%)	8,990 (1.9%)	15,379 (4.8%)
Native Hawaiian and Other Pacific Islander	4,197 (0.5%)	1,599 (0.3%)	2,598 (0.8%)

Indicator	Snohomish County	Broader Service Area	High-need Service Area
Other Race	24,764 (3.1%)	9,966 (2.1%)	14,798 (4.6%)
Two or more Races	50,089 (6.3%)	25,442 (5.3%)	24,647 (7.7%)
White	601,915 (75.4%)	379,597 (79.1%)	222,318 (69.7%)
Ethnicity: Hispanic	81,495 (10.2%)	34,781 (7.2%)	46,714 (14.6%)

Source: 2019 American Community Survey 5-year estimates.

Graph 2. Percent of Population by Race



SOCIOECONOMIC INDICATORS

The average median household income for census tracts in the high-need service area is more than $38,000 lower than the median household income for the broader service area. The average median household income for census tracts in the broader service area is approximately $21,000 higher than that of Snohomish County.

Severe housing cost burden is defined as households spending 50% or more of their income on housing costs. The average severe housing cost burden by population in the high-need service area is 23.2%, which is higher than the county value (21.7%) and the broader service area (18.1%).

In Snohomish County, 18.9% of the population is considered low-income (below 200% of the Federal poverty level). In the high-need service area, that increases to 28.7% of the population.

The Supplemental Nutrition Assistance Program (SNAP) is a government food assistance program that provides nutrition benefits to supplement the food budget of families with low incomes so they can purchase healthy food and move towards self-sufficiency. In the high-need service area, 14.6% of households receive SNAP benefits. Households receiving SNAP can be used as a proxy measure to identify households that may be experiencing food insecurity.

Table 3. Socioeconomic Indicators

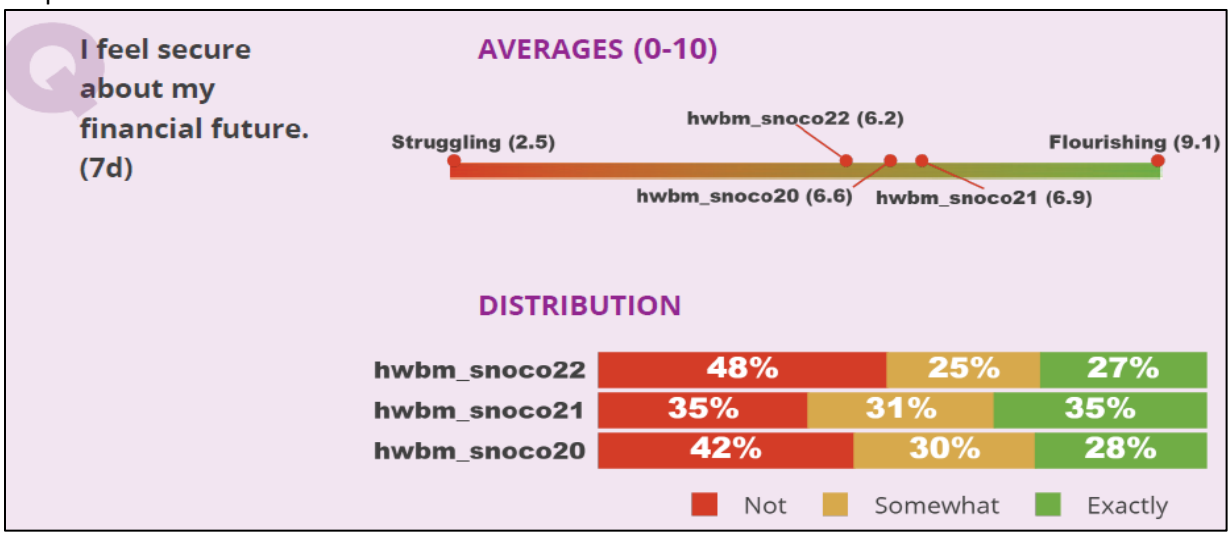
Indicator	Snohomish County	Broader Service Area	High-need Service Area	Washington State
Median Income	$85,276	$106,544	$67,999	$73.775
Renter Households with Severe Housing Cost Burden	21.7%	18.1%	23.2%	21.1%
Population below 200% of Federal Poverty Level	18.9%	12.4%	28.7%	20.6%
Households receiving SNAP benefits	9.8%	5.9%	14.6%	11.9%

Source: American Community Survey 2019, 5-year estimates

ABILITY TO MEET BASIC NEEDS

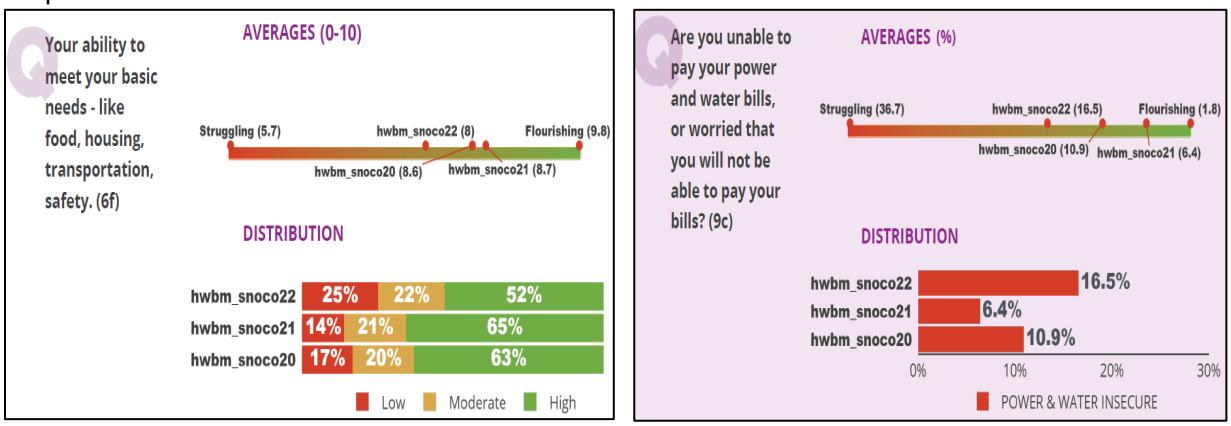
When surveyed by the Health & Well-Being Monitor™, nearly half of respondents report not feeling financially secure, up significantly from 2021 and 2020. Only half of respondents are meeting basic needs, versus two-thirds in 2021 and 2020. When asked if they are unable to pay power and water bills, or worried that they will not be able to pay bills, 16.5% said yes, up significantly from 6.4% in 2021.

Graph 3. Financial Future



Source: 2022 Health & Well-Being Monitor™

Graph 4. Basic Needs

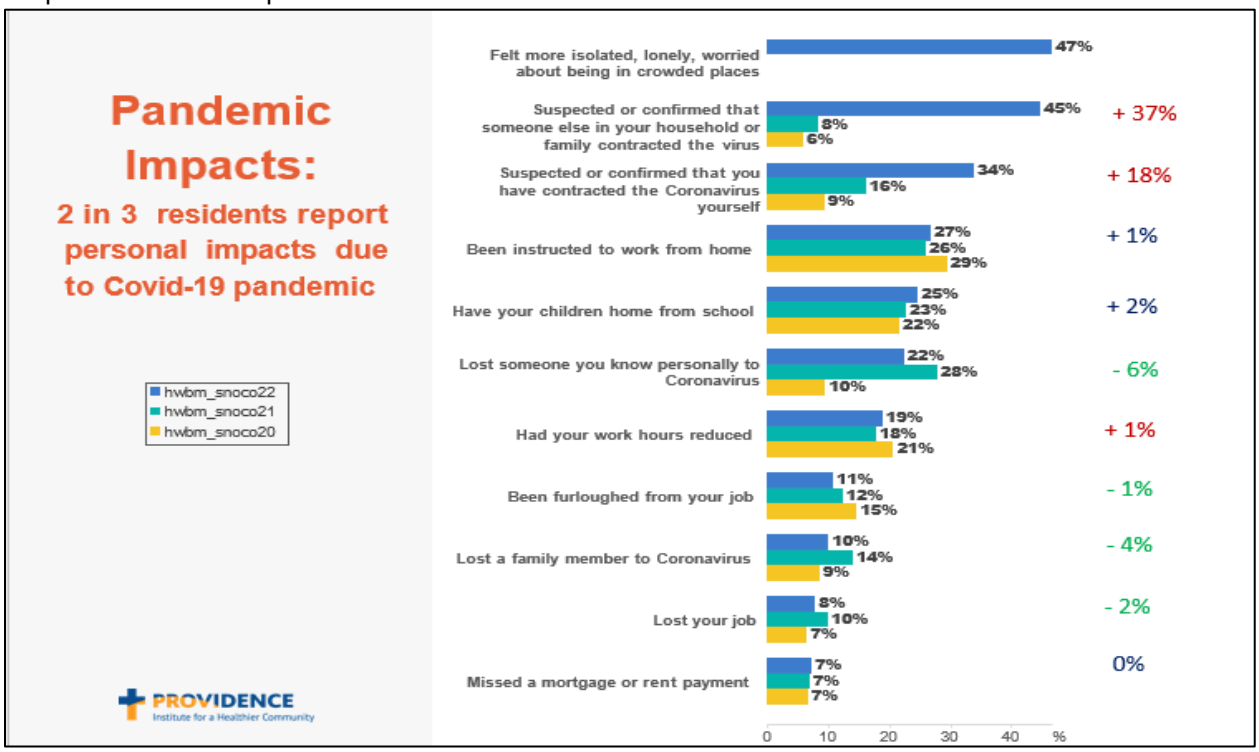


Source: 2022 Health & Well-Being Monitor™

COVID IMPACT

When surveyed by the Providence Health & Well-Being Monitor™, 2 out of 3 respondents reported personal impacts due to the COVID-19 pandemic in various ways from missed mortgage/rent payment, losing a job, being furloughed, or feeling more isolated/lonely.

Graph 5. Pandemic Impact



Source: 2022 Health & Well-Being Monitor™

HOMELESSNESS AND HOUSING INSECURITY

A person experiencing homelessness is defined as an individual without permanent housing who may live on the streets, stay in a shelter, a mission, single room occupancy facility, abandoned building or vehicle, or any other unstable or non-permanent situation. Snohomish County Human Services released the annual homeless point-in-time (PIT) count conducted in February 2022 for Snohomish County. The

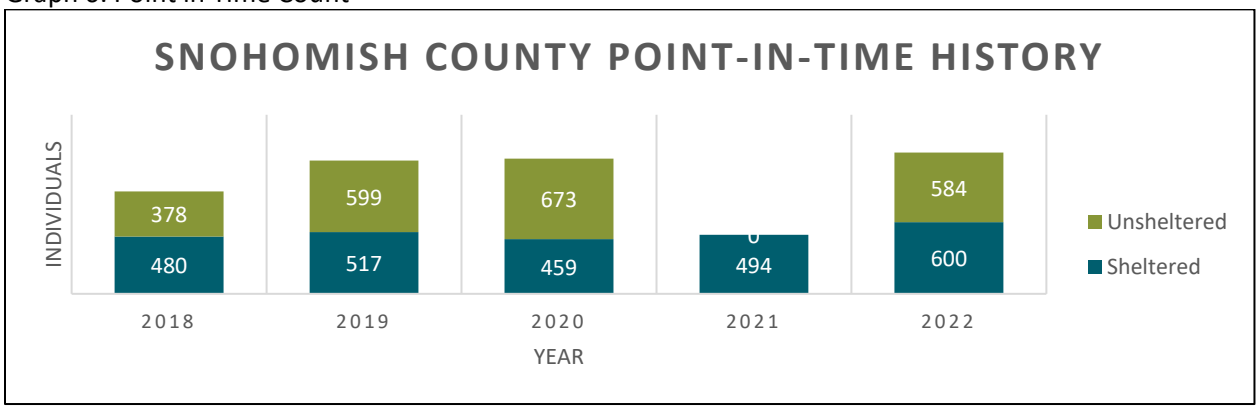
count was not conducted in 2021 due to the COVID-19 pandemic. In 2022, there were 1,184 people identified as homeless either residing in a shelter, in transitional housing, or living without shelter. This represents the highest number since 2012. The number of people reporting that they are living without stable housing, currently homeless or worried about losing their housing was up significantly at 13.6% compared to just 7.8% in 2021 and 9.7% in 2020.

Table 4. Point in Time Count

	2022	2020	Trend
Homeless	1,184	1,132	Highest since 2012 42.8% increase 2020 - 2022
Unsheltered Persons	584	673	13.2% decrease 2020 - 2022 116% increase 2015 – 2020
Sheltered Persons	600	459	30% increase due to increase in shelter capacity.
Households sheltered homeless	256	168	52.4% increase
Households with Children Experiencing Homelessness	29	37	Slight decrease
Households without Children Experiencing Homelessness	499	448	Increase

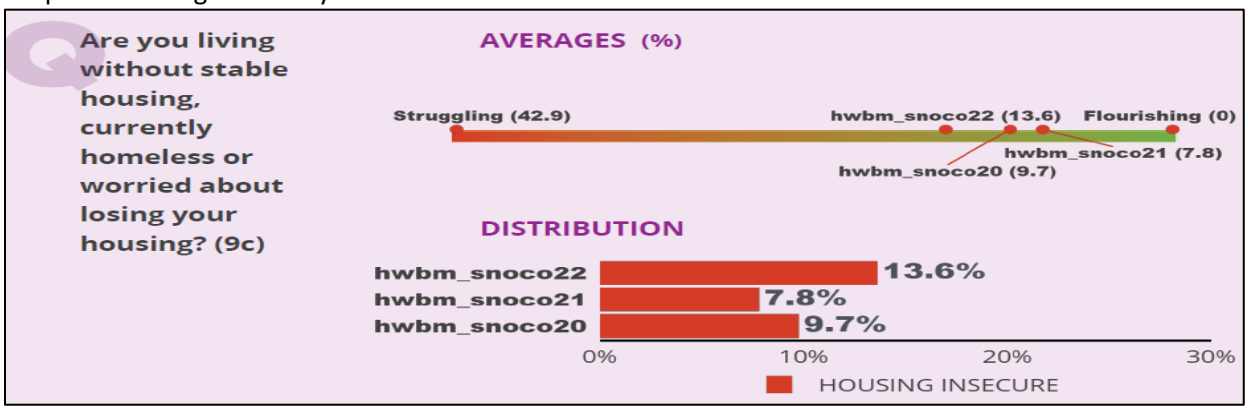
Source: Point in Time (PIT) | Snohomish County, WA - Official Website (snohomishcountywa.gov)

Graph 6. Point in Time Count



Source: Point in Time (PIT) | Snohomish County, WA - Official Website (snohomishcountywa.gov)

Graph 7. Housing Instability



Source: 2022 Health & Well-Being Monitor™

UNEMPLOYEMENT

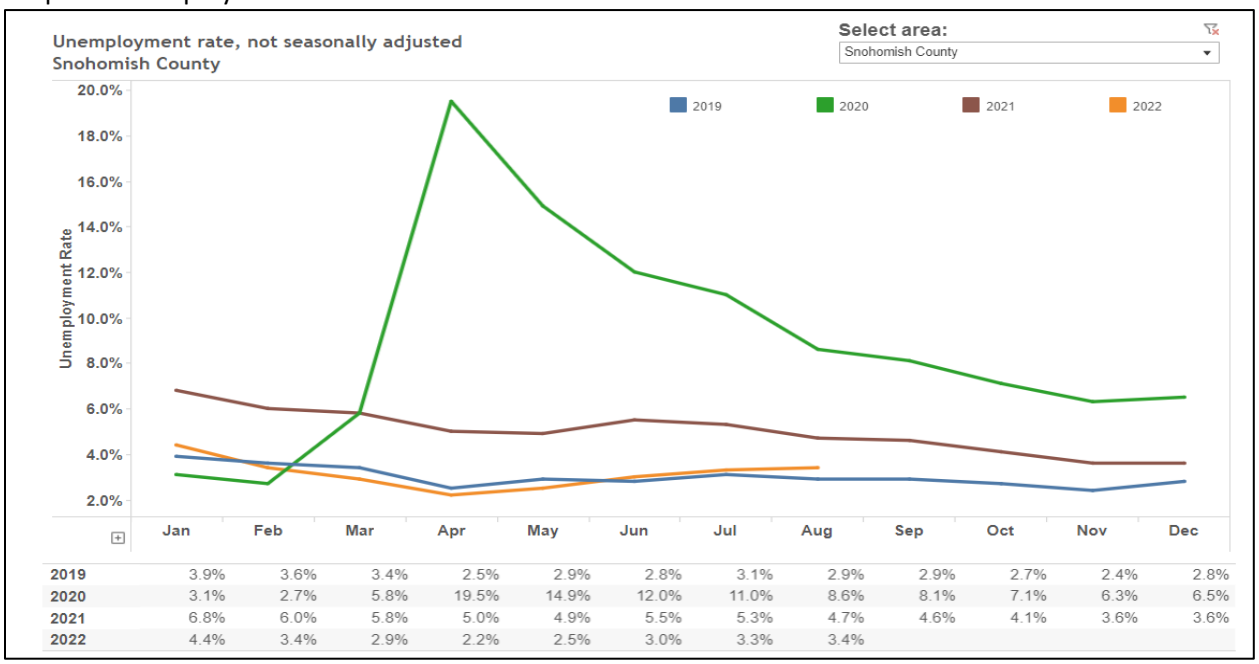
According to County Health Rankings and Roadmaps[6], the unemployed population experiences worse health and higher mortality rates than the employed population. Because employer-sponsored health insurance is the most common source of health insurance coverage, unemployment can also limit access to health care. In August 2022, the unemployment rate in Snohomish County was 3.4% (not seasonally adjusted) for those 16 years old and over. Snohomish County has a lower unemployment rate than Washington State but comparable to that of the U.S.

Table 5. Unemployment Rate

Indicator	Snohomish county	Washington State	U.S.
Unemployed rate	3.4%	4.1%	3.7%

Source: Employment Security Department, 2022

Graph 8. Unemployment Rate



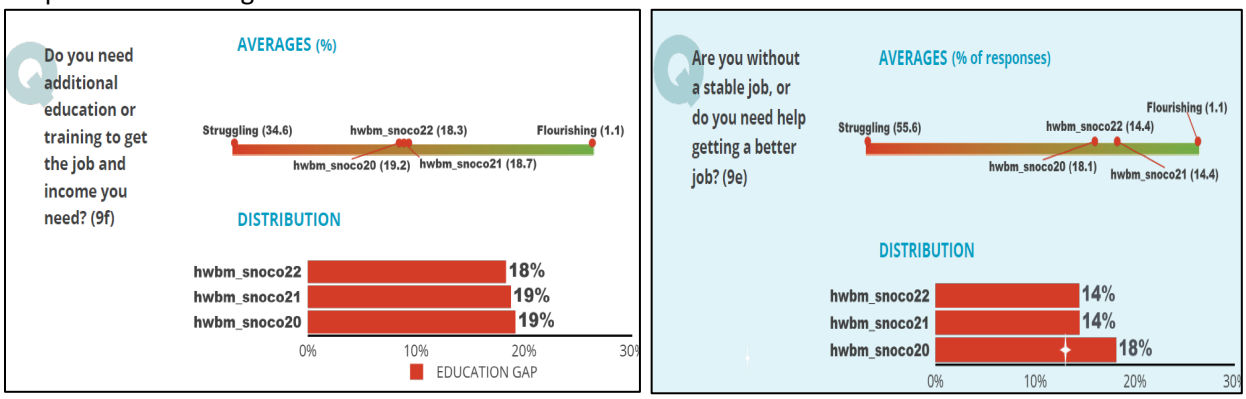
Source: ESDWAGOV - Labor area summaries

JOB TRAINING

The Health & Well-Being Monitor™ survey asked respondents if they need additional education or training to get the job and the income they need. 18% said yes, down slightly from the 2020 and 2021 survey. When asked a similar question, 14% responded yes to the question "are you without a stable job, or do you need help getting a better job." This is the same as 2021 but down 4 percentage points from 2020.

[6] www.countyhealthrakings.org

Graph 9. Job Training & Assistance



Source: 2022 Health & Well-Being Monitor™

HEALTH PROFESSIONAL SHORTAGE AREA

The Federal Health Resources and Services Administration designates Health Professional Shortage Areas as areas with a shortage of primary medical care, dental care, or mental health providers. They are designated into three types:

- Geographic HPSA: a shortage of providers for an entire group of people within a defined geographic area
- Population HPSA: a shortage of providers for a specific group of people within a defined geographic area
- Facility HPSA: These include correctional facilities, state/county mental hospitals, Federally Qualified Health Centers, Indian Health Facilities, Tribal Hospitals, and others

Snohomish County has several geographic areas, population segments, and facilities that are designated as shortage areas. This information can be used to understand access issues, state and local health care planning, placement of providers, and allocation of limited health care resources

Table 6. Health Professional Shortage Areas

Indicator	Primary Care	Dental Care	Mental Health
Geographic Shortage Area	Darrington Monroe/Sultan Tulalip	Darrington Monroe/Sultan	Monroe/Sultan Northwest Snohomish
Population Shortage Area	Lynnwood Low Income Marysville Low Income Everett Low Income	None	None
Facility Shortage Area	Monroe CC Community Health CSC Sea-Mar CHC Stillaguamish HC Tulalip HC	Monroe CC Community Health CC Sea-Mar CHC Stillaguamish HC Tulalip HC	Monroe CC Community Health CC Sea-Mar CHC Stillaguamish HC Tulalip HC

Source: HPSA Find (hrsa.gov)

OVERVIEW OF CHNA FRAMEWORK AND PROCESS

The CHNA process is based on the understanding that health and wellness are influenced by factors not only within medical facilities, but within our communities. In gathering information on the communities served by the hospital, we looked at the health conditions of the population, as well as the socioeconomic factors, the physical environment, and health behaviors. Additionally, we invited key stakeholders and community members to provide additional context through interviews and listening sessions. As often as possible, equity was at the forefront of these conversations and when evaluating the data, which often have biases based on collection methodology.

In addition, we recognize that there are often geographic areas where the conditions for supporting health are substantially poorer than nearby areas. Whenever possible and reliable, data are reported at the zip code or census tract level. These smaller geographic areas allow us to better understand the neighborhood-level needs of our communities and better address inequities within and across communities.

Data Collection

The primary data utilized in the CHNA was the qualitative data collected from stakeholder interviews, community listening sessions and community surveys. Listening to and engaging the people who live and work in the community is a crucial component of the CHNA as these individuals have firsthand knowledge of the needs and strengths of the community. See Appendix 2 for additional detail on the qualitative data and Appendix 5 for the community survey results.

The secondary data utilized in the CHNA was data collected from a variety of public sources, including the American Community Survey, Washington State Department of Health reports, and the Behavioral Risk Factor Surveillance Survey. In addition, we include hospital utilization data to identify disparities in utilization by income and insurance, geography, and race/ethnicity when reliably collected. Providence developed a dashboard that maps many of the public health surveillance indicators at the census tract level. The dashboard with interactive maps that visually depict demographics, social risk, and other indicators can be found here: NWWA - Data Hub 2022 (arcgis.com). See Appendix 1 for additional detail on the quantitative data collected.

Data Limitations and Information Gaps

While care was taken to select and gather data that would tell the story of the hospital's service area, it is important to recognize the limitations and gaps in information that naturally occur, including the following:

- Not all desired data were readily available, so sometimes we had to rely on tangential or proxy measures or not have any data at all.
- While most indicators are relatively consistent from year to year, other indicators are changing quickly (such as percentage of people uninsured) and the most recent data available are not a good reflection of the current state.

- Reporting data at the county level can mask inequities within communities. This can also be true when reporting data by race, which can mask what is happening within racial and ethnic subgroups. Therefore, when appropriate and available, we disaggregated the data by geography and race.
- Data that are gathered through interviews and surveys may be biased depending on who is responding to the questions and whether they are representative of the population.
- The accuracy of data gathered through interviews and surveys depends on how consistently the questions are interpreted across all respondents and how honest people are in providing their answers.

Gathering Comments on Previous CHNA and Summary of Comments

Written comments were solicited on the 2019 CHNA and 2020-2022 CHIP reports made available to the public via posting on the internet in December 2019 (CHNA) and May 2020 (CHIP), as well as through various channels with our community-based organization partners. No comments were received for either the CHNA or the CHIP reports.

HEALTH INDICATORS

Health Behaviors

ANNUAL CHECKUP

Accessing preventive health care services, such as getting routine physical checkups, receiving recommended vaccinations, and having blood pressure and cholesterol checks can reduce morbidity and mortality from chronic diseases. In Snohomish County, 68% of adults report having been to the doctor for a checkup in the previous year compared to 66.7% in the high-need area.

Table 7. Annual Checkup

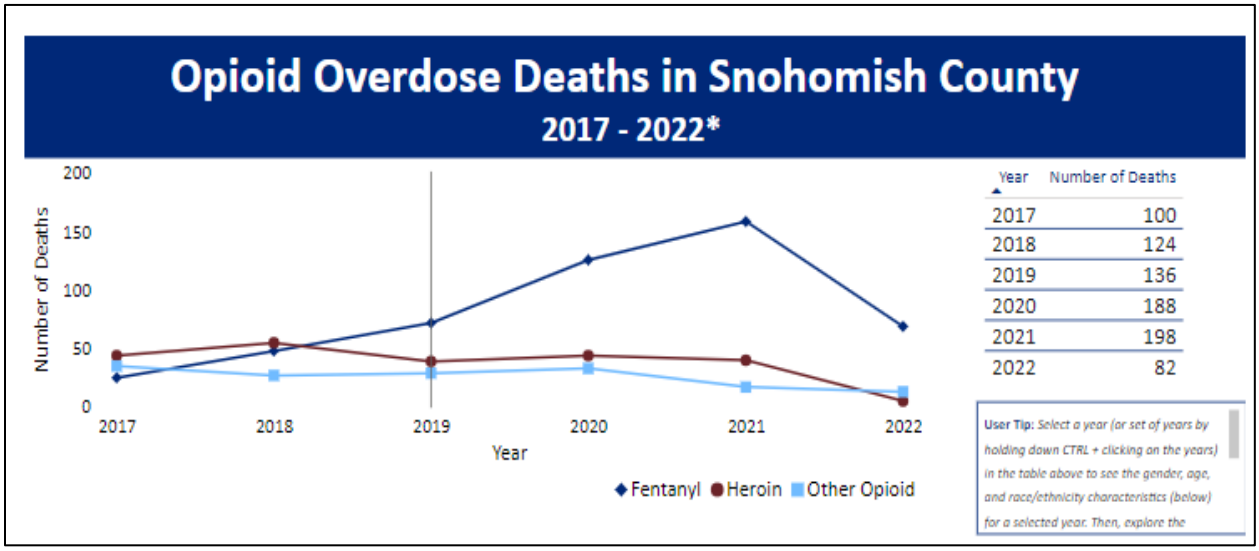
Indicator	Snohomish County	Broader Service Area	High-need Service Area
Annual Checkup Crude Prevalence	68.3%	68.2%	66.7%

Source: American Community Survey 2019, 5-year estimates

OPIOID USE

Opioid use disorders can be linked to health problems, emergency department visits, and even death. In recent years, opioid overdose deaths in Snohomish County have been increasing from 100 deaths in 2017 to 198 in 2021. Rates of use for heroin and other opioid deaths have been dropping, but fentanyl deaths have been increasing since 2019.

Graph 10. Snohomish County Opioid Overdose Deaths



Data source: Data - Snohomish Overdose Prevention, *2022 is not full year data

ALCOHOL CONSUMPTION

Binge drinking is defined as consuming a certain amount of alcohol within a set period. For males this is five or more drinks per occasion and for females it is four or more drinks per occasion in the last 30 days. The rate of binge drinking for adults over the age of 18 in Snohomish County was 15.2%. According to the Center for Disease Control, binge drinking is a risk factor for many health and social problems,

including motor-vehicle accidents, violence, suicide, hypertension, acute myocardial infarction, sexually transmitted diseases, unintended pregnancy, fetal alcohol spectrum disorders, and sudden infant death syndrome.

Table 8. Alcohol Use

Indicator	Snohomish County	Broader Service Area	High-need Service Area	Washington State
Binge Drinking Crude Prevalence	15.2%	16.3%	15.7%	14.1%

Data Source: Behavioral Risk Factor Surveillance System, 2019

Access to Health Care

UNINSURED

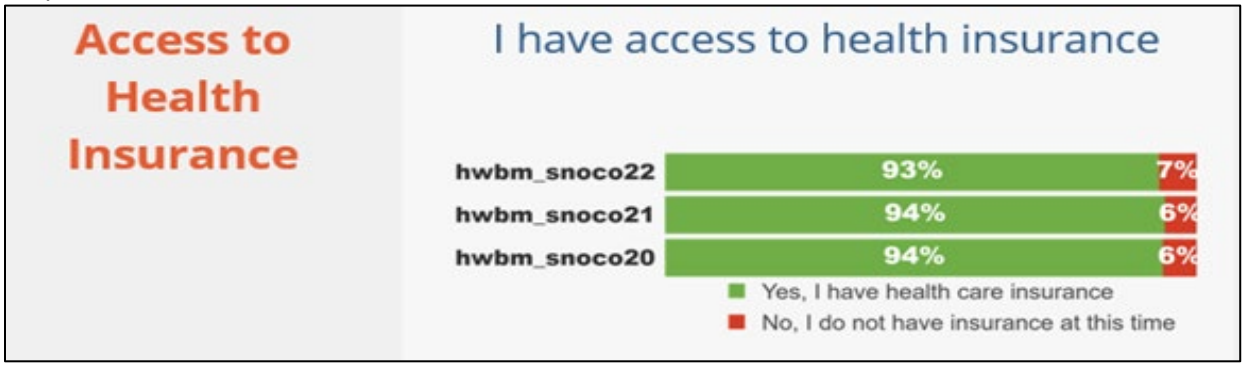
According to Healthy People 2020, inadequate health insurance is one of the largest barriers to health. In the high-need service area 8.4% of residents are uninsured compared to 6.1% in Snohomish County. This has been dropping over the last several years. When self-reported through the Health & Well-Being Monitor™, 93% indicated they have access to health insurance, down from 94% in the prior two years.

Table 9. Uninsured

Indicator	Snohomish County	Broader Service Area	High-need Service Area	Washington State
Population Uninsured	6.1%	4.2%	8.4%	6.3%

Source: American Community Survey 2019, 5-year estimates

Graph 11. Access to Health Insurance

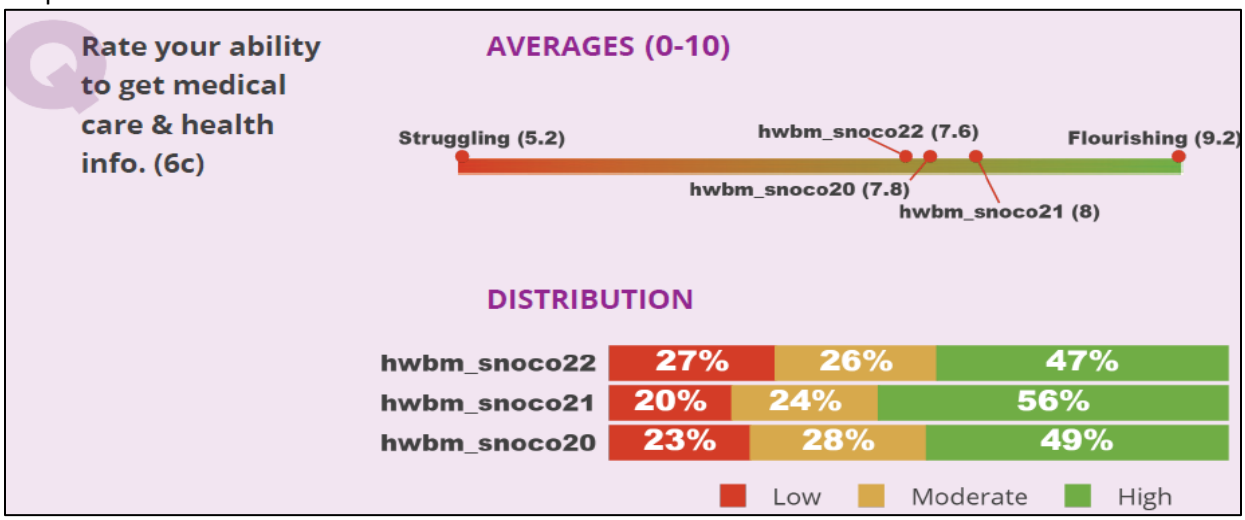


Source: 2022 Health & Well-Being Monitor™

ABILITY TO GET MEDICAL CARE

Despite the number of people that have health coverage, 47% of respondents rated their ability to get health care and information ”high”, a decline of 9% after increasing in 2021. This is important as access to health information does not always equal the ability to get care.

Graph 12. Access to Healthcare and Information



Source: 2022 Health & Well-Being Monitor™

PHYSICIAN RATIO

Snohomish County has fewer primary care, mental health, and dental providers compared to that of Washington State and top U.S. performers. There is one primary care provider (defined general family medicine, general practice, general internal medicine, and general pediatrics) for 1,930 people in Snohomish County compared to one for every 1,180 in the state. Similarly, the ratio of population to mental health providers at 280:1 is greater than that of the state and top U.S. performers. The dentist ratio of 1,340:1 compares to 1,200:1 for the state.

Table 10. Physician Ratio

Indicator	Snohomish County	Washington State	Top U.S. Performers
Ratio of population to primary care physician	1930:1	1180:1	1010:1
Ratio of population to mental health provider	280:1	230:1	250:1
Ratio of population to dentist	1340:1	1200:1	1210:1

Source: County Health Rankings and Roadmaps

Mortality/Death Rates

The top three leading causes of death in Snohomish County are malignant neoplasms (cancer), heart disease and accidents. In 2020, COVID-19 was fourth in the county at an age-adjusted rate of 39.8 per 100,000.

Table 11. Leading Causes of Death

Cause	Number of Deaths	Age Adjusted Rate per 100,000
Malignant neoplasms	1,269	128.4
Diseases of the Heart	1,069	113.8
Accidents	501	56.9
COVID-19	364	39.8

Cause	Number of Deaths	Age Adjusted Rate per 100,000
Alzheimer's Disease	303	34.6
Chronic Lower Respiratory Diseases	265	27.7
Cerebrovascular Diseases	286	31.8
Diabetes Mellitus	242	24.4
Intentional Self Harm	119	14.1
Chronic Liver Disease	131	13.0
Influenza and pneumonia	63	6.6

Data Source: WA State Department of Health, 2020 Death Data | Washington State Department of Health

Mental Health

Individuals over the age of 18 who report 14 or more days during the past 30 days during which their mental health was not good is much higher in the high-need service area, at 15%, compared to 12.9% in Snohomish County. The prevalence of depression in Snohomish County is like that of the state, but higher in the high-need service area at 26.6%.

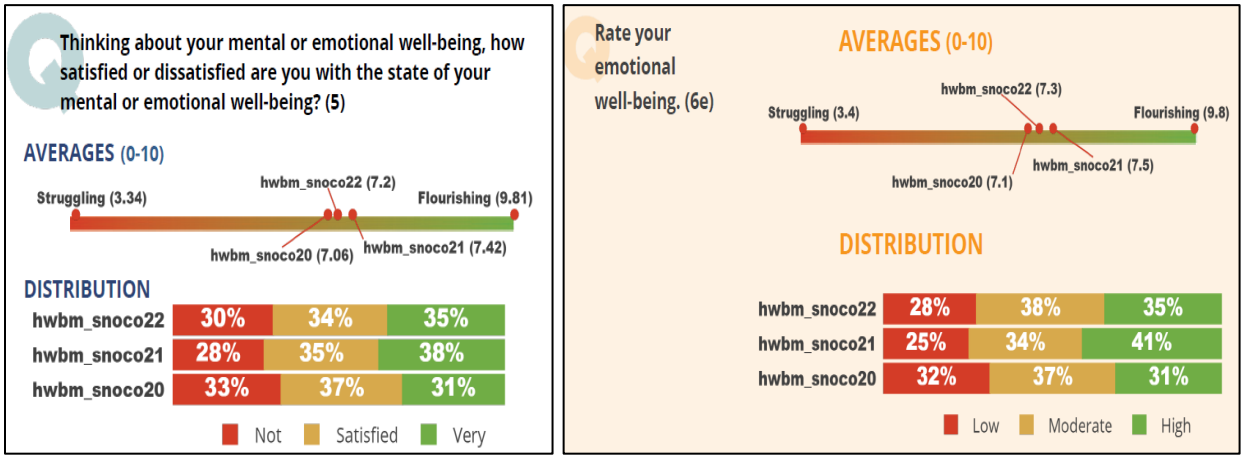
When surveyed through the Health & Well-Being Monitor™, 30% of respondents said that they were not very satisfied with the state of their mental or emotional well-being. This is up slightly from the 2021 survey but still below 2020. When asked to rate their emotional well-being, 28% of respondents rated it low. Emotional well-being remains better than in 2020 but is also down from 2021.

Table 12. Mental Health Distress

Indicator	Snohomish County	Broader Service Area	High-need Service Area	Washington State
Frequent Mental Health Distress	12.9%	12.8%	15.0%	13.6%
Depression Crude Prevalence	24.4%	25.6%	26.6%	24.2%

Data Source: Behavioral Risk Factor Surveillance System, 2019

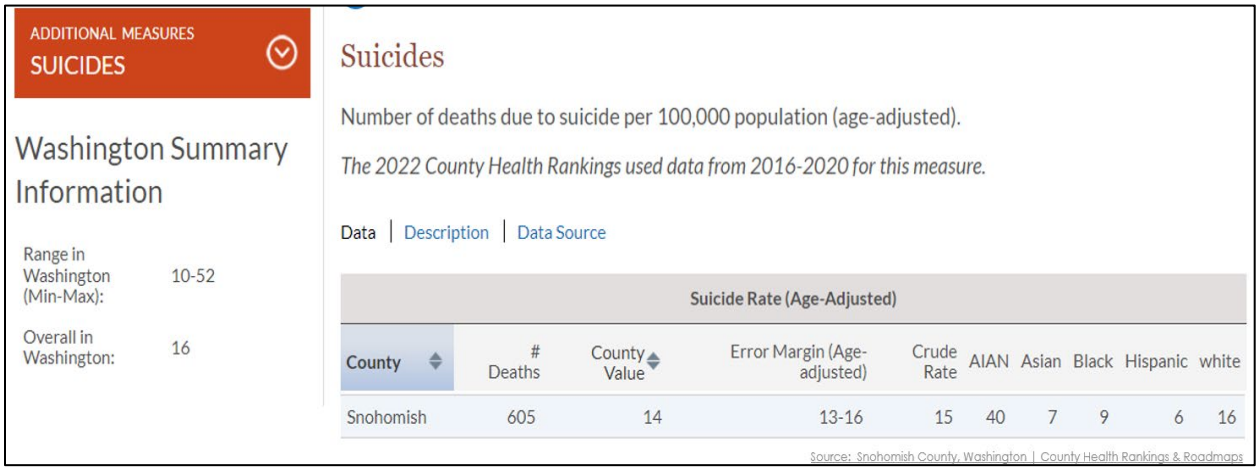
Graph 13. Mental and Emotional Well-Being



Source: 2022 Health & Well-Being Monitor™

The number of deaths due to suicide per 100,000 population in Snohomish County was 14, lower than Washington State at 16.

Figure 6. Suicide Rate

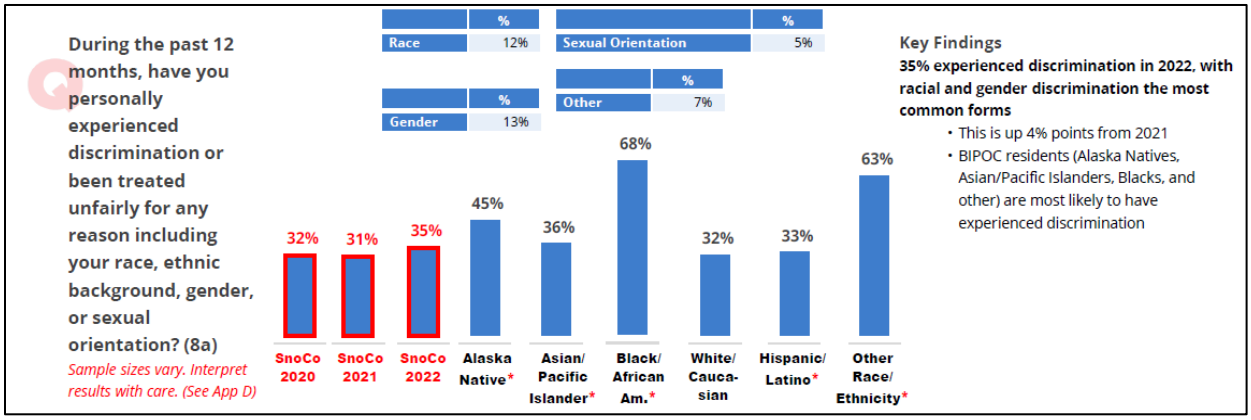


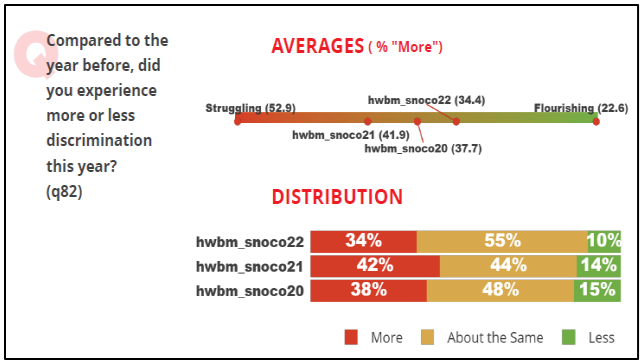
Source: County Health Rankings.org

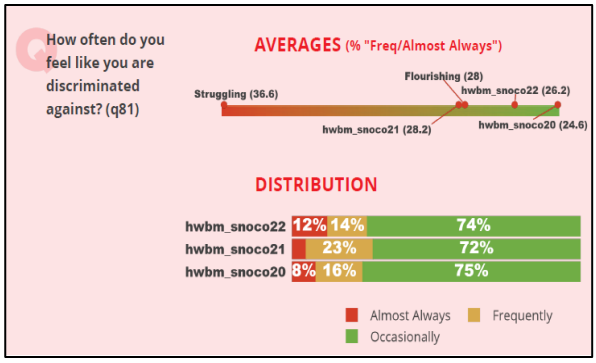
HEALTH EQUITY, RACISM, AND DISCRIMINATION

Healthy relationships are vital to health. Strong family ties, friendships and partnerships can increase our sense of security, self-esteem, and belonging and provide a buffer against stress, anxiety, and depression. The number of people experiencing discrimination is 35%, an increase compared to both 2020 and 2021. Racial and gender discrimination are the most common forms. BIPOC residents are most likely to have experienced discrimination. However, the amount of discrimination experienced is down compared to benchmarks, although it's still widespread.

Graph 14. Discrimination Occurrence







Source: 2022 Health & Well-Being Monitor™

Hospital Utilization Data

In addition to public health surveillance data, the hospital can provide timely information regarding access to care and disease burden across our service area. We were particularly interested in studying potentially avoidable emergency department (AED) visits. AED use is reported as a percentage of all emergency department visits over a given period, which are identified based on an algorithm developed by the Providence's Population Health Care Management team based on New York University and Medi-Cal definitions. AED discharges typically contain primary diagnoses that are deemed non-emergent, primary care treatable or preventable/avoidable with better managed care. AED use serves as a proxy for inadequate access to, or engagement in, primary care. When possible, we look at the data for total utilization, frequency of diagnosis, and demographics to identify disparities.

AVOIDABLE OUTPATIENT EMERGENCY DEPARTMENT (ED) CASES

AED cases have been declining over the last three years. The most common reasons for preventable emergency department visits include diagnosis related substance use disorders, skin infections, urinary tract infections, and behavioral health. The majority of AED cases are from the 18-64 age groups with American Indian/Alaska Native and Black/African American races as the highest group by race.

Table 13. Outpatient Avoidable Emergency Department (AED) Cases

PRMCE	2019	2020	2021
Avoidable ED %	30.3%	29.5%	25.8%

Data Source: Providence Regional Medical Center Everett

Table 14. Outpatient Avoidable Department (AED) Cases by Diagnosis – Top 5

Diagnosis Care Families	% Of Total AED Cases
Substance Use Disorders	10.8%
Skin Infection	8.4%
Urinary Tract Infection	7.2%
Psychosis	5.1%
Nonspecific Back and Neck Pain	5.0%

Data Source: Providence Regional Medical Center Everett, 2021

Behavioral Health Emergency Department Cases

The number of outpatient behavioral health cases in the emergency department over the last three years has remained relatively stable at an average of 5,000 cases. The most common diagnosis is related to substance use disorder, mood disorder, and psychosis.

Table 15. Outpatient Behavioral Health ED Cases

Behavioral Health ED Cases by Year	2019	2020	2021
% Behavioral Health	8.5%	10.1%	9.1%

Data Source: Providence Regional Medical Center Everett

Table 16. Behavioral Health ED Cases by Diagnosis Group – Top 5

Behavioral Health ED Cases by Diagnosis Groupings	% Of Total Behavioral Health ED Cases
Substance Use Disorders	34.1%
Mood Disorders, Episodic	24.5%
Psychosis	16.2%
Anxiety and Personality Disorders	13.2%
Poisonings, Commonly Abused Drugs	7.2%

Data Source: Providence Regional Medical Center Everett, 2021

AED data have been disaggregated and reviewed by patient race, ethnicity, age group, ZIP Code, and diagnosis. Additionally, behavioral health ED cases have been disaggregated by diagnosis grouping. Please email CHI@Providence.org to request additional utilization data and information.

See Appendix 1 for additional detail on the quantitative data collected.

COMMUNITY INPUT

Summary of Community Input

Listening to and engaging with the people who live and work in the community is a crucial component of the CHNA. To better understand the unique perspectives, opinions, experiences, and knowledge of community members, Providence conducted listening session, stakeholder interviews, a community survey, and a community health summit. Providence aimed to engage stakeholders from social service agencies, medically underserved, education, faith communities, government groups, and those representing the Black, Brown, Indigenous, and other people of color (BBIPOC), among others, to ensure a wide range of perspectives.

Stakeholder Interviews and Listening Sessions

On behalf of PRMCE, the Providence Institute for a Healthier Community (PIHC) and the PIHC Strategic Oversight Committee conducted 14 stakeholder interviews with representatives from the community and six listening sessions with 58 community members between March and April 2022. During these interviews and listening sessions, community members, nonprofit, and government stakeholders discussed the issues and opportunities of the people, neighborhoods, and cities in the service area. Below is a high-level summary of the findings of these sessions. Full details on the protocols, findings, and attendees are available in Appendix 2.

VISION FOR A HEALTHIER COMMUNITY

Listening session participants were asked to describe their vision of a healthy community. This question is important for understanding what matters to community members and how they define health and wellness for themselves, their families, and their communities. The following is a list of the themes that emerged as necessary for a healthy community:

- Community engagement and connection
- Recreation and green spaces
- Basic needs are met, including housing, food, and employment
- Safe community
- Access to health care services and physical health

COMMUNITY STRENGTHS

While a CHNA is primarily used to identify gaps in services and challenges in the community, we want to ensure that we highlight and leverage the community strengths that already exist, including the following strengths identified by stakeholders:

- Resilient and engaged community members that take care of one another and work hard to better their families' situations
- Organizations with trusted community relationships that prioritize collaborating to meet community needs

COMMUNITY NEEDS

Stakeholders and listening session participants were asked to identify the top health-related needs in the community. Listening session participants primarily spoke to the following needs: behavioral health, homelessness/housing insecurity, economic insecurity, access to health care, racism and discrimination, affordable childcare and preschools, and community involvement and belonging. The following four needs were frequently prioritized and discussed by stakeholders and listening session participants.

Behavioral Health	Stakeholders and listening session participants emphasized behavioral health is a critical component of people's overall health and was identified by almost every participant as a priority need. They spoke to a need for improved access to mental health services in the community, including more providers, particularly those that accept Medicaid and sliding fee rates. Staffing shortages have contributed to challenges accessing appointments for patients. Cost of care and transportation were also noted as barriers for people getting care. Stakeholders were particularly concerned about young people, noting rising cases of suicide, depression, anxiety, and substance use. They shared seeing more behavioral issues during the COVID-19 pandemic and a need for more mental health services in schools. Older adults may also be experiencing increased mental health needs because of social isolation. Stakeholders spoke to Black, Brown, Indigenous, and People of Color (BBIPOC) experiencing racism and its negative impacts on mental health. They discussed the healing components of being in community and the need for more BBIPOC mental health professionals. They emphasized that addressing mental health needs is not just about access, but also about ensuring the care is culturally sensitive and intentionally designed to meet the unique needs of communities. Listening session participants echoed these themes, noting a need for more safe places for people to feel heard and share their experiences, like support groups.
Homelessness and housing instability	Listening session participants and stakeholders spoke to housing as a foundational need, noting people must first be safe and stably housed before addressing other needs. They shared that the high cost of housing forces families to move farther from their jobs or to live in over-crowded conditions. Stakeholders were concerned that people with low incomes have few good-quality housing options, noting there are not a lot of rentals available. Community members noted it can be challenging and time consuming to get rental support, and there are few supports for mixed status families (those with a combination of immigration statuses). Stakeholders were also concerned that the number of people experiencing homelessness in Snohomish County is increasing. They spoke to a need for more support for families experiencing homelessness as they can often feel unseen. There is also a need for increased hygiene services, including bathrooms and showers. The eviction moratorium's ending has led to families being evicted and there is little legal help available due to the high demand.
Economic insecurity, education, and job skills	Stakeholders shared the importance of ensuring families are financially stable and have living wage job opportunities to meet their other needs. Particularly in households with only one working adult, people may need to make spending tradeoffs. Due to the "benefits cliff" people may make too much money to qualify for assistance programs, but not enough to pay for their basic needs. Economic insecurity disproportionately affects BBIPOC communities. Stakeholders and listening session participants noted the importance of programs to support communities in closing the income gap and improving financial literacy. They also noted the importance of potential employers valuing lived experience when hiring. Stakeholders and listening session participants emphasized investing in career preparation and mentorship for young people to move into vocational training programs and for adults to gain new skills. This may be especially important for refugees, immigrants, and people involved in the criminal legal system. They also discussed the importance of supporting educational opportunities, providing families support to help them navigate their child's school system and for adults seeking higher education.

Access to Health Care Services	Stakeholders and listening session participants noted navigating the health care system can be challenging and intimidating, particularly if there are language or technology barriers. Transportation is a barrier for many people, including the cost of public transportation. Stakeholders spoke to a need for more bilingual and bicultural providers for patients who speak Spanish and other languages. Listening session participants and stakeholders shared a need to ensure all adults have access to health insurance, noting people may not be able to afford it or qualify because of immigration status. Racism was frequently discussed as a barrier for BBIPOC communities, noting providers make assumptions about patients and may dismiss their concerns, leading to unfavorable outcomes. They shared building trust with providers is important, frequent provider changes make it challenging for patients to feel comfortable and heard. When patients feel uncomfortable or unsafe with providers, they may not share their concerns or seek preventive care, waiting until it becomes an emergency. Listening session participants shared a need for more BBIPOC providers. The COVID-19 pandemic highlighted the lack of trust some BBIPOC communities have in health care systems and the challenges they face in accessing care.

The following needs were also discussed by stakeholders and listening session participants as medium-priority health-related needs, based on community input:

Racism and Discrimination	Stakeholders spoke to the harmful effects of racism on BBIPOC communities, noting how racism contributes to poor physical and mental health, food insecurity, housing instability, and more. They shared that when addressing any need, the effects of racism and social inequities need to be addressed. They shared concern for BBIPOC young people not being made to feel welcome in school and being bullied. In health care, stakeholders spoke to BBIPOC concerns being frequently dismissed, for example, Black people's pain concerns being minimized by health care providers. They spoke to BBIPOC people experiencing daily racism and harm in their workplaces and schools, contributing to chronic stress. Stakeholders and listening session participants shared there is a need for improved representation in local efforts, noting that they want to see more BBIPOC leaders from within the community directing efforts to address community needs.
Affordable Childcare and Preschool	Stakeholders shared there is a deep need in the community for more affordable childcare, which will allow families to meet many of their other needs. They noted that this need has become even more apparent during the pandemic and causes a lot of stress on families. Listening session participants noted it can be hard to work because they cannot afford childcare, contributing to economic insecurity and other challenges. For some people, childcare costs more than what they are paid at their job. Childcare hours may not meet families' needs if they work outside of traditional hours. The current childcare model may not work for some cultures who prefer to leave their child with a trusted family member or friend. Staffing challenges in childcare may also result from staff being underpaid. There is a need for more capacity in programs like Head Start and the Early Childhood Education and Assistance Program (ECEAP), which make a huge difference in a child's education. As a result of the pandemic, educators are reporting less kindergarten readiness.
Community involvement and belonging	Listening session participants spoke to wanting more community-building opportunities, like barbeques or other gatherings to help connect people. They thought this is particularly important for BBIPOC communities, as well as immigrants and refugees, who may not always be made to feel welcome. They spoke to the healing power of being in community. They were particularly concerned about older adults who may be isolated and suggested more gathering places and culturally relevant programming.

	They recommended giving people opportunities to be involved by sharing their skill set or passion through volunteer opportunities. Other suggestions include more recreational opportunities for young people and their families to keep them engaged in the community and active. Stakeholders shared similar themes around creating more opportunities for people to be in community and feel seen, heard, and acknowledged.

Community Health Summit

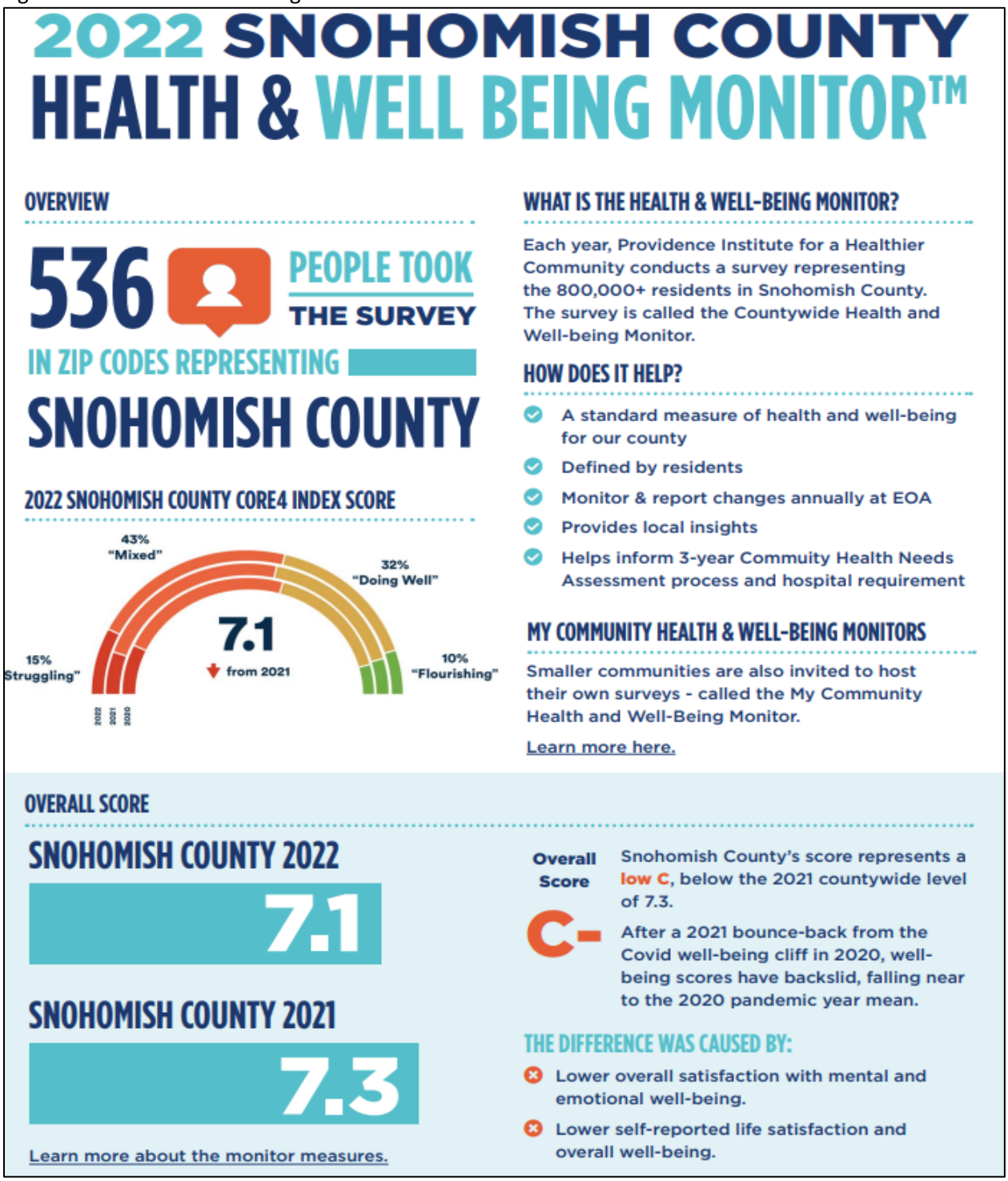
Now in its eighth year, the PIHC Edge of Amazing is an annual community health forum that brings together over 300 members of the community representing individuals, private and public organizations, educational institutions, government, youth, seniors, and others to identify and develop ways to improve community health and well-being across Snohomish County. At each summit, participants review and give feedback on the current state of health in Snohomish County, set a vision and priorities, and share best practices. A committee made up of community members reviews feedback from the previous Edge of Amazing summit and incorporates other emerging themes to identify conference topics that are shown to be important to the community. Due to COVID-19 restrictions, the 2022 forum was held virtually on Oct. 5. In addition to reviewing the current Health and Well-Being Monitor™ survey results, community members participated in discussions focused on equity, racism and diversity, financial empowerment, and youth mental health.

Community Survey

In addition to the listening sessions and stakeholder interviews, due to the limited data available through local, state, and national sources, the Providence Institute for a Healthier Community conducts an annual survey to obtain additional feedback directly from Snohomish County residents on the community strengths and indicators of health and well-being. The 2022 Health and Well-being Monitor™ survey was conducted in May 2022. A total of 536 adults over the age of 18 took the survey through phone and online surveys. The three largest racial groups among survey respondents self-identified as White/Caucasian (75.9%), Asian/Pacific Islander (7.9%) and Black/African American (4.5%). The survey was available in English and Spanish. Every effort was made to ensure the survey responses represented the diversity of the community and captured input from those with low incomes and those otherwise underserved in the community.

The 2022 results utilized the outcomes from the 2020 and 2021 surveys as benchmarks. The central questions of the monitor include how residents define their health and well-being, factors that residents find important to health and well-being, and how satisfied residents are with their own health and well-being. The report groups findings into six dimensions: connections and relationships; physical health; mental/emotional and spiritual health; security and basic needs; neighborhood and environment; and work, learning, and growth. To look at health from the point of view of the residents, respondents also self-reported their current state of overall health, physical health, mental/emotional health, and life satisfaction/well-being. The results of the survey form the basis for the Snohomish County Health and Well-Being Index.

Figure 7. Health and Well Being Monitor™ Index.



In 2022, the index score was a 7.1 or a C rating. The index is down from 2021, falling instead to near the 2020 pandemic year mean. The Index scores were most strongly correlated with these top 10 influences in ranked order, with the most influential listed first:

1. Emotional well-being
2. Physical health
3. Relationships with other people
4. Opportunities for learning and growth
5. Work or job rating
6. Security about financial future
7. Number of poor mental health days per month
8. Feeling like they are part of a community
9. Ability to meet basic needs
10. Debilitating health days/month

In addition to the countywide Health & Well-Being Monitor™, in 2019 PIHC began working with diverse communities to build upon the infrastructure of the Health & Well-Being Monitor™ to create a tailored community version to assist organizations and community networks with measuring well-being, informing action steps, and tracking progress. The community level My Community Health & Well-Being Monitor™ provides self-defined communities with a snapshot of the perceptions, satisfaction and behaviors related to the six dimensions of health. This method allows individual communities to become more active well-being partners based on what matters to them. See Appendix 5: Community Health & Well-Being Monitor™ survey for the full methodology and findings from the survey.

Challenges in Obtaining Community Input

Obtaining robust community input during the COVID-19 pandemic was challenging due to the limited ability to conduct in-person conversations. Many of the stakeholder interviews were conducted virtually, as was the Community Health Summit. While video conferencing does facilitate information sharing, it is difficult to achieve the level of dialogue that would take place in person. Additionally, due to many community organizations engaging in COVID-19 response, some organizations had limited capacity and were not able to participate.

In the past, PRMCE was able to utilize the expertise of the Snohomish Health District by directly participating in their CHNA community process and utilizing the outcome to inform the PRMCE CHNA. Due to the timing of the Snohomish Health District's 2023 CHNA, we were not able to leverage that expertise for this cycle. However, the Health District's community health reports were used as a reference when conducting the PRMCE CHNA[7]. Additionally, PRMCE is represented on the Snohomish Health District 2023 CHNA data evaluation committee, which will meet bi-weekly in early 2023 to examine health indicator data and share feedback. Furthermore, the PRMCE director of Quality chaired the 2022 Snohomish Health District Public Health Advisory Council which consists of appointed community members representing 18 sectors of the community including behavioral health, health inequities, public health, government, and health care, among others. The Advisory Council's role is to consider public health issues and make recommendations relevant to improving the health of the citizens of Snohomish County. Through both channels, PRMCE is able to leverage the expertise of the Snohomish Health District to ensure the PRMCE CHNA and CHIP priorities are in alignment. PRMCE will evaluate these plans on a regular cadence and make modifications or add additional areas of emphasis to the PRMCE CHNA plan as necessary.

[7] Community Health Reports | Snohomish Health District, WA (snohd.org)

SIGNIFICANT HEALTH NEEDS

A CHNA Advisory Committee was established to inform and guide the CHNA process and to identify the top health priorities for the community based on community input and community health data. The committee comprised local community leaders who represent the broad interest and demographics of the community. The CHNA Advisory Committee met monthly from February through September 2022. See Appendix 4 for a list of the participants.

Prioritization Process and Criteria

The evaluation portion of the process started with a review of the qualitative findings from the key stakeholder interviews and group listening sessions. These findings were used to frame the discussion of the top health needs. A review of the quantitative data and the community-wide Health and Well-Being Monitor™ results was then used to validate and enrich discussion of the qualitative findings. Throughout the process we evaluated health and community need using a holistic framework that included social determinants of health, lifestyle choices, and clinical care.

Through a facilitated discussion and an on-line ranking tool, the CHNA Advisory Group utilized a methodology adopted from the Snohomish Health District's 2018 community health needs assessment which compares local data to state and national data, identifying worsening trends and evaluating the size and seriousness of the problem. The CHNA Advisory Committee utilized these criteria and added the disproportionate impact on low-income and/or BBIPOC communities to rank order 19 metrics. The results of the ranking and prioritization revealed the following six significant health needs of Snohomish County, in ranked order:

1. ACCESS TO HEALTH CARE

   Access to comprehensive, high-quality, affordable health care is important to physical, social, and mental health. Overcoming obstacles such as health insurance coverage, local care access, transportation, and language barriers can help to ensure health care needs are met.

2. HOUSING INSTABILITY / HOMELESSNESS

   People experiencing housing instability are not necessarily experiencing homelessness. Housing instability is often defined to include rent cost burden, risk of eviction, or frequent moves. People are considered to be homeless if they stay in a shelter, live in transitional housing, or sleep in a place not meant for human habitation, such as a car or outdoors. Sometimes people are considered to be homeless if they are living in a motel or are doubled up with family or friends because they do not have anywhere else to stay. [8]

[8] Center for Disease Control, www.cdc.gov

3. BEHAVIORAL HEALTH

Behavioral health includes mental health and substance use. Mental health is an important part of overall health and well-being and includes our emotional, psychological, and social well-being. It helps determine how we handle stress, relate to others, and make healthy choices[9]. Substance use occurs when the recurrent use of alcohol and/or drugs causes clinically significant impairment, including health problems, disability, and inability to meet major responsibilities at work, school, or home.

4. HEALTH EQUITY, RACISM, AND DISCRIMINATION

We acknowledge that all people do not have equal opportunities and access to living their fullest, healthiest lives due to systems of oppression and inequities. Discrimination is treating a person unfairly because of who they are or because they possess certain characteristics or identities. When addressing housing, behavioral health, and access to health care, Providence will use an equity framework for planning and implementation.

5. FOOD INSECURITY

Food insecurity is the lack of consistent access to enough nutritious food for an active, healthy lifestyle.[10] It's closely linked with availability of financial resources. Many people do not have the resources to meet their basic needs, which increases the risk of food insecurity.

6. ECONOMIC INSECURITY

Economic or financial insecurity is the ability to access resources that are essential to one's life. It has a strong influence on overall well-being and a person's ability to meet basic needs. With economic insecurity comes an increased risk of food insecurity, homelessness, and inability to meet other basic needs such as health care. Education, job security and availability of affordable childcare are also significant factors in ensuring economic stability.

Alignment with Other Public Health Priorities

To ensure alignment with local public health improvement processes and identified needs, we evaluated the needs of other publicly available sources that engaged the community in setting priorities, including the Snohomish County Office of Recovery and Resilience (2022), Verdant Health Commission CHNA (2022), and the Swedish Edmonds CHNA (2021). After the CHNA Advisory Committee ranked and prioritized the significant health needs, these resources were reviewed to confirm that the Providence identified community health needs were aligned with various government and non-profit organizations serving Snohomish County. Access to health care, housing instability/homelessness, behavioral health, equity/racism/discrimination, food insecurity and financial security were present in the assessments that were reviewed.

[9] Center for Disease Control and Prevention, www.cdc.org

[10] U.S. Department of Agriculture

Table 17. Public Health Priorities

PRMCE Identified Significant Needs of the Community	Swedish Edmonds CHNA Priorities	Snohomish County Office of Recovery and Resilience - Priorities	Verdant Health Commission CHNA Priorities
• Access to health care • Housing Instability and Homelessness • Behavioral health • Health equity, racism, and discrimination • Food insecurity • Economic security	• Access to health care • Affordable childcare and preschools • Housing instability and homelessness • Behavioral health • Chronic conditions • Dental care • Economic insecurity • Racism and discrimination	• Behavioral and mental health services • Growth and stability • Shelter and homelessness • Child care and early childhood education • Workforce development • Focus on youth	• Health disparities • Health care affordability • Health care quality • Mental health • Substance use • Economic stability • Housing • Food security • Safety and community connection

2022 Priority Needs

There are a number of health needs in our community, however, due to lack of effective interventions, resource constraints, or absence of expertise, PRMCE cannot directly address all needs identified in a CHNA. Based on the outcome of the evaluation from the CHNA Advisory Committee to identify the significant health needs of the community, the PRMCE executive leadership team reviewed these ranked priorities and scored the significant needs of the community using the following criteria:

- Alignment with the strategic plan and existing Providence priorities
- Availability of resources and/or partnerships
- Confidence in Providence's ability to have a positive impact.

The results of the ranking and prioritization revealed the following priority areas that PRMCE will address as part of the 2023 – 2025 Community Health Improvement Plan:

1. Behavioral health – mental health and substance use
2. Access to health care
3. Housing instability and homelessness
4. Health equity, racism, and discrimination

Potential Resources Available to Address Significant Health Needs

PRMCE and community partners cannot address the significant Snohomish County health needs independently. Improving Snohomish County health requires collaboration among many stakeholders. To that end, Snohomish County has tremendous health care assets that, with stakeholders working together, can make tangible, measurable differences in our community. Understanding the potential resources available to address significant health needs is fundamental to determining current-state capacity and gaps. The organized health care delivery systems include organizations such as the Snohomish Health District, Swedish Edmonds, Evergreen Health Monroe, Cascade Valley Hospital, Community Health Center of Snohomish County, Sea Mar, The Everett Clinic and Western Washington

Medical Group. In addition, there are numerous social services, non-profit agencies, and faith-based organizations that contribute resources to address these identified needs.

PRMCE understands that local community resources and assets are vital to improving the health of the population. PIHC created an on-line search and collaboration resource tool called LiveWellLocal™ that makes it easier to find and connect with the many community assets in Snohomish County that support health and healing. It provides a way for communities to work together to gather and share information, expanding the depth, usability, and equity of available resources. For a list of resources potentially available to address significant health needs see Appendix 3 or visit www.pihchub.org/livewell/.

EVALUATION OF 2020-2022 CHIP IMPACT

This report evaluates the impact of the 2020-2022 Community Health Improvement Plan (CHIP). PRMCE responded to community needs by making investments of direct funding, time, and resources to internal and external programs dedicated to addressing the previously prioritized needs using evidence-based and leading practices.

Mental health: The goal is to improve access to quality, timely mental health services, and reduce the stigma and discrimination associated with mental illness. The programs and services implemented to improve this community need and the resulting outcomes are described in the table below.

Table 18. Mental Health Programs

Program	Description	Results/Outcomes
Integrated behavioral health care	Improve whole person care by embedding mental health programs into primary care.	• Integrated mental health into primary care, pediatric, and women's services at Providence Medical Group (PMG) clinics. • Expanded integrated care into the WSU Internal Medicine Residency clinic
Access	Increase access to mental health services	• Opened 24-bed inpatient behavioral health unit at PRMCE • Opened a PMG mental health urgent care clinic • Recruited mental health providers (psychiatrist, psychiatric nurse practitioners, master-level social workers, counselors) • Participated in the Institute for Healthcare Improvement collaborative in the emergency department and upstream to improve patient outcomes, and experience of care, and decrease avoidable ED visits for individuals with mental health and substance use issues.
Education	Educate providers, caregivers, and community in order to decrease stigma and discrimination associated with mental illness.	• Coordinated conference for community primary care providers focusing on adult ADHD and Bipolar disorders. • Educated medical staff providers and staff on trauma informed care. • Implemented behavioral response team for inpatient care and behavioral health multidisciplinary team huddles in the emergency department. • Conducted Management of Aggressive Behaviors (MOAB) training for staff. • Participated in Mental Health First Aid USA / Service Alternatives training for staff and community. • Coordinated panel discussion for community partners on the future of mental health services
Community partnerships	Collaborate with and support community partners.	• Participated in a community behavioral health committee with focus on identifying barriers, raising level of care, and improving access. • Aligned grants and donations with community organizations that support mental health. • Coordinated annual community conference (Edge of Amazing) with break-out groups discussing community barriers and solutions to behavioral health.

Program	Description	Results/Outcomes
		• Collaborated with Center for Human Services to provide on-site, long-term mental health counseling and therapy at Mill Creek campus. • Participated in the Snohomish County Collaborative to expand trauma informed care.

Opioid use disorder: The goal is to reduce the morbidity and mortality caused by the abuse of prescription and illegal opioids and decrease the stigma and discrimination associated with substance use disorders. The programs and services implemented to improve this community need and the resulting outcomes are described in the table below.

Table 19. Opioid Use Disorder Programs

Program	Description	Results/Outcomes
Access to care	Increase access to treatment options	• Offered clinical research study for those wanting to get off opioids and go into medication-assisted treatment • Continued Providence Drug and Alcohol Addiction Services as a subsidized service and expanded access to Medicaid population • Expanded medication assisted treatment for opioid use disorder in the emergency department and among the medical hospitalist team, and Women and Children's providers. • Added substance use disorder professional to inpatient units to improve access to intervention and treatment referrals. • Participated in the Institute for Healthcare Improvement collaborative in the emergency department and upstream to improve patient outcomes, experience of care and decrease avoidable ED visits for individuals with mental health and substance use issues.
Opioid prescribing	Prevent inappropriate opioid prescribing to reduce opioid misuse.	• Hardwired order sets to minimize narcotic prescribing. • Educated medical staff providers regarding narcotic alternatives for pain control with a specific focus on obstetric providers and perioperative surgical team. • Coordinated conferences for community providers on the fundamentals of addiction medicine and pain relief beyond opioids.
Education	Educate providers, caregivers, and community on effects to decrease stigma and discrimination associated with opioid use disorder.	• Conducted staff education on opioid use disorder and screening • Communicated and ensured caregivers are knowledgeable about and have access to resources for themselves, their families, and their friends. • Provided Inside Out Organ Show to schools and community organizations to show the damage drugs and alcohol have on the body's internal organs. • Educated primary care providers on medication for addiction treatment.
Screening	Provide screening assessments for community members and patients to identify social	• Expanded Total Health screening for social determinants of health in physician offices and with social service and other community partners to screen for unmet needs. • Initiated substance use disorder screening and treatment for inpatients.

Program	Description	Results/Outcomes
	determinants of health including drug use disorder.	
Community partnerships	Collaborate with and support community partners.	• Aligned grants and donations with community organizations that support treatment for opioid use disorder. • Coordinated annual community conference (Edge of Amazing) with break-out groups discussing community barriers and solution to the opioid epidemic. • Participated in the Snohomish Health District opioid overdose outreach program to collect information about overdose patients in the emergency department. • Participated in the Snohomish Health District medication take-back program in pharmacies at PRMCE Colby and PMG Monroe

Housing insecurity and homelessness: The goal is to reduce the number of individuals and families experiencing homelessness, connect PRMCE patients to stable housing, and decrease the stigma and discrimination associated with homelessness. The programs and services implemented to improve this community need and the resulting outcomes are described in the table below.

Table 20. Access to Housing/Homeless Programs

Program	Description	Results/Outcomes
Health care needs	Identify solutions to the health care needs of the homeless population post discharge	• Partnered with the Everett Gospel Mission to provide medical respite beds for men experiencing homelessness who need a place to recover and heal following hospital discharge • Participated in community collaboratives (Partnership to End Homelessness, CHART) • Provided clothing for individuals experiencing homelessness being discharged from the emergency department in need of clean clothing. • Provided influenza vaccine to patients experiencing homelessness seen in the emergency department. • Provided funding to Northwest Justice project to provide legal aid for low-income and persons experiencing homelessness to help address poor-quality housing conditions.
Screening	Provide screening assessments for community members and patients to identify social determinants of health including homelessness, housing insecurity, and mental health needs, etc.	• Offered Total Health patient screening and follow-up via housing navigators in the primary care clinics (discontinued program). • Expanded Total Health screening to first generation Latino immigrants and residents with undocumented status and increased access to the screening tool through on-line resources.
Community partnerships	Collaborate with and support community partners.	• Collaborated with the Snohomish County community containment protection program to provide hotel vouchers for COVID-positive individuals experiencing homelessness.

Program	Description	Results/Outcomes
		• Aligned grants and donations with community organizations that support housing insecurity and homelessness. • Provided staffing for Angel of the Winds COVID isolation/quarantine center • Coordinated annual community conference (Edge of Amazing) with break-out groups discussing community barriers and solutions to housing access, homelessness. • Participated in the Improving School Attendance for Families Experiencing Homelessness collaborative • Participated in the Fair Lending pilot to reduce barriers to homeownership for BIPOC community members.

Access to primary care: The goal is to assist Snohomish County residents with accessing primary care at the right time and in the right care setting. The programs and services implemented to improve this community need and the resulting outcomes are described in the table below.

Table 21. Access to Primary Care Programs

Program	Description	Results/Outcomes
Patient experience	Improve the patient experience with new access options, digital tools, and convenience access	• Implemented cultural health navigators and community health worker program to help improve access to health care and COVID-19 related services for BBIPOC communities. • Increased the number of appointments available by expanding hours, adding Saturday appointments, Express Care collaboration, and Providence Health Connect • Implemented an electronic, mobile appointment reminder, scheduling, and referral system • Expanded telehealth options for patients • Created a centralized hub for pediatric services • Opened PACE (Program of All-Inclusive Care for the Elderly) in Snohomish County to provide primary and medical care, nursing care, social workers, and other services to individuals over age 55. (Providence Home and Community Care program) • Integrated behavioral health specialists into primary care clinics to address mental health needs and support.
Health care workforce	Collaborate with community partners to increase the available workforce and interest in the health care sector	• Initiated partnerships to serve as a training site for WSU Elson S. Floyd College of Medicine's Internal Medicine Residency program and Sea Mar Marysville Family Medicine Residency program. • Participated in health care programs at area high schools to increase interest in the healthcare field (Everett High School, Archbishop Murphy High School) • Partnered with Sno-Isle Skills Center and other schools to create medical assistant apprentice programs within Providence Medical Group. • Participated in community health fairs to draw interest to health care careers and promote openings at Providence.

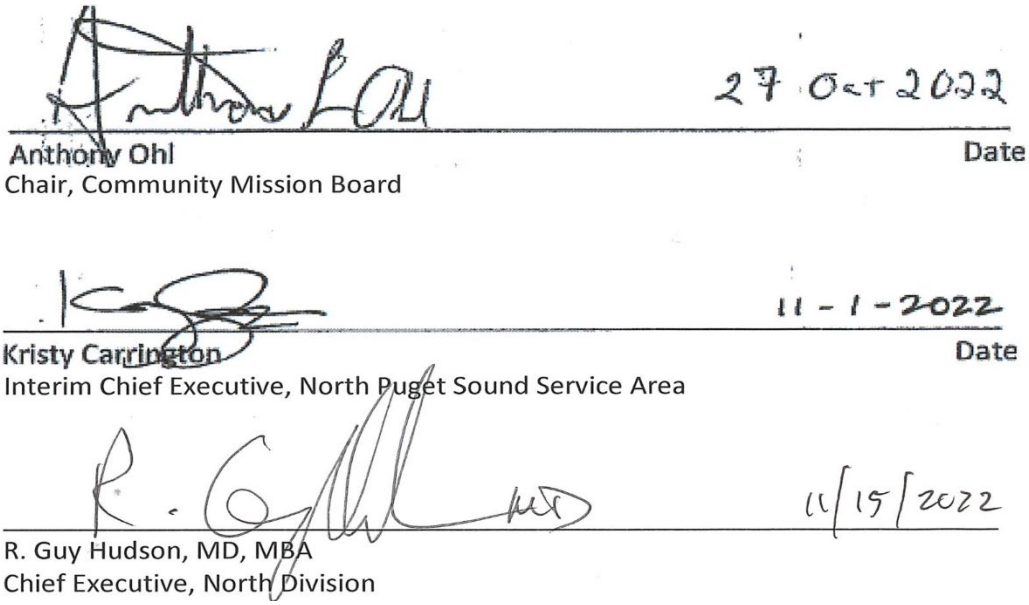
Addressing Identified Needs

The CHIP developed for the service area will consider the prioritized health needs identified in this CHNA and develop strategies to address needs considering resources, community capacity, and core competencies. Those strategies will be documented in the CHIP, describing how PRMCE plans to address the health needs. If the hospital does not intend to address a need or plans to have limited response to the identified need, the CHIP will explain why. The CHIP will not only describe the actions PRMCE intends to take, but also the anticipated impact of these actions and the resources the hospital plans to commit to address the health need.

Because partnership is important when addressing health needs, the CHIP will describe any planned collaboration between PRMCE and community-based organizations in addressing the health need. The CHIP will be approved and made publicly available no later than May 15, 2023.

2022 CHNA GOVERNANCE APPROVAL

This Community Health Needs Assessment was adopted by the Community Mission Board of the hospital on October 20, 2022. The final report was made widely available by December 28, 2022.



27 Oct 2022

Anthony Ohl
Chair, Community Mission Board

Date

11-1-2022

Kristy Carrington
Interim Chief Executive, North Puget Sound Service Area

Date

11/15/2022

R. Guy Hudson, MD, MBA
Chief Executive, North Division

CHNA/CHIP Contact:

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To request a copy free of charge, provide comments, or view electronic copies of current and previous Community Health Needs Assessments, please email CHI@providence.org.

APPENDICES

Appendix 1: Quantitative Data

POPULATION AND SOCIO-ECONOMIC FACTORS

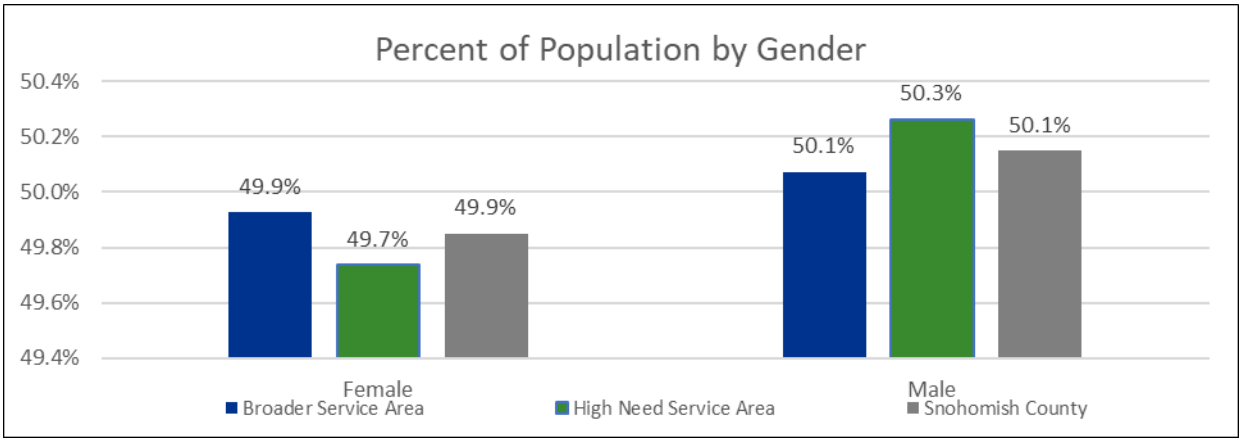
POPULATION BY GENDER

Table 22. Population By Gender

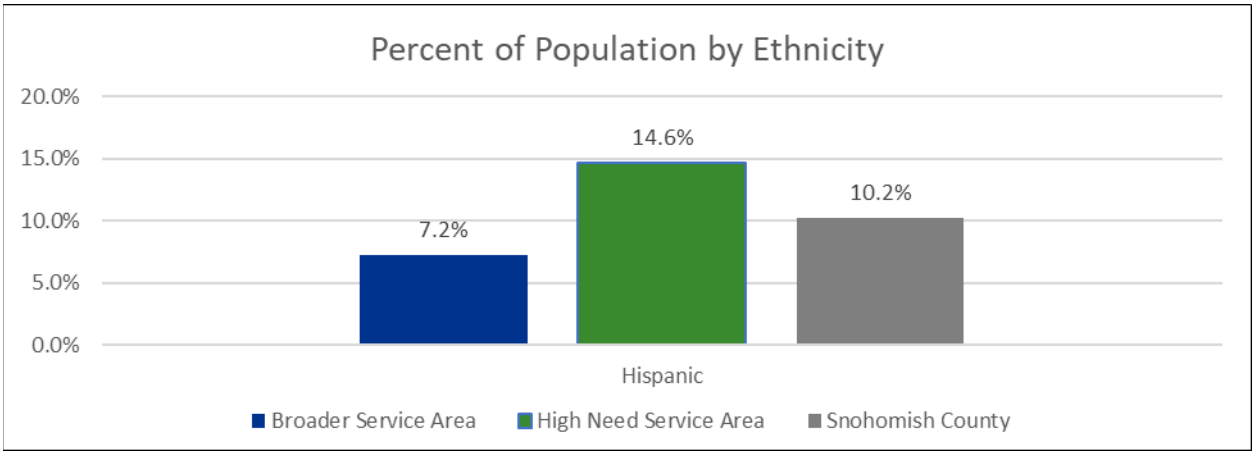
Indicator	Snohomish County	Broader Service Area	High-need Service Area
Female Population	398,214 (49.9%)	239,549 (49.9%)	158,665 (49.7%)
Male Population	400,594 (50.1%)	240,247 (50.1%)	160,347 (50.3%)

Source: 2019 American Community Survey 5-year estimates.

Graph 15. Percent of Population by Gender



Graph 16. Percent of Population by Ethnicity



HEALTH PROFESSIONAL SHORTAGE AREA

The Federal Health Resources and Services Administration (HRSA) designates Health Professional Shortage Areas HPSAs as areas with a shortage of primary medical care, dental care, or mental health providers. They are designated according to geography (i.e., service area), demographics (i.e., low-income population), or institutions (i.e., comprehensive health centers).

Snohomish County has locations that are designated as shortage areas. This information can be used to understand access issues, state and local health care planning, placement of providers, and allocation of limited health care resources. The maps below depict these shortage areas. An interactive map can also be found on the HRSA website: [HPSA (arcgis.com).]

Figure 8. Primary Care HPSA

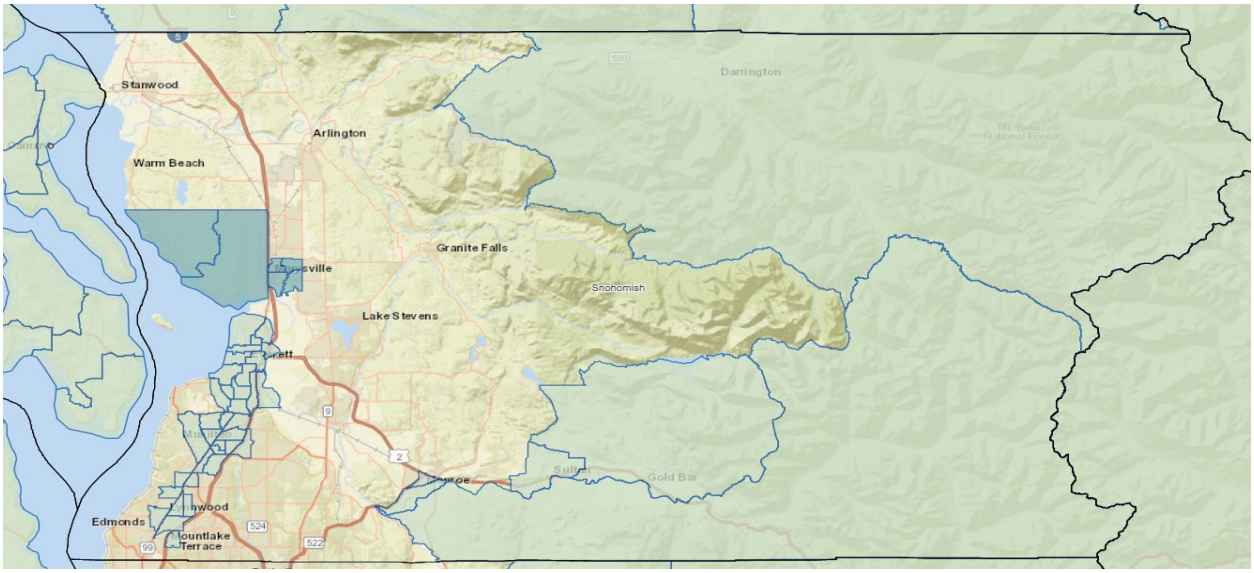


Figure 9. Mental Health HPSA

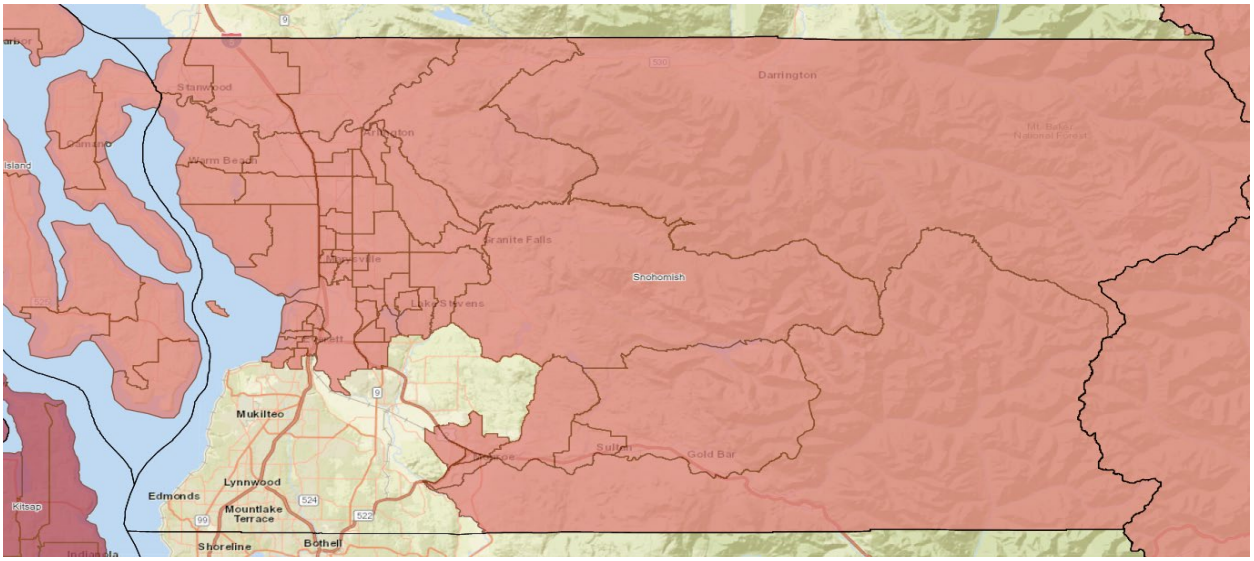
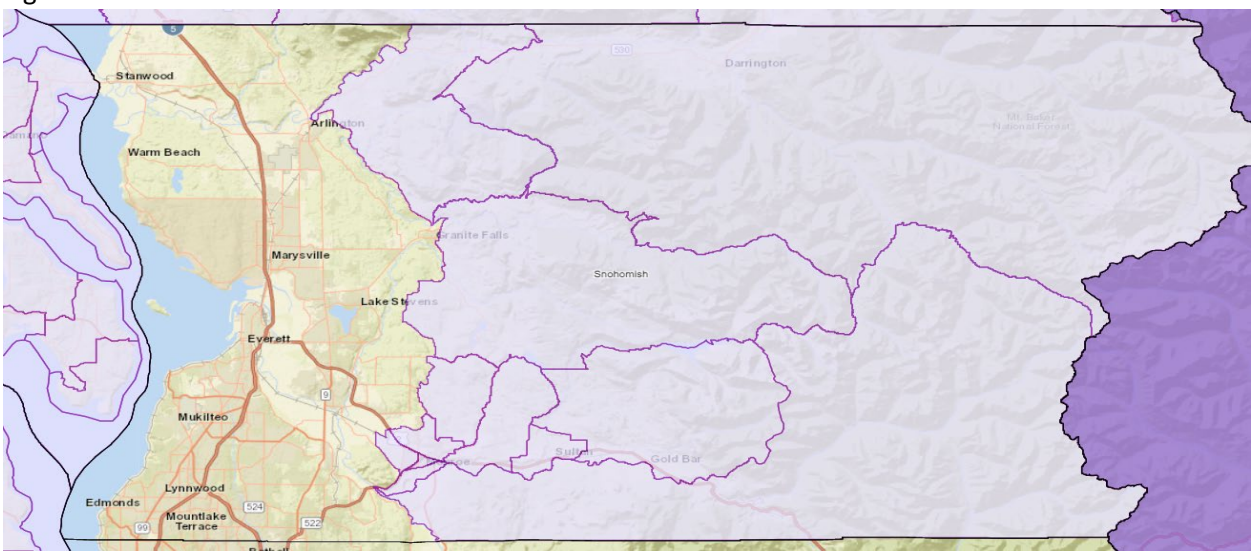


Figure 10. Dental Care HPSA

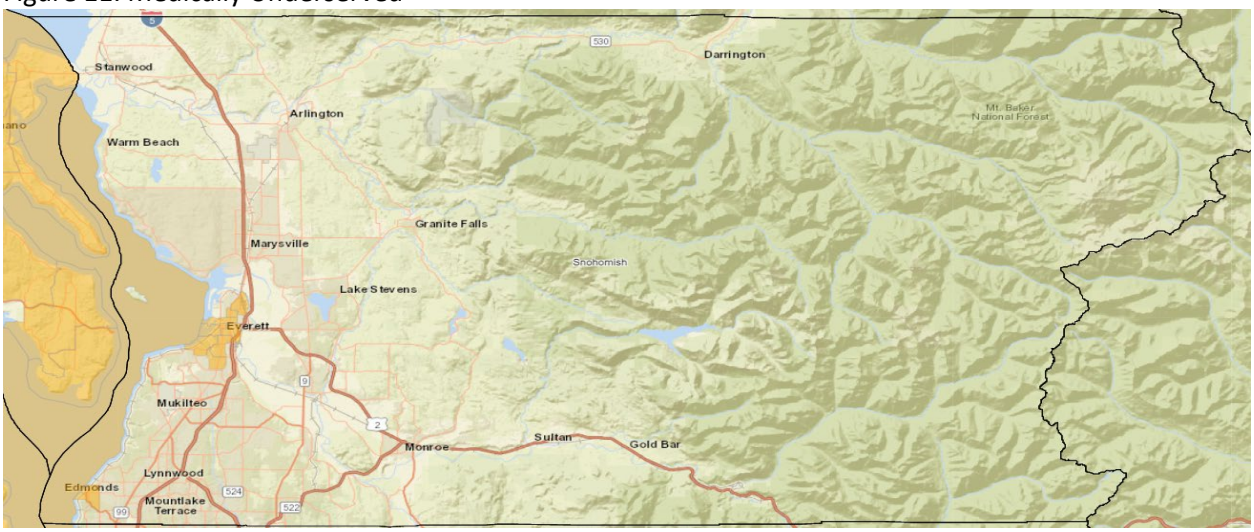


MEDICALLY UNDERSERVED AREA / MEDICAL PROFESSIONAL SHORTAGE AREA

Medically Underserved Areas (MUAs) and Medically Underserved Populations (MUPs) are defined by the federal government to include areas or populations that demonstrate a shortage of primary health care services. MUAs are identified by calculating a composite index of need indicators compiled with national averages to determine an area's level of medical "under service." MUPs are identified based on documentation of unusual local conditions that result in access barriers to medical services. MUAs and MUPs are permanently set, and no renewal process is necessary.

Snohomish County has two areas that are designated as medically underserved: Central Everett and West Edmonds. The following map depicts the MUAs within Snohomish County.

Figure 11. Medically Underserved

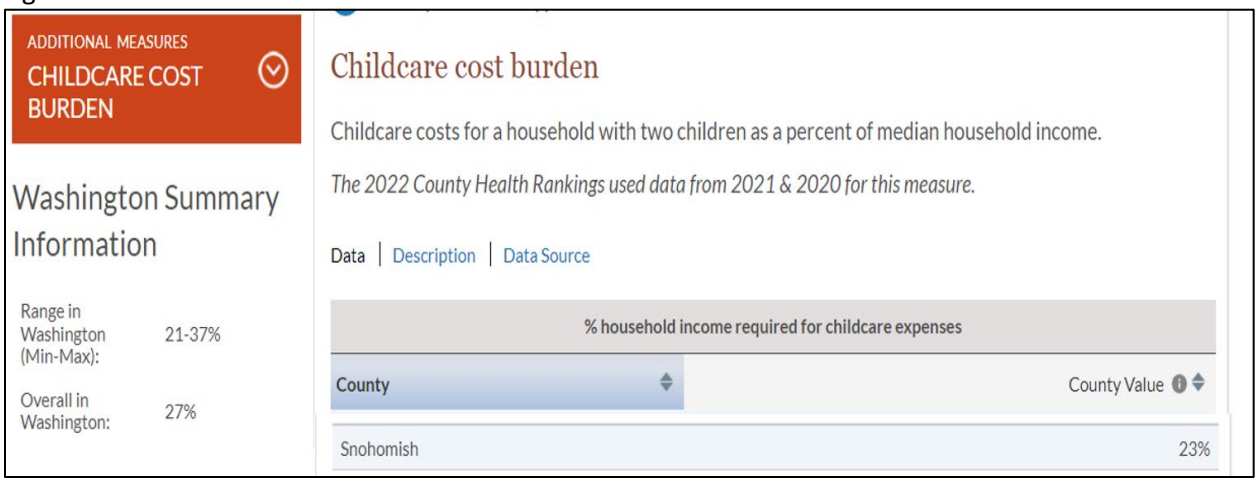


Source: MUA Find (hrsa.gov)

CHILDCARE COST

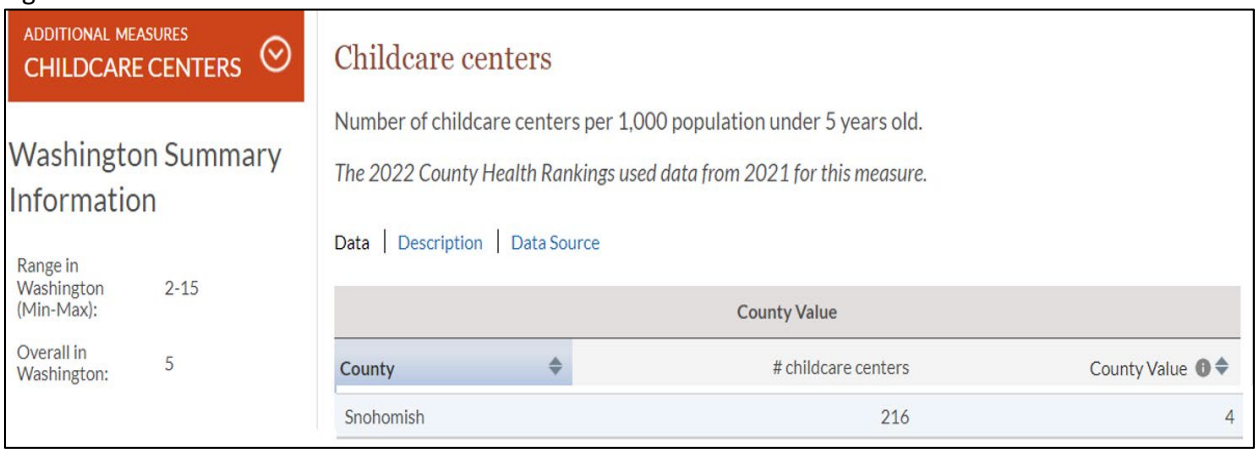
The U.S. Department of Health and Human Services indicates that childcare is not affordable if a household spends more than 25% of their income on childcare. Snohomish County's childcare cost for a household with two children as a percent of median household income is 23%, less than the state at 27%. Additionally, the number of childcare centers per 1,000 population in Snohomish County is four compared to five in the state.

Figure 12. Childcare Cost Burden



Source: County Health Rankings.org

Figure 13. Childcare Centers



Source: County Health Rankings.org

LANGUAGE PROFICIENCY

This variable identifies populations five years and older living in households that may need English-language assistance. A limited English-speaking household is one in which no member 14 years and older speaks only English at home or speaks a language other than English at home. Having limited English can be a barrier to accessing health care and other social services and understanding health information. In the high-need service area, 6.2% of the population lives in a limited English household, compared to Snohomish County at 3.9%.

Table 23. Limited English Households

Indicator	Snohomish County	Broader Service Area	High-need Service Area	Washington State
Population in limited English Households	3.9%	1.6%	6.2%	3.8%

Source: American Community Survey 2019, 5-year estimates

HIGH SCHOOL EDUCATION

Healthy People 2030 states that dropping out of high school is linked to a variety of negative health impacts, including limited employment prospects, low wages, and poverty. In Snohomish County, 92.3% of the adult population, ages 25 and older, has a high school diploma compared to 89.3% of the population in the high-need service area.

Table 24. High School Diploma

Indicator	Snohomish County	Broader Service Area	High-need Service Area	Washington State
Population ages 25+ with at least a High School education	92.3%	95.0%	89.3%	91.3%

Source: American Community Survey 2019, 5-year estimates

INTERNET ACCESS

Access to reliable internet improves access to education, employment, and health care opportunities. Households without internet access are higher in the high-need service area at 8.8% compared to 6.6% for Snohomish County

Table 25. Internet Access

Indicator	Snohomish County	Broader Service Area	High-need Service Area	Washington State
Households with No Internet Access	6.6%	4.7%	9.4%	8.8%

Source: American Community Survey 2019, 5-year estimates

HEALTH BEHAVIORS:

OBESITY AND PHYSICAL INACTIVITY

Obesity is measured for those over 18 with a body mass index >30.0 kg. The rate of individuals with obesity in the high-need service area within Snohomish County is higher than Snohomish County and the state at 31.6%.

Regular physical activity can improve the health and quality of life. In the high-need service area 21% of individuals did not participate in any physical activity or exercise in the last 30 days compared to 19% in the county and state.

Table 26. Obesity and Physical Inactivity

Indicator	Snohomish County	Broader Service Area	High-need Service Area	Washington State
Obesity Crude Prevalence	30.4%	29.7%	31.6%	28.3%
Physical Inactivity Crude Prevalence	19.3%	17.2%	21.2%	19.2%

Data Source: Behavioral Risk Factor Surveillance System, 2019

SMOKING

Smoking is one of the leading preventable causes of death in the U.S. Smoking increases the risk for heart disease, stroke, multiple types of cancer and chronic lung disease. The rate of smoking in the Snohomish County high-need service area is greater than that of Snohomish County and Washington State at 16.8%.

Table 27. Smoking

Indicator	Snohomish County	Broader Service Area	High-need Service Area	Washington State
Smoking Crude Prevalence	14%	13.8%	16.8%	12.7%

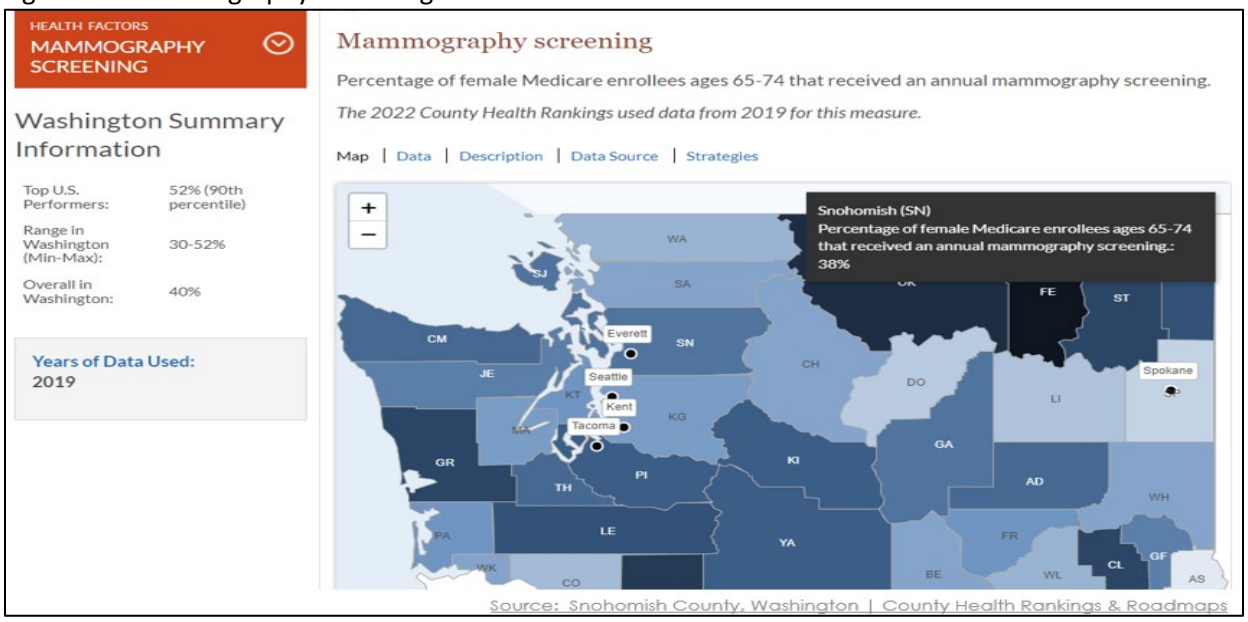
Data Source: Behavioral Risk Factor Surveillance System, 2019

CLINICAL CARE:

MAMMOGRAPHY SCREENING

Mammograms are the best way to detect breast cancer early. The percentage of females between the ages of 65-74 who have received an annual mammogram is 38%, lower than that of the state (40%) and top U.S. performers (52%).

Figure 14. Mammography Screening



Source: County Health Rankings.org

DENTAL CARE

Most oral diseases are preventable in part with regular visits to the dentist. In Snohomish County, the rate of dental visits by those over age of 18 is higher than that of Washington State at 71.2%, however the high-need service area is well below at 67%.

Table 28. Dental Visit

Indicator	Snohomish County	Broader Service Area	High-need Service Area	Washington State
Dental Visit Crude Prevalence	71.2%	74.4%	67.0%	69.2%

Source: Behavioral Risk Factor Surveillance System, 2019

HEALTH OUTCOMES

PHYSICAL HEALTH

Physical health is an important component of quality of life. Residents over the age of 18 who report 14 or more days during the past 30 days during which their physical health was not good was slightly better in Snohomish County than the state. Residents who report their health as fair/poor in the high-need area was high than that of Washington State

Table 29. Physical Health

Indicator	Snohomish County	Broader Service Area	High-need Service Area	Washington State
Physical Health Distress	11.5%	10.8%	12.8%	12.2%
Fair or Poor Health	15%	13.1%	16.8%	15%

Data Source: Behavioral Risk Factor Surveillance System, 2019

ASTHMA

The crude prevalence of asthma is 10% in Snohomish County which is comparable to the State.

Table 301. Asthma Prevalence

Indicator	Snohomish County	Broader Service Area	High-need Service Area	Washington State
Asthma Crude Prevalence	10%	10.1%	10.8%	9.9%

Data Source: Behavioral Risk Factor Surveillance System, 2019

DIABETES

According to the Center for Disease Control (CDC), the impact of diabetes in the U.S. has increased with the prevalence of obesity. The crude prevalence of diabetes in Snohomish County is 9.1%, comparable to Washington State, but higher than the high-need and broader service areas in the county. Diabetes is one of the top 10 leading causes of death in Snohomish County.

Table 31. Diabetes Prevalence

Indicator	Snohomish County	Broader Service Area	High-need Service Area	Washington State
Diabetes Crude Prevalence	9.1%	7.8%	8.9%	9.4%

Data Source: Behavioral Risk Factor Surveillance System, 2019

CORONARY HEART DISEASE

Coronary heart disease is the most common type of heart disease. Both Snohomish County (4.7%) and the high-need area (4.9%) are above that of Washington State (3.4%). Heart disease is the second leading cause of death in Snohomish County.

Table 32. COPD

Indicator	Snohomish County	Broader Service Area	High-need Service Area	Washington State
Coronary Heart Disease prevalence	4.7%	4.3%	4.9%	3.4%

Data Source: Behavioral Risk Factor Surveillance System, 2019

KIDNEY DISEASE

The crude prevalence of persons with kidney disease in Snohomish County is equivalent to that of the state.

Table 33. Kidney Disease

Indicator	Snohomish County	Broader Service Area	High-need Service Area	Washington State
Chronic Kidney Disease prevalence	2.5%	2.3%	2.6%	2.7%

Data Source: Behavioral Risk Factor Surveillance System, 2019

CANCER

Cancer is a leading cause of death in the U.S. and Snohomish County, although incidence and death rates have been declining. For those over 18 years of age, the prevalence of cancer for Snohomish County at 6.5% is less than that of the state (7.6%).

Table 34. Cancer

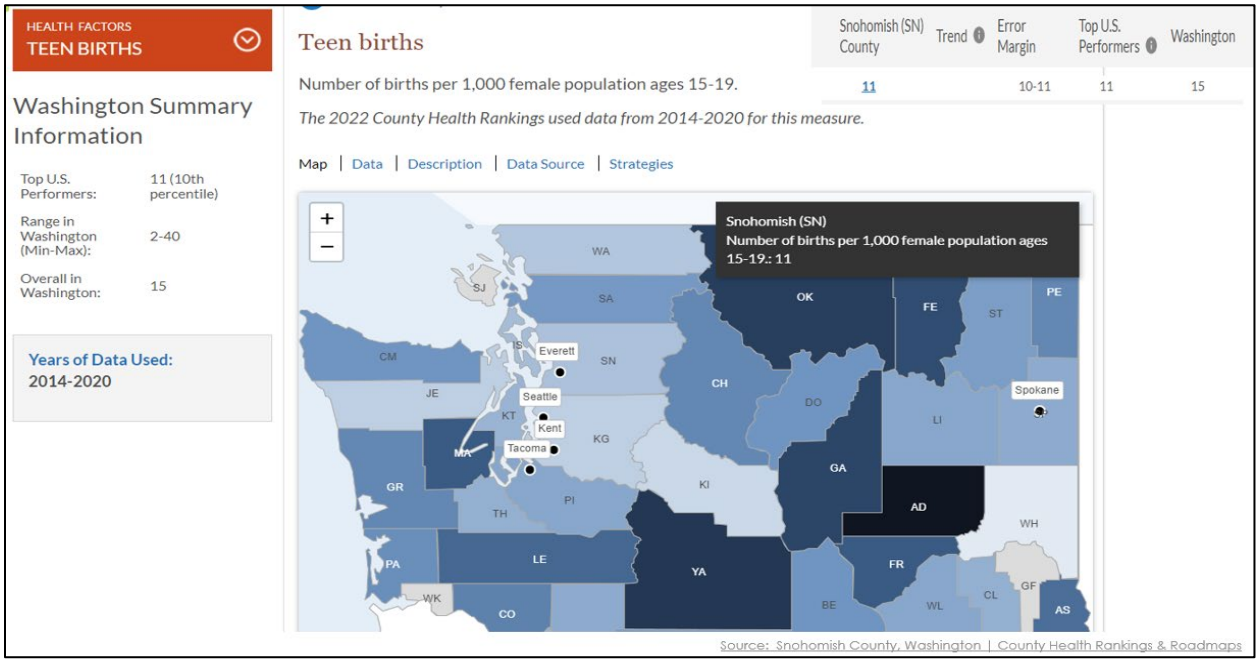
Indicator	Snohomish County	Broader Service Area	High-need Service Area	Washington State
Cancer Prevalence (except skin)	6.5%	6.5%	6.1%	7.6%

Data Source: Behavioral Risk Factor Surveillance System, 2019

TEEN BIRTH RATE

The number of births per 1,000 female population between the ages of 15 – 19 in Snohomish County is 11. This is much lower than Washington State and is a top U.S. performer at 11.

Figure 15. Teen Births



Source: County Health Rankings.org

MATERNAL AND CHILD HEALTH

Babies born with a birth weight less than 2500 grams are defined as low birth weight. In Snohomish County, 618 (6.6%) babies were born at low birth weight which is comparable to the state. The percentage of mothers who smoke during pregnancy is at 5.5%. Each of these factors has been decreasing since 2016 for Snohomish County and the state.

Table 35. Birth Indicators

Cause	Snohomish County	Washington State
Total Births	9,331	82,990
Low Weight Births	618 (6.6%)	5,562 (6.7%)
Mother smoking during pregnancy	5.5%	5.7%

Data Source: WA State Department of Health, 2020 Birth Risk Factors Dashboard - County | Washington State Department of Health

Appendix 2: Community Input

INTRODUCTION

Providence Regional Medical Center (PRMCE), in partnership with the Providence Institute for a Healthier Community (PIHC) and the PIHC Strategic Oversight Committee, conducted stakeholder interviews and listening sessions. Listening to and engaging with the people who live and work in the community is a crucial component of the CHNA, as these individuals have firsthand knowledge of the needs and strengths of the community. PIHC conducted 14 stakeholder interviews with people who are invested in the well-being of the community. They also conducted six listening sessions with a total of 58 community members. The goal of the interviews and listening sessions was to identify what needs are currently not being met in the community and what assets could be leveraged to address these needs.

METHODOLOGY

Selection

The listening sessions were held in-person in April 2022 at various locations throughout the community. Listening session groups were selected based on Providence's attempt to identify community groups in underrepresented communities. Session participants represented Latino, Black/African American, Native American, Asian/Pacific Islanders, refugees, and immigrants, those with low-Income, and the general population.

Table 36. Listening Sessions

Community Input Type and Population	Location of Session	Date	Language
Listening session with Latina women, ages 55 through 40 (half of the participants spoke Mixteco or Zapotec as their first language)	Silver Creek Family Church	4/11/2022	Spanish & English
Listening session with adults from the Everett YMCA	Everett YMCA	4/13/2022	English
Listening session with Black/African American adults	NAACP Snohomish County Office, Everett	4/16/2022	English
Listening session with Asian and Pacific Islander communities	Everett Community College	4/20/2022	English
Listening session with Black, Brown, Indigenous, and People of Color (BBIPOC) women, ages 35 through 50 (half of the participants spoke Mixteco or Zapotec as their first language)	Silver Creek Family Church	4/14/2022	Spanish & English
Listening session with Tulalip Tribes	Tulalip Health Clinic	4/29/2022	English

PRMCE conducted the stakeholder interviews between March and April 2022. Stakeholders were selected based on their knowledge of the community and engagement in work that directly serves people experiencing health disparities and systemic inequities. PRMCE aimed to engage stakeholders from social service agencies, health care, education, housing, and government, among others, to ensure a wide range of perspectives.

Table 37. Key Community Stakeholder Input

Organization	Name	Title	Sector
Archbishop Murphy High School	Steve Schmutz	President	College preparatory school
City of Arlington	Barb Tolbert	Mayor	Government
Communities of Color Coalition	Jacque Julien	Executive Director	Education and advocacy for social justice and human rights
Housing Hope Improving School Attendance CORE Collaborative	Monica Best-Wilson	School Psychologist Collaborative Coordinator	Housing and homelessness
MercyWatch	Dennis Kelly	Founder and Executive Director	Homelessness, health care access
NAACP of Snohomish County Snohomish County Equity Partnership	Dr. Janice R. Greene	President Founding Lead Partner	Civil rights organizations fighting to end racial inequality
Snohomish County Latino Coalition Oye Productions	Karina Gasperin	Executive Director Founder and CEO	Social service agency and Bilingual media and entertainment
Providence Medical Group	Andi McCay-Correa	Cultural Health Navigator	Health care access, population health
Refugee & Immigrant Services Northwest	Van Dinh-Kuno	Executive Director	Immigrant and refugee services
Rise Up Academy Greater Trinity Church Snohomish County Equity Partnership	Rev. Dr. Paul A. Stoot, Sr.	Executive Director Senior Pastor Founding Lead Partner	Early education
Stanwood-Camano Area Foundation	Bev Pronishan	Executive Director	Philanthropy
WAGRO Foundation City of Lynnwood Snohomish County Equity Partnership	Julieta Altamirano-Crosby	Co-Founder and Executive Director City Councilmember Founding Lead Partner	Services and resources to support Latinos and Indigenous Mexicans Government
YMCA of Snohomish County	Peyton Tune	CEO	Youth development, healthy living, social responsibility
YWCA Seattle King Snohomish	Mary Anne Dillon	Executive Director - Snohomish County	Housing and homelessness, health care access

FACILITATION GUIDE

For the listening sessions, participants were asked an icebreaker and three questions:

1. Icebreaker: Description of community or greatest community strength
2. What makes a health community? How can you tell when your community is healthy?
3. What's needed? What more could be done to help your community be healthy?
4. What's working? What are the resources that currently help your community be healthy?

For the stakeholder interviews, PIHC developed a facilitation guide that touched on the below questions and asked about their Six Dimensions of Health[11]:

1. The community served by the stakeholder's organization
2. The community strengths
3. Prioritization of unmet health related needs in the community, including social determinants of health
4. The COVID-19 pandemic's effects on community needs
5. Suggestions for how to leverage community strengths to address community needs
6. Opportunities for collaboration among organizations

TRAINING

The facilitation guides provided instructions on how to conduct a stakeholder interview and listening session, including basic language on framing the purpose of the sessions.

DATA COLLECTION

Stakeholder interviews were conducted virtually and recorded with the participant's permission, while thorough notes were taken. The group listening sessions were conducted at a location close to the community group. The facilitator of the session was a trusted leader of the group, and efforts were made to conduct the session in the language in which the group was most fluent. Each session had two notetakers to assist with documenting comments from the participants.

ANALYSIS

Qualitative data analysis was conducted by Providence. The data were coded into themes, which allows the grouping of similar ideas across the interviews, while preserving the individual voice. The analyst used the complete notes for the data analysis and referred to the recordings as needed. Stakeholder names were removed from the files and assigned a number to reduce the potential for coding bias. The analyst read through the notes and developed a preliminary list of codes, or common topics that were mentioned multiple times. These codes represent themes from the dataset and help organize the notes into smaller pieces of information that can be rearranged to tell a story. The analyst developed a definition for each code which explained what information would be included in that code.

The analyst coded eight domains relating to the topics of the questions: 1) name, title, and organization of stakeholder, 2) population served by organization, 3) greatest community strength and opportunities to leverage these strengths 4) unmet health-related needs, 5) disproportionately affected population, 6) effects of COVID-19, 7) successful programs and initiatives, and 8) opportunities to work together.

[11] https://www.pihcsnohomish.org/six-dimensions/

The analyst then coded the information line by line. All information was coded, and new codes were created as necessary. All quotations, or other discrete information from the notes, were coded with a domain and a theme. Codes were then refined to better represent the information. Codes with only one or two quotations were coded as "other," and similar codes were grouped together into the same category. The analyst reviewed the code definitions and revised as necessary to best represent the information included in the code. The analyst documented patterns related to the frequency of codes and codes that were typically used together.

This process was repeated for the listening sessions. The analyst coded three domains related to the topics of the questions: 1) vision, 2) needs, and 3) strengths.

FINDINGS FROM COMMUNITY LISTENING SESSIONS

Vision of a Healthy Community

Listening session participants were asked to share their vision of a healthy community. The following themes emerged:

- **Community engagement and connection:** In a healthy community people know one another and care for one another, particularly when someone needs help. Participants shared in a healthy community people are working together, talking to one another, and engaging in community activities. This also means kids are playing together and there are intergenerational relationships.
- **Recreation and green spaces:** A healthy environment, including places for people to be outside and stay active, is crucial in a healthy community. Participants shared healthy communities have good air to breath and clean green spaces.
- **Basic needs are met, including housing, food, and employment:** In a healthy community everyone can meet their basic needs. This means people have a safe place to live, access to healthy foods, and a job to support their families.
- **Safety**: In a healthy community people feel safe being outside and having their children play outside, free of violence and fighting. Older adults and young people need to be safe in a healthy community.
- **Access to health care services and physical health**: In a healthy community everyone has health insurance and can care for their physical health. Participants shared people are physically healthy, without a lot of disease, in a healthy community.

Community Needs

Listening session participants primarily spoke to the following community needs:

- **Economic insecurity, education, and job skills:** Listening session participants noted a need for better paying jobs so that families can meet their basic needs, like childcare, healthy food, and housing. A lot of jobs require higher education and do not value lived experience. They would like to see more job skill training, particularly training for refugees, immigrants, and people with a history of criminal-legal system involvement. They would also like to see more vocational and trade schooling. Additionally, there should be access to higher education for adults who want to access new career opportunities.
- **Mental health:** Listening session participants would like more affordable mental health services that are easier to access in a timely way. They were particularly concerned about young people who may have difficulty accessing mental health services. Additionally, older adults may be isolated, negatively affecting their mental health. Participants spoke to the mental health

benefits of having opportunities for people to gather and connect in spaces where they feel heard and are not judged.

- **Access to health care services:** Participants were concerned about the cost of health care services and insurance. They would like to see health insurance for families with undocumented status and improved support for accessing Medicaid, as the current process is cumbersome and feels violating due to the level of information needed. Participants would like to better understand how to navigate the health care system but need support. There is a lack of providers that reflect the diversity of Snohomish County. Participants want to see additional Black, Brown, Indigenous, and People of Color (BBIPOC) providers that have cultural awareness and sensitivity. BBIPOC participants shared they feel talked down to and like they do not receive the high-quality care they deserve due to racism and discrimination. Long wait times for referrals and specialists were also a concern.
- **Racism and discrimination:** Participants shared BBIPOC community members do not feel included in local decision making. They way want to grow and become leaders in the local community, noting a need for more opportunities for BBIPOC community members to be included in decision-making spaces. Racism affects the quality-of-care BBIPOC patients receive, with participants sharing they are talked down to and not provided with the quality of care they deserve. Participants shared they experience racism in their neighborhoods.
- **Homelessness and housing instability:** Listening session participants noted a need for more affordable housing and improved support for accessing housing resources. They shared they can feel judged asking for help and the process takes a lot of time. They shared a need for rental assistance for mixed status families and repair services for older adults trying to remain safely in their home.
- **Community involvement and belonging:** Listening session participants spoke to wanting more community-building opportunities, like barbeques or other gatherings to help connect people. They thought this is particularly important for BBIPOC communities, as well as immigrants and refugees, who may not always be made to feel welcome. They spoke to the healing power of being in community. They were particularly concerned about older adults who may be isolated and suggested more gathering places and culturally relevant programming. They recommended giving people opportunities to be involved by sharing their skill set or passion through volunteer opportunities. Other suggestions include more recreational opportunities for young people and their families to keep them engaged in the community and active.

Community Strengths

The following table includes programs, initiatives, or other resources that members noted are working well for them.

Table 38. Community Programs

Area of Need	Program, Initiative, or Other Resource
Behavioral health	• Alcoholics Anonymous and Narcotics Anonymous
Community resources and information	• Churches • Connect Casino Road • Familias Unidas Latino Community Resource Center
Education	• YMCA's Y Achievers Program
Food security	• Alimentando al Pueblo • Free lunch programs through schools • Local food banks

Area of Need	Program, Initiative, or Other Resource
Housing and homelessness	• Cocoon House • Millennia Ministries
Latino/a services	• Alimentando al Pueblo • Casa Latina • Community of Color Coalition • El Centro de La Raza • Familias Unidas Latino Community Resource Center • Latino Educational Training Institute • Madres de Casino Road • Mujeres con Actitud Latina • Snohomish County Latino Coalition • WAGRO Foundation
Recreation	• Gyms • Parks

FINDINGS FROM STAKEHOLDER INTERVIEWS

Community Strengths

The interviewer asked stakeholders to share one of the strengths they see in the community and discuss how we can leverage these community strengths to address community needs. This is an important question because all communities have strengths. While a CHNA is primarily used to identify gaps in services and challenges, we also want to ensure that we highlight and leverage the community strengths that already exist. The following strengths emerged as themes:

Resilient and engaged community members

Stakeholders identified the community members of Snohomish County as the greatest strength. They described the people they serve as resilient, resourceful, and strong. They spoke to refugees, people experiencing homelessness, and mothers as working hard to care for their families and themselves. Additionally, people support one another and have strong relationships. People share resources by word of mouth, and they step up to care for others in times of crisis.

Organizations with trusted community relationships

Stakeholders described the community organizations in Snohomish County as being trusted resources to meet local needs. Community members know who they can turn to for support. Organizations prioritize collaborating with one another to build upon these relationships with the community and ensure they can better meet the needs.

Unmet Health-Related Needs

Stakeholders were asked to identify their top five health-related needs in the community. Four needs were prioritized by most stakeholders. Two additional needs were categorized as medium priority. Stakeholders were most concerned about the following health-related needs:

1. Mental health
2. Homelessness and housing instability
3. Economic insecurity, education, and job skills
4. Access to health care services

1. Mental health

Stakeholders emphasized mental health is a critical component of people's overall health and was identified by almost every participant as a priority need. They spoke to a need for improved access to mental health services in the community, including more providers, particularly those that accept Medicaid and sliding fee scales.

Staffing shortages have contributed to challenges accessing appointments for patients. Improving and supporting the professional development and pipeline of more mental health professionals will be important in ensuring the workforce can meet the demand, as capacity is a current issue. Cost of care and transportation were also noted as barriers for people getting care. Stakeholders spoke specifically to the mental health needs of the following populations:

- Young people: Stakeholders noted rising cases of suicide, depression, and anxiety. They shared seeing more behavioral issues during the COVID-19 pandemic and a need for more mental health services in schools. They also shared wanting to see more educational opportunities that teach children how to express their feelings.
- Older adults: This population may also be experiencing increased mental health needs as a result of social isolation throughout the COVID-19 pandemic. Senior centers are reporting more mental health challenges and concerns related to suicide.
- Families with low incomes: Stakeholders shared that financial challenges contribute to stress for the entire family. Children pick up on their parents' stress related to bills and other issues, negatively affecting everyone's mental health.

Stakeholders spoke to Black, Brown, Indigenous, and People of Color (BBIPOC) communities experiencing racism, negatively affecting mental health. Immigrant communities may be missing family that are in other parts of the world, making building community challenging. Stakeholders emphasized the importance of making immigrants and refugees feel welcome and like they belong.

Stakeholders shared there is a need for more culturally responsive and linguistically appropriate care. Receiving care that lacks respect, compassion, and cultural sensitivity can worsen people's feelings of isolation and depression. Mental health services need to consider and acknowledge people's primary language and cultural identity. Stakeholders would like to see more intentional mental health programs specifically designed to support the Latino/a community and Indigenous Peoples of America.

The COVID-19 pandemic has negatively affected many people's mental health. Isolation, financial stressors, job loss, routine disruption, and more contributed to stress, depression, and anxiety. Stakeholders were particularly concerned about the effects on young people. On a positive note, more people have been talking about mental health and normalizing these conversations, which stakeholders saw as an important step.

2. Homelessness and housing instability

Stakeholders spoke to housing as a foundational need, noting people must first be safe and stably housed before addressing other needs. Meeting people's basic need for shelter can relieve a lot of stress.

They shared the cost of housing is high and only increasing. People's incomes are not keeping up with the high cost of housing, emphasizing the need for people to be paid a living wage. Stakeholders were concerned that people with low incomes have few high-quality housing options, noting there are not a lot of rentals available. This may force families to move north to other areas where rent may be cheaper, but farther from their jobs, contributing to transportation challenges. The high cost of housing can also lead to overcrowded housing, meaning people have little privacy and poor-quality living conditions.

Community members noted it can be challenging and time consuming to get rental support, and there are few supports for mixed status families (those with a combination of immigration statuses). People with poor credit scores may also need support securing a rental. Stakeholders were concerned that the number of people experiencing homelessness in Snohomish County is increasing. They spoke to a need for more support for families experiencing homelessness as they can often feel unseen. There is also a need for increased hygiene services, including bathrooms and showers.

The COVID-19 eviction moratorium's ending has led to families being evicted and there is little legal help available due to the high demand.

3. Economic insecurity, education, and job skills

Stakeholders shared the importance of ensuring families are financially stable and have living wage job opportunities to meet their other needs. Particularly in households with only one working adult, people may need to make spending tradeoffs. These spending tradeoffs might be paying the rent and foregoing healthy food options, which contributes to diabetes and other chronic conditions. When families are financially unstable, it is hard to think about the future because surviving the current state has to take priority. Economic security is foundational; when people are financial stable, they can take care of their other needs.

Due to the "benefits cliff" people may make too much money to qualify for assistance programs, but not enough to pay for their basic needs, like childcare. People might get a small raise and then lose their benefits, leading some people to turn down those opportunities.

Economic insecurity disproportionately affects BBIPOC communities, with stakeholders and listening session participants noting the importance of programs to support communities in closing the income gap and to improve financial literacy. They also noted the importance of potential employers valuing lived experience when hiring. Due to racism, BBIPOC communities may be in jobs that do not pay a living wage or lack good benefits. People may also be forced to leave their jobs because of the racism and trauma they experience in the work environment. Stakeholders emphasized investing in career preparation and mentorship for young people to move into vocational training programs and for adults to gain new skills. This may be especially important for refugees, immigrants, and people involved in the criminal legal system.

They also discussed the importance of educational opportunities, providing families support to help them navigate their child's school system and for adults seeking higher education. BBIPOC families, particularly Latino/a parents in some schools, may need support and assistance advocating for their child and navigating the school system. This can be particularly challenging when staffing in the schools does not reflect the community.

The COVID-19 pandemic has highlighted that BBIPOC community members are overrepresented in essential worker roles, meaning many were required to continue working in person, risking their health and safety to meet their economic needs. Some people lost their jobs or hours at the start of the pandemic and others were forced to stay home due to caregiving responsibilities. Many families were financially affected by the pandemic, contributing to more stress.

4. Access to health care services

Stakeholders noted navigating the health care system can be challenging and intimidating for many patients. They spoke to the following barriers as preventing people from easily accessing timely and responsive health care services:

- Frequent provider changes: Stakeholders spoke to the importance of providers building consistent relationships with patients, which fosters trust. Patients may feel frustrated explaining their needs and concerns multiple times. Particularly for Latino/a patients, relationships are central to building trust and are highly valued.
- Racism: Providers may make assumptions about a patient based on how they look, and implicit bias may affect their caregiving. Health care needs to consider how racism effects the care and treatment of BBIPOC patients, ultimately effecting their health outcomes and contributing to health disparities. Racism also deteriorates people's health. Having more BBIPOC providers is important. When patients feel uncomfortable or unsafe with providers, they may not share their concerns or seek preventive care, waiting until it becomes an emergency. Stakeholders shared stories of Black patients not being treated with the same dignity and respect as other patients.
- Health literacy: Navigating the complexities of the health care system is difficult and can be intimidating. It is especially challenging for people coming from different countries and cultures who may not be familiar with how the United States health system and insurance function. Providing navigation support in community-based settings is important.
- Language: Patients have a right to receive care in their preferred language. Ensuring access to interpreters is good, but there is a need for more bilingual providers who can communicate directly with patients. Stakeholders shared there is a particular need to support interpretation services for patients that speak Indigenous languages from Mexico.
- Transportation: Transportation can be a barrier to getting to medical appointments, particularly for people without reliable transportation. Patients may have to take multiple buses to get to an appointment, taking a lot of their time.
- Cost of care: People may not be able to afford the cost of care, even with insurance. They may be afraid to seek care for fear of receiving a bill they cannot afford.

Stakeholders spoke to a need for more bilingual and bicultural providers for patients that speak Spanish and other languages to ensure patients receive culturally responsive and linguistically appropriate care. Having providers that understand other cultures and traditions is important. For the Latino/a community, traditional medicine, including the use of herbs and remedies, can be an important part of their health.

Stakeholders discussed the additional barriers to care for immigrant and refugee populations. Within mixed status families, all members may not have access to health insurance, leading to fear accessing preventive health services. This can mean people wait until they are in crisis to seek emergency care. For some immigrant families, seeking care can bring up fear related to documentation status.

Stakeholders also discussed the specific health care needs of patients living unsheltered. They shared a need for more respite and hospice services for this population.

The COVID-19 pandemic highlighted the lack of trust some BBIPOC communities have in health care systems and the challenges in accessing care.

Medium Priority Unmet Health-Related Needs

Two additional needs were often prioritized by stakeholders:

5. Racism and discrimination
6. Affordable childcare and preschools

5. Racism and discrimination

Stakeholders spoke to the harmful effects of racism on BBIPOC communities, noting how racism contributes to poor physical and mental health, food insecurity, housing instability, and more. They shared that when addressing any need, the effects of racism and social inequities need to be addressed. They shared concern for BBIPOC young people not being made to feel welcome in school and being bullied. They specifically discussed concerns about immigrant and refugee children being treated poorly for their English skills, clothing, culture, and more. There were concerns about Latino/a children experiencing racism in school, making them feel as if they do not belong in the community.

In health care, stakeholders spoke to the concerns of BBIPOC patients being frequently dismissed, for example Black people's pain concerns being minimized. They shared stories of providers not taking concerns seriously until the issue became an emergency. They spoke to BBIPOC people experiencing daily racism and harm in their workplaces and schools, contributing to chronic stress. Chronic stress from racism can contribute to chronic illnesses and poor health outcomes. To address some of this chronic stress and the resulting mental health needs, stakeholders emphasized the importance of holding space for people to support one another through community. Racism also contributes to inequitable access of healthy food, with BBIPOC communities often having less access to affordable, fresh foods due to structural inequities.

Stakeholders shared there is a need for improved representation in local efforts, sharing they want to see more BBIPOC leaders from within the community leading efforts to address community needs. They emphasized local efforts need to do better and avoid tokenizing BBIPOC communities. They also want the voices of BBIPOC community members to be centered in conversation about BBIPOC communities. Institutions should engage these voices in decision-making spaces. Stakeholders discussed the importance of community members knowing one another and building empathy for their neighbors. They suggested more community-building opportunities to help build understanding.

6. Affordable childcare and preschools

Stakeholders shared there is a deep need in the community for more affordable childcare, which will allow families to meet many of their other needs. They noted that this need has become even more apparent during the pandemic and causes a lot of stress on families. For some people, childcare costs more than what they are paid, forcing families to make difficult decision.

Childcare hours may not meet families' needs if they work outside of traditional hours. For example, some families may need childcare services very early in the day or late at night. The current childcare

model may not work for some cultures who prefer to leave their child with a trusted family member or friend, although this may not always be a reimbursable form of care. Families may not feel comfortable leaving their child with a stranger. Staffing challenges in childcare may also result from staff being underpaid. There is a need for more spots in programs like Head Start and the Early Childhood Education and Assistance Program (ECEAP), which make a huge difference in a child's education. As a result of the pandemic, educators are reporting seeing less kindergarten readiness.

Community Stakeholders: Opportunities to Work Together

Participants were asked, "What suggestions do you have for organizations to work together to provide better services and improve the overall health of your community?" Stakeholders shared the following opportunities:

- Avoid territorialism and siloed work: Stakeholders emphasized the importance of recognizing the benefits of working together rather than competing or working in a silo. This helps prevent duplication of services and ultimately will mean better services for community members.
- Invest time and resources into formal collaborations: They shared the benefits of ensuring there is a strategic plan in place for collaborations that outlines roles and responsibilities.
- Ensure organizations are listening to the community and build on trusted relationships: Certain organizations may have trusted relationships already established with specific populations. Organizations that are trying to connect with these specific populations should collaborate with organizations that already have relationships. Importantly, engaging with community should involve listening to people with lived experience and letting them lead identifying solutions.
- Listen and learn from one another: Often organizations may not fully understand the services provided by another organization or what opportunities for collaboration exist. Stakeholders suggested more opportunities to come together to listen to and learn form one another. They would like to see more sharing of information.

LIMITATIONS

While stakeholders and listening sessions participants were intentionally recruited from a variety of organizations, some selection bias is possible. Multiple interviewers conducted the session, which may affect the consistency in how the questions were asked. Multiple note-takers affected the consistency of notes across different listening sessions. Two of the stakeholders provided their feedback in written format, rather than in an oral interview. The analysis was completed by only one analyst and is therefore subject to influence by the analyst's unique identities and experiences.

Appendix 3: Community Resources Available to Address Significant Health Needs

PRMCE cannot address all the significant community health needs by working alone. Improving community health requires collaboration among community stakeholders and with community engagement. Outlined below is a list of community resources potentially available to address access to health care, housing/homelessness, mental health, and equity as the identified community needs.

This is not a comprehensive list of all available resources. Refer to Community Services Database | LiveWellLocal | PIHC Hub for a list of local assets that support and enhance the quality of life for the community.

Table 39. Potentially Available Resources

(By listing an organization in this table, it does not imply that Providence endorses the products/services they offer).

Organization or Program	Description of services offered	Address	Significant Health Need			
			Housing	Mental Health	Access to HC	Equity
Alcoholics Anonymous	Alcoholism treatment program and support group	1625 Marine View Dr, Everett		x		
Bridgeways	Services that promote quality of life for individuals living with mental illness	5801 23rd Drive W., Everett	x			x
Cascade Valley Hospital, Skagit Regional Health	Inpatient and outpatient medical services	330 S. Stillaguamish Ave, Arlington			x	
Catholic Community Services	Chronically homeless housing, child, youth and family services, addiction recovery, mental health, services for seniors and people with disabilities	1918 Everett Ave, Everett	x	x	x	x
Cocoon House	Provides short- and long-term housing to young people experiencing homelessness and their children.	3530 Colby Ave, Everett	x	x		x
Communities of Color Coalition	educating and advocating for social justice and human rights, especially for people of color and other under-represented groups	23931 Hwy 99, Edmonds				x
Community Health Center of Snohomish County	Community medical, dental, and behavioral health provider focusing on serving underinsured and uninsured	Various		x	x	
Compass Health	Provides mental and chemical dependency services to all ages, income levels and ethnic cultures	Various		x		
Domestic Violence Services	Emergency shelter, legal advocacy, support for those impacted by DV	PO Box 7, Everett	x	x		
Everett Area Narcotics Anonymous	Support group	3606 Rockefeller Ave., Everett		x		

Organization or Program	Description of services offered	Address	Significant Health Need			
			Housing	Mental Health	Access to HC	Equity
Everett Gospel Mission	Food, shelter for men, women and children who are experiencing homelessness	2222 52nd St SE, Everett	x			
Evergreen Health Monroe	Inpatient and outpatient medical services	14701 179th Ave SE, Monroe		X	x	
Fairfax	Inpatient facility in Everett, Monroe, and Kirkland	Everett		x		
Habitat for Humanity	Affordable home building for low-income	16929 Hwy 99, Lynnwood	x			
Housing Hope, Hope Works Social Enterprise	Promotes and provides affordable housing and tailored services to reduce homelessness and poverty	3331 Broadway, Everett	x			x
Interfaith Family Shelter	Services for families experiencing poverty and homelessness	2520 Cedar Street, Everett	x			
Millennia Ministries	Crisis, transition, and permanent housing and food to help end homelessness	3426 Broadway, Everett	X			x
Mercy Watch	Serve those on the streets with addiction, mental health crisis, social needs, etc.	PO Box 1550, Mukilteo	x	x	x	x
NAACP Snohomish County	Ensure the political, educational, social, and economic equality of rights for all persons	PO Box 5676, Everett				x
Pacific Islander Community Association	Social services agency focusing on the AAPI community	33710 9th Ave S., Federal Way, WA				x
Peoria Home	Long-term secure housing with support services for women with a history of sex trafficking, prostitution, and chemical dependency	3331 Broadway, Everett	x	x		x
Project SEACH	Program supporting students with developmental disabilities and delays to receive job training skills to help them find meaningful employment after graduation.	Various				x
Refugee and Immigrant Services Northwest	Assistance to newly arrived refugees and immigrants to rebuild lives and become self-sufficient	2000 Tower Street, Everett	x			x
Safe Harbor Free Clinic	Free medical care to individuals and families without insurance or underinsured	7209 265th St NW, Stanwood			x	
School Districts – Washington Kids in Transition	Resources for students and families in the school districts that are experiencing homelessness	Various	x			
Sea Mar	In-office and school-based services for mental health, chemical dependency,	Various locations		x	x	x

Organization or Program	Description of services offered	Address	Significant Health Need			
			Housing	Mental Health	Access to HC	Equity
	primary care, educating health care providers					
Shag	Senior living housing, housing assistance	Various	x			
Smokey Point Behavioral Health	Inpatient and outpatient psychiatric care	Marysville	x			
Snohomish County Latino Association	Advocacy for Hispanic, Latino, Latinx community through empowerment, unification, equity, inclusion, and accountability					x
Swedish Edmonds	Inpatient and outpatient medical care	21601 76th Ave W., Edmonds			x	
The Everett Clinic	Primary and specialty medical care	Various			x	
United Way	Social service agency removing barriers to help families escape poverty, committed to equity	3120 McDougall Ave, Everett				x
Volunteers of America	Food, shelter, housing, outreach, counseling, dispute resolution, referrals for mental health professionals, community resource centers	2802 Broadway, Everett	x	x		x
WAGRO Foundation	Social service agency connecting opportunities for the Latinx community	16825 48th Ave. W, Lynnwood				x
WA State Department of Social and Health Services	Aged, blind, disabled assistance programs and referrals to Housing and Essential Needs program	Various	x			x
Washington State University	Medical school program located in Everett	915 N Broadway, Everett			x	
Western WA Medical Group	Primary and specialty medical care	Various			x	
YMCA of Snohomish County	Social service organization committed to strengthening community by improving health and well-being of people of all ages.	Various	x			x
YWCA Pathways for Women	Safe haven for single women and mothers with children seeking affordable and safe housing	6027 208th St SW, Lynnwood	x			

Appendix 4: CHNA Committees and Governance Committees

CHNA ADVISORY COMMITTEE

The CHNA Advisory Committee has accountability for guiding the development of the CHNA, evaluating qualitative and quantitative date, ranking, prioritizing, and selecting the significant health needs of the Snohomish County community. The committee has representation from a cross section of the community.

Table 40. CHNA Advisory Committee

Name	Title	Organization	Sector
Alcorta, Dora	Outreach Director	St. Mary Magdalen Parish	Faith community
Altamirano-Crosby, Julieta	Executive Director Council Member	WAGRO Foundation and Lynnwood City Council	Social services focusing on BBIPOC community. Government
Bai, Amelia	Director, Community services	Pacific Islander Community Association	Social services focusing on AAPI community
Carson, Sr. Maribeth	Sister Representative, Sister of Providence	Providence	Faith community
Clay, Kevin MD	Physician, retired	Community member	Health care
Dinh-Kuno, Van	Executive Director	Refugee & Immigrant Services Northwest	Social services focusing on refugee and immigrant community
Drewel, Bob	Retired executive	Community Member	Government and education
Greene, Janice	President	NAACP of Snohomish County	Social services focusing on BBIPOC community
Harkins, Pam	Retired, human resource executive	Community member	Human resources
Leach, Bob	Retired, financial advisor	Community member	Banking
Schmutz, Steve	President	Archbishop Murphy High School	Education
Vandree, John MD	Retired physician	Community member	Health care
Whitehead, Carol	Retired public school superintendent	Community member	Education

CHNA OVERSIGHT COMMITTEE

The CHNA Oversight Committee has accountability to lead the process and development of the CHNA and CHIP.

Table 41. CHNA Oversight Committee

Name	Title
Burt, Jessica	Director Equity & Caregiver Well-Being, Providence Institute for a Healthier Community
Forslund, Scott	Executive Director, Providence Institute for a Healthier Community
Carrington, Kristy	Chief Executive, Providence Swedish North Puget Sound (effective September 2022)
Nichols, Patty	Program Manager, Providence Institute for a Healthier Community
Okazaki, DeAnne	Director Administrative Programs, Providence Regional Medical Center Everett

Name	Title
Redick, Darren	Chief Executive, Providence Swedish North Puget Sound (through August 2022)
Stueve, Barry	Chief Mission Officer, Providence Swedish North Puget Sound

PROVIDENCE EVERETT COMMUNITY MISSION BOARD

The Providence Everett Community Mission Board serves as the governing body for PRMCE. The board committee membership includes community members who represent a broad cross-section of the community. The committee meets every other month with the goal of ensuring the Providence Mission, core values and vision are integrated throughout the northwest Washington region of Providence. The board approves the final CHNA/CHIP but delegates responsibility for the development process to the Providence Institute for Healthier Communities Strategic Oversight Council.

Table 42. Community Mission Board

Name	Title
Adams, Christopher	Attorney, Adams & Duncan Law Firm
Allen PhD, David	Retired university professor
Anderson, Sylvia	Chief Executive Officer, Everett Gospel Mission
Carson, Sr. Maribeth	Sister Representative, Sisters of Providence
Dinh-Kuno, Van	Executive Director, Refugee & Immigrant Services Northwest
Duffy, Mark	President & CEO, Mountain Pacific Bank
Hansen MD, Sarah	Physician, North Sound Emergency Medicine
Harkins, Pam	Retired human resource executive
Johndrow, Shanley	VP Client Services, Retirement Plan Services
Kahn MD, Barry	President, CellNetix Pathology & Laboratories
Leach, Daniel	Sr. Vice President, DA Davidson
Liu MD, Brandon	Physician, Radia Inc.
Ohl, Anthony	Financial Advisor, Edward Jones
Petkus, Edward	Retired airplane engineer and executive
Pitre PhD, Paul	Chancellor, Washington State University Everett campus
Rogers MD, Cliff	Physician, The Everett Clinic
Scott, Philip	Retired executive
Shea, Rick	Chief Executive Officer, Sterifre Medical, Inc.
White, Sharron	President, Providence General Children's Association
Whitehead, Carol	Retired public school superintendent

PROVIDENCE EVERETT EXECUTIVE LEADERSHIP TEAM

The PRMCE executive leadership team has accountability for the ongoing planning, budgeting, and implementation of community benefit activities, and selecting the community health need priorities that Providence will focus on.

Table 43. Providence Regional Medical Center Everett Executive Leadership Team

Name	Title
Alvarez, Kaila	Manager, Diversity, Equity & Inclusion

Name	Title
Calamusa, Casey	Director, Communications
Campbell, Steve MD	Chief Medical Officer, PMG
Carrington, Kristy	Chief Executive (effective September 2022)
Combs, Scott	Chief Financial Officer
Cook, James MD	Chief Medical Officer
Gaffney, Michael	Executive Director Operations
Gilson, Tina	Chief Philanthropy Officer
Holbrook, Janine	Chief Nursing Officer
Lewin, Maurice	Chief Human Resource Officer
Okazaki, DeAnne	Director, Administrative Programs
Parikh, Mitesh	Chief Operating Officer, PMG
Peterson, Jason	Executive Director, Strategy and Business Development
Redick, Darren	Chief Executive (through August 2022)
Stueve, Barry	Chief Mission Officer

Appendix 5: Community Health & Well Being Monitor™ survey

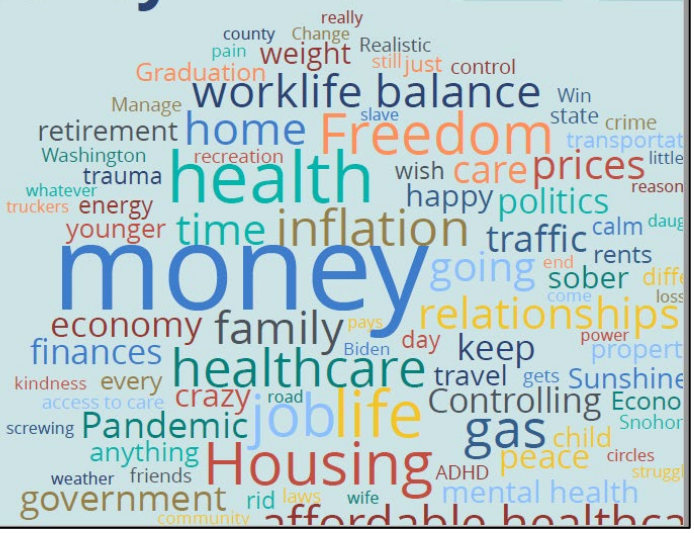
Health & Well-being Monitor 2022 Results Report for Snohomish County

With SnoCo 2021 and SnoCo 2020 Benchmark Results

Prepared for:

Prepared by:

PROVIDENCE
Institute for a Healthier Community



How Your Results are Organized

Your results for Anchorage 2021 are organized into three parts:

1. **Part I: Summary Results & Six Dimensions Roadmap**
2. **Part II: Key Findings**
   - Your Core4™ Well-being Index Score
   - Your HWBM Composite Measure™ (the "Speedo")
   - "One More Thing": Your Respondents' Wishes for Health
   - Your Cantril's Ladder well-being score
3. **Part III: Detailed Results**
   - Charts, graphs and highlights for each indicator, organized into Six Dimensions of Health
   - Index to Results of your Tailored Questions (reported in the relevant Six Dimensions section.)

Appendices: Here you will find a summary of the Survey Methodology.Verbatims of open-ended questions available upon request.

3 Health & Well-being Monitor | Anchorage 2021

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Welcome.

Congratulations on taking this next step on the journey to assess and enhance the health and well-being of the Snohomish County community! Your 2022 Health & Well-being Monitor™ provides a snapshot of your community's health and well-being – perceptions, satisfaction, and behaviors, related to Six Dimensions of Health™ that resonate with your community because they were affirmed by your community.

Having this survey data reveals your health and well-being strengths, along with opportunities for improvement. Accompanying 2021 and 2020 benchmarks throughout your report add context to your HWBM results.

Most importantly, the Providence Institute for a Healthier Community is honored to join you on your journey to better community health. It is our greatest hope that this report supports your efforts to set community health improvement priorities that enhance the overall health and well-being of the Snohomish County community.

At A Glance

Your Community Health & Well-being Monitor™ Report provides:

1. A snapshot of your community's overall health and well-being
2. Benchmark data to contextualize your results
3. Insights into focus areas for improvement
4. A way to monitor progress over time, with subsequent Health & Well-being Monitors.

Thank you for forging a healthier community together

On behalf of the entire Institute team, thank you for your commitment to the health and well-being of our communities. You join a broad array of organizations building this work together over more than a half-decade. Your report, along with all the work of the Providence Institute for a Healthier Community, is organized around Six Dimensions of Health™ and well-being, based on foundational work of the Institute in community-based participatory research in 2015, listening to and learning how communities define health and well-being.

You are making history

The original research drew on insights from 130 community members from organizations as diverse as Familias Unidas, Native peoples, the NAACP, Minority Achievers Program alums, low-income housing residents, university students, YMCA members, faith leaders; street interviews; conventional focus groups of different ages, income and geography and more.

The original question was simple: how do you define health and well-being? The wisdom of our community was energizing. In that qualitative work, combined with literature review, 24 common attributes emerged. We tested the model in a regional January 2016 survey fielded by Elway Research, augmented by nationally validated questions. Factor analysis of those 24 attributes revealed natural groupings into Six Dimensions of Health™ faithful to the voice of the community. Because that is how communities define wellbeing, so do we: we have organized everything we do around those Six Dimensions ever since.

Since 2016, more than 12,000 people have participated in the Institute's regional and Community Health & Well-being Monitor studies, yielding a growing body of research data including under-represented populations unlikely to be included in conventional research, along with innovations in community-based fielding techniques. Your efforts serve not only you -- you are 'paying it forward' even as you benefit from insights that rely upon those who came before you.

Your 2022 results are a blueprint for action

Your 2022 Health & Well-being Monitor relies on three years of robust sampling of residents of Snohomish County. This is the most comprehensive, community-based study of well-being of its kind for Providence. We believe your data provide powerful insights for planning and prioritizing.

Our entire Institute team thanks you for your commitment to community well-being. Now--let's get to your results!

In good health.

Scott Forslund
Executive Director
Providence Institute for a Healthier Community

How Your Results are Organized

Your results are organized into four parts:

Part I: Executive Summary & Six Dimensions Roadmap

- What Your Community is Telling You - key insights
- What Your Community Can Flourish - strategies ***already shown to be responsible*** for the greatest differences in your Core4 Well-being Index score.
- Your Well-being Dashboard

Part II: Key Findings

- Your Core4™ Well-being Index Score
- Your HWBM Composite Measure™ (the "Speedo")
- "One More Thing": Your Respondents' Wishes for Health
- "Can-Do" scores -- your community's capacity to improve
- Your Cantril's Ladder well-being score

Part III: Detailed Results

- Charts, graphs and highlights of 40 well-being indicators, organized by the Six Dimensions of Health
- Results of your Tailored Questions

Part IV: Appendices:

- A summary of the Survey Methodology. Respondent profile and weightings. Verbatims of open-ended questions upon request.

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Things to Keep in Mind

- **Listen to and support your community.** Well-being is individual and communal. ***These results belong to your community*** and reflect its collective voice. Your community, not you, must interpret *their* results and do *their* work, with *your* support. To discern full meaning & where to go next:
  1. ***Share these results*** with your community (Need ideas on how? We can help.)
  2. ***Ask for and listen to what resonates***
  3. ***Set priorities together***
  4. ***Pledge to remove barriers*** to *their* success.
- **It All Matters:** look at the data, but remember a start anywhere is a step towards better overall health &well-being.
- **Tune In to Heart & Soul:** what are your communities' interests, priorities, values? They matter.
- **Start Small:** Is there an easy 'win'? Build confidence and self-efficacy - 'We Can Do This.'
- **Assess Resources:** Have enough people, time, money or other supports? Supports ensure success.

Each Dimension of your community's health influences, impacts, & contributes to other Dimensions and overall well-being. Well-being is dynamic.

Six Dimensions of Health

Well-being is broad definition addressing many attributes—happiness, health, stability, purpose and meaning. Health is multi-dimensional. Your Community HWBM Report represents six dimensions of well-being that resonated with communities like yours. A spirit of learning, and growing in each of these dimensions is important if we are to feel fulfilled and whole as individuals and communities, both in the absence and presence of disease!

- Relationships & Social Connections
- Mental, Emotional & Spiritual Health
- Neighborhood & Environment
- Work, Learning & Growth
- Security and Basic Needs
- Physical Health

Isolation is fatal, according to psychiatrists Jacqueline Olds and Richard Schwartz. Their decades of research support the idea that a lack of relationships can cause multiple problems with physical, emotional, and spiritual health.

Executive Summary

What Your Community is Telling You
How Your Community Can Flourish
Your Well-being Dashboard
Your Six Dimensions of Health Roadmap

What Your Community is Telling You

Key Findings

1. **Overall well-being is down versus 2021**
   - Well-being improved in 2021 after the 2020 start of the pandemic, but has decreased, potentially reflecting COVID fatigue among community members.
2. **Individual capacity to change is also down**
   - Community members also report less ability to impact community decisions than in prior years.
3. **There is room to improve in all dimensions**
   - There are areas across all 6 dimensions of well-being where improvements can be made.

Relationships & Social Connections

- Personal relationships have remained relatively strong and stable over the course of the pandemic.
- Community connections have suffered, however, with a slight, yet clear, decline in how strongly residents feel they are part of or can influence their communities.
- The number experiencing discrimination is up, but the frequency one experiences discrimination experienced is down.

Mental & Emotional Health

- Emotional Health was down after improving in 2021, following year 1 of the pandemic.
- The number of days spent dealing with mental and debilitating health challenges continued to trend up.
- Religion and spirituality have lost salience.

Neighborhood and Environment

- Community satisfaction with neighborhoods has decreased, with more residents rating their neighborhood low (0-6 on a 10-point scale) than in prior years.
- Consumption of fresh fruits and vegetables is also at a low point.
- Exercise has remained relatively stable, but lags CDC recommendations.

Work, Learning & Growth

- Work satisfaction is down versus last year, and more similar to 2020.
- Perceived opportunities for learning and growth are down.
- Job insecurity continues to be a problem for more than 1 in 10 residents.

Security & Basic Needs

- Fewer are financially secure than in 2021, similar to the number of insecure in 2020 (the beginning of the COVID 19 pandemic)
- Likewise, the ability to meet basic needs is down. Nearly half of residents are meeting basic needs at a high level -- this is significantly fewer than did so in 2021 and 2020.
- Health insurance remains nearly universal, but fewer are able to get medical care or information.

Physical Health

- The state of community physical health continues to need improvement: a third of residents in 2022 rated their physical health as low.
- The average number who spend at least 1 day in poor physical health per month has been on the rise. Nearly half also experienced at least one debilitating health day per month.
- Consumption of fresh fruits and vegetable, and regular exercise and sleep lag CDC guidelines.

How Our Community Can Flourish

The good news: Improvements in multiple Dimensions of Health can exert a powerful influence on community's well-being.

Better news: These are inter-related. Improvement in any Dimension contributes to overall wellbeing *and* is likely to positively influence other areas as well.

xx% *The battery depicts the potential power of investing in each area, based on how each impacts your community's Core4 ratings.*

Mental & Emotional Health

73%

- **most influential determinant** of overall well-being.
- help develop a **sense of purpose and meaning**,
- encourage **growing relationships with other people**
- provide **opportunities for learning and growth**

Physical Health

59%

- **2nd most influential**
- Most influenced by **daily exercise**.
- Also, strongly related **emotional well-being** and a **sense of purpose and meaning** and **a good job**

Relationships & Social Connections

55%

- strong predictor of **overall emotional well-being**.
- help residents **feel like part of a community/belonging**
- ensure that resident's **basic needs are met**

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How Our Community Can Flourish

The good news: Improvements in multiple Dimensions of Health can exert a powerful influence on community's well-being.

Better news: These are inter-related. Improvement in any Dimension contributes to overall wellbeing *and* is likely to positively influence other areas as well.

xx% *The battery depicts the potential power of investing in each area, based on how each impacts your community's Core4 ratings.*

Work, Learning & Growth

52%

- **Opportunities for learning and growth** is influential to many areas of well-being, including
- **emotional, physical health**, and **basic needs**.
- assure residents have access to **options to further their self-development** and **find good jobs**.

Security & Basic Needs

45%

- **Financial security** has a strong influence on overall well-being and a person's ability to meet basic needs, in additions to;
- **Access to medical care and health information**
- Support **access to good jobs**

Neighborhood and Environment

31%

- key role in **overall well-being**, and
- **ability to build and foster relationships with others.**
- Promote neighborhood culture where **children and seniors alike feel welcome and safe**

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2022 Well-being Dashboard

SCORE KEY

Above prior year
At prior year
Below prior year

Your Engagement Results

SAMPLE FRAME: Snohomish County zip codes
SAMPLE SIZE: Year 3: 536 / May-June 2022
- Year 2: SnoCo 2021, 583 responses
- Year 1: SnoCo 2020, 598 responses
- **Total combined sample: 1,717**

Core4 Well-being Index - Pandemic Years 1 metric, linked to Core4™ measures, with benchmarks *See page 10*		**7.07** 2022 Snohomish County "C-"	**7.28** 2021 Snohomish County "C"	**7.01** 2020 Snohomish County "C-"
CORE4™ Well-being Scores Satisfaction Indicators A catalyst for change *See page 11*	**6.97** Life Satisfaction Year 2, 2021: 7.23 Year 1, 2020: 6.84	**6.74** Physical Health Satisfaction Year 2, 2021: 6.81 Year 1, 2020: 6.74	**7.20** Mental Health Satisfaction Year 2, 2021: 7.42 Year 1, 2020: 7.06	**7.32** Overall Health Satisfaction Year 2, 2021: 7.62 Year 1, 2020: 7.38
HWBM Composite™ The distribution of your community's well-being *See page 12*	**15%** Struggling Year 2, 2021: 11% Year 1, 2020: 13%	**43%** Mixed Year 2, 2021: 46% Year 1, 2020: 47%	**32%** Doing Well Year 2, 2021: 35% Year 1, 2020: 32%	**10%** Flourishing Year 2, 2021: 9% Year 1, 2020: 8%
Your CAN-DO™ Scores Capacity & Motivation to improve: Individual and your community *See page 14*	**64%** Individual Capacity Year 2, 2021: 70% Year 1, 2020: 73%	**41%** Individual Low Motivation Year 2, 2021: 46% Year 1, 2020: 48%	**23%** Individual High Motivation Year 2, 2021: 24% Year 1, 2020: 25%	**13%** Community Efficacy Year 2, 2021: 18% Year 1, 2020: 19%

Six Dimensions Of Health™
Key Dimensions of Well-being (change vs. 2021)
Starting on page 20


Relationships & Social Connections
page 20

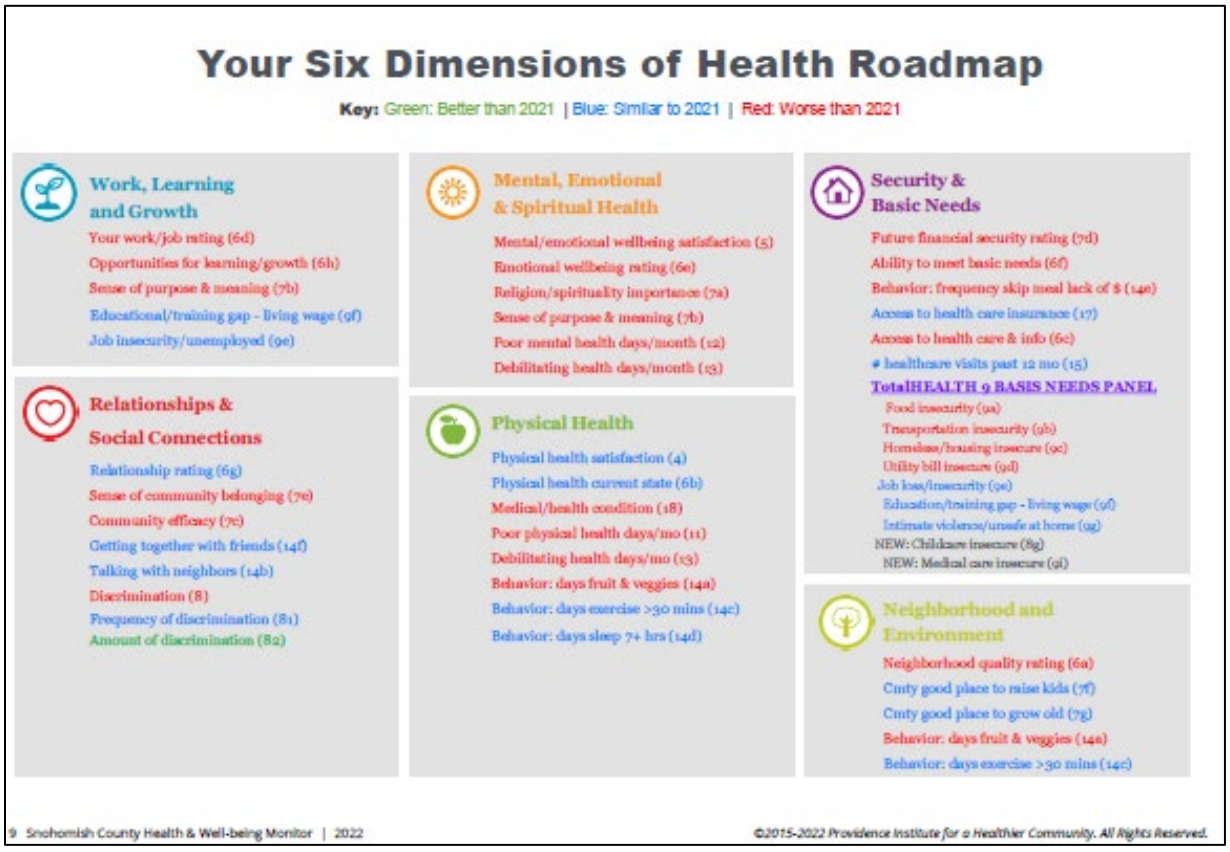

Mental, Emotional Spiritual
page 25


Neighborhood & Environment
page 29


Work, Learning & Growth
page 32


Security & Basic Needs
page 36


Physical Health
page 49


Your Six Dimensions of Health Roadmap
Key: Green: Better than 2021 | Blue: Similar to 2021 | Red: Worse than 2021
Work, Learning and Growth
Your work/job rating (6d)
Opportunities for learning/growth (6h)
Sense of purpose & meaning (7b)
Educational/training gap - living wage (9f)
Job insecurity/unemployed (9e)
Relationships & Social Connections
Relationship rating (6g)
Sense of community belonging (7e)
Community efficacy (7c)
Getting together with friends (14f)
Talking with neighbors (14b)
Discrimination (8)
Frequency of discrimination (81)
Amount of discrimination (82)
Mental, Emotional & Spiritual Health
Mental/emotional wellbeing satisfaction (5)
Emotional wellbeing rating (6e)
Religion/spirituality importance (7a)
Sense of purpose & meaning (7b)
Poor mental health days/month (12)
Debilitating health days/month (13)
Physical Health
Physical health satisfaction (4)
Physical health current state (6b)
Medical/health condition (18)
Poor physical health days/mo (11)
Debilitating health days/mo (13)
Behavior: days fruit & veggies (14a)
Behavior: days exercise >30 mins (14c)
Behavior: days sleep 7+ hrs (14d)
Security & Basic Needs
Future financial security rating (7d)
Ability to meet basic needs (6f)
Behavior: frequency skip meal lack of $ (14e)
Access to health care insurance (17)
Access to health care & info (6c)
healthcare visits past 12 mo (15)
TotalHEALTH 9 BASIS NEEDS PANEL
Food insecurity (9a)
Transportation insecurity (9b)
Homeless/housing insecure (9c)
Utility bill insecure (9d)
Job loss/insecurity (9e)
Education/training gap - living wage (9f)
Intimate violence/unsafe at home (9g)
NEW: Childcare insecure (8g)
NEW: Medical care insecure (9i)
Neighborhood and Environment
Neighborhood quality rating (6a)
Cmty good place to raise kids (7f)
Cmty good place to grow old (7g)
Behavior: days fruit & veggies (14a)
Behavior: days exercise >30 mins (14c)
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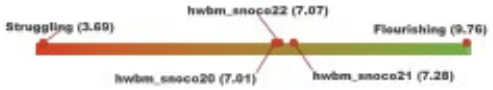
Key Findings

Core4™ Well-being Index Score
HWBM Composite Measure™
Individual & Community Can-DO™
"One More Thing": Respondents' Wish for Health
Cantril's Ladder Score

CORE4™ WELL-BEING INDEX SCORE

AVERAGES (0-10)



KEY FINDINGS

- SnoCo22 Core4 Well-being Index Score is 7.07 (a 'C').
- Among 15% who are STRUGGLING, the score was 3.7 (F). Among 10% who are FLOURISHING, the score was 9.8 (High A).
- The 2022 Index is down from 2021, falling instead to near the 2020 "pandemic year" mean.
- The level of well-being a person has is strongly correlated with his or her Core4 score, with those Struggling rating low across all dimensions, and those Flourishing rating high. This points to the importance of positive emotional, physical, and mental health, and security in basic needs, to a person's overall life satisfaction.
- Well-being also differs by demographics, health, and basic needs insecurity:
  - Generally, groups who score **LOW** across well-being measures are:
    - Women, age <55, lower income, those not employed, no college degree, singles, those in multigenerational households, BIPOC residents, those who have poor PH/MH days, and those who are insecure in basic needs.
  - Groups who score **HIGHER** include men, age 55+, those employed, incomes $100k+, couples, those with a Bachelor's degree+, couples, and Caucasians.

KEY INFLUENCES

Your Core4 Well-being Index scores were most strongly correlated with:

- Ratings of emotional well-being (.83)
- Physical health rating (.73)
- Relationships with other people (.69)
- Opportunities for learning and growth (.68)
- Work or job rating (.66)
- Security about financial future (.64)
- Number of poor mental health days / month (-.59)
- Feeling like part of a community (.58)
- Ability to meet basic needs (.56)
- Debilitating health days/month (-.55)
- Ratings of residential neighborhood (.52)
- Ratings of community as a good place to grow old (.50)
- Ratings of community as a good place to raise kids (.47)
- Access to healthcare and health info (.47)
- Ability to influence decisions being made in community (.44)

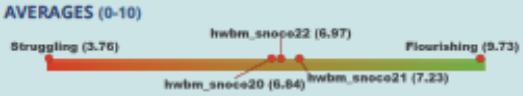
Overall well-being was weakly associated with these behaviors:

- Days with 30+ minutes of walking/exercise (.42)
- Nights with 7+ sleep hours (.35)
- Number of poor physical health days (-.34)
- Time spent with friends and family (.33)

CORE4™ WELL-BEING COMPONENT SCORES

Thinking about your overall life, are you satisfied or dissatisfied with the way things are in your life these days? (2)

AVERAGES (0-10)



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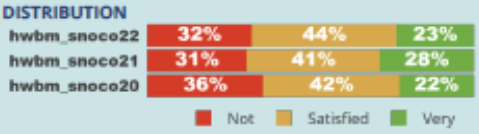
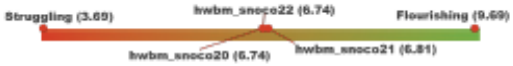


Thinking about your physical health, are you satisfied or dissatisfied with the current state of your physical health? (4)

AVERAGES (0-10)



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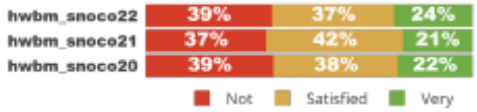
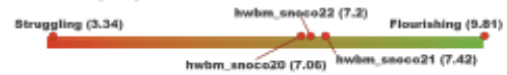


Thinking about your mental or emotional well-being, how satisfied or dissatisfied are you with the state of your mental or emotional well-being? (5)

AVERAGES (0-10)



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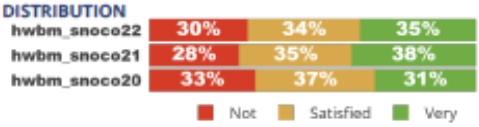
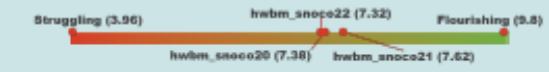
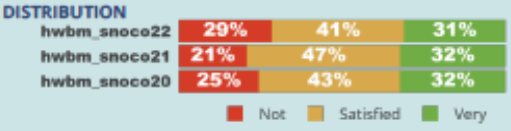


Taking everything into account, how satisfied are you with your overall well-being? (10)

AVERAGES (0-10)



DISTRIBUTION



HWBM Composite Measure™

The Core4™ Index Score provides a single measure of well-being based on four key aspects – overall life, physical, mental/emotional/spiritual, and overall well-being.

However, a calculated average does not tell the whole story. Six years of research with over 12,000 respondents has shown that many things must go well for well-being to flourish.

The HWBM Composite Measure™ is a picture of how each member of your community is doing across all four Core4 measures.

- People who are scoring highest (9-10) on all four are FLOURISHING
- Those whose scores are all positive (7-10) are DOING WELL.
- People with a mix of lower and higher scores (0-10) are MIXED.
- People whose scores are all low (0-6) are STRUGGLING.

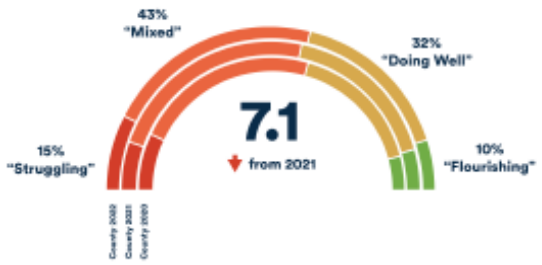
The Composite Measure categories strongly link to the Core4 Index scores as the chart at upper right shows.

Your community's Composite Measure is displayed on an arc (we call The Speedo), compared to a broader community benchmark – in this case, ***Snohomish County, Washington, in June 2021, and in June 2020***

STRUGGLING	MIXED	DOING WELL	FLOURISHING
All Low Scores (0-6)	Varied Low & High Scores (0-10)	Varied Positive Scores (7-10)	All Very High Scores (9-10)
Core4 Well-being Index Score: 3.7	Core4 Well-being Index Score: 6.7	Core4 Well-being Index Score: 8.3	Core4 Well-being Index Score: 9.8

[See page 16 for a demographic profile of each well-being level.]

2022 Snohomish County Countywide Health & Well-Being Index Score



Individual & Community Level Can-Do™

Your Can-Do™ score gives insights into your community's current CAPACITY to improve well-being and MOTIVATION to change. Capacity is the % of respondents who say they can be doing more to improve their health. Motivation is indexed by the percentage who say they can do "a little more" or "a lot more." We provide you with insights into your respondents' capacity to improve their INDIVIDUAL well-being, as well as your community's belief that it can influence well-being on a community-level. ***For a more detailed description of the Can-Do measurements, see Appendix E.***

When it comes to maintaining or improving your health, which of these statements best describes you. (16)

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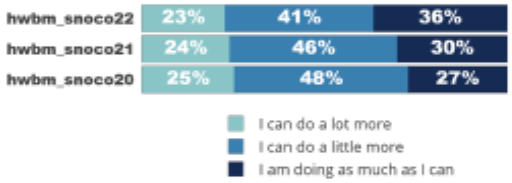

Key Findings

64% say they can do more; 36% are doing all they can.

- 2022 sees fewer who feel they can do more, compared to benchmarks.

If I made up my mind to try, I could have a significant influence on decisions being made in my community (7c)

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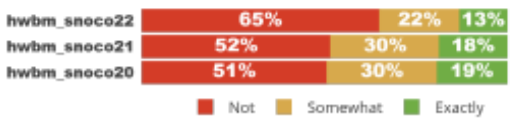


Key Findings

- 2022 is down considerably versus benchmarks, with two-thirds believing they cannot influence community decisions.
- 66% of "Exactly"=DOING WELL/FLOURISHING; 69% of "Not" = STRUGGLING/MIXED

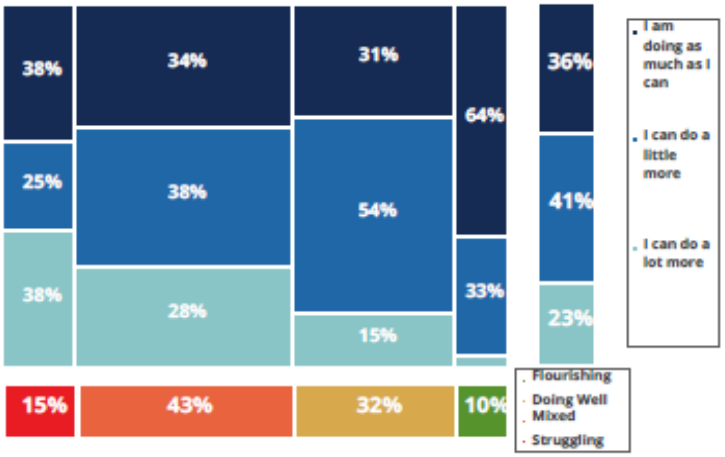
Your Can-DO™ Profile By Well-being Level

The Can-Do Grid™ reveals the capacity and motivation of your community members to improve their health at every level of well-being, from STRUGGLING to FLOURISHING

Snohomish County residents the highest capacity/motivation in the DOING WELL, MIXED, and STRUGGLING well-being segments -- where your community needs it most -- but motivation to do more is down against benchmarks in all groups except those struggling.

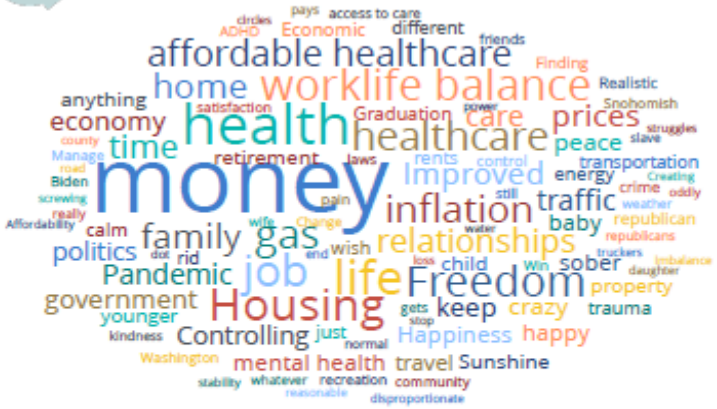
Your Can-DO grid is unfavorable to benchmarks.

- While there is high capacity to improve, all groups report less capacity to improve than in 2021 and 2020. However, significant capacity remains in the DOING WELL, MIXED, and STRUGGLING segments, who need improvement most. A brief profile of each segment follows.
- **FLOURISHING** (10%): This segment over-indexes among men, those employed, HHs with $100k+ incomes, and Caucasians. Those flourishing are less likely to have suffered discrimination, have poor mental or physical health days, or to lack basic needs.
- **DOING WELL** (32%): Those doing tend to be older people (55+), those with jobs and higher incomes, and those who are part of a couple. About half of those doing report 1 or 2 poor mental health days per month, but very few lack basic needs.
- **MIXED** (43%): This segment mirrors the population in age, gender, and income, but over-indexes among those without a 4-year college degree and among BIPOC residents. These residents are more likely to have experienced discrimination, have multiple poor physical and mental health days per month, and lack some basic needs (education, utilities).
- **STRUGGLING** (15%): Those struggling tend to be women, younger people (under age 64), who are not employed, earn less than average, and are single or who live in multigenerational homes. More than half have experienced discrimination, most have 6+ poor physical and mental health days per month, and many lack basic needs.



One Thing That Would Make Life Better

If you were to name one thing that would make your life better, what would that be? (3)



Here are key themes:

- Health & healthcare/affordable healthcare, mental health
- Money, finances, and the economy
- Happiness, freedom, and independence
- Basic needs, such as housing, job security, and transportation
- Relationships with family, friends and romantic partners, and community
- Worklife balance

Cantril's Ladder

The Cantril Self-Anchoring Scale, developed by pioneering social researcher Dr. Hadley Cantril in 1965, is a well validated and widely used measure of general well-being, including Gallup's World Poll of more than 150 countries, representing more than 98% of the world's population, and Gallup's in-depth daily poll of America's well-being (Gallup-Sharecare Well-Being Index; Harter & Gurley, 2008).

- The "Cantril's Ladder" questions correlate with multiple indicators of well-being on this survey.
- Compared to the HWBM Core4™ Index, Cantril's Ladder scores generally are not as strongly correlated with a range of health and well-being indicators.
- Inclusion of the Cantril's results adds a comparative, independent measure to your results and serves to further validate the strength of the Health & Well-being Monitor Core4™ Well-being Index and survey.
- **Based on Gallup groupings, your residents are most likely to fall at the low margin of the "THRIVING" category.**

Further description of the Cantril's Ladder Scale from Gallup follows here:
Analyses of data from different regions of the world make it clear that the general tendency is for respondents to provide more optimistic views of the next five years than the present. This is the case for respondents in most countries, with a few exceptions. Based on statistical studies of the ladder-present and ladder future scale and how each relates to other items and dimensions as outlined above, Gallup formed three distinct (and independent) groups, for summary purposes:

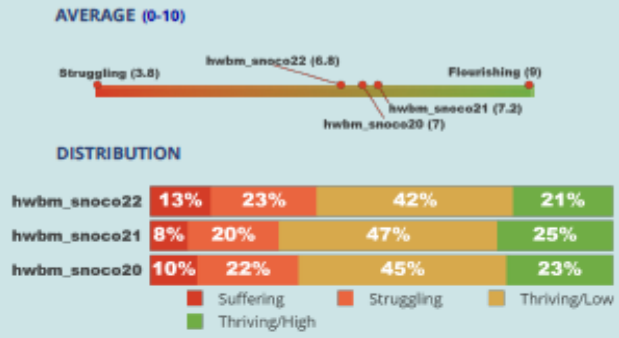
THRIVING: Well-being that is strong, consistent, and progressing. These respondents have positive views of their present life situation (7+) and have positive views of the next five years (8+). They report significantly fewer health problems, fewer sick days, less worry, stress, sadness, anger, and more happiness, enjoyment, interest, and respect.

[NOTE: Because a score of 7 is typically below the average score for communities, in this analysis we break out THRIVING further, into THRIVING/LOW (7-8 ratings) and THRIVING/HIGH (9-10 ratings).]

STRUGGLING: Well-being that is moderate or inconsistent. These respondents have moderate views of their present life situation OR moderate OR negative views of their future. They are either struggling in the present, or expect to struggle in the future. They report more daily stress and worry about money than the "thriving" respondents, and more than double the amount of sick days. They are more likely to smoke, and are less likely to eat healthy.

SUFFERING: Well-being that is at high risk. These respondents have poor ratings of their current life situation (4 and below) AND negative views of the next five years (4 and below). They are more likely to report lacking the basics of food and shelter, more likely to have physical pain, a lot of stress, worry, sadness, and anger. They have less access to health insurance and care, and more than double the disease burden, in comparison to "thriving" respondents.

Imagine a ladder with steps numbered from zero at the bottom to ten at the top. The top of the ladder represents the best possible life for you and the bottom of the ladder represents the worst possible life for you. (C1)



Key Findings

Average score: 6.8.

- Significant decline from 2021 benchmark (7.2)
- 81% with high ratings are DOING WELL/FLOURISHING; 99% who are suffering are STRUGGLING/MIXED

Who scored LOW *(frequency index, actual vs. expected)*:

Those not employed and with lower incomes (less than $50k per year) are the most of all demographic groups to score low across the Core4 index components and the Can Do measures. In addition, those who have had any poor physical, mental, or debilitating health days, those who have experienced discrimination, and those with insecurity in basic needs (*Food Insecure shown here) are also among the most likely to score low across these measures.

	Total	Women	Age 18-54	Not Employed	Income <$50k	No college degree	Singles	Multigen HH	Race: BIPOC	Discrim: Yes	1+ Poor PH Days	1+ Poor Mntl Hlth Days	1+ Debil Hlth days	Food Insecure*
Well-being segment: Struggling	15%	18%	17%	42%	33%	17%	19%	27%	11%	26%	20%	22%	25%	30%
Overall life sat LOW	25%	34%	35%	60%	55%	36%	41%	43%	39%	51%	39%	43%	47%	63%
Physical health sat LOW	24%	44%	38%	51%	56%	41%	43%	51%	34%	44%	50%	48%	52%	50%
Emotional well-being sat LOW	35%	38%	36%	53%	49%	32%	35%	48%	32%	48%	37%	45%	48%	43%
Overall well-being sat LOW	31%	30%	34%	68%	51%	34%	33%	41%	30%	48%	38%	42%	44%	63%
"Can do no more"	36%	35%	37%	51%	51%	39%	38%	43%	33%	38%	34%	29%	35%	43%
Community influence LOW	65%	65%	70%	78%	80%	71%	73%	77%	57%	76%	70%	74%	73%	80%

Who scored HIGH *(frequency index, actual vs. expected)*:

Those age 55+ and with high incomes ($100k+) are among the most likely to rate highly across the Core4 index components and Can Do measures. Men are among the most likely to score highly on satisfaction with emotional well-being.

	Total	Men	Age 55+	Employed	Income: $100k+	Bachelor's Degree+	Couples	Caucasian	Discrim: No
Well-being segment: Flourishing	10%	12%	11%	12%	16%	12%	10%	12%	14%
Overall life sat HI	32%	27%	25%	27%	31%	31%	26%	25%	28%
Physical health sat HI	39%	30%	22%	26%	28%	28%	23%	24%	24%
Emotional well-being sat HI	30%	44%	42%	39%	47%	38%	38%	39%	41%
Overall well-being sat HI	29%	36%	41%	32%	38%	38%	35%	33%	37%
"I can do a lot more"	23%	19%	19%	23%	25%	29%	22%	23%	20%
Community influence HIGH	13%	11%	11%	14%	18%	15%	16%	13%	15%

Dimension 1

Relationships & Social Connections

Healthy relationships are vital to health. Strong family ties, friendships, and partnerships can increase our sense of security, self-esteem, and belonging and provide a buffer against stress, anxiety, and depression. Low social connection is linked to declines in physical health, healing and mental health.

Overall Scores

- **13% above benchmark**
- **38% at benchmark**
- **50% below benchmark**

Key Findings

Personal relationships have remained stable over the course of the pandemic

- Since 2020, most residents report moderate to high satisfaction with their relationship with other people.
- Visits with friends and family in both 2021 and 2022 occur more frequently than they did in 2020, as the pandemic began.
- Residents have remained similarly likely to talk to their neighbors throughout the past 3 years, doing so an average of twice per week.

Community connections have suffered, however

- Since 2020, there has been a slight, yet clear, decline in how strongly residents feel they are part of a community/have a sense of belonging.
- Significantly fewer feel they could have an influence on community decisions, suggesting people feel less empowered than before.

Reported Discrimination is up

- Discrimination is up versus both 2020 and 2021, with racial and gender discrimination the most common forms.
- However, the amount of discrimination experienced is down compared to benchmarks, meaning that, while more widespread, frequency is down.

Relationships and Social Connections remain an important piece of overall well-being

- Those Flourishing score far higher across all dimensions in this category than do those Struggling
- LOW ratings tend to be more prevalent among the same groups who fall into the Mixed/Struggling segment (women, younger people, low income, not employed, singles, multigen. HH, BIPOC, basic need insecure, have poor PH/MH days)

How Your Community Can Flourish

Key Driver Analysis of your data indicates 4 strategies* can influence/explain 55% of the variation in your Core4 Well-being Index scores:

Relationships with other people are key to health and well-being and are a strong predictor of overall emotional well-being. To encourage positive relationships, promote initiatives that help residents **feel like part of a community** and ensure that resident's **basic needs are met** (a Security and Basic Needs measure).

Who scored LOW *(frequency index, actual vs. expected)*:

Those not employed, with incomes under $50,000, and who are insecure in basic needs (*Housing Insecure shown here) score lowest across RSC measures. Other groups scoring lower on some or all RSC measures include women, those age 18-54, those lacking a 4-year college degree, singles, those in multigenerational HHs, BIPOC residents, and those with poor physical or mental health days.

	Total	Women	Age 18-54	Not Employed	Income: <$50k	No college degree	Singles	Multi-gen HH	Race: BIPOC	Discrim: Yes	1+ Poor PH Days	1+ Poor Mntl Hlth Days	1+ Debil Hlth days	Housing In-secure*
Relationships with others LOW	20%	22%	25%	58%	48%	23%	23%	35%	25%	34%	27%	30%	34%	58%
Feel part of a community LOW	54%	53%	60%	76%	73%	60%	63%	78%	60%	68%	64%	67%	69%	83%
Ability to influence community LOW	65%	65%	70%	78%	80%	71%	73%	77%	57%	76%	70%	74%	73%	89%
Get together with others (0 TIMES/WK)	16%	20%	17%	28%	29%	17%	19%	26%	10%	20%	19%	20%	22%	43%
Talk with neighbors (0 TIMES/WK)	34%	36%	40%	57%	43%	35%	38%	52%	34%	47%	36%	39%	40%	55%
Experience discrimination (YES)	35%	38%	41%	55%	52%	33%	43%	49%	45%	NA	42%	42%	47%	78%

Who scored HIGH *(frequency index, actual vs. expected)*:

Community RSC is highest among those age 55+, retirees, and those with incomes $100k+. Couples, Caucasians, men, and those who have not experienced discrimination also tend to score higher on RSC measures.

	Total	Men	Age 55+	Retired	Income: $100k+	Bachelor's Degree+	Couples	Race: Caucasian	Discrim: No
Relationships with others HIGH	44%	45%	55%	53%	56%	45%	52%	46%	52%
Feel part of a community HIGH	22%	20%	26%	29%	23%	27%	28%	23%	26%
Ability to influence community HIGH	13%	11%	11%	12%	18%	16%	16%	13%	15%
Get together with others (5+ Times/Wk)	28%	31%	30%	26%	40%	26%	29%	27%	29%
Talk with neighbors (5+ Times/Wk)	17%	14%	20%	27%	15%	15%	19%	17%	18%
Experienced discrimination NO	65%	71%	74%	77%	74%	63%	75%	68%	NA

How satisfied are you with your relationships with other people? (6g)

AVERAGES (0-10)

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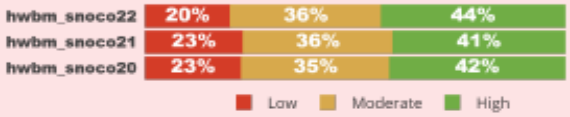


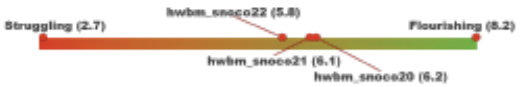
Key Findings

Average score: 7.8 (strong)

- 2022 similar to benchmarks.
- 65% with high ratings DOING WELL/FLOURISHING; 94% with low ratings are STRUGGLING/MIXED

I feel like I am part of a community / sense of belonging. (7e)

AVERAGES (0-10)



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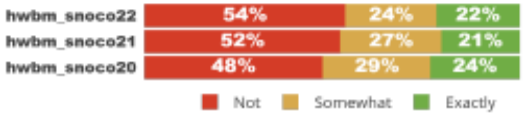
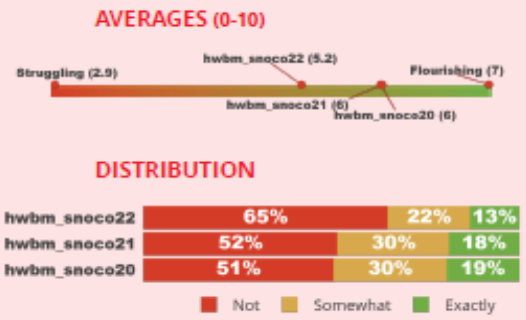


Key Findings

Avg score: 5.8 (moderate)

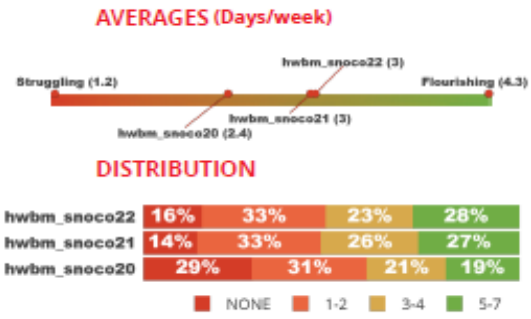
- 2022 is down from benchmarks.
- 73% with high ratings DOING WELL/FLOURISHING; 77% with low ratings are STRUGGLING/MIXED

If I made up my mind to try, I could have a significant influence on decisions being made in my community. (7c)



Key Findings
- Avg score: **5.2 (moderate)**
- 2022 is down significantly from 2021 and 2020 benchmarks.
- 66% of "Exactly"=DOING WELL/FLOURISHING; 69% of "Not" = STRUGGLING/MIXED

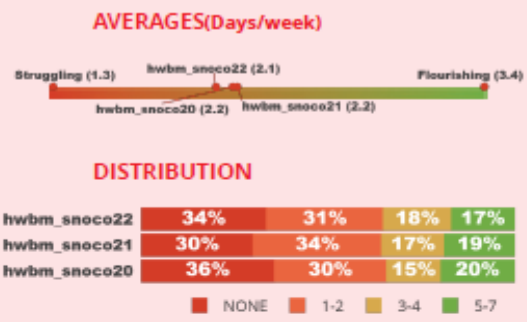
In the last week, how many days did you: Get together with family and friends? (14f)



Key Findings

Average: 3.0 days/week
- Socializing remains higher compared to 2020 benchmark (early pandemic).
- 56% with high 5-7 days DOING WELL/FLOURISH; 78% with 0 days are STRUGGLING/MIXED

In the last week, how many days did you: Talk with your neighbors? (14b)

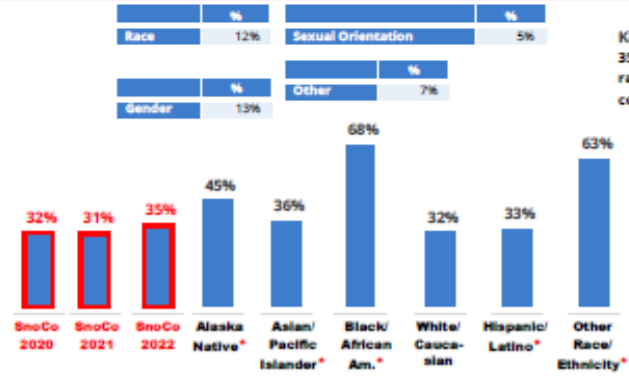


Key Findings

Average: 2.1 days/week
- Statistically unchanged relative to benchmarks.
- 55% with 5-7 days DOING WELL/FLOURISHING; 67% with 0 days are STRUGGLING/MIXED

During the past 12 months, have you personally experienced discrimination or been treated unfairly for any reason including your race, ethnic background, gender, or sexual orientation? (8a)

Sample sizes vary. Interpret results with care. (See App D)



Key Findings

35% experienced discrimination in 2022, with racial and gender discrimination the most common forms
- This is up 4% points from 2021
- BIPOC residents (Alaska Natives, Asian/Pacific Islanders, Blacks, and other) are most likely to have experienced discrimination

How often do you feel like you are discriminated against? (q81)

AVERAGES (% "Freq/Almost Always")

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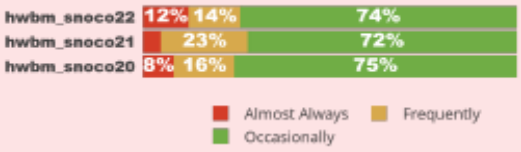
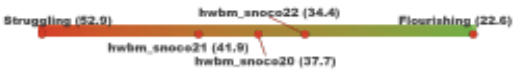


Key Findings

- Frequency of discrimination remains similar to benchmarks

Compared to the year before, did you experience more or less discrimination this year? (q82)

AVERAGES (% "More")



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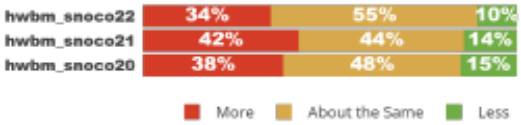


Key Findings

- However, the amount of discrimination that residents experience is down compared to benchmarks (fewer experience "more" discrimination than in prior years)

Dimension 2

Mental, Emotional & Spiritual Health

Recognizing your own and others' emotions and responding appropriately makes a difference. It is the ability to cultivate positive thoughts, practice self-compassion, express emotions and consciously choose your responses; including, engaging in support systems to help cope. A strong sense of spirituality provides important benefits to health. It is linked with a sense of meaning and purpose which offers a sense of direction, shapes goals, influences behavior, and provides comfort during life's challenges.

Overall Scores

- 0% above benchmark
- 0% at benchmark
- 100% below benchmark

Key Findings

Emotional Health increased in 2021, following year 1 of the pandemic, but emotional health in 2022 declined.

- Overall emotional well-being remains better than in 2020 but is down from 2021.
- Fewer report having a sense of purpose and meaning than in 2021 or 2020.

The number of days spent dealing with mental health challenges continued to trend up.

- The number of poor mental health days is up slightly over benchmarks.
- The number of debilitating health days exceeds both 2021 and 2020.

Religion and Spirituality lost salience

- Religion and spirituality were less important in 2022 than in either of the previous two years, with more than half of residents indicating they are "not" important.

Mental, Emotional & Spiritual health is a key part of overall well-being

- Those Flourishing score far higher across all dimensions in this category than do those Struggling, particularly on overall emotional well-being and number of poor mental health days.
- LOW ratings tend to be more prevalent among the same groups who fall into the Mixed/Struggling segment (women, younger people, low income, not employed, singles, multigen. HH, BIPOC, basic need insecure, have poor PH/MH days)

How Your Community Can Flourish

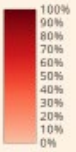
Key Driver Analysis of your data indicates 4 strategies* can influence/explain 73% of the variation in your Core4 Well-being Index scores:

In Snohomish County, **emotional well-being** is among the most influential determinants of overall well-being. Invest in improving overall emotional well-being by helping residents develop a **sense of purpose and meaning**, as well as encouraging your community members **grow relationships with other people** (a Relationships measure) and providing **opportunities for learning and growth** (a Work, Learning & Growth measure).

Who scored LOW *(frequency index, actual vs. expected)*:

Similar to other dimensions of well-being, those not employed and with incomes under $50k score lowest across MES measures. Poor physical and mental health, and insecurity in basic needs (*Safety Insecure shown here) is also related to lower MES scores. Other groups who score low across some or all of these measures include women, age 18-34, those with no college degree, singles, those in multi-generational HHs, and those who have experienced discrimination.

	Total	Women	Age 18-34	Not emp-loyed	Income: <$50k	No college degree	Singles	Multi-gen HH	Discrim: Yes	1+ Poor PH Days	1+ Poor Mntl Hlth Days	1+ Debil Hlth days	Safety In-secure*
Emotional well-being LOW	28%	32%	35%	54%	46%	31%	35%	42%	45%	34%	42%	44%	79%
Religion or spirituality LOW	57%	53%	74%	78%	68%	59%	63%	69%	68%	59%	66%	67%	62%
Sense of purpose and meaning LOW	30%	34%	39%	62%	57%	34%	35%	57%	47%	38%	43%	49%	64%
6+ Poor Mental Health days	33%	42%	45%	54%	51%	36%	35%	63%	49%	44%	54%	56%	69%
6+ Debilitating Health days	26%	35%	37%	40%	40%	30%	30%	60%	43%	38%	40%	55%	50%

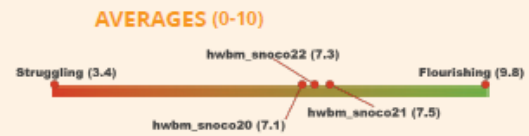


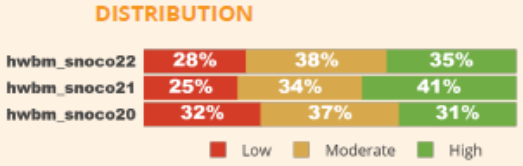
Who scored HIGH *(frequency index, actual vs. expected)*:

Among those with the highest MES scores include those age 55+, retirees, and those in households earning $100k+ per year. Other groups scoring high across some or all of these measures include those employed, those with a Bachelor's Degree or higher, those with no kids in the HH, couples, Caucasians, and those who have not experienced discrimination.

	Total	Men	Age 55+	Employed	Retired	Income: $100k+	Bachelor's Degree+	No Kids in HH	Couples	Race: Caucasian	Discrim: No
Emotional well-being HIGH	35%	39%	45%	37%	39%	48%	39%	41%	38%	37%	40%
Religion or spirituality HIGH	28%	26%	37%	24%	45%	28%	33%	28%	32%	27%	31%
Sense of purpose and meaning HIGH	41%	44%	47%	43%	43%	48%	46%	43%	49%	43%	47%
0 Poor Mental Health days	39%	50%	53%	39%	52%	37%	40%	44%	40%	40%	45%
0 Debilitating Health days	52%	64%	57%	56%	52%	54%	51%	57%	60%	54%	61%

Rate your emotional well-being. (6e)



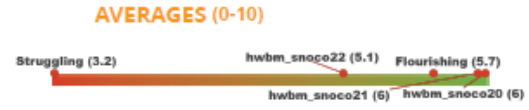


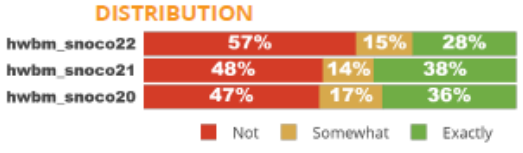
Key Findings

Average score: 7.3 (Strong)

- Emotional well-being remains better than in 2020, but is down from 2021
- 75% with high ratings DOING WELL/FLOURISHING; 97% with low ratings are STRUGGLING/MIXED

Religion or spirituality is important to me. (7a)





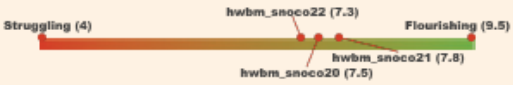
Key Findings

Avg score: 5.1 (Moderate)

- Importance of religion and spirituality down from benchmarks
- 59% with high ratings DOING WELL/FLOURISHING; 68% who say religion or spirituality is not important are STRUGGLING/MIXED

I have a sense of purpose and meaning in my life (7b)

AVERAGES (0-10)



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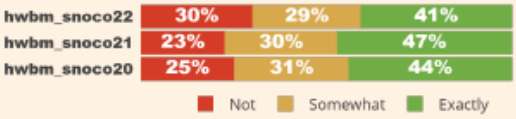


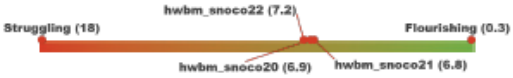
Key Findings

Average score: 7.3 (strong)

- Sense of purpose is down from benchmarks
- 71% with high ratings DOING WELL/FLOURISHING; 91% with low ratings are STRUGGLING/MIXED

Now thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health not good? (12)

AVERAGES (Days/month)



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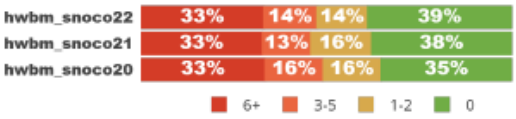


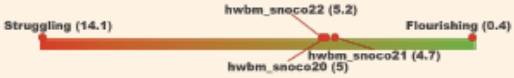
Key Findings

Average: 7.3 days/month

- Number of poor mental health days up slightly over benchmarks
- 66% with zero poor mental health days DOING WELL/FLOURISHING; 91% with 6+ days are STRUGGLING/MIXED

During the past 30 days, for about how many days did poor physical or mental health keep you from doing your usual activities, such as self-care, work, or recreation? (13)

AVERAGES (Days/month)



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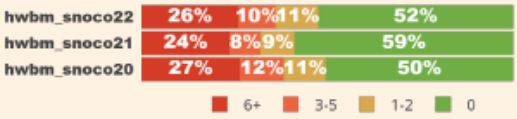


Key Findings

Average: 5.2 days/month: increase over 2022, and exceeding 2020 pandemic surge levels

- A quarter of residents had 6+ debilitating health days, similar to 2020
- 60% with zero debilitating mental health days DOING WELL/FLOURISHING; 94% with 6+ days are STRUGGLING/MIXED

Dimension 3

Neighborhood & Environment

In important ways, your location defines your health. Safe, connected, walkable neighborhoods with access to nutritional food, good education for children, and human services make it easier to enjoy well-being. Being in nature not only makes you feel better emotionally, it contributes to your physical well-being. It soothes, restores and connects. People who live near parks and natural areas are more physically active, live longer, and these open spaces draw people together, enhancing social connections.

Overall Scores

- **0% above benchmark**
- **60% at benchmark**
- **40% below benchmark**

Key Findings

Community satisfaction with neighborhoods has decreased

- Versus both 2021 and 2020, more residents rate their neighborhood low (0-6 on a 10-point scale).
- Nearly all those who rate their neighborhood low are in the Struggling/Mixed segments (86%).

Consumption of fresh fruits and vegetables is also at a low point

- Two-thirds of Snohomish County residents eat fresh fruit and vegetables fewer than 5 times per week, and more than 1 in 5 never do.
- This is well below CDC guidelines.

Exercise has remained relatively stable, but lags CDC recommendations

- Snohomish County residents average 3.5 days of exercise per week, similar to 2021 and 2020, but below the recommended 5+ days recommended by the CDC.

Neighborhood & Environment is statistically less impactful than other dimensions on overall well-being, but the same groups Suffering in these measures are most likely to suffer in others

- Those Flourishing score higher across all dimensions in Neighborhood & Environment measures than do those Struggling
- LOW ratings are more prevalent among the same groups who fall into the Mixed/Struggling segment (women, younger people, low income, not employed, singles (in this case, single people with kids), multigen. HH, BIPOC, basic need insecure, have poor PH/MH days).

How Your Community Can Flourish

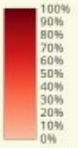
Key Driver Analysis of your data indicates 3 strategies* can influence/ explain 31% of the variation in your Core4 Well-being Index scores:

A person's neighborhood and plays a key role in their overall well-being, and in their ability to build and foster relationships with others. Promoting neighborhood culture where **children and seniors alike feel welcome and safe** will pay dividends in improving overall well-being.

Who scored LOW *(frequency index, actual vs. expected)*:

Those who are single with kids in the household are the most likely to score low across NE measures, followed by those who are insecure in basic needs (*Food Insecure shown here). Other groups who score low on one or more of these measures include women, age 18-34, those with low income or who are unemployed, those without a college degree, multigenerational HH members, those suffering discrimination, and those with poor physical or mental health days.

	Total	Women	Age 18-34	Not emp-loyed	Income: <$50k	No college degree	Single with Kids in HH	Multi-gen HH	Discrim: Yes	1+ Poor PH Days	1+ Poor Mntl Hlth Days	1+ Debil Hlth days	Food In-secure*
Neighborhood you live in LOW	26%	32%	37%	41%	46%	32%	52%	37%	45%	35%	35%	38%	61%
Cmty good place to raise kids LOW	37%	40%	45%	56%	66%	43%	45%	57%	56%	45%	47%	49%	74%
Cmty good place to grow old LOW	41%	44%	48%	59%	64%	45%	58%	60%	64%	51%	54%	54%	74%
Fresh vegetables and fruit (0 Times/Wk)	22%	22%	28%	27%	31%	28%	49%	31%	30%	21%	24%	24%	34%
exercise 30 min or more (0 Times/Wk)	21%	23%	20%	35%	33%	23%	46%	33%	24%	23%	25%	28%	33%



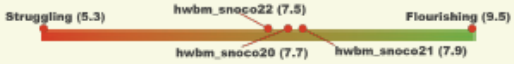
Who scored HIGH *(frequency index, actual vs. expected)*:

Those scoring highest in NE measures include: men, age 55+, retirees, those with incomes $100k+, those with a Bachelor's Degree or higher, couples, Caucasians, and those who have not suffered discrimination.

	Total	Men	Age 55+	Retired	Income: $100k+	Bachelor's Degree+	Couples	Race: Caucasian	Discrim: No
Neighborhood you live in HIGH	40%	49%	49%	51%	47%	48%	44%	43%	48%
Cmty good place to raise kids HIGH	29%	33%	32%	36%	34%	36%	34%	31%	34%
Cmty good place to grow old HIGH	26%	29%	28%	33%	31%	29%	29%	28%	31%
Fresh vegetables and fruit (5+ Times/Wk)	37%	39%	48%	44%	42%	45%	46%	36%	39%
Exercise 30 min+ (5+ Times/Wk)	40%	46%	43%	42%	45%	40%	41%	39%	39%

Rate the neighborhood you live in. (6a)

AVERAGES (0-10)



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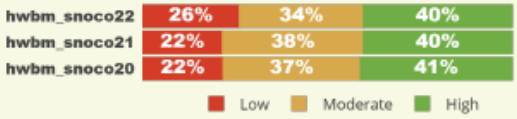


Key Findings

Avg score: 7.5 (down from benchmarks)

- 63% with high ratings DOING WELL/FLOURISHING; 86% with low ratings STRUGGLING/MIXED

My community is a good place to raise children. (7f)

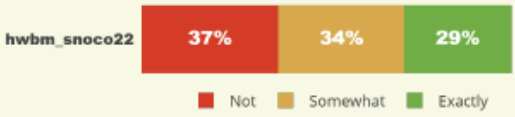
AVERAGES (0-10)

Key Findings

Avg score: 6.6

- 61% with high ratings DOING WELL/FLOURISHING; 78% with low ratings STRUGGLING/MIXED

DISTRIBUTION



My community is a good place to grow old. (7g)

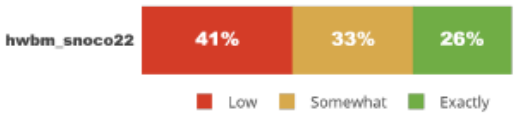
AVERAGES (0-10)

Key Findings

Avg score: 7.5 (down from benchmarks)

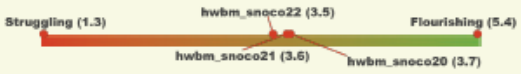
- 63% with high ratings DOING WELL/FLOURISHING; 81% with low ratings STRUGGLING/MIXED

DISTRIBUTION



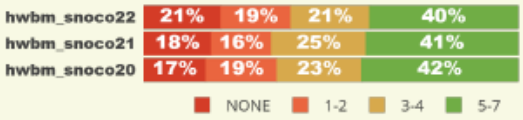
In the past week, how many days did you walk or exercise 30 minutes or more? (14c)

AVERAGES (Days/week)



DISTRIBUTION

CDC guidelines: Adults 5+ days/week



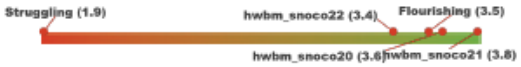
Key Findings

Average: 3.5 days/week (similar to benchmarks)

- County average trails CDC guidelines of 5+ days
- FLOURISHING (average 5.4 days/wk) exceed CDC guidelines of 5+ days
- 59% with high 5-7 days are DOING WELL/FLOURISHING; 82% with 0 days are STRUGGLING/MIXED

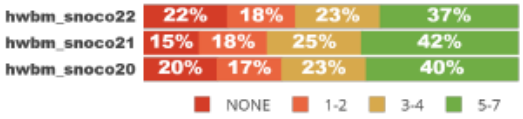
How many days do you eat 5 servings of fresh vegetables & fruit, past week? (14a)

AVERAGES (Days/week)



DISTRIBUTION

CDC guidelines: Adults: 1.5-2 cup equivalents of fruits and 2-3 cup equivalents of vegetables per day.



Key Findings

Average: 3.4 days/wk (down from benchmarks)

- 52% with high 5-7 days are DOING WELL/FLOURISHING; 65% with 0 days are STRUGGLING/MIXED

Dimension 4

Work, Learning & Growth

Employment, education and opportunities for personal growth are bedrocks of well-being.

Using available resources to develop and create opportunities that resonate with your unique gifts, skills, and talents contributes to meaning and purpose, and helps you remain active and involved throughout life.

Education is deeply connected with well-being. Opportunities for ongoing growth brings a sense of purpose and meaning. A work life or career consistent with your personal values, interests, beliefs and balances both work and can contributes greatly to all six dimensions of well-being.

Overall Scores

- **0% above benchmark**
- **40% at benchmark**
- **60% below benchmark**

Key Findings

Work satisfaction is down versus last year, and more similar to 2020

- Snohomish County residents rate their work/jobs less highly than last year, and closer to how they rated their employment in 2020.

Perceived opportunities for learning and growth are down

- Fewer this year say that have a high opportunity for learning and growth than in either 2021 or 2020.
- But, similar to 2021 and 2020, about 1 in 5 needs additional education or training

Job insecurity continues to be a problem

- A similar number as in 2021 continue to need help finding a stable or better job (14%).

Work, Learning, and Growth is a key area of differentiation across residents who are Flourishing, and those Struggling

- Half (52%) of those Struggling need help finding a stable or better job, versus 1% of those flourishing.
- Nearly all those who rate their work and opportunities for growth are Struggling.
- LOW ratings are more prevalent among the same groups who rate lower across all areas of well-being (women, younger people, low income, not employed, singles (in this case, single people with kids), multigen. HH, BIPOC, basic need insecure, have poor PH/MH days).

How Your Community Can Flourish

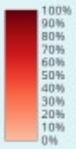
Key Driver Analysis of your data indicates 4 strategies* can influence/explain 52% of the variation in your Core4 Well-being Index scores:

Opportunities for learning and growth is influential to many areas of well-being, including **emotional**, **physical health**, and **basic needs**. The community well-being can benefit from assuring residents have access to options to further their self-development and find good jobs.

Who scored LOW *(frequency index, actual vs. expected)*:

Those not employed and those who are insecure in basic needs (*Job Insecure shown here) scored lowest across WLG measures. Those with incomes under $50,000, those who are single with children at home, and those experiencing discrimination also scored relatively low across measures. Other groups who scored lower on one or more measures include women, age 18-44, those with no college degree, multigenerational HH members, BIPOC, and those with poor physical or mental health days.

	Total	Women	Age 18-44	Not employed	Income: <$50k	No college degree	Single with Kids in HH	Multi-gen HH	Race: BIPOC	Discrim: Yes	1+ Poor PH Days	1+ Poor Mntl Hlth Days	1+ Debil Hlth days	Job In-secure*
Work or job LOW	33%	38%	38%	81%	63%	38%	53%	46%	34%	53%	40%	43%	48%	83%
Opp for learning and growth LOW	30%	31%	33%	67%	57%	34%	53%	30%	31%	50%	37%	41%	43%	77%
Sense of purpose and meaning LOW	30%	34%	33%	62%	57%	34%	48%	57%	30%	47%	38%	43%	49%	73%
Need additional education/training YES	17%	20%	27%	45%	43%	23%	40%	29%	27%	29%	20%	24%	25%	51%
Without a stable job YES	14%	16%	19%	50%	31%	16%	30%	28%	24%	30%	17%	20%	22%	NA



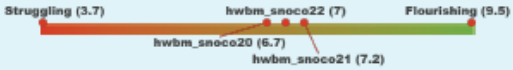
Who scored HIGH *(frequency index, actual vs. expected)*:

WLG measures are highest among retirees, those with incomes $100k+ per year, and those with a Bachelor's Degree or higher. Other groups that also score high on these measures are men, age 55+, those with no kids in the HH, couples, Caucasians, and those who have not experienced discrimination.

	Total	Men	Age 55+	Retired	Income: $100k+	Bachelor's Degree+	No Kids in HH	Couples	Race: Caucasian	Discrim: No
Work or job HIGH	32%	41%	42%	54%	40%	37%	42%	33%	36%	37%
Opp for learning and growth HIGH	34%	34%	41%	40%	46%	45%	40%	37%	36%	42%
Sense of purpose and meaning HIGH	41%	44%	47%	43%	48%	46%	43%	49%	43%	47%
Need additional education/training NO	83%	86%	96%	97%	91%	93%	90%	87%	84%	88%
Without a stable job NO	86%	91%	94%	96%	94%	90%	89%	91%	89%	93%

Rate your work or job (poor-excellent). (6d)

AVERAGES (0-10)



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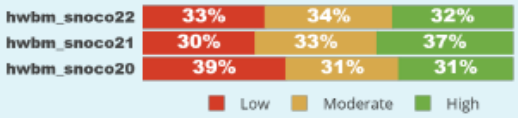


Key Findings

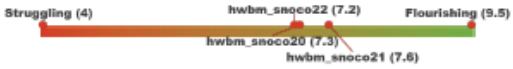
Average score: 7.0 / up from 2020, down from 2021

2020 still leads with most low ratings

- 70% high ratings are DOING WELL/FLOURISHING; 84% with low ratings are STRUGGLING/MIXED

Rate your opportunities for learning and growth (poor-excellent). (6h)

AVERAGES (0-10)



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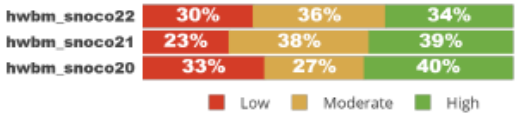


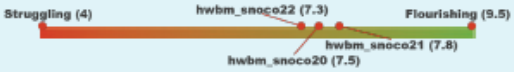
Key Findings

Average score: 7.2 / similar to 2020 and down from 2021

- Opportunities for learning and growth returned to 2020 benchmark level after increasing in 2021
- 68% with high ratings DOING WELL/FLOURISHING; 90% with low ratings are STRUGGLING/MIXED

I have a sense of purpose and meaning in my life. (7b)

AVERAGES (0-10)



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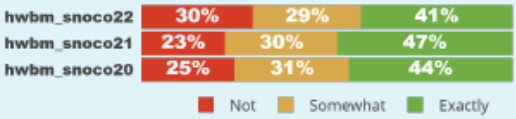


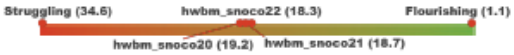
Key Findings

Average score: 7.3 (down from benchmarks)

- 71% with high ratings DOING WELL/FLOURISHING; 91% with low ratings are STRUGGLING/MIXED

Do you need additional education or training to get the job and income you need? (9f)

AVERAGES (%)



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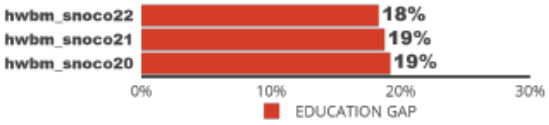


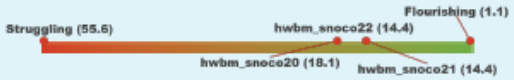
Key Findings

Overall: 18% / similar to benchmarks.

- 83% of those who need additional education or training to get the job income they need are STRUGGLING/MIXED

Are you without a stable job, or do you need help getting a better job? (9e)

AVERAGES (% of responses)



DISTRIBUTION

Key Findings

Overall: 14% / down 4% vs. 2020, similar to 2021

- Job insecure are 8% DOING WELL/FLOURISHING; 92% are STRUGGLING/MIXED

Dimension 5

Security & Basic Needs

Having enough, and freedom from worry. We need enough money for food, rent or mortgage, health care, medical bills and basic expenses of daily living. Lack of access to basic needs and personal safety are linked at all stages of life to physical and mental illness, post-traumatic stress, shorter lifespans and poorer quality of life.

The experience of others affects you. 2019 Monitor™ research found that overall community well-being was measurably lower for ALL where rates of homelessness are higher. Research shows that 'extras' don't really contribute to our well-being-unless it is for fun activities and friends, or expenses that match our values.

Overall Scores

- **0% above benchmark**
- **38% at benchmark**
- **62% below benchmark**

Key Findings

Fewer are financially secure than in 2021, similar to the number of insecure in 2020 (the beginning of the COVID 19 pandemic)

- While the community recovered a sense of financial security in 2021, this sense dropped off in 2022.
- In fact, nearly half (48%) of Snohomish County residents are not financially secure, significantly more than in either 2021 or 2020.

Likewise, the ability to meet basic needs is down

- Nearly half of residents are meeting basic needs at a high level -- this is significantly fewer than did so in 2021 and 2020.
- One in 10 residents reported going without food at least 1 day per week in 2022, higher than in either 2021 or 2020.

Health insurance remains nearly universal, but fewer are able to get medical care or information

- Nearly all have health insurance (93%), similar to prior year.
- Despite this, the number who rate their ability to get medical care and information highly declined after increasing in 2021.

Core4 Well-Being scores are positively influenced by routine healthcare visits

- Taking care of one's health is positively related to higher Core4 Well-Being index, particularly among those who visited a primary care physician or dentist.
- Conversely, those who visited a substance use treatment facility or mental health provider scored far lower on the Core4 Index than those who did not.

Those lacking Security & Basic Needs are the same groups who score low across other dimensions

- As in the WLG dimension, income and employment are particularly highly related to low scores in this category

How Your Community Can Flourish

Key Driver Analysis of your data indicates 4 strategies* can influence/explain 45% of the variation in your Core4 Well-being Index scores:

Financial security has a strong influence on overall well-being and a person's ability to meet basic needs. **Access to medical care and health information** influences a person's sense that his or her basic needs are being met. Promote opportunities for community members to sustain or improve their financial circumstances through access to good jobs, and ensure that residents can find suitable medical care and health information when they need it.

Who scored LOW *(frequency index, actual vs. expected)*:

Those not employed, with incomes under $50,000, those who have experienced discrimination, and those with basic needs insecurity (*Food Insecure shown here) scored lowest across SBN measures. Other groups scoring low on one or more of these areas include age 18-54, those with no college degree, singles, and those with poor physical or mental health days.

	Total	Age 18-54	Not Employed	Income: <$50k	No College Degree	Singles	Discrim: Yes	1+ Poor PH Days	1+ Poor Mntl Hlth Days	1+ Debil Hlth days	Food Insecure*
Ever go without a meal YES	9%	12%	25%	20%	13%	14%	23%	12%	12%	14%	61%
Health insurance NO	7%	8%	23%	14%	9%	8%	10%	7%	5%	6%	24%
Secure about financial future LOW	48%	54%	77%	78%	55%	55%	73%	57%	62%	62%	90%
Ability to meet basic needs LOW	25%	30%	55%	53%	33%	32%	47%	32%	34%	34%	78%
Ability to get med care/info LOW	27%	33%	64%	38%	33%	34%	44%	32%	35%	36%	71%

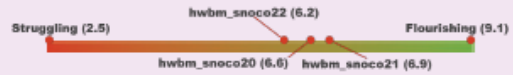
Who scored HIGH *(frequency index, actual vs. expected)*:

Those scoring highest across SBN measures include age 55+, retirees, those with incomes $100k+, those with a Bachelor's Degree+, those in HH with no kids, couples, and those who have not experienced discrimination.

	Total	Age 55+	Retired	Income: $100k+	Bachelor's Degree+	No Kids in HH	Couples	Discrim: No
Ever go without a meal NO	91%	97%	96%	95%	98%	93%	97%	97%
Health insurance YES	93%	96%	100%	97%	98%	95%	96%	95%
Secure about financial future HIGH	27%	35%	37%	37%	31%	33%	34%	34%
Ability to meet basic needs HIGH	52%	59%	57%	70%	64%	59%	60%	64%
Ability to get med care/info HIGH	47%	58%	58%	57%	56%	50%	53%	54%

I feel secure about my financial future. (7d)

AVERAGES (0-10)



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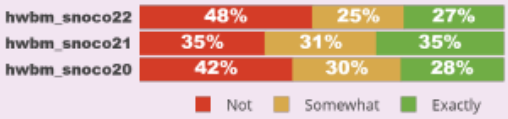


Key Findings

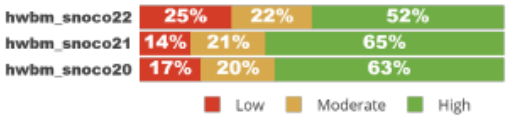
Average score: 6.2 (down from benchmarks)

- Nearly half of Snohomish County residents are not financially secure, up significantly from 2021 and 2020
- 71% of high ratings DOING WELL/ FLOURISHING; 83% of low ratings STRUGGLING/ MIXED

Your ability to meet your basic needs - like food, housing, transportation, safety. (6f)

AVERAGES (0-10)

DISTRIBUTION



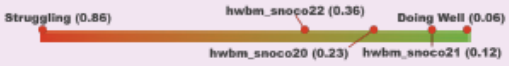
Key Findings

Average score: 8.0 (down from benchmarks)

- Only half are meeting basic needs, versus two-thirds in 2021 and 2020
- 61% of high ratings DOING WELL/ FLOURISHING; 90% of low ratings are STRUGGLING/ MIXED

In the past week, how often did you go without a meal due to lack of money? (14e)

AVERAGES



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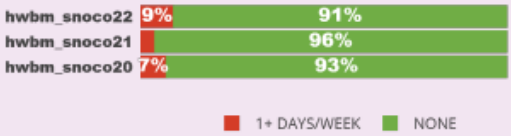


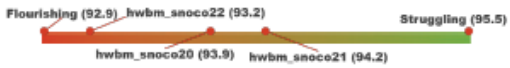
Key Findings

Average: 9% – Close to 1 in 10 skipped one or more meals in the past week for lack of money.

- Up significantly from 2021 (+5% pts) and directionally from 2020 (+2% pts)
- 90% of those who go at least 1 day without a meal are STUGGLING/MIXED

Are you covered by any form of health insurance or health care plan? (17)

AVERAGES



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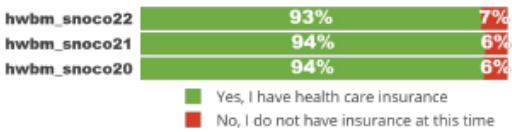


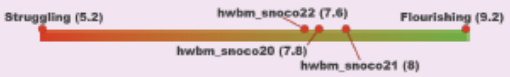
Key Findings

Average: 93% have health care coverage, similar to benchmarks.

- More than 9 in 10 have health insurance, regardless of whether Struggling/Mixed or Doing Well/Flourishing

Rate your ability to get medical care & health info. (6c)

AVERAGES (0-10)



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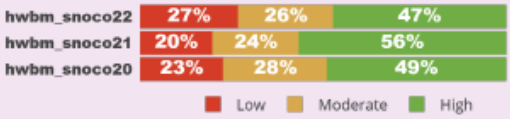


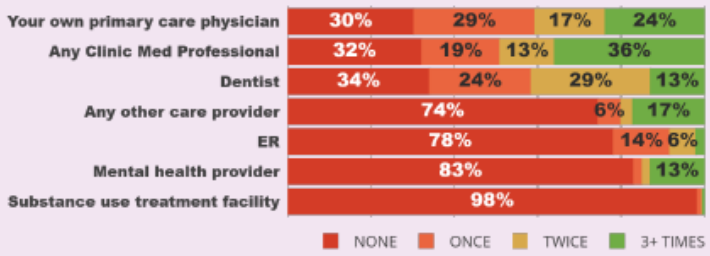
Key Findings

Average score: 7.6 (down from benchmarks)

- 61% of high ratings DOING WELL/FLOURISHING; 83% of low ratings are STRUGGLING/MIXED

About how many times in the last year– if any - have you visited a healthcare professional? (15)

DISTRIBUTION



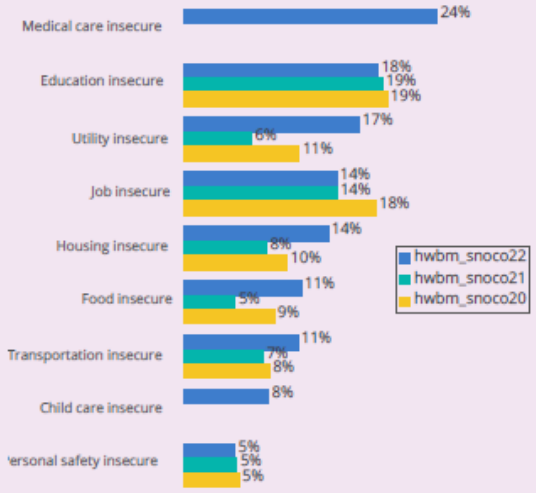
Key Findings

- Snohomish County residents averaged 5.5 healthcare visits in 2022, most commonly visiting a primary care physical, clinical med professional, or dentist. Few sought help for mental health (17%) or substance abuse treatment (2%).
- Core4 Wellbeing scores were influenced by healthcare visits. Those visiting a primary care physician or dentist had the highest well-being scores, while those seeking treatment for substance abuse or mental health conditions were lowest.

TotalHealth9™ Basic Needs Panel

Well-being is elusive if basic needs are not met. These seven basic needs are among the most critical. The institute and a range of partners have tracked and addressed these needs for thousands of people through its TotalHEALTH™ community collaboration initiative.

Percent of Snohomish County residents who are:



Key Findings

Close to half (45%) of Snohomish County residents fear being unable to access at least one basic need.

- Most commonly, residents fear not being able to access medical care, education, and utilities.

The number who fear losing access to several of these basic needs is up from 2021 and 2020

- Specifically, power & water insecurity, housing insecurity, food insecurity, and transportation insecurity are higher than in 2020, even though all three declined in 2021.

The number lacking at least one basic need differs by Well-Being segment:

- 94% of those Struggling lack at least one basic need;
- 53% in the Mixed segment lack;
- 27% of those Doing Well lack;
- Only 7% of those Flourishing lack any basic need

Groups who are most likely to lack basic needs are similar to those who rate low across other dimensions of well-being. However, some groups stand out in certain categories:

- More than 40% of **single parents with kids** are utility insecure, education insecure, and medical care insecure.
- About half of those **not employed** report insecurity with utilities, job, education, and medical care.
- 45% of **lower income residents** (<$50k/year) say they are education insecure.

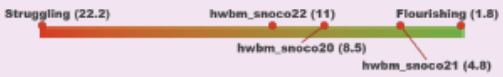
Who is Most Likely to Lack Basic Needs *(frequency index, actual vs. expected)*:

Those not employed, those with incomes less than $50k, and single parents are the most likely to lack basic needs. Other groups who are more likely to lack some basic needs are age 18-44, those without a college degree, singles who live alone or with other adults, those in multigenerational HHs, BIPOC, those wiwho have experienced discrimination, and those who have poor physical or mental health days.

	Total	Age 18-44	Not Employed	Income: <$50k	No College Degree	Single with kids in HH	Single, live alone	Single, live with other adults	Multi-gen HH	BIPOC	Discrim: Yes	1+ Poor PH Days	1+ Poor Mntl Hlth Days	1+ Debil Hlth days
Food insecure	11%	16%	30%	27%	15%	36%	7%	19%	13%	15%	25%	15%	16%	18%
Transporation insecure	11%	16%	35%	31%	14%	26%	11%	18%	17%	14%	24%	15%	16%	18%
Housing insecure	14%	19%	34%	34%	18%	38%	12%	24%	24%	15%	33%	19%	20%	23%
Utility insecure	17%	21%	45%	30%	22%	43%	13%	31%	16%	20%	29%	21%	24%	24%
Job insecure	14%	20%	52%	32%	16%	31%	7%	26%	30%	24%	30%	18%	21%	24%
Education insecure	18%	28%	47%	45%	24%	42%	5%	27%	31%	27%	31%	21%	25%	27%
Personal safety insecure	5%	4%	7%	9%	6%	3%	10%	1%	6%	1%	7%	6%	7%	8%
Child care insecure	8%	14%	23%	12%	8%	32%	1%	5%	15%	14%	12%	10%	11%	14%
Medical care insecure	24%	31%	56%	38%	28%	42%	18%	38%	27%	27%	41%	30%	33%	35%

Are you worried that you or others in your home will not have enough food to eat? (9a)

AVERAGES (%)



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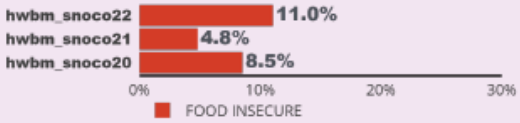


Key Findings

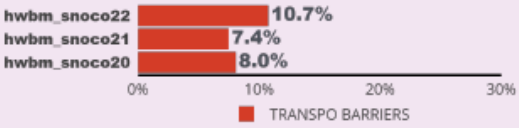
Overall: Food insecurity is up 6% pts over 2021 benchmark, and 2% pts higher than in 2020

- Among Food Insecure, 13% are DOING WELL/FLOURISHING; 87% are STRUGGLING/MIXED

Are you worried about getting to work, school, groceries or appointments because you don't have a way to get there? (9b)

AVERAGES (%)

DISTRIBUTION



Key Findings

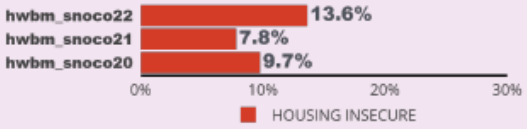
Overall: 11% / 4% pts increase from 2021 benchmark, and up 3% pts from 2020

- Among Transportation Insecure, 5% are DOING WELL/FLOURISHING; 95% are STRUGGLING/MIXED

Are you living without stable housing, currently homeless or worried about losing your housing? (9c)

AVERAGES (%)

DISTRIBUTION



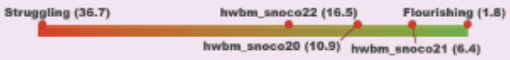
Key Findings

Overall: 13% / up vs. 2021 and 2020 benchmarks

- Among Housing Insecure, 7% are DOING WELL/FLOURISHING; 93% are STRUGGLING/MIXED

Are you unable to pay your power and water bills, or worried that you will not be able to pay your bills? (9c)

AVERAGES (%)



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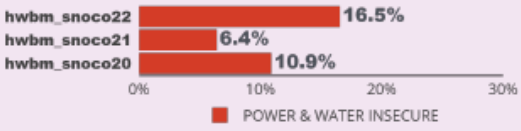


Key Findings

Overall: 16% / up significantly from 2021 and 2020 benchmarks

- Among this group, 10% are DOING WELL/FLOURISHING; 90% are STRUGGLING/MIXED

Are you without a stable job, or do you need help getting a better job? (9e)

AVERAGES (%)

DISTRIBUTION

*Countywide, job insecurity is 14.8% overall, but 10% among employed persons)

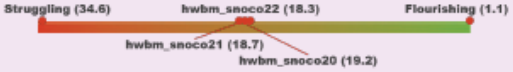
Key Findings

Overall: 14% / similar to 2021, down from 2020

- Among job insecure, 8% are DOING WELL/FLOURISHING; 92% STRUGGLING/MIXED

Do you need additional education or training to get the job and income you need? (9f)

AVERAGES (%)



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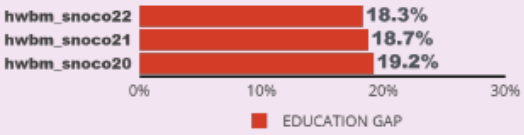


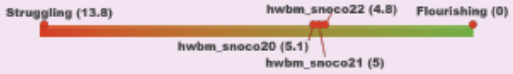
Key Findings

Overall: 18% / similar to 2021 and 2020.

- Among this group, 17% are DOING WELL/FLOURISHING; 83% are STRUGGLING/MIXED

Do you ever feel unsafe in your relationship or at home? (9g)

AVERAGES (%)



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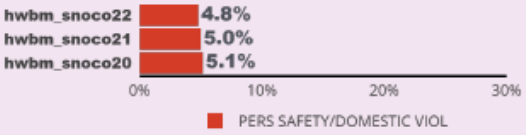


Key Findings

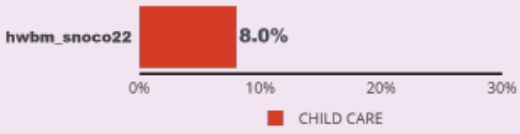
Overall: 5% / similar to 2021 and 2020.

- Among those who feel unsafe, 14% are DOING WELL/FLOURISHING; 86% are STRUGGLING/MIXED

Are you living without stable child care, unable to find good child care, or worried about losing your child care? (9h)

AVERAGES (%)

DISTRIBUTION



Key Findings

Overall: 8%

- Among this group, 22% are DOING WELL/FLOURISHING; 78% are STRUGGLING/MIXED

MEDICAL CARE: Are you unable to get the medical or mental health care you need, or worried about losing your access to healthcare? (9i)

AVERAGES (%)

DISTRIBUTION

Key Findings

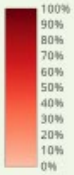
Overall: 24%

- Among this group, 18% are DOING WELL/FLOURISHING; 82% are STRUGGLING/MIXED

Who scored LOW *(frequency index, actual vs. expected)*:

Those not employed, with incomes under $50,000, and who are retired scored lowest on PE measures. Other groups scoring low on PH measures include women, those without a college degree, singles, those living in multi-generational HHs, those who have experienced discrimination, those who are insecure in basic needs (*Medical Care Insecure shown), and those who have poor physical or mental health days.

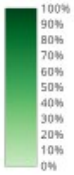
	Total	Female	Not Employed	Retired	Income: <$50k	No College Degree	Singles	Multi-gen HH	Discrim: Yes	1+ Poor PH Days	1+ Poor Mntl Hlth Days	1+ Debil Hlth days	Med Care Insecure*
State of physical health LOW	32%	36%	51%	38%	50%	35%	40%	33%	38%	43%	41%	46%	49%
Medical or health condition YES	42%	49%	55%	53%	44%	40%	44%	49%	55%	53%	49%	56%	59%
Chronic illness YES	25%	28%	32%	44%	27%	27%	28%	21%	24%	33%	29%	27%	27%
6+ Poor physical health days	27%	36%	30%	36%	36%	29%	33%	53%	34%	44%	37%	48%	38%
6+ Debilitating health days	26%	35%	40%	26%	40%	30%	30%	60%	43%	38%	40%	55%	47%



Who scored HIGH *(frequency index, actual vs. expected)*:

Men, those employed, those with incomes $100k+, those with a Bachelor's Degree or higher, couples, and those who haven't experienced discrimination are report the higher on PH measures.

	Total	Male	Employed	Income: $100k+	Bachelor's Degree+	Couples	Discrim: No
State of physical health HIGH	26%	30%	29%	33%	27%	24%	26%
Medical or health condition NO	58%	68%	63%	65%	55%	61%	64%
Chronic illness NO	75%	78%	81%	80%	78%	75%	75%
0 Poor physical health days	39%	48%	41%	38%	40%	40%	45%
0 Debilitating health days	52%	64%	56%	54%	51%	60%	61%



Dimension 6

Physical Health

Physical health is both a state of being and a practice. Behaviors such as diet, exercise, sleep and stress have a profound effect on disease conditions and well-being. Physical health is also directly linked to hygiene routines, use of tobacco, alcohol and other drugs, the use of personal protective equipment, workplace safety and following safety guidelines, not taking unnecessary risks and the wise use of healthcare resources, including regular checkups and recommended screenings.

Overall Scores

- **0% above benchmark**
- **50% at benchmark**
- **50% below benchmark**

Key Findings

The state of community physical health continues to need improvement

- Snohomish County residents continue to give themselves a C+ overall when it comes to physical health, similar to prior years, but with only 1 in 4 rating themselves highly in this area.
- A full third of residents in 2022 rated their physical health as low, and the average number who spend at least 1 day in poor physical health per month has been on the rise.
- Nearly half also experienced at least one debilitating health day per month.

Consumption of fresh fruits and vegetable, and regular exercise and sleep lag CDC guidelines

- Two-thirds of residents ate fresh fruits and vegetables fewer than 5 times per week (CDC guideline: 7 times/wk)
- Fewer than half exercised 5+ days per week (CDC guideline: 5+ times/wk)
- Only 58% had 5-7 nights a week with 7+ hours of sleep (CDC guideline: 7+ hours every night).

Physical Health is highly correlated with wellbeing levels in the community:

- 98% of those who rate their physical health low are Struggling/Mixed.
- Those Struggling report an average of 10 poor physical health days per month, compared to fewer than 1 day on average among those Flourishing.
- Likewise, those Struggling report an average of 14 debilitating health days per month, compared to fewer than 1 day on average among those Flourishing.
- LOW ratings are more prevalent among the same groups who fall into the Mixed/Struggling segment (women, younger people, low income, not employed, singles, multigen. HH, BIPOC, basic need insecure, have poor PH/MH days).

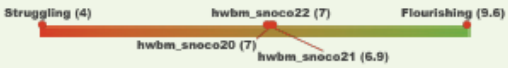
How Your Community Can Flourish

Key Driver Analysis of your data indicates 3 strategies* can influence/explain 72% of the variation in your Core4 Well-being Index scores:

Physical health is a key dimension with outsize influence over overall well-being. Most influential to improved physical health: **daily exercise**. In addition, **emotional well-being** and a **sense of purpose and meaning** (both Mental & Emotional Health measures), and a **good job** (a Work, Learning, and Growth measure) are all strongly related to positive ratings of physical health. Promote opportunities for residents to get physical activity, and provide opportunity for residents to find satisfying employment.

Rate the current state of your physical health. (6b)

AVERAGES (0-10)



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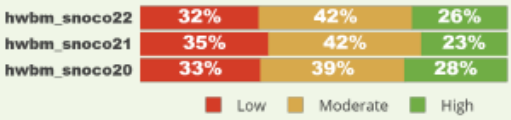


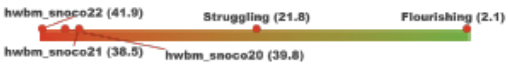
Key Findings

Average score: 7.0 / unchanged vs. 2021 and 2020.

- 66% with high ratings DOING WELL/FLOURISHING;
- 97% with low ratings are STRUGGLING/MIXED

Do you have a medical or health condition that requires treatment or special care? (18)

AVERAGES (%)



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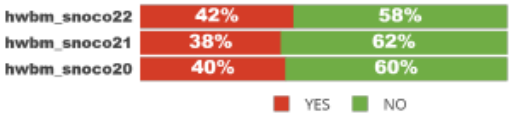


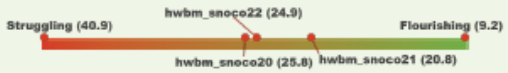
Key Findings

Overall: 42% / up directionally from benchmarks

- Among the group with medical conditions, 27% are DOING WELL/FLOURISHING; 73% STRUGGLING/MIXED

Are you living with a chronic illness (such as diabetes, heart disease or cancer)? (a1)

AVERAGES (%)



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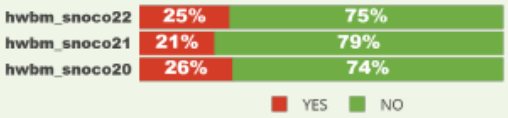


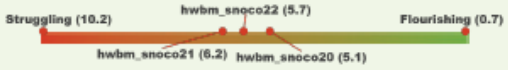
Key Findings

Average: 25% / Up from 2021, similar to 2020

- 34% living with a chronic illness are DOING WELL/FLOURISHING; 66% are STRUGGLING/MIXED

Poor physical health days/month: Thinking about your physical health, which includes physical illness and injury, for how many days during the past 30 days was your physical health not good? (11)

AVERAGES (Days/month)



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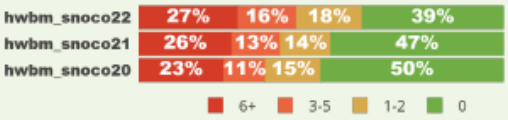


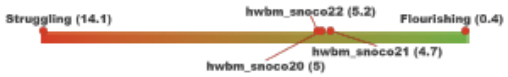
Key Findings

Average: 5.7 days/month (down 0.5 day/mo from 2021, but up .6 day/mo from 2020).

- 60% with 0 days are DOING WELL/FLOURISHING;
- 86% with 6+ days are STRUGGLING/MIXED

Debilitating health days/month: During the past 30 days, for about how many days did poor physical or mental health keep you from doing your usual activities, such as self-care, work, or recreation? (13)

AVERAGES (Days/month)



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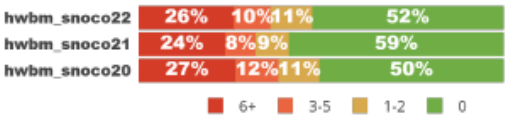


Key Findings

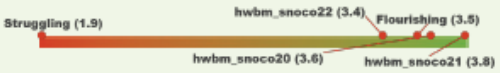
Average: 5.2 days/month (up 0.5 days/mo from 2021, and similar to 2020)

- 60% of 0 days DOING WELL/ FLOURISHING;
- 94% of 6+ days are STRUGGLING/MIXED

In the last week, how many days did you eat 5 servings of fresh vegetables & fruit? (14a)

CDC guidelines: Adults: 1.5-2 cup equivalents of fruits and 2-3 cup equivalents of vegetables per day.

AVERAGES (Days)



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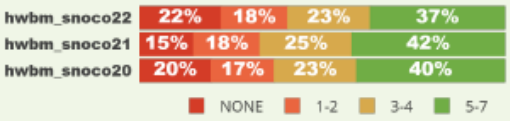


Key Findings

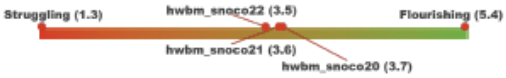
Average: 3.4 days/wk (slight trend down from benchmarks)

- FLOURISHING (average 5 days/wk) are below CDC guidelines
- 52% with high 5-7 days are DOING WELL/FLOURISHING; 65% with 0 days are STRUGGLING/MIXED

How many days in the past week did you walk or exercise 30 minutes or more? (14c)

CDC guidelines: Adults 5+ days/week

AVERAGES (Days)



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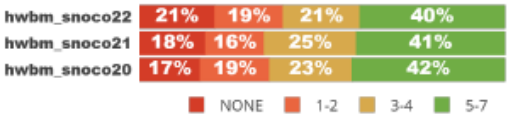


Key Findings

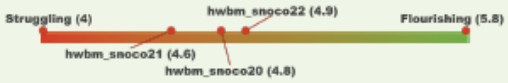
Average: 3.5 days/week (similar to benchmarks)

- Average 3.5 days does not meet CDC guidelines.
- FLOURISHING (average 5.4 days/wk) meets CDC guidelines of 5+ days/week.
- 59% with high 5-7 days are DOING WELL/FLOURISHING; 82% with 0 days are STRUGGLING/MIXED

In the last week, how many days did you sleep at least 7 hours? (14d)

CDC guidelines: 7+ hours every night

AVERAGES (Days/week)



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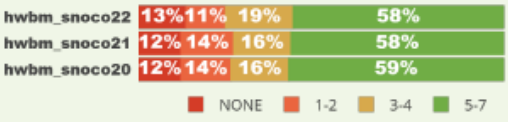


Key Findings

Average: 4.9 days/wk (similar to benchmarks)

- FLOURISHING (average 5.8 days/week) does not meet CDC guidelines
- 54% with high 5-7 days/week are DOING WELL/FLOURISHING; 81% with 0 days are STRUGGLING/MIXED

Tailored Questions

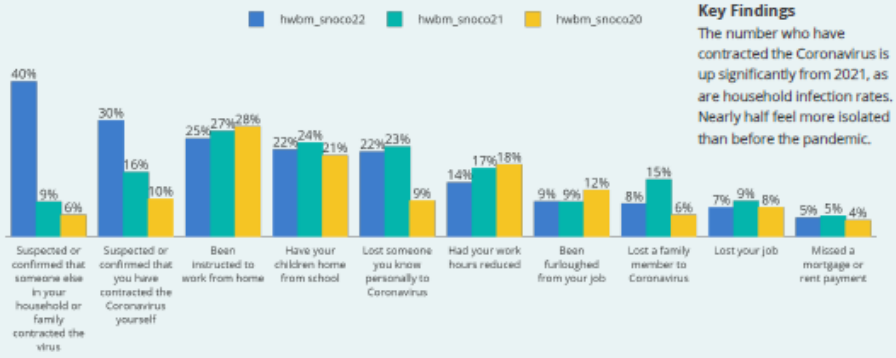
The Health & Well-being Monitor is designed to incorporate a comprehensive set of well-being indicators, along with tailored questions that are relevant at the local level.

INDEX TO TAILORED QUESTIONS

- (a2) Which of the following have you experienced since the beginning of the Coronavirus pandemic?
- (a3) When it comes to the Coronavirus vaccination, which best describes you?
- (a4) What is the main reason you will not or may not get vaccinated?
- (a5) (Impact of Coronavirus on daily life) Which of these statements best describes you today?
- (a6) How much, if at all, do you think global climate change is currently affecting your local community?
- (a7) Are you concerned that you or a member of your family will be personally affected by climate change?

Which of the following have you experienced since the beginning of the Coronavirus pandemic (A2)

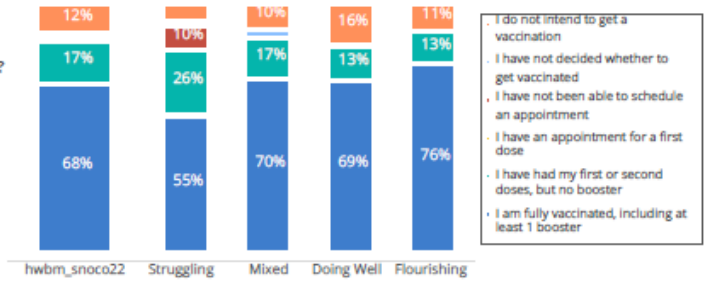
New this year: 47% have felt more isolated, lonely, worried about being in crowded places



Key Findings

The number who have contracted the Coronavirus is up significantly from 2021, as are household infection rates. Nearly half feel more isolated than before the pandemic.

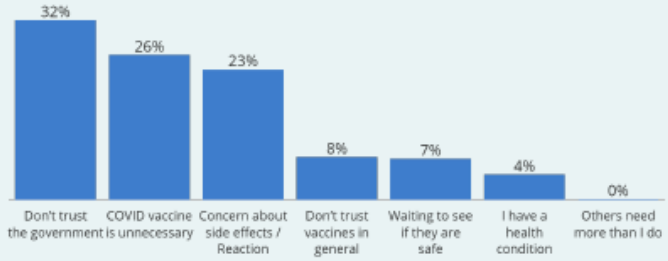
When it comes to the Coronavirus vaccination, which best describes you? (A3)



Key Findings

Snohomish County is similar to Washington State overall in the number who are vaccinated (85% at least one dose). Those Struggling are the most likely to have missed taking a booster shot.

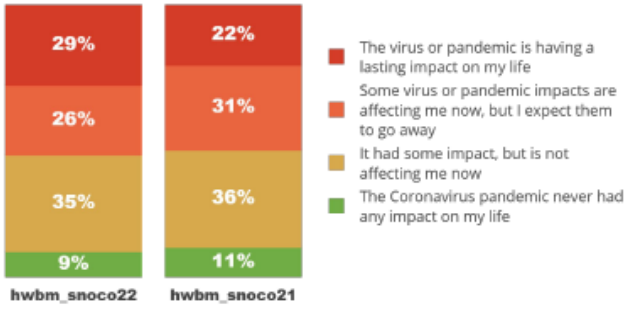
What is the main reason you will not or may not get vaccinated? (A4)



Key Findings

Among the 12% of Snohomish County residents who do not plan on getting vaccinated against COVID-19, the main reasons are mistrust of government, belief that the vaccine is unnecessary, and concern about side effects.

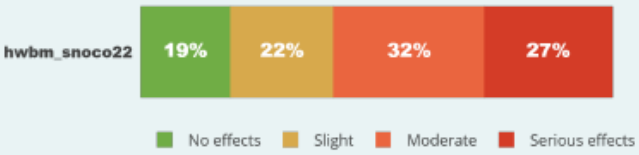
Which of these statements best describes you today? (A5)



Key Findings

The number for whom the pandemic is having lasting impact increased from 2021 from 22% to 29% of residents. However, most continue to be positive and report no pandemic-related problems, or expect them to go away.

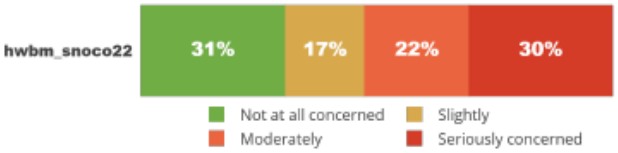
How much, if at all, do you think global climate change is currently affecting your local community? (A6)



Key Findings

More than half (55%) believe climate change is having at least a moderate effect on Snohomish County communities.

Are you concerned that you or a member of your family will be personally affected by climate change? (A6)



Key Findings

The community is divided on whether climate change will affect them or their family members: Close to a third each are "not at all" and "seriously" concerned about climate change.

APPENDIX A: Snohomish County 2022 Health & Well-being Monitor™ survey methods and data

PRIMARY STUDY OBJECTIVES. The 2022 Snohomish County survey had the following objectives:

- Carry out a trending study tracking changes from Q2 2021 and Q2 2020 surveys of Snohomish County residents
- Collect data to inform decisions about county-wide well-being priorities for 2022

SURVEY RESPONSES & MARGIN OF ERROR. 536 Snohomish County residents participated in the 2022 survey. The survey results have a ±5% margin of error at the 95% confidence level.

FIELDING DATES. Q2 2022

DATA COLLECTION. 532 completes gathered via phone and online surveys targeting a randomly selected sample of residents.

BENCHMARK RESULTS. A hallmark of the HWBM™ is providing our clients with the most recent available community-wide benchmarks for comparison. The 2022 results are compared to two benchmarks:

- **Benchmark 1:** Results from the HWBM 2021 Snohomish County survey, fielded in Q2 2021 (n=583), with a ±5% margin of error at the 95% confidence level.
- **Benchmark 2:** Results from the HWBM 2020 Snohomish County survey, fielded in Q2 2020 (n=598), with a ±5% margin of error at the 95% confidence level.

DATASETS & SAMPLE WEIGHTING USED FOR THIS REPORT. Data from all surveys were weighted to reflect Snohomish County demographics by gender, age, education, and income

APPENDIX B: 2022 Health & Well-being Monitor Weighting

Data were weighted to reflect population distributions across: Gender, Age, Income, Education

Unweighted Proportions

Gender

%	hwbm_snoco22
Male	47.2%
Female	52.0%
Self-describe	.8%

Age

%	hwbm_snoco22
18-24	2.9%
25-34	11.5%
35-44	17.7%
45-54	15.2%
55-64	17.7%
65-74	18.3%
75+	16.7%

Education

%	hwbm_snoco22
<High school	2.1%
High school/GED	13.6%
Voc/Tech School	6.3%
Some College/AA	29.4%
BA/BS	29.1%
Grad School	19.5%

Income

%	hwbm_snoco22
<$25k	8.2%
$25k-$49.9k	15.5%
$50k-$74.9k	21.1%
$75k-$99.9k	15.2%
$100k-$124.9k	13.6%
$125k-$149.9k	6.8%
$150k-$199k	8.7%
$200k+	11.0%

Weighted Proportions - Used for Reporting

Gender

%	hwbm_snoco22
Male	48.5%
Female	49.9%
Self-describe	1.7%

Age

%	hwbm_snoco22
18-24	12.7%
25-34	17.2%
35-44	17.9%
45-54	16.2%
55-64	17.1%
65-74	11.7%
75+	7.0%

Education

%	hwbm_snoco22
<High school	6.0%
High school/GED	21.5%
Voc/Tech School	8.3%
Some College/AA	28.1%
BA/BS	24.3%
Grad School	11.7%

Income

%	hwbm_snoco22
<$25k	10.8%
$25k-$49.9k	13.6%
$50k-$74.9k	16.4%
$75k-$99.9k	15.1%
$100k-$124.9k	16.1%
$125k-$149.9k	7.2%
$150k-$199k	10.0%
$200k+	10.8%

APPENDIX C: 2022 Health & Well-being Monitor™ Full Respondent Profile (Weighted)

Gender

%	hwbm_snoco22
Male	48.5%
Female	49.9%
Self-describe	1.7%

Age

%	hwbm_snoco22
18-24	12.7%
25-34	17.2%
35-44	17.9%
45-54	16.2%
55-64	17.1%
65-74	11.7%
75+	7.0%

Education

%	hwbm_snoco22
<High school	6.0%
High school/GED	21.5%
Voc/Tech School	8.3%
Some College/AA	28.1%
BA/BS	24.3%
Grad School	11.7%

Income

%	hwbm_snoco22
<$25k	10.8%
$25k-$49.9k	13.6%
$50k-$74.9k	16.4%
$75k-$99.9k	15.1%
$100k-$124.9k	16.1%
$125k-$149.9k	7.2%
$150k-$199k	10.0%
$200k+	10.8%

Race/Ethnicity

%	hwbm_snoco22
American Indian, Eskimo, or Alaska Native	2.5%
Asian or Pacific Islander	7.9%
Black or African American	4.5%
White or Caucasian	75.9%
Hispanic or Latino	4.3%
Other	4.9%

Household Composition

%	hwbm_snoco22
Couple with kids in HH	28.6%
Couple no kids in HH	22.4%
Single with kids in HH	6.2%
Single no kids in HH	18.7%
Single living with other adults	13.0%
Multigenerational	10.9%

Employment

%	hwbm_snoco22
Employed FT	61.0%
Employed PT	6.2%
Not employed	11.7%
Student	1.9%
Retired	19.2%

APPENDIX D: 2022 Health & Well-being Monitor™ Core4 Well-being index by demographic groups

The heat maps below visually clarify the demographic groups that score highest and lowest on the Core4 Well-being Index, and how groups' scores have increased or decreased year-over-year. Darker green indicates higher scores; likewise, lighter greens indicate lower scores.

Appendix E: Individual & Community Level Can-Do™

Why It Matters

We are humans becoming—always on a journey. As life continually changes, our beliefs and what we think is important changes. In this continual ebb and flow, a sense of self-efficacy* can play a major role in how one approaches goals, tasks, and challenges, and either takes action or doesn't take action in cultivating well-being. Moving towards a greater sense of self-efficacy makes a difference in improving and, more importantly, sustaining overall well-being.

Your Can-Do™ score gives insights into your community's current CAPACITY to improve well-being and MOTIVATION to change. Capacity is the % of respondents who say they can be doing more to improve their health. Motivation is indexed by the percentage who say they can do "a little more" or "a lot more." You can compare your community profile to a larger community benchmark – and to your own baseline from previous Monitors and/or when you run a follow-up Monitor™ in the future.

INDIVIDUAL vs. COMMUNITY EFFICACY. We provide you with insights into your respondents' capacity to improve their INDIVIDUAL well-being, as well as your community's belief that it can influence well-being on a community-level.

What Your Community Can Do

Create experiences for mastery using small achievable goals and cooperative learning strategies. Progress creates positive cycle of success. Reflect on accomplishments, and recognize strengths you already have to achieve new goals.

Highlight stories of people similar to your community who have succeeded and sustained their efforts. People learn by observing others, especially role models. Influential people make a difference-parents, leaders, teachers, etc. Hearing 'we can do it' strengthens our beliefs that we have what it takes.

Create nurturing environments—emotions influence self-efficacy. Stress, anxiety, and depression have a 'negative' interpretation from society. Recognize emotions as normal and okay, while also working to address anxiety, depression and negative perceptions.

Create vision boards or other visual imagery, to influence self-efficacy through 'imagination experiences'.

**Self-efficacy beliefs determine how people feel, think, motivate themselves and behave -a sense of mastery over yourself, confidence to affect life's challenges, and abilities to control your environment. Self-efficacy has been linked to well-being and strengths processes, such as resilience, in past studies and is considered a basic human need.*

Thank You

For more information, contact:
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Phone: 425-261-3344
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