COMMUNITY HEALTH NEEDS ASSESSMENT 2020

Providence Centralia Hospital
Providence St. Peter Hospital

This CHNA was conducted in partnership with
Providence Centralia Hospital, Centralia, WA
Providence St. Peter Hospital, Olympia, WA

To provide feedback about this CHNA or obtain a printed copy free of charge, please email swcommunications@providence.org

PROVIDENCE
Health & Services
Washington

CONTENTS

MESSAGE TO THE COMMUNITY

To Our Communities:

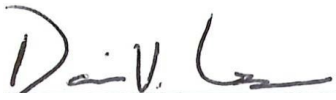
Providence is proud to be our community's health care partner and remains committed to delivering compassionate health for those who trust us with their care. We know access to quality education, employment, housing and health care factor into a person's overall health and wellbeing.

As an extension of our strategic planning process, every three years we participate in a Community Health Needs Assessment (CHNA) survey to ensure our resources are aligned to the greatest needs of those we serve. We also consider partnerships with like-minded organizations with community benefit investments so together, we can strengthen and build healthier communities.

As outlined in our **2020 CHNA,** the following health needs emerged across the communities we serve in Thurston and Lewis Counties during the assessment process:

- ***Housing Instability and Homelessness***
- ***Mental Health and Substance Use***
- ***Access to Health Care (including the digital divide)***

These three health-related needs will be addressed using a **health and racial equity** framework. With this understanding, we will develop a community health improvement plan (CHIP) to specifically address many of these barriers to improve health in our community. The CHIP will outline a process of strengthening our existing programs, suggest new programs that will make a greater impact, and work to identify partnership opportunities to collaborate on solutions. This ensures Providence will continue to be focused on the critical needs of the residents in Thurston and Lewis counties. With implementation of our strategies, our patients and communities can take comfort in knowing Providence will continue to work toward making our community a healthier place.



Darin Goss

Chief Executive, Providence Southwest Washington

ACKNOWLEDGEMENTS

Special thanks to all of the community members, leaders, and organizations that collaborated to make this Community Health Needs Assessment a success. We appreciate the time and expertise provided by the community stakeholder interview participants:

- CHOICE Regional Health Network: Abigail Schroff, Amber Shirk, Caitlin Moore, Carol Palay, Caroline Sedano, Christine Haywood, Ivan Rodriguez, Jean Clark, Joshua Plaster, Katrin Palmer, Megan Szabla, Michael O'Neill, and Randy Thomas
- North Thurston School Board: Mel Hartley
- Olympia Free Clinic: Katie Madinger and Winter Forsyth
- Behavioral Health Resources: Laurie Tebo, Ian Harrel, Larry Horne, Eric Jensen, Tiffany Buchanan, Lauren Farmer, and Angela Crowley
- Cascade Mental Health Care: Richard Stride

Thank you to the Population Health Leadership Workgroup, in particular the Chairperson, Andrea Corona, as well as the Community Mission Board representatives, Brian Mittge and Dr. Rachel Wood, who provided expertise in the data review and prioritization process.

Biel Consulting, Inc. completed the Community Health Needs Assessment report. Led by Dr. Melissa Biel, Biel Consulting, Inc. has extensive experience conducting hospital Community Health Needs Assessments and working with hospitals on developing, implementing, and evaluating community benefit programs. www.bielconsulting.com

We are grateful for the oversight and guidance provided by the entire Community Mission Board and for the leadership of Jennifer Groberg.

Thank you to the Data Integration Team at Providence St. Joseph Health for the technical expertise and support.

EXECUTIVE SUMMARY

Understanding and Responding to Community Needs, Together

Improving the health of our communities is foundational to our Mission and deeply rooted in our heritage and purpose. Our Mission calls us to be steadfast in serving all, with a special focus on our most economically poor and vulnerable. This core belief drives the programs we build, investments we make, and strategies we implement.

Knowing where to focus our resources starts with our Community Health Needs Assessment (CHNA), an opportunity in which we engage the community every three years to help us identify and prioritize the most pressing needs, assets, and opportunities. The 2020 CHNA was approved by the Community Ministry Boards on October 22, 2020 and made publicly available by December 31, 2020.

RESPONDING TO THE COVID-19 PANDEMIC

The 2020 Community Health Needs Assessment process was disrupted by the SARS-COV-2 virus and COVID-19, which has impacted all of our communities. While our communities have focused on crisis response, it has required concentration of resources and reduced community engagement, which impacted survey fielding and community listening sessions. Additionally, the impacts of COVID-19 are likely to effect community health and well-being beyond what is currently captured in secondary and publicly available data. We will seek to engage the community as directly as possible in prioritizing needs and through the community health improvement process.

We recognize that in these unprecedented times, COVID-19 is likely to exacerbate existing community needs and may bring others to the forefront. Our commitment first and foremost is to respond to the needs of our communities, particularly individuals who are disproportionately impacted by the economic and social effects of COVID-19. While this is a dynamic situation, we recognize the greatest needs of our communities will change in the coming months, and it is important that we adapt our efforts to respond accordingly. We are committed to supporting, strengthening, and serving our communities in ways that align with our Mission, engage our expertise, and leverage our Community Benefit dollars in the most impactful ways.

Our Starting Point: Gathering Community Health Data and Community Input

Through a mixed-methods approach using quantitative and qualitative data, the CHNA process used several sources of information to identify community needs. Across Lewis and Thurston Counties, information collected includes U.S. Census American Community Survey data, County Health Rankings and hospital prevention quality indicators and Emergency Department utilization. Stakeholder

interviews were conducted with representatives from organizations that serve low-income, and/or are medically underserved populations. Some key findings include the following:

- The service area counties have a high percentage of seniors. Many seniors experience barriers to accessing care and needed community resources, such as healthy food and transportation.
- Death rates in Lewis County for injuries, suicides, and firearm fatalities exceed state rates for those causes of deaths.
- Area adults have high rates of alcohol use and cigarette smoking.
- As a direct result of COVID-19, people are delaying care, including well child visits, vaccinations, dental care, chronic disease management, and mental health services, which may have lasting effects.

Identifying Top Health Priorities, Together

Through stakeholder interviews, the community identified significant health needs and prioritized these needs. The top three priority areas were identified:

PRIORITY 1: HOMELESSNESS/LACK OF SAFE AFFORDABLE HOUSING

Homelessness and a lack of safe, affordable housing was prioritized by all stakeholders and consistently ranked as the most important issue that needs to be addressed in the service area. Despite efforts to address housing challenges, there is a lack of housing available in Thurston and Lewis counties, particularly affordable rental units and permanent supportive housing.

PRIORITY 2: BEHAVIORAL HEALTH (INCLUDES MENTAL HEALTH AND SUBSTANCE USE)

There is a lack of mental health and substance use treatment services in the community. Gaps include a lack of behavioral health integration into primary care, school-based mental health services, a local inpatient detox facility, and case management services. People have difficulty accessing mental health services due to long wait times, a lack of providers who take Medicaid and Medicare, and transportation barriers. These populations include school-aged children, older adults, people experiencing homelessness, people living in rural communities, veterans, people who are undocumented, and monolingual Spanish speakers.

PRIORITY 3: ACCESS TO HEALTH CARE

There are a number of barriers to accessing health care. A common concern was transportation, particularly for older adults, people experiencing homelessness, and people living in rural communities. Language barriers prevent people from receiving appropriate and responsive care and documentation status is a barrier to accessing health insurance.

Stakeholders chose to prioritize a fourth health-related need, health and racial equity, throughout the improvement plans for all three needs listed above. This means when addressing housing, mental health and substance use, and access to care, Providence Southwest Washington will use an equity framework for approaching planning and implementation.

Community Health Improvement Plan

Providence Centralia and Providence St. Peter Hospitals will develop a three-year Community Health Improvement Plan (CHIP) to respond to these prioritized needs in collaboration with community partners in early 2021 considering resources, community capacity, and core competencies. The 2021-2023 CHIP will be approved and made publicly available no later than May 15, 2021.

INTRODUCTION

Mission, Vision, and Values

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

Who We Are

The Providence Southwest Washington network includes two nonprofit hospitals, which share a service area – Providence Centralia Hospital and Providence St. Peter Hospital.

Providence Centralia Hospital is an acute-care hospital that was formed in 1988 when St. Helen's Hospital, Chehalis merged with Centralia General Hospital. The hospital has 128 licensed beds. Providence Centralia Hospital has a staff of more than 850 caregivers (employees). Major programs and services offered to the community include the following: emergency, diagnostic, cancer, birthing and surgical services, specializing in knee and hip replacements.

Providence St. Peter Hospital is an acute-care hospital founded in 1887 and located in Olympia, Washington. The hospital has 339 licensed beds. Providence St. Peter Hospital has a staff of more than 2,900. Major programs and services offered to the community include the following: behavioral health, cancer, heart and vascular, neurology, orthopedics, rehabilitation, senior health and women's and children's health.

Providence Medical Group operates 31 primary and specialty care clinics in 38 locations in the region, with more than 270 providers.

Our Commitment to Community

Providence Southwest Washington dedicates resources to improve the health and quality of life for the communities it serves, with special emphasis on the needs of the economically poor and vulnerable.

During 2019, our hospitals provided $66,000,000 in Community Benefit[1] in response to unmet needs and improved the health and well-being of those we serve in Southwest Washington. Our region includes five counties served by Providence St. Peter and Providence Centralia hospitals. Within this geographical area, Thurston and Lewis Counties are designated as the primary service area for the two hospitals. The secondary service area includes Grays Harbor, Mason, and Pacific Counties.

Providence Health & Services Southwest Washington further demonstrates organizational commitment to the community health needs assessment (CHNA) through the allocation of staff time, financial resources, participation and collaboration to address community identified needs. The Southwest Washington Chief Mission Integration Officer is responsible for ensuring compliance with Federal 501r requirements, as well as providing the opportunity for community leaders and internal hospital leadership, physicians, and others to work together in planning and implementing the resulting Community Health Improvement Plan (CHIP).

Health Equity

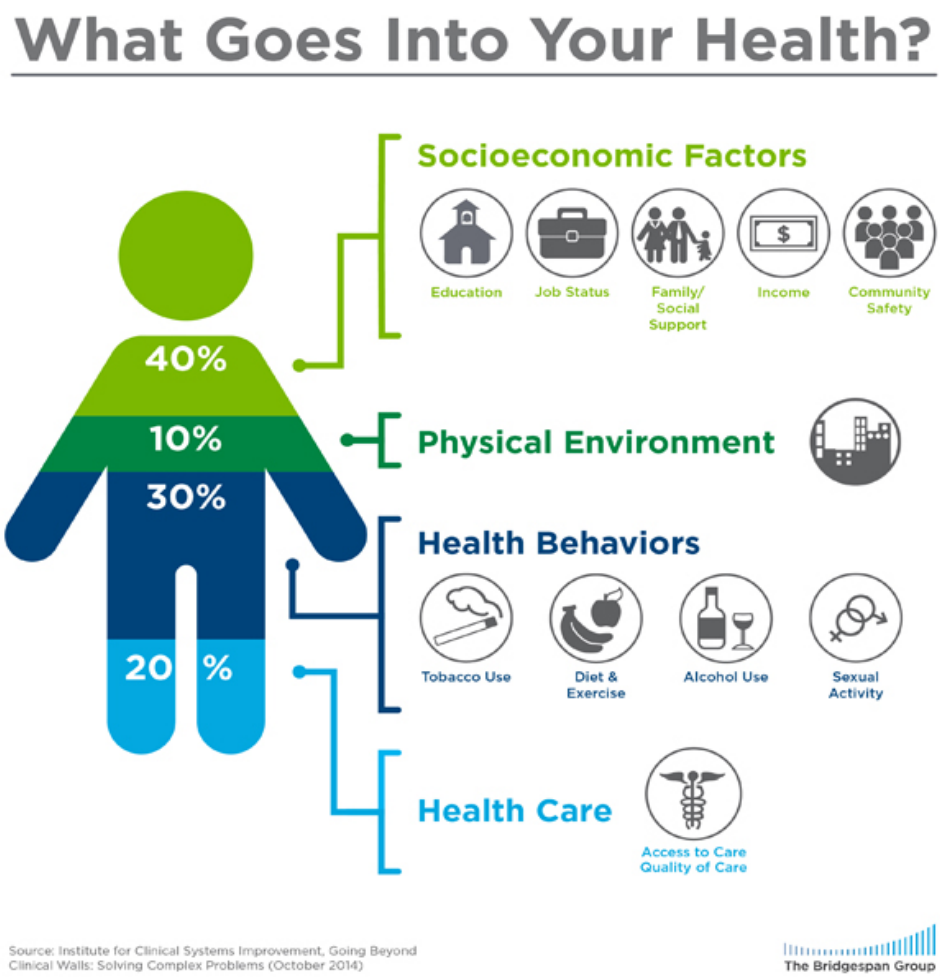
At Providence St. Joseph Health, we acknowledge that all people do not have equal opportunities and access to living their fullest, healthiest lives due to systems of oppression and inequities. We are committed to ensuring health equity for all by addressing the underlying causes of racial and economic 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 and economic factors, the physical environment, and the health behaviors that all play an active role in determining health outcomes (see Figure 1[2]).

[1] A community benefit is an initiative, program or activity that provides treatment or promotes health and healing as a response to identified community needs and meets at least one of the following community benefit objectives: a. Improves access to health services; b. Enhances public health; c. Advances increased general knowledge; and/or d. Relieves government burden to improve health. Note: Community benefit includes both services to the economically poor and broader community. To be reported as a community benefit initiative or program, community need must be demonstrated. Community need can be demonstrated through the following: 1) community health needs assessment developed by the ministry or in partnership with other community organizations; 2) documentation that demonstrates community need and/or a request from a public agency or community group was the basis for initiating or continuing the activity or program; 3) or the involvement of unrelated, collaborative tax-exempt or government organizations as partners in the community benefit initiative or program.

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

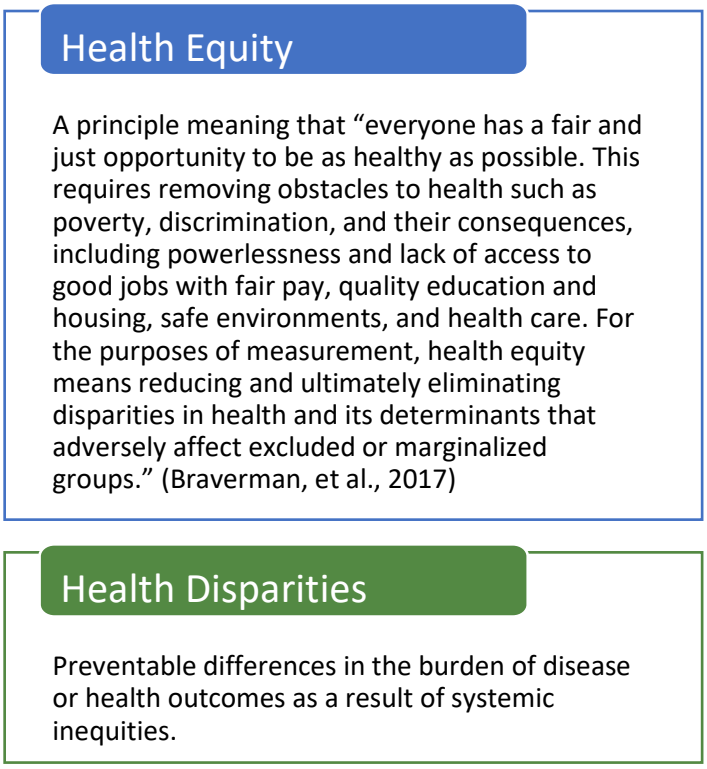
The Community Health Needs Assessment (CHNA) is an important tool we use to better understand health disparities and inequities within the communities we serve, as well as the community strengths and assets (see Figure 2 for definition of terms[3]). Through the literature and our community partners, 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 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 1. Factors Contributing to Overall Health and Well-being



[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.

Figure 2. Definitions of Key Terms



To ensure that equity is foundational to our CHNA, we have developed an equity framework that outlines the best practices that each of our hospitals 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 to address masking of needs at county level

Disaggregate data when responsible and appropriate

Acknowledge inherent bias in data and screening tools

Providence St. Peter and Providence Centralia Hospitals' Community Health Needs Assessment Committee

The Community Health Needs Assessment process was overseen by a CHNA team that included Providence staff and committee members. The Southwest Washington Community Mission Board provided oversight and approval of the CHNA. Members included:

Table 1. Southwest Washington Community Mission Board Members

Southwest Washington Community Mission Board Members	
Officers	
Jennifer Groberg, Chair	Attorney at Law
Daidre West, RN	Risk Manager *(retired)*
Board Members	
Becky Brewer	RN, IT Planning/Strategy *(retired)*
Greg Cuoio	City Manager *(retired)*
Susan Hettinger	Attorney *(retired)*
Joann Hutchison, RN	Manager *(retired)*
Dan Keahey	Real Estate
Peggy King	Banking
Amber Lewis	Political consulting
Michael Matlock, MD	Physician, Infectious Disease *(retired)*
Eileen McKenzie Sullivan	Executive Director, Senior Services
William Mitchell, MD	Physician, Gastroenterology
Brian Mittge	Journalist
Larry Poplack	Financial Advisor/Investor
Gerald Pumphrey, Ed.D.	Community College President *(retired)*
Richard Stride	Mental health services
Ian Timms, MD	Physician, Radiologist
Steve Ward	Education / Finance
Rachel Wood, MD	Lewis County Public Health Officer
Staff to the Board	
Darin Goss	Chief Executive
Irvina Crepeau	Executive Assistant

The Population Health Leadership Workgroup, as well as two Community Mission Board representatives, Brian Mittge and Dr. Rachel Wood, provided expertise in the data review and prioritization process. Members included the following:

Table 2. Population Health Leadership Workgroup Members

Population Health Leadership Workgroup Members	
Andrea Corona, Chair	Director of Ambulatory Population Health
Anne McGuire	Director of Behavioral Health Integration, PMG
Diana Currie	Medical Director of Quality, PMG
Elijah Adeoye	Senior Business Analyst and Project Manager
John Lanning	Manager of Outpatient Behavioral Health
Lenna Lizberg	Director of Quality Risk and CDI
Lisa Humphrey	Director of Nursing and Quality, PMG
Lynette Gregory	Director of Care Management
Michelle Gosse	RN Care Navigator Lead
Romil Wadhawan	Medical Director Clinical Quality
Sheri Mitchell	Projects Director
Tendai Masiriri	Director of Behavioral Health

**PMG: Providence Medical Group*

OUR COMMUNITY

Description of Community Served

Providence Centralia and Providence St. Peter Hospitals provide Lewis County and Thurston County communities in southwestern Washington with access to advanced care and advanced caring. This includes a population of approximately 368,367 people, an increase of 6.3% from the prior assessment.

Hospital Service Area

The 2020 service areas for Providence St. Peter Hospital and Providence Centralia Hospital were defined using census tracts within Thurston and Lewis Counties. There are 49 census tracts within Thurston County and 20 census tracts in Lewis County. Census tracts were enriched with social determinants of health in order to analyze the differences in the overall health of those populations. The service area cities/communities, ZIP Codes and counties are detailed in Table 2.

Table 3. Cities and ZIP Codes Included in Total Service Area

Cities/ Communities	ZIP Codes	Counties
Adna	98522	Lewis County
Bucoda	98530	Thurston County
Centralia	98531	Lewis County
Chehalis	98532	Lewis County
Cinebar	98533	Lewis County
Curtis	98538	Lewis County
Doty	98539	Lewis County
East Olympia	98540	Thurston County
Ethel	98542	Lewis County
Galvin	98544	Lewis County
Glenoma	98336	Lewis County
Lacey	98503, 98509	Thurston County
Littlerock	98556	Thurston County
Mineral	98355	Lewis County
Morton	98356	Lewis County
Mossyrock	98564	Lewis County
Napavine	98565	Lewis County

Cities/ Communities	ZIP Codes	Counties
Olympia	98501, 98502, 98504, 98505, 98506, 98507, 98508, 98512, 98513, 98516, 98599	Thurston County
Onalaska	98570	Lewis County
Packwood	98361	Lewis County
Pe Ell	98572	Lewis County
Rainer	98576	Thurston County
Randle	98377	Lewis County
Rochester	98579	Thurston County
Salkum	98582	Lewis County
Silver Creek	98585	Lewis County
Tenino	98589	Thurston County
Toledo	98591	Lewis County
Tumwater	98511	Thurston County
Vader	98593	Lewis County
Winlock	98696	Lewis County
Yelm	98597	Thurston County

HIGH NEED SERVICE AREA

Within the hospitals' 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 work done by the Public Health Alliance of Southern California and their Healthy Places Index (HPI) tool the following variables were used in the calculation of a high need census tract:

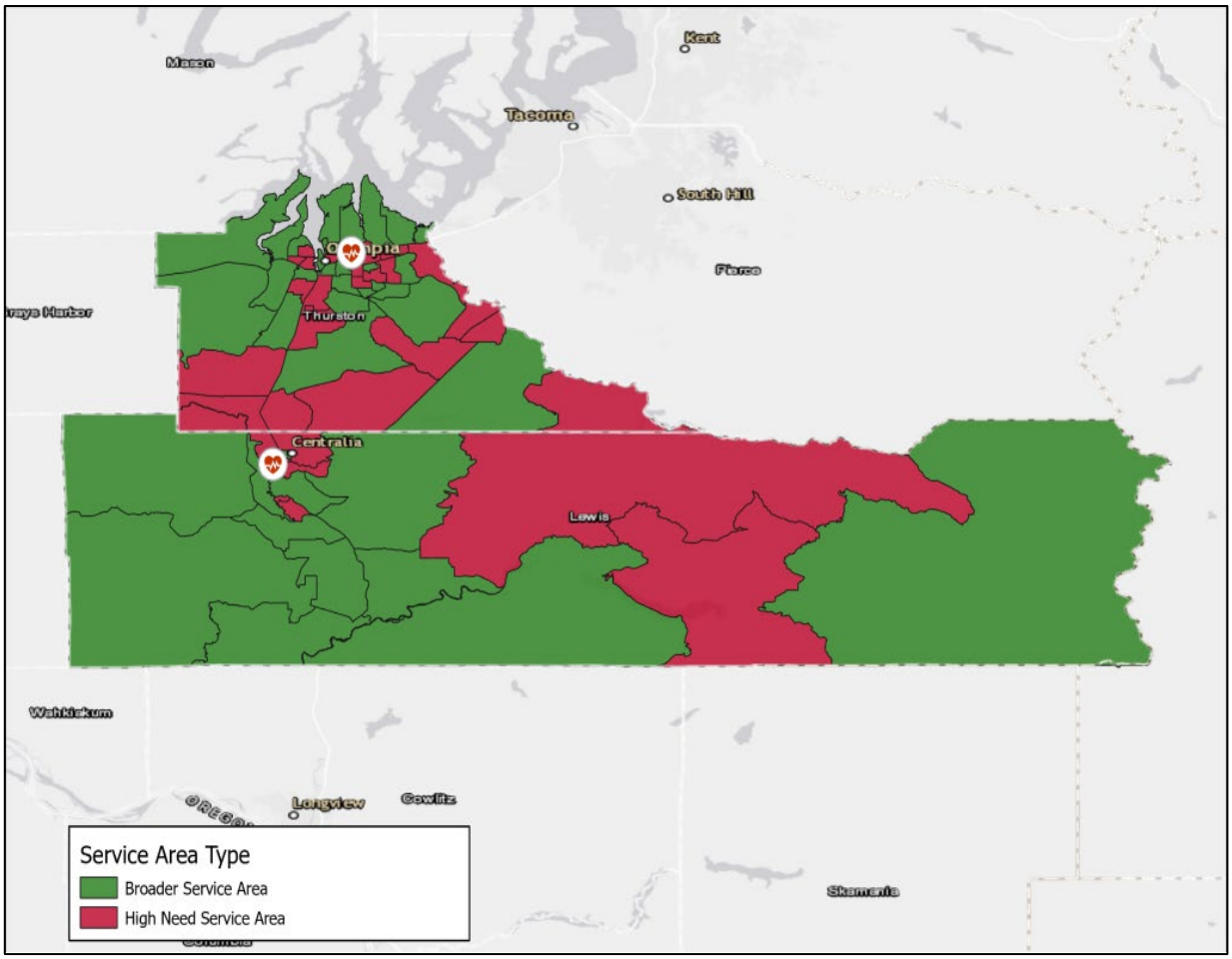
- Percent of population Below 200% the Federal Poverty Level (FPL) (2019, American Community Survey)
- Percent of Population with at least a high school diploma (2019, American Community Survey)
- Percent of population unemployed (2019, American Community Survey)
- Life Expectancy at Birth (Estimates based on 2010 – 2015 data, CDC)

For this analysis, census tracts with more people below 200% FPL, fewer people with at least a high school education, more people who are unemployed, and a lower life expectancy at birth were identified as "high need." For reference, 200% FPL is equivalent to an annual household income of $51,500 or less for a family of 4. These households are more likely to regularly make spending tradeoffs regarding utilities, rent, groceries, medicine, and other basic expenses.

In Figure 3, the map shows the entire service area (red and green combined), areas of high need (red)

and the broader service area (green).

Figure 3 Providence Centralia Hospital and Providence St. Peter Hospital Service Area



Community Demographics

POPULATION AND AGE DEMOGRAPHICS

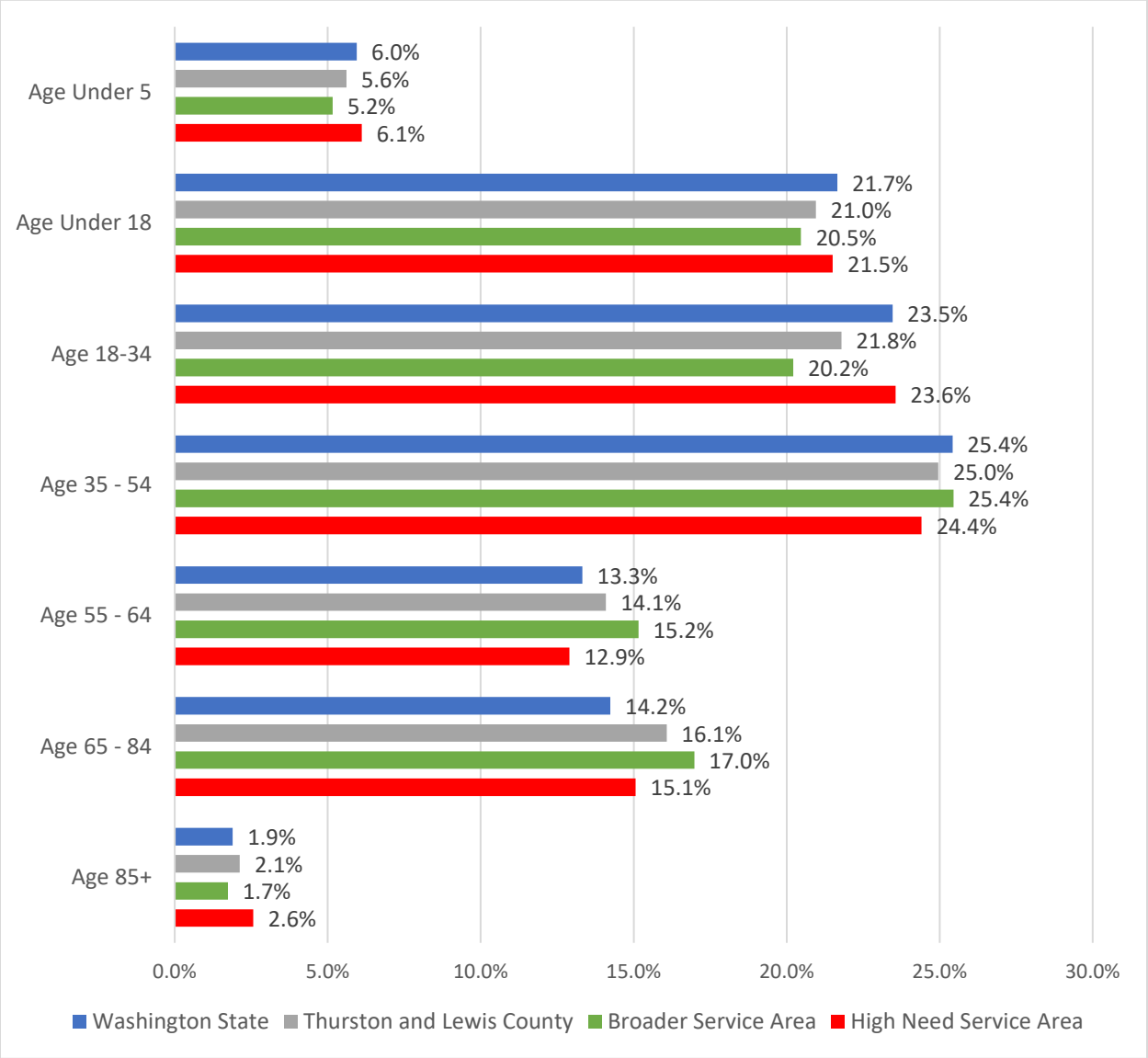
Table 4. Population Demographics for Southwest Washington Service Area

Indicator	High Need Service Area	Broader Service Area	Thurston and Lewis County	Washington State
2019 Total Population	173,512	194,855	368,367	7,608,571
Female Population	51.23%	50.63%	50.91%	50.16%
Male Population	48.77%	49.37%	49.09%	49.84%

Of the over 368,000 permanent residents in Thurston and Lewis Counties, roughly 47% live in the "high need" area. The male-to-female distribution is roughly equal across Southwest Washington geographies.

Figure 4 shows the age groups in the service area. The high need service area consists of a disproportionate amount of residents ages 18 to 34, while older adults, ages 65 to 84 are less likely to live in the high need service area. Lewis and Thurston Counties have higher percentages of people over age 65 than the state.

Figure 4. Population by Age Groups



POPULATION BY RACE AND ETHNICITY

In the service area, the majority population (80.3%) are white. 5.9% of service area residents identify as two or more races, 5.9% are Asian/Pacific Islander, 3.4% are another race, 2.9% are Black, and 1.6% are American Indian. In the hospitals' service area, 9.77% of the population is of Hispanic ethnicity. Within the high need portion of the service area, 11.07% of the population is of Hispanic ethnicity.

Individuals who identify as Hispanic or "other" race are more likely to live in high needs census tracts than their peers of other races. People who identify as white are slightly less likely to live in high need census tracts, highlighting inequities by race.

Figure 5. Population by Race

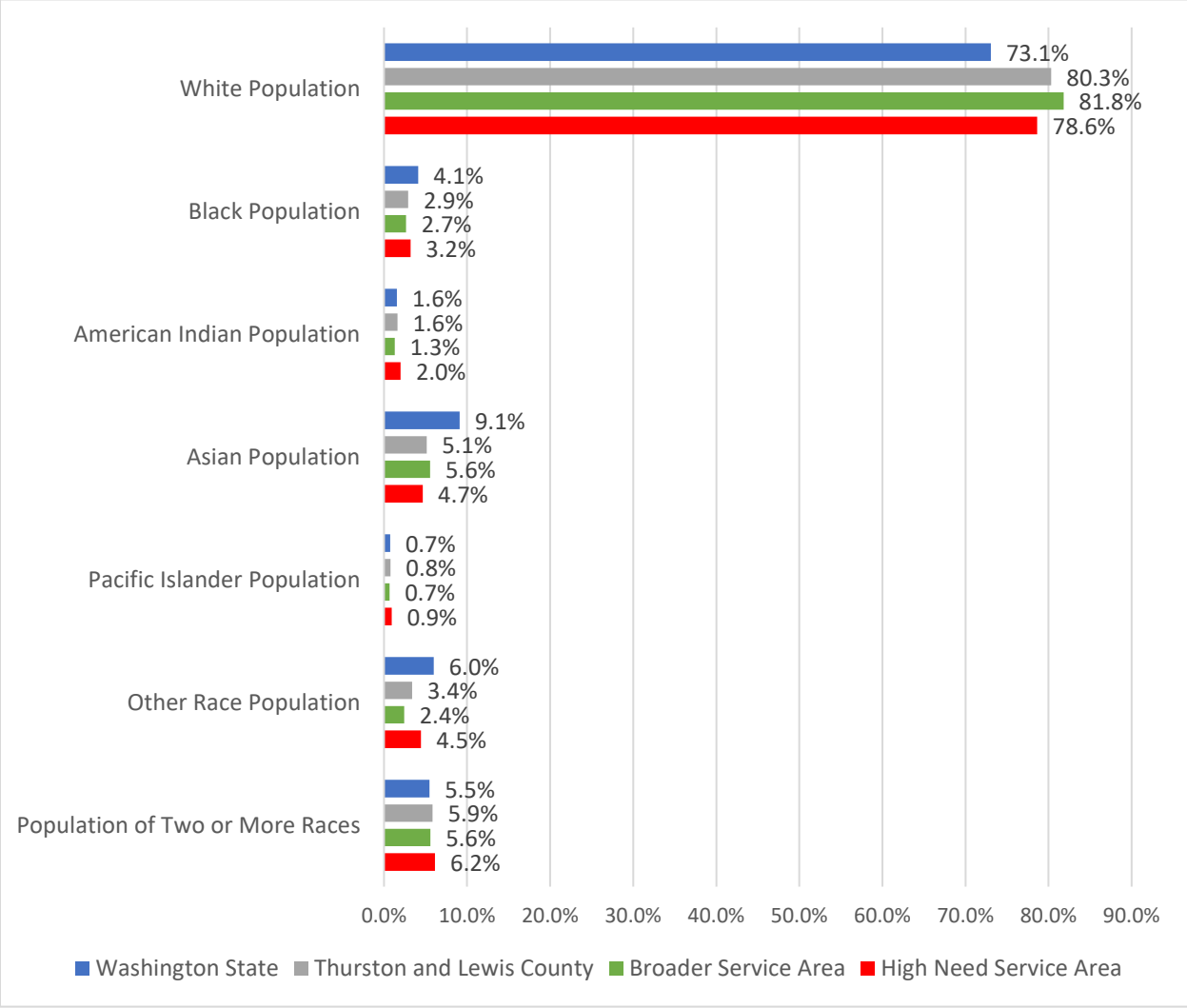
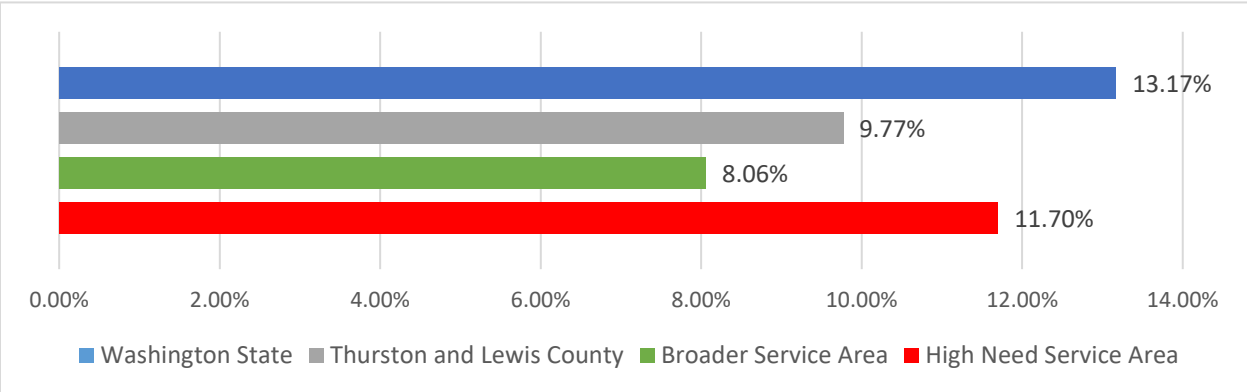


Figure 6. Hispanic Population by Geography



EDUCATION INDICATORS

Of the service area residents, 93% of people, ages 25 and older have a high school diploma. This exceeds the Healthy People 2020 objective for 87% of adults to have graduated high school.

ECONOMIC INDICATORS

The hospitals' service area has a lower economic status when compared to the state. The median household income in the service area is $66,242. Over one quarter (29.4%) of the area is considered low-income, living at 200% of less of the federal poverty level (FPL). 6.7% of area adults are unemployed and 16.1% access SNAP (food stamp) benefits. Among area renters, 25.6% experience a severe housing cost burden, as they spend 50% or more of their income on rent.

Table 5. Economic Indicators

Indicator	High Need Service Area	Broader Service Area	Thurston and Lewis Counties	Washington State
Median Household Income	$56,707	$76,890	$66,242	$73,627
Percent of Population Below 200% FPL	35.67%	23.82%	29.42%	28.20%
Percent of Labor Force Employed	93.34%	94.82%	93.30%	95.41%
Percent of Renter Households with Severe Housing Cost Burden (Spending 50% or more of Income on Rent)	25.23%	19.04%	25.60%	21.76%
Percent of Households on SNAP Benefits	18.32%	10.23%	16.14%	13.28%

Source: American Community Survey, 2019

Figure 7. 2019 Median Household Income in Southwest WA Service Area

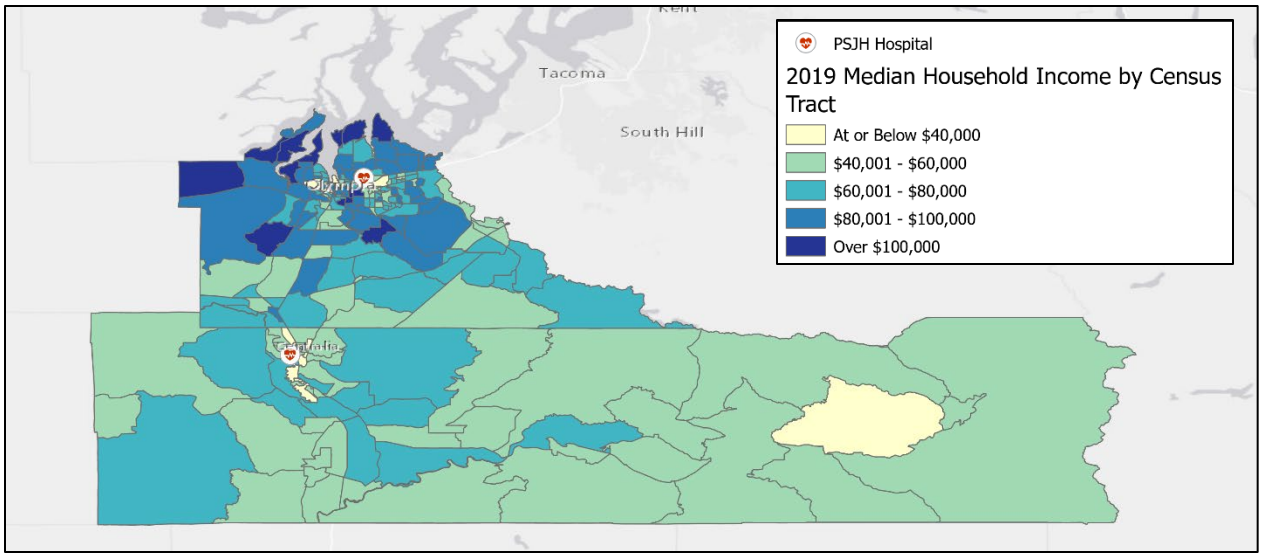
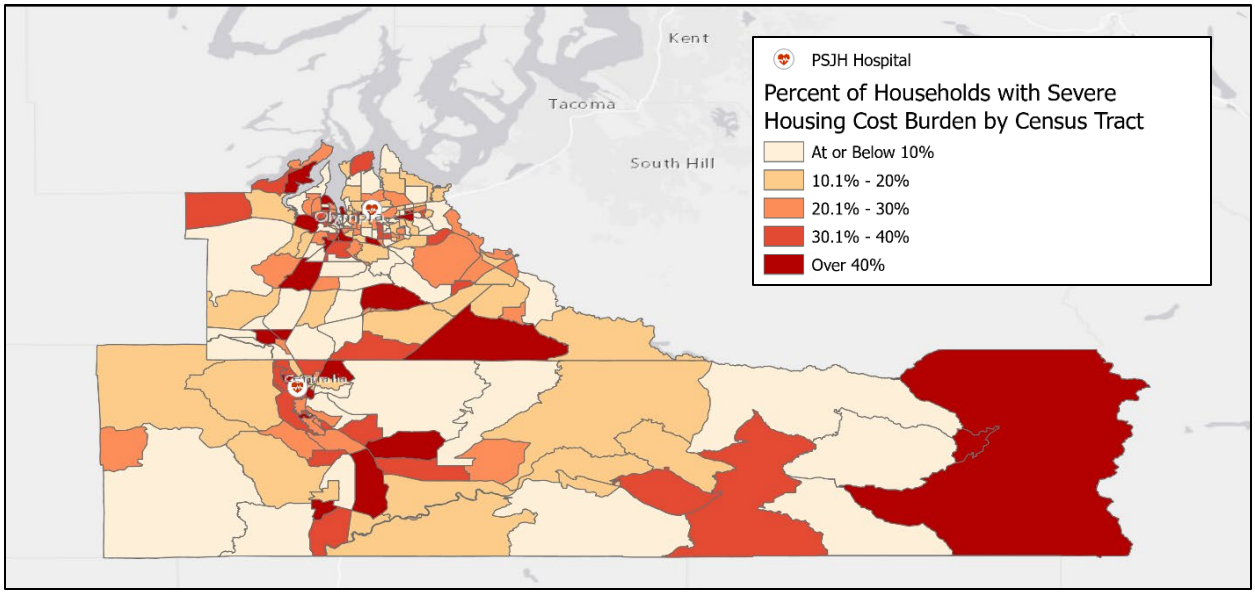


Figure 8. Percent of Households with Severe Housing Cost Burden in Southwest WA Service Area



Food insecurity is the state of being without reliable access to a sufficient quantity of affordable, nutritious food. In Lewis County, 14% of residents are food insecure and 12% of Thurston County residents are food insecure. 8% of Lewis County residents and 7% of Thurston County residents have limited access to healthy food. 50% of Lewis County children and 36% of Thurston County children are eligible for the free and reduced-price meal program.

Table 6. Food Insecurity

Indicator	Lewis County	Thurston County	Washington State
Food insecure	14%	12%	12%
Limited access to healthy food	8%	7%	6%
Children eligible for the free and reduced-price meal program	50%	36%	43%

Source: County Health Rankings, 2020

LANGUAGE PROFICIENCY

In Thurston and Lewis Counties, 1.4% of the population, ages 5 and older, do not speak English very well. This is a lower rate than found in the state (2.8%).

HEALTH PROFESSIONAL SHORTAGE AREA

Providence Centralia Hospital and Providence St. Peter Hospital are located in Health Professional Shortage Areas (HPSAs). Lewis County is designated as a primary care, dental health, and mental health

HPSA. Additionally, Lewis County Community Health Services (a Federally Qualified Health Center), Arbor Health Mossyrock Clinic (a rural health clinic), and Arbor Health Randle Clinic (a rural health clinic) are designated HPSAs for primary care, dental health, and mental health.

Thurston County has two designated geographic HPSAs, North and South Thurston County, for primary care, dental health, and mental health. Additionally, Nisqually Health Clinic (an Indian Health Service, Tribal Health, and Urban Indian Health Organization) and Rochester Family Medicine Clinic (a rural health clinic) are designated HPSAs for primary care, dental health, and mental health.

See Appendix 2 for additional demographic data tables and data maps.

OVERVIEW OF CHNA FRAMEWORK AND PROCESS

The Community Health Needs Assessment (CHNA) process is based on the understanding that health and wellness are influenced by factors within our communities, not only within medical facilities. In gathering information on the communities served by the hospitals, we looked not only at the health conditions of the population, but also at socioeconomic factors, the physical environment, and health behaviors. Additionally, we invited key stakeholders and community members to provide additional context to the quantitative data through qualitative data in the form of interviews. As often as possible, equity is at the forefront of our conversations and presentation of 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 block group level. These smaller geographic areas allow us to better understand the neighborhood level needs of our communities and better address disparities within and across communities.

We reviewed data from the American Community Survey, County Health Rankings, and local public health authorities. In addition, we included hospital utilization data to identify disparities in utilization by income and insurance, geography, and race/ethnicity when reliably collected. A glossary of terms from the CHNA can be found in **Appendix 1.**

Data Limitations and Information Gaps

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

- There are some data limitations. Some data were only available at a county level, limiting the assessment of health needs at a neighborhood level.
- Data are not always collected on a yearly basis, resulting in some data that are several years old.
- Not all desired health-related data were available. As a result, proxy measures were used when available. For example, there are limited ZIP Code level data on the incidence of mental health, or health behaviors such as substance use.

Process for Gathering Comments on Previous CHNA and Summary of Comments Received

Written comments were solicited on the 2017 CHNA and 2018-2020 CHIP reports, which were made widely available to the public via posting on the internet in December 2017 (CHNA) and May 2018 (CHIP), as well as through various channels with our community-based organization partners. At this time, no comments were received.

HEALTH INDICATORS

Hospital Utilization Data

In addition to this public health surveillance data, our hospitals can provide timely information regarding access to care and disease burden across Thurston and Lewis Counties. We were particularly interested in studying potentially avoidable Emergency Department visits and Prevention Quality Indicators. Avoidable Emergency Department (AED) is reported as a percentage of all Emergency Department visits over a given time period and are identified based on an algorithm developed by PSJH's Population Health Care Management team based on NYU and Medi-Cal's definitions.

The Prevention Quality Indicators (PQIs) are similar, although they are based on in-patient admissions. Both PQIs and AED serve as proxies for inadequate access to, or engagement in, primary care. As possible, we look at the data for total utilization, frequency of diagnoses, demographics, and payer to identify disparities.

AVOIDABLE EMERGENCY DEPARTMENT VISITS

Over 31% of Providence St. Peter Hospital Emergency Department (ED) visits were coded as avoidable and almost 32% of Providence Centralia Hospital ED visits were coded avoidable.

Table 7. Avoidable Emergency Department Visits for PSJH WA and MT Ministries

Facility	Avoidable ED Cases	Not Avoidable ED Cases	Total ED Cases	Percent of Avoidable ED Cases
Providence St. Peter Hospital	14,513	31,780	46,295	31.3%
Providence Centralia Hospital	9,075	19,660	28,735	31.6%
Total PSJH Hospitals in WA and MT	118,463	251,975	370,458	32.0%

The following tables list the top 10 patient diagnoses for avoidable emergency department discharges (AED) at the hospitals. Aside from patients leaving before being seen by a provider, upper respiratory infection and headache are the top AED diagnoses at the hospitals.

Table 8. Providence St. Peter Hospital Top 10 Diagnoses for AED Encounters

Diagnosis	Number of Encounters	Percent of Total AED Encounters
Procedure and treatment not carried out due to patient leaving prior to being seen by health care provider	1,958	11.7%
Acute upper respiratory infection, unspecified	893	5.3%
Procedure and treatment not carried out because of patient's decision for unspecified reasons	787	4.7%
Headache	698	4.2%
Major depressive disorder, single episode, unspecified	567	3.4%
Dizziness and giddiness	467	2.8%
Low back pain	359	2.1%
Periapical abscess without sinus	359	2.1%
Essential (primary) hypertension	248	1.5%
Unspecified psychosis not due to a substance or known physiological condition	236	1.4%

Table 9. Providence Centralia Hospital Top 10 Diagnoses for AED Encounters

Diagnosis	Number of Encounters	Percent of Total AED Encounters
Procedure and treatment not carried out due to patient leaving prior to being seen by health care provider	1,122	11.1%
Acute upper respiratory infection, unspecified	410	4.1%
Headache	373	3.7%
Periapical abscess without sinus	249	2.5%
Dizziness and giddiness	228	2.3%
Low back pain	225	2.2%
Chronic obstructive pulmonary disease with (acute) exacerbation	215	2.1%
Essential (primary) hypertension	209	2.1%
Acute cystitis with hematuria	205	2.0%
Noninfective gastroenteritis and colitis, unspecified	177	1.8%

PREVENTION QUALITY INDICATORS

PQIs were developed by the Agency for Healthcare Research and Quality to measure potentially avoidable hospitalizations for Ambulatory Care Sensitive Conditions (ACSCs). ACSCs are conditions for which hospitalizations can potentially be avoided with better outpatient care and which early intervention can prevent complications. PQIs were calculated for acute care facilities in the Washington/Montana region using inpatient admission data for the year 2019. More information on PQIs can be found on the following links:

https://www.qualityindicators.ahrq.gov/modules/pqi_overview.aspx

https://www.qualityindicators.ahrq.gov/modules/pqi_resources.aspx

Table 10. Prevention Quality Indicator Admissions, Cases, and Rates by Hospital

Facility	PQI Admissions	Total Inpatient Cases	PQI Rate Per 1,000 Visits
Providence Centralia Hospital	628	4,080	153.92
Providence St. Peter Hospital	1,831	18,014	101.64
Total PSJH Hospitals in WA and MT	13,166	164,445	80.06

Table 11. Prevention Quality Indicator Rates by Hospital

Prevention Quality Indicator	Rate Per 1,000 Visits
PQI 1 - Diabetes Short-Term Complications Admission Rate	**Observed Rate Per 1,000 Visits**
Providence Centralia Hospital	14.46
Providence St. Peter Hospital	8.38
PQI 3 - Diabetes Long-Term Complications Admission Rate	**Observed Rate Per 1,000 Visits**
Providence Centralia Hospital	8.82
Providence St. Peter Hospital	10.05
PQI 5 – Chronic Obstructive Pulmonary Disease (COPD) Or Asthma in Older Adults Admission Rate	**Observed Rate Per 1,000 Visits**
Providence Centralia Hospital	23.28
Providence St. Peter Hospital	10.55
PQI 7 - Hypertension Admission Rate	**Observed Rate Per 1,000 Visits**
Providence Centralia Hospital	2.85

Prevention Quality Indicator	Rate Per 1,000 Visits
Providence St. Peter Hospital	4.65
PQI 8 - Heart Failure Admission Rate	**Observed Rate Per 1,000 Visits**
Providence Centralia Hospital	60.05
Providence St. Peter Hospital	45.08
PQI 10 - Dehydration Admission Rate	**Observed Rate Per 1,000 Visits**
Providence Centralia Hospital	18.14
Providence St. Peter Hospital	11.94
PQI 11 - Community-Acquired Pneumonia Admission Rate	**Observed Rate Per 1,000 Visits**
Providence Centralia Hospital	16.67
Providence St. Peter Hospital	5.33
PQI 12 - Urinary Tract Infection Admission Rate	**Observed Rate Per 1,000 Visits**
Providence Centralia Hospital	6.37
Providence St. Peter Hospital	5.61
PQI 14 - Uncontrolled Diabetes Admission Rate	**Observed Rate Per 1,000 Visits**
Providence Centralia Hospital	7.60
Providence St. Peter Hospital	5.00
PQI 16 - Lower Extremity Amputations Among Patients with Diabetes Admission Rate	**Observed Rate Per 1,000 Visits**
Providence Centralia Hospital	2.70
Providence St. Peter Hospital	5.16

Access to Healthcare

In Lewis County, 9% of the population is uninsured and in Thurston County, 6% are uninsured. There are higher percentages of uninsured adults compared to uninsured children. Lewis County has fewer primary care providers and dentists than Thurston County when calculated as a population ratio. Thurston County has a higher ratio of mental health care providers to the population, which equates to fewer providers per person compared to Lewis County.

Table 12. Access to Healthcare

Indicator	Lewis County	Thurston County	Washington State
Uninsured, total population, under age 65	9%	6%	7%
Uninsured, adults	11%	7%	9%
Uninsured, children	3%	2%	3%
Ration of population to primary care providers	2234:1	1002:1	1183:1
Ratio of population to dentists	1531:1	1345:1	1226:1
Ratio of population to mental health providers	275:1	297:1	268:1

Source: County Health Rankings, 2020

Health Behaviors

In Lewis County, the life expectancy is 77.7 years and in Thurston County it is 80.3 years. These life expectancies are lower than the state life expectancy of 80.4 years. A reliable estimate of health is people's reports of days when their physical health or mental health were not good. Residents of Lewis County experience, on average, 4.2 poor physical health days and 4.4 poor mental health days a month. Residents of Thurston County experience, on average, 3.7 poor physical health days and 3.8 poor mental health days a month.

Table 13. Life Expectancy, Poor Physical and Mental Health Days

Indicator	Lewis County	Thurston County	Washington State
Life expectancy (in years)	77.7	80.3	80.4
Poor of fair health, adults, age-adjusted	17%	13%	16%
Poor physical health (average days per month), age-adjusted	4.2	3.7	3.9
Poor mental health (average days per month), age-adjusted	4.4	3.8	4.1

Source: County Health Rankings, 2020

The adult obesity proportion is 35% in Lewis County and 30% in Thurston County. These percentages of adult obesity exceed those of the state (28%). The Healthy People 2020 objective is 30.5% adult obesity. Among adults in Lewis County, 24% are physically inactive, while 54% of the population has access to

exercise opportunities. In Thurston County, 17% of adults are physically inactive and 75% of the population has access to exercise opportunities.

Table 14. Obesity and Physical Activity

Indicator	Lewis County	Thurston County	Washington State
Adult obesity, age 20 and older	35%	30%	28%
Physical inactivity	24%	17%	17%
Access to exercise opportunities	54%	75%	86%

Source: County Health Rankings, 2020

Mortality/Death Rates

Death rates in Lewis County for injuries, suicides, and firearm fatalities exceed state rates for those causes of deaths. Drug overdose death rates are lower in Lewis and Thurston Counties when compared to the state. Motor vehicle death rates are higher in Lewis County than in Thurston County and the state.

Table 15. Mortality Rates, per 100,000 Persons

Indicator	Lewis County	Thurston County	Washington State
Premature death rate (under age 75), age-adjusted	380	285	287
Injury	87	68	66
Suicide	20	17	16
Firearm fatalities	15	11	10
Drug overdose	14	12	15
Motor vehicle	12	8	8
Homicide	3	2	3

Source: County Health Rankings, 2020

Disease Prevalence

In Lewis and Thurston Counties, 10% of the adult population has been diagnosed with diabetes. Rates of chlamydia and HIV are lower in Lewis and Thurston Counties when compared to the state rates.

Table 16. Disease Prevalence

Indicator	Lewis County	Thurston County	Washington State
Diabetes, adults	10%	10%	9%
HIV rate per 100,000 persons	80	119	209
Chlamydia rate per 100,000 persons	360.6	404.5	435.2

Source: County Health Rankings, 2020

Maternal and Child Health

The Lewis County child mortality rate (69 per 100,000 persons) and infant mortality rate (7 per 1,000 live births) exceed these rates in Thurston County and the state. The Healthy People 2020 objective for infant deaths is 6.0 per 1,000 live births. Of live births, 7% are low birth weight in Lewis County and 6% are low birth weight in Thurston County. The Healthy People 2020 objective for low birth weight births is 7.8% of live births. Lewis County has a higher teen birth rate (32 per 1,000 females, ages 15-19) compared to Thurston County and the state.

Table 17. Maternal and Child Health Indicators

Indicator	Lewis County	Thurston County	Washington State
Child mortality rate, under age 18, per 100,000 persons	69	39	40
Infant mortality rate (within 1 year), per 1,000 live births	7	5	4
Low birth weight, percentage of live births <2,500 grams	7%	6%	6%
Teen birth rate, per 1,000 female population, ages 15-19	32	17	18

Source: County Health Rankings, 2020

Preventive Practices

Lower percentages of female Medicare enrollees in Lewis and Thurston Counties received an annual mammogram than at the state level. Among fee-for-service Medicare enrollees, 35% in Lewis County and 48% in Thurston County received an annual flu vaccine. The Healthy People 2020 objective is for 90% of the population to receive an annual flu vaccine.

Table 18. Preventive Practices Among Medicare Enrollees

Indicator	Lewis County	Thurston County	Washington State
Annual mammograms, female Medicare enrollees, ages 65-74	33%	36%	39%
Annual flu vaccines, fee for service Medicare enrollees	35%	48%	46%

Source: County Health Rankings, 2020

Substance Use

In Lewis County, 33% of driving deaths involved alcohol. In Thurston County, 29% of driving deaths involved alcohol. In Lewis County 15% of adults reported binge or heavy drinking and 16% smoked cigarettes. In Thurston County, 18% of adults engaged in excessive drinking and 13% smoked cigarettes. The Healthy People 2020 objective for cigarette smoking among adults is 12%.

Table 19. Alcohol Use and Cigarette Smoking, Adults

Indicator	Lewis County	Thurston County	Washington State
Percentage of driving deaths with alcohol involvement	33%	29%	32%
Excessive drinking, adults	15%	18%	17%
Smoking, adult	16%	13%	13%

Source: County Health Rankings, 2020

See Appendix 2: Quantitative Data for additional data sets and maps.

COMMUNITY INPUT

Summary of Community Input

To better understand the unique perspectives, opinions, experiences, and knowledge of community stakeholders, representatives from Providence Southwest Washington conducted stakeholder interviews with representatives from 5 community-based organizations, including 24 participants. During these interviews, nonprofit and government stakeholders discussed the issues and opportunities of the people, neighborhoods, and cities of 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 3**. The following findings represent the **high-priority health-related needs**, based on feedback from stakeholders:

Homelessness/ lack of safe, affordable housing	Homelessness/lack of safe, affordable housing was prioritized by all stakeholders and consistently ranked as the most important issue that needs to be addressed. Stakeholders stressed that despite efforts to address housing challenges, there is a lack of housing available in Thurston and Lewis counties, particularly **affordable rental units** and **permanent supportive housing**, as well as foster homes and adult family homes**.** Stakeholders were concerned about **families with low incomes** who are unstably housed and **young people, particularly those identifying as LGBTQ**, who may be experiencing homelessness. A common theme was that **housing is foundational** to all other needs; once people are housed securely, they can address other needs related to their health and wellbeing. Stakeholders shared that with the COVID-19 pandemic, they are expecting homelessness to increase, and are particularly concerned about an increase in students unstably housed.
Behavioral health challenges (includes both mental health and substance use disorder) and access to care	Stakeholders shared there is a lack of mental health and substance use treatment services in the community. Gaps include a lack of **behavioral health integration into primary care**, enough **school-based mental health** services, a **local inpatient detox facility**, and **case management services** for individuals discharged from inpatient psychiatric facilities if they lack insurance. Stakeholders were concerned about many groups of people who may have difficulty accessing mental health services due to **long wait times**, a **lack of providers** who take Medicaid and Medicare, and **transportation** barriers. Those populations include school-aged children, older adults, people experiencing homelessness, people living in rural communities, veterans, people who are undocumented, and monolingual Spanish speakers. The COVID-19 pandemic has only exacerbated these barriers and concerns, reducing access to care for many, particularly those who lack the technology, privacy, and abilities to engage successfully in **telehealth**. The added **stress** and **isolation** have contributed to increased concern for the wellbeing of older adults, young people, people with low-incomes, Native populations due to historical trauma, and individuals with substance use disorders.

Access to health care services	Stakeholders shared a variety of barriers that keep people from accessing the health care services they need to stay healthy. The most common concern was **transportation**, particularly for older adults, people experiencing homelessness, and people living in rural communities. They were also concerned about **cost of care** for older adults, people who are slightly above the threshold for Medicaid, and people experiencing homelessness. Stakeholders shared **language** barriers prevent people from receiving appropriate and responsive care and **documentation status** is a barrier to accessing health insurance. Strict requirements related to **proof of income and identification** can prevent people who are experiencing homelessness, who are undocumented, and with severe mental illness from demonstrating qualification for services. Stakeholders shared they are seeing people **delay care** due to COVID-19 and not everyone is able to engage successfully using **telehealth**.

The following findings represent **medium-priority health-related needs** based on feedback from stakeholders:

Unemployment and lack of living wage jobs	Stakeholders were concerned with rising unemployment as a result of COVID-19, as well as individuals who are not paid sufficient income to meet their basic needs, such as **housing** and **food**. They shared that unemployment and lack of job stability are leading to increased **mental health challenges**, such as stress, depression, and suicidal thoughts. Stakeholders noted that many people are underemployed, meaning they are working in low-paying or low-skill jobs, affecting their ability to pay for **childcare**.
Food insecurity	Stakeholders were concerned about community members' access to good quality, nutritious food, particularly because the pandemic has exacerbated the need. They shared food insecurity is closely linked with **income**; families with low incomes or job loss are forced to make tradeoffs in how they spend their money. Stakeholders were particularly concerned about two groups having enough nutritious food during the pandemic: **school-aged children** due to school closures and **older adults** who are homebound.
Access to oral health care	Stakeholders described accessing oral health care as a major challenge for many patients, stating that services remain inaccessible. They shared that addressing barriers to accessing oral health services is important because of how closely linked oral health is with physical health overall. There are limited dental services available for people with **Medicaid** and individuals with low incomes often cannot afford the **cost of care**, even with a sliding scale. Stakeholders shared there is no **oral surgeon** in the region who serves Medicaid clients and limited dental services for **children on Medicaid**. **Older adults** have limited access to dental insurance and providers.

Stakeholders discussed the **effects of the COVID-19 pandemic** on the communities they serve:

Effects of COVID-19	Stakeholders discussed how the pandemic has prevented their clients from accessing health care and behavioral health services, stating that while telehealth has increased access for some individuals, it has prevented others from receiving the care they need. People are delaying care, including **well child visits**, **vaccinations**, **dental care**, **chronic disease management**, and **mental health services**, which may have lasting effects. Stakeholders shared some clients would prefer to delay care until they can be seen in person and others lack the **technology**, **internet**, and/or **privacy** for telehealth appointments. They shared they have not been able to contact some of the hardest to serve individuals, particularly **clients experiencing homelessness**. Stakeholders noted increased isolation for **older adults** and added stress on **families** with children.

Challenges in Obtaining Community Input

Obtaining robust community input during the COVID-19 pandemic was especially challenging and prevented Providence Southwest Washington from completing any in-person conversations. Multiple community listening sessions were planned for April and May but were cancelled due to the pandemic. Stakeholder interviews were collected between May 27 and July 14, 2020, although many community organizations expressed not having capacity to participate in interviews. Several attempts were made to connect with representatives from Lewis County Public Health and Social Services and Thurston County Public Health and Social Services, but due to competing priorities related to COVID-19, they were not able to participate in stakeholder interviews. Dr. Rachel Wood, Lewis County Public Health Officer, did participate in the data review and prioritization process.

To ensure alignment with local Public Health improvement planning, we emailed Lewis County Public Health and Social Services and Thurston County Public Health and Social Services for their most up-to-date CHNA available, as the findings are not yet available online. Alignment in priorities is discussed in the 2021-2023 CHIP Priorities section.

SIGNIFICANT HEALTH NEEDS

Prioritization Process

As noted, Providence Southwest Washington (SW WA) conducted stakeholder interviews, recognizing the importance of including the voices of community leaders who help make Lewis and Thurston Counties healthier. 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. The stakeholder interviews are particularly important this CHNA cycle as the COVID-19 pandemic prevented us from facilitating listening sessions with community members. We relied on community stakeholders to represent the broad needs of the communities they serve.

As part of the interviews, the stakeholders were asked to identify the top health-related needs in the community. Three needs stood out as universally important to stakeholders and were categorized as high priority. Three needs were also frequently prioritized and categorized as medium priority. **Appendix 3** details the interview methodology and reasons given by stakeholders for selecting these priority needs.

2020 Priority Needs

The list below summarizes the rank ordered significant health needs identified through the 2020 Community Health Needs Assessment community engagement process:

PRIORITY 1: HOMELESSNESS/LACK OF SAFE AFFORDABLE HOUSING

Homelessness and a lack of safe, affordable housing was prioritized by all stakeholders and consistently ranked as the most important issue that needs to be addressed in the service area. Despite efforts to address housing challenges, there is a lack of housing available in Thurston and Lewis counties, particularly affordable rental units and permanent supportive housing.

PRIORITY 2: BEHAVIORAL HEALTH (INCLUDES MENTAL HEALTH AND SUBSTANCE USE)

There is a lack of mental health and substance use treatment services in the community. Gaps include a lack of behavioral health integration into primary care, school-based mental health services, a local inpatient detox facility, and case management services. People have difficulty accessing mental health services due to long wait times, a lack of providers who take Medicaid and Medicare, and transportation barriers. These populations include school-aged children, older adults, people experiencing homelessness, people living in rural communities, veterans, people who are undocumented, and monolingual Spanish speakers.

PRIORITY 3: ACCESS TO HEALTH CARE

There are a number of barriers to accessing health care. A common concern was transportation, particularly for older adults, people experiencing homelessness, and people living in rural communities.

Language barriers prevent people from receiving appropriate and responsive care and documentation status is a barrier to accessing health insurance.

PRIORITY 4: UNEMPLOYMENT AND LACK OF LIVING WAGE JOBS

6.7% of area adults are unemployed. However, unemployment rates are rising as a result of COVID-19. Residents are not paid sufficient income to meet their basic needs. Unemployment and lack of job stability are leading to increased mental health challenges, such as stress, depression, and suicidal thoughts.

PRIORITY 5: FOOD INSECURITY

Food insecurity is closely linked with income. In Lewis County, 14% of residents are food insecure and 12% of Thurston County residents are food insecure. School aged children and home bound seniors are at special risk for food insecurity and may lack access to healthy food options.

PRIORITY 6: ACCESS TO ORAL HEALTH CARE

Accessing oral health care is a major challenge for many residents in the service area. There are limited dental services available for people with Medicaid and individuals with low incomes often cannot afford the cost of care, even with a sliding scale.

Potential Resources Available to Address Significant Health Needs

Understanding the potential resources to address significant health needs is fundamental to determining current state capacity and gaps. The organized health care delivery systems include the Department of Public Health and area hospitals. In addition, there are numerous social service nonprofit agencies, faith-based organizations, and private and public-school systems that contribute resources to address these identified needs. For a list of potentially available resources available to address significant health needs see **Appendix 4**.

EVALUATION OF 2018-2020 CHIP IMPACT

The 2017 CHNA identified 7 significant health needs: mental health services (including substance abuse services); access to primary and specialty services; physical activity and nutrition; poverty, economic development, and job growth; chronic disease; healthy aging; and homelessness. Due to the breadth of these needs and limited resources, the CHIP priority was mental health services, though our programs and interventions also addressed access to primary and specialty services, poverty, economic development, and job growth, and homelessness.

Providence in SW Washington focused on expanding behavioral health services through integration in primary care, and the development of the Providence Community Care Center. The Community Care Center co-located several social service providers, focusing on housing, older adult care, resource support, case management, primary and specialty care, behavioral health services, employment assistance, peer support, veteran's services, as well as laundry, restrooms, and showers at the day shelter.

Table 20. Outcomes from 2018-2020 CHIP

Priority Need	Program or Service Name	Results/Outcomes	Type of Support
Mental health services (including substance use services)	Integration of behavioral health in primary care	• Provided access to integrated behavioral health at 100% of all PMG primary care clinics in the SW region. • Behavioral Health Specialist physically embedded at six clinics. • Implemented evidenced-based models of behavioral health care. • 60.2% of clinic patients received annual depression screening (baseline 55.1% in 2017). • Depression response (50% reduction in PHQ-9) or depression remission (HEDIS metrics = PHQ-9 < 5) for 45 % of patients enrolled in collaborative care. Results – 41% achieved by Q3 2019.	Program

Priority Need	Program or Service Name	Results/Outcomes	Type of Support
Mental health services (including substance use services)	Providence Community Care Center	• 1,167 behavioral health service contacts at Behavioral Health Resources[4]. • 547 program caseload contacts (9/2017-12/2019) at Behavioral Health Resources. • 4,761 behavioral health services contacts at Providence. • 1,226 program caseload contacts (9/2017-12/2019) at Providence. • 2,045 housing services enrollments. • 3,153 medical care visits for 2,341 patients. • 145 average number of daily guests to the community day center.	Program

[4] These data are an underrepresentation of the services provided as they only include the work of Master's Level Case Managers and do not include Psych ARNP medication management or SUD treatment.

2021-2023 CHIP PRIORITIES

Prioritization Process and Criteria

The Population Health Leadership Workgroup served as the oversight committee to identify and prioritize the top health-related needs in the community for the 2021-2023 CHIP. Committee members reviewed and analyzed the quantitative and qualitative data in the CHNA, as well as the needs prioritized by the community stakeholders. The Population Health Leadership Workgroup and Community Mission Board representatives, Brian Mittge and Dr. Rachel Wood, reviewed and analyzed the aggregated quantitative and qualitative CHNA data. The Providence St. Joseph Health Data Integration Team presented an in-depth review of publicly available data, internal utilization data, and findings from the stakeholder interviews. The workgroup then completed an online prioritization survey identifying the top three health-related needs from the following list of significant health needs:

- Access to health care (including digital divide)
- Health and racial equity
- Housing instability and homelessness
- Mental health and substance use
- Economic insecurity
- Healthy aging
- Food insecurity
- Oral health
- Transportation
- Health literacy

The following criteria were used in the prioritization process:

- Worsening trend over time
- Disproportionate impact on low income and/or Black, Brown, Indigenous, and People of Color (BBIPOC) communities
- PSJH service area/high need service area rates worse than state average and/or national benchmarks
- Opportunity to impact: organizational commitment, partnership, severity, and/or scale of need
- Alignment with existing System priorities

The Population Health Leadership Workgroup members discussed their ranking choices and refined the language and scope of the health-related needs.

The results of the online criteria-based ranking and the subsequent qualitative input determined the 2021-2023 CHIP priorities, which were reviewed, confirmed, and/or refined based on committee

member input. The list below summarizes the significant health needs for the 2021-2023 CHIP identified through the 2020 CHNA process:

- **Housing Instability and Homelessness**
- **Mental Health and Substance Use**
- **Access to Health Care (including the digital divide)**

Stakeholders chose to prioritize a fourth health-related need, **health and racial equity**, throughout the improvement plans for all three needs listed above. This means when addressing housing, mental health and substance use, and access to care, Providence Southwest Washington will use an equity framework for approaching planning and implementation.

ALIGNMENT WITH PUBLIC HEALTH PRIORITIES

To ensure alignment with local Public Health improvement planning, we requested the most recent community health assessments from Lewis County Public Health and Social Services and Thurston County Public Health and Social Services, as the findings were not yet available online. Additionally, Dr. Rachel Wood, Lewis County Public Health Officer, participated in the data review and prioritization process. In 2019, Thurston Thrives, a community health initiative consisting of partnerships across the Thurston County region, identified priority community health issues for the county:

- Access to care (inclusive of access to behavioral health services)
- Education (inclusive of access to behavioral health services that support students in the school environment across K-12)
- Economics
- Housing
- Resilience

There is alignment between the needs identified and prioritized by Providence Southwest Washington and those of Thurston County. Both assessments prioritized access to care and housing. Additionally, both included addressing mental health and substance use challenges and access to behavioral health services. Both assessments utilize an equity framework to address health disparities and systemic inequities in community improvement planning.

Addressing Identified Needs

The Community Health Improvement Plan developed for the Southwest Washington 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 Providence Centralia and Providence St. Peter Hospitals plan to address the health needs. If the hospitals do 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

Providence Centralia and Providence St. Peter Hospitals intend to take, but also the anticipated impact of these actions and the resources the hospitals plan to commit to address the health needs.

Because partnership is important when addressing health needs, the CHIP will describe any planned collaboration between Providence Centralia Hospital, Providence St. Peter Hospital and community-based organizations in addressing the health needs. The CHIP will be approved and made publicly available no later than May 15, 2021.

2020 CHNA GOVERNANCE APPROVAL

This Community Health Needs Assessment was adopted on October 22, 2020 by the Community Mission Board for Providence St. Peter and Providence Centralia hospitals. The final report was made widely available by December 31, 2020.

11/19/2020

Darin Goss — Date
Chief Executive, Providence Southwest Washington

11/19/2020

Jennifer Groberg — Date
Chair, Providence Southwest Washington Community Mission Board

12/01/2020

Joel Gilbertson — Date
Executive Vice President, Community Partnerships
Providence St. Joseph Health

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

APPENDICES

Appendix 1: Definition of Terms Related to Community Input

Access to health care services: The timely use of personal health services to achieve the best health outcomes (excluding oral health and behavioral health care services, which are included in other categories). Health care services include primary care providers, pediatricians, OB/GYN, and specialists. Access encompasses issues around insurance coverage, cost of care, timing and availability of appointments, geographic availability, availability of culturally responsive and linguistically appropriate providers, and navigating the complexities of the health care system.

Access to oral health care services: The timely use of oral health care services to achieve the best health outcomes related to dental care, tooth loss, oral cancer, and gum disease. Access encompasses issues around insurance coverage, cost of care, timing and availability of appointments, geographic availability, availability of culturally responsive and linguistically appropriate providers, and navigating the complexities of the health care system. Access to safe, nearby transportation

Accessibility for people with disabilities: The ease with which a person with a disability can utilize or navigate a product, device, service, or environment.

Affordable daycare and preschools: All families, regardless of income, can find high-quality, reasonably priced, convenient childcare options for their children birth to five. This includes free or reduced cost daycare and preschools for families that meet certain income requirements.

Aging problems: The challenges faced by adults as they age, specifically those over the age of 65, who may experience memory, hearing, vision, and mobility challenges. Adults over the age of 65 make up a larger percentage of the U.S. population than ever before and require specific supportive services related to health care, housing, mobility, etc.

Air quality: The degree to which the air is pollution and smoke-free.

Avoidable Emergency Department Utilization (AED): Based on algorithms by MediCal and NYU, PSJH Healthcare Intelligence developed an "AED" flag. This is a list of conditions by diagnostic code that should not require Emergency Department care and are better treated at a more appropriate level of care. Reported at the hospital level and by payor group.

Behavioral health challenges and access to care: Includes challenges related to both mental health and substance use disorders, as well as difficulties getting the support services and care to address related challenges. Covers all areas of emotional and social well-being for all ages, including issues of stress, depression, coping skills, as well as more serious health conditions such as mental illness and Adverse Childhood Experiences. Access encompasses issues around insurance coverage, cost of care, timing and availability of appointments, geographic availability, availability of culturally responsive and linguistically appropriate providers, and navigating the complexities of the health care system.

Bullying and verbal abuse: Put downs and personal attacks that cause a person emotional harm. Examples include name calling, shaming, jokes at the expense of someone else, excessive criticism, yelling and swearing, and threats. Specifically referring to instances taking place outside of the home, in places in the community such as school and the workplace.

Child abuse and neglect: "Injury, sexual abuse, sexual exploitation, negligent treatment or maltreatment of a child by any person under circumstances which indicate that the child's health, welfare, and safety is harmed."[5]

Discrimination: Treating a person unfairly because of who they are or because they possess certain characteristics or identities. Examples of characteristics or identities that are discriminated against include the following: age, gender, race, sexual orientation, disability, religion, pregnancy and maternity, gender reassignment, and marriage and civil partnership.[6]

Domestic violence: Also called intimate partner violence, "a pattern of abusive behavior in any relationship that is used by one partner to gain or maintain control over another intimate partner."[7]

Economic Insecurity: Lacking stable income or other resources to support a standard of living now and in the foreseeable future.

Few arts and cultural events: A lack of representation of different cultures and groups in the community demonstrated through music, dance, painting, crafts, etc.

Firearm-related injuries: Gun-related deaths and injuries.

Food insecurity: A lack of consistent access to enough good-quality, healthy food for an active, healthy life.

Gang activity/ violence: Encompasses the incidence of crime and violence in the community as well as the fear of it, which prevents people from using open space or enjoying their community.

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."[8]

[5] https://www.dcyf.wa.gov/safety/what-is-abuse
[6] https://www.eoc.org.uk/what-is-discrimination/
[7] https://www.thehotline.org/is-this-abuse/abuse-defined/
[8] 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.

HIV/AIDS: Acquired immunodeficiency syndrome (AIDS), a chronic potentially life-threatening condition caused by the human immunodeficiency virus (HIV). Refers to challenges addressing the spread of HIV in the community and challenges providing treatment, support, and health education related to HIV and AIDS.

Homelessness/ lack of safe, affordable housing: Affordability, availability, overcrowding, and quality of housing available in the community. Includes the state of having no shelter or inadequate shelter.

Job skills training: Occupational training with an emphasis on developing the necessary skills to support and guide individuals in finding jobs that meet their interests and pay a livable wage.

Lack of community involvement: Individuals in a defined geographic area do not actively engage in the identification of their needs, nor do they participate in addressing those needs.

Obesity: Primarily defined as the health condition in which individuals are sufficiently overweight as to have detrimental effects on their overall health. This does not include issues of exercise or food choices, which are listed as separate issues.

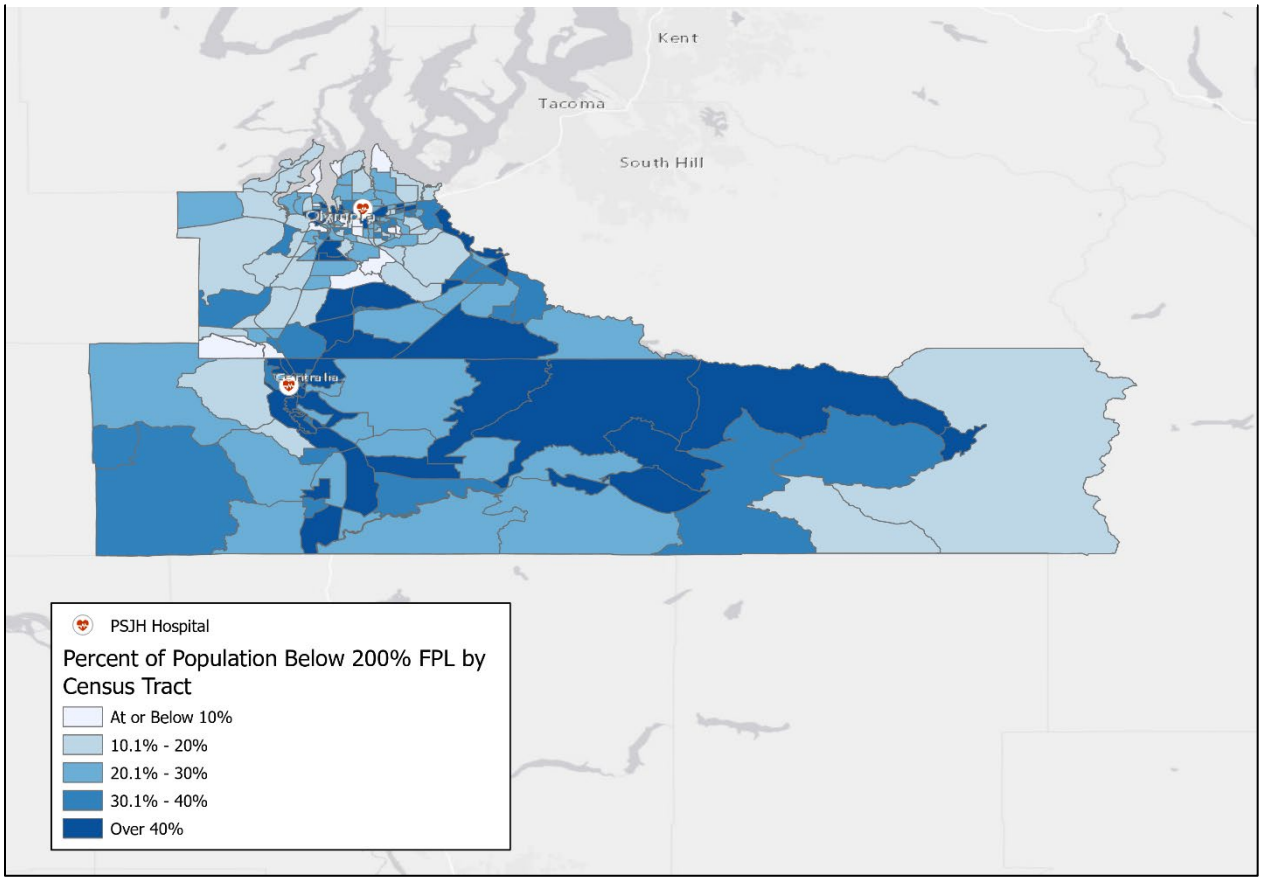
Appendix 2: Quantitative Data

POPULATION LEVEL DATA

Apx 2_Table 1. Population Below 200% FPL for Southwest WA Service Area

Indicator	High Need Service Area	Broader Service Area	Thurston and Lewis Counties	Washington State
Percent of Population Below 200% Federal Poverty Level Data Source: American Community Survey Year: 2019	35.67%	23.82%	29.42%	28.20%

Apx 2_Figure 1. Population Below 200% FPL for Southwest WA Service Area

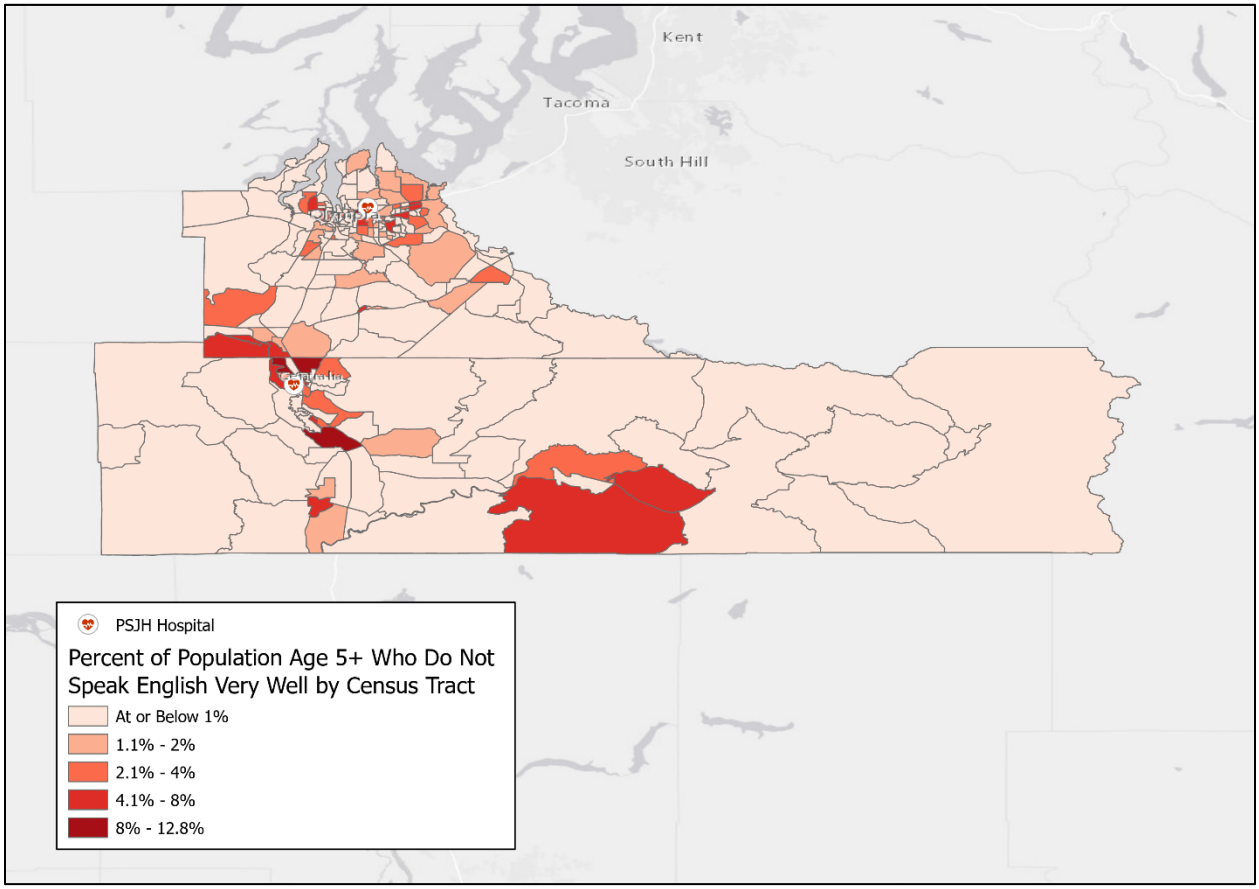


- The high need service area for Thurston and Lewis Counties has a larger proportion of population living below 200% FPL, 36%, compared to the counties overall, 29%.
- The gap is even wider between the high need service area, 36%, and the broader service area, 24%, when comparing percent of population living below 200% FPL.

Apx 2_Table 2. Population Age 5 and Older that Does Not Speak English Very Well for Southwest WA Service Area

Indicator	High Need Service Area	Broader Service Area	Thurston and Lewis Counties	Washington State
Percent of Population Age 5+ Who Do Not Speak English Very Well Data Source: American Community Survey Year: 2019	1.60%	1.18%	1.36%	2.75%

Apx 2_Figure 2. Population Age 5 and Older that Does Not Speak English Very Well for Southwest WA Service Area

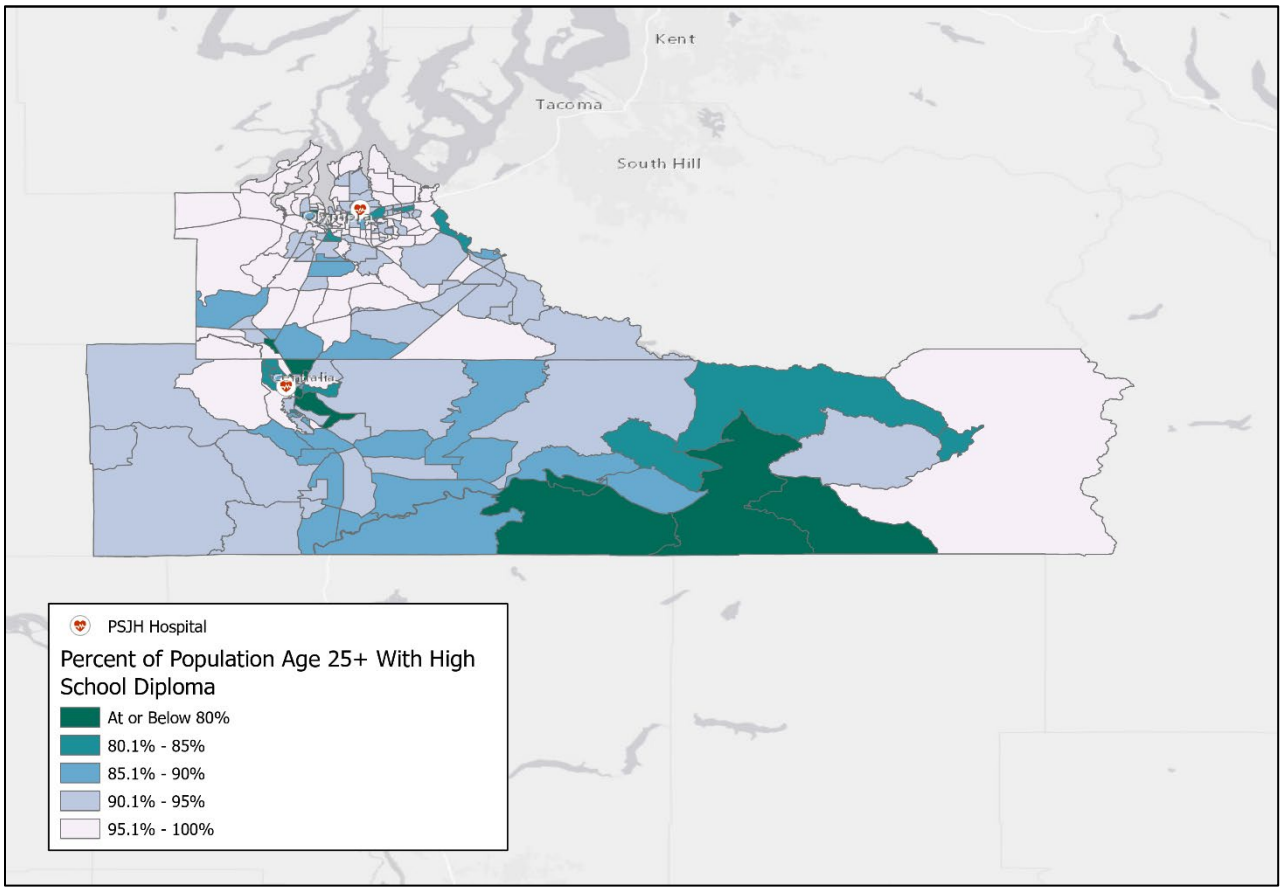


- The high need service area has a slightly higher percentage of population age 5 and above who do not speak English very well, 1.60%, compared to the broader service area, 1.18%.
- Overall, the percent of population that does not speak English very well is comparable between the county, broader service area, and high need service area, although there are census tracts within each county that have rates over five times the county average.

Apx 2_Table 3. Population with a High School Diploma for Southwest WA Service Area

Indicator	High Need Service Area	Broader Service Area	Thurston and Lewis Counties	Washington State
Percent of Population Age 25+ With A High School Diploma Data Source: American Community Survey Year: 2019	91.02%	94.75%	93.01%	91.56%

Apx 2_Figure 3. Population with a High School Diploma for Southwest WA Service Area

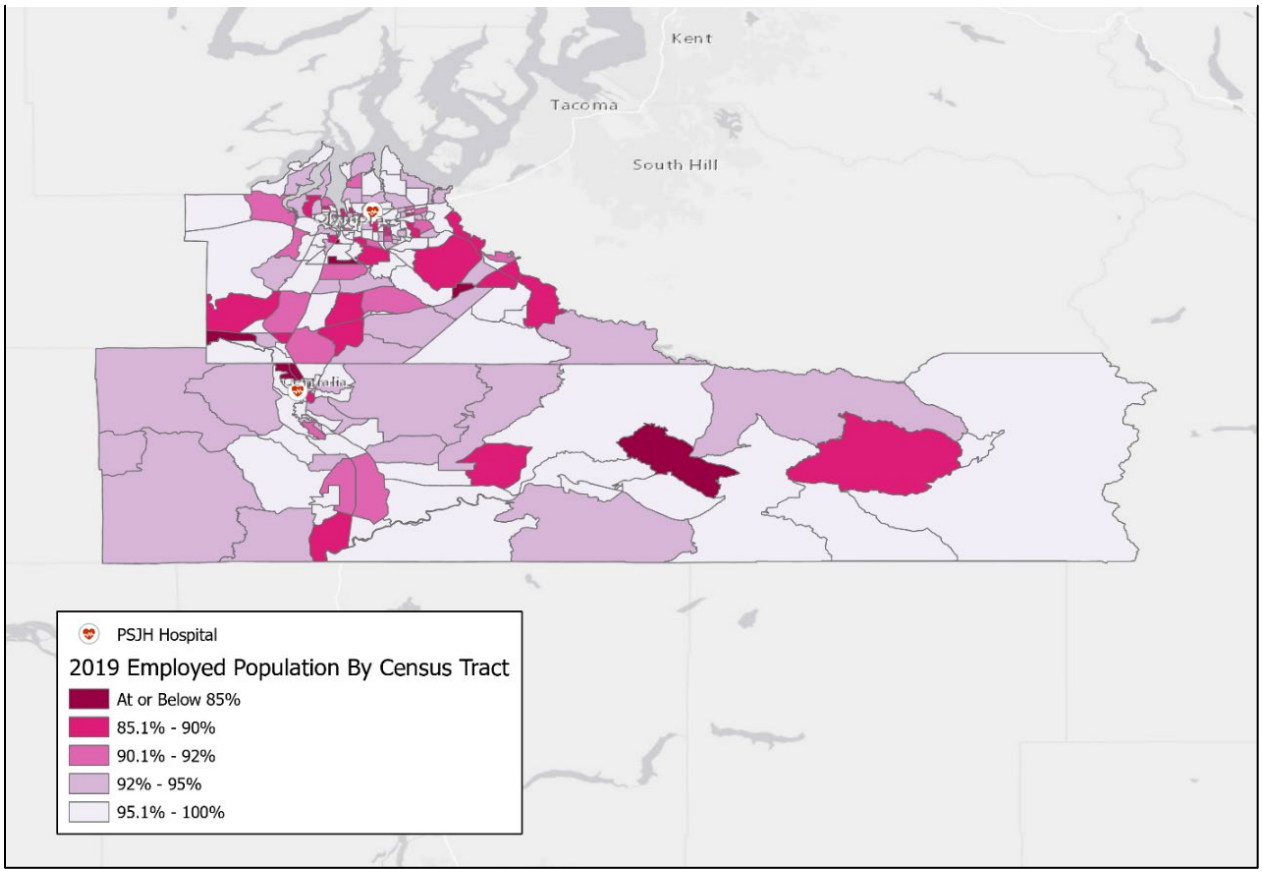


- There are four census tracts around Providence Centralia Hospital with high school graduation percentages lower than 80%, which are some of the lowest within the two counties.
- About 91% of people living in the high need service area who are over 25 years have a high school diploma compared to 95% in the broader service area.

Apx 2_Table 4. Percent of Labor Force Employed for Southwest WA Service Area

Indicator	High Need Service Area	Broader Service Area	Thurston and Lewis Counties	Washington State
Percent of Population Age 16+ Who Are Employed Data Source: American Community Survey Year: 2019	93.34%	94.82%	93.30%	95.41%

Apx 2_Figure 4. Percent of Labor Force Employed for Southwest WA Service Area

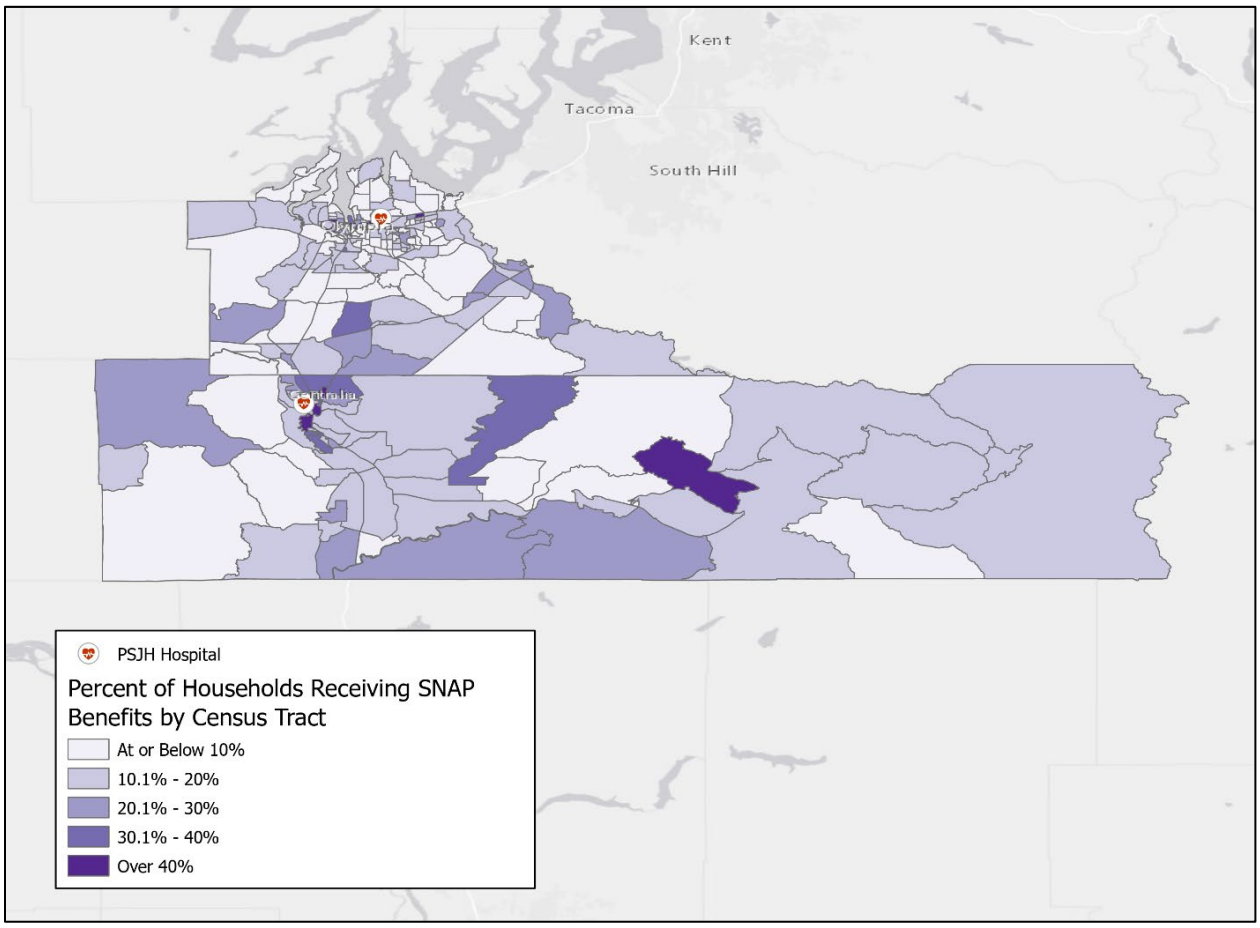


- The high need service area has 93% of people employed compared to 95% in the broader service area.
- While the percent employed in Lewis and Thurston Counties are comparable to the broader and high need service areas overall, there are still census tracts throughout both counties that are far below the county average.
- In Lewis County, the census tract with the lowest employed population has 75.23% of people employed, while in Thurston County, the census tract with the lowest employed population has 80.66% of people employed.

Apx 2_Table 5. Percent of Households Receiving SNAP Benefits for Southwest WA Service Area

Indicator	High Need Service Area	Broader Service Area	Thurston and Lewis Counties	Washington State
Percent of Households Receiving SNAP Benefits Data Source: American Community Survey Year: Estimates based on 2013 – 2017 data	18.32%	10.23%	16.14%	13.28%

Apx 2_Figure 5. Percent of Households Receiving SNAP Benefits for Southwest WA Service Area

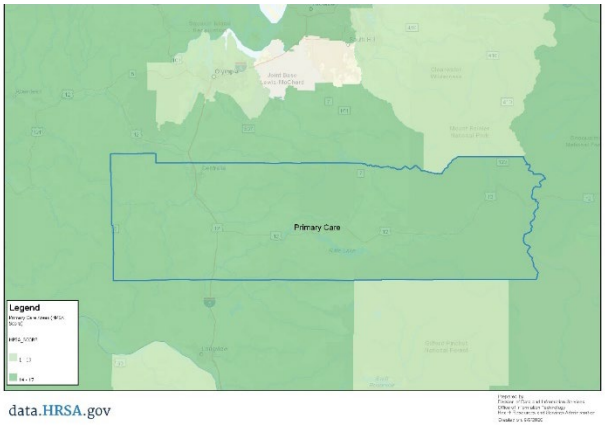


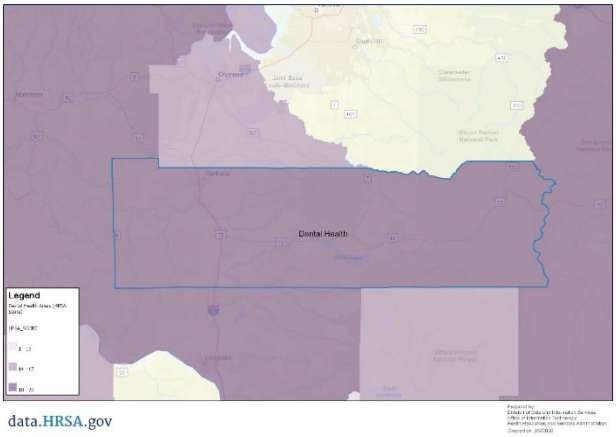
- The high need service area has substantially more households receiving SNAP benefits, 18%, compared to the broader service area, 10%.
- The census tracts with the highest percentage of households receiving SNAP benefits are found around Providence Centralia Hospital, near the center of Lewis County.

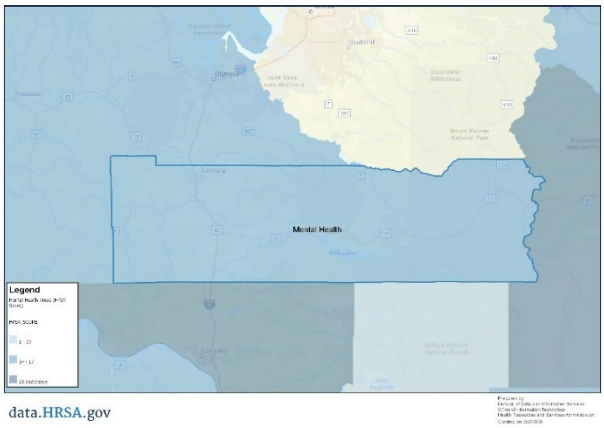
HEALTH PROFESSIONAL SHORTAGE AREAS

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). Providence Centralia Hospital is located in a HPSA, with Lewis County being designated as a primary care and dental health HPSA for low income, homeless, and migrant farmworker populations. Lewis County is also a high need geographic HPSA for mental health.

Apx 2_Figure 6. Lewis County Primary Care (Green), Dental Health (Purple), and Mental Health (Blue) HPSAs

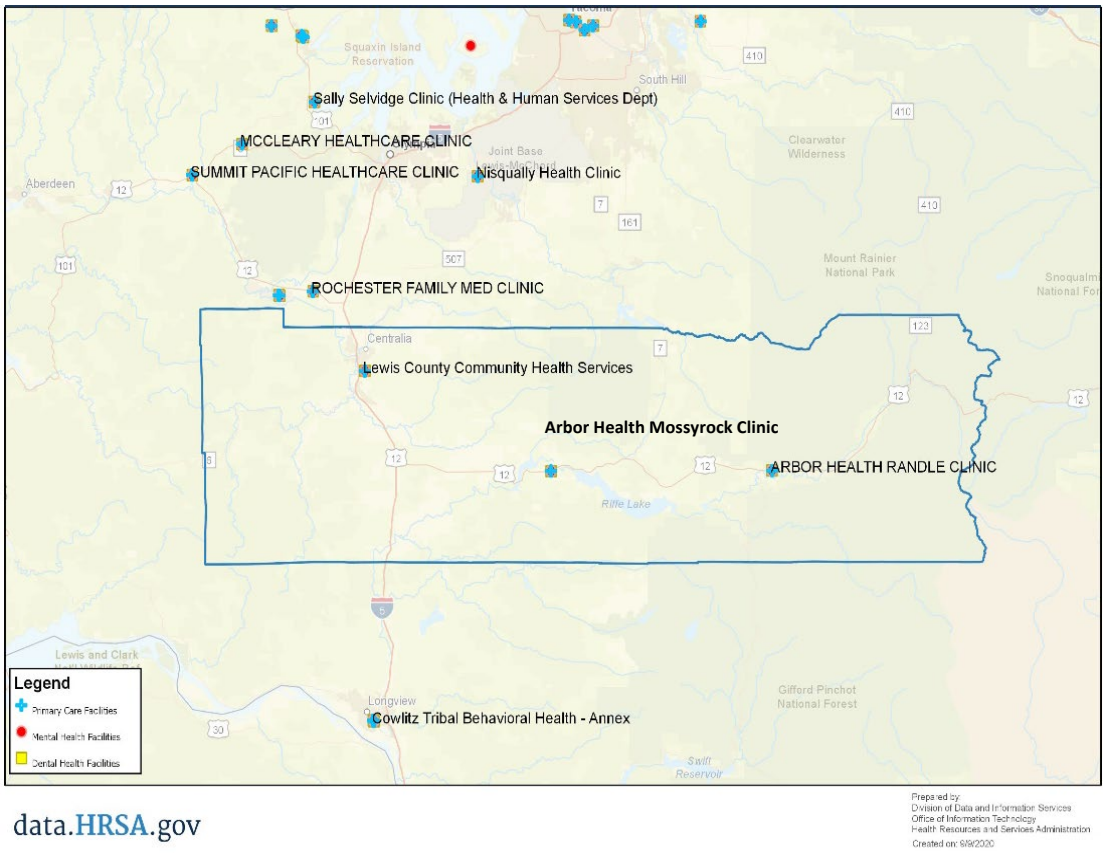






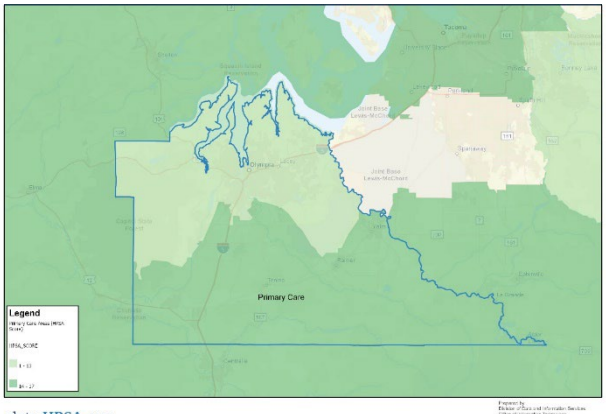
Additionally, Lewis County Community Health Services (a Federally Qualified Health Center), Arbor Health Mossyrock Clinic (a rural health clinic), and Arbor Health Randle Clinic (a rural health clinic) are designated HPSAs for primary care, dental health, and mental health.

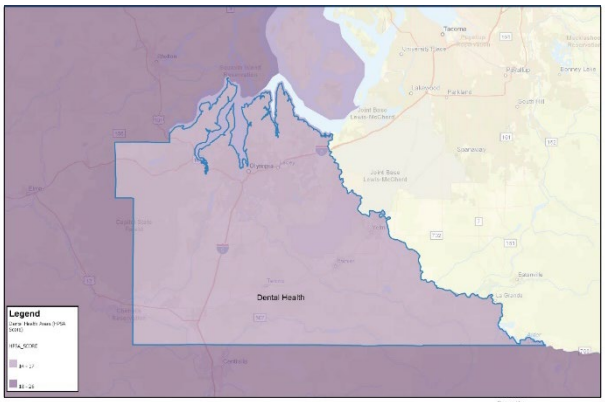
Apx 2_Figure 7. Lewis County Designated HPSA Facilities

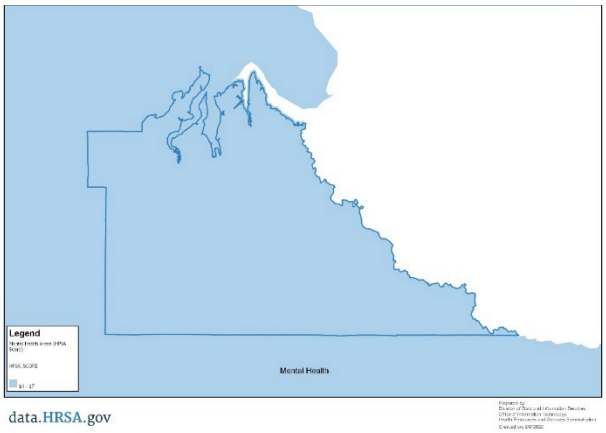


Providence St. Peter Hospital is also located in a HPSA, with Thurston County having two designated geographic HPSAs, North and South Thurston County, for primary care, dental health, and mental health.

Apx 2_Figure 8. Thurston County Primary Care (Green), Dental Health (Purple), and Mental Health (Blue) HPSAs

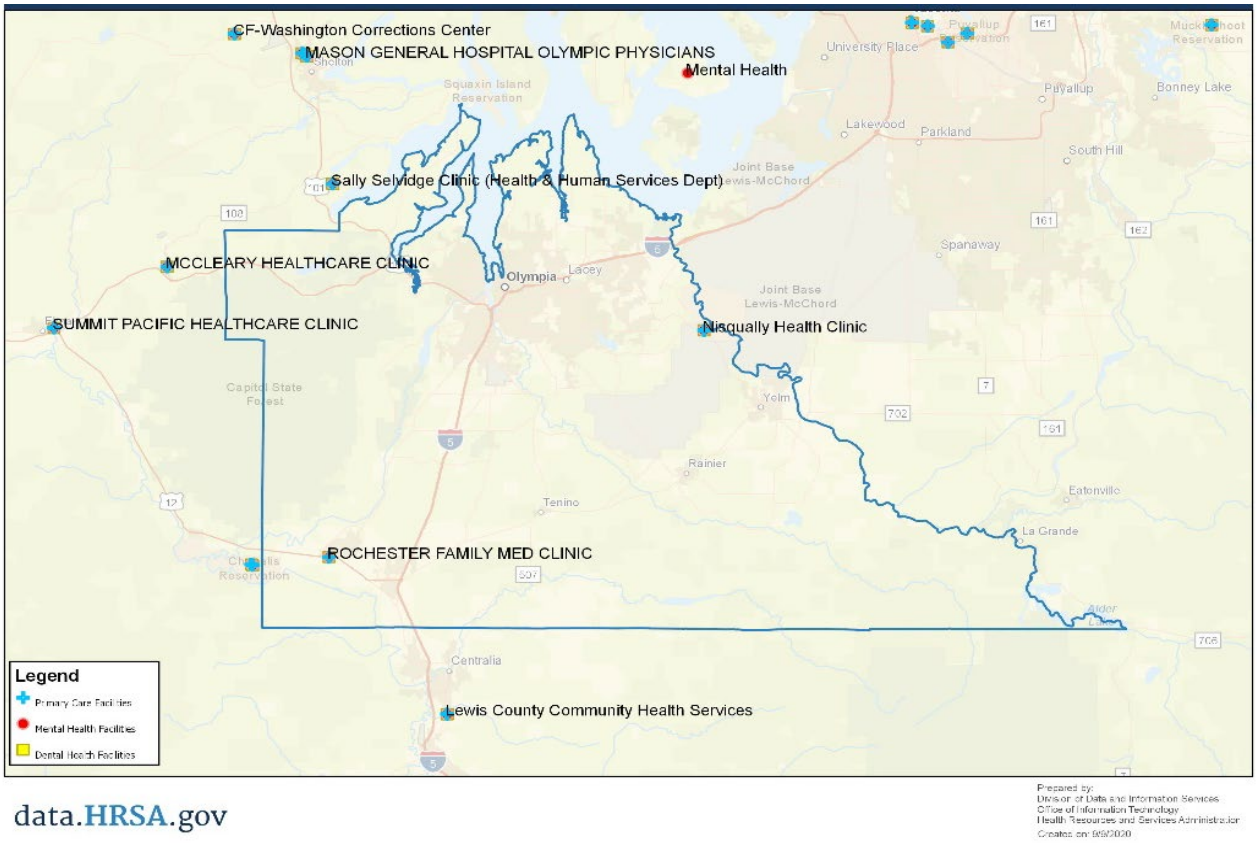






Additionally, Nisqually Health Clinic (an Indian Health Service, Tribal Health, and Urban Indian Health Organization) and Rochester Family Medicine Clinic (a rural health clinic) are designated HPSAs for primary care, dental health, and mental health.

Apx 2_Figure 9. Thurston County Designated HPSA Facilities



MEDICALLY UNDERSERVED AREAS/MEDICALLY UNDERSERVED POPULATIONS

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 health care services. This designation process was established to assist the government in allocating the Community Health Center Fund to areas of greatest need. 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. Lewis County has two MUAs based on the governor's designation, including 11 census tracts. Thurston County has an MUA (including two census tracts) and MUP (including four census tracts) for people with low incomes.

HOSPITAL UTILIZATION DATA

Avoidable Emergency Department Visits

Emergency department discharges for the year 2019 were coded as "avoidable" per the Providence St. Joseph Health definition for Providence St. Peter Hospital, Providence Centralia Hospital, and nearby PSJH hospitals. Avoidable Emergency Department (AED) visits are based on the primary diagnosis for a discharge and includes diagnoses that are deemed non-emergent, primary care treatable or preventable/avoidable with better managed care.

Apx 2_Table 6. Avoidable ED Visits for Providence St. Peter Hospital by Patient Race

Patient Race	Non-AED Visit	AED Visit	Total	AED%
(Blank)	86	56	142	39.4%
Patient Refused	71	44	115	38.3%
Native Hawaiian or Other Pacific Islander	455	268	723	37.1%
Black or African American	1,500	822	2,322	35.4%
American Indian or Alaska Native	646	309	955	32.4%
Other	2,556	1,195	3,751	31.9%
White or Caucasian	25,155	11,256	36,411	30.9%
Asian	805	358	1,163	30.8%
Unknown	337	150	487	30.8%
Unspecified	155	51	206	24.8%

Apx 2_Table 7. Avoidable ED Visits for Providence Centralia Hospital by Patient Race

Patient Race	Non-AED Visit	AED Visit	Total	AED%
(Blank)	13	9	22	40.9%
American Indian Or Alaska Native	285	165	450	36.7%
Black or African American	280	161	441	36.5%
Unspecified	56	27	83	32.5%
White or Caucasian	17,101	7,875	24,976	31.5%
Unknown	166	75	241	31.1%
Other	1,573	696	2,269	30.7%
Patient Refused	28	11	39	28.2%

Patient Race	Non-AED Visit	AED Visit	Total	AED%
Native Hawaiian or Other Pacific Islander	64	24	88	27.3%
Asian	99	35	134	26.1%

Prevention Quality Indicators

Both Providence Centralia Hospital and Providence St. Peter Hospital has above average rates of potentially avoidable hospitalizations in the PSJH WA/MT services areas. Providence Centralia Hospital had the second highest PQI overall composite rate in the region.

Apx 2_Table 8. Prevention Quality Composite Rates for Providence Centralia and St. Peter Hospitals

Indicator	Label	Observed Rate Per 1,000 Visits
PQI 90	**Prevention Quality Overall Composite, per 1,000 visits**	
	Providence Centralia Hospital	153.92
	Providence St. Peter Hospital	101.64
PQI 91	**Prevention Quality Acute Composite, per 1,000 visits**	
	Providence Centralia Hospital	41.18
	Providence St. Peter Hospital	22.87
PQI 92	**Prevention Quality Chronic Composite, per 1,000 visits**	
	Providence Centralia Hospital	112.75
	Providence St. Peter Hospital	78.77

Appendix 3: Community Input

INTRODUCTION

Representatives from Providence Southwest Washington conducted interviews with representatives from 5 community-based organizations, including 24 stakeholders, people who are invested in the well-being of the community and have first-hand knowledge of community needs and strengths. The goal of the interviews 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

A total of 5 stakeholder interviews, which included 24 participants, were completed by representatives from Providence Southwest Washington. Stakeholders were selected based on their knowledge of the community and engagement in work that directly serves people who have low incomes, have chronic conditions, and/or are medically underserved. Providence Southwest Washington aimed to engage stakeholders from social service agencies, health care, education, housing, and government, among others, to ensure a wide range of perspectives.

Several attempts were made to connect with representatives from Lewis County Public Health and Social Services and Thurston County Public Health and Social Services, but due to competing priorities related to COVID-19, they were not able to participate in stakeholder interviews. We emailed both health departments to ask for the most up-to-date CHNA available. Dr. Rachel Wood, Lewis County's Health Officer, is a Providence board member and served on the CHNA oversight committee, providing insight during the data review and prioritization processes.

Apx 3_Table 1. Key Community Stakeholder Participants

Organization	Name	Title	Sector
CHOICE Regional Health Network	Abigail Schroff	Chronic Disease and Transitional Care Program Manager	Nonprofit collaborative; health care; Grays Harbor, Lewis, Mason, Pacific, and Thurston Counties
	Amber Shirk	Outreach and Tribal Liaison	
	Caitlin Moore	Navigator Program Manager, and Marijuana Prevention Program Manager	
	Carol Palay	Communications Manager	
	Caroline Sedano	Reproductive, Maternal and Child Health Program Manager, and Oral Health Program Manager	
	Christine Haywood	Human Resources Manager	
	Ivan Rodriguez	Data and IT Manager	
	Jean Clark	Chief Executive Assistant	

Organization	Name	Title	Sector
	Joshua Plaster	Program Support Coordinator	
	Katrin Palmer	Oral Health Coordinator	
	Megan Szabla	Executive Assistant	
	Michael O'Neill	Community CarePort Program Manager	
	Randy Thomas	Data and IT Analyst	
North Thurston School Board	Mel Hartley	School Board President, District 3	Education; Thurston County
Olympia Free Clinic	Katie Madinger	Executive Director	Nonprofit community-based organization; health care; Thurston, Mason, Lewis Counties
	Winter Forsyth	Director of Patient Services	
Behavioral Health Resources	Laurie Tebo	Chief Executive Officer	Community-based organization; mental health and substance use; Thurston, Mason, Grays Harbor Counties
	Ian Harrel	Chief Operating Officer	
	Larry Horne	Director of Quality Assurance	
	Eric Jensen	Director of Finance	
	Tiffany Buchanan	Director of Adult Outpatient Services	
	Lauren Farmer	Director of Children, Youth, and Family Outpatient Services	
	Angela Crowley	Director of Grays Harbor Outpatient Services	
Cascade Mental Health Care	Richard Stride	Chief Executive Officer	Nonprofit community-based organization; mental health and substance use; Lewis County

Facilitation Guide

Providence St. Joseph Health developed a facilitation guide that was used across all hospitals completing their 2020 CHNAs (see "Stakeholder Interview Questions" in this appendix):

- The role of the stakeholder's organization and community served (omitted for CARE Network listening sessions)
- Prioritization of unmet health related needs in the community, including social determinants of health
- Populations disproportionately affected by the unmet health-related needs
- Gaps in services that contribute to unmet health-related needs
- Barriers that contribute to unmet health-related needs
- Community assets that address these health-related needs
- Opportunities for collaboration between organizations

Training

The facilitation guide provided instructions on how to conduct a stakeholder interview, including basic language on framing the purpose of the interview. Each facilitator was provided a list of questions to ask the stakeholder.

Data Collection

The facilitator conducted all the interviews using the Microsoft Teams platforms and recorded the interviews with participants' permission.

Analysis

Qualitative data analysis of stakeholder interviews was conducted by Providence St. Joseph Health using Atlas.ti, a qualitative data analysis software. The data were coded into themes, which allows the grouping of similar ideas across the interviews, while preserving the individual voice.

The recorded interviews were sent to a third party for transcription. The analyst listened to all audio files to ensure accurate transcription. The stakeholder names were removed from the files and assigned a number to reduce the potential for coding bias. The files were imported into Atlas.ti. 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) role of organization, 2) population served by organization, 3) unmet health-related needs, 4) disproportionately affected population, 5) gaps in services, 6) barriers to services, 7) community assets, and 8) opportunities to work together.

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 groups 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 determined the frequency each code was applied to the dataset, highlighting which codes were mentioned most frequently. The analyst used the query tool and the co-occurrence table to better understand which codes were used frequently together. For example, the code "mental health" can occur often with the code "stigma." Codes for unmet health-related needs were cross-referenced with the domains to better understand the populations most affected by a certain unmet health-related need and the barriers to addressing those needs. The analyst documented patterns from the dataset related to the frequency of codes and codes that were typically used together.

FINDINGS FROM STAKEHOLDER INTERVIEWS

Stakeholders were asked to identify their top five health-related needs in the community. Three needs stood out as universally important to stakeholders and were categorized as high priority. Three needs were also frequently prioritized and categorized as medium priority. The effects of the COVID-19 pandemic are woven throughout the following sections on health-related needs and COVID-19 comments are also summarized in its own section.

High Priority Unmet Health-Related Needs

Stakeholders were most concerned about the following health-related needs (in order of priority):

1. Homelessness/ lack of safe, affordable housing
2. Behavioral health challenges (includes both mental health and substance use disorder) and access to behavioral health care
3. Access to health care services

Homelessness/ lack of safe, affordable housing

Homelessness/lack of safe, affordable housing was prioritized by all stakeholders and consistently ranked as the most urgent need in the community. They described housing as a major issue for many of the clients they serve despite recent efforts to address the problem.

> *"I think that housing is a really interesting one because there are plenty of organizations working on the issue. I think that there's still such a lack of actual housing units and a lack of affordable housing so that even though there are organizations addressing the issue, it's not necessarily improving. I think that's one gap is that even with work it's still not fully addressed." – Community Stakeholder*

Stakeholders shared they prioritize housing as so important because it is **foundational to other needs**. When people are stably and safely housed, they are better able to address their physical and mental health needs.

> *"Those patients who are houseless have very little bandwidth to address long-term healthcare needs because every moment is based on survival. When they're focused on trying to figure out where they're going to stay that evening, it's difficult to get them into the clinic to stay to get a wound taken care of, things like that." – Community Stakeholder*

Stakeholders shared a need for more of the following types of housing:

- **Affordable rental units**: Stakeholders spoke to very low availability of housing
- **Supportive housing**: Stakeholders shared a need for a full continuum of housing to serve clients

> *"We don't have a fully-fleshed out continuum of housing to serve our clients. If they can't find housing when they come out of the hospital or even are living in the community and have a not so great rental record, there just isn't flexibility with the resources to serve them*

in a way that they need in order to maintain the housing that they might be able to find." – Community Stakeholder

- **Adult family home placements**, specifically those that accept "more challenging" clients
- **Foster homes**

Stakeholders specifically noted a need for more housing for **families with low incomes** or **those with income right above qualifying for public services**. They connected economic insecurity with being unstably housed.

"I feel like there's a whole lot of people that are just one major life event away from being homeless or having a major something that would happen that would have a major impact on their life."—Community Stakeholder

Stakeholders were also concerned about **young people** experiencing homelessness, particularly those who **identify as LGBTQ+** and a need for more intentional support for this population.

Stakeholders were concerned about increasing homelessness and housing instability as a result of the **COVID-19 pandemic**, specifically noting concern for students experiencing homelessness.

Behavioral health challenges (includes both mental health and substance use disorder) and access to care

Stakeholders described a mental health crisis that has only worsened with the COVID-19 pandemic. They shared a need for more of the following mental health and substance use disorder (SUD) services:

- **Mental health services** in general: Stakeholders spoke to a general lack of sufficient mental health services in Lewis and Thurston County. They also shared a need for **school-based mental health services.**
- **Parenting support**: Stakeholders noted a need for support for parents' mental health, as well as classes for parents to support children with mental health needs.
- **Integration between primary care and behavioral health services**: People are presenting in primary care with severe mental health challenges and need to be linked with appropriate services.

"In that same department, I think there needs to be better links between primary care and community behavioral health. You do have a lot of people presenting in primary care who have serious mental illness and there are just long waiting times to get into community behavioral health. That's a huge need. This is not just adult populations, it also extends to children and adolescents, so the same points apply there."—Community Stakeholder

- **Inpatient detox facility**: People must travel long distances, sometimes to the other side of Washington to receive detox services.
- **Support for people being discharged from inpatient psychiatric hospitals**: Strong need for wraparound case management services particularly for people who lack insurance.

Stakeholders identified long wait times for services, difficulty finding a mental health provider who accepts Medicaid and Medicare, and transportation as the main barriers to accessing behavioral health services.

They identified the following populations as experiencing additional barriers to receiving the behavioral support they need:

- **Young people**: There are a lack of school counselors to meet students' needs and challenges getting parents to support or engage in services with their children.
- **Older adults**: May experience additional challenges finding a provider who accepts Medicare and may experience increased transportation barriers.
- **People experiencing homelessness**: May have co-occurring needs that make engaging in behavioral health services consistently more difficult.
- **People living in rural areas**: May have increased transportation challenges.
- **Veterans**: Typically, must travel outside of the community to receive services.

"As you're probably aware, we have a really high percentage of veterans in Lewis County. They oftentimes have to go to Tacoma or Vancouver or to sometimes even Spokane to get services, unfortunately."—Community Stakeholder

- **People who are undocumented**: Organizations lack funding to serve people who are undocumented, and they may have additional fear accessing services related to immigration.
- **Monolingual Spanish speakers**: There are a lack of bilingual, bicultural mental health providers.

"It would be nice if we had more services for monolingual Spanish speakers. We don't have a whole lot of that here. We have a couple of therapists, one in SUD and one in mental health, but that's really not enough."—Community Stakeholder

The COVID-19 pandemic has only exacerbated the community mental health and SUD needs. Stakeholders spoke to people feeling more anxious, depressed, and isolated. They were specifically worried about engaging with the hardest to reach populations. They shared that **clients experiencing homelessness** often use drop-in hours to connect with services, which are not currently available. Many of these clients have been lost to care or are only able to contact services when they have access to a phone.

"This team, they go around to some of the hardest-to-serve individuals that are at a level four program. Those individuals, we haven't been able to engage like we used to. That's been huge… We haven't been able to contact some of these people. We're not sure if they've left or where they've gone. We just can't track them. That's really, really difficult and disheartening to our case managers and therapists who put so much time meeting these individuals and had worked with them over the years and gotten them stable, and now, we just can't find them."—Community Stakeholder

Additionally, stakeholders acknowledged the impact of historical trauma on **Native communities** and racism on **Black communities** that is always negatively affecting the mental health of these groups, but particularly during the pandemic.

Stakeholders expressed concern for **young people** who are not receiving school counseling services during school closures. They also noted that children of first responders may be experiencing additional stress knowing their parents are responding to COVID-19.

Stakeholders discussed the negative effects of increased social isolation, especially on **older adults** who may be experiencing increased depression and anxiety.

> *"The elder community, it has been really devastated. The Senior Center, I know they're still doing the Meals on Wheels thing and still trying to get out there and actually bring the meals to people with safety precautions, but there's a lot of individuals that are isolating. Depression is high and that demographic anxiety because they do have underlying health conditions, many of them, and being exposed to COVID-19 could be a death sentence for them. There's a lot of fear in that community."—Community Stakeholder*

Stakeholders spoke to the added stress **many people, especially those with low incomes**, are feeling due to the economic crisis associated with the pandemic and the toll that has taken on people's mental and emotional well-being.

> *"One of the things that I've heard a lot is just that the Coronavirus is impacting community members unequally depending on income, gender, and race. That it's taking a toll on mental and emotional wellbeing of many, but low-income households seem to be most concerned about jobs, income stability, and healthcare coverage. Multiple of the local forums have told me that the ERs and routine medical visits and MAT treatments are down by 25% to 35% and that behavioral health needs, depression, stress, and suicidal thoughts are up, but most of them didn't have numbers on that."—Community Stakeholder*

Stakeholders noted that **telehealth visits** have expanded for behavioral health care, which works well for some patients, although not for all. Some patients are unable to engage successfully due to limited access to **technology**, **broadband** (especially in East Lewis County), and **privacy** for a visit. Some patients have shared they are waiting until they can be seen in person to engage in services, leading to concern that these patients may be decompensating without their typical support.

Access to health care services

Stakeholders described a variety of barriers to accessing needed health care services. The most common barrier that was named was **transportation**, particularly for people living in rural areas and older adults. Other barriers include the following:

- **Cost of care**, including prescriptions: This is especially a barrier for individuals who are uninsured or have low incomes. People who do not qualify for Medicaid but cannot afford private insurance may not be able to afford the cost of care. Older adults are another group that

may not be able to afford care, whether that is because Medicare out-of-pocket costs are too high or because their fixed income does not meet their needs.

"The cost of prescription drugs. That is a major barrier for many of our patients. We end up taking community donations and purchasing medications that we then can dispense for our patients because they won't ever, for example, insulin, be able to afford that without insurance."—Community Stakeholder

- **Identification documents and proof of income:** This can be especially challenging for individuals with a behavioral health challenge or people experiencing homelessness who may not have a safe place to keep these documents or may not have the organization skills. Without these documents, people may get denied services, despite qualifying.

"That's because we've seen from people's experiences from going other places where we know they qualify and they know they qualify, but they didn't get in because they don't have a valid ID which is really common for some parts of our population, or aren't organized enough or don't have a place to keep documents about their income and so they don't know how to prove that. We've seen stuff like that happen a lot with places that they do qualify for, but just have systems in place for them to show that they qualify for that they're not able to navigate."—Community Stakeholder

- **Language**: Individuals may receive an interpreter for the medical appointment, but may still have difficulty with making appointments, navigating websites, or reading signage exclusively in English. This can make finding and accessing care more challenging.

Certain populations may be disproportionately affected by access to care challenges or experience unique barriers, including the following:

- **Young people**: Young people are often reliant on someone else to take them to appointments. Stakeholders spoke to a need for more school-based health services including immunizations, sports physicals, medication management, and reproductive health services. They specifically noted a need for school-based services for young people with Medicaid or those who are uninsured.
- **People experiencing homelessness**: People experiencing homelessness may have added challenges getting care due to cost of care, lack of identification documents and proof of income, co-occurring behavioral health challenges, among other reasons. Stakeholders spoke to the importance of first getting people stably housed and then addressing their health needs.
- **People who are undocumented**: People who do not qualify for Medicaid have few other options for health coverage.
- **People with severe and chronic, persistent mental conditions**: People living with a mental health condition may be barred from services for their behavior that is deemed inappropriate.

Mental health also contributes to people's ability to manage appointments and successfully engage in care.

Having **co-located services**, such as those that address food insecurity in a health care setting may reduce some of the barriers to accessing services.

The **COVID-19 pandemic** has created additional barriers for people receiving care. Stakeholders spoke to patients delaying care, especially if they lack technology, broadband, and privacy for appointments. This may be especially challenging for people living rural areas without sufficient broadband, people living in overcrowded housing, or people experiencing homelessness.

Stakeholders shared they are seeing a reduction in pediatric visits, with families delaying well-child visits (including immunizations) and sick visits. Some people may be delaying care because of fear of exposure to COVID-19.

> *"Visit rates are really down for pediatric providers. A lot of clients who got services, whether behavioral health or medical services aren't necessarily going in for care. They've seen drops in well-child visits as well as sick visits. There's concerns that immunization rates are going down for pediatric clients in our region as well as elsewhere."—Community Stakeholder*

Stakeholders spoke to **overburdened systems**, specifically for people applying for health insurance or trying to navigate accessing care. These challenges contribute to people feeling more afraid and frustrated as they are unable to receive the compassionate guidance needed.

> *"One of the overall biggest things that I have noticed is that the systems are overburdened and that leaves people without an ability to speak to somebody live. That leaves them more fearful. It leaves them more frustrated, and when somebody is in distress or facing trauma, they don't process things the same. Having to read through a bunch of multiple FAQ pages to find out what meets their certain situation in the hopes that they're going to find something that meets their certain situation oftentimes leaves them overwhelmed. It doesn't compute, and if somebody's already stressed and feeling foggy-brained due to their anxiety and depression, that leaves them feeling further isolated without anybody to talk to for further answers, just adding to that isolation."—Community Stakeholder*

Medium Priority Unmet Health-Related Needs

Three additional needs were often prioritized by stakeholders, although with less frequency and importance than the high-priority needs (in order of priority):

1. Unemployment and lack of living wage jobs
2. Food insecurity
3. Access to oral health care

Unemployment and lack of living wage jobs

Stakeholders discussed the connection between lack of living wage jobs and **food insecurity** and **housing instability**. They shared many people cannot meet their basic needs due to rising unemployment and

underemployment, meaning people are working in roles that do not fully take advantage of their skill set and capabilities.

Stakeholders shared that people with low incomes may have challenges affording **daycare** services. Parents are forced to keep their income below a certain threshold to qualify for low-income childcare due to the "benefits cliff," meaning benefits taper off quickly as income increases.

"If people are employed, they're underemployed. They oftentimes can't afford daycare."—Community Stakeholder

Due to **COVID-19**, unemployment and economic instability are increasing, leading to depression, stress, and suicidal thoughts.

"One of the things that I've heard a lot is just that the Coronavirus is impacting community members unequally depending on income, gender, and race. That it's taking a toll on mental and emotional wellbeing of many but low-income households seem to be most concerned about jobs, income stability, and healthcare coverage."—Community Stakeholder

Food insecurity

Stakeholders described food insecurity as not having enough access to good quality, nutritious foods. They shared that a **lack of living wage jobs** is tied to food insecurity, with many families not being able to afford healthy foods despite working.

They were particularly concerned about food insecurity due to the pandemic. Stakeholders shared that there have been many efforts to ensure **school-age children** still have access to meals despite school closures.

"Food insecurity right now is huge for kids. We've always served breakfast and lunch for children that qualified for free lunch below the poverty level, but right now, we're bumping that up and we're offering free breakfast and lunch takeout bags to any child that shows up at any of our over 30 community sites. We're using our school buses right now to be mobile food delivery sites."—Community Stakeholder

Programs, such as Meals on Wheels, have also worked to ensure **older adults** get food delivered to their house.

Access to oral health care

Stakeholders stressed the importance of oral health on **overall health and well-being**. They shared that chronic oral disease is one of the leading chronic conditions of childhood and that kids who are on free and reduced lunch are more likely to experience dental pain, which can affect school attendance and focus.

Stakeholders described Thurston County as a "desert" for oral health care and a major challenge in Lewis County as well. There is also a lack of oral surgeons in the area. While it might sometimes look like people have access to dental services, in reality they do not.

> *"I think that it would be hard for us to stress enough how much dental care has been a gap from a lot of different angles. It's been an interesting problem because patients who on paper looked like they would get covered in our county weren't getting covered in our county… I remember that our core was surprised that certain groups of our patients weren't getting care because on paper, it looked like those services were available to them around us. We are working on that, but I have seen our patients dealing with what really should have been an emergency dental care issues for really long periods of time, patients who I've seen trying to get care for wounds reoccurring in their mouth for months and months. It is definitely one of the biggest things that we see, unlike other things that has not been addressed like the other barriers." – Community Stakeholder*

The barriers that prevent people from getting care include **cost of care**; even when sliding fees are available, $25 can be too much money.

> *"The other ones are sliding scale fees. Many of our patients, the services exist, they could walk into the federally qualified health centers and there is a system in place that addresses people who don't have insurance. It's that you pay what you can pay. When our patients can't even afford the bus, we give them bus passes to go up there, then that $25 base fee is just as totally inaccessible to them. Is the service available? Yes. Is it accessible? In theory but in practice, it's really not."—Community Stakeholder*

People may not qualify for these services because they do not have **proof of income** or valid **identification**. Finding a **Medicaid provider** is a challenge and **older adults** have limited access to dental insurance and providers.

Stakeholders shared a need for more **co-located dental services** where people get their primary or mental health care.

Effects of COVID-19

Stakeholders primarily discussed how COVID-19 has led to many patients **delaying care**. For both behavioral health services and primary care, **telehealth** has been a challenge for some patients without the technology, broadband, and/or privacy for a successful visit. **Patients experiencing homelessness** in particular have been challenging to serve as they typically rely on walk-in hours that are no longer available.

> *"There's also the issue of many of our patients don't have a private place to talk even if they could get on a video call. If they're living outside, they're not going to find a private place or many are living in cramped living conditions just due to rate price setting and stuff like that. That's the major issue. The way that our homeless patients would usually access us is also*

now no longer testable because we would be open during working hours at the community care center, but since such services are closed during COVID-19, people who might not have a phone don't know how to reach us, can't get to us or are able to call us but then can't get here because there are no buses, which they normally would rely on."—Community Stakeholder

Stakeholders shared they are seeing increased mental health challenges in the community.

"The Department of Health is projecting a big wave and a big increase of behavioral health needs, especially this year, mainly in response to COVID. That's going to be a huge unmet need especially with behavioral health agencies losing some providers and generally not having enough staff on hand to serve all the clients they need to."—Community Stakeholder

Fear of exposure to COVID-19 has also caused some people to delay care, particularly older adults and children. Stakeholders spoke to fewer **well-child visits** and **immunizations**, which could have long-term effects.

"I would add it decreased access coupled with increased barriers in that combination, especially for the population that we see is really very tricky to balance. We are seeing fewer patients just across the board, we're getting fewer calls. Maybe the triplicate is that there's the fear of accessing healthcare services right now that's keeping people away who really need that routine ongoing care."—Community Stakeholder

Public transportation has also been reduced or stopped in certain areas making accessing services and necessities more challenging for people without cars.

Stakeholders expressed concern that there is more **economic insecurity** due to job loss and reduced wages and hours. This could have long-term negative effects on **housing stability** and **food security**. Stakeholders shared they are expecting to see an increase in the number of people experiencing homelessness or housing insecurity.

"Before COVID, I think we had around 650 McKinney-Vento kids. The numbers have gone up. They've trended up considerably in the last two years, just because housing has continued to be outrageous... I would expect those numbers to just triple quadruple when we get everybody back [to school] get a chance to ask them what their living situation is."—Community Stakeholder

Stakeholders were concerned with families' wellbeing overall, especially with remote learning and reduced **childcare** options. With more people at home social distancing, stakeholders shared concern for increasing **domestic violence** and **child abuse/neglect**. Families have less contact with mandated reporters, which leads to less opportunity for identification and disclosure of unsafe situations.

Stakeholders also shared that they are seeing increased **social tension** as people are divided on wearing masks and social distancing, which has led to more division and stress.

"There seems to be a huge divide in the personal ideas and ideals around social distancing, mask, and protective gear, and that is causing a lot of stress and discourse amongst community members who usually don't have discourse."—Community Stakeholder

Opportunities to Work Together

Stakeholders agreed that there are opportunities for more **cross-sector collaboration** of service providers to address all of the social determinants of health. These opportunities to collaborate would help create **shared regional health improvement strategies** and goals to address challenges related to referrals, transportation, and other gaps in communication.

"I do think that there's space [chuckles] for more collaboration across the board in the geographic area. I think that there's space for creative collaboration where it doesn't necessarily just have to be the healthcare entities. It can be everybody addressing all of the social determinants of health coming together and making broader plans for even things like how do we make a referral to this organization or how do we get this person? The transportation services could be part of the conversation. How do you get this person to the food bank once a week and to their appointment at [the clinic]? I do think that there's more room for service providers to be talking."—Community Stakeholder

They saw opportunities to bring together law enforcement, public health, behavioral health, faith-based organizations and more, knowing that community health improvement really comes from bringing together community-based and health care organizations. They noted that forming collaborations is an opportunity to **share resources**, including **financial and human capital** and **data**. Collaborations are most successful when organizations **build trust and relationships**.

"As we've alluded to our call today, as well as various studies and initiatives across the United States show that when community-based organizations work with healthcare organizations… that's when health in the community really improves overall. Several of the studies have showed that when community based human service organizations are working with healthcare service industries and the hospitals insurers, the most successful of those programs are when they actually share resources related to financial capital, human capital, as well as data. When there's that real effort to share those resources collaboratively, and then also the convening and bringing the various players together for educational purposes, for awareness."—Community Stakeholder

Stakeholders suggested considering more opportunities to **co-locate services** to reduce barriers for patients. Specifically, they would like to see more health services offered in schools for kids on Medicaid or who are uninsured.

LIMITATIONS

While stakeholders were intentionally recruited from a variety of types of organizations, there may be some selection bias as to who was selected as a stakeholder. The analysis was completed by only one analyst and is, therefore, subject to influence by the analyst's unique identities and experiences.

STAKEHOLDER INTERVIEW QUESTIONS

1. How would you describe your organization's role within the community?
2. How would you describe the community your organization serves? Please include the geographic area.
3. Please identify and discuss specific unmet health-related needs in your community for the persons you serve. We are interested in hearing about needs related to not only health conditions, but also the social determinants of health, such as housing, transportation, and access to care, just to name a few.
4. Can you prioritize these issues? What are your top concerns*?*
5. Using the table, please identify the five most important "issues" that need to be addressed to make your community healthy (1 being most important). [see table below]
6. Has the COVID-19 pandemic influenced or changed the unmet health-related needs in your community? If yes, in what ways?
7. Are there specific populations or groups in your community who are disproportionately affected by these unmet health-related needs?
8. Please identify and discuss specific gaps in community services for the persons you serve that contribute to the unmet health-related needs you identified earlier.
9. Please identify and discuss specific barriers for the persons you serve that contribute to the unmet health-related needs you identified earlier.
10. What existing community health initiatives or programs in your community are helpful in addressing the health-related needs of the persons you serve, especially in relation to the health-related needs you identified earlier? Can you rank them in terms of effectiveness?
11. What suggestions do you have for organizations to work together to provide better services and improve the overall health of your community?
12. Is there anything else you would like to share?

Using the table below, please identify the five most important "issues" that need to be addressed to make your community healthy (1 being most important).			
	Aging problems (e.g. memory/hearing/vision loss)		Access to oral health care
	Air quality (e.g. pollution, smoke)		Access to safe, nearby transportation
	Obesity		Lack of community involvement
	Bullying/ verbal abuse		Affordable daycare and preschools
	Domestic violence, child abuse/neglect		Job skills training
	Few arts and cultural events		Accessibility for people with disabilities
	Firearm-related injuries		Safe and accessible parks/recreation

Using the table below, please identify the five most important "issues" that need to be addressed to make your community healthy (1 being most important).			
	Gang activity/violence		Behavioral health challenges and access to care (includes both mental health and substance use disorders)
	HIV/ AIDS		Poor quality of schools
	Homelessness/lack of safe, affordable housing		Racism/discrimination
	Food insecurity		Unemployment/lack of living wage jobs
	Access to health care services		Safe streets for all users (e.g. crosswalks, bike lanes, lighting, speed limits)
			Other

Appendix 4: Community Resources Available to Address Significant Health Needs

Providence Southwest Washington cannot address all of the significant community health needs by working alone. Improving community health requires collaboration across community stakeholders and with community engagement. Below outlines a list of community resources potentially available to address identified community needs.

Apx 4_Table 1. Community Resources Available to Address Significant Health Needs

Organization Type	Organization or Program	Description of services offered	Street Address (including city and ZIP Code)	Significant Health Need Addressed
Mental health and substance use services	**Behavioral Health Resources**	Supports and strengthens individuals, families and the community by promoting mental health and substance use disorder recovery. Provides a variety of programs and services including Harvest Home (serves pregnant and parenting women who are seeking abstinence from drugs or alcohol), New Journeys (coordinated specialty care program for first-episode psychosis), Program for Assertive Community Treatment (an intensive, multidisciplinary, and person-centered approach in working with people who have schizophrenia, schizoaffective disorder, or bipolar disorder), and Recovery-Integrated Treatment Services (intensive case management and substance use services in the community and in the office).	**Children, Youth and Family Services** 3857 Martin Way E Olympia, WA 98506 **Recovery Services/Harvest** 6128 Capitol Blvd SE Tumwater, WA 98501	Mental health and substance use
Nonprofit after-school program for young people	**Boys & Girls Club of Chehalis Boys & Girls Clubs of Thurston County—**	Their mission is to enable all young people, especially those who need us most, to reach their full potential as productive, caring, responsible citizens.	2071 Jackson Hwy. Chehalis, WA 98532 2200 Conger Ave NW Olympia, WA 98502	Healthy lifestyles, education

Organization Type	Organization or Program	Description of services offered	Street Address (including city and ZIP Code)	Significant Health Need Addressed
	Olympia Branch			
Health care alliance	**Cascade Pacific Action Alliance (CPAA)**	Led and managed by CHOICE Regional Health Network, an alliance of health care partners that work to improve health care access, care coordination and integration, prevent and manage chronic disease, prevent and mitigate Adverse Childhood Experiences, and enhance economic and educational opportunities. Services include oral health support, chronic disease self-management programs, Community CarePort, and health insurance assistance.	1217 4th Ave. E, Suite 200 Olympia, WA 98506	Access to health and dental care, mental health and substance use
Nonprofit community mental health center	**Cascade Mental Health**	A nonprofit community mental health center serving Lewis County and surrounding areas. With five locations throughout Lewis County, they offer a range of services including the WISe Program (Wraparound with Intensive Services is a program that provides recovery support services that address the complex emotional, behavioral, and social issues of individuals 20 years of age or younger and their family). They also operate the Cascade Evaluation and Treatment Center, a 22-bed facility treating adults 18 and over who are experiencing a mental health crisis and/or recovering from a severe mental health condition.	2428 West Reynolds Ave., Centralia, WA 98531	Mental health and substance use
Non-profit collaborative to improve community health	**CHOICE Regional Health Network**	A nonprofit collaborative of health care leaders in a five-county region that includes Grays Harbor, Lewis, Mason, Pacific, and Thurston County. The goal is to improve community health in Central	1217 Fourth Ave. E, Suite 200, Olympia, WA 98506	Access to care, dental care

Organization Type	Organization or Program	Description of services offered	Street Address (including city and ZIP Code)	Significant Health Need Addressed
		Western Washington through collective planning and action of health care leaders.		
Care coordination program	**Community CarePort**	A service of Cascade Pacific Action Alliance: Implements the Pathways Community HUB model to help coordinate the services between physical health, behavioral health, and social support systems. The goal is to break down silos, coordinate care, and improve health.	1217 4th Ave. E, Suite 200 Olympia, WA 98506	Access to health care, mental health and substance use
Nonprofit family support services	**Family Education Support Services**	A nonprofit agency that strives to inspire healthy child development through the provision of quality family support services. The Kinship Programs link grandparents and other relative caregivers to support groups, provides education, and increased access to resources in the community.	6840 Capitol Blvd SE, Tumwater, WA 98501	Education, domestic violence
Nonprofit multi-service agency for families and survivors of violence	**Family Support Center of South Sound**	The Family Support Center seeks to build strong, health, safe, and hopeful families through collaborative programs and multiple services: Homeless Family Services; Pear Blossom Place: A Family Support Community; Parent & Child Education; Family Resource Services Navigator Program; Family Justice Center Program	3545 7th Ave SW, Suite 200, Olympia, WA 98502	Homelessness, domestic violence, legal services, education
Nonprofit health center	**Olympia Free Clinic**	A volunteer-based, nonprofit organizations that provides medical, mental health, and specialty care services to uninsured and underinsured adults at no cost to the patient. They provide accessible, high-quality health services in a caring, respectful environment, and work to connect our patients to other community	225 State Ave NE, Olympia, WA 98501 (co-located at Providence Community Care Center)	Access to health care, mental health and substance use

Organization Type	Organization or Program	Description of services offered	Street Address (including city and ZIP Code)	Significant Health Need Addressed
		resources in pursuit of improved overall health.		
Collaborative center for accessing co-located social and health services	**Providence Community Care Center**	A social services hub located in downtown Olympia that brings together already existing organizations to work collaboratively and provide a single point of access for individuals. The center connects people with the basic building blocks of healthy living: food and shelter, mental and physical health care.	225 State Ave NE, Olympia, WA 98501	Access to care, mental health and substance use, homelessness, food insecurity, basic needs, education and job assistance
Nonprofit youth organization	**South Sound YMCA**	Our mission is to provide youth and our community an affordable and accessible resource for the positive development of spirit, mind, and body through recreational, health, and leadership programs.	Association Offices: 2102 Carriage Dr SW, #K, Olympia, WA 98502	Healthy lifestyles, education
Opioid response oversight group	**Thurston County Opioid Response Task Force**	The Thurston County Opioid Response Task Force was convened in 2018 to address the opioid epidemic. The Task Force consists of a wide range of local partners and is co-chaired by Jon Tunheim, Thurston County Prosecuting Attorney and Schelli Slaughter, Director of Thurston County Public Health & Social Services.	412 Lilly Road NE Olympia, WA 98506	Mental health and substance use
Federally Qualified Health Center	**Valley View Health Center**	A non-profit, federally qualified health center committed to providing quality integrated medical, dental, behavioral health, and pharmacy services to families and individuals of all ages, regardless of the ability to pay. They provide co-located services on site at the Community Care Center, Cascade Mental Health Care, among others.	3775 Martin Way E, Suite A, Olympia, WA 98506 2428 W. Reynolds Ave, Centralia, WA 98531	Access to Care