COMMUNITY HEALTH NEEDS ASSESSMENT

2020

Providence St. Joseph Medical Center

This CHNA was conducted by Providence St. Joseph Medical Center in Polson, Montana

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

PROVIDENCE
St. Joseph
Medical Center

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MESSAGE TO THE COMMUNITY AND ACKNOWLEDGEMENTS

As a not-for-profit Catholic health care ministry, Providence St. Joseph Medical Center embraces its responsibilities to respond to our community's needs. The Community Health Needs Assessment (CHNA) process is crucial to how our community tells us what those needs are. A healthy community relies on many people and many resources. When the Sisters of Providence began our tradition of caring over 160 years ago, our ministry greatly depended on partnering with others in the community who were committed to doing good, and we continue those partnerships today.

Providence's vision of "Health for a Better World" starts with our commitment to understanding and serving the needs of the community, especially those who are poor and vulnerable. With each investment we make and partnership we develop, we find ways to best address and prioritize our region's most challenging needs as identified through our CHNA. In 2019, driven by our Mission to care for our community, Providence Montana, which includes Providence St. Joseph Medical Center, Providence Medical Group, as well as St. Patrick Hospital in Missoula, invested more than $31.3 million in our communities. Together with our partners, we are building communities that promote and transform health and well-being.

With input and guidance from many of our community partners we complete a CHNA every three years to identify the greatest unmet needs in our community. The objectives of the CHNA are to understand the greatest needs in the community, determine how Providence Joseph Medical Center can respond to those needs in partnership with other community organizations, and develop implementation strategies that will lead to health improvement. In the coming year, we will focus our efforts on supporting and growing programs that address access to mental health care and substance use treatment.

Our ultimate goal is to identify solutions that transform the health of our communities and collectively with our partners achieve Health for a Better World. We invite you to learn more about how we are working to meet community needs and help people live their healthiest lives.

Sincerely,

Joyce Dombrouski, MHA, RN, CPH
Chief Executive
Providence Montana

EXECUTIVE SUMMARY

Understanding and Responding to Community Needs, Together

Improving the health of our communities is foundational to our Mission and a commitment 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 neighbors. 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 Providence St. Joseph Medical Center Advisory Council on October 28, 2020.

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 Lake County, information collected includes public health data regarding health behaviors, hospital utilization data, input from key community stakeholders, and surveys of target neighborhoods. Stakeholder interviews were conducted with representatives from organizations that serve these populations. Some key findings include the following:

- Stakeholders interviewed consistently expressed the need for improved access to behavioral health care and low-barrier substance use treatment.
- Of individuals who responded to the community survey, 35% called for more mental health services in the community, and 18% specified the need for more substance use disorder treatment options.
- Compared to other counties in Montana, Lake County dropped in its ranking in “Health Outcomes” from 2017 (38) to 2020 (42). With 56 counties in Montana, this puts Lake County in the bottom 25% for health outcomes. Alcohol-impaired driving deaths increased substantially from 45% in 2017 to 61% in 2020. Conversely, the population with adequate access to locations for physical activity improved from 46% to 55%, and teen births decreased from 50 to 37.
- Median household income increased by over 13%; despite this, the percentage of children eligible for free or reduced price lunch increased from 70% to 77%.

Identifying Top Health Priorities, Together

Through a collaborative process engaging Providence St. Joseph Advisory Council, the following priority areas were agreed upon:

Prioritized Need	Definition	Rationale
PRIORITY 1: ACCESS TO MENTAL HEALTH SERVICES	Access to mental health and behavioral health services, including for children and adolescents, regardless of payer source or ability to pay for services, as well as rapid access for people experiencing a mental health crisis.	• Montana consistently ranks in the top three states for rate of suicide; 2018 was the first year Montana dropped out of the top three states for suicide in ten years, ranking fourth *(https://suicidology.org/facts-and-statistics/)* • Lake County has the third highest rate of suicide in the state, with 41 deaths per 100,000 population; for the American Indian Population, the rate is 51 per 100,000 (*countyhealthrankings.org/app/montana/2020/overview)* • Residents of Lake County experience an average of 4.3 poor mental health days per month compared to 3.7 for Montana (*countyhealthrankings.org/app/montana/2020/overview)* • In Montana, Major Depressive Episode (MDE) among youth aged 12-17 in the prior year: ○ Increased to 11.4% (2013-2017) from 8.9% in 2004-2008 ○ 41.1 % received care for depression in the past year *(samhsa.gov)* • In the Montana service area: ○ Economically-vulnerable patient groups (people who are disabled; people who are experiencing homelessness or have unstable housing) have high rates of mental health diagnosis and/or substance use disorder ○ Minority populations, including the American Indian population, LGBTQ+, and the Black population have high rates of mental health diagnosis and/or substance use disorder
PRIORITY 2: ACCESS TO SUBSTANCE USE DISORDER TREATMENT SERVICES	Access to both outpatient and inpatient alcohol and drug treatment and detox, regardless of payer source or ability to pay, as well as expanded treatment models, such as medication-assisted treatment and peer support programs.	• At Providence St. Joseph Medical Center, ○ Substance Use Disorders were the third most common diagnosis in 2019, accounting for 7% of all avoidable ED encounters ○ 60% of avoidable ED encounters and inpatient admissions for Substance Abuse Disorders were by patients with Medicaid; treatment options are limited and waiting times for services are prohibitive for patients covered through Medicaid • Alcohol-impaired driving deaths increased substantially from 45% in 2017 to 61% in 2020 (*countyhealthrankings.org/app/montana/2020/overview)*

PRIORITY 3: SAFE AND AFFORDABLE HOUSING	Safe and affordable housing allows households to pay for other nondiscretionary expenses that are integral to good health, like healthy food, health care, and education.	• Health and safe, stable housing are inextricably linked, but the community faces an ongoing challenge in its low stock of affordable housing units. • Lake County's cost of living, including cost of housing, is high compared to the minimum wage of $8.50/hour. The living wage for one adult working full time is $10.39; if that adult is supporting a child, the living wage is $23.76. (*livingwage.mit.edu)* • Approximately 14% of households in Lake County are severely housing cost burdened. *(American Community Survey, estimates based on 2013 – 2017 data)*

Next Steps: Making a Community Health Improvement Plan

Providence St. Joseph Medical Center 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.

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 affect 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.

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

Providence St. Joseph Medical Center is a critical access hospital founded in 1916 and located in Polson, Montana; the Sisters of Providence took responsibility of the hospital in 1990. It is one of eight critical access hospitals in the Montana service area and has 23 licensed beds. Providence St. Joseph Medical Center has a staff of more than 270. Major programs and services offered to the community include acute inpatient care, primary care, specialty clinics, outpatient diagnostics, surgical services, as well as an assisted living facility.

Our Commitment to Community

Providence St. Joseph Medical Center 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, Providence Montana provided $31.3 million in Community Benefit[1] in response to unmet needs and to improve the health and well-being of those we serve in western Montana, including $7.1 million in free and low-cost care for people who are underinsured or uninsured. The Providence Montana service area includes Providence St. Joseph Medical Center, Providence St. Patrick Hospital in Missoula, and Providence Medical Group, including 11 outpatient primary care clinics and 14 specialty clinics throughout western Montana.

[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.

Figure 1. PSJH Community Benefit in Montana in 2019

Providence St. Joseph Medical Center further demonstrates organizational commitment to the CHNA through the allocation of staff time, financial resources, participation and collaboration to address community identified needs. Providence St. Joseph Medical Center is responsible for ensuring compliance to the Federal 501(r) 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, 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]).

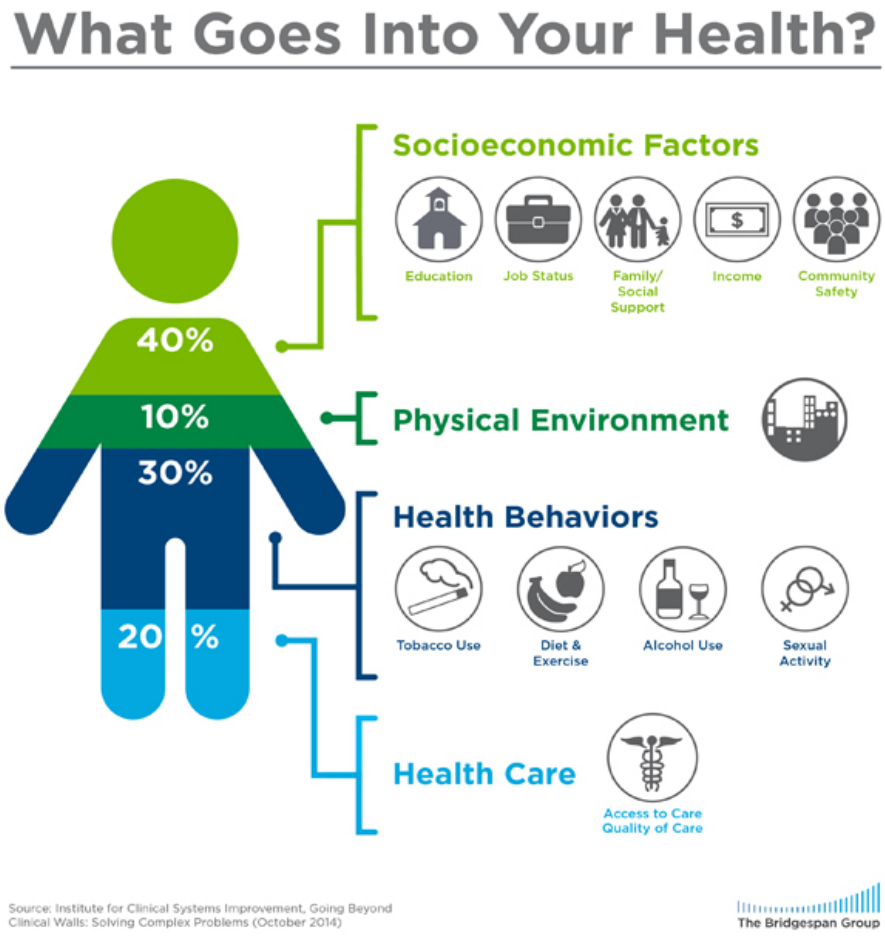


Figure 2. Factors Contributing to Overall Health and Well-being

[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.

Health Equity

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

Health Disparities

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

Figure 3. 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

[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.

OUR COMMUNITY

Description of Community Served

Providence St. Joseph Medical Center serves as a critical access hospital to Lake County and surrounding communities, including the Flathead Indian Reservation, which is the ancestral home of the Bitterroot, Salish, Kootenai and Pend d'Oreille tribes, organized as the Confederated Salish and Kootenai Tribes of the Flathead Nation. Lake County, as well as the immediate surrounding area, is rural. Flathead County (to the north and northeast) and Missoula County (to the south and southeast) include the cities of Kalispell and Missoula, respectively, which each have larger hospitals. Sanders County, to the west, is rural, and is home to another critical access hospital. Lake County's population is 30,458, .7% higher than at the time of the previous CHNA.

Hospital Total Service Area

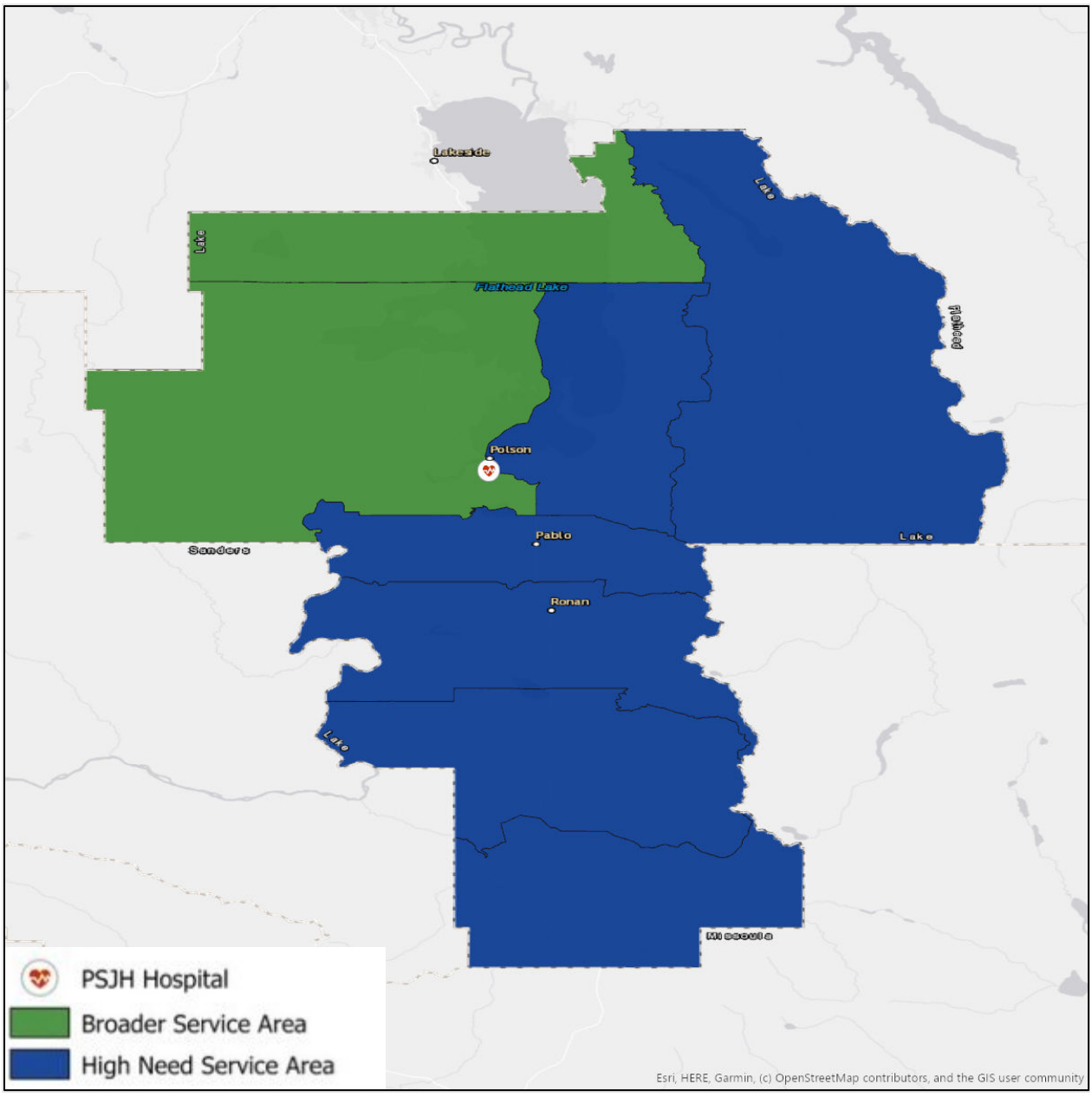
The table and map below are representative of the hospital service area, Lake County.

Table 1. Cities and ZIP Codes Included in Service Area

Cities/ Communities	ZIP Codes
Arlee	59821
Big Arm	59910
Charlo, Moiese	59824
Dayton	59914
Elmo	59915
Pablo	59855
Polson	59860
Proctor	59929
Ravalli	59863
Rollins	59931
Ronan	59864
Saint Ignatius	59865

The blue portions of the map below are considered “high need” census tracts, and the green portions are the broader service area. Together, these areas make up the total service area, Lake County.

Figure 4. Providence St. Joseph Medical Center Total Service Area



Community Demographics

The tables and graphs below provide basic demographic and socioeconomic information about Providence St. Joseph Medical Center's service area and how the high need area compares to the broader service area. The service area of Providence St. Joseph includes approximately 31,000 people and encompasses all of Lake County. The high need area includes census tracts identified based upon lower life expectancy at birth, lower high school graduation rates, and more households at or below 200% FPL (annual household income of $51,500 or less for a family of 4) compared to county averages.

POPULATION AND AGE DEMOGRAPHICS

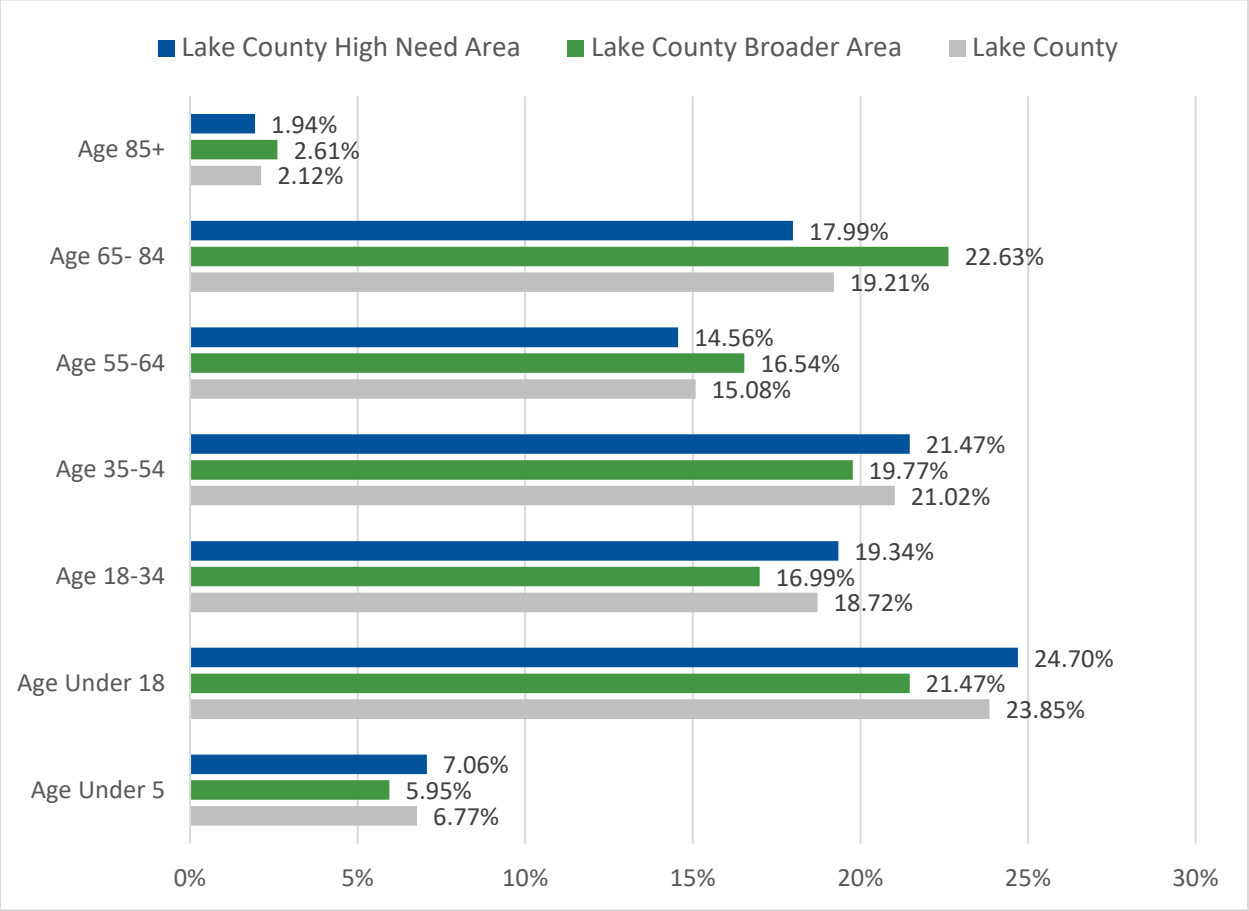
Table 2. Population Demographics for Lake County Service Area

Indicator	Lake County	Broader Service Area	High Need Service Area
2019 Total Population	31,036	8,134	22,902
Female Population	50.36%	50.91%	50.17%
Male Population	49.64%	49.09%	49.83%

For the most part, the age distribution is roughly proportional across Lake County geographies, with those aged between under the age of 34 slightly more likely to live in a high need area, likely young families and those in and around college towns. Those aged 65-84 are less likely to live in a high need area compared to the broader service area, perhaps due in part to secondary and/or vacation homes.

The male-to-female ratio is approximately equal across geographies.

Figure 5. Age Groups by Geography in Lake County Service Area



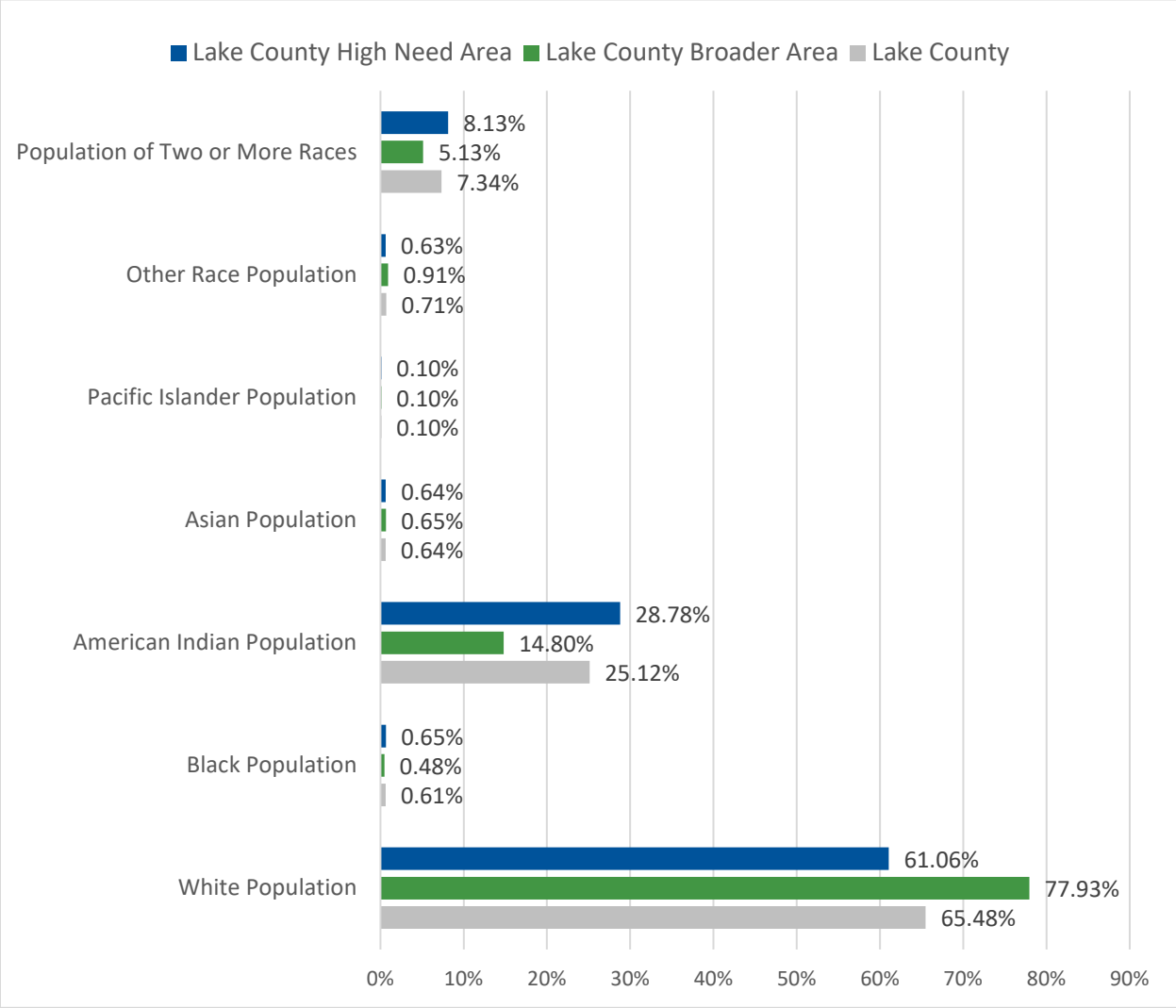
POPULATION BY RACE AND ETHNICITY

Table 3. Hispanic Population by Geography in Lake County Service Area

Indicator	Lake County	Broader Service Area	High Need Service Area
Hispanic Population	4.82%	3.86%	5.16%

The American Indian population is more likely to live in a high need area, as well as people identifying as two or more races. The Hispanic population is also more likely to live in a high need service area. White people are less likely to live in a high need area.

Figure 6. Race by Geography in Lake County Service Area

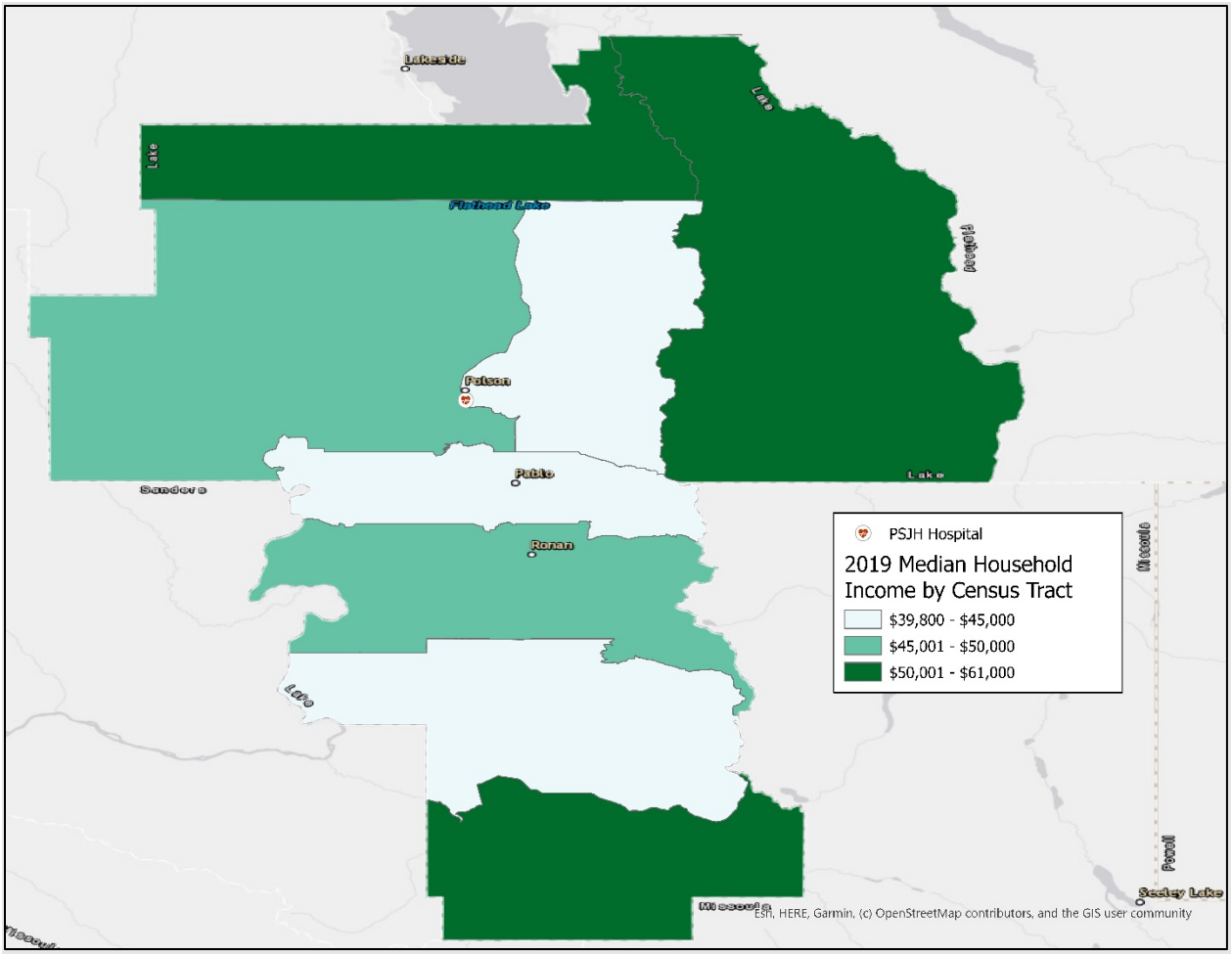


MEDIAN INCOME

Table 4.2019 Median Household Income for Lake County Service Area

Indicator	Lake County	Broader Service Area	High Need Service Area
Median Household Income Data Source: American Community Survey Year: 2019	$47,594	$51,681	$45,735

Figure 7. 2019 Median Household Income for Lake County Service Area



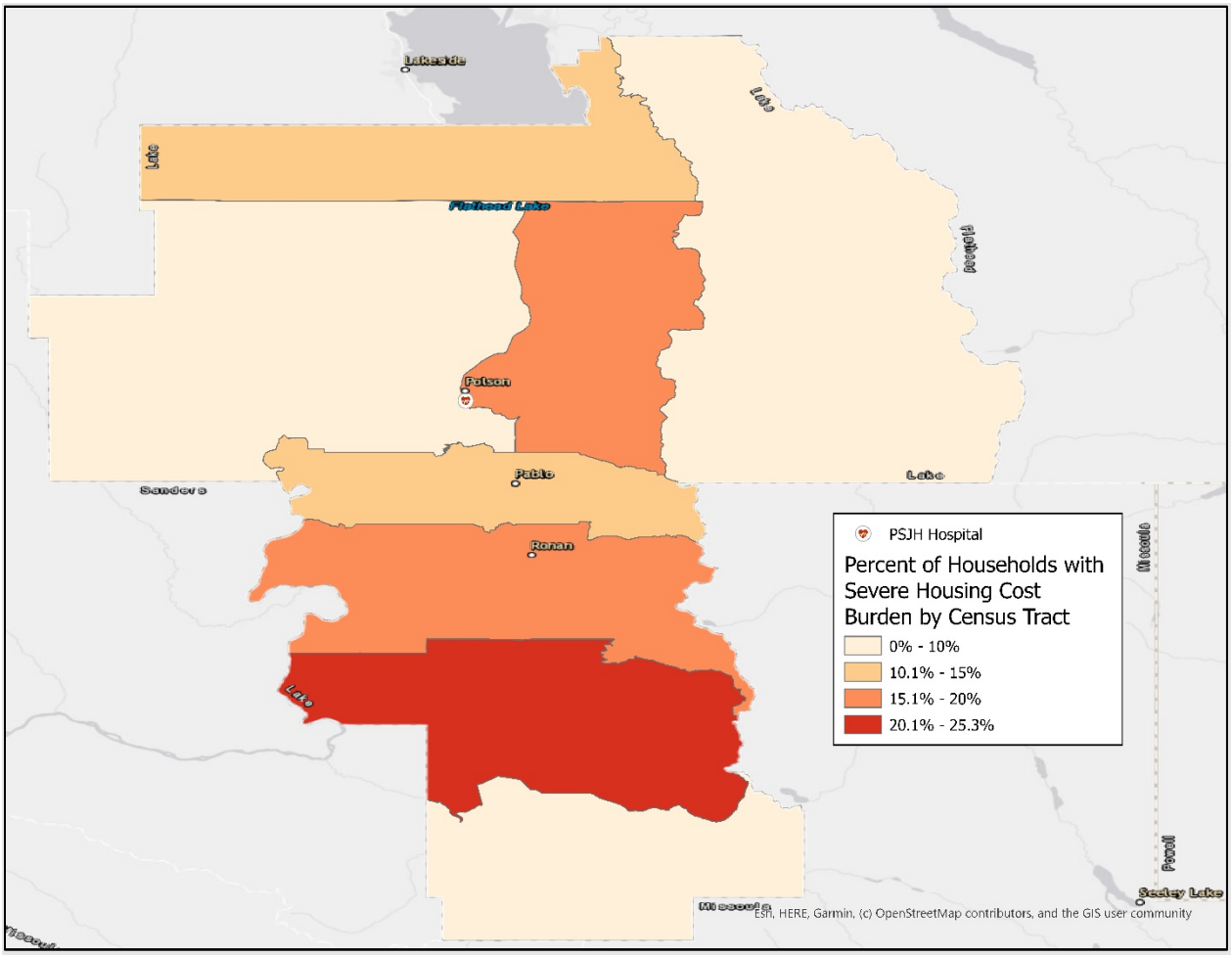
- The median income in the high need service area is slightly lower than Lake County overall, with the high need service area being almost $2,000 lower.
- There difference in median income between the broader service area and the high need service area is slightly greater, with the high need service area being almost $6,000 lower.

SEVERE HOUSING COST BURDEN

Table 5. Percent of Households with Severe Housing Cost Burden in Lake County Service Area

Indicator	Lake County	Broader Service Area	High Need Service Area
Percent of Renter Households with Severe Housing Cost Burden Data Source: American Community Survey Year: Estimates based on 2013 – 2017 data	14.20%	9.91%	15.55%

Figure 8. Percent of Households with Severe Housing Cost Burden in Lake County Service Area



Severe housing cost burden is defined as households that are spending 50% or more of their income on housing costs. On average, approximately 14% of households in Lake County are severely housing cost burdened. This is slightly lower than the high need areas in which 16% of renter households are severely housing cost burdened.

RURAL HOUSEHOLDS

Compared to Montana, Lake County has substantially more people living in rural areas.

Table 6. Percent of Population Living in a Rural Area in Lake County Compared to Montana

Indicator	Lake County	Montana
Percent of Population Living in a Rural Area Data Source: County Health Rankings, 2010	83.4%	44.1%

See Appendix 2: Quantiative Data for more population level data for the service area.

HEALTH PROFESSIONAL SHORTAGE AREA

Lake County is a designated Health Resources and Services Administration (HRSA) Health Professional Shortage Area (HPSA) for low-income populations for primary, dental and mental health care. Surrounding counties in the greater Providence Montana service area all have HPSA designations, with the exception of Lewis and Clark County.

See Appendix 2: Quantitative Data for more information related to HPSA, Medically Underserved Areas, and Medically Underserved Populations.

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 Providence St. Joseph Medical Center, 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 health disparities within and across communities.

We reviewed data from the American Community Survey and local public health authorities. In addition, we include 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 hospital's service area, it is important to recognize the limitations and gaps in information that naturally occur. For example, not all data are available to be analyzed by ZIP Code, race/ethnicity, or other socioeconomic factors. Data may have a time lag and therefore may be several years old. Additionally, some data may not be available for trend analysis due to changes in definition or data collection methods.

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. To date, no public comments have been received.

Members of the public may respond to the 2020 CHNA by phone, e-mail or in writing:

Hollie Timmons (406) 327-3337
Hollie.Timmons@providence.org
Providence Montana
Community Health Investment
PO Box 4587
Missoula, MT 59806

HEALTH INDICATORS

County Health Rankings

Compared to other counties in Montana, Lake County dropped in its ranking in "Health Outcomes" from 2017 (38) to 2020 (42). Montana has 56 counties, 48 of which are ranked. The measures in the Health Outcomes category include premature death and quality of life indicators, all of which declined. Premature deaths, measured in years of potential life lost, increased by over 17%.

Other areas of concern include a significant jump in alcohol-impaired driving deaths, from 45% in 2017 to 61% in 2020. Preventable hospital stays increased by over 16%, despite the ratio of providers improving, including primary care, dentists, and mental health providers. The percent of population uninsured for Lake County has decreased dramatically in the years following Medicaid expansion, from 25% to 15%.

Positive changes from 2017 data include a decrease in the teen birth rate from 50 to 37 births per 1,000 females ages 15 to 19 years, as well as in increase of people with access to exercise opportunities from 46% to 55%. The food environment index improved by 13%, and children in poverty decreased from 29% to 26%. Drug overdose deaths decreased from 25 to 13.

Lake County has a substantially higher percentage of children eligible for free or reduced lunch compared to Montana, which corresponds to a lower median household income. Additionally, a substantially greater percentage of adults and a slightly greater percentage of children are uninsured in Lake County compared to Montana.

Table 7. Key Health Factors from County Health Rankings

Indicator	Lake County	Montana
Children eligible for free or reduced lunch	77%	45%
Uninsured adults	19%	12%
Uninsured children	8%	6%

Source: County Health Rankings

See Appendix 2: Quantitative Data for full table of 2017 and 2020 County Health Rankings metrics for Lake County.

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 Lake County. 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.

Table 8. Avoidable Emergency Department Visits for PSJH Washington and Montana Hospitals

Facility	Non-AED Visits	AED Visits	Total ED Visits	AED %
Providence Regional Medical Center Everett	38,379	16,765	55,144	30.4%
Kadlec Regional Medical Center	50,836	25,216	76,054	33.2%
Providence St Mary Medical Center	15,622	7,417	23,041	32.2%
Providence St Peter Hospital	31,780	14,513	46,295	31.3%
Providence Centralia Hospital	19,660	9,075	28,735	31.6%
Providence SHMC and Children's Hosp	37,099	19,121	56,222	34.0%
Providence Holy Family Hospital	29,829	13,567	43,396	31.3%
Providence Mount Carmel Hospital	6,519	2,742	9,266	29.6%
Providence St Joseph Hosp Chewelah	2,963	1,259	4,223	29.8%
Providence St Patrick Hospital—Missoula	15,832	7,394	23,227	31.8%
Providence St Joseph Medical Center—Polson	3,456	1,394	4,855	28.7%
Grand Total	**251,975**	**118,463**	**370,458**	**32.0%**

Across PSJH's Washington and Montana service area, Providence St. Joseph Medical Center had the lowest percentage of potentially avoidable ED utilization in 2019. Individuals identifying as Asian were most likely to have an avoidable ED visit at Providence St. Joseph Medical Center, although it should be noted there were fewer than 10 cases total in this population, meaning these data should be interpreted with caution. About one in three visits by an individual identifying as American Indian or Alaska Native was potentially avoidable, though again, the sample size is small.

ZIP Codes 59860, 59864, and 59855 produced the greatest number of potentially avoidable visits at Providence St. Joseph Medical Center. These three ZIP Codes were responsible for approximately 78% (1,082) of all potentially avoidable visits in 2019.

Table 9. Top Three Patient ZIP Codes for Avoidable Emergency Department Visits at Providence St. Joseph Medical Center

Encounters by Patient Zip Code	Non-AED Visits	AED Visit	Total ED Visits	AED %
Providence St Joseph Medical Center	**3,456**	**1,394**	**4,855**	**28.7%**
59860	2,017	773	2,790	27.7%
59864	433	206	639	32.2%
59855	221	103	324	31.8%

See Appendix 2: Quantitative Data for more information on AED and PQI data.

Social and Economic Effects of the COVID-19 Pandemic

While much of the quantitative data available for the CHNA was generated prior to the COVID-19 pandemic, there are state-level indicators of how the pandemic has affected the wellbeing of Montanans. The U.S. Census Bureau has launched the multi-phase Pulse Survey to assess the impact of COVID-19, including loss of employment income, food scarcity, delayed medical care, housing instability, anxiety and depression, and educational changes.

Key results of the final week of the first phase, conducted April 23 – July 21, 2020, include:

- Nearly 51% of households in Montana have experienced some loss of employment income since the beginning of the pandemic
- About 24% of adult Montanans needed non-COVID-related medical care, but did not receive treatment
- Anxiety and depression are high across employment status, but particularly for those who have experienced loss of employment
- 12% of households reported no confidence or slight confidence in paying the next month's rent
- Approximately 45% of households used stimulus funds, credit, borrowed from friends/family, savings, or other "non-regular income" to pay for rent

(Source: U.S. Census Bureau)

COMMUNITY INPUT

Summary of Community Input

STAKEHOLDER INTERVIEWS

To better understand the unique perspectives, opinions, experiences, and knowledge of community members, representatives from Providence St. Joseph Medical Center conducted 6 stakeholder interviews. 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 community input:

Behavioral health challenges and access to behavioral health care (includes both mental health and substance use disorder)	Stakeholders described behavioral health as interconnected with several other community needs. They identified a history of **trauma** and **child abuse/neglect** as contributors to both mental health challenges and substance use disorders (SUD). Additionally, having a mental health challenge or SUD compromises **access to health care** and **housing stability**, emphasizing the need for more supportive housing for these individuals. Stakeholders discussed behavioral health challenges in connection to **poverty** and lack of opportunities, leading to **a lack of hope** and contributing to deaths of despair. Barriers to addressing these behavioral health needs include **stigma**, the **criminalization of substance use** and fear of legal repercussions, and a **lack of healthy coping skills**. Specific gaps in the community include a lack of **inpatient SUD treatment services** and agencies that address SUD. Accessing SUD treatment is especially challenging for people who are uninsured, have low incomes, or have co-occurring, complex health and behavioral needs. Stakeholders also spoke to a lack of **crisis services** for people needing immediate, but short-term support, other than the Emergency Department. Another gap is a lack of **counseling services** for people who have low incomes and school-age children.
Homelessness/ lack of safe, affordable housing	Stakeholders agreed there is a need for more **affordable housing** and **housing for seniors**. They shared that mental health and SUD challenges make it hard to keep people in stable housing. Therefore, there is a need for more **supportive housing** with connected services that are equipped to address behavioral health needs. Barriers to moving people into housing include **low housing stock**, **poor credit**, and **poor housing history**. Stakeholders shared there are a lack of services specifically for people experiencing homelessness within Polson.

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

Aging problems	Stakeholders spoke to a need for more **nursing homes**, specifically for people with Alzheimer's and dementia, and **adult daycare services**. They shared a need for more **in-home services** for older adults needing hands on care, specifically for people who have low incomes but do not qualify for Medicaid. This is important for mitigating isolation. Within Lake County there is a lack of **fiduciary services**. Stakeholders were concerned about older adults whose Social Security benefits put their income slightly above the threshold for **Medicare savings**, meaning they are unable to afford Medicare premiums and therefore forego necessary health services due to cost of care.
Food insecurity	Stakeholders were concerned about community members' consistent access to good-quality, nutritious food, particularly because the pandemic has exacerbated the need. They shared **cost** of healthy, fresh foods, **transportation**, and **lack of nearby grocery stores** contribute to food insecurity, particularly for people with **low incomes** and people living **in rural areas**. Stakeholders also named **older adults**, **Native American communities**, and **children** as having reduced access to healthy foods. As a result of the COVID-19 pandemic, people who are immunocompromised and older adults may be more anxious about leaving their home to get food or experience increased transportation barriers.
Unemployment and lack of living wage jobs	Stakeholders spoke to the connection between living wage jobs and housing stability, food security, quality of life, mental health, and the ability to afford daycare. They also shared that having affordable, high-quality **daycare** is crucial for ensuring people can hold a consistent job. They shared concern for **older adults** who need to continue to work to make ends meet and **individuals who make slightly too much to qualify for public benefits**, but not enough to meet their basic needs. They shared a need for more **job skills training** in the community and more jobs with **good benefits**.

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

Effects of COVID-19	Stakeholders discussed how the COVID-19 pandemic has exacerbated needs. Related to **aging problems**, some in-home services have been paused, meaning that many older adults with low incomes are not getting the care they need and not getting in-person interactions, raising concerns about isolation. **Mental health** in general is a concern. As a positive, more individuals have offered support and check-ins for older adults during the pandemic. **Transportation** has been more challenging with a reduction in the Tribal Transportation in Polson. **Sharing up-to-date information** has been difficult and people have been frustrated trying to figure out which services are available. Related to **access to care**, people have been delaying important care and the pandemic has highlighted many individuals lack a primary care provider. Additionally, the **COVID-19 testing fees** (for the visit and collection) have been a barrier for some. Stakeholders shared a concern for increased **unemployment**, particularly workers who lost their job as a result of quarantining. Related to **education**, stakeholders shared a lack of access to technology and broadband, as well as a lack of engagement from some students will only increase the student opportunity gap.

COMMUNITY SURVEY

In July 2020, the hospital invited households in Lake County to respond to an anonymous online survey. Postcards with the survey link were mailed to households with an annual income of $35,000 or less in ZIP Codes 59821, 59860, 59864 and 59865. The survey link was also shared by Providence staff and partner organizations in the community. The survey was open from July 8 – July 26 and 220 responses were received. See Appendix 3 for a summary of the survey responses, as well as a comparison to 2017 survey responses.

See Appendix 3: Community Input: Qualitative Data

Challenges in Obtaining Community Input

Obtaining robust community input during the COVID-19 pandemic was especially challenging and prevented Providence St. Joseph Medical Center from completing any in-person conversations. In prior Community Health Needs Assessment years, the hospital conducted public in-person listening sessions or focus groups in accessible public spaces. Our initial planning for this assessment included the intent for public listening sessions but given the need to avoid in-person interaction due to COVID-19, we shifted our community input strategy to focus on online stakeholder interviews and anonymous online surveys. Additionally, due to many community organizations engaging in COVID-19 response, some organizations had limited capacity and were not able to participate in interviews.

SIGNIFICANT HEALTH NEEDS

Prioritization Process and Criteria

The SJMC Advisory Council met online August 12, 2020 to review community needs and prioritize needs for the 2020 CHNA and 2020-2022 Community Health Improvement Plan. The committee reviewed the data packet, including the quantitative and qualitative data included in this document. Following discussion, the committee voted to determine the two highest priority needs.

See Appendix 4: Prioritization Protocol and Criteria

2020 Priority Needs

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

PRIORITY 1: ACCESS TO MENTAL HEALTH SERVICES

Access to mental health and behavioral health services, including for children and adolescents, regardless of payer source or ability to pay for services, as well as rapid access for people experiencing a mental health crisis.

PRIORITY 2: ACCESS TO SUBSTANCE USE DISORDER TREATMENT SERVICES

Access to both outpatient and inpatient alcohol and drug treatment and detox, regardless of payer source or ability to pay, as well as expanded treatment models, such as medication-assisted treatment and peer support programs.

PRIORITY 3: SAFE AND AFFORDABLE HOUSING

Safe and affordable housing allows households to pay for other nondiscretionary expenses that are integral to good health, like healthy food, health care, and education.

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 Lake County Public Health and Confederated Salish and Kootenai Tribal Health. In addition, there are several social service non-profit 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 5.

See Appendix 5: Resources potentially available to address the significant health needs identified through the CHNA

EVALUATION OF 2018-2020 CHIP IMPACT

This report evaluates the impact of the 2018-2020 Community Health Improvement Plan (CHIP). Providence St. Joseph Medical Center responded to community needs by making investments of direct funding, time, and resources to internal and external programs dedicated to addressing the previously prioritized needs using evidence-based and leading practices.

SOCIAL DETERMINANTS OF HEALTH AND WELL-BEING

Table 10. Outcomes from 2018-2020 CHIP: Social Determinants of Health and Well-being

Focus Area	Program or Service Name	Results / Outcomes	Type of Support
Obesity Prevention	Reduced-cost student sports physicals	Students can meet participation criteria for school athletics, regardless of ability to pay	Grant
Food Insecurity and Poor Nutrition	Polson School District Winter Food Program	Students in food-insecure households receive transportation to school for meals and activities while school is on break; in 2019, 110 students participated.	Grant
	Polson Loaves and Fishes Food Bank	Support access to healthy food for 4,000-6,000 people in Lake County who experience food insecurity	Grant
	Ronan Bread Basket	Support access to healthy food for 4,000-6,000 people in Lake County who experience food insecurity	Grant
Youth and Family Health	Boys and Girls Club of the Flathead Reservation	Contribution to after-school and summer youth programs in Polson and Ronan	Grant
	Safe Harbor Domestic Violence Shelter	Emergency shelter, counseling and other support services for families fleeing domestic violence	Grant

MENTAL HEALTH

Table 11. Outcomes from 2018-2020 CHIP: Mental Health

Focus Area	Program or Service Name	Results / Outcomes	Type of Support
Collaborate with and support community partners to **reduce suicides**	Warrior Movement	Contribution to community and youth-led suicide prevention and awareness	Grant

Focus Area	Program or Service Name	Results / Outcomes	Type of Support
Improve access to **outpatient and acute mental health services**	Telepsychiatry	Service expansion through 2019	Program
	Integrated Behavioral Health	Providence Medical Group added behavioral health care managers to nine primary care clinics with funding from Montana Healthcare Foundation	Program
	Trauma-Informed Care for Rural Children, funded through Mental Health Trust, to provide integrated physical and mental health care	384 children and teens have received screening	

ACCESS TO CARE

Table 12. Outcomes from 2018-2020 CHIP: Access to Care

Focus Area	Program or Service Name	Results / Outcomes	Type of Support
Improved Access	Medication Assistance	Prescriptions funded by hospital for patients who cannot afford medication	Program
	Enrollment Assistance	Year-round assistance for enrollment in Medicaid and Marketplace plans; assistance for applying for SSDI	Program
	Providence Plan Partners	Phone support following emergency department encounters, including assistance with arranging follow-up care	Program
	Outpatient Care Management	RN Care Managers and Behavioral Health Care Managers support patients at high risk and rising risk of poor health outcomes	Program
	Providence Express Care	Virtual care option launched for patients and the public; service is at a flat-rate, billable to insurance	Program

SUBSTANCE ABUSE

Table 13. Outcomes from 2018-2020 CHIP: Substance Abuse

Focus Area	Program or Service Name	Results / Outcomes	Type of Support
Promote treatment and support services in the community	Eat, Sleep, Console / Bridge to Hope	Protocol for neonatal abstinence syndrome established with initial support from Montana Healthcare Foundation	Program
	Integrated Medication Assisted Treatment (IMAT) services for opioid substance abuse disorder; funded through State of Montana	170 patients served; program ongoing	In-Kind Staff Time
	Open Aid Alliance (OAA) Syringe Services Program	Promote holistic harm reduction and increase access to health care for people who use illicit substances; in 2017, state program expanded access to naloxone; OAA provides education on overdose recognition and response	Grant

Addressing Identified Needs

The Community Health Improvement Plan (CHIP) developed for Providence St. Joseph Medical Center 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 St. Joseph Medical Center plans to address the health needs. If the hospital does not intend to address a need or plans to have limited response to the identified need, the CHIP will explain why. The CHIP will not only describe the actions Providence St. Joseph Medical Center intends to take, but also the anticipated impact of these actions and the resources the hospital plans to commit to address the health need.

Because partnership is important when addressing health needs, the CHIP will describe any planned collaboration between Providence St. Joseph Medical Center and community-based organizations in addressing the health need. 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 28, 2020 by the Providence St. Joseph Medical Center Advisory Council.[4] The final report was made widely available[5] by December 28, 2020.

Joyce Dombrouski 10/28/2020

Joyce Dombrouski — Date
Chief Executive, Providence Montana

Caryl Cox 10/30/2020

Caryl Cox — Date
Chair, Providence St. Joseph Medical Center Advisory Council

12/01/2020

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

CHNA/CHIP Contact:

Hollie Timmons
Community Health Investment Coordinator
PO Box 4587
500 W Broadway
Missoula, MT 59806
Hollie.Timmons@providence.org

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

[4] **See Appendix 6: Providence St. Joseph Medical Center Community Health Needs Assessment Advisory Council**

[5] Per § 1.501(r)-3 IRS Requirements, posted on hospital website

APPENDICES

Appendix 1: Definition of Terms

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 Medi-Cal 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."[6]

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.[7]

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."[8]

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."[9]

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.

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[6] https://www.dcyf.wa.gov/safety/what-is-abuse

[7] https://www.eoc.org.uk/what-is-discrimination/

[8] https://www.thehotline.org/is-this-abuse/abuse-defined/

[9] 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.

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.

Poor quality of schools: Schools that do not provide a quality education to all students regardless of race, ethnicity, gender, socioeconomic status, or geographic location. A quality education is defined as one that "provides the outcomes needed for individuals, communities, and societies to prosper. It allows schools to align and integrate fully with their communities and access a range of services across sectors designed to support the educational development of their students."[10]

Racism: "Prejudice against someone based on race, when those prejudices are reinforced by systems of power."[11]

Safe and accessible parks/recreation: Issues around a shortage of parks or green spaces, or existing parks/green spaces being poorly maintained, inaccessible, or unsafe.

Safe streets for all users: People walking, biking, driving, and using public transportation can generally trust that they are safe on the road. Includes safety features such as crosswalks, bike lanes, lighting, and speed limits.

Social Determinants of Health: Conditions in the environment in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.

Unemployment/ lack of living wage jobs: Not having employment or lacking a job that pays the minimum income necessary for a worker to meet their basic needs.

[10] http://www.ascd.org/ASCD/pdf/siteASCD/policy/ASCD-EI-Quality-Education-Statement.pdf

[11] Oluo, Ijeoma. *So You Want to Talk About Race.*

Appendix 2: Quantitative Data

POPULATION LEVEL DATA

2017 vs. 2020 County Health Rankings—Lake County

Apx 2_Table 1. County Health Rankings Data for Lake County 2017 vs. 2020

	Montana - 2020	Lake 2020	Lake 2017
Health Outcomes		42	38
Length of Life		*40*	*24*
Premature death	7,200	9,600	8,200
Quality of Life		*43*	*40*
Poor or fair health	15%	17%	16%
Poor physical health days	3.8	4.2	4.1
Poor mental health days	3.7	4.3	4
Low birthweight	7%	9%	9%
Health Factors		41	39
Health Behaviors		*38*	*34*
Adult smoking	17%	20%	19%
Adult obesity	26%	29%	28%
Food environment index	7.3	7.9	7
Physical inactivity	22%	22%	23%
Access to exercise opportunities	75%	55%	46%
Excessive drinking	21%	18%	18%
Alcohol-impaired driving deaths	45%	61%	45%
Sexually transmitted infections	434.1	591.3	523.8
Teen births	24	37	50
Clinical Care		*34*	*30*
Uninsured	10%	15%	25%
Primary care physicians	1,250:1	1,440:1	1,620:1
Dentists	1,390:1	1,160:1	1,400:1
Mental health providers	330:1	420:1	550:1
Preventable hospital stays	3,142	4,902	4,200
Mammography screening	42%	42%	84%
Flu vaccinations	42%	38%	65%
Social & Economic Factors		*38*	*41*
High school graduation	86%	89%	88%
Some college	68%	62%	58%
Unemployment	3.70%	4.30%	4.90%
Children in poverty	16%	26%	29%
Income inequality	4.5	4.9	4.9
Children in single-parent households	27%	38%	38%
Social associations	14.3	9.2	10.7

Violent crime	346	446	438
Injury deaths	91	118	113
Physical Environment		*46*	*43*
Air pollution - particulate matter	6	8.8	6.4
Drinking water violations		No	Yes
Severe housing problems	15%	18%	20%
Driving alone to work	76%	75%	71%
Long commute - driving alone	16%	22%	20%
Length of Life			
Life expectancy	78.8	77.9	
Premature age-adjusted mortality	340	390	60
Child mortality	60	90	9
Infant mortality	6		
Quality of Life			
Frequent physical distress	12%	13%	13%
Frequent mental distress	12%	14%	14%
Diabetes prevalence	8%	9%	9%
HIV prevalence	68	73	38
Health Behaviors			
Food insecurity	11%	14%	15%
Limited access to healthy foods	8%	3%	8%
Drug overdose deaths	12	13	25
Motor vehicle crash deaths	19	24	24
Insufficient sleep	28%	30%	30%
Clinical Care			
Uninsured adults	12%	19%	31%
Uninsured children	6%	8%	12%
Other primary care providers	803:01:00	1,008:1	1,227:1
Social & Economic Factors			
Disconnected youth	7%	17%	26%
Reading scores	3.1	2.8	
Math scores	3	2.6	
Median household income	$55,200	$44,800	$39,400
Children eligible for free or reduced price lunch	45%	77%	70%
Residential segregation - Black/White	77	64	
Residential segregation - non-White/White	50	25	27
Homicides	3	6	
Suicides	26	41	
Firearm fatalities	19	31	28
Juvenile arrests	42	35	
Physical Environment			
Traffic volume	146	51	

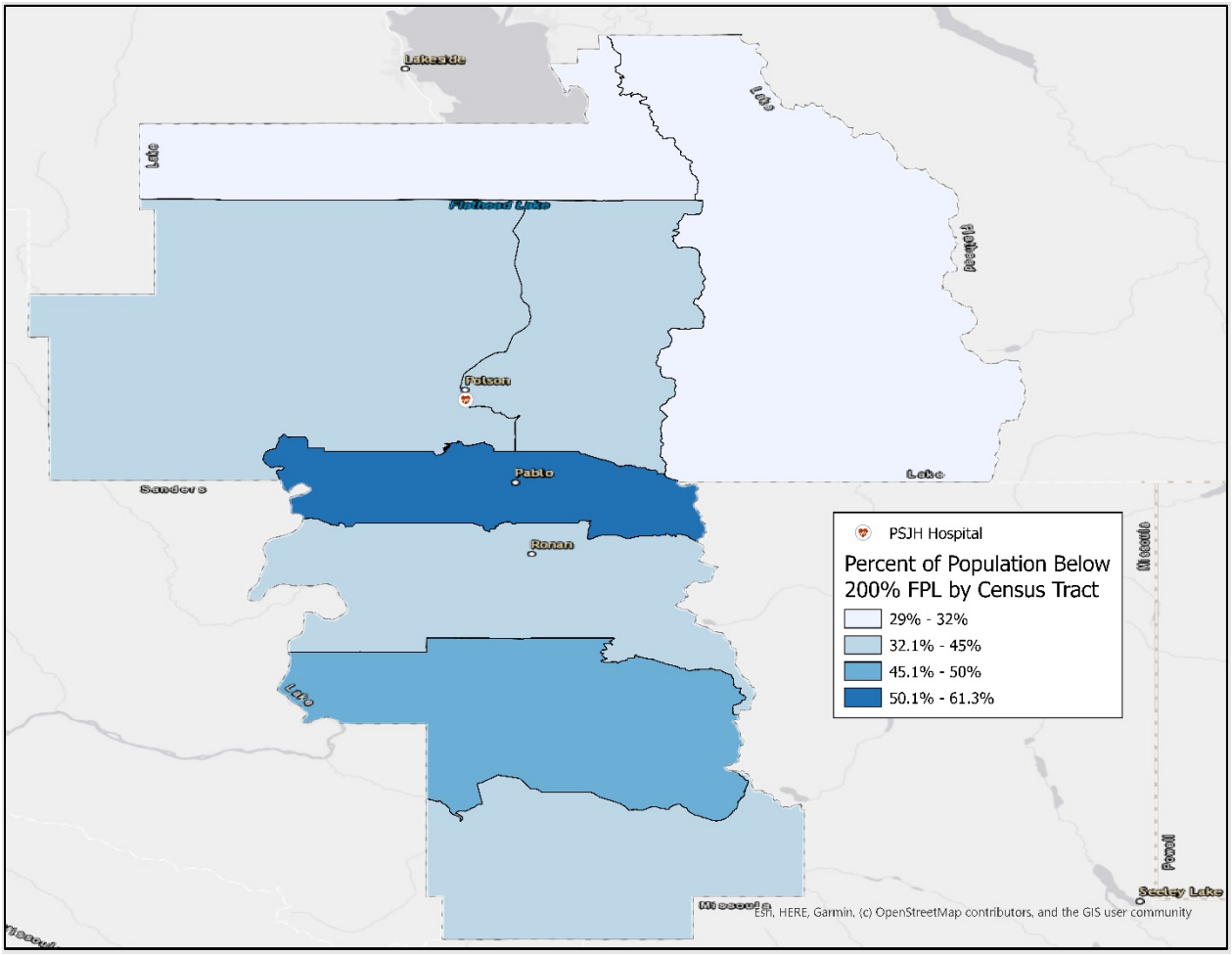
Homeownership	68%	72%
Severe housing cost burden	13%	15%

Population Below 200% Federal Poverty Level

Apx 2_Table 2. Percent of Population Below 200% Federal Poverty Level in Lake County Service Area

Indicator	Lake County	Broader Service Area	High Need Service Area
Percent of Population Below 200% Federal Poverty Level **Data Source: American Community Survey Year: 2019**	45.12%	38.13%	47.52%

Apx 2_Figure 1. Percent of Population Below 200% Federal Poverty Level in Lake County Service Area



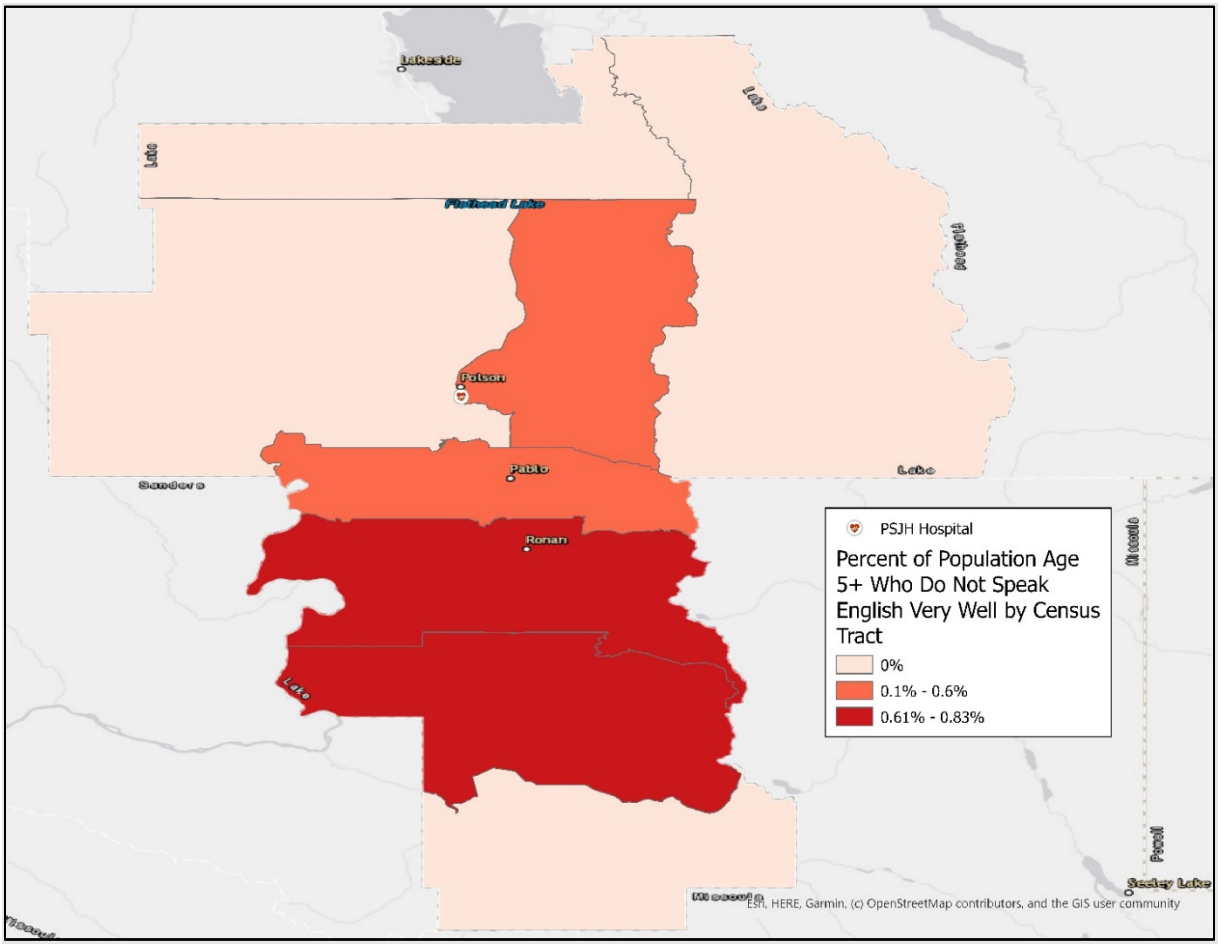
- The high need service area has a slightly larger proportion of population living below 200% FPL, 48%, compared to Lake County, 45%.
- The gap is even wider between the high needs service area, 48%, and the broader service area, 38%, when comparing percent of population living below 200% FPL.

Language Proficiency

Apx 2_Table 3. Percent of Population Age 5+ Who Do Not Speak English Very Well in Lake County Service Area

Indicator	Lake County	Broader Service Area	High Need Service Area
Percent of Population Age 5+ Who Do Not Speak English Very Well **Data Source: American Community Survey Year: 2019**	0.41%	0.00%	0.54%

Apx 2_Figure 2. Percent of Population Age 5+ Who Do Not Speak English Very Well in Lake County Service Area



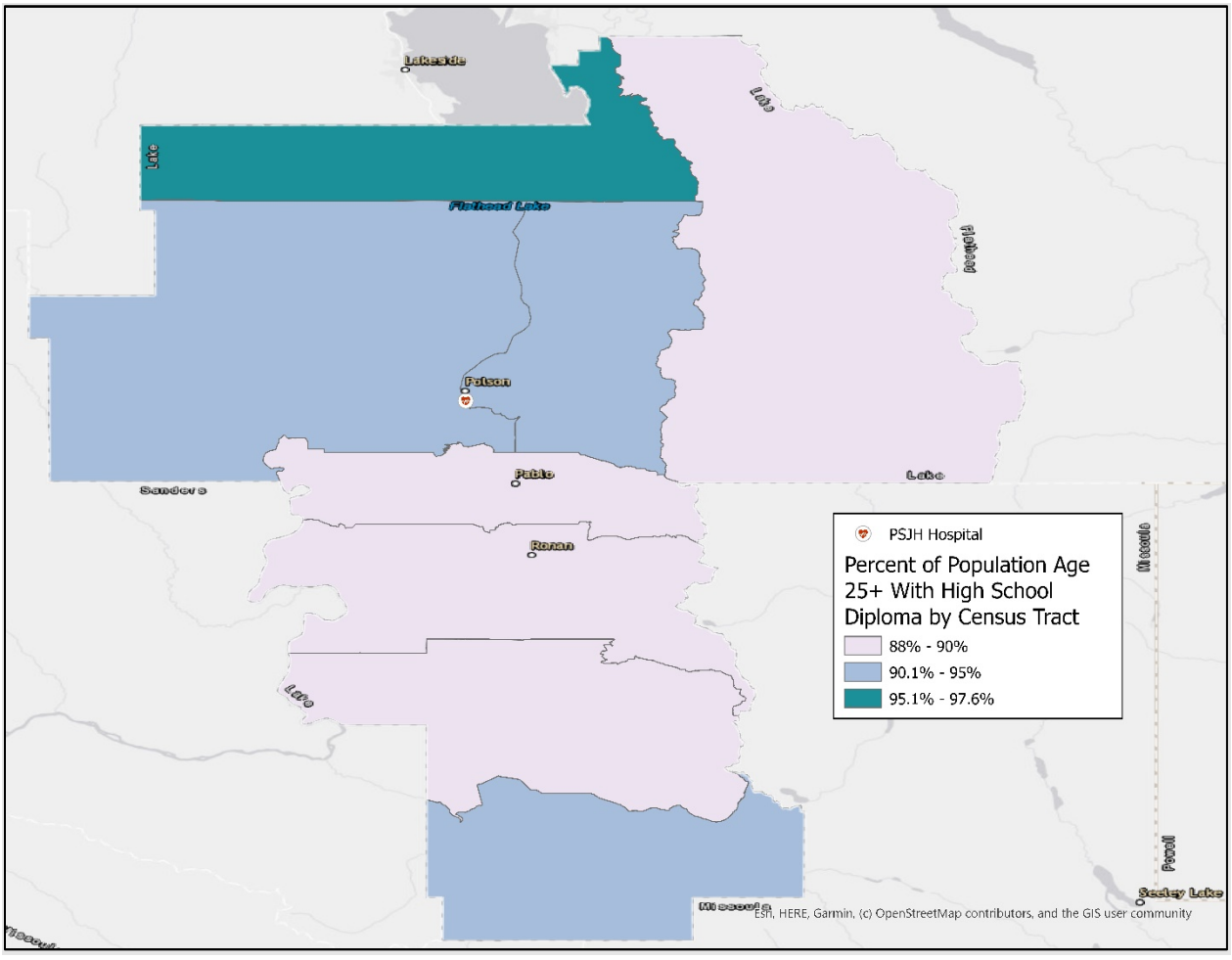
- There is slight variation between the high need service area and broader service area for percent of population over 5 who do not speak English very well. There were few census tracts with above 0.5% of the population over 5 who do not speak English very well.

Percent of Population with A High School Education

Apx 2_Table 4. Percent of Population Age 25+ with a High School Diploma in Lake County Service Area

Indicator	Lake County	Broader Service Area	High Need Service Area
Percent of Population Age 25+ With A High School Diploma **Data Source: American Community Survey Year: 2019**	91.18%	94.30%	90.01%

Apx 2_Figure 3. Percent of Population Age 25+ with a High School Diploma in Lake County Service Area



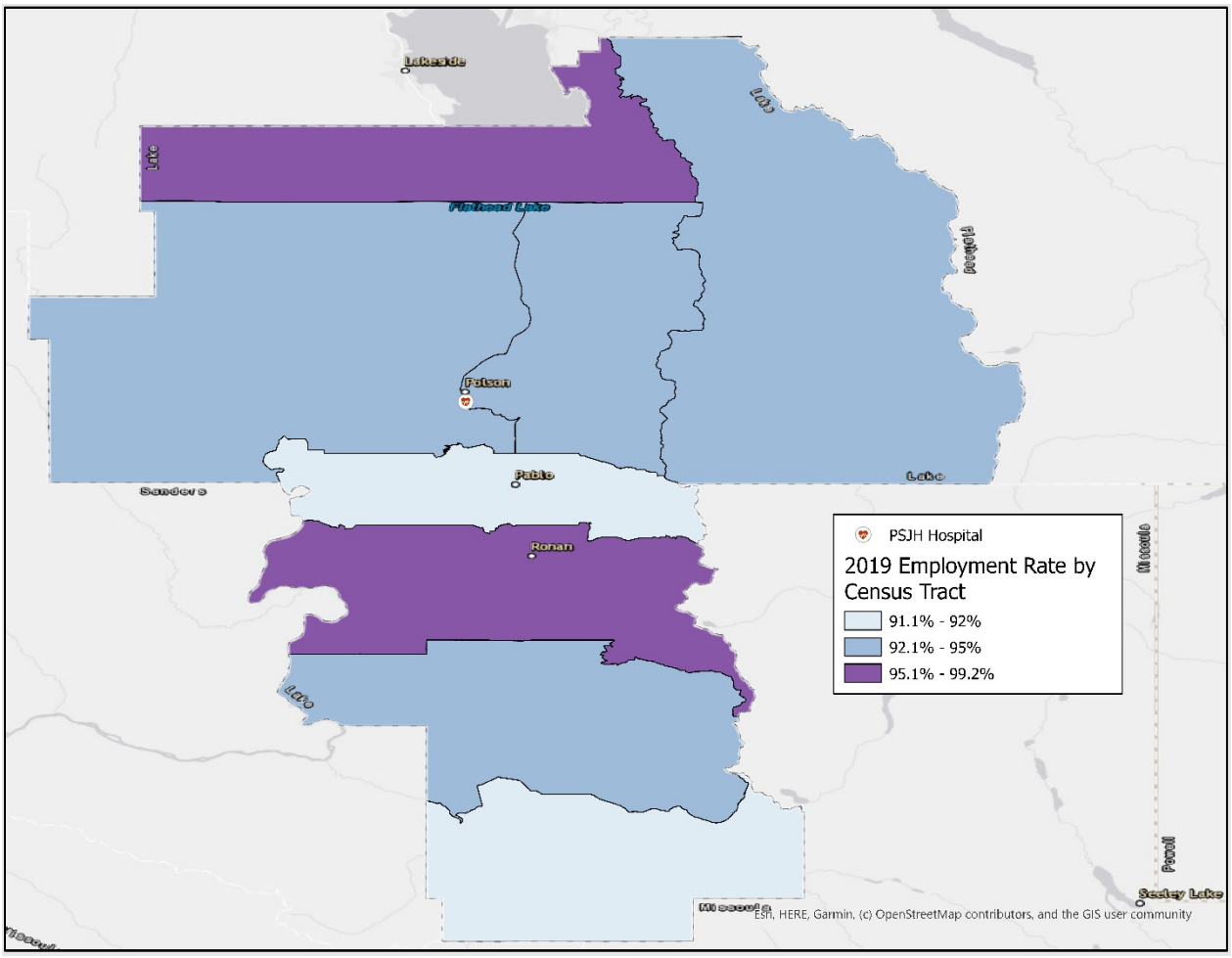
- About 90% of people living in the high need service area who are over 25 years have a high school diploma compared to 94% in the broader service area.

Percent of Labor Force Employed

Apx 2_Table 5. Percent of Population Age 16+ Who are Employed in Lake County Service Area

Indicator	Lake County	Broader Service Area	High Need Service Area
Percent of Population Age 16+ Who Are Employed **Data Source: American Community Survey** **Year: 2019**	94.12%	95.15%	93.74%

Apx 2_Figure 4. Percent of Population Age 16+ Who are Employed in Lake County Service Area



- Over 95% of the population is employed in the broader service area compared the 94% in the high need service area. There is only slight variation from Lake County.

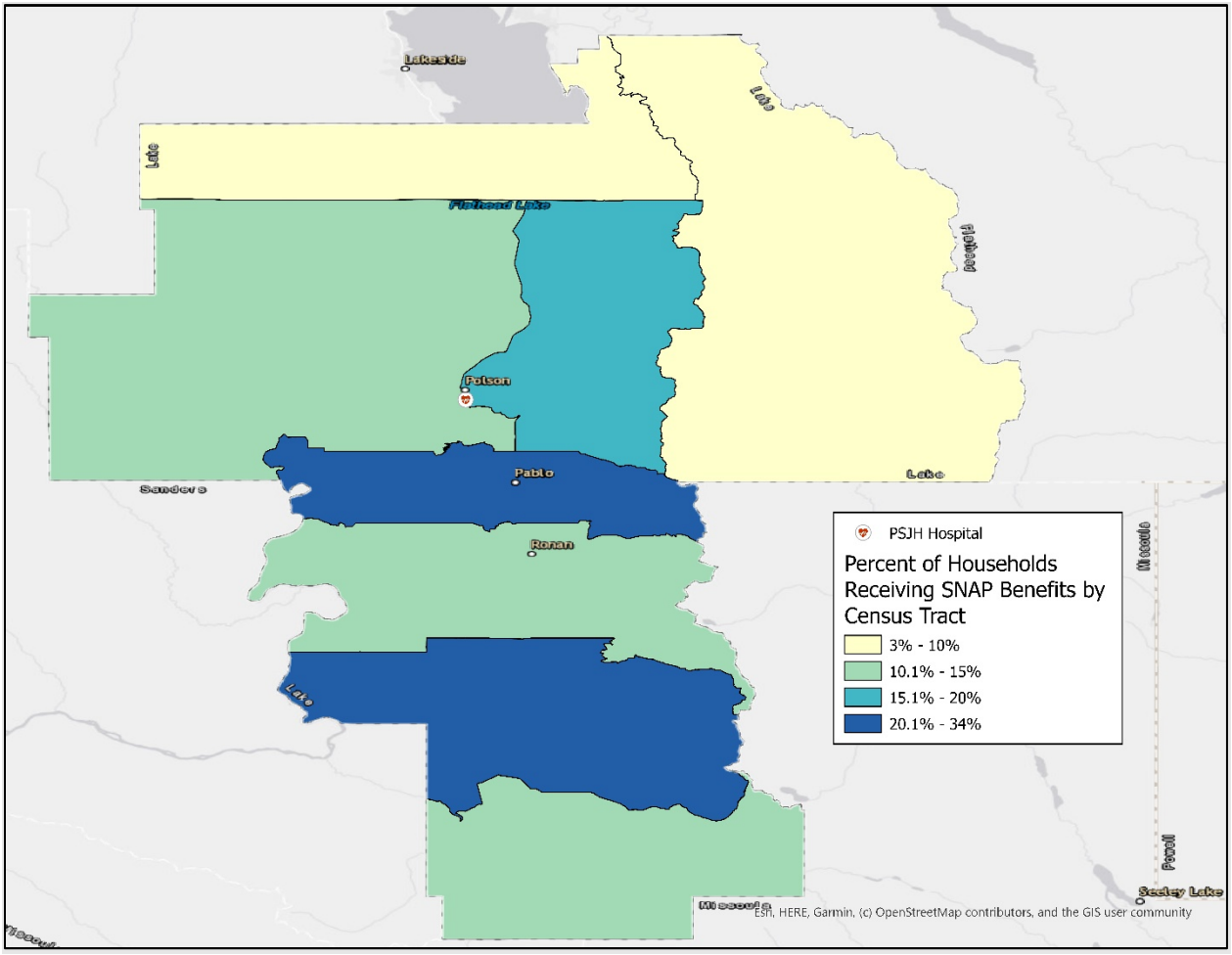
- These data are from 2019 and do not yet represent the economic effects of the COVID-19 pandemic.

Percent of Households Receiving SNAP Benefits

Apx 2_Table 6. Percent of Households Receiving SNAP Benefits in Lake County

Indicator	Lake County	Broader Service Area	High Need Service Area
Percent of Households Receiving SNAP Benefits **Data Source: American Community Survey** **Year: Estimates based on 2013 – 2017 data**	16.61%	12.61%	18.15%

Apx 2_Figure 5. Percent of Households Receiving SNAP Benefits in Lake County



- The high need service area has a substantially higher percentage of households receiving SNAP, 18%, compared to the broader service area, 13%.

- The range of percentages of households receiving SNAP benefits varies widely by census tract in Lake County.

HOSPITAL LEVEL DATA

Avoidable Emergency Department (AED) Visits

Emergency department discharges for the year 2019 were coded as "avoidable" per the Providence St. Joseph Health definition for Providence St. Joseph Medical Center and nearby PSJH hospitals. Avoidable emergency department (AED) 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 7. Avoidable Emergency Department Visits by PSJH Hospital in Washington and Montana

Facility	Non-AED Visits	AED Visits	Total ED Visits	AED %
Providence Regional Medical Center Everett	38,379	16,765	55,144	30.4%
Kadlec Regional Medical Center	50,836	25,216	76,054	33.2%
Providence St Mary Medical Center	15,622	7,417	23,041	32.2%
Providence St Peter Hospital	31,780	14,513	46,295	31.3%
Providence Centralia Hospital	19,660	9,075	28,735	31.6%
Providence SHMC and Children's Hosp	37,099	19,121	56,222	34.0%
Providence Holy Family Hospital	29,829	13,567	43,396	31.3%
Providence Mount Carmel Hospital	6,519	2,742	9,266	29.6%
Providence St Joseph Hospital-Chewelah	2,963	1,259	4,223	29.8%
Providence St Patrick Hospital—Missoula	15,832	7,394	23,227	31.8%
Providence St Joseph Medical Center—Polson	3,456	1,394	4,855	28.7%
Grand Total	**251,975**	**118,463**	**370,458**	**32.0%**

Apx 2_Table 8. Avoidable Emergency Department Visits by Race at Providence St. Joseph Medical Center

Facility and Race	Non-AED Visits	AED Visit	Total ED Visits	AED %
Providence St Joseph Medical Center	**3,456**	**1,394**	**4,855**	**28.7%**
American Indian or Alaska Native	1,253	618	1,871	33.0%
Asian	*	*	*	*
Black or African American	24	*	*	*
Native Hawaiian or Other Pacific Islander	*	*	*	*
Other	40	13	53	24.5%

Facility and Race	Non-AED Visits	AED Visit	Total ED Visits	AED %
Patient Refused	*	*	*	*
Unknown	85	26	111	23.4%
Unspecified	16	*	*	*
White or Caucasian	2,028	723	2,751	26.3%
(Blank)	*	*	*	*

*Data suppressed when <10.

Apx 2_Table 9. Avoidable Emergency Department Visits by Ethnicity at Providence St. Joseph Medical Center

Facility and Ethnicity	Non-AED Visits	AED Visit	Total ED Visits	AED %
Providence St Joseph Medical Center	**3,456**	**1,394**	**4,855**	**28.7%**
Hispanic or Latino	112	38	**150**	25.3%
Not Hispanic or Latino	3,225	1,305	**4,530**	28.8%
Patient Refused	*	*	**20**	*
Unknown	89	42	**131**	32.1%
Unspecified	16	*	*	*
(Blank)	*	*	*	*

*Data suppressed when <10.

Apx 2_Table 10. Avoidable Emergency Department Visits by ZIP Code at Providence St. Joseph Medical Center

Encounters by Patient Zip Code	Non-AED Visits	AED Visit	Total ED Visits	AED %
Providence St Joseph Medical Center	**3,456**	**1,394**	**4,855**	**28.7%**
59860	2,017	773	2,790	27.7%
59864	433	206	639	32.2%
59855	221	103	324	31.8%
59915	98	44	142	31.0%
59865	96	37	133	27.8%

- Approximately 43% of Emergency Department visits made by individuals who identified as Asian were potentially avoidable, although with low numbers of individuals (7) these data should be interpreted with caution.
- Approximately 33% of ED visits by people identifying as American Indian or Alaska Natives were potentially avoidable.
- Approximately 33% of self-pay and 32% of Medicaid visits were potentially avoidable.
- The most common diagnoses associated with Avoidable ED use were noninfective gastroenteritis and colitis, unspecified (4.3%), headache (4.2%), chronic obstructive pulmonary disease with acute exacerbation (3.1%) and acute cystitis without hematuria (2.9%).

- The ZIP codes with the greatest proportion of AED visits were 59860, 59864, 59855 and account for 78% of avoidable visits.

Apx 2_Table 11. Top 20 Diagnosis Groups for Avoidable Emergency Department Visits at Providence St. Joseph Medical Center

Top 20 Diagnosis Groups* for AED Visits	Avoidable Visits	Percent of Total Avoidable Visits
Providence St. Joseph Medical Center- Polson	**1,395**	
Urinary Tract Infection	109	8%
Skin Infection	100	7%
Substance Use Disorders	98	7%
Bronchitis and Other Upper Respiratory Disease	85	6%
Tonsillitis	74	5%
Nonspecific Back and Neck Pain	63	5%
Inflammatory Bowel Disease	60	4%
Headache/Migraine	58	4%
Anxiety and Personality Disorders	55	4%
Chronic Obstructive Pulmonary Disease	53	4%
Acute Otitis Media and Sinusitis	43	3%
Diabetes Mellitus	41	3%
Pneumonia Including Aspiration Pneumonia	39	3%
Esophageal Disease Including GERD	33	2%
Mood Disorders, Episodic	31	2%
Oral and Dental Disease	30	2%
Dizziness	29	2%
Asthma	28	2%
Psychosis	28	2%
Hypertension	24	2%

**Diagnoses are grouped by Care Family; method is Sg2 CARE Grouper. For example, for this data set, 9 diagnoses are grouped together as "Urinary Tract Infection"*

- The twenty most common AED visits by diagnosis group account for 77% of all AED visits.
- Individual patients with AED visits in 2019 averaged 1.27 visits across all diagnoses
- The top three highest AED visits per patient by diagnoses group are Psychosis (1.47 average AED visits), Chronic Obstructive Pulmonary Disease (1.32 average AED visits) and Esophageal Disease Including GERD (1.22 average AED visits)
- Mental health-related AED visits combined with Substance Use Disorders AED visits accounted for 15% of avoidable ED use in 2019

Prevention Quality Indicators

Prevention Quality Indicators 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.

More info 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
PQIs were calculated using inpatient admission data for the year 2019.

Providence St. Joseph Medical Center had a slightly below average rate of potentially avoidable hospitalizations compared to other PSJH hospitals in Washington and Montana 88.61 per 1,000 compared to an average of 92.13). Each of the PQI composite scores (90, 91, and 92) for Providence St. Joseph Medical Center were below average.

The most common PQIs for Providence St. Joseph Medical Center are

1. COPD or asthma in older adults: 25.32 per 1,000 visits
2. Heart failure: 19.89 per 1,000 visits
3. Urinary tract infections: 10.85 per 1,000 visits

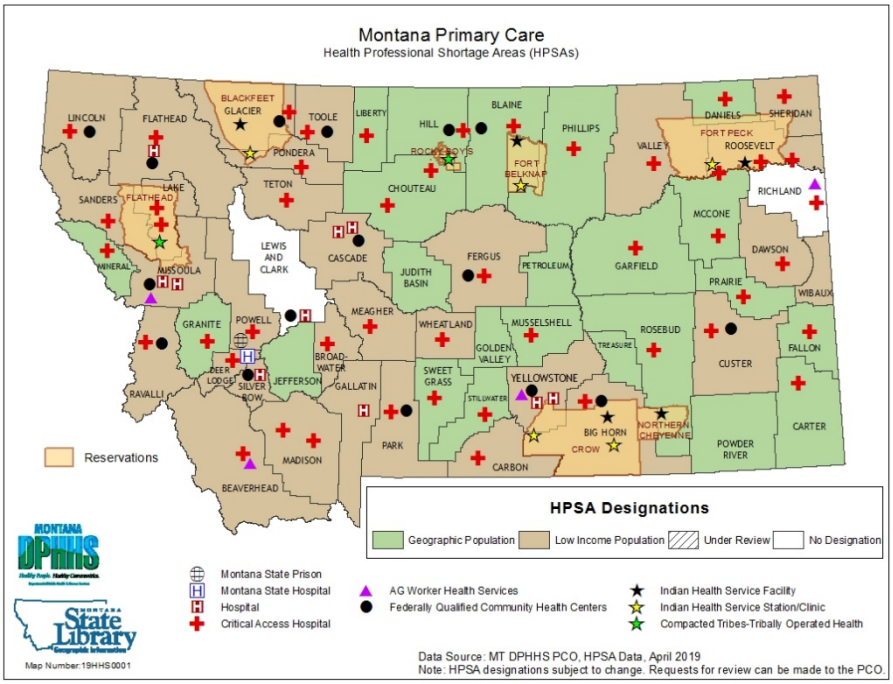
Apx 2_Table 12. Prevention Quality Composite Rates for Providence St. Joseph Medical Center

Indicator	Label	Numerator	Denominator	Observed Rate Per 1,000 Visits
PQI 90	**Prevention Quality Overall Composite, per 1,000 visits**			
	ST JOSEPH MEDICAL CENTER POLSON	49	553	88.61
PQI 91	**Prevention Quality Acute Composite, per 1,000 visits**			
	ST JOSEPH MEDICAL CENTER POLSON	14	553	25.32
PQI 92	**Prevention Quality Chronic Composite, per 1,000 visits**			
	ST JOSEPH MEDICAL CENTER POLSON	35	553	63.29

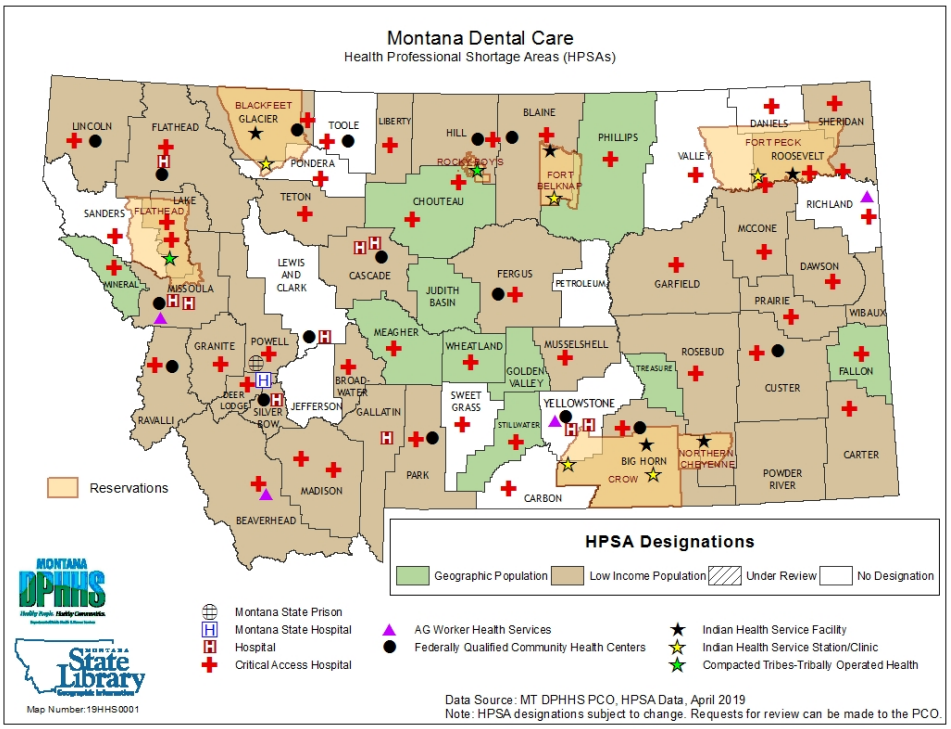
HEALTH PROFESSIONAL SHORTAGE AREA

The Federal Health Resources and Services Administration (HRSA) designates Health Professional Shortage Areas HPSAs) as areas with a shortage of primary medical care, dental care, or mental health providers. They are designated according to geography (i.e., service area), demographics (i.e., low-income population), or institutions (i.e., comprehensive health centers). Lake County is a designated HRSA Health Professional Shortage Area (HPSA) for low-income populations for primary, dental and mental health care. Surrounding counties in the greater Providence Montana service area all have HPSA designations, except for Lewis and Clark County.

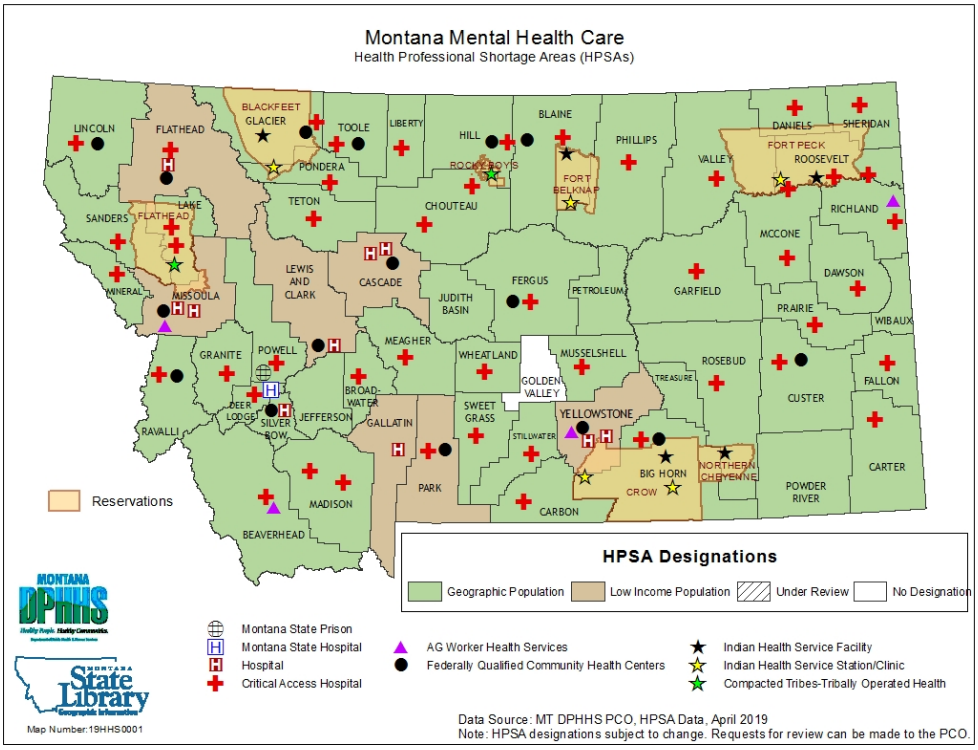
Apx 2_Figure 6. Montana Primary Care Health Professional Shortage Areas



Apx 2_Figure 7. Montana Dental Care Health Professional Shortage Areas



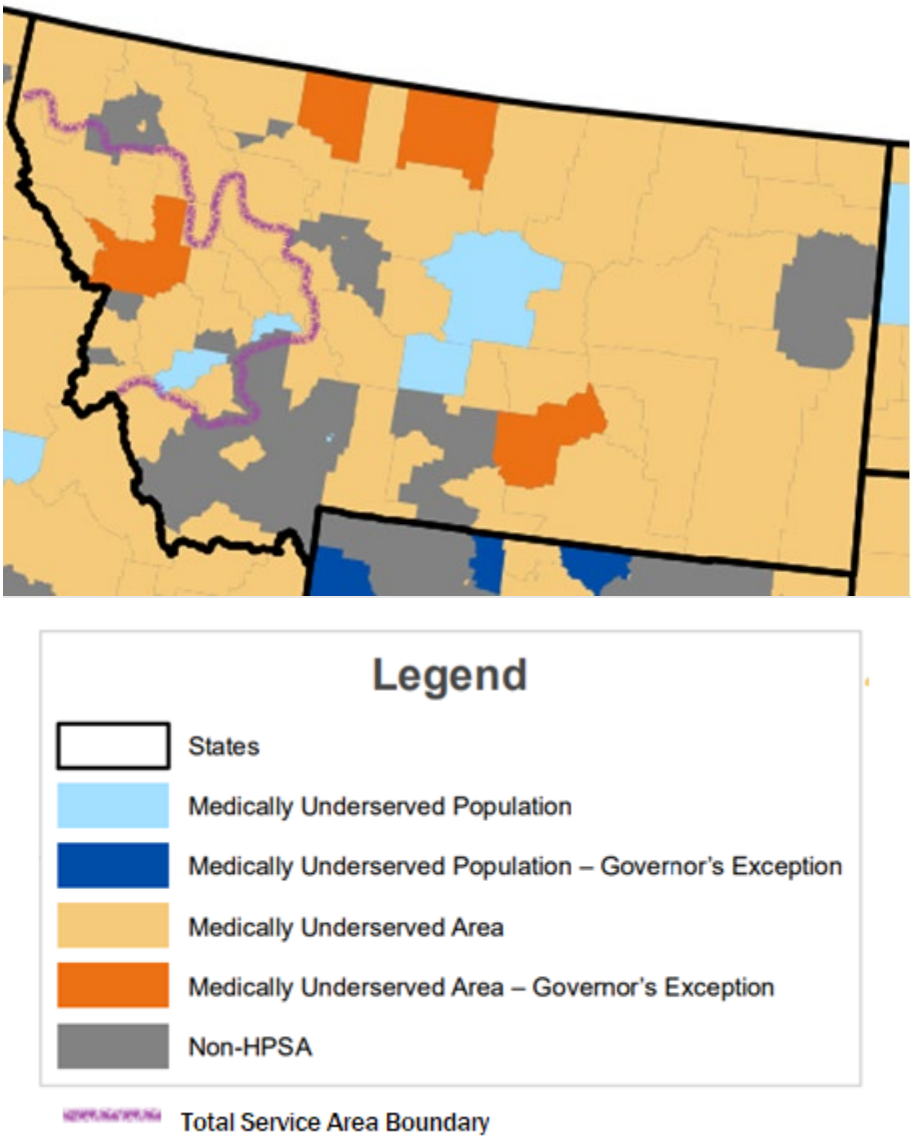
Apx 2_Figure 8. Montana Mental Health Care Health Professional Shortage Areas



MEDICALLY UNDERSERVED AREA / MEDICAL PROFESSIONAL SHORTAGE AREA

Medically Underserved Areas (MUAs) and Medically Underserved Populations (MUPs) are defined by the Federal Government to include areas or populations that demonstrate a shortage of health care services. This designation process was originally established to assist the government in allocating the Community Health Center Fund to the areas of greatest need. MUAs are identified by calculating a composite index of need indicators compiled and 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. The following map depicts the MUAs and MUPs in Montana; almost all the Providence Montana area is designated as MUA or MUP.

Apx 2_Figure 9. Medically Underserved Populations and Areas in Montana



Appendix 3: Community Input

STAKEHOLDER INTERVIEWS

Introduction

Providence St. Joseph Medical Center conducted stakeholder interviews, recognizing the importance of including the voices of community leaders who help make Lake County 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 has prevented us from facilitating listening sessions with community members. We relied on community stakeholders to represent the broad needs of the communities they serve.

Providence St. Joseph Medical Center included the insight of 6 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 6 stakeholder interviews were completed by representatives from Providence St. Joseph Medical Center. 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 St. Joseph Medical Center aimed to engage stakeholders from social service agencies, health care, education, housing, and government, among others, to ensure a wide range of perspectives. Included in the interviews was a representative from the Lake County Public Health.

Apx 3_Table 1. Community Stakeholder Interview Participants

Organization	Name	Title	Sector
Boys and Girls Club of the Flathead Indian Reservation	Aric Cooksley	Director of Operations	Youth
Council on Aging	Dara Rodda	Project Director	Aging Population
Lake County Agency on Aging	Samantha Walker	Area VI Coordinator	Aging Population
Lake County Public Health	Emily Colomeda	Health Services Director	Public Health
Montana Food Bank Network	Gayle Carlson	Executive Director	Food Security
Open Aid Alliance	Christa Weathers	Executive Director	Health

Facilitation Guide

Providence St. Joseph Health developed a facilitation guide that was used across all hospitals completing their 2020 CHNAs (see "Stakeholder Interview Questions" at the end of Appendix 3 for full questions):

- The role of the stakeholder's organization and community served
- 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. Two needs were mentioned in most interviews and were categorized as high priority. Four additional needs were also frequently prioritized and categorized as medium priority. The effects of the COVID-19 pandemic will be woven throughout the following sections on health-related needs but will also be summarized in its own section.

High Priority Unmet Health-Related Needs

Across the board, stakeholders were most concerned about the following health-related needs (in order of priority):

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

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

Stakeholders described behavioral health as interconnected with several other community needs:

- A history of **trauma** and **child abuse/neglect:** Stakeholders identified these experiences as contributors to both mental health challenges and substance use disorders (SUD).
- **Housing instability**: Stakeholders shared behavioral health challenges can contribute to a chaotic lifestyle, emphasizing the need for more supportive housing for these individuals.
- **Access to health care challenges**: People with a behavioral health challenge may have had poor experiences interacting with health care services. For example, they may have been turned away from medical care because of their behavior or felt shamed when seeking care for injection-related wounds. Stakeholders spoke to a lot of fear and misinformation, leading people to avoid calling 911 and trying to self-treat wounds.
- **Poverty** and lack of opportunities: A lack of opportunities can contribute to people not having hope that their lives will improve in 5 or 10 years, contributing to hopelessness and mental health challenges. Stakeholders shared a lack of hope can contribute to deaths of despair.

"It's very closely tied to that whole notion of a lack of hope. If I don't have the perspective in my head that there's something better coming around the corner or there's opportunity for

life to be better in the next year, five years, months, 10 years or whatever." —Community Stakeholder

"Although there is extreme beauty, there's a pretty significant lack of opportunity. I think that creates a lack of hope because if this is where I feel grounded, if this is where everything that I've ever known is and yet I don't have an opportunity to become whatever it might be or it feels like that opportunity is so far out there and I don't have a place to belong, I think you, you end up with a lot of despair. That lack of hope ultimately becomes a huge stumbling block. Then, as a result, we have a high suicide rate and we have a high at-risk population from bad choices and things like that." —Community Stakeholder

Barriers to addressing these behavioral health needs include **stigma** and a lack of healthy coping skills. The **criminalization of substance use** and fear of legal repercussions, including losing their children, prevent people from being honest about their substance use. Being **shamed** for their substance use in a health care setting may also prevent people from seeking needed care.

"Some of it is access but I think some of it too is reluctance to talk about those health needs in an open and honest way, whether it's drug use, sexual health risks. I just don't think these are topics that, again, bringing us back to stigma and just having those conversations with health providers in an open and honest way I think can be really hard sometimes."—Community Stakeholder

Specific gaps in the community include the following:

- A lack of **inpatient SUD treatment services:** Stakeholders shared that there are not many agencies that address SUD. Accessing SUD treatment is especially challenging for people who are uninsured, have low incomes, or have co-occurring, complex health and behavioral needs. Single parents may not be able to utilize inpatient SUD treatment services if they do not have someone to care for their child.
- **Crisis services** for people needing immediate, but short-term support, besides the Emergency Department: Stakeholder spoke to wanting to prevent people from ending up in jails or the ED for mental health needs. This might be for people who simply need a safe place to be for a night or two if they are having suicidal ideation or detoxing.
- **Counseling services:** Accessing these services can be especially challenging for people who have low incomes and school-age children. Children are often reliant on their parents to take them to services, highlighting the need for more focus on social-emotional health in schools.

Stakeholders shared concern for increasing mental health needs as a result of the **COVID-19 pandemic**. They noted that it will take time to fully realize and understand the full mental health effects of the pandemic.

Homelessness/ lack of safe, affordable housing

Stakeholders described housing instability as connected to a lack of living wage jobs, which can also contribute to food insecurity. Stakeholders agreed there is a need for more **affordable housing** and **housing for seniors**, particularly for people with low incomes.

They shared that mental health and SUD challenges make it hard to keep people in stable housing. Behavioral health challenges can contribute to a chaotic lifestyle, leading to overall instability. Therefore, there is a need for more **supportive housing** with connected services that are equipped to address behavioral health needs. They emphasized the need for housing that encourages positive behaviors and stability.

> *"Untreated mental health, isolation, substance use, those are kind of where we see the biggest impacts, so those will compromise healthcare and housing significantly, and we see that over and over again. We have money to pay for housing but keeping people in housing becomes the challenge." – Community Stakeholder*

Barriers to moving people into housing include **low housing stock**, **poor credit**, and **poor housing history**.

> *"Even currently, again, we have several homeless folks right now that we've been on the search for housing. I mean housing stock right now is really low but also housing for people with not great credit and not great housing history, those folks, again it's like money is not the issue but you cannot find a home. It may not even be an appropriate home, but you still can't find one." – Community Stakeholder*

Stakeholders shared there are **a lack of services** specifically for people experiencing homelessness within Polson. People may have to travel to other counties to access the support services they need.

Medium Priority Unmet Health-Related Needs

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

3. Aging problems
4. Food insecurity
5. Unemployment and lack of living wage jobs

Aging problems

Stakeholders spoke to a need for more support services for the aging population, specifically the following:

- **Nursing homes**, specifically for people with Alzheimer's and dementia: Stakeholders were concerned about a lack of nursing homes for older adults, particularly ones that include memory care.

"When I say nursing home, I mean more specific to Alzheimer's and dementia. We have a real issue with that here."—Community Stakeholder

- **Adult daycare services**

"Each county that we serve, we see a need for more nursing homes, adult day care and affordable housing."—Community Stakeholder

- **In-home services** for older adults needing hands on care, specifically for people who have low incomes but do not qualify for Medicaid: This is important for reducing isolation, which can have negative consequences on people's mental health.
- **Fiduciary services**: There are a lack of these services within Lake County. If older adults do not have a family member to help them then this can be a big challenge and create a lot of confusion.

Stakeholders were concerned about older adults whose Social Security benefits put their income slightly above the threshold for **Medicare Savings Programs**, meaning they are unable to afford Medicare premiums and therefore forego necessary health services due to cost of care. This prevents older adults from managing their chronic conditions or seeking any dental care, which can affect their overall quality of life.

As a result of the **COVID-19 pandemic**, stakeholders reported seeing more community members come together to support the aging populations. For example, people delivering groceries and providing rides. Overall, the attention and care given to this population has improved during the pandemic.

"We really do feel, as an agency, that the community businesses, organizations have come together and a lot more attention is being given to the older population. Pick up groceries, calling your order, someone from the store can take it to you. Things that are extremely important to the vulnerable."—Community Stakeholder

Particularly concerning to stakeholders was that many in-home services have been paused during the pandemic, particularly for older adults with low-incomes who cannot afford other options. Therefore, they are home alone, with little help or support, and very isolated. While people may call to check in, the interaction is not the same as seeing people in person.

"We have clients with dementia that are especially in need. We call our clients right now and check on them, but it is not the same."—Community Stakeholder

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 shared that even people who are employed still cannot meet their basic needs. Additionally, since they do have income, they may not qualify for SNAP or they receive

minimal benefits, which does not cover their needs. Stakeholders were primarily concerned with people with low incomes experiencing food insecurity.

"A majority of the clients who utilize any emergency food services are typically employed, underemployed, and just unable to make ends meet and because of their employment, public assistance programs are minimal, if not allowed to them at all because they do have a source of income."—Community Stakeholder

Stakeholders shared the following barriers to accessing good-quality, nutritious foods:

- **Cost of healthy, fresh foods**: These foods can be expensive, particularly for people who may only have access to a local convenience store. Stakeholders shared a big concern is food affordability, contributing to people needing to utilize food banks.
- **Transportation**: Particularly in rural areas, people may need to travel many miles to get to a full-service grocery store. Transportation can also be a barrier to getting to a food bank.

"They just need the food banks to be able to make ends meet. In some communities that, especially in those very rural remote [areas], it's just the inability to access food is a big concern. A lot of those rural communities have pretty high poverty levels anyway, but then the fact that they can't access food or the food is so expensive in these small mom-and-pop stores, or they only have access to a convenience store or they have to drive 30, 40, 50 miles to a store. There's all kinds of concerns that go along with that."—Community Stakeholder

- **Lack of consistent access to healthy foods:** While there are farmers markets in the summer months, they are not available in the winter months. Particularly for people living in rural areas, they may have to rely on a convenience store to get their produce when the farmers markets are closed.

"If you don't have access to a full-service grocery store, you're utilizing your local convenience store. You're lucky if you find a couple of bananas sitting on the counter. Their consistent access to healthy foods is a challenge."—Community Stakeholder

Besides people with low incomes and people living in rural areas, stakeholders were also concerned about the following populations having reduced access to healthy foods:

- **Older adults**: Stakeholders were concerned about older adults who may not access food resources due to pride and misperceptions. They may consider themselves self-sufficient and not want to be reliant on social services. They may also be concerned about taking needed resources from families and children.
- **Native American communities**: Stakeholders spoke to Native American communities as being disproportionately affected by food insecurity, particularly on reservations.
- **Children**: Stakeholders from organizations that provide meals to children noted they often see kids who are experiencing hunger and report not getting sufficient meals from home.

"We've had kids with regularity tell us, 'I'm so thankful that you serve meals because without that, I don't know where I'd eaten until tomorrow morning.' There are definitely needs around food security" – Community Stakeholder

Especially during the **COVID-19 pandemic**, people who are immunocompromised may be more anxious about leaving their home to get food or experience transportation barriers. They reported seeing food insecurity as an increasing need as financial challenges have increased. They shared people are utilizing the food banks for the first time in their lives as a result of COVID-19.

Unemployment and lack of living wage jobs

Stakeholders spoke to the connection between living wage jobs and all other needs, particularly housing instability and food insecurity.

"To me, you fix unemployment, lack of living wage, and you fix safe and affordable housing. Then, food insecurity isn't necessarily as big of an issue anymore."—Community Stakeholder

They also shared that a living wage is crucial for being able to afford high-quality daycare, which is necessary for ensuring people can hold a consistent job. Economic security is tied to mental health and overall quality of life. They shared concern for **older adults** who need to continue to work to make ends meet and **individuals who make slightly too much to qualify for public benefits**, but not enough to meet their basic needs. This is a reference to the "benefits cliff," meaning that as income increases, public benefits quickly taper off.

"We have some folks here who should be enjoying their twilight years and yet they've got a couple of part-time jobs which then they're trying to make ends meet, but then they're over income for any state or federal health program. Once again, we're just talking about the quality of life." – Community Stakeholder

"The lack of living-wage jobs, I think are a catalyst for a lot of those other pieces; the homelessness piece, the food insecurity piece, the affordable daycare, all of those things are tied back to that lack of a living wage." – Community Stakeholder

They shared a need for more **job skills training** in the community and more jobs with **good benefits** to support people in gaining employment with benefits and better wages.

As a result of the **COVID-19 pandemic**, stakeholders have seen increased unemployment and people losing their jobs as a result of quarantining.

Effects of COVID-19

Stakeholders discussed how the COVID-19 pandemic has exacerbated needs. Related to **aging problems**, some in-home services have been paused, meaning that many older adults with low incomes are not getting the care they need and not getting in-person interactions, raising concerns about isolation. **Mental health** in general is a concern as a result of the stress of the pandemic, but especially for people who are extremely isolated. As a positive, more individuals have offered support and check-ins for older adults during the pandemic.

Transportation has been more challenging with a reduction in the Tribal Transportation in Polson, limiting people's ability to access needed health care, social services, and food resources.

> *"I think people are trying to come to the office less frequently and transportation especially in Polson is a huge issue. When they sat down, for example, the Tribal Transportation, it was a huge issue. For months now, we've been sitting in the parking lot of the Polson Health Department waiting for people to come to the site and they are not coming. We are transitioning that service to delivery because the public transportation closures have just been such a barrier."—Community Stakeholder*

Sharing up-to-date information has been difficult during the pandemic and people have been frustrated trying to figure out which services are available. They noted a need for having information centralized.

> *"Well, through COVID, for sure, it was like where do we as a community centralize information and how do we make sure people get it, have access to it, can navigate these things? I saw that I think as a challenge as a community but also as an individual organization. It was like where do we put our information so that the people, we serve actually have access to it and know how to access it. I think if we could work on the messaging around that, I think that in itself could be really helpful."—Community Stakeholder*

Related to **access to care**, people have been delaying important care and the pandemic has highlighted many individuals lack a primary care provider. Additionally, the **COVID-19 testing fees** (for the visit and collection) have been a barrier for some, particularly for people without insurance.

Stakeholders shared a concern for increased **unemployment**, particularly workers who lost their job as a result of quarantining. Related to **education**, stakeholders shared a lack of access to technology and broadband, as well as a lack of engagement from some students will only increase the student opportunity gap. Additionally, school closures have highlighted concerns that children may not be receiving sufficient meals at home.

> *"Broadband-lack of access- especially when schools went online. How many people don't have access to good reliable internet and devices to use internet. That's something that needs to be addressed, especially if COVID is changing how we do things."—Community Stakeholder*

Community Stakeholder Identified Assets

The following table lists all the community organizations, programs, or services that were named by community stakeholders during the interviews.

Apx 3_Table 2. Community Stakeholder Identified Assets

Health-related need	Community program, organization, or services (number of times mentioned if more than 1)
Behavioral Health	Alcoholics Anonymous and Narcotics Anonymous Bridge to Hope

	Integrated Medication Assisted Treatment (IMAT) Syringe Services Program Wrapped in Hope
Education	Polson School District
Family and Child Support	Boys & Girls Club of the Flathead Reservation and Lake County
Food Security	Commodity Supplemental Food Program Double SNAP Dollars Local food banks (3) SNAP
Health Care	Partnership Health Center
Housing and Homelessness	Lake County Haven Ronan Housing Authority
Resources and Social Services	Community Action Partnership NW MT (CAPNM) energy assistance program Helping Hands Fund (2)
Services for the Aging Population	Area VI Agency on Aging
Transportation	Confederated Salish & Kootenai Tribes (CSKT) Flathead Transit

Opportunities to Work Together

Participants were asked, "What suggestions do you have for organizations to work together to provide better services and improve the overall health of your community?" Stakeholders spoke to the importance of collaborating instead of competing for funding and resources to better meet community needs. They shared the "ultra-siloed" approach leads to **competitiveness** and hinders collaboration.

They shared the following suggestions for working together:

- Use **screening tools** to identify needs: This is one way to help ensure that all service providers are considering and helping to identify client needs. For example, primary care providers can complete food insecurity screenings in primary care settings.

  "One of the things that we worked on for a while, and we're getting back into it again, is called screen and intervene. Which is strictly a two-question kind of screening that the front-line healthcare providers can do to help identify food insecurity and then refer them, because we're of the opinion that there's a vast majority of health issues that hospitals, clinics and so on deal with that are driven by malnutrition. That's right front in the beginning barrier to food insecurity later on."—Community Stakeholder

- Bring together cross-sector organizations to engage in "**resource roundtables:**" This allows for sharing of community resources and opportunities to leverage shared funding to address large-scale community needs. Stakeholders shared the importance of including **policy makers** in these conversations, recognizing the role that policy plays in addressing community needs.

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. All sessions were conducted virtually which has its limitations in fostering group conversation.

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?

Question 5: 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
	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:

PRIMARY DATA COLLECTION SURVEY RESULTS

In July 2020, we mailed out postcard invitations with a link and QR codes to an online survey. The postcards were mailed to households with median income of $35k or less in zip codes 59821, 59860, 59864, and 59865. The survey link was also shared by Providence staff and partner organizations in the community. The survey was open from July 8 – July 26. 220 responses were submitted.

Many questions in the 2020 survey were added or modified from 2017. The following table is a comparison to responses to the same questions from 2017 to 2020:

Apx 3_Table 3. Survey Responses Compared Between 2017 and 2020

		2020	%age*	2017	%age*
	Total Responses	220		257	
Gender identity					
	Female	174	80%	189	74%
	Male	43	20%	68	26%
	Other	0		0	
What is your current employment status?					
	Employed full time	121	55.3%	231	90.9%
	Employed part time	15	6.8%	15	5.9%
	Self-employed	10	4.6%		
	Retired	57	26.0%	6	2.4%
	Unable to work due to illness, injury, or disability	6	2.7%	0	0.0%
	Homemaker or stay at home parent	3	1.4%	1	0.4%
	Student	2	0.9%	1	0.4%
	Unemployed	5	2.3%	0	0.0%
Do you have a primary care provider?					
	Yes	205	94%	210	86%
	No	13	6%	33	14%
What kind of health coverage or insurance do you have?					
	Medicaid	16	5.9%	5	1.9%
	Medicare	55	20.4%	9	3.4%
	VA, TRICARE or other military health care	7	2.6%	7	2.6%
	Indian Health Service (IHS)	20	7.4%	9	3.4%
	Private coverage through an employer or family member's employer	128	47.4%	227	85.0%
	A private plan I pay for myself	29	10.7%	3	1.1%
	Other	13	4.8%	6	2.2%
	No coverage	6	2.2%	1	0.4%
How would you rate your overall physical and mental health?					
	Excellent	26	11.8%	39	16.5%
	Very good	73	33.2%	111	46.8%
	Good	92	41.8%	73	30.8%
	Fair	23	10.5%	13	5.5%
	Poor	6	2.7%	1	0.4%

Based on responses to question, not overall survey response total, as people had option to skip questions; some questions allowed multiple responses

The survey included two short form questions:

What health-related services are needed, but are not currently being provided in our community?

35% of responses called for more mental health services. 18% called for more substance abuse treatment options. 11% mentioned the need for more specialty medical providers in the community.

Selected quote:

> *"Mental health services and substance abuse treatment services are needed in abundance; however, we will never make the kind of progress we need to end these cycles until we incorporate trauma informed / Adverse Childhood Experiences education into our school systems and the community. This education, in an age appropriate manner, will prepare young people and arm them with knowledge about brain architecture which will help them understand themselves better in order to make better choices. This will decrease our suicide rate, among other things, as well."*

What one thing could be done to improve the overall health and quality of life in our county?

20% of responses specified the need for improved mental health access. 18% called for more substance abuse treatment options. 9% discussed the need for safe options for recreation and physical activity for all ages, including in the winter.

Selected quote:

> *"The one thing we need is strong, forward-thinking leadership that believes in working together with other community leaders and agencies to solve the issues that face our county residents. Our governing leadership needs to understand the root causes of poverty and trauma that contribute to the health issues we face to even begin to make changes. We need a comprehensive community plan for the future; I don't feel we have that (nor do we have leadership with those skills). It is not the responsibility of a single agency or entity to accomplish that. We are so much stronger together."*

Apx 3_Table 4. Community Input Type

Community Input Type	City, State	Dates	Notes
Online anonymous survey	Arlee, Polson, Ronan, St. Ignatius Montana	July 8 – July 26, 2020	• Survey invitations were mailed to households with median income of $35k or less in zip codes 59821, 59860, 59864, and 59865 • Survey link shared internally with Providence staff and with partner organizations in the community

MONTANA CHNA SURVEY QUESTIONS

Demographics

1. Zip Code: _____
2. Year of birth: _____

3. Gender identity:
   - ❑ Female
   - ❑ Male
   - ❑ Transgender
   - ❑ Other, self-identify: _____

4. Are you of Hispanic, Latino, or Spanish origin?
   - ❑ Yes
   - ❑ No

5. Which one or more of the following would you say is your race? *Mark all that apply*.
   - ❑ White
   - ❑ Black or African American
   - ❑ Asian
   - ❑ Native Hawaiian or Other Pacific Islander
   - ❑ American Indian or Alaska Native
   - ❑ Don't know/ Not sure

Household Finances

6. Altogether, how many people currently live in your home? *Count adults and children under 18*.

   Me, plus ___ other adults and ____ children

7. What is your gross household income (before taxes and deductions are taken out) for last year (2019)? *Your best estimate is fine.*
   - ❑ $0
   - ❑ $1 to $10,000
   - ❑ $10,001 to $20,000
   - ❑ $20,001 to $30,000
   - ❑ $30,001 to $40,000
   - ❑ $40,001 to $50,000
   - ❑ $50,001 to $60,000
   - ❑ $60,001 to $70,000
   - ❑ $70,001 to $80,000
   - ❑ $80,001 to $90,000
   - ❑ $90,001 to $100,000
   - ❑ $100,001 or more

8. What is your current employment status?
   - ❑ Employed full time
   - ❑ Employed part time

- ❑ Self-employed
- ❑ Retired
- ❑ Unable to work due to illness, injury, or disability
- ❑ Homemaker or stay at home parent
- ❑ Student
- ❑ Unemployed

9. Have you or someone in your household lost a job or hours due to the COVID-19 (coronavirus) outbreak?
   - ❑ Yes
   - ❑ No

10. Which of the following best describes your housing situation today?
    - ❑ I have housing of my own and I'm NOT worried about losing it
    - ❑ I have housing of my own, but I AM worried about losing it
    - ❑ I'm staying with friends or family
    - ❑ I'm staying in a shelter, in a car, or on the street
    - ❑ Other (tell us): _____

11. In the past 12 months, have you or someone in your household had to go without any of the following when it was really needed because you were having trouble making ends meet?

	Yes	No	Not Applicable
Food			
Utilities			
Transportation			
Clothing			
Stable housing or shelter			
Medical care			
Childcare			
Dental care			

Access to Health Services

12. In the past 12 months, have you or a member of your household had concerns about alcohol, tobacco, or substance use?
    - ❑ Yes
    - ❑ No (If no, skip to question 14)

13. In the past 12 months, have you or a member of your household been able to access the care needed to address your concerns about alcohol, tobacco, or substance use?

Health Service	Yes	No	n/a
Smoking cessation program			
Alcohol treatment program			
Medication Assisted Treatment program (I.e. Suboxone)			
Substance use disorder counseling and treatment (not including alcohol)			

14. A personal doctor is the one you would see if you need a check-up, want advice about a health problem, or get sick or hurt. Do you have a personal doctor?
    - ❑ Yes
    - ❑ No

15. Do you currently have any type of health coverage or insurance?
    - ❑ Yes
    - ❑ No

16. What kind of health coverage or insurance do you have? *Mark all that apply.*
    - ❑ Medicaid
    - ❑ Medicare
    - ❑ VA, TRICARE or other military health care
    - ❑ Indian Health Service (IHS)
    - ❑ Private coverage through an employer or family member's employer
    - ❑ A private plan I pay for myself
    - ❑ Other (tell us): _____
    - ❑ I don't have any insurance now
    - ❑ I don't know

17. If you do <u>not</u> current have any kind of health coverage or insurance, what are the main reasons why? *Mark all that apply.*
    - ❑ It costs too much
    - ❑ I don't think I need insurance
    - ❑ I am waiting to get coverage through a job
    - ❑ Signing up is too confusing
    - ❑ I haven't had time to deal with it
    - ❑ Other (tell us): _____

18. Have you or a member of your household needed health care in the last 12 months?
    - ❑ Yes
    - ❑ No (skip question to question 20)

19. When you or a member of your household needed health care in the last 12 months, did you get all the care you needed? *Mark all that apply.*
    - ❑ I got all the care I needed
    - ❑ I got some but not all the care I needed
    - ❑ I had to delay getting care
    - ❑ I got no care at all
    - ❑ I don't know

20. The most recent time you or a member of your household delayed or went without needed health care, what were the main reasons? *Mark all that apply.*
    - ❑ Cost
    - ❑ Not having a regular health care provider
    - ❑ Not knowing where to go
    - ❑ Couldn't get appointments quickly enough
    - ❑ Offices aren't open when I can go
    - ❑ Needed childcare
    - ❑ Needed transportation
    - ❑ Not having a provider that understands my culture or speaks my language
    - ❑ COVID-19 (coronavirus): appointment cancellation, concern of infection, or other related concerns
    - ❑ Other reasons (tell us): _____
    - ❑ Not applicable

Quality of Life Issues

The following questions focus on aspects of your geographical community. Please tell us whether you "strongly disagree," "disagree," feel "neutral," "agree," or "strongly agree" with each of the following statements thinking specifically about your community as you see it. Please circle the number that best represents your opinion of each statement. If you don't know, please respond "Don't know."

Statements	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Don't Know
I can get the health care I need. Consider the cost and quality, number of options and availability of health care within a reasonable distance to your home.	1	2	3	4	5	DK
My community is a good place to raise children. Consider the quality and safety of school and childcare, after school care and places to play in your neighborhood.	1	2	3	4	5	DK
My community is a good place to grow old. Consider elder friendly housing, transportation to medical services, access to shopping centers and businesses, recreation, and services for the elderly.	1	2	3	4	5	DK
I feel safe in my home. Consider everything that makes you feel safe, such as neighbors, presence of law enforcement, etc. and everything that could make you feel unsafe at home, including family violence, robbery, housing conditions, etc.	1	2	3	4	5	DK
I feel safe in my community. Consider how safe your feel in and around your neighborhood, schools, playgrounds, parks, businesses, and shopping centers.	1	2	3	4	5	DK
I feel prepared for an emergency. Consider everything that makes you feel prepared, such as toolkits, smoke alarms, fire extinguishers, etc.	1	2	3	4	5	DK
People of all races, ethnicities, backgrounds and beliefs in my community are treated fairly. Consider any form of discrimination as well as programs and institutions that treat diversity as an asset.	1	2	3	4	5	DK
People in my community can access mental health services and substance use treatment. Consider counseling services, support groups, and substance use disorder counseling and treatment centers.	1	2	3	4	5	DK
Healthy food is available in my community. Consider grocery stores, supermarkets, corner stores, and farmers' markets that sell fresh fruits, vegetables, lean proteins/meats and other healthy options.	1	2	3	4	5	DK
There are places to be physically active near my home. Consider parks, trails, places to walk and playgrounds.	1	2	3	4	5	DK
I have enough financial resources to meet my basic needs. Consider income for purchasing food, clothing, housing, and utilities.	1	2	3	4	5	DK

Adapted from Lake County Community Health Assessment, 2018

21. Please imagine a ladder with steps numbered from zero at the bottom to ten at the top. Suppose we say that the top of the ladder represents the best possible life for you and the bottom of the ladder represents the worst possible life for you.

    If the top step is 10 and the bottom step is 0, on which step of the ladder would you say you personally feel you stand at this time?

    - ❑ 10—Best possible life
    - ❑ 9
    - ❑ 8
    - ❑ 7
    - ❑ 6
    - ❑ 5
    - ❑ 4
    - ❑ 3
    - ❑ 2
    - ❑ 1
    - ❑ 0—Worst possible life

    On which step do you think you will stand about five years from now?

    - ❑ 10—Best possible life
    - ❑ 9
    - ❑ 8
    - ❑ 7
    - ❑ 6
    - ❑ 5
    - ❑ 4
    - ❑ 3
    - ❑ 2
    - ❑ 1
    - ❑ 0—Worst possible life

22. How would you rate your overall physical and mental health?
    - ❑ Excellent
    - ❑ Very good
    - ❑ Good
    - ❑ Fair
    - ❑ Poor

Short Answers

23. What health-related services are needed, but are not currently being provided in our community?

    _____
    _____

24. What one thing could be done to improve the overall health and quality of life in our county?

    _____
    _____

Appendix 4: Prioritization Protocol and Criteria

Apx 4_Figure 1. Prioritization Process Voting Results

Ten individuals from the SJMC Advisory Council voted for the three to five most important needs to prioritize for the CHNA. The top two needs the committee voted to prioritize included a tie at 26%. Ranking of the needs was based on the committee poll results, with tiebreakers for ranking determined by stakeholder and community member input from interviews and surveys.

Appendix 5: Community Resources Available to Address Significant Health Needs

Providence St. Joseph Medical Center cannot address all 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 5_Table 1. Community Resources Available to Address Significant Health Needs

Organization Type	Organization or Program	Description of services offered	Street Address	Significant Health Need Addressed
Agency on Aging	Agency on Aging	Serves people with the goal of enabling persons 60 years or older to lead independent, meaningful, and dignified lives, by providing direct services, contracting for services, and networking with the community to locate services	110 Main St, Ste 5 Polson, MT 59860	Access to Services
Agency on Aging	Lake County Council on Aging	Public transportation (48-hour notice), food program, in-home housekeeping (cost), respite care for caregivers (cost), foot clinic and farmer's market. Senior Centers in Arlee, Charlo, Polson, Ronan, St. Ignatius. Tribal Centers in Arlee, Elmo, Polson, Ronan and St. Ignatius	528 Main Street SW Ronan, MT 59864	Access to Services
Disability Services	Summit Independent Living	Provides consumer and advocacy services to people with mobility, neurological, hearing, visual and other disabilities	124 Main St P.O. Box 434, Ronan, MT 59864	Advocacy
Domestic Violence	Safe Harbor	Domestic and sexual violence services, including emergency shelter	PO Box 497 Ronan, MT 59864	Emergency Shelter

Domestic Violence	Domestic Violence Programs Intervention (DOVES)	Advocacy and support to victims of domestic violence and their families	P.O. Box 1773 Polson, MT 59860	Advocacy
Food Pantry	Bread Basket	Provides emergency food services (3-4 days' worth of food, once a month) to needy families in Ronan, Charlo, and Moiese areas	10 6th Ave SW P.O. Box 346, Ronan, MT 59864	Food Insecurity
Food Pantry	Food Distribution	Restricted to those who live on the Reservation	410 Mountain View Dr. St. Ignatius, MT 59865	Food Insecurity
Food Pantry	West Shore Food Bank	Emergency food services	7150 Hwy 93 S P.O. Box 192 Lakeside, 59922	Food Insecurity
Food Pantry	Mission Valley Food Pantry	Food Service for needy families at or below 200% of the poverty level	203 Baine Street St. Ignatius, MT 59865	Food Insecurity
Food Pantry	Polson Loaves and Fish Pantry	Food service for needy families	904 1st Street E Polson, MT 59860	Food Insecurity
Hospital	Providence St. Joseph Medical Center	Primary medical care services	6 13th Ave E Polson, MT 59860	Access to Care Medical Care
Legal Aid	Montana Legal Services Association	Attorneys who work with low-income people by providing legal information, advice, and other services free of charge. MLSA works to help low-income people escape domestic violence, keep their housing, preserve their public benefits, protect their finances, and more	1535 Liberty Ln, #110D Missoula, MT 59808	Legal, Individual and Community Advocacy

Mental Health	Sunburst Community Service Foundation	Provides licensed outpatient mental health services to children, adults and families including psychiatric assessments, medication management, therapy, community rehabilitation, vocational support, and case management	103 Whitewater, Suite A Polson, MT 59860 109 1st Ave St. Ignatius, MT 59865	Access to Mental Health Care
Mental Health	Western Montana Mental Health Center	Mental health counseling and services for adults, children and families	8 2nd Ave SW Ronan, MT 59864 1105 1st St E Polson, MT 59860 Lake House Crisis Facility 7 13th Ave W Polson, MT 59860	Access to Mental Health Care
Mental Health and Disability Services	AWARE	Provides mental health and disability services to adolescents and adults, including job placement	1055 W Sussex, Missoula, MT 59801	Mental Health
Public Benefits	Office of Public Assistance	Administers programs for low-income Montanans including SNAP, Medicaid, medical assistance, emergency aid for dependent children, and TANF	49627 Hwy 93, Polson, MT 59860	Food Insecurity Housing Stability
Public Benefits	WIC (Women, Infants, and Children)	Supplemental nutrition program for women, infants, and children, providing short term, low cost, preventative health services to families who are at risk due to nutrition related health conditions	7 3rd Ave W, Polson, MT 59860	Food Insecurity

Public Housing Agency	Community Action Partnership of Northwestern Montana (CAPNM)	Offers services for several housing specific needs, including a Section 8 Voucher program for very low-income people, a low income home ownership program (Community Land Trust), and some emergency housing and utility solutions.	110 Main St P.O. Box 132, Polson, MT 59860	Housing
Veterans Services	Disabled American Veterans	Referral, information, advocacy, and hospital equipment loan to disabled veterans	203 6th Ave E Polson, MT 59860	Access to Services

Appendix 6: Providence St. Joseph Medical Center Community Health Needs Assessment Advisory Council

Apx 6_Table 1. Community Health Needs Assessment Advisory Council Members

Name	Title	Organization	Sector
Brodie Moll	Director (Retired)	Mission Mountain Enterprises	Business
Caryl Cox, PhD	Council Chairperson	Polson School Board (Former)	Education
Dermot O'Halloran	Senior Director	SKC Technologies	Business
Devin Huntley	Chief Operating Officer	Providence St. Joseph Medical Center	Health
Gale Decker	County Commissioner	Lake County	Government
Joyce Dombrouski	Chief Executive	Providence Montana	Health
Kirk Bodlovic	Chief Operating Officer	Providence Montana	Health
Shauna Rubel	Vice President	Glacier Bank	Business
Tracie McDonald	Dean of Students	Salish-Kootenai College	Education
William Bekemeyer, MD	Physician (Retired)	Providence Montana	Health