2023

COMMUNITY HEALTH NEEDS ASSESSMENT

Providence SWEDISH

Providence St. Peter Hospital
Olympia, Washington

Providence Centralia Hospital
Centralia, Washington

To provide feedback on this Community Health Needs Assessment or obtain a printed copy free of charge, please email Liz Selsor at liz.selsor@providence.org.

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MESSAGE TO THE COMMUNITY

To Our Communities:

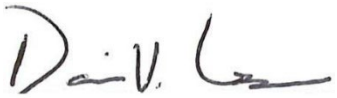
Providence Swedish is proud to be South Puget Sound's health care partner, and we remain committed to delivering compassionate care to our diverse population. Access to care is a fundamental human right, and we are working tirelessly to make sure services are accessible for everyone.

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

As outlined in our **2023 CHNA,** the following health needs emerged across the communities we serve in Thurston and Lewis counties during the assessment process:

- ***Behavioral Health***
  - *Suicide prevention; substance use/misuse and overdose prevention; social and community supports*
- ***Basic Needs/Economic Security***
  - *Income; housing; food; education; technology; language access; social and community supports*
- ***Access to Health Care***
  - *Underserved populations; primary, specialty and acute care; dental health; insurance*

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



Darin Goss
Chief Executive
Providence Swedish South Puget Sound

EXECUTIVE SUMMARY

Understanding and Responding to Community Needs

The Community Health Needs Assessment (CHNA) is an opportunity for Providence St. Peter and Centralia Hospitals to engage the community every two to three years with the goal of better understanding community strengths and needs. At Providence Swedish, this process informs our partnerships, programs, and investments. Improving the health of our communities is fundamental to our Mission and deeply rooted in our heritage and purpose.

The 2023 CHNA was approved by the Community Mission Board of Providence Swedish South Puget Sound on October 26, 2023, and made publicly available by December 28, 2023.

Gathering Community Health Data and Community Input

Through a mixed-methods approach, using quantitative and qualitative data, we collected information from the following sources: American Community Survey, Behavioral Risk Factor Surveillance System, U.S. Decennial Census, U.S. Census Bureau Small Area Income and Poverty Estimates, USDA Food and Nutrition Service, U.S. Department of Education, CDC QuickFacts, U.S. Health Resources & Services Adminstration, 2023 County Health Rankings, Washington State Department of Health, Washington State Health Youth Survey, Massachusetts Institute of Technology Living Wage Calculator, local public health data, hospital-level data, and input from community members. Some key findings include the following:

- Behavioral health, including both mental health and substance use/misuse, is a severe health need in both counties in the South Puget Sound area.
- There is a high need for social and community supports, as pertains to diversity, equity, inclusion, and belonging, especially in the wake of the COVID-19 pandemic.
- Significant disparities and additional barriers exist in the South Puget Sound area, including for young people, people experiencing homelessness, people identifying as lesbian, gay, bisexual, transgender, queer, questioning, intersex, asexual, or other identities not encompassed (LGBTQIA+), Black, Brown, Indigenous, and People of Color (BBIPOC) communities, people living in more rural areas of Thurston County, and military families.
- Health factors relating to children and youth often meet or exceed those of their adult counterparts, posing a great risk not only for their current health and wellbeing, but also for their futures.

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.

Identifying Top Health Priorities

Through a collaborative process, the CHNA Community Advisory Council identified the following priority areas, listed in order of priority:

PRIORITY 1: BEHAVIORAL HEALTH

Behavioral Health, encompassing both mental health and substance use/misuse is the most pressing need in our communities. Access to behavioral health care, mental health and suicide prevention, and substance use/misuse and overdose prevention were all identified as areas of concern. Many residents have experienced significant stress and isolation from the COVID-19 pandemic, resulting in more suicidal ideation and unaddressed mental health challenges. Of particular concern is an increase in fentanyl use and resulting overdoses, as well as the broader community impacts of overdose and overdose deaths.

Access to behavioral health care especially difficult due to a lack of system capacity and providers to meet the demand, leading to long wait times for both mental health and substance use/misuse treatment services. Services needed to improve access to behavioral health care include residential or inpatient substance use disorder (SUD) treatment services; detox centers; crisis response and stabilization beyond the Emergency Department (ED); community-based mental health care that is a step-down from hospitalization; and follow-up care for people after being discharged from inpatient care for a mental health condition, including medication management. Specific populations may experience unique or additional barriers to accessing services including young people, people experiencing homelessness, people identifying as lesbian, gay, bisexual, transgender, queer, questioning, intersex, asexual, or other identities not encompassed (LGBTQIA+), Black, Brown, Indigenous, and People of Color (BBIPOC) communities, people living in more rural areas, and military families.

PRIORITY 2: BASIC NEEDS / ECONOMIC SECURITY

Economic security is important for people's health and well-being. Low wages, high unemployment, and a high cost of living contribute to economic insecurity for many families. There are inequities in how resources and educational opportunities are distributed in the community. People with low incomes may be unable to afford their basic needs, such as food, health care, car seats, baby formula, etc., particularly with the rising cost of living. One event or accident could be financially catastrophic for a family. Individuals and families with incomes slightly above the threshold for qualifying for public benefits, but without enough money to afford those basic needs without assistance, are especially vulnerable. This is called the "benefits cliff," which means public benefits drop off sharply with a small increase in income.

There are limited employment opportunities a living for people to make a living wage without higher education. Investing in low-barrier educational and employment opportunities and in job skills and technical training could help people increase their economic security. Economic insecurity may

disproportionately affect people living in rural areas, as well as BBIPOC community members, people with behavioral health conditions, older adults, and women.

Access to nutritious, affordable food, as well as food resources is a major issue for many families and individuals, especially in rural areas. A lack of healthy and nutritious food contributes to long-term health challenges, like obesity and diabetes. The need has recently increased with cuts to Supplemental Nutrition Assistance Program (SNAP) benefits, leading more people to seek other food resources. Families with low incomes may be especially affected by food insecurity, particularly with the rising cost of housing. People may have to travel long distances to the nearest food bank and may experience transportation barriers, particularly with the increased cost of fuel.

The interconnectedness of housing and health is key, and housing was identified as a major need, with a lack of safe and healthy housing available for families and employees. The cost of housing is the primary barrier for people, with a need for more affordable housing for people with low incomes, as wages have not kept pace with housing costs. There is also a need for more supportive and transitional housing, particularly for people experiencing homelessness or housing stability, and as well those needing support services to remain stably housed. More permanent supportive housing and emergency, short-term, and long-term shelters. The complexity of the housing system can be difficult for people to navigate and can be a barrier for people finding stable housing. Specific populations experiencing housing-related challenges include older adults, BBIPOC communities, particularly Latino/a/x[1] community members and Indigenous peoples, LGBTQIA+ community members (especially LGBTQIA+ youth), unaccompanied minors, and people with behavioral health conditions.

PRIORITY 3: ACCESS TO HEALTH CARE

Access to both primary and specialty care was identified as a top health concern. A lack of Primary Care Providers (PCPs) has strained the health care system, contributing to people using the Emergency Department (ED) as their main form of health care, and to a prevalence of unmanaged chronic conditions. Patients who have difficulty finding primary care, along those having a behavioral health crisis, put stress on the ED and overwhelm capacity. There is a need for more access to primary care, urgent care, and behavioral health crisis services, as well as a need for increased access to specialty care, as many patients travel outside of their local area to receive services. More health care providers, home care aids and caregivers, hospital capacity, care coordination, and cancer screening are needed in the community. Transportation is a significant barrier to care, as are hours of appointments during work time, a lack of health care literacy, trust in the medical system, and access to or comfort with technology. Specific populations may experience additional barriers to accessing responsive and affirming care, including people experiencing homelessness, BBIPOC community members, LGBTQIA+ community members, mixed-status families, and people with behavioral health conditions. Stigma and discrimination and a lack of providers that are bilingual and bicultural contribute to these challenges. There are few resources for people who are uninsured, underinsured, or not Medicaid-eligible.

[1] Key informants used the terms Latino, Latina, Latinx, and Hispanic to refer to the people their organizations serve. To remain consistent and inclusive, we will use the term Latino/a/x throughout the report, acknowledging that individuals may have strong preferences as to how they self-identify.

Providence St. Peter and Centralia Hospitals will develop a three-year Community Health Improvement Plan (CHIP) to respond to these prioritized needs in collaboration with community partners considering resources and community strengths and capacity. The 2024-2026 CHIP will be approved and made publicly available no later than May 15, 2024.

Measuring Our Success: Results from the 2020 CHNA and 2021-2023 CHIP

This report evaluates the impact of the 2021-2023 CHIP. Providence St. Peter and Centralia Hospitals 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. In addition, we invited written comments on the 2020 CHNA and 2021-2023 CHIP, made widely available to the public through posting on our website and distribution to community partners. No written comments were received on the 2020 CHNA and 2021-2023 CHIP. The 2020 CHNA and 2021-2023 CHIP priorities were the following: Homelessness/Lack of Safe and Affordable Housing, Behavioral Health, and Access to Health Care. A few of the key outcomes from the previous CHIP are listed below:

- Providence St. Peter and Centralia Hospitals continue to invest in programs and grants benefitting the South Puget Sound communities, aligning with our CHNA and CHIP priorities. These Providence programs include the Special Care Nursery for infants with special needs, Abuse Intervention Center, Community Care Center, Chemical Dependency Center, and Family Birthing Center, as well as medication assistance, mental health services, and residency programs for health care providers.
- In partnership with other community organizations, Providence South Puget Sound has supported six Medical Respite beds, providing 30-45 days in a safe, healing environment for unhoused individuals needing medical respite post hospital discharge. Case managers at Interfaith Works and Catholic Community Services work with these individuals during their stay to assist with follow-up care and to help obtain housing for those who are interested.
- Providence St. Peter Hospital launched an outreach model called Street Medicine, where the Providence team meets clients where they are, removing the obstacle of finding transportation. Services include basic health care, wound care, prescribing necessary medications, and mental health counseling. This program provides comprehensive preventative healthcare to clients experiencing homelessness around Thurston County and helps make connections to other social service agencies.
- Providence Swedish provides support for Thurston County's Built for Zero cohort, a large coalition of community partners and providers who are working together to end homelessness. The cohort has achieved great strides in implementing and continuously improving data systems and processes, as well as in setting and meeting collaborative goals to achieve Functional Zero in Thurston County for single adults who are experiencing chronic homelessness and/or who are unhoused Veterans.

INTRODUCTION

Who We Are

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

Our Vision Health for a Better World.

Our Values Compassion — Dignity — Justice — Excellence — Integrity

Providence Centralia Hospital is a 128-bed, acute care not-for-profit hospital providing emergency, diagnostic, cancer, birthing, and surgical services to the greater Lewis County region. Located in Centralia, Washington, it was formed in 1988 when Centralia General Hospital merged with St. Helen's Hospital, Chehalis. It is one of only 405 U.S. hospitals and critical access hospitals earning the distinction of top performer on key quality measures from The Joint Commission. Major programs and services include the following:

- Cardiology
- Emergency Care
- Family Birth Center
- General Surgery
- Imaging Center
- Orthopedic Care
- Palliative Care
- Physical Therapy
- Providence Regional Cancer System

Providence St. Peter Hospital is a Magnet® recognized 390-bed not-for-profit teaching hospital, founded by the Sisters of Providence in 1887. Located in Olympia, Washington, the state capital, it offers comprehensive medical, surgical, and behavioral health services. As the largest medical center in the five-county area of southwest Washington, it serves as a regional referral center, providing a full array of services to communities in Thurston, Lewis, Mason, Grays Harbor and Pacific counties. Major programs and services include the following:

- Anticoagulation Clinic
- Behavioral Health and Recovery
- Diagnostic Imaging
- Emergency Care – Level III Trauma Center
- Family Birth Center and Special Care Nursery

- Orthopedic Care
- Palliative Care
- Providence Abuse Intervention Center
- Providence Regional Cancer System
- Sleep Medicine
- St. Peter Regional Heart Center
- Specialty Surgeries, including Cardiac surgery, da Vinci surgery, ENT procedures, Neurosurgery, Obstetrics and gynecology, Pediatric surgery, Thoracic surgery, Urology, and Vascular surgery

For more information on the resources invested to improve the health and quality of life for the communities we serve, please refer to our Annual Report to our Communities: https://www.providence.org/about/annual-report.

COLLABORATING PARTNERS

Collaborating Community Partners

In Thurston County, key informants were collaboratively selected by Providence Swedish South Puget Sound and the Thurston County Public Health and Social Services Department. Interviews were facilitated by Providence Swedish South Puget Sound staff and Thurston County Public Health and Social Services Department staff, as part of an effort to align interview methodology, facilitator training, and documentation. Through its 2022 CHNA efforts, MultiCare Capital Medical Center also collaborated in this process. We are grateful to these partners for their contributions to creating healthy communities.

OVERVIEW OF CHNA FRAMEWORK AND PROCESS

Equity Framework

Our vision, Health for a Better World, is driven by a belief that health is a human right. Every person deserves the chance to live their healthiest life. At Providence Swedish, we recognize that long-standing inequities and systemic injustices exist in the world. This has led to health disparities among communities that have been marginalized because of their race, ethnicity, gender, sexual orientation, age, ability, religion, or socioeconomic status. Our health equity statement can be found online: https://www.providence.org/about/health-equity.

The CHNA is an important tool we use to better understand health disparities and inequities within the communities we serve, as well as the community strengths and assets. 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.

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

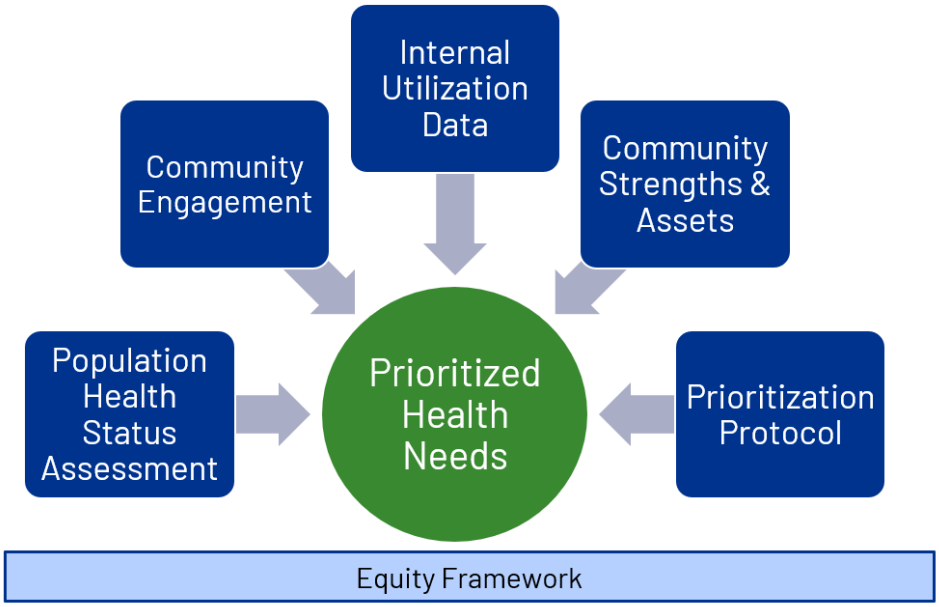
Report data at the census tract level to address masking of needs at county level

Disaggregate data when responsible and appropriate

Acknowledge inherent bias in data and screening tools

CHNA Framework

The equity framework is foundational to our overall CHNA framework, a modified version of the Mobilizing for Action through Planning and Partnerships (MAPP) developed by the National Association of County and City Health Officials (NACCHO). The modified MAPP framework takes a mixed-methods approach to prioritize health needs, considering population health data, community input, internal utilization data, community strengths and assets, and a prioritization protocol.



*modified MAPP Framework

Data Sources

In gathering information on the communities served by St. Peter and Centralia Hospitals, we looked not only at the health conditions of the population, but also at socioeconomic factors, the physical environment, and health behaviors. In addition, we recognize that there are often geographic areas where the conditions for supporting health are poorer than nearby areas. Whenever possible and reliable, data are reported at census tract level. These smaller geographic areas allow us to better understand the neighborhood level needs of our communities and better address inequities within and across communities.

We reviewed data from the following sources:

Primary Data Sources	Secondary Data Sources
• Key informant interviews • Internal hospital utilization data	• American Community Survey • Behavioral Risk Factor Surveillance System (BRFSS) • Centers for Disease Control and Prevention (CDC) • CDC Foundation • County Health Rankings • Lewis County Public Health and Social Services • Massachusetts Institute of Technology Living Wage Calculator • National Center for Health Statistics • Robert Wood Johnson Foundation • School Finance Indicators Database • Small Area Income and Poverty Estimates • Thurston County Public Health and Social Services Department • U.S. Census Bureau • U.S. Department of Education • U.S. Health Resources & Services Adminstration • U.S. Department of Agriculture Food and Nutrition Service • Washington State Department of Health • Washington State Healthy Youth Survey

Data Limitations and Information Gaps

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

- Not all desired data were readily available, so sometimes we had to rely on tangential or proxy measures or not have any data at all. For example, there is little community-level data on the incidence of mental health or substance use.
- While most indicators are relatively consistent from year to year, other indicators are changing quickly (such as percentage of people uninsured) and the most recent data available are not a good reflection of the current state.
- Reporting data at the county level can mask inequities within communities. This can also be true when reporting data by race, which can mask what is happening within racial and ethnic subgroups. Therefore, when appropriate and available, we disaggregated the data by geography and race.

- Data that are gathered through interviews and surveys may be biased depending on who is willing to respond to the questions and whether they are representative of the population as a whole.
- The accuracy of data gathered through interviews and surveys depends on how consistently the questions are interpreted across all respondents and how honest people are in providing their answers.

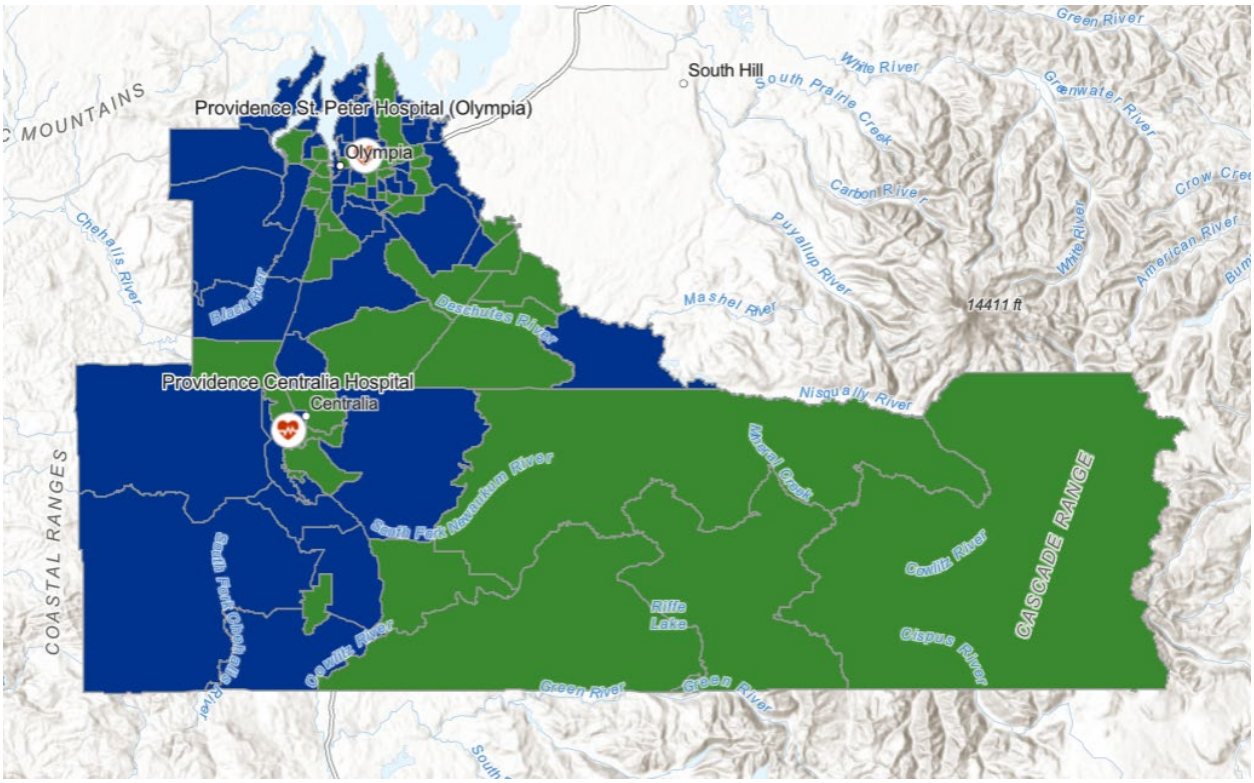
Process for Gathering Comments on Previous CHNA and Summary of Comments Received

Written comments were solicited on the 2020 CHNA and 2021-2023 CHIP reports, which were made widely available to the public via posting on the internet in December 2020 (CHNA) and May 2021 (CHIP), as well as through various channels with our community-based organization partners. No comments were received.

OUR COMMUNITY

CHNA Service Area and Community Served

Based on the availability of data, geographic access to the facilities, and other hospitals in neighboring counties, Lewis and Thurston Counties in southwest Washington State comprise the Providence Swedish South Puget Sound service area. Providence Centralia Hospital is located in Lewis County, in Centralia, Washington; Providence St. Peter Hospital is located in Thurston County, in Olympia, Washington.



Census Tract

- High Need Service Area
- Broader Service Area

Based on data from the 2022 American Community Survey and the 2023 County Health Rankings:

- Of 39 counties in Washington, Lewis County is the 16th largest county by population, with 85,370 residents. It is comprised of 2,402.8 square miles of land and is the 6th largest county by total area. It is ranked 33rd in the County Health Rankings, the 17th percentile in the state.

- Thurston County is the 6th largest by population, with 298,758 residents. It is comprised of 722.5 square miles of land and is the 32nd largest county by total area. It is ranked 17th in the County Health Rankings, the 61st percentile in the state.

Providence Need Index

To facilitate identifying health disparities and social inequities by place, we designated a "high need" service area and a "broader" service area, which together make up the South Puget Sound service area, encompassing both Lewis and Thurston Counties. Based on work done by the Public Health Alliance of Southern California and their Healthy Places Index (HPI) tool, we identified the high need service area based on income, education, English proficiency, and life expectancy.[2]

For this analysis, census tracks with more people below 200% Federal Poverty Level (FPL), more people without a high school diploma, more limited English households, and a lower life expectancy at birth were identified as "high need." The mean value of nearest neighbors was used to insert missing data for variables by way of the Neighborhood Summary Statistics geoprocessing tool in ArcGIS Pro 3.1. All variables were weighted equally. The census tracts were assigned a score between 0 and 100 where 0 represents the census tract with the lowest need and 100 represents the highest need, according to the criteria. Census tracts that scored higher than the average were classified as a high need service area and are depicted in green. In the South Puget Sound service area, 41 of 82 census tracts (50%) scored above the average of 45.1, indicating a high need.

Community Demographics

The graphs below provide demographic and socioeconomic information about the service area and how the high need area compares to the broader service area. We have developed a dashboard that maps each CHNA indicator at the census tract level. The dashboard can be found here: https://experience.arcgis.com/experience/a9990291518845709850f5520bdc6f93/.

POPULATION DEMOGRAPHICS

The following population demographics are from the 2021 American Community Survey 5-Year Estimates.

[2] The following variables were used for the PNI analysis: Population below 200% the Federal Poverty Level (American Community Survey, 2021); Percent of population with at least a high school education (American Community Survey, 2021); Percent of population, ages 5 Years and older in Limited English Households (American Community Survey, 2021); Life expectancy at birth (estimates based on CDC, 2010 – 2015 data)

Figure 1. Population Age Groups by Geography

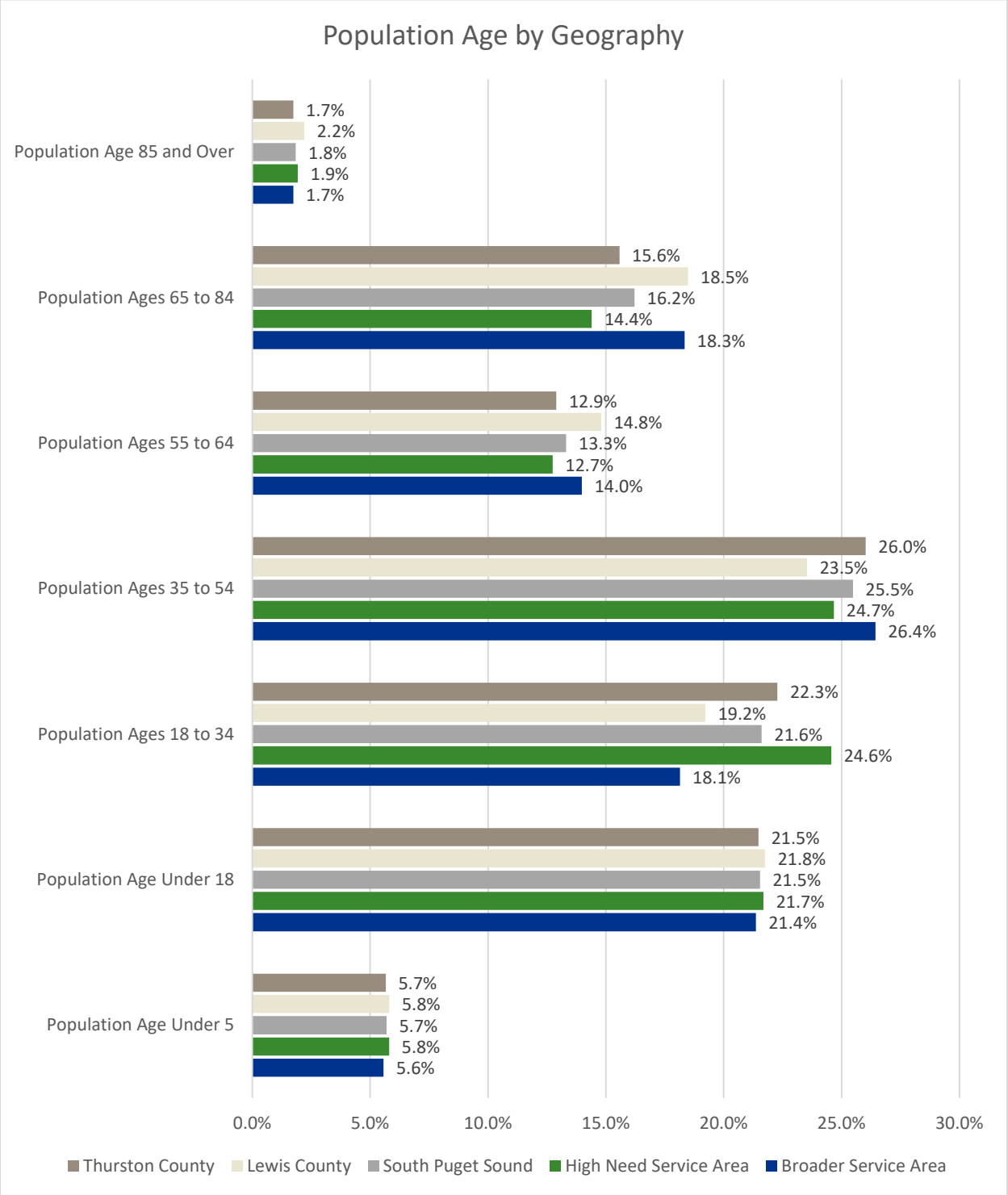


Figure 2. Population Sex by Geography

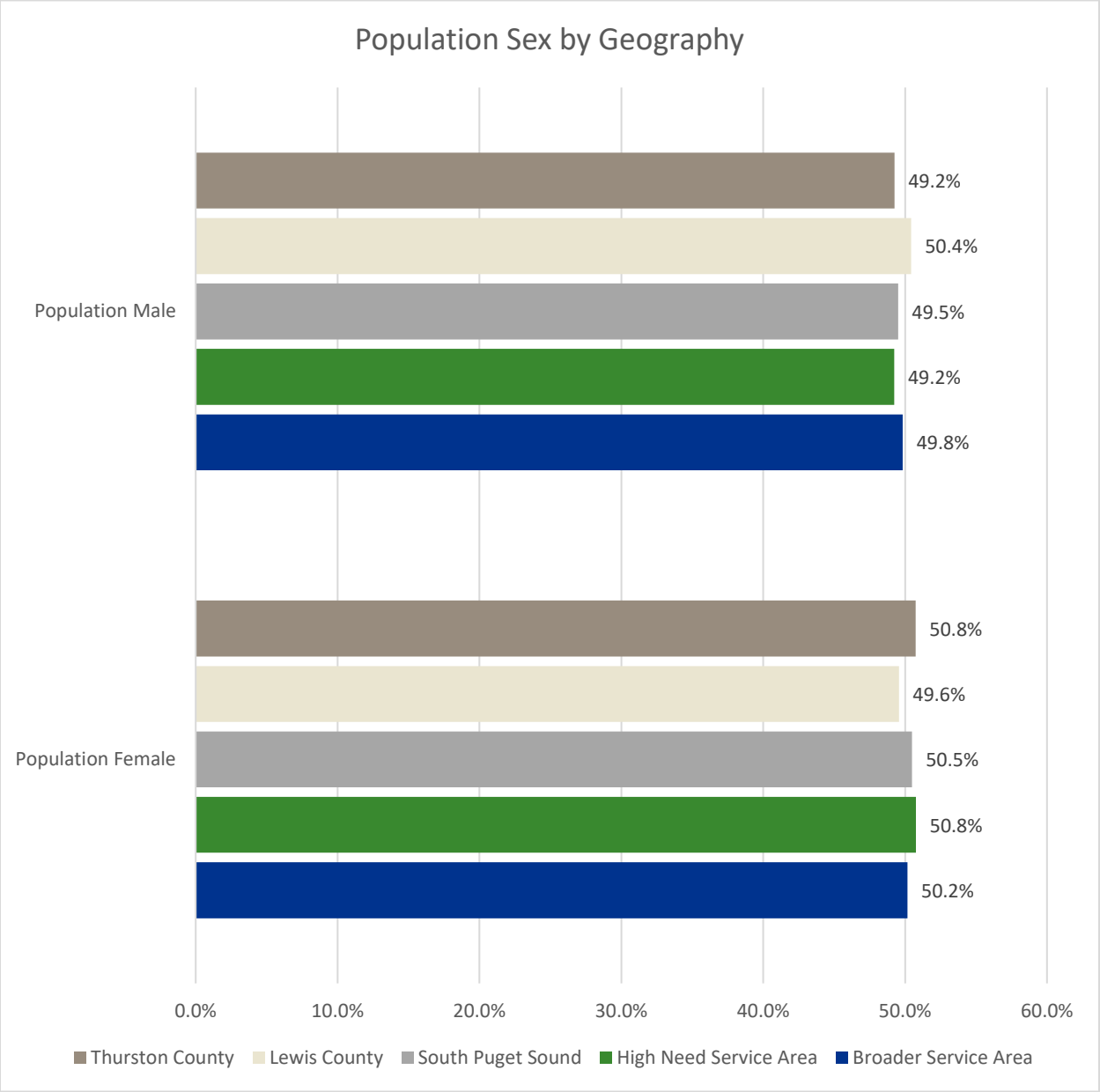
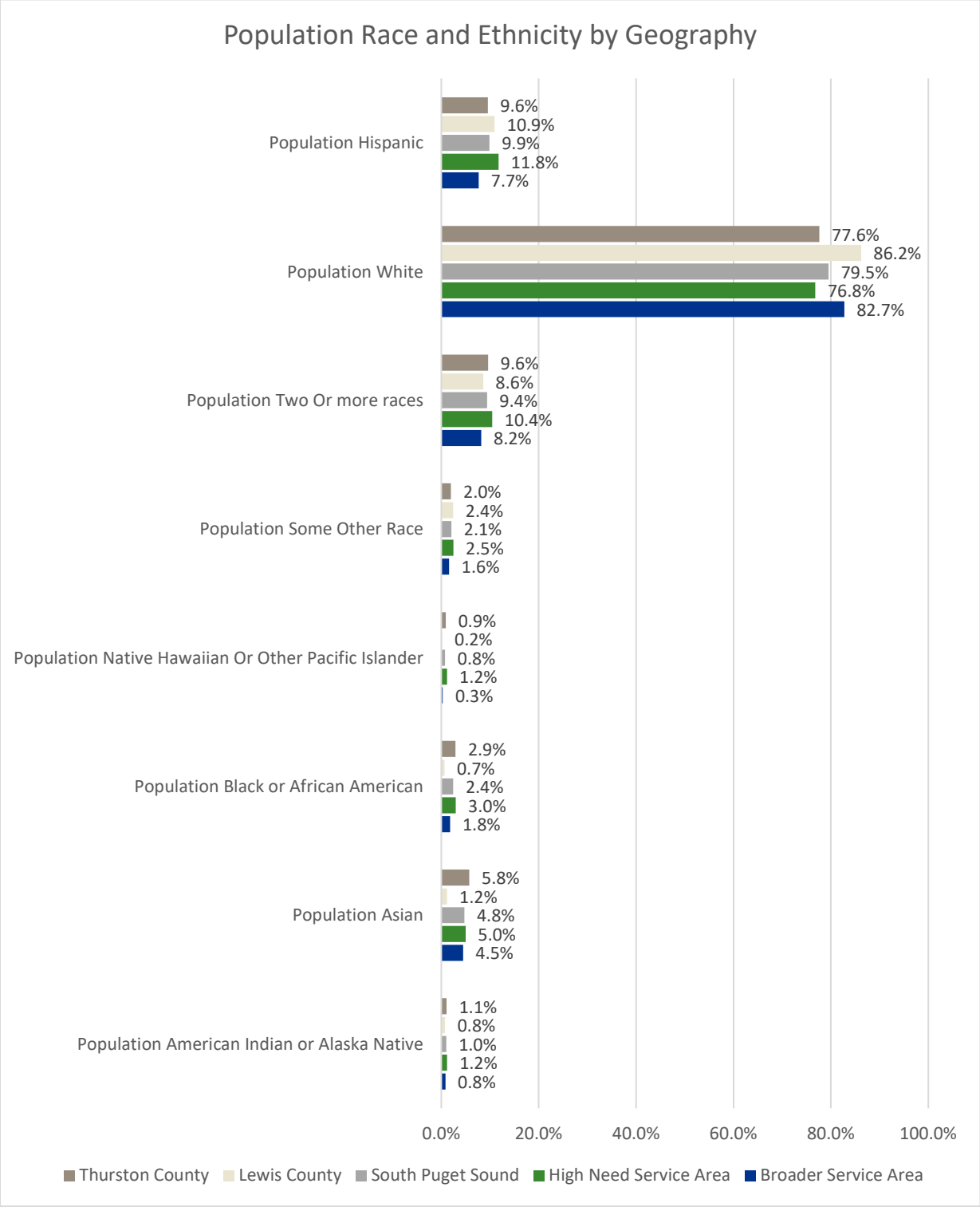


Figure 3. Population Race and Ethnicity by Geography



About one in four people in the South Puget Sound service area is between the ages of 35 and 54. This age group, along with people between the ages of 55 and 84, are over-represented in the high need service area. People ages 18 to 34 are over-represented in the high need service area.

Male and female sexes are roughly proportional across the service areas.

Almost 80% of people in the South Puget Sound service area identify as white, which is slightly over-represented in the broader service area compared to the South Puget Sound service area. People identifying as two or more races, some other race, Native Hawaiian or other Pacific Islander, Black or African American, Asian, and American Indian or Alaska Native are slightly over-represented in the high need service area. Individuals identifying as Hispanic/Latino/Latina are also over-represented in the high need service are compared to the South Puget Sound service area.

HOUSEHOLD MEDIAN INCOME

Household median income includes the income of the householder and all other individuals 15 years old and over in the household, whether they are related to the householder or not. Because many households consist of only one person, average household income is usually less than average family income. Lewis's County's median household income is nearly $20,000 below that of Thurston County, and more than $27,000 below that of the Broader Need Area of South Puget Sound. Thurston County also falls slightly behind the state in this measure. *(Source: American Community Survey, 2021, 5-Year Estimates)*

County/State
Lewis County: $60,524
Thurston County: $80,141
Washington State: $81,548

South Puget Sound Service Area
High Need Area: $66,457
Broader Need Area: $87,814
Total Service Area: $77,135

SEVERE HOUSING COST BURDEN

Renter households experiencing severe housing cost burden are households spending 50% or more of the income on housing costs. The information offers an excellent measure of housing affordability and excessive shelter costs. About 21% of renter households in both Washington State and Lewis County are severely housing-cost burdened, while 24% renters in Thurston County and 25% in the High Need Area of the South Puget Sound are experiencing this strain. *(Source: American Community Survey, 2021, 5-Year Estimates)*

HEALTH PROFESSIONAL SHORTAGE AREAS

In the South Puget Sound, the areas below are designated by the Health Resources & Services Adminstration as having a shortage of primary, dental, or mental health care providers.

Table 1. Health Professional Shortage Areas

Discipline	HPSA Name
Primary Care	Lewis County, North Thurston County, South Thurston County
Mental Health	Lewis County, North Thurston County, South Thurston County
Dental Health	Lewis County, Olympia-Lacey Service Area, North Thurston County, South Thurston County

The geographic areas and populations behow are designated by the Health Resources & Services Adminstration as having a lack of access to primary care services.

Table 2. Medically Underserved Areas and Populations

County	Service Area Name
Lewis	Eastern Lewis Service Area, Western Lewis Service Area
Thurston	Low Income - Downtown Olympia, Panorama

See Appendix 1 for additional details on HPSA and Medically Underserved Areas and Medically Underserved Populations.

HEALTH INDICATORS

Please refer to the 2023 South Puget Sound Data Hub to review each of the following health indicators mapped at the census tract level: https://experience.arcgis.com/experience/a9990291518845709850f5520bdc6f93/.

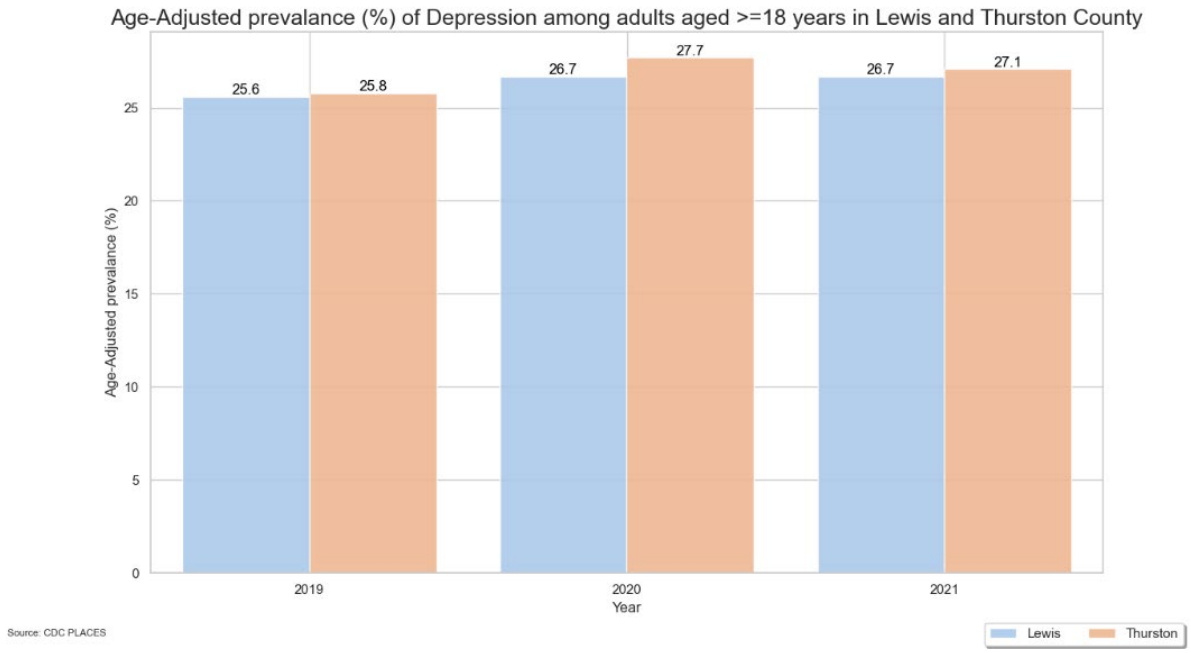
The hub provides data on each indicator in Lewis and Thurston Counties, high need and broader need service areas, and the state of Washington, as well as information about the importance of each indicator.

Behavioral Health

DEPRESSION

In the South Puget Sound area, more than one quarter of adults have been diagnosed with depressive disorder at some point in their lives, about 27% in Lewis and Thurston Counties. These figures are significantly higher than the state average of 24% and the U.S. average of 20%.

Figure 4. Depression in Adults

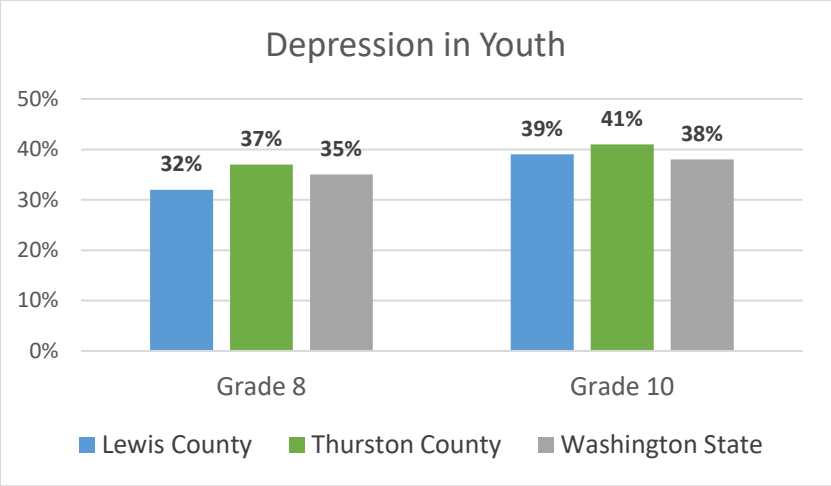


Source: Behavioral Risk Factor Surveillance System (from CDC PLACES for county and national estimates), 2021

In middle school and high school, depressive feelings are even more pervasive. Among 8th graders, 32% of students in Lewis County and 37% in Thurston County reported they felt so sad or hopeless, almost every day for two weeks or more in a row, that they stopped doing some usual activities in the past

year. These figures are even higher among 10th graders, with 39% of students in Lewis County and 41% in Thurston County reporting feelings of depression, greater even than the statewide average of 38%.

Figure 5. Youth Depression

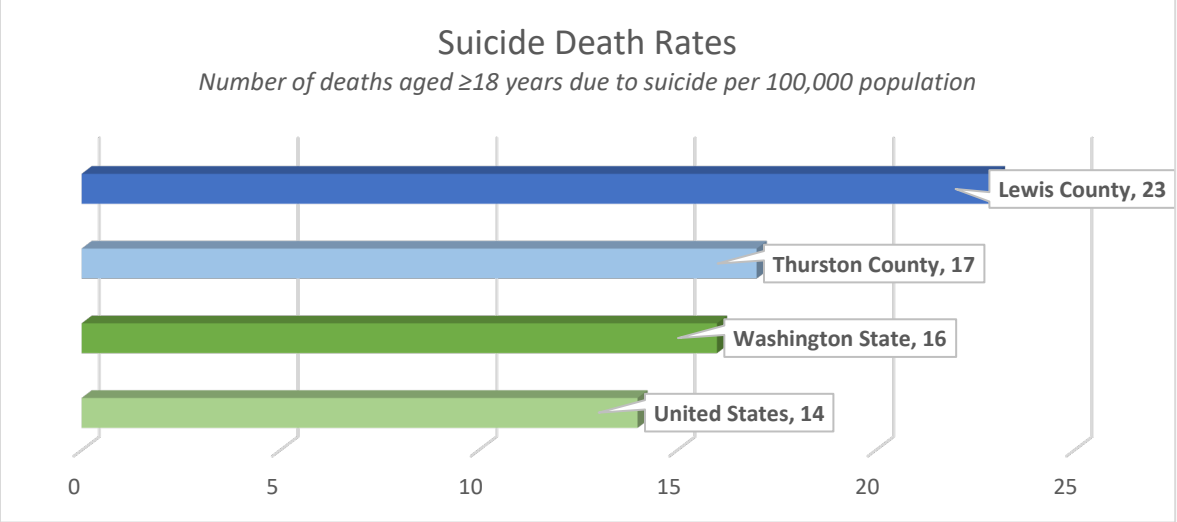


Source: Washington State Healthy Youth Survey, 2021

SUICIDE

Among adults 18 years and older, the death rate due to suicide is slightly higher in Thurston County (17 per 100,000) and notably higher in Lewis County (23 per 100,000) compared to Washington State (16 per 100,000).

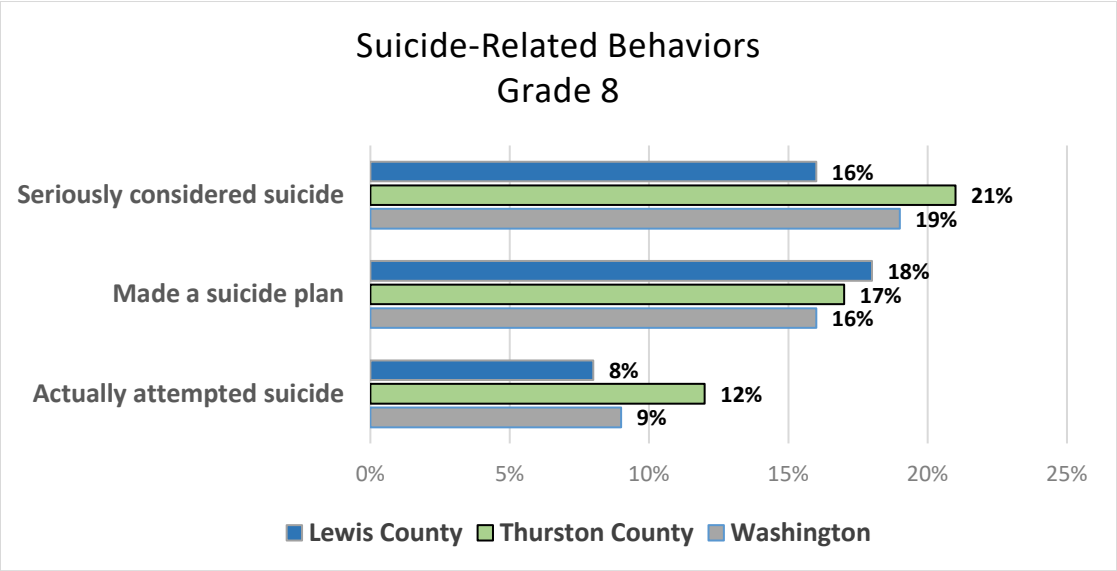
Figure 6. Suicide Death Rates



Source: National Center for Health Statistics - Mortality Files, 2016-2020

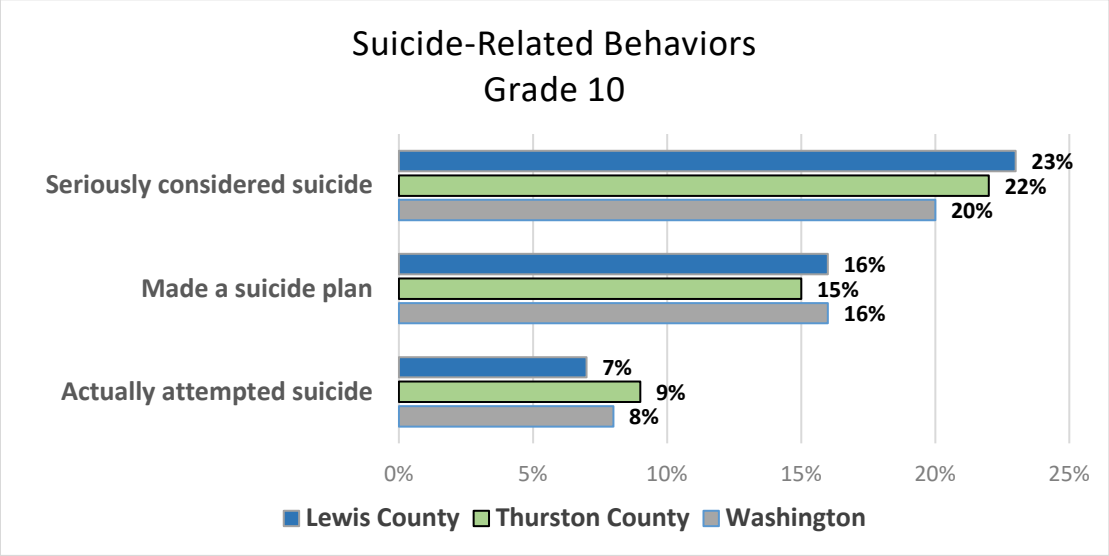
Suicidal thoughts and behaviors are extremely troubling among youth in middle and high schools. According to the 2021 Washington State Healthy Youth Survey, 23% of 10th graders in Lewis County and 22% in Thurston County reported seriously considering suicide, more than the state average of 20%. Thurston County students also reported a higher percentage of suicide attempts, 12% of 8th graders and 9% of 10th graders, compared to statewide figures.

Figure 7. Suicide-Related Behaviors, Grade 8



Source: Washington State Healthy Youth Survey, 2021

Figure 8. Suicide-Related Behaviors, Grade 10



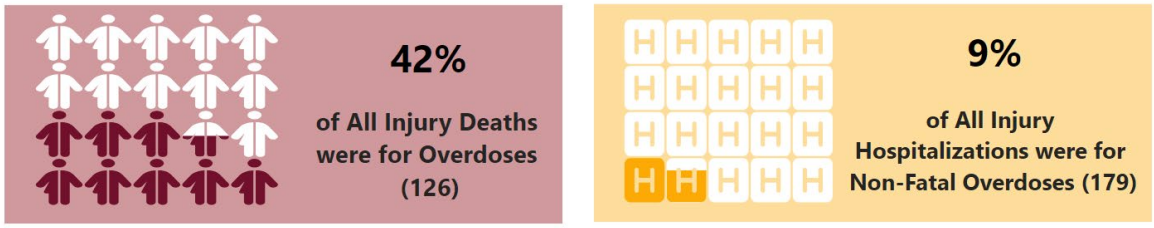
Source: Washington State Healthy Youth Survey, 2021

OVERDOSES

Drug overdoses, both fatal and non-fatal, are of great concern in the South Puget Sound. In 2022, 42% of all injury deaths in Thurston County were due to confirmed overdoses, much higher than the state value of 36%. While lower, Lewis County's overdose burden is significant, accounting for 23% of all injury deaths and 7% of injury hospitalizations. *(Source: Washington State Department of Health, 2022)*

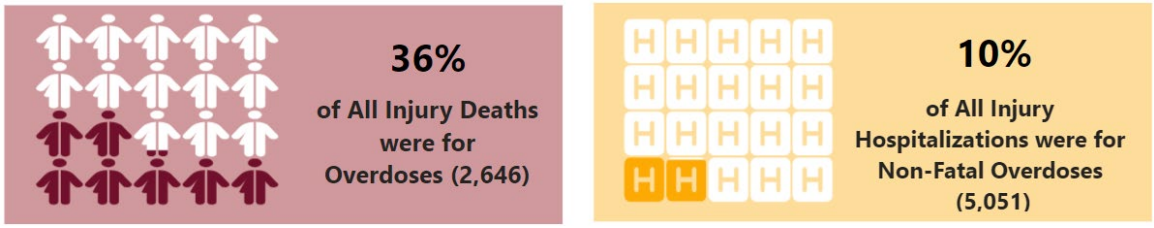
Figure 9. Overdose Burden, Lewis County

Figure 10. Overdose Burden, Thurston County



Source: Washington State Department of Health, 2022

Figure 11. Overdose Burden, Washington State



Source: Washington State Department of Health, 2022

Basic Needs and Economic Security

POVERTY

In the South Puget Sound Service Area overall, nearly 26% of residents live below 200% of the Federal Poverty Level (FPL), an amount equivalent to an annual household income of $60,000 or less for a family of four. In the South Puget Sound's High Need area, that figure jumps to nearly 33% of residents. 32% of Lewis County's population lives below this threshold as well, compared to 24% in Washington State overall. *(Source: American Community Survey, 2021, 5-Year Estimate)*

FOOD INSECURITY

The number of households receiving Supplemental Nutrition Assistance Program (SNAP) benefits, formerly referred to as the food stamp program, is used as a proxy measure to identify households that may be experiencing food insecurity. 13% of households in the South Puget Service Area receive SNAP benefits – 17.7% in Lewis County and 11.4% in Thurston County – all of which top statewide figures. *(Source: American Community Survey, 2021, 5-Year Estimate)*

Children and youth bear even more of this burden. 42% of Washington State students overall are eligible to receive free or reduced price meals at school, based upon their families' income levels. 35% of Thurston County students qualify for this benefit, and the number rises sharply to 58% in Lewis County. *(Source: National Center for Education Statistics, 2020-2021, accessed from countyhealthrankings.org)*

TECHNOLOGY

Access to technology is a significant factor in peoples' ability to learn, work, and connect with the world in a wide variety of important and meaningful ways.

According to the 2023 County Health Rankings, "Access to reliable, high-speed broadband internet improves access to education, employment, and health care opportunities and is associated with increased economic development. … Broadband access is required to efficiently support employment opportunities, workforce development, education, health care (telehealth), and access to/enrollment in state and federal programs (e.g., Supplemental Nutrition Assistance Program or SNAP). Broadband access can foster social connectedness, particularly among older populations, reducing the burden of social isolation, strengthening community support, and decreasing loneliness."

Broadband infrastructure and affordability can be critical barriers to peoples' ability to utilize technology. In Lewis County, over 12% of households do not use or cannot connect to the Internet, regardless of whether or not they pay for the service; more than 16% do not have a broadband Internet subscription and nearly 8% do not have a computer. These figures are much higher than, and are at times nearly double, those of Thurston County and Washington State as a whole. Due to Lewis County's rural geography, technology access can be even more crucial to the health and wellbeing of its residents.

Table 3. Technology Access

	Lewis County	Thurston County	Washington
Households without Internet access*	12.3%	5.8%	6.3%
Households without a computer**	7.70%	4.40%	4.40%
Households without a broadband Internet subscription**	16.30%	8.40%	8.70%

**Source: American Community Survey, 2021, 5-Year Estimate*
***Source: CDC QuickFacts, 2022*

EDUCATION

To obtain living-wage employment and economic security, it has become increasingly important in today's job market to attain post-secondary education, such as enrollment in vocational/technical schools, apprenticeship programs, colleges, or universities.

In Lewis County, 59% of adults ages 25-44 have some post-secondary education, compared with 73% in Thurston County and 72% statewide. This data includes those who pursued education following high school but did not receive a degree, as well as those who attained degrees. This is an important indicator for considering how to support young people in pursuing post-secondary educational opportunities, including colleges or universities, but also vocational and technical schools.

Attainment of a Bachelor's degree (or higher) in Lewis County is 19% -- approximately half of the statewide figure. Thurston County also falls below the state by one percentage.

Table 4. Post-Secondary Education

	Lewis County	Thurston County	Washington
Population ages 25-44 with some post-secondary education*	59%	73%	72%
Adults 25 years and older with a Bachelor's degree or higher**	19%	36.2%	37.3%

**Source: American Community Survey, 2021, 5-Year Estimate*
***Source: CDC QuickFacts, 2017-2021*

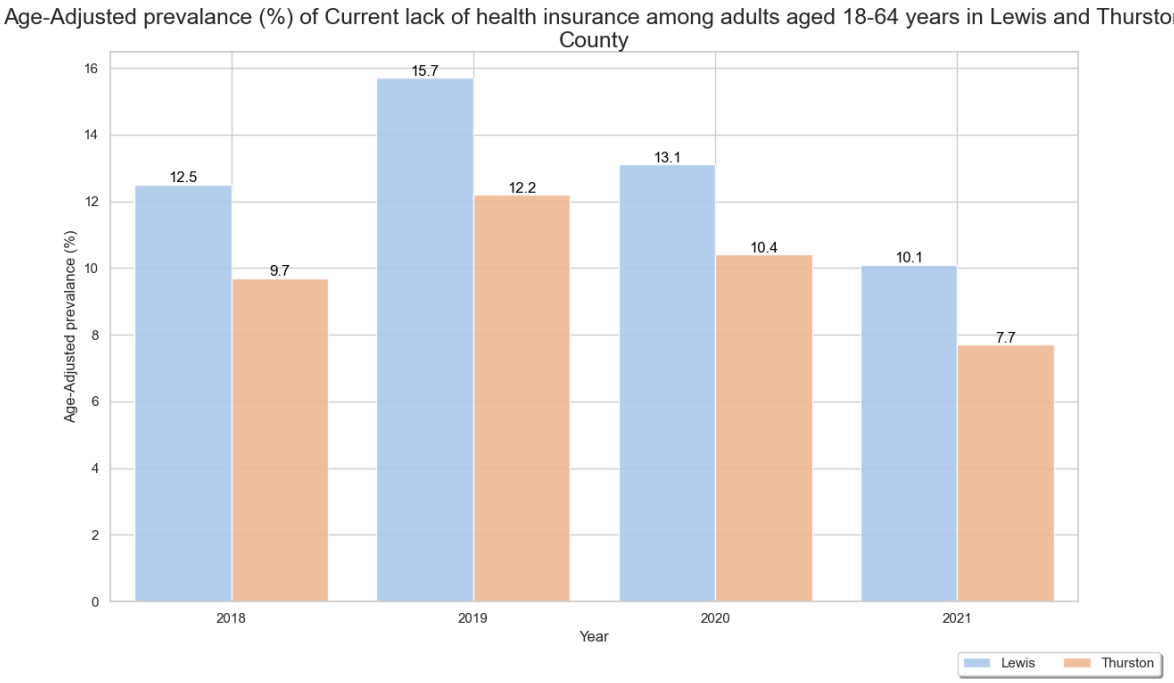
Access to Health Care

UNINSURED

In Washington State, approximately 7% of adults ages 18-64 years do not have some form of health insurance coverage.

In this age group, 10% of residents in Lewis County and 8% in Thurston County lack comprehensive health insurance. Plans that provide insurance only for specific conditions or situations such as cancer and long-term care policies, or other types of insurance like dental, vision, life, and disability insurance, are not considered comprehensive coverage. Between 2018-2021, the percentage of this uninsured population has been consistently greater in Lewis County than in Thurston.

Figure 12. Uninsured Adults



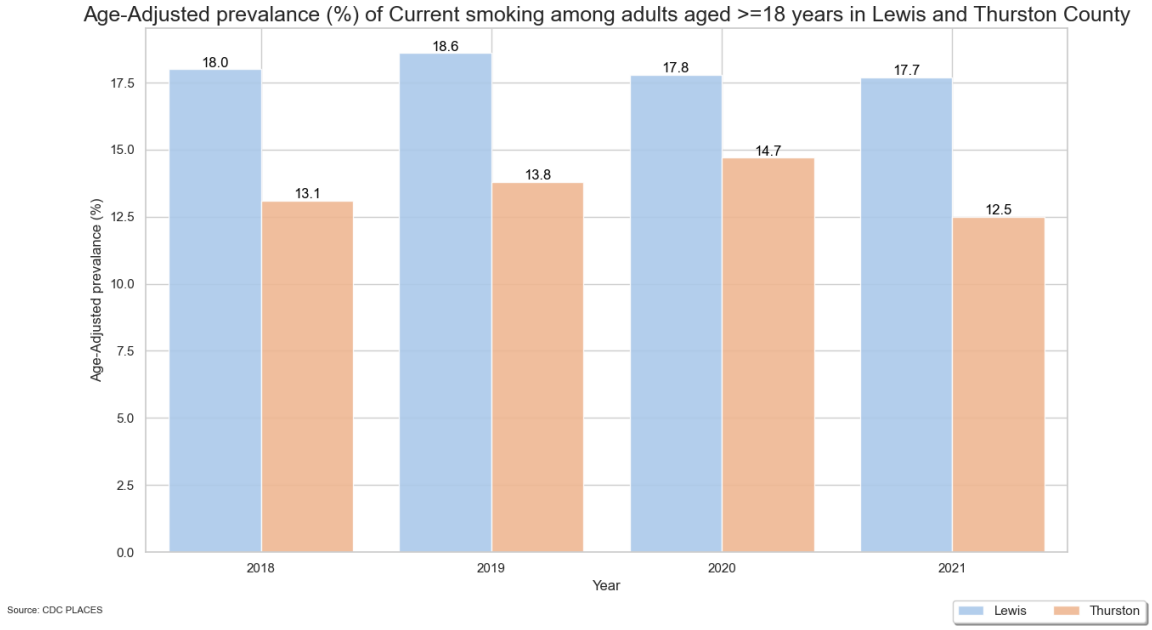
Source: Behavioral Risk Factor Surveillance System (from CDC PLACES for county estimates), 2021

Physical Health

SMOKING

The prevalence of adult cigarette smoking in the South Puget Sound Service Area is significantly higher than in Washington State as a whole. Approximately 11% of Washington adults 18 years of age and older report they have smoked 100 or more cigarettes in their lifetime *and* currently smoke every day or some days. Nearly 13% of adults in Thurston County meet this threshold, as do nearly 18% in Lewis County. Over time, Lewis County's smoking prevalence has been consistently higher than Thurston's by approximately 3-5% annually.

Figure 13. Adult Smoking

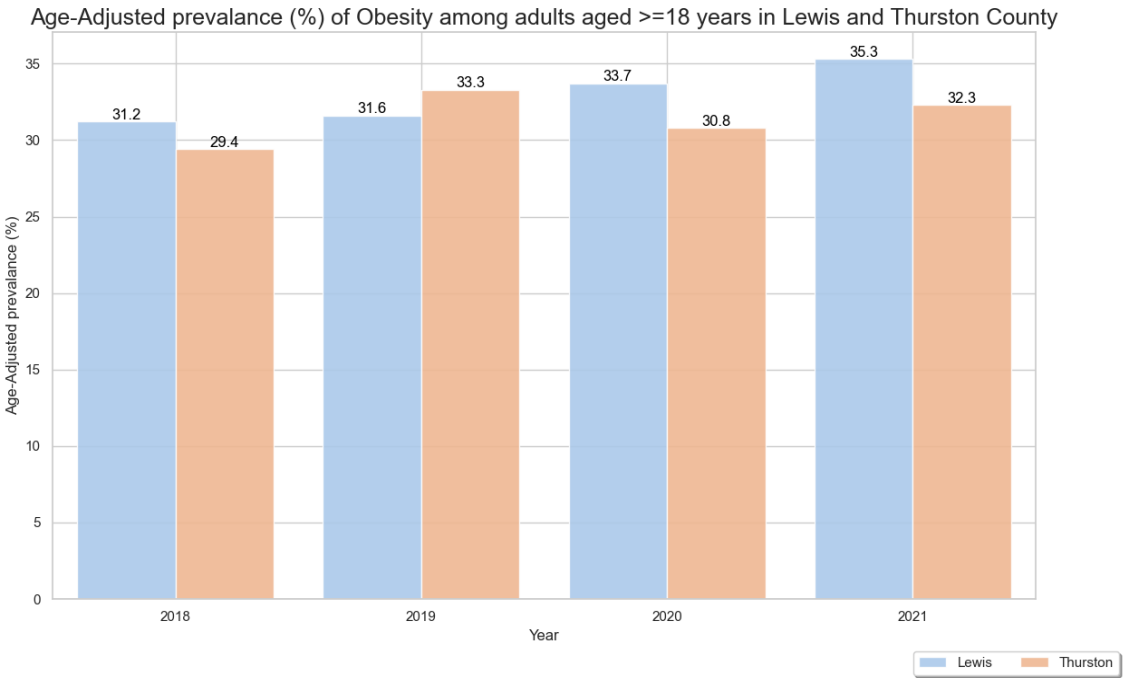


Source: Behavioral Risk Factor Surveillance System (from CDC PLACES for county estimates), 2021

OVERWEIGHT AND OBESITY

Overweight and obesity are risk factors for many serious diseases and health conditions, including diabetes, coronary heart disease, high blood pressure, stroke, and mortality. In the South Puget Sound Service Area, adult overweight and obesity are more prevalent than statewide: 29% in Washington State, 32% in Thurston County, and 35% in Lewis County in 2021.

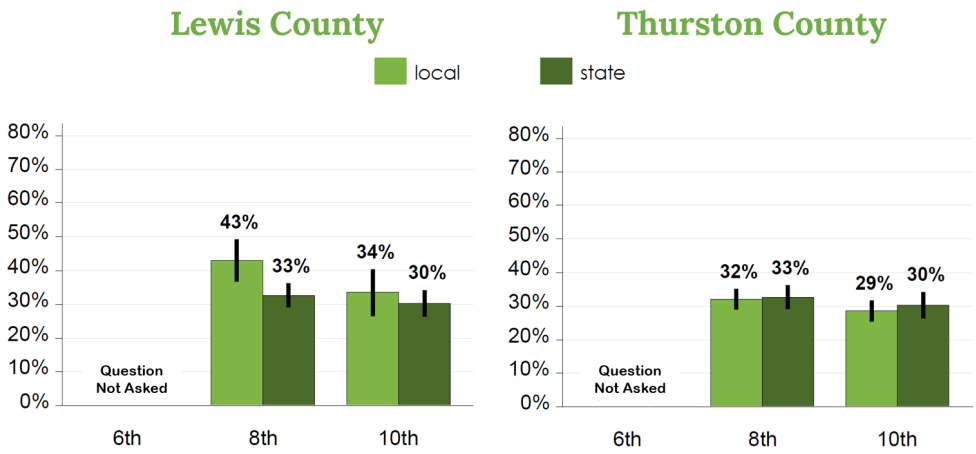
Figure 14. Obesity in Adults



Source: Behavioral Risk Factor Surveillance System (From CDC PLACES for county estimates), 2021

In middle and high school students, the data includes both overweight and obesity. In Lewis County, 43% of 8th graders and 34% of 10th graders are overweight or obese, a significantly higher percentage than in Thurston County or the state as a whole.

Figure 15. Overweight and Obesity in Youth



Source: Washington State Healthy Youth Survey, 2021

ANNUAL CHECKUP

In both Lewis and Thurston Counties, fewer adults visit a health care provider for an annual checkup than residents of the United States overall. Of adults aged 18 and over, only 65% of residents in Lewis County and 66% in Thurston County report having been to a doctor for a routine checkup or general physical exam in the previous year, compared to 65% in Washington State and 72% nationwide. *(Source: CDC PLACES [BRFSS for state estimates], 2021)*

Similarly, 8th grade students in both Lewis and Thurston Counties saw a health care provider for a wellness visit less frequently than their counterparts statewide. In Washington State, 68% of 8th graders reported, in the last year, they saw a doctor or health care provider for a check-up or physical exam when they were not sick or injured. This figure was 66% in Lewis County and 63% in Thurston.

Figure 16: Adult Annual Checkups

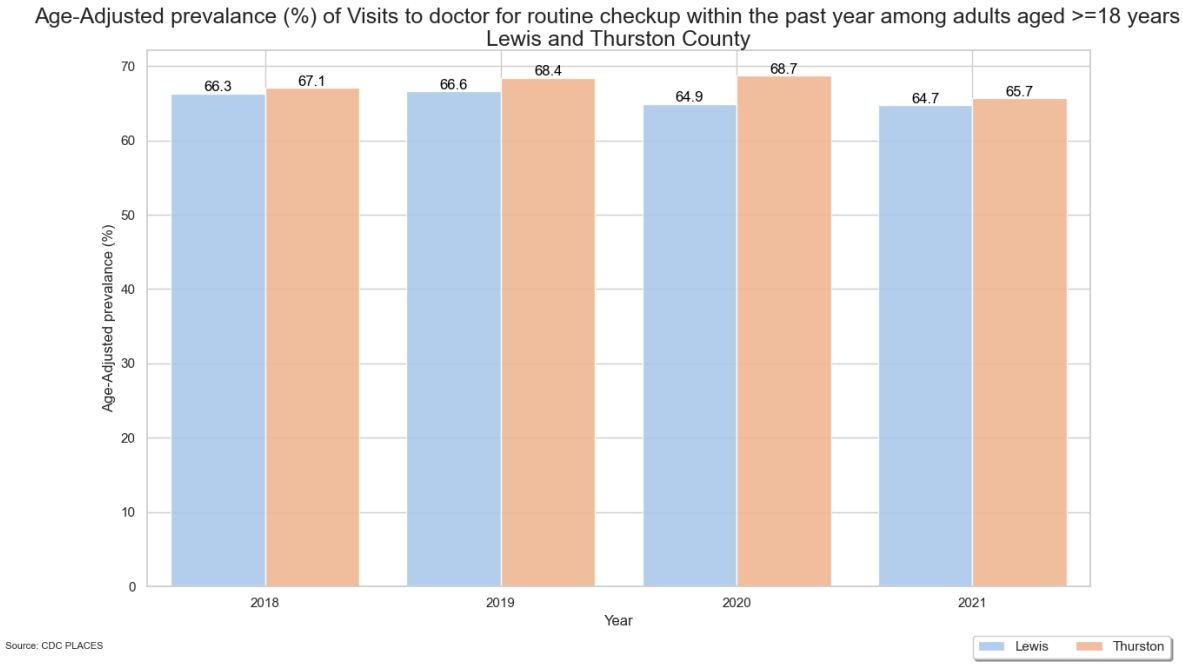
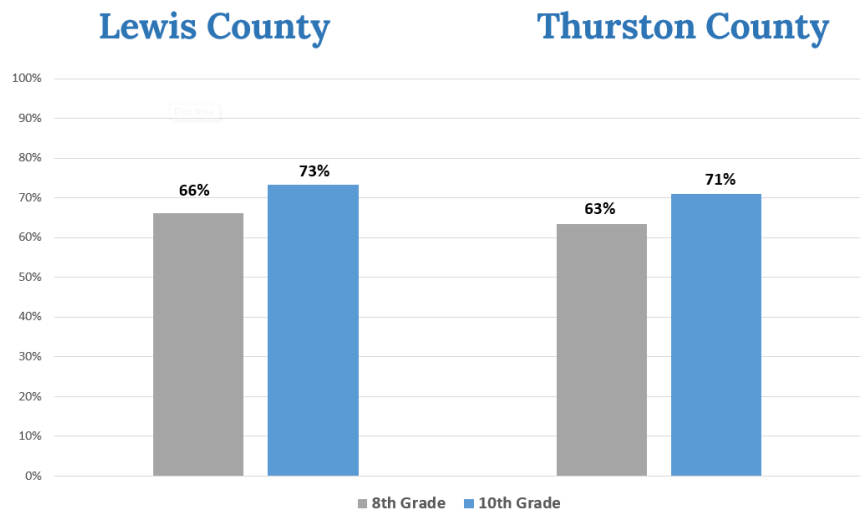


Figure 17: Youth Annual Checkups



Source: Washington State Healthy Youth Survey, 2021

See Appendix 1 for additional Population Health Data

Hospital Utilization Data

In addition to public health surveillance data, our hospitals can provide timely information regarding access to care and disease burden across the service area. Avoidable Emergency Department (AED) use is reported as a percentage of all Emergency Department visits over a given period, which are identified based on an algorithm developed by Providence's Population Health Care Management team based on NYU and Medi-Cal definitions. AED use serves as a proxy for inadequate access to or engagement in primary care. We review and stratify utilization data by a several factors including self-reported race and ethnicity, patient origin ZIP Code, age, and sex. This detail helps us identify disparities to better improve our outreach and partnerships.

In 2022, our data showed the following key insights:

- In 2022, 27.9% of emergency visits made to Providence Centralia Hospital and Providence St. Peter Hospital were potentially avoidable (29.6% and 26.9%, respectively).
- Of the total patients that visited the emergency department at Providence Centralia Hospital and identified as American Indian or Alaska Native, 33.5% of those cases were potentially avoidable. Avoidable visits by American Indian or Alaska Native patients made up2.1% of total avoidable visits for the medical center.
- American Indian or Alaska Native and Black and African American, patients had the highest percentages of ED visits identified as potentially avoidable at both Providence Centralia Hospital and Providence St Peter Hospital.

- At Providence Centralia Hospital, patients that identified as not Hispanic or Latino had a higher percentage of visits identified as avoidable (29.9%) compared to patients that identified as Hispanic or Latino (26.9%).

At Providence Centralia Hospital and Providence St. Peter Hospital, patients ages 18-39 years (31.0% and 28.1%, respectively) and patients ages 40-64 years (31.0% and 28.7%, respectively) had the highest percentage of visits identified as avoidable compared to other age groups. For additional information regarding these findings, please contact Liz Selsor, Community Health Investment Manager, at liz.selsor@providence.org.

COMMUNITY INPUT

Summary of Community Input

To better understand the unique perspectives, opinions, experiences, and knowledge of community members, representatives from Providence Centralia and St. Peter Hospitals, in partnership with the Thurston County Public Health and Social Services Department, conducted 39 key informant interviews with 45 individuals representing 41 community-based organizations, between September 2022 and August 2023. During these interviews, community members and nonprofit and government key informants 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 methodology and participants are available **Appendix 2.**

Key informants are defined as people with knowledge of community needs and strengths because of their experience as community leaders, professionals, and/or residents of Lewis and Thurston Counties. Key informants have a wide range of knowledge related to community health and well-being and work within organizations or agencies serving county residents, including diverse communities, people with low incomes, and people experiencing barriers to care.

LEWIS COUNTY COMMUNITY INPUT

COMMUNITY STRENGTHS – LEWIS COUNTY

The interviewer asked key informants to share one of the strengths they see in the community and discuss how we can leverage these strengths to address needs. This is an important question because all communities have strengths. The following strengths emerged as themes:

- Many organizations are motivated to serve the community and work with one another to address complex needs.
- A strong sense of community, pride, cohesion, and caring for and relying on one another.
- Resiliency to change and challenges.

COMMUNITY NEEDS – LEWIS COUNTY

Prioritized Unmet Health-Related Needs

Access to behavioral health care (including substance	Key informants identified “access to behavioral health care” as the most pressing need in Lewis County, along with “mental health and suicide prevention” and “substance use/misuse and overdose prevention” as needs that were ranked fourth and fifth, respectively. **Mental health and suicide prevention** is a pressing need because of increased stress and isolation from the COVID-19 pandemic and because

use/misuse, overdose prevention, mental health, and suicide prevention)	many people have unaddressed mental health needs. To address **substance use/misuse and overdose prevention**, key informants stressed the importance of harm reduction programs and peer models. This is especially important because of the increasing rates of overdoses locally. **Access to behavioral health care** in Lewis County is especially difficult due to a lack of system capacity and providers to meet the demand. Provider burnout and turnover makes establishing care and building trust difficult. Due to a lack of psychiatrists, primary care providers (PCPs) may need to manage patients' behavioral health needs. A lack of providers means patients experience long wait times for care. Transportation is also a barrier for patients. The following services are needed to improve access to behavioral health care: inpatient substance use disorder (SUD) treatment services; detox centers; crisis response and stabilization beyond the Emergency Department (ED); community-based mental health care that is a step-down from hospitalization; and reunification support services for people in recovery. Young people were of particular concern to key informants due to a lack of providers to serve them, increasing behavioral health challenges, exposure to negative information on social media, increased smoking and vaping, and a lack of hope and belonging. Older adults, people experiencing homelessness, the Latino/a/x[3] community, and veterans may experience additional behavioral health needs and barriers to care.
Affordable housing and homelessness	Housing is a major issue in Lewis County, with a lack of safe and healthy housing available for families and employees. The cost of housing is the primary barrier for people, with a need for more affordable housing for people with low incomes, as wages have not kept pace with housing costs. There is also a need for more supportive and transitional housing, particularly for people needing support services to remain stably housed. Key informants spoke of a need for more homeless services and shelter beds. Shelter space is very limited, although organizations are working on developing a night-by-night shelter program in 2023. It is important for the community to ensure there are wraparound support services for stabilization and health and hygiene services for people living unsheltered. The complexity of the housing system can be difficult for people to navigate and can be a barrier for people finding stable housing. Older adults may be experiencing housing instability or even homelessness for the first time due to economic insecurity. Addressing behavioral health needs is also essential for addressing homelessness.
Access to health care	Key informants spoke about a lack of primary and specialty care. They emphasized it can be especially difficult to establish primary care, with people waiting up to six months to get a new PCP. The closure of some primary care clinics has forced patients to find a new PCP, straining the system. A lack of PCPs contributes to people using the ED as their main form of health care and to a prevalence of unmanaged chronic conditions. These patients, along with those having a behavioral health crisis, put stress on the ED and overwhelm capacity, signaling a need for

[3] Key informants used the terms Latino, Latina, Latinx, and Hispanic to refer to the people their organizations serve. To remain consistent and inclusive, we will use the term Latino/a/x throughout the report, acknowledging that individuals may have strong preferences as to how they self-identify.

	more access to primary care, urgent care, and behavioral health crisis services. Accessing specialist care is also difficult, with many people traveling outside of Lewis County to Olympia, Tacoma, or Vancouver to access specialists. More health care providers, home care aids and caregivers, hospital capacity, care coordination, and cancer screening are needed in the community. Transportation was highlighted as a primary barrier to care, both in traveling within Lewis County and to other areas for specialty care. A lack of health care literacy, trust in the medical system, access to technology and broadband, and comfort with technology may also be barriers. Older adults may have more difficulty accessing care due to transportation barriers and a lack of availability of in-home caregiving. People in east Lewis County have access to fewer health care resources. A lack of bilingual and bicultural health care providers and staff make accessing care and navigating services more difficult for the Latino/a/x community. Accessing local care that is responsive to and affirming for LGBTQIA+ health needs is difficult. There are few resources for people who do not have insurance or are not Medicaid-eligible.
Economic security and income inequality	Economic security is important for people's health and well-being; it helps them be happier and contribute to the community. Key informants were particularly concerned about the low wages people are paid, high unemployment, and high cost of living in Lewis County, contributing to economic insecurity for many families. They spoke of the need for more educational opportunities and job skills and technical training to address people's financial stability. There are inequities in how resources and educational opportunities are distributed in the community. Bachelor's degree attainment is lower in Lewis County than in the state overall, and a lack of hope and conversations about the future may contribute to fewer young people pursuing higher education. The economy in Lewis County has been transitioning away from agricultural industries, contributing to a lack of well-paying job opportunities and young people leaving the community. Key informants shared that public benefits only help people up to a certain income level and then quickly stop (otherwise known as the benefits cliff). This system incentivizes people to pass up promotions or pay raises, keeping them in fear and preventing opportunities for growth. Economic insecurity may disproportionately affect people living in rural areas, including east Lewis County, Latino/a/x families, older adults, and women.
Food security and nutrition	Key informants emphasized that access to nutritious, affordable food is a major issue for many families and individuals living in Lewis County. The need has recently increased with the cuts to Supplemental Nutrition Assistance Program (SNAP) benefits, leading more people to seek other food resources. Families with low incomes may be especially affected by food insecurity, particularly with the rising cost of housing. Accessing nutritious, affordable food, as well as food resources, is more difficult in rural parts of the county, including east Lewis County. People may have to travel long distances to the nearest food bank and may experience transportation barriers, particularly with the increased cost of gas. A lack of healthy and nutritious food contributes to long-term health challenges, like obesity and

	diabetes. Key informants suggested more education regarding nutrition and healthy cooking.
Aging adult health and fall prevention	Lewis County has a large population of older adults and needs more resources to support aging adult health and prevent falls. The high number of falls in Lewis County is a serious concern because they can lead to hospitalization and death. Falls are especially a concern for older adults living alone without people checking on them. Key informants spoke of needing more in-home health care and caregiving for older adults. This care should also include support for older adults after discharge from the hospital to ensure that they have help with follow-up appointments, filling prescriptions, and making home modifications (such as installing grab bars) to prevent future falls. Accessing care in Lewis County can be particularly difficult for older adults because of a lack of specialists locally, a lack of providers accepting Medicare, and transportation barriers.

THURSTON COUNTY COMMUNITY INPUT

COMMUNITY STRENGTHS – THURSTON COUNTY

The interviewer asked key informants to share one of the strengths they see in the community and discuss how we can leverage these strengths to address needs. This is an important question because all communities have strengths. The following strengths emerged as themes:

- Organizations want to collaborate and work together to meet needs more effectively.
- Community members are engaged and have unique knowledge and wisdom to share to make the community healthier.
- Community members are resilient and hopeful, working towards improving their lives and the lives of their families.

COMMUNITY NEEDS – THURSTON COUNTY

Prioritized Unmet Health-Related Needs

Access to behavioral health care (including substance use/misuse, overdose prevention,	Key informants identified “access to behavioral health care” as the most pressing need in Thurston County. They also identified “substance use/misuse and overdose prevention” and “mental health and suicide prevention” as needs that were ranked third and fifth, respectively, and spoke of these three needs as interconnected and inseparable. Therefore, they are discussed together in this report. Regarding **substance use/misuse and overdose prevention,** key informants were particularly concerned about an increase in fentanyl and resulting deaths by overdose, as well as the broader community impacts of overdose and overdose deaths. They spoke

mental health, and suicide prevention)	highly of harm reduction programs, including trainings for administering naloxone, although they think there is a need for additional low-barrier supportive services for people with a substance use disorder (SUD). **Mental health and suicide prevention** is a pressing concern because key informants are seeing more suicidal ideation and mental health challenges coming out of the COVID-19 pandemic. They also noted that providing follow-up care is needed for people after being discharged from inpatient care for a mental health condition, including medication management. More mental health services for young people are specifically needed. There are a variety of factors that are seriously affecting **access to behavioral health care** in Thurston County. In general, there is a lack of capacity to meet the growing need, leading to long wait times for both mental health and substance use/misuse treatment services. There is a need for residential or inpatient care facilities, crisis response and stabilization, and treatment services for folks with dual diagnoses needing high levels of care. A lack of funding, community coordination, staffing (particularly trauma-informed and culturally informed staffing), and alignment between physical and behavioral health care contribute to these gaps in services. The following barriers prevent people from accessing needed behavioral health care: a lack of providers that are bilingual and bicultural, cost of care, transportation, and hours of services. Specific populations may experience unique or additional barriers to accessing services including young people, people experiencing homelessness, people identifying as lesbian, gay, bisexual, transgender, queer, questioning, intersex, asexual, or other identities not encompassed (LGBTQIA+), Black, Brown, Indigenous, and People of Color (BBIPOC) communities, people living in more rural areas of Thurston County, and military families.
Affordable housing and homelessness	Key informants identified affordable housing and homelessness as one of the most pressing needs because without housing, other needs cannot be met. The need for safe, affordable housing is only growing in Thurston County with the cost of living increasing. Particularly in some areas of the county, people live in unhealthy housing, where there is mold and other hazards. There may be a specific lack of low-income housing in south Thurston County. Key informants spoke of the interconnectedness of housing and health, as well as the need for more low-barrier housing across the spectrum to support people experiencing homelessness and housing instability, including permanent supportive housing and emergency, short-term, and long-term shelters. To support people living unsheltered, there is a need to provide more homelessness services including a sanctioned encampment, hygiene services, and street-based medicine. Specific populations experiencing housing-related challenges include older adults, BBIPOC communities, particularly Latino/a/x[4] community members and Indigenous peoples, LGBTQIA+ community members (especially LGBTQIA+ youth), unaccompanied minors, and people with behavioral health conditions.

[4] Key informants used the terms Latino, Latina, Latinx, and Hispanic to refer to the people their organizations serve. To remain consistent and inclusive, we will use the term Latino/a/x throughout the report, acknowledging that individuals may have strong preferences as to how they self-identify.

Diversity, inclusion, and belonging	Diversity, inclusion, and belonging is closely connected to racism and discrimination and is a driver of most other needs, including economic insecurity and income inequality. Key informants identified that BBIPOC communities experience barriers to accessing programs and services, contributing to more economic insecurity and housing instability. They also mentioned that without inclusion and belonging, there are more mental health challenges and isolation, which can have negative health outcomes. Ensuring students have a sense of belonging in their school community is important for them to be able to learn. When people feel included in the community, they are more likely to be engaged and involved. Key informants also identified a need for feeling safe and building trust, especially with people in positions of authority, and the need for mentors, advocates, etc. Key informants identified specific populations that are not always made to feel like they belong: LGBTQIA+ community members, mixed-status families (families whose members have differing immigration statuses), people whose first language is not English, and people experiencing homelessness.
Access to health care	Key informants shared that there is a lack of capacity to meet everyone's health care needs in Thurston County, particularly for people who are uninsured and underinsured. They mentioned that people with resources, transportation, and high-quality insurance are able to access the care they need, but inequities exist in the community. Locally, there can be fairly long wait lists for specialists, with people traveling to other areas for quicker access. Primary care can also have long wait lists, with people waiting two or three months to get a health care appointment. Key informants also spoke of hospitals being very busy and shared that more partnerships and an additional hospital in south Thurston County would be beneficial, as well as recruitment for additional health care providers and medical staff to prevent provider burnout. Specific barriers to accessing timely and appropriate care include the following: transportation, hours of appointments during work time, lack of broadband access and comfort with technology, stigma and discrimination and a lack of providers that are bilingual and bicultural. Specific populations may experience barriers and other barriers to accessing responsive care, including people experiencing homelessness, BBIPOC community members, LGBTQIA+ community members, mixed-status families, and people with behavioral health conditions.
Economic security and income inequality	Key informants shared concern for people with low incomes being able to afford their basic needs, such as food, health care, car seats, baby formula, etc., particularly with the rising cost of living. One event or accident could be financially catastrophic for a family. Key informants were most concerned about people with incomes slightly above the threshold for qualifying for public benefits, but without enough money to afford those basic needs without assistance. This is called the "benefits cliff," which means public benefits drop off sharply with a small increase in income. Key informants spoke about the importance of investing in low-barrier educational and employment opportunities and job skills and technical training.

	They were particularly concerned about BBIPOC students and those with low incomes because they can have less access to quality education. Addressing racism, including the school-to-prison pipeline, and ensuring a sense of belonging for students is important. There are limited employment opportunities paying a living wage for people in Thurston County without higher education. Job skills and technical training could help people increase their economic security. Groups that may experience more economic insecurity include BBIPOC community members and people with behavioral health conditions.
Racism and discrimination	Key informants discussed how racism and discrimination contribute to most needs and are closely connected to diversity, inclusion, and belonging, which are foundational to all other needs. Racism contributes to BBIPOC communities having differences in maternal and child mortality, increased risk for climate change impacts, and fewer educational and economic opportunities, which leads to more economic insecurity. The school-to-prison pipeline pushes BBIPOC children out of education settings and into the criminal legal system. LGBTQIA+ community members experience discrimination and a potential lack of safety when seeking health care services and even out in certain areas of the community. Providers may not be respectful of transgender patients or provide affirming care. People with behavioral health conditions and people experiencing homelessness, especially those actively using substances, may not be treated with the same care and respect as other patients. Key informants identified BBIPOC community members, LGBTQIA+ community members, people with behavioral health conditions, and people experiencing homelessness as experiencing racism and discrimination in Thurston County. Many key informants would like to see more leveraging of relationships to work on addressing racism and discrimination in the community, rather than just talking about its importance.
Community engagement and involvement	Key informants shared that in order to have engagement and involvement from community members, people need to have a sense of belonging and inclusion. A strength of the community is that many people already are engaged and have knowledge to share related to community wellbeing. Leveraging this strength could help build connections with school communities, individual community members, health care providers, and community groups. Organizations can more meaningfully engage community voice by creating space for people with lived experience and from diverse communities. Opportunities for engagement include sitting on advisory boards and making decisions about funding. Organizations can also ask people how they want to receive services and engage with grassroots organizations that have trusted relationships already established.

SIGNIFICANT HEALTH NEEDS

Review of Primary and Secondary Data

After a careful review of the qualitative and quantitative data, we developed a preliminary list of identified community health needs. These needs were identified by interview participants through a weighted ranking process and through discussion and theming of the data. Additionally, needs were identified after review of the quantitative data.

Identification and Prioritization of Significant Health Needs

The CHNA Advisory Council reviewed a summary of all quantitative data collected from key informant interviews, as well as relevant quantitative data for each of the following community health-related need areas:

- Physical Health
- Access to Health Care
- Basic Needs / Economic Security
- Behavioral Health

After this in-depth data review, the Council prioritized the need areas based on the following criteria:

- **Size and Scope**: What is the significance of the health issue in terms of the number/percent of people affected?
- **Severity:** How serious are the negative impacts of this issue on individuals, families, and the community?
- **Ability to Impact:** What is the probability that the community could succeed in addressing this health issue? (They took into consideration factors such as community resources, whether there are known interventions, and community commitment to addressing the need.)

2023 South Puget Sound Priority Needs

The list below summarizes the significant health needs identified through the 2023 Community Health Needs Assessment process, listed in order of priority:

PRIORITY 1: BEHAVIORAL HEALTH

Behavioral Health, encompassing both mental health and substance use/misuse is the most pressing need in our communities. Access to behavioral health care, mental health and suicide prevention, and substance use/misuse and overdose prevention were all identified as areas of concern. Many residents have experienced significant stress and isolation from the COVID-19 pandemic, resulting in more suicidal

ideation and unaddressed mental health challenges. Of particular concern is an increase in fentanyl use and resulting overdoses, as well as the broader community impacts of overdose and overdose deaths.

Access to behavioral health care especially difficult due to a lack of system capacity and providers to meet the demand, leading to long wait times for both mental health and substance use/misuse treatment services. Services needed to improve access to behavioral health care include residential or inpatient substance use disorder (SUD) treatment services; detox centers; crisis response and stabilization beyond the Emergency Department (ED); community-based mental health care that is a step-down from hospitalization; and follow-up care for people after being discharged from inpatient care for a mental health condition, including medication management. Specific populations may experience unique or additional barriers to accessing services including young people, people experiencing homelessness, people identifying as lesbian, gay, bisexual, transgender, queer, questioning, intersex, asexual, or other identities not encompassed (LGBTQIA+), Black, Brown, Indigenous, and People of Color (BBIPOC) communities, people living in more rural areas, and military families.

PRIORITY 2: BASIC NEEDS / ECONOMIC SECURITY

Economic security is important for people's health and well-being. Low wages, high unemployment, and a high cost of living contribute to economic insecurity for many families. There are inequities in how resources and educational opportunities are distributed in the community. People with low incomes may be unable to afford their basic needs, such as food, health care, car seats, baby formula, etc., particularly with the rising cost of living. One event or accident could be financially catastrophic for a family. Individuals and families with incomes slightly above the threshold for qualifying for public benefits, but without enough money to afford those basic needs without assistance, are especially vulnerable. This is called the "benefits cliff," which means public benefits drop off sharply with a small increase in income.

There are limited employment opportunities a living for people to make a living wage without higher education. Investing in low-barrier educational and employment opportunities and in job skills and technical training could help people increase their economic security. Economic insecurity may disproportionately affect people living in rural areas, as well as BBIPOC community members, people with behavioral health conditions, older adults, and women.

Access to nutritious, affordable food, as well as food resources is a major issue for many families and individuals, especially in rural areas. A lack of healthy and nutritious food contributes to long-term health challenges, like obesity and diabetes. The need has recently increased with cuts to Supplemental Nutrition Assistance Program (SNAP) benefits, leading more people to seek other food resources. Families with low incomes may be especially affected by food insecurity, particularly with the rising cost of housing. People may have to travel long distances to the nearest food bank and may experience transportation barriers, particularly with the increased cost of fuel.

The interconnectedness of housing and health is key, and housing was identified as a major need, with a lack of safe and healthy housing available for families and employees. The cost of housing is the primary barrier for people, with a need for more affordable housing for people with low incomes, as wages have not kept pace with housing costs. There is also a need for more supportive and transitional housing, particularly for people experiencing homelessness or housing stability, and as well those needing support services to remain stably housed. More permanent supportive housing and emergency, short-term, and long-term shelters. The complexity of the housing system can be difficult for people to navigate and can be a barrier for people finding stable housing. Specific populations experiencing housing-related challenges include older adults, BBIPOC communities, particularly Latino/a/x[5] community members and Indigenous peoples, LGBTQIA+ community members (especially LGBTQIA+ youth), unaccompanied minors, and people with behavioral health conditions.

PRIORITY 3: ACCESS TO HEALTH CARE

Access to both primary and specialty care was identified as a top health concern. A lack of Primary Care Providers (PCPs) has strained the health care system, contributing to people using the Emergency Department (ED) as their main form of health care, and to a prevalence of unmanaged chronic conditions. Patients who have difficulty finding primary care, along those having a behavioral health crisis, put stress on the ED and overwhelm capacity. There is a need for more access to primary care, urgent care, and behavioral health crisis services, as well as a need for increased access to specialty care, as many patients travel outside of their local area to receive services. More health care providers, home care aids and caregivers, hospital capacity, care coordination, and cancer screening are needed in the community. Transportation is a significant barrier to care, as are hours of appointments during work time, a lack of health care literacy, trust in the medical system, and access to or comfort with technology. Specific populations may experience additional barriers to accessing responsive and affirming care, including people experiencing homelessness, BBIPOC community members, LGBTQIA+ community members, mixed-status families, and people with behavioral health conditions. Stigma and discrimination and a lack of providers that are bilingual and bicultural contribute to these challenges. There are few resources for people who are uninsured, underinsured, or not Medicaid-eligible.

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. Organized health care delivery systems in Lewis County include Providence Centralia Hospital, Arbor Health, and Lewis County Public Health and Social Services; and in Thurston County, Providence St. Peter Hospital, MultiCare Capital Medical Center, and the Thurston County Public Health and Social Services Department.

In addition, numerous social-service non-profit agencies, faith-based organizations, private and public-school systems, government agencies, and health care providers contribute resources to address these identified needs. For a comprehensive list of potentially available resources available, see **Appendix 3**.

[5] Key informants used the terms Latino, Latina, Latinx, and Hispanic to refer to the people their organizations serve. To remain consistent and inclusive, we will use the term Latino/a/x throughout the report, acknowledging that individuals may have strong preferences as to how they self-identify.

EVALUATION OF 2021-2023 CHIP

The 2020 CHNA and 2021-2023 CHIP priorities were the following: Affordable Housing and Homelessness, Behavioral Health, and Access to Health Care. This report evaluates the impact of the 2021-2023 Community Health Improvement Plan (CHIP). Providence St. Peter and Centralia Hospitals 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. The 2021-2023 CHIP priorities were the following:

- Homelessness/ Lack of Safe Affordable Housing
- Behavioral Health (Includes Mental Health and Substance Use)
- Access to Health Care

Programs and Outcomes

Table 5. Outcomes from 2021-2023 CHIP

Priority Needs	Program or Service Name	Program or Service Description	Results/Outcomes
▪ Homelessness/ Lack of Safe and Affordable Housing ▪ Access to Health Care	Medical Respite	Since 2021, funding has been sustained for four medical respite beds in Interfaith Works' REST program (Restorative Experience for a Safer Transition). Most recently, as part of the Catholic Healthcare Collaboration, Providence St. Peter and Catholic Community Services of Southwest Washington have partnered to open two more respite beds at Drexel House, using the same model.	This has been a success in providing 30-45 days in a safe, healing environment for unhoused individuals needing medical respite post hospital discharge. Case managers at Interfaith and Catholic Community Services work with these individuals during their stay to assist with follow-up care, provide referrals to social service agencies, and help obtain housing for those who are interested.
▪ Homelessness/ Lack of Safe and Affordable Housing ▪ Behavioral Health ▪ Access to Health Care	Mobile Health Clinic and Outreach Program	This program provides comprehensive preventative healthcare to clients experiencing homelessness around Thurston County. Services include basic health care, wound care, prescribing necessary medications, and mental health counseling.	Providence St. Peter Hospital launched an outreach model called Street Medicine, where the Providence team meets clients where they are, removing the obstacle of finding transportation. This approach is effective at reaching the community's most vulnerable residents.

		The Providence St. Peter Street Medicine Team is comprised of one ARNP Program Manager; five providers, including one ARNP/prescriber focused on physical health, two Mental Health Counselors, and two Patient Navigators; Nursing program students; Leaders and residents from the St. Peter Family Medicine Residency program; and Select volunteers who are Providence Swedish Caregivers.	They provide direct, comprehensive care and help make connections to other social service agencies. They also partner with Thurston County to jointly operate a Homeless Outreach Stabilization Team with established connections in local encampments and tiny-home communities. Additionally, the team travels to other locations to provide care, including shelters, places that provide free meal services, and the county justice center. The mobile clinic and outreach program was implemented in August 2022. As of October 2023, the project has been able to serve a total of 484 unique individuals and 1,507 visits. 511 were single visits and 996 were repeat visits.
▪ Behavioral Health ▪ Access to Health Care	Abuse Intervention Center	The Abuse Intervention Center is part of Providence St. Peter Hospital and Providence Behavioral Health Services, serving residents of Thurston, Lewis, Mason, Grays Harbor and Pacific counties, and collaborating with Indian Child Welfare and Tribal communities. Physicians, nurse practitioners and nurses provide special medical evaluations for children, adolescents, and adults.	Founded in 1991, the Abuse Intervention Center (formerly the Sexual Assault Clinic and Child Maltreatment Center) is a nationally accredited Child Advocacy Center and a national care model for providing medical services to children and adults who are victims of sexual or physical abuse. It is the only facility of its kind in a five-county region. Social workers provide crisis counseling for the victims and families of sexual assault, physical abuse, or chronic neglect. Sexual assault nurse examiners are on call 24 hours a day to provide comfort and care, and to collect forensic evidence in the emergency departments at Providence St. Peter and Centralia hospitals, and Madigan Army Medical Center. Clinic physicians and advanced practice nurses often serve as expert

			witnesses when these sexual abuse cases go to criminal trials. Each year, the Center receives more than 600 referrals to provide much-needed, compassionate care to patients who have experienced trauma and their families.
▪ Access to Health Care	Special Care Nursery	Located within the Providence St. Peter Hospital Family Birth Center is a 13-bed, Level II Special Care Nursery for Advanced Neonatal Care. This designation indicates a high level of specialized care for high-risk newborns such as pre-term infants and those with serious medical conditions. The Nursery cares for babies born prematurely at a gestational age of 32 weeks and above, as well as newborns with respiratory distress, jaundice, neonatal abstinence syndrome, neonatal opiate withdrawal syndrome or other more complex conditions.	The Special Care Nursery is highly successful at providing essential care to infants and families with special needs. The team consists of dedicated caregivers, hospitalists from Seattle Children's Hospital, a pediatrician that is in-house 24/7 attending to all deliveries, and a respiratory therapy team that attends to all high-risk deliveries and assists babies who require any sort of respiratory support. The Nursery collaborates with Seattle Children's tele-Neonatology program to evaluate and treat babies that may need more advanced care, keeping them closer to home whenever possible. The next nearest Level II nurseries are in Tacoma, WA to the north and Vancouver, WA to the south, so St. Peter dedicated caregivers serve babies requiring a higher level of care from several counties in the region, preventing babies and parents from needing to drive up to two hours away in order to receive critical services.
▪ Access to Health Care	Medication Assistance Program	As part of the Providence Regional Cancer System, program managers at both St. Peter and Centralia hospitals work with pharmaceutical companies to remove barriers to care and secure free medications for patients in need.	In 2021 alone, the team worked with more than 1,000 patients, providing free drugs and co-pay assistance totaling more than $3.5 million.

▪ Homelessness/ Lack of Safe and Affordable Housing	Built for Zero Thurston County Community Cohort	Thurston County's Built for Zero (BFZ) cohort is made up of a large group of community partners and providers who are working together to end homelessness. This community coalition is focused on single adults who are chronically experiencing homelessness and/or who are unhoused Veterans.	In 2021, Providence provided a large initial investment in this effort by funding multi-year professional technical assistance for Thurston County from Community Solutions, the organization that designed the Built for Zero model. In 2022, Providence Swedish South Puget Sound partnered with Thurston County Public Health and Social Services and the Family Support Center of South Sound (FSCSS) to write a successful grant to fund a full-time Built for Zero Coordinator in Thurston County. Additionally, since 2021 Providence Swedish South Puget Sound has provided continuing financial support for leaders from the Thurston County BFZ cohort to attend an annual national learning session/conference to enhance their knowledge and expertise. The cohort has achieved great strides in implementing and continuously improving data systems and processes; setting and meeting collaborative goals; and creating a quality By Name List (BNL) of individuals experiencing homelessness in Thurston County. They working to achieve Functional Zero by December 2025 for individuals who are experiencing chronic homelessness.

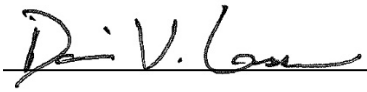
Addressing Identified Needs

The 2023-2025 Community Health Improvement Plan developed for the South Puget Sound service area will consider the prioritized health needs identified in this CHNA and develop strategies to address needs considering resources, community capacity, and core competencies. Those strategies will be documented in the CHIP, describing how Providence St. Peter and Centralia Hospitals plan 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. Peter and Centralia Hospitals intend 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. Peter Hospital, Providence Swedish Centralia Hospital, and community-based organizations in addressing each health need. The CHIP will be approved and made publicly available no later than May 15, 2024.

2023 CHNA GOVERNANCE APPROVAL

This Community Health Needs Assessment was adopted by the Community Mission Board[5] of the hospitals on October 26, 2023. The final report was made widely available by December 28, 2023.



11/10/2023

Darin Goss
Chief Executive, South Puget Sound
Providence Swedish

Date

11/10/2023

Steve Ward
Chair, South Puget Sound Community Mission Board
Providence Swedish

Date

11/18/2023

Kevin Brooks
Chief Executive, North Division
Providence

Date

Community Health Needs Assessment Contact:

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

APPENDICES

Appendix 1: Quantitative Data

POPULATION LEVEL DATA

Table_Apx 1.

Indicator	Providence Swedish South Puget Sound	Broader Service Area	High Need Service Area	Lewis County	Thurston County
Population by Age Groups					
Total Population	371,856	170,997	200,859	81,214	290,642
Population Age Under 5	5.7% (21,182)	5.6% (9,525)	5.8% (11,657)	5.8% (4,720)	5.7% (16,462)
Population Age Under 18	21.5% (80,096)	21.4% (36,537)	21.7% (43,559)	21.8% (17,665)	21.5% (62,431)
Population Ages 18 to 34	21.6% (80,361)	18.1% (31,022)	24.6% (49,339)	19.2% (15,609)	22.3% (64,752)
Population Ages 35 to 54	25.5% (94,756)	26.4% (45,202)	24.7% (49,554)	23.5% (19,113)	26.0% (75,643)
Population Ages 55 to 64	13.3% (49,504)	14.0% (23,908)	12.7% (25,596)	14.8% (12,024)	12.9% (37,480)
Population Ages 65 to 84	16.2% (60,282)	18.3% (31,355)	14.4% (28,927)	18.5% (15,013)	15.6% (45,269)
Population Age 85 and Over	1.8% (6,857)	1.7% (2,973)	1.9% (3,884)	2.2% (1,790)	1.7% (5,067)
Population by Gender					
Female	50.5% (187,762)	50.2% (85,789)	50.8% (101,973)	49.6% (40,257)	50.8% (147,505)
Male	49.5% (184,094)	49.8% (85,208)	49.2% (98,886)	50.4% (40,957)	49.2% (143,137)
Population by Race / Ethnicity					
American Indian and Alaska Native	1.0% (3,825)	0.8% (1,440)	1.2% (2,385)	0.8% (623)	1.1% (3,202)

Asian Population	4.8% (17,676)	4.5% (7,671)	5.0% (10,005)	1.2% (951)	5.8% (16,725)
Black or African American Population	2.4% (9,066)	1.8% (3,085)	3.0% (5,981)	0.7% (534)	2.9% (8,532)
Native Hawaiian and Other Pacific Islander Population	0.8% (2,882)	0.3% (541)	1.2% (2,341)	0.2% (149)	0.9% (2,733)
Other Race Population	2.1% (7,738)	1.6% (2,754)	2.5% (4,984)	2.4% (1,964)	2.0% (5,774)
Two or more Races Population	9.4% (34,992)	8.2% (14,026)	10.4% (20,966)	8.6% (6,982)	9.6% (28,010)
White Population	79.5% (295,677)	82.7% (141,480)	76.8% (154,197)	86.2% (70,011)	77.6% (225,666)
Hispanic Population	9.9% (36,716)	7.7% (13,103)	11.8% (23,613)	10.9% (8,881)	9.6% (27,835)

Source: American Community Survey, 2021, 5-Year Estimates

DATA ON IDENTIFIED HEALTH NEEDS

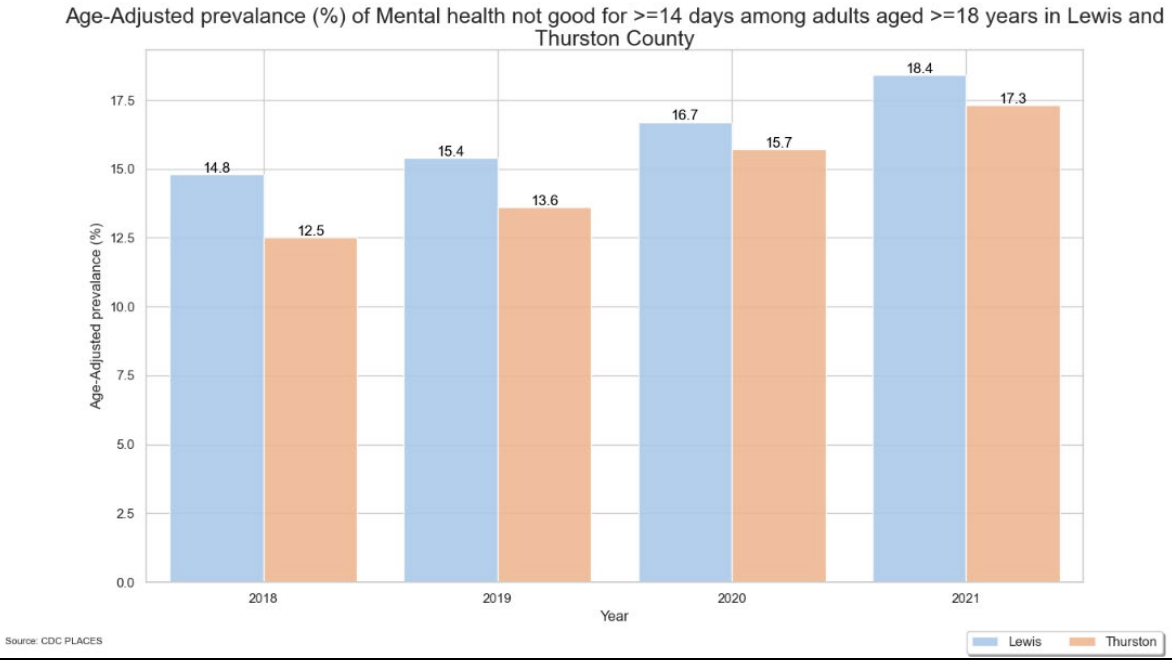
BEHAVIORAL HEALTH

Mental Health

Frequent Mental Health Distress Prevalence (%)

Source: Behavioral Risk Factor Surveillance System (from CDC PLACES for county estimates), 2021

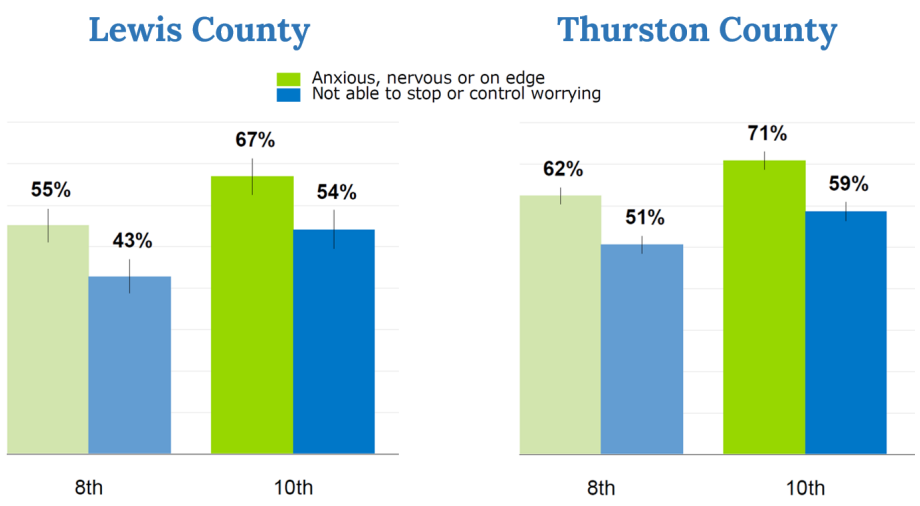
Lewis County: 18.4% (Age-adjusted prevalence)
Thurston County: 17.3% (Age-adjusted prevalence)
Washington State: 16.1% (Age-adjusted prevalence)



Measure: Respondents aged ≥18 years who report 14 or more days during the past 30 days during which their mental health was not good.

Anxiety in Youth (%)

Source: Washington State Healthy Youth Survey, 2021



Measure: Percentage of students who report feeling nervous, anxious, or on edge, or not being able to stop or control worrying in the past 2 weeks.

Substance Use/Misuse

Drug Overdose Hospitalizations (Rate)

Source: Washington Tracking Network, State Department of Health, 3-Year Estimate, 2015-2017

Lewis County: 102.2
Thurston County: 78.9
Washington State 80.3

Measure: Hospitalizations due to any drug overdose aged ≥18 years per 100,000 population.

Drug Overdose Fatalities (Rate)

Source: Washington Tracking Network, State Department of Health, 2020

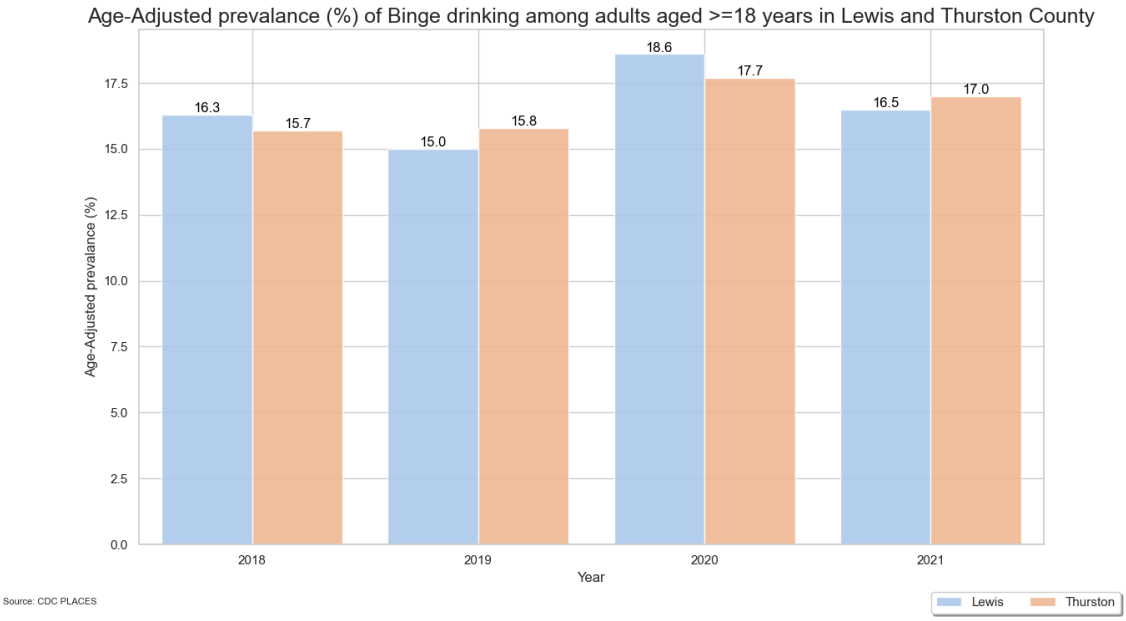
Lewis County: 38.9
Thurston County: 17.5
Washington State: 24.4

Measure: Rate of fatal overdoses (all drugs combined) aged ≥18 years due to suicide per 100,000 population.

Binge Drinking Prevalence (%)

Source: Behavioral Risk Factor Surveillance System (from CDC PLACES for county estimates), 2021

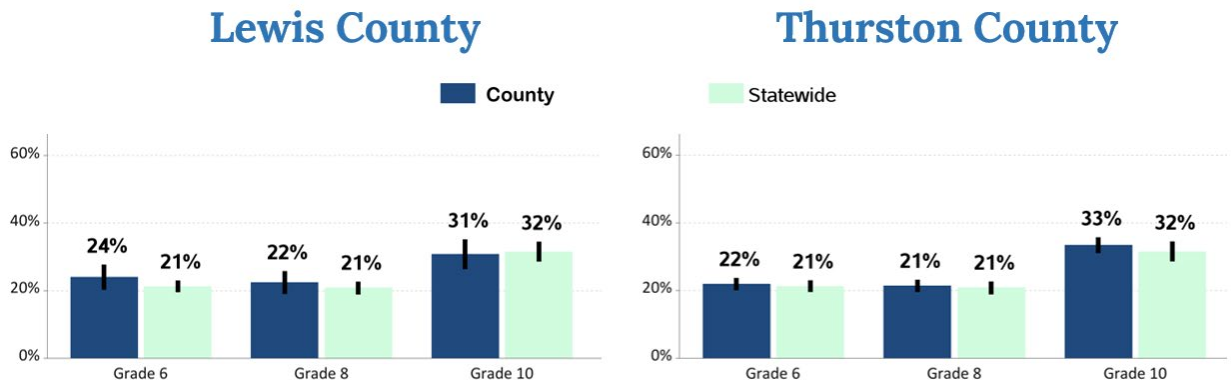
Lewis County: 16.5% (Age-adjusted prevalence)
Thurston County: 17.0% (Age-adjusted prevalence)
Washington State: 16.2% (Age-adjusted prevalence)



Measure: Adults aged ≥18 years who report having five or more drinks (men) or four or more drinks (women) on an occasion in the past 30 days.

Youth Alcohol Use (Lifetime)

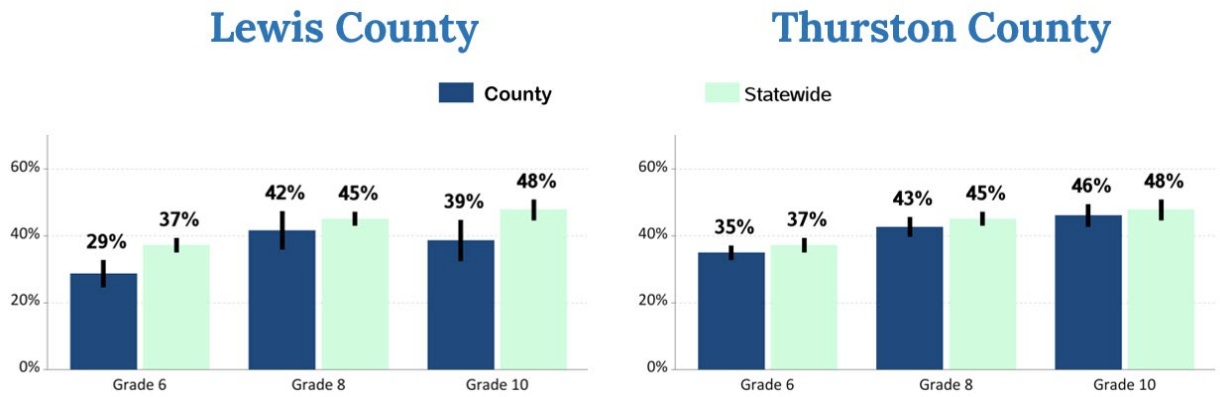
Source: Washington State Healthy Youth Survey, 2021



Measure: Percentage of students who report having ever drunk more than a sip of alcohol.

Youth Perceptions of Regular Alcohol Use

Source: Washington State Healthy Youth Survey, 2021

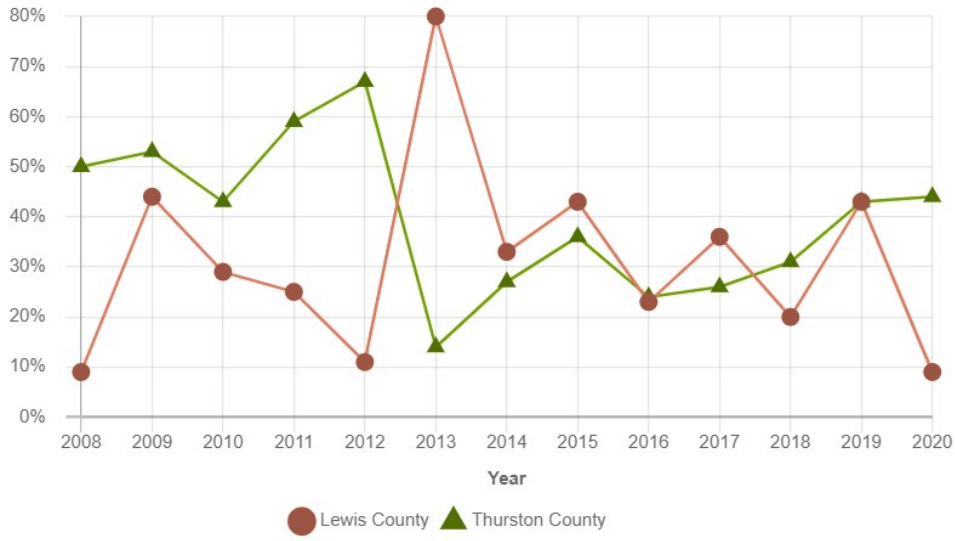


Measure: Percentage of students who report "great risk" of harm from drinking alcohol daily.

Alcohol-Impaired Driving Deaths (%)

Source: Fatality Analysis Reporting System, 2016-2020, accessed from CountyHealthRankings.org

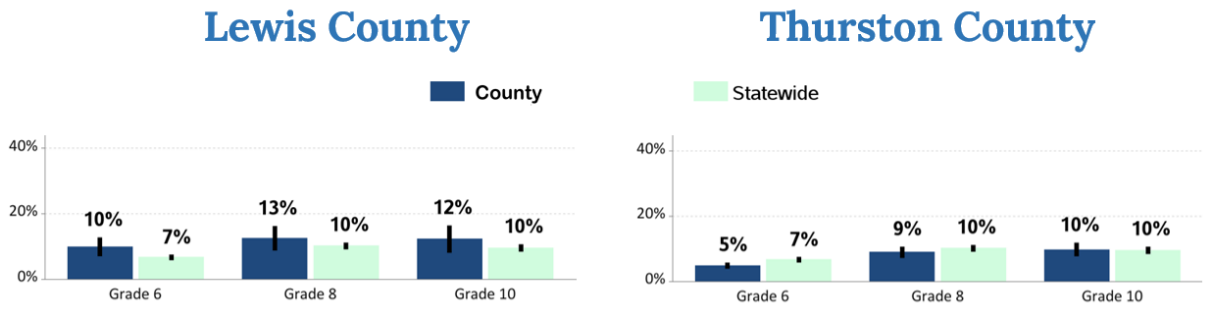
Lewis County: 28%
Thurston County: 34%
Washington State: 33%



Measure: Percentage of driving deaths with alcohol involvement. (Note: Trend graph uses single-year estimates)

Youth Riding with a Drinking Driver

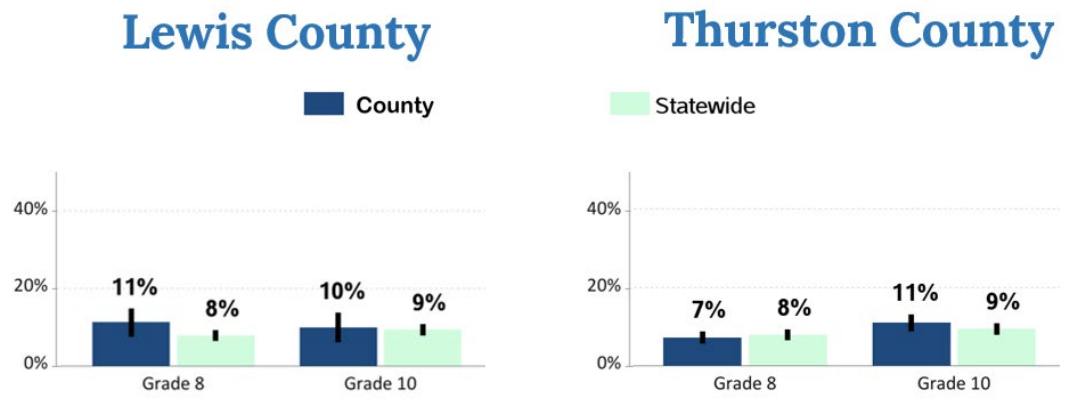
Source: Washington State Healthy Youth Survey, 2021



Measure: Percentage of students who report having ridden in the past 30 days with a driver who had been drinking alcohol.

Youth Riding with a Recent Marijuana User

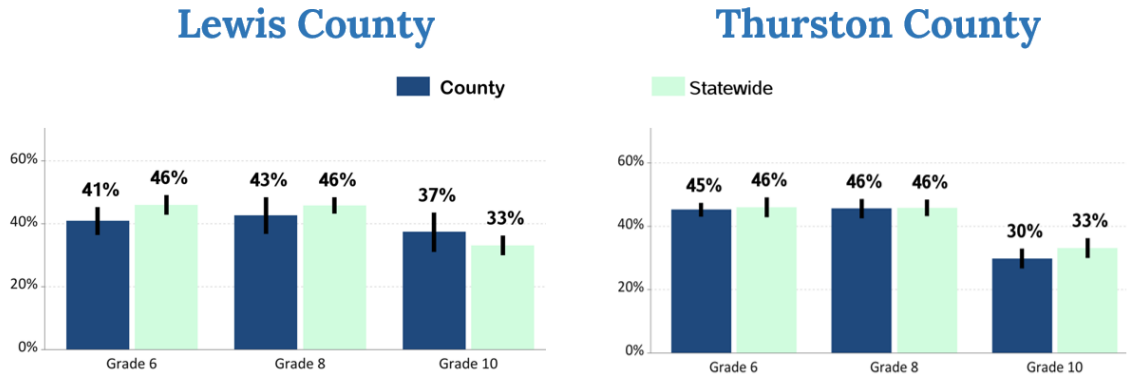
Source: Washington State Healthy Youth Survey, 2021



Measure: Percentage of students who report having ridden in the past 30 days with a driver who had been using marijuana.

Youth Perceptions of Regular Marijuana Use

Source: Washington State Healthy Youth Survey, 2021



Measure: Percentage of students who report "great risk" of harm from using marijuana at least once or twice a week.

Behavioral Health (BH) Emergency Department (ED) Cases

Behavioral health cases are Emergency department discharges in which the primary ICD-10 code is mapped to the SG2 Service Line Group of "Behavioral Health." The Behavioral Health SG2 Service Line Group is comprised of SG2 CARE Families of the following categories:

- Adjustment Disorders
- Anxiety and Personality Disorders
- Attention Deficit Hyperactivity Disorder
- Autism
- Bipolar Disorders
- Eating Disorders
- Learning Disorders
- Mood Disorders, Episodic
- Mood Disorders, Persistent
- Poisonings - Commonly Abused Drugs
- Psychosis
- Substance Use Disorders
- Trauma-Related Disorders

The Sg2 model aggregates patient diagnoses (ICD-9 and ICD-10 diagnosis codes) into more than 200 clinically meaningful categories called CARE Families. CARE Families can be used to group both inpatient and outpatient data and are designed to facilitate the tracking of similar conditions across multiple sites of care.

Table_Apx 2. Behavioral Health ED Cases, 2022

Medical Center	BH Cases %
PROVIDENCE CENTRALIA HOSPITAL	4.5%
PROVIDENCE ST PETER HOSPITAL	7.1%
Grand Total	6.1%

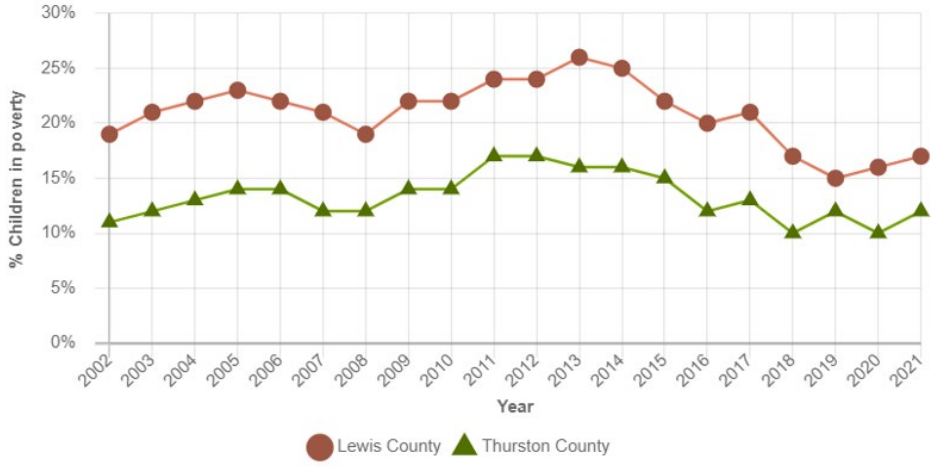
ECONOMIC SECURITY AND BASIC NEEDS

Income Security

Children in Poverty

Source: U.S. Census Bureau Small Area Income and Poverty Estimates (SAIPE), 2021, accessed from CountyHealthRankings.org

Lewis County: 17%
Thurston County: 12%
Washington State: 12%



Notes: Prior to 2005, Children in poverty was based on the Current Population Survey; beginning in 2005, it was based on the American Community Survey.

Definition: Percentage of people under age 18 at or below 100% of the Federal Poverty Level.

Household Median Income

Source: American Community Survey, 2021, 5-Year Estimate

County/State
Lewis County: $60,524
Thurston County: $80,141
Washington State: $81,548

South Puget Sound Service Area
High Need Area: $66,457
Broader Need Area: $87,814
Total Service Area: $77,135

Definition: Household median income includes the income of the householder and all other individuals 15 years old and over in the household, whether they are related to the householder or not. Because many households consist of only one person, average household income is usually less than average family income.

Unemployed Population

Source: American Community Survey, 2021, 5-Year Estimate

Lewis County: 7.1% (2,541 persons)
Thurston County: 5.7% (8,147 persons)
Washington State: 5.1% (198,259 persons)

Definition: All civilians 16 years old and over are classified as unemployed if they were neither "at work" nor "with a job but not at work" during the reference week and were actively looking for work during the last 4 weeks, and were available to start a job. Also included as unemployed are civilians who did not work at all during the reference week, were waiting to be called back to a job from which they had been laid off and were available for work except for temporary illness.

Childcare Cost Burden

Source: Massachusetts Institute of Technology Living Wage Calculator, 2021-2022; U.S. Census Bureau Small Area Income and Poverty Estimates, 2021-2022 (accessed from CountyHealthRankings.org)

Lewis County: 28%
Thurston County: 23%
Washington State: 27%

Definition: Childcare costs for a household with two children as a percent of median household income.

Travel Time to Work (One-Way)

Source: CDC QuickFacts, 5-Year Estimate, 2017-2021

Lewis County: 28 minutes
Thurston County: 27.4 minutes

Definition: Mean one-way travel time to work (minutes), workers age 16 years and older.

Food Security

Population Who Lacks Adequate Access to Food

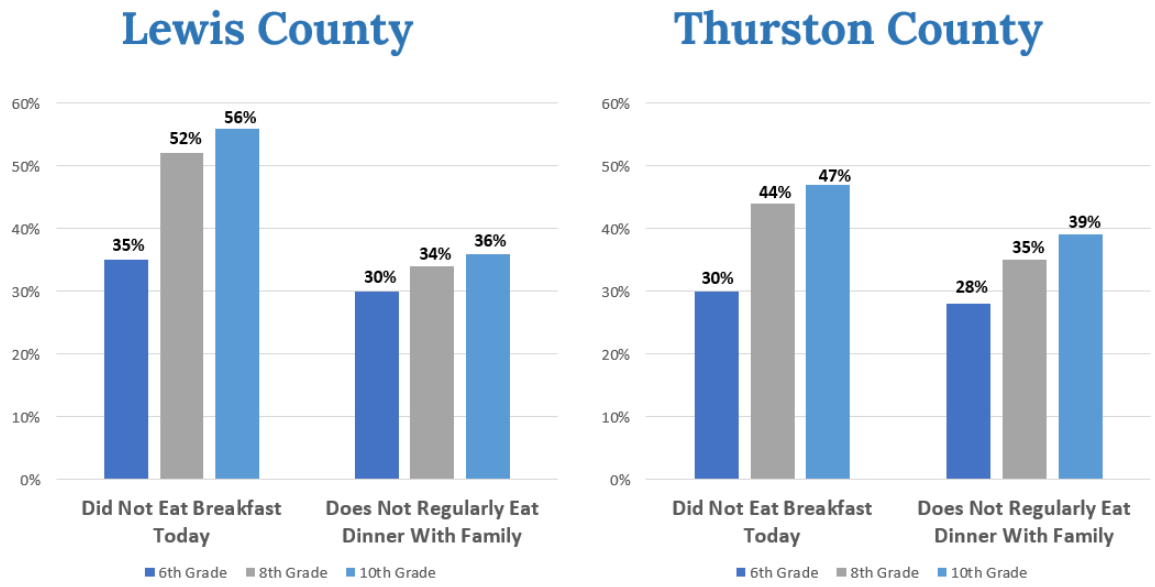
Source: Map the Meal Gap, 2020, accessed from CountyHealthRankings.org

Lewis County: 13%
Thurston County: 10%
Washington State: 9%

Definition: Lack of adequate access to food may exist even if residents receive SNAP or other government benefits.

Food Habits in Children and Youth

Source: Washington State Healthy Youth Survey, 2021



Measure: Percentage of students who reported they did not eat breakfast today.
Measure: Percentage of students who reported they eat dinner with their family "never," "rarely," or "sometimes." (The other response options were "most of the time" and "always."

Housing

Table_Apx 3. Housing Costs and Availability
Source: CDC QuickFacts

	Lewis County	Thurston County
Number of Households, 2017-2021	31,223	114,556
Housing units, July 1, 2022, (V2022)	36,364	125,166
Owner-occupied housing unit rate, 2017-2021	71.90%	66.80%
Median value of owner-occupied housing units, 2017-2021	$260,900	$344,700
Median selected monthly owner costs -with a mortgage, 2017-2021	$1,553	$1,905
Median gross rent, 2017-2021	$933	$1,373

Education

School Funding Adequacy

Source: School Finance Indicators Database, 2020, accessed from CountyHealthRankings.org

Lewis County: $1,925
Thurston County: $4,500
Washington State: $3,143
United States: $1,062

Definition: The average gap in dollars between actual and required spending per pupil among public school districts. Required spending is an estimate of dollars needed to achieve U.S. average test scores in each district. This measure looks at funding through an equity lens, not every district's needs for funding are the same, and this measure of school funding takes that into account. Higher values signify higher gaps.

High School Graduation

Source: EDFacts, U.S. Department of Education, 2019-2020, accessed from CountyHealthRankings.org

Lewis County: 83%
Thurston County: 83%
Washington State: 83%

Definition: Percentage of ninth-grade cohort that graduated from high school in four years.

Disconnected Youth

Source: American Community Survey, 2021, 5-Year Estimate, accessed from CountyHealthRankings.org

Lewis County: 8%
Thurston County: 8%
Washington State: 7%

Definition: Percentage of teens and young adults ages 16-19 who are neither working nor in school.

Population with at Least a High School Education

Source: American Community Survey, 2021, 5-Year Estimate

County/State
Lewis County: 89.3% (51,438 persons)
Thurston County: 94.2% (193,221 persons)
Washington State: 91.9% (4,845,059 persons)
South Puget Sound Service Area
High Need Area: 90.6% (127,693 persons)
Broader Need Area: 95.2% (116,966 persons)
Total Service Area: 92.9% (244,659 persons)

Definition: Population with at least a high school diploma includes adults 25 years and older whose highest degree was a high school diploma or its equivalent, those who attended college but did not receive a degree, and those who received an associate's, bachelor's, master's, or professional, or doctorate degree. People who reported completing the 12th grade but not receiving a diploma are not included.

Language Access

Population in Limited English Households

Source: American Community Survey, 2021, 5-Year Estimate

County/State
Lewis County: 1.1% (839 persons)
Thurston County: 1.8% (5,064 persons)
Washington State: 3.7% (262,123 persons)
South Puget Sound Service Area
High Need Area: 2.5% (4,941 persons)
Broader Need Area: 0.5% (962 persons)
Total Service Area: 1.5% (5,903 persons)

Definition: This variable identifies population 5 years and older living in households that may need English-language assistance. A "Limited English speaking household" is one in which no member 14 years old and over (1) speaks only English at home or (2) speaks a language other than English at home and speaks English "Very well."

Language other than English spoken at home, age 5 years+

Source: American Community Survey, 2021, 5-Year Estimate

Lewis County: 8.3%
Thurston County: 11.9%

ACCESS TO HEALTH CARE

Uninsured

Population Uninsured (All Ages)

Source: American Community Survey, 2021, 5-Year Estimate

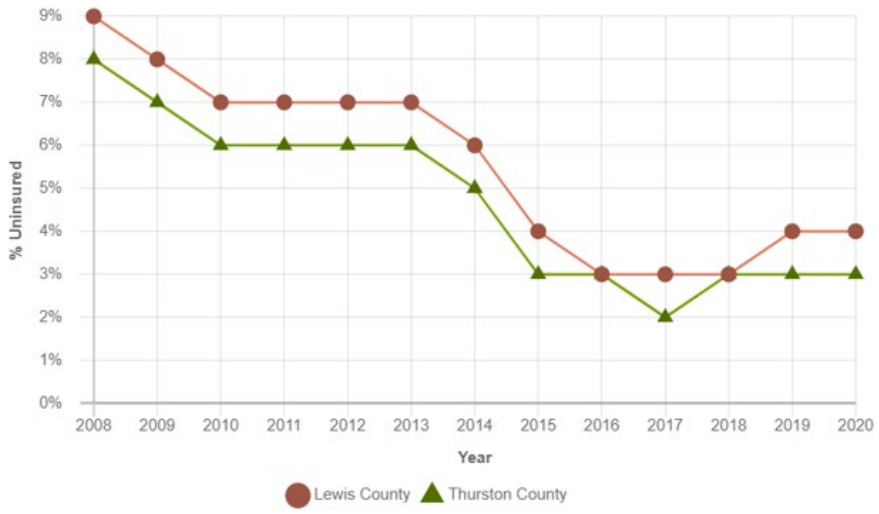
County/State
Lewis County: 7.2% (5,808 persons)
Thurston County: 5.0% (14,211 persons)
Washington State: 6.4% (477,069 persons)

South Puget Sound Service Area
High Need Area: 6.3% (12,231 persons)
Broader Need Area: 4.8% (7,788 persons)
Total Service Area: 5.6% (20,019 persons)

Uninsured Children

Source: US Census Bureau's Small Area Health Insurance Estimates, 2020, accessed from CountyHealthRankings.org

Lewis County: 4%
Thurston County: 3%
Washington State: 3%

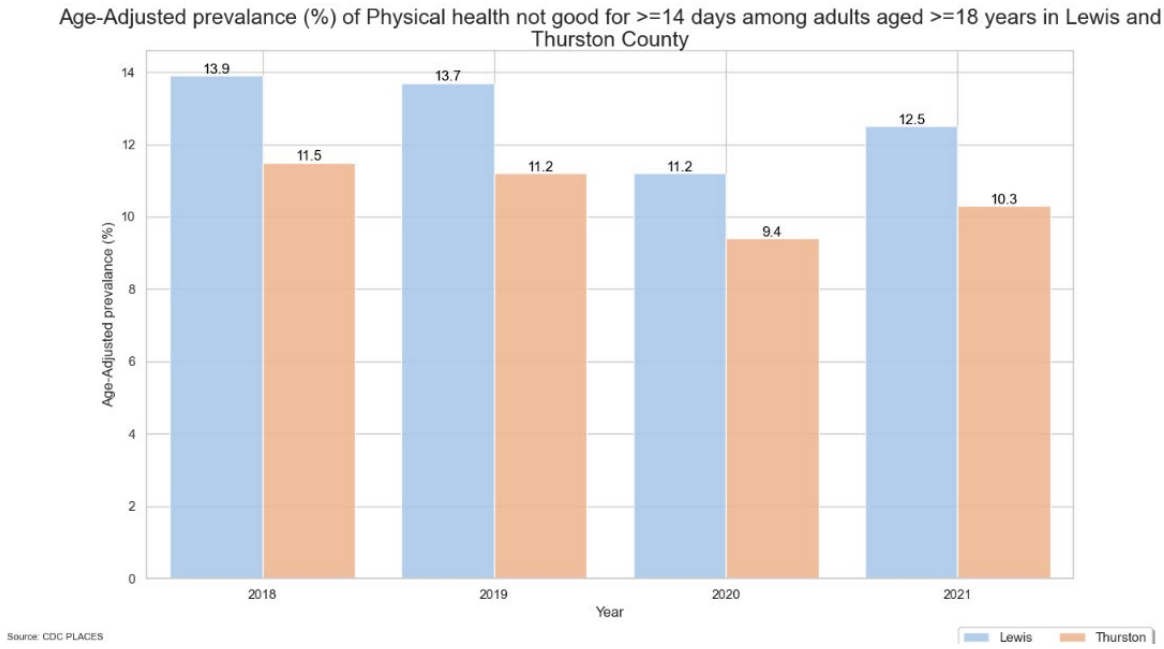


Measure: Percentage of children under age 19 without health insurance.

Frequent Physical Health Distress Prevalence (%)

Source: Behavioral Risk Factor Surveillance System (from CDC PLACES for county estimates), 2021

Lewis County: 12.5% (Age-adjusted prevalence)
Thurston County: 10.3% (Age-adjusted prevalence)
Washington State: 10.6% (Age-adjusted prevalence)

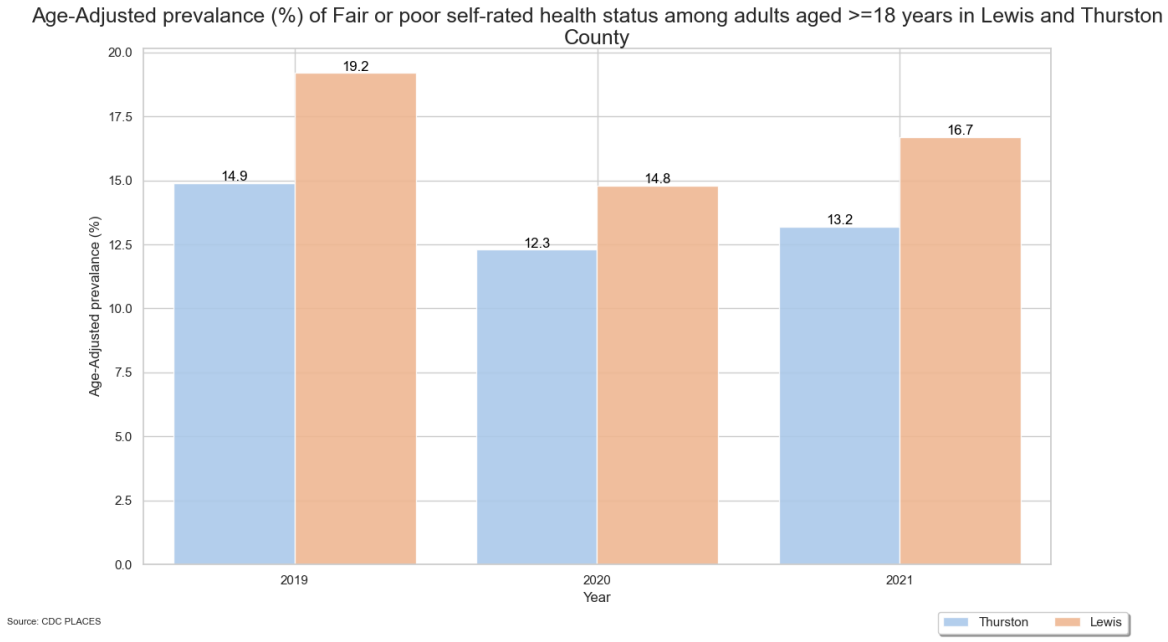


Measure: Respondents aged ≥18 years who report 14 or more days during the past 30 days during which their physical health was not good.

Poor Health Status (%)

Source: Behavioral Risk Factor Surveillance System (from CDC PLACES for county estimates), 2021

Lewis County: 16.7% (Age-adjusted prevalence)
Thurston County: 13.2% (Age-adjusted prevalence)
Washington State: 14.3% (Age-adjusted prevalence)

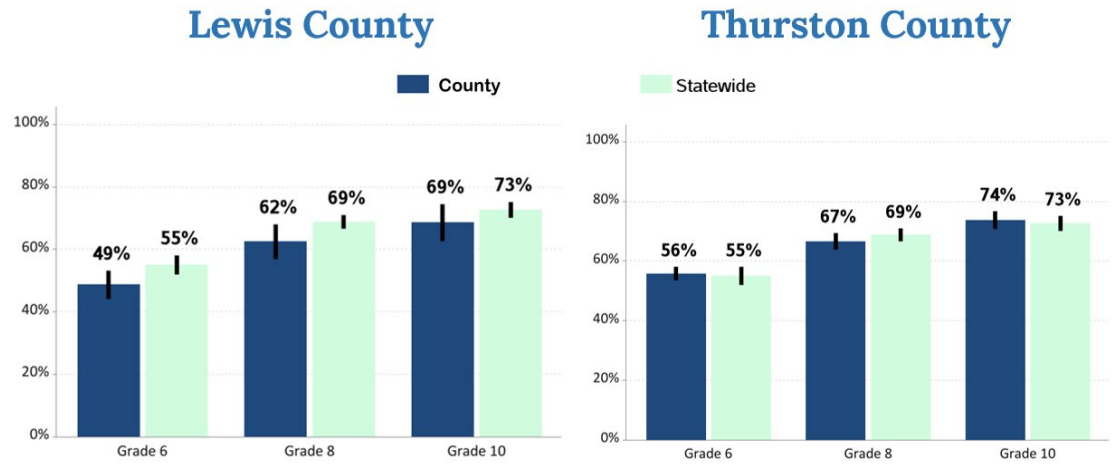


Measure: Respondents aged ≥ 18 years who report their general health status as “fair” or “poor.”

Healthy Behaviors

Youth Perceptions of Cigarette Smoking

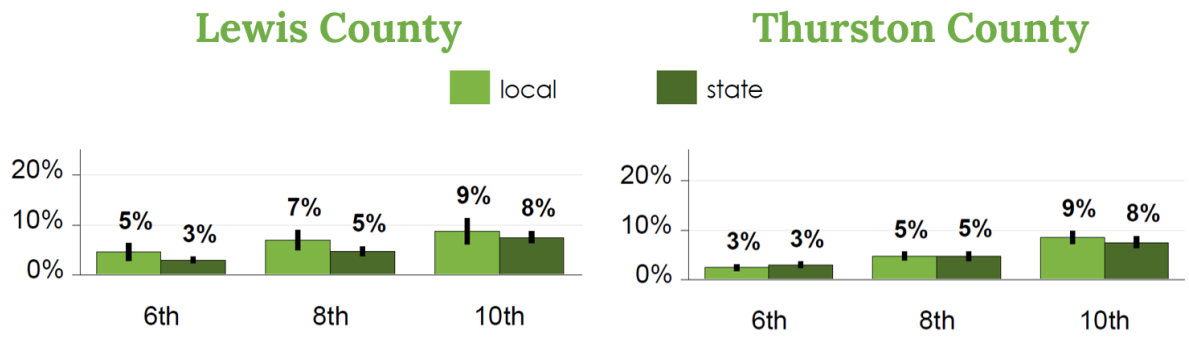
Source: Washington State Healthy Youth Survey, 2021



Measure: Percentage of students who report "great risk" of harm from smoking a pack or more a day.

Youth Vapor Product Use (%)

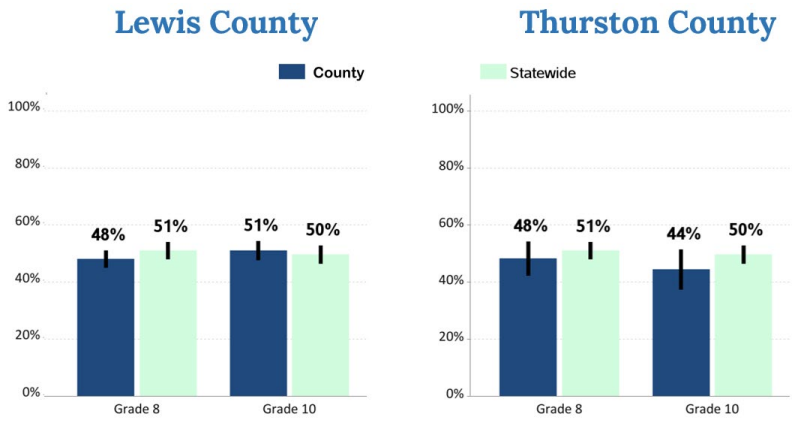
Source: Washington State Healthy Youth Survey, 2021



Measure: Percentage of students who report using an electronic cigarette, e-cig, JUUL, or vape pen in the past 30 days.

Youth Perceptions of E-Cigarette Smoking or Vaping

Source: Washington State Healthy Youth Survey, 2021

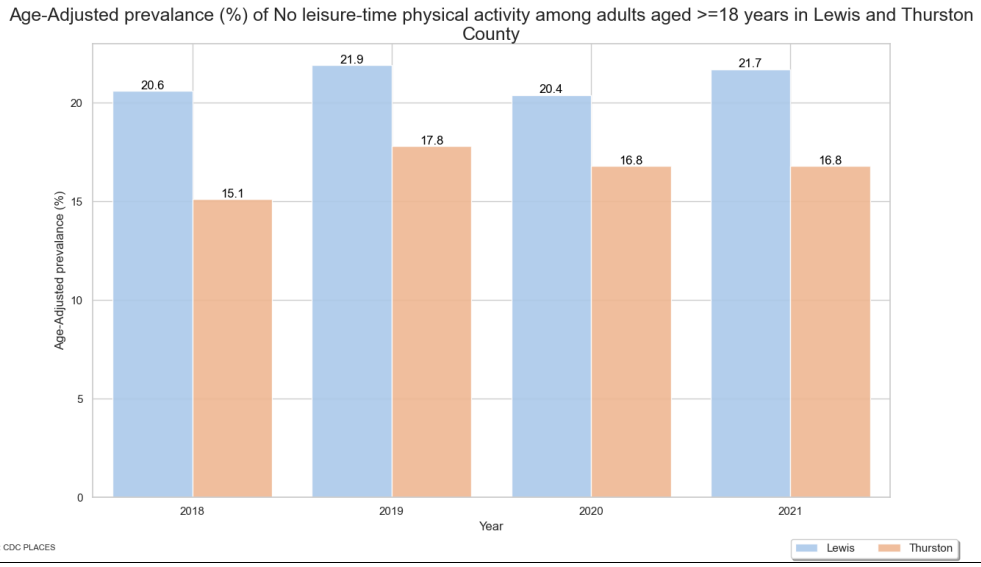


Measure: Percentage of students who report "great risk" of harm from using e-cigarette, JUUL, or vape pen regularly (almost daily).

Adult Physical Inactivity Prevalence (%)

Source: Behavioral Risk Factor Surveillance System (from CDC PLACES for county estimates), 2021

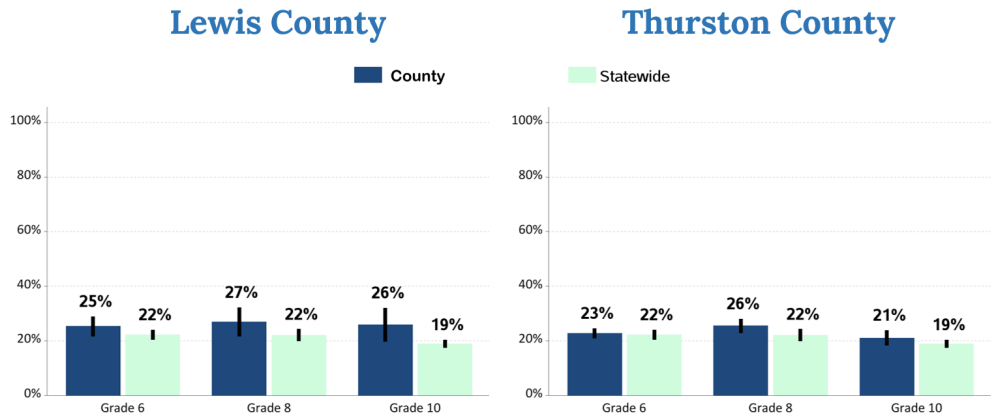
Lewis County: 21.7% (Age-adjusted prevalence)
Thurston County: 16.8% (Age-adjusted prevalence)
Washington State: 17.8% (Age-adjusted prevalence)



Measure: Respondents aged ≥18 years who answered “no” to the following question: “During the past month, other than your regular job, did you participate in any physical activities or exercises such as running, calisthenics, golf, gardening, or walking for exercise?”

Youth Physical Activity (%)

Source: Washington State Healthy Youth Survey, 2021



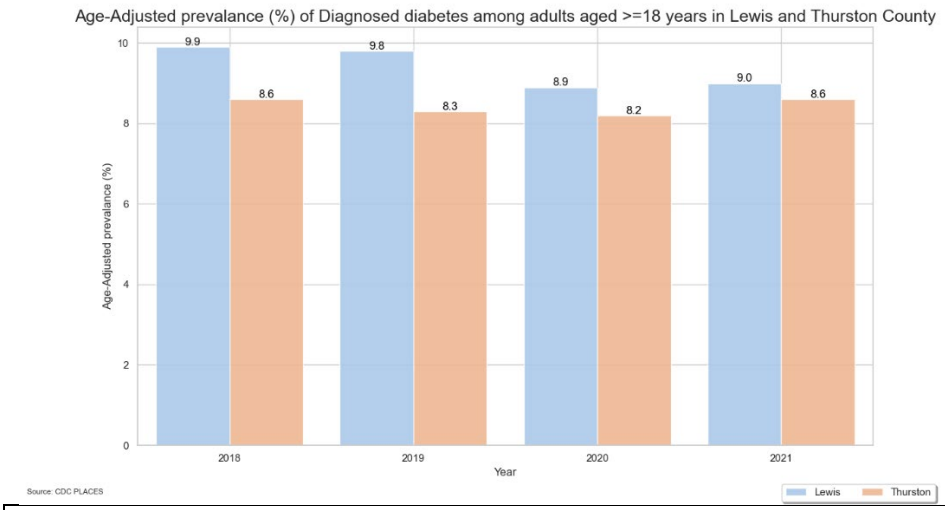
Measure: Percentage of students who report being physically active 60 minutes per day, 7 days a week. (Students were prompted: "Add up all the time you spent in any kind of physical activity that increases your heart rate or makes you breathe hard some of the time.")

Chronic Conditions

Diabetes Prevalence (%)

Source: Behavioral Risk Factor Surveillance System (from CDC PLACES for county estimates), 2021

Lewis County: 9.0% (Age-adjusted prevalence)
Thurston County: 8.6% (Age-adjusted prevalence)
Washington State: 7.9% (Age-adjusted prevalence)

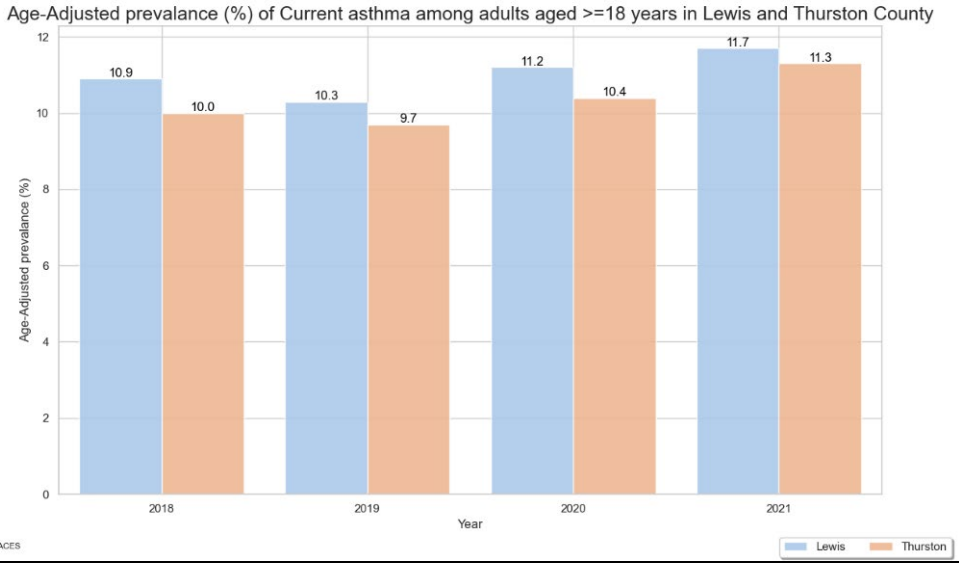


Measure: Respondents aged ≥18 years who report ever been told by a doctor, nurse, or other health professional that they have diabetes other than diabetes during pregnancy.

Current Asthma Prevalence (%)

Source: Behavioral Risk Factor Surveillance System (from CDC PLACES for county estimates), 2021

Lewis County: 11.7% (Age-adjusted prevalence)
Thurston County: 11.3% (Age-adjusted prevalence)
Thurston County: 10.5% (Age-adjusted prevalence)

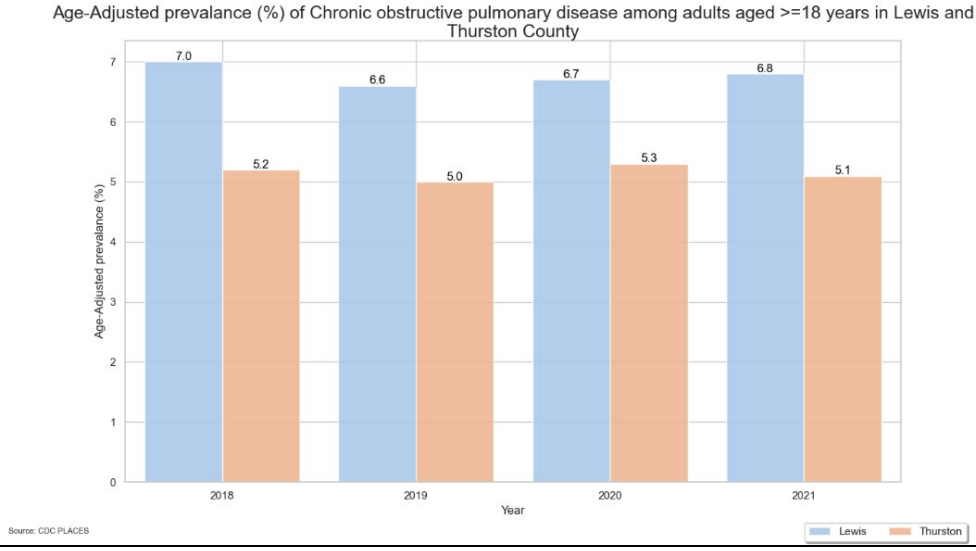


Measure: Weighted number of respondents who answer "yes" both to both of the following questions: "Have you ever been told by a doctor, nurse, or other health professional that you have asthma?" and the question "Do you still have asthma?"

COPD Prevalence (%)

Source: Behavioral Risk Factor Surveillance System (from CDC PLACES for county estimates), 2021

Lewis County: 6.8% (Age-adjusted prevalence)
Thurston County: 5.1% (Age-adjusted prevalence)
Washington State: 4.7% (Age-adjusted prevalence)

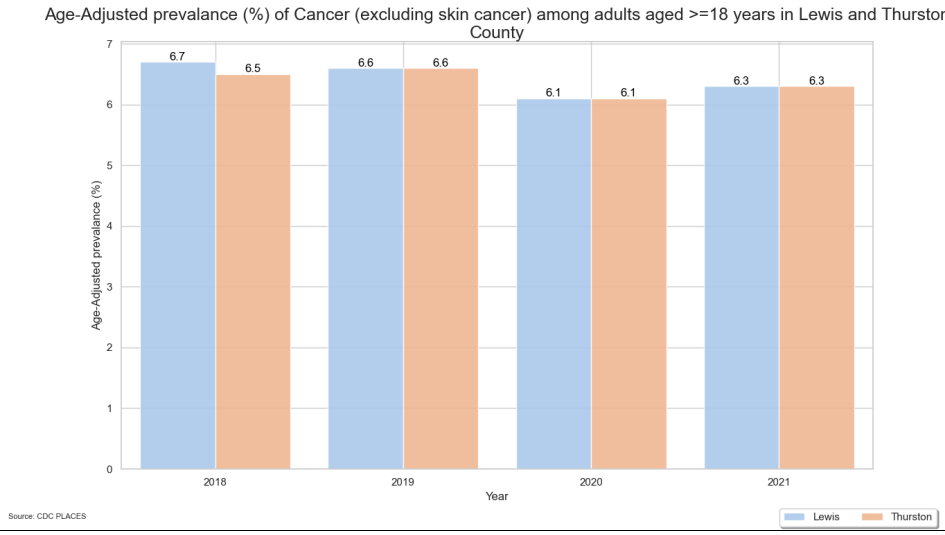


Measure: Respondents aged ≥18 years who report ever having been told by a doctor, nurse, or other health professional that they had chronic obstructive pulmonary disease (COPD), emphysema, or chronic bronchitis.

Cancer (Except Skin) Prevalence (%)

Source: Behavioral Risk Factor Surveillance System (from CDC PLACES for county estimates), 2021

Lewis County: 6.3% (Age-adjusted prevalence)
Thurston County: 6.3% (Age-adjusted prevalence)
Washington State: 6.2% (Age-adjusted prevalence)

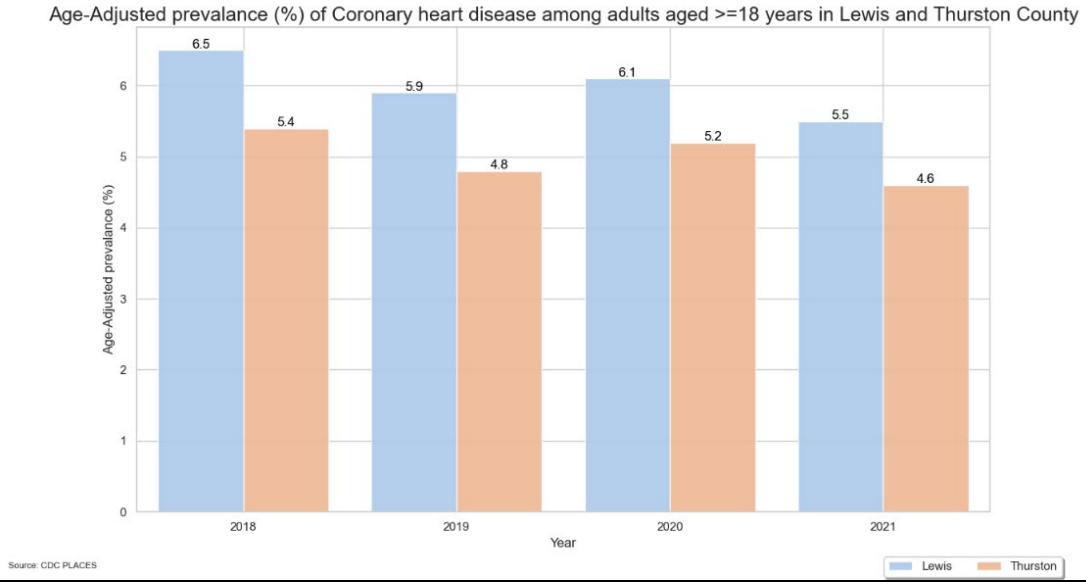


Measure: Respondents aged ≥18 years who report ever having been told by a doctor, nurse, or other health professional that they have any other types (besides skin) of cancer.

Coronary Heart Disease Prevalence (%)

Source: Behavioral Risk Factor Surveillance System (from CDC PLACES for county estimates), 2021

Lewis County: 5.5% (Age-adjusted prevalence)
Thurston County: 4.8% (Age-adjusted prevalence)
Washington State: 3.0% (Age-adjusted prevalence)

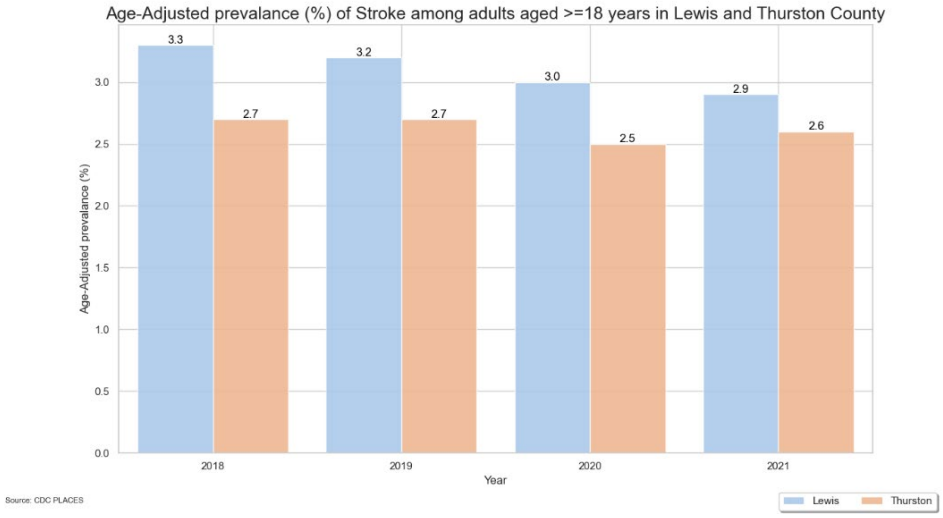


Measure: Respondents aged ≥18 years who report ever having been told by a doctor, nurse, or other health professional that they had angina or coronary heart disease.

Stroke Prevalence (%)

Source: CDC Places, 2021

Lewis County: 2.9% (Age-adjusted prevalence)
Thurston County: 2.6% (Age-adjusted prevalence)



Measure: Respondents aged ≥18 years who report ever having been told by a doctor, nurse, or other health professional that they have had a stroke.

Preventive Care

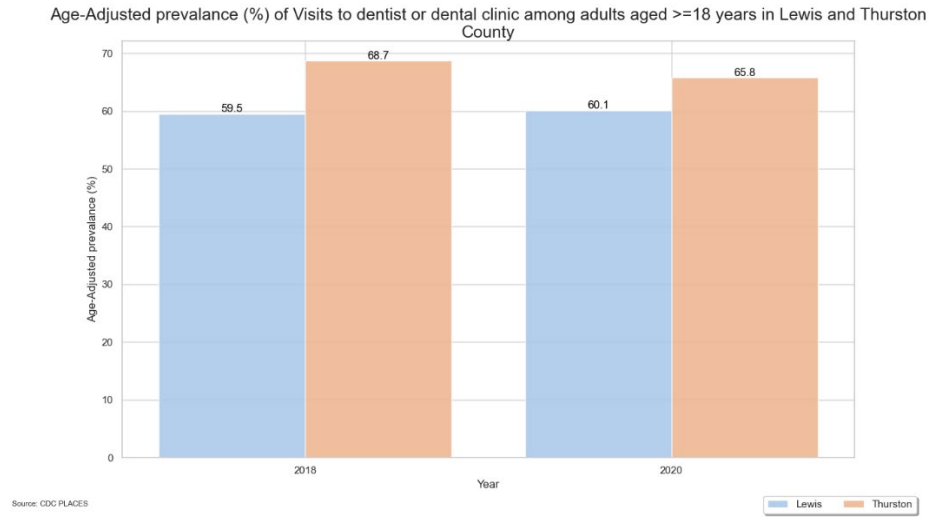
Dental Visit Prevalence (%)

Source: Behavioral Risk Factor Surveillance System (from CDC PLACES for county estimates), 2021

Lewis County: 60.1% (Age-adjusted prevalence)

Thurston County: 65.8% (Age-adjusted prevalence)

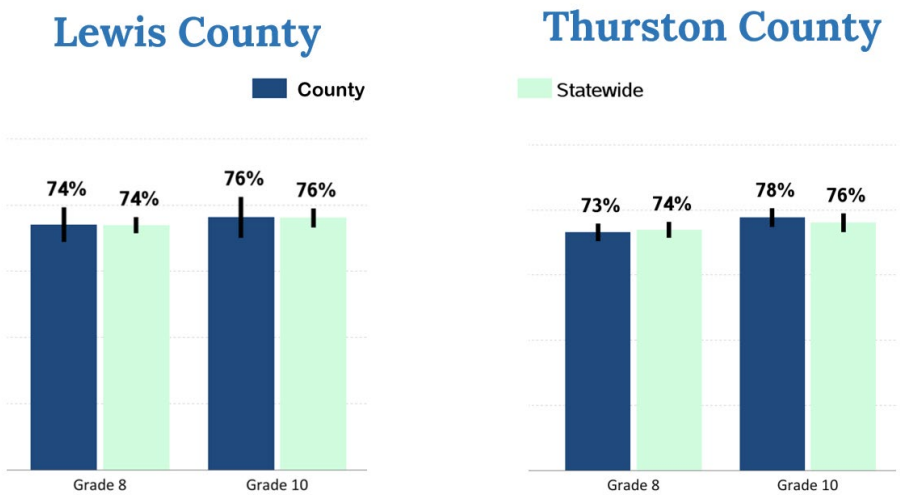
Washington State: 69.0% (Age-adjusted prevalence)



Measure: Respondents aged ≥18 years who report having been to the dentist or dental clinic in the previous year

Youth Dental Visit Prevalence (%)

Source: Washington State Healthy Youth Survey, 2021



Measure: Percentage of students who report visiting a dentist for a routine checkup in the past year.

HEALTH PROFESSIONAL SHORTAGE AREAS

The Federal Health Resources and Services Administration (HRSA) designates Health Professional Shortage Areas (HPSAs) as areas with a shortage of primary medical care, dental care, or mental health providers. They are designated according to geography (i.e., service area), demographics (i.e., low-income population), or institutions (i.e., comprehensive health centers). The table below depicts these shortage areas relative to the locations of Providence St. Peter and Providence Swedish Centralia Hospitals.

Table_Apx 4. Health Professional Shortage Areas

Discipline	HPSA Name	Designation Type	FTE Shortage*
Primary Care	Lewis County	Low Income, Homeless, Migrant Farmworker Populations HPSA	1.824
Primary Care	North Thurston County	Geographic HPSA	18.12
Primary Care	South Thurston County	Geographic HPSA	6.865
Mental Health	Lewis County	High Needs Geographic HPSA	3.35
Mental Health	South Thurston County	Geographic HPSA	3.44
Mental Health	North Thurston County	Geographic HPSA	7.12
Dental Health	Lewis County	Low Income Population HPSA	1.252

Dental Health	South Thurston County	Geographic HPSA	7.13
Dental Health	Olympia-Lacey Service Area	Low Income Population HPSA	0.773

*This attribute represents the number of full-time equivalent (FTE) practitioners needed in the Health Professional Shortage Area (HPSA) so that it will achieve the population to practitioner target ratio. The target ratio is determined by the type (discipline) of the HPSA.

MEDICALLY UNDERSERVED AREAS / MEDICALLY UNDERSERVED POPULATIONS

Medically Underserved Areas (MUAs) and Medically Underserved Populations (MUPs) are defined by the Federal Government to include areas or populations that demonstrate a shortage of health care services. This designation process was 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 table depicts the MUAs and MUPs within a 30-mile radius from Providence Centralia and St. Peter Hospitals.

Table_Apx 5. Medically Underserved Areas and Populations

County	Service Area Name	Designation Type	Index of Underservice Score*	Rural Status
Thurston	Panorama	Medically Underserved Area	57.1	Non-Rural
Thurston	Low Income – Downtown Olympia	Medically Underserved Population	59.8	Non-Rural
Lewis	Eastern Lewis Service Area	Medically Underserved Area: Governor's Exception	N/A	Rural
Lewis	Western Lewis Service Area	Medically Underserved Area: Governor's Exception	N/A	Rural

*This attribute represents the Index of Medical Underservice (IMU) score. The lowest score (highest need) is 0; the highest score (lowest need) is 100. In order to qualify for designation, the IMU score must be less than or equal to 62.0, except for a Governor designation, which does not receive an IMU score. The score applies to the MUA or MUP as a whole, and not to individual portions of it.

Appendix 2: Community Input

METHODOLOGY

PARTICIPANTS

Providence Swedish collaborated with the Thurston County Public Health and Social Services Department to complete 39 key informant interviews that included a total of 45 participants. The interviews took place between September 2022 and August 2023.

The goal was to engage representatives from social service agencies, health care, education, housing, and government, among others, to ensure a wide range of perspectives. The hospital included the Deputy Director of Lewis County Public Health and Social Services and the Opioid Response Coordinator of the Thurston County Public Health and Social Services Department as key informants to ensure the input from a state, local, tribal, or regional governmental public health department.

Table_Apx 6. Lewis County Community Key Informant Participants

Organization	Name	Title	Sector
Cascade Community Healthcare	Dr. Richard J. Stride	President and Chief Executive Officer	Health Care
Centralia College	Dr. Bob Mohrbacher	President	Higher Education
Centralia Police Department	Stacy Denham	Chief	Law Enforcement
Centralia School District	Dr. Lisa Grant	Superintendent	Education
CHOICE (Community Health Organization Improving Care and Equity)	JP Anderson	Chief Executive Officer	Community-Based Health; Accountable Community of Health
Economic Alliance of Lewis County	Richard DeBolt	Executive Director	Public-Private Partnership
Gather Church Gather Community Services	Cole Meckle	Pastor Executive Director	Faith Community Nonprofit
Lewis County Board of County Commissioners	Sean Swope	Commissioner, Lewis County District 1	County Government
Lewis County Fire District 8	Duran McDaniel	Chief	Fire and Emergency Services
Lewis County Public Health and Social Services	John Abplanalp	Deputy Director	Public Health

Lewis-Mason-Thurston Area Agency on Aging	Donna Feddern	Community Supports Director	State Government
Providence Chehalis Family Medicine	Juan M. Lee, MD Rein Lambrecht, MD	Rural Care Program Faculty	Health Care
Reliable Enterprises	Brett Mitchell	Executive Director	Nonprofit
Valley View Health Center	Gaelon Spradley	Chief Executive Officer	Health Care, Federally Qualified Health Center (FQHC)

Table_Apx 7. Thurston County Community Key Informant Participants

Organization	Name	Title	Sector
Child Care Action Council	Danielle King	Coordinator, Safe Kids Thurston County; Grants Manager, Special Projects	Nonprofit
CHOICE (Community Health Organization Improving Care and Equity)	JP Anderson	Chief Executive Officer	Community-Based Health; Accountable Community of Health
Community Youth Services	Derek R. Harris	Chief Executive Officer	Nonprofit
Diversity Alliance of the Puget Sound	Skye Locke Rowan Duran	Secretary Co-Chair	Nonprofit
Family Education and Support Services	Shelly Willis	Executive Director	Nonprofit
Family Support Center of South Sound Griffin School District	Trish Gregory	Executive Director School Board Director #5	Nonprofit Education
Interfaith Works	Meg Martin	Executive Director	Nonprofit
Innovations Human Trafficking Collaborative	Jeri Moomaw	Founder and Executive Director	Nonprofit
Lacey Parks, Culture, and Recreation	Sarah Smith	Executive Assistant	City Government
Lewis-Mason-Thurston Area Agency on Aging	Donna Feddern	Community Supports Director	State Government
Mi Chiantla	Carlos Mejia Rodriguez	Founder and Executive Director	Nonprofit
Olympia Bupe Clinic Purpose. Dignity. Action. (PDA)	Malika Lamont	Director, Harm Reduction Practices	Health Care

		Director, VOCAL-WA; Technical Support Director, Washington LEAD	Community-Based Organization
Olympia Crisis Response Unit (CRU)	Amy King Teal Russell	Police Lieutenant Crisis Response Unit Lead	Social Services Outreach, Law Enforcement
The Olympia Free Clinic	Katie Madinger	Executive Director	Health Care
Rochester Organization of Families (ROOF) Community Services	Kellie McNelly	Executive Director	Nonprofit
South Sound Behavioral Hospital	TJ O'Reilly	Chief Executive Officer	Health Care
South Sound Parent to Parent	Kim Smith	Executive Director	Nonprofit
St. Martin's University Student Health Center	Jamie Nixon, PA-C	Medical Director	Health Care
Thurston Climate Action Team	Melinda Hughes	Executive Director	Nonprofit
Thurston County Board of County Commissioners	Nicole Miller	Racial Equity Program Manager	County Government
Thurston County Pretrial Services	Andre Clark	Interim Manager, Thurston County Resource Hub	County Government, Legal
Thurston County Public Health and Social Services Department	Katie Strozyk	Opioid Response Coordinator	Public Health
Thurston Regional Planning Council	Michael Ambrogi Paul Brewster Veronica Jarvis Karen Parkhurst	Senior Planner Senior Planner Transportation Demand Management Planner Planning and Policy Director	Regional Council of Governments
Thurston Thrives	Josefina Magaña	Director	Nonprofit
TOGETHER!	Tami Lathrop	Director, Host Homes Program	Nonprofit
Valley View Health Center	Gaelon Spradley	Chief Executive Officer	Health Care, Federally Qualified Health Center (FQHC)
Washington State LGBTQ Commission	Tracey Carlos	Program Manager	State Government

Yelm Community Schools	Shannon Powell	Director, Office of Student Support	Education

FACILITATION GUIDES

For the key informant interviews, Providence developed a facilitation guide that was used across all hospitals completing their 2023 CHNAs:

- The community served by the key informant's organization
- The community strengths
- Prioritization and discussion of unmet health related needs in the community, including social determinants of health
- Suggestions for how to leverage community strengths to address community needs
- Successful community health initiatives and programs
- Opportunities for collaboration between organizations to address health equity

TRAINING

The facilitation guides provided instructions on how to conduct a key informant interview, including basic language on framing the purpose of the sessions. Facilitators participated in trainings on how to successfully facilitate a key informant interview and were provided question guides.

DATA COLLECTION

Key informant interviews were conducted virtually, and information was collected in two ways: 1) recorded with the participant's permission and 2) a note taker documented the conversation.

ANALYSIS

Qualitative data analysis was conducted by Providence 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.

If applicable, the recorded interviews were sent to a third party for transcription, or the notes were typed and reviewed. The key informant 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 used a standard list of codes, or common topics that are mentioned multiple times. These codes represent themes from the dataset and help organize the notes into smaller pieces of information that can be rearranged to tell a story. The analyst developed a definition for each code which explained what information would be included in that code. The analyst coded eight domains relating to the topics of the questions: 1) name, title, and organization of key informant, 2) population served by organization, 3) greatest community strength and opportunities to leverage these strengths 4) unmet health-related needs, 5) disproportionately affected population, 6) effects of COVID-19, 7) successful programs and initiatives, and 8) opportunities to work together.

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. 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. The analyst documented patterns from the dataset related to the frequency of codes and codes that were typically used together.

LIMITATIONS

While key informants were intentionally recruited from a variety of types of organizations, there may be some selection bias as to who was selected as a key informant. Multiple interviewers may affect the consistency in how the questions were asked. Multiple note-takers may affect the consistency and quality of notes across the different sessions.

Interviews were conducted virtually, which may have created barriers for some people to participate. Virtual sessions can also make facilitating conversation between participants more challenging.

The analysis was completed by only one analyst and is therefore subject to influence by the analyst's unique identities and experiences.

LEWIS COUNTY: FINDINGS FROM KEY INFORMANT INTERVIEWS

COMMUNITY STRENGTHS

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

Many organizations are motivated to serve the community and work with one another to address complex needs

Lewis County is a large enough community that there are many people doing wonderful work and striving to help others, while still small enough that people can come together on shared goals. Key informants emphasized there are already good efforts taking place, including affordable housing

developments, strong partnerships, and collaboration between health care providers. Key informants emphasized that people are willing to work together, lean in, and engage in the community.

> *"I think our partnerships would be one of the biggest strengths that already exists." — Key Informant*

While there is good work happening, organizations and resources can be spread thin and operate in silos. There is a need to harness that enthusiasm and those good ideas to better coordinate efforts and services to be more effective in meeting needs.

> *"Oftentimes, it's just a small group of people who all have this wonderful idea for Lewis County, but they all are spreading their selves [sic] a little thin. I think that one of the greatest strengths is there are all these wonderful groups that are trying to do stuff. I think one of the best things that we could do is try to figure out how to get those organizations to work a little bit better together." — Key Informant*

> *"I think we've got opportunity. If I look at Centralia right now, we've got people really willing, and in leadership positions in so many ways, that see the hope and potential in our community, in our school district, in Centralia itself that if we can harness some of that, and coordinate that, we could really set an example for other communities in our state and other places." — Key Informant*

> *"I think one of the things, the more we can connect, collaborate, partner, and leverage the resources we have versus operating in silos or repeating or replicating services, the better." — Key Informant*

Organizations may be focused on their own work and hesitate or lack the capacity to collaborate with others. Having more conversations and focusing on building relationships is important, particularly to address complex problems like food insecurity, homelessness, and fall prevention. To do this, key informants advocated for more interdisciplinary groups to tackle complex needs.

> *"Some of [the issues] are too big, they're multi-level issues that some of it will need to be addressed at the federal level, the state level, but there are things that could happen at the local level. I think getting interdisciplinary groups together to start talking about them and strategizing about them and having the right players at the table who can not only make policy decisions but who have resources to invest in solutions." — Key Informant*

Groups working together should share a common vision, priorities, and metrics of success. Having shared metrics of success will help create accountability and ensure that progress is being made. Sharing data, like from health care organizations, on what they are seeing in their patient population could also help the community understand the needs and challenges in real time.

Focusing on organizations' strengths and leveraging what each is good at will be important for addressing needs. Then organizations can come together to identify how to leverage resources to address the other needs that are not already being met.

Collaborating will also ensure the community is better served by providing wraparound services to people, wholistically meeting their needs.

> *"It's about all of us. We've been discussing it more as a community to make sure that we understand, truly, what a wraparound service is and how we bring those services to being." — Key Informant*

Leveraging the trust developed by some community-based organizations with specific groups or populations is a way to promote health equity. These organizations can help ensure specific needs are being met and information is shared in a culturally relevant way. For example, using community health workers and peers with lived experience can help remove barriers to care for people with complex needs, such as people with a behavioral health challenge or experiencing homelessness. Another example is developing a paramedicine program to prevent people from needing to be hospitalized.

To ensure that all of the resources available are known and to promote referrals and coordination, it would be beneficial to have a centralized list of resources and share them widely. For example, ensure that school districts know what is available so that they can direct families to those resources. Also, ensure that health care providers can easily understand what resources are available and can quickly refer clients. New providers may have to invest a great deal of time and energy into meeting their patients' social needs, which can contribute to burnout and stress.

> *"As new doctors to the community, it would be wonderful if there was some great resource for them to know what are all the wonderful organizations that exist in the community. We've done a lot of that work to figure that out but still, keeping that up to date and having that information is really challenging. That can often lead to turnover of providers as well because when you're challenged all the time with addressing all of the medical needs, but then also all the other psychosocial needs of your patients and you're trying to do that in 20 minutes, that's basically impossible." — Key Informant*

A strong sense of community, pride, cohesion, and caring for and relying on one another

Key informants emphasized there is a strong sense of community in Lewis County, meaning people come together to care for one another. When people care for one another, it creates a sense of belonging and motivates others to do the same.

> *"[Community members] really watch out for one another. There are always going to be exceptions, but we experience a lot of folks that receive, say, food resources, and they're not just there to try and take care of themselves, but their neighbors, or somebody that's nearby, or somebody else that they know about that has need.*

There's a lot of people within the communities that we serve that have one another's backs. A lot of advocacy for others in similar situations." — Key Informant

"I think a lot of folks here have a sense of belonging and I think that's really important. A sense of belonging, a sense of community, because it helps create a sense of purpose." — Key Informant

"People pull together here." — Key Informant

People care for one another by sharing resources, giving of their time and money, and volunteering. Key informants described Lewis County as a generous community.

"We give out of necessity and so [we are] a very, very giving community, which I think is an incredible strength that we have." — Key Informant

"I think one of our strengths is that I think we have a really tight-knit community that we support each other quite a bit." — Key Informant

People's compassion and community cohesion is especially apparent in times of disaster, like when there are fires or flooding. Key informants emphasized that the people in Lewis County are independent, relying on one another rather than outside help.

"We have a pretty high level of community cohesion. We've had a lot of natural disasters down here, everything from pretty significant forest fires to major flooding events. We've seen a really strong community response of neighbors helping neighbors. People have, I think, taken a lot of pride in taking care of their own." — Key Informant

Some of this cohesion is due to many families staying in Lewis County for generations, so people know one another. There is also a strong faith-based community that steps up to help people. Additionally, schools are a big force for creating a "hyperlocal sense of pride," as people identify with their local high school or district.

"I think there is a real sense of community both in Lewis County in general and in the various towns here. I think there's a lot of people whose family have lived here for a long time, and they very much identify with their town, their county, their local high school or whatever it is. I think there's a lot of people who are very involved in a number of community efforts." — Key Informant

Resiliency to change and challenges

People in Lewis County are resilient in times of challenges. Over the past couple of decades, the economy has shifted away from agriculture, which has affected people's jobs and income. Additionally, natural disasters, such as floods and fires, have threatened the community, but people have come together to care for one another.

The community overall is fiercely independent, meaning they rely on one another rather than outside help.

Despite individual challenges, including trauma, behavioral health challenges, and homelessness, people continue to work hard and find ways to persevere.

> *"I would say resiliency. They've always been very strong and resilient when it comes to issues that are facing them, whether it be flooding or homelessness or whatever."*
> *— Key Informant*

PRIORITIZED UNMET HEALTH-RELATED NEEDS

Key informants were asked to identify their top five health-related needs in the community. The health issues that were highly ranked by key informants are below in order of rank:

1. Access to behavioral health care
2. Affordable housing and homelessness
3. Access to health care
4. Mental health and suicide prevention
5. Substance use/misuse and overdose prevention
6. Economic security and income inequality
7. Food security and nutrition
8. Aging adult health and fall prevention

Access to behavioral health care, mental health, and substance use/misuse

Key informants identified "access to behavioral health care" as the most pressing need in Lewis County. They also identified "mental health and suicide prevention" and "substance use/misuse and overdose prevention" as needs ranked fourth and fifth, respectively, and spoke of these three needs as interconnected and inseparable. Therefore, they are discussed together in this report.

Key informants emphasized that the COVID-19 pandemic has increased the needs related to **mental health and suicide prevention**. They noted seeing exacerbated mental health concerns due to increased stress and isolation. Social isolation, generational trauma, and Adverse Childhood Experiences (ACEs) all contribute to mental health conditions and can contribute to poor physical health. Key informants were concerned that many people are not receiving mental health support services, potentially due to access issues, but also because they may not want to engage in services.

Substance use/misuse and overdose prevention is also an urgent need in the community because substance use/misuse is seen as "rampant" in the community, with concerns about increasing rates of overdoses.

"We're seeing drug overdose at an alarming rate not just in state [sic] of Washington, but in Lewis County. We're at a record pace right now with people overdosing on drugs and so we've got to get that under control."— Key Informant

They were concerned about prescription misuse, alcohol misuse, and use of illicit substances. To address substance use/misuse, key informants emphasized the benefits and importance of harm reduction programs, like needle exchange programs, and peer models (using people with lived experience to support people seeking recovery).

"In my opinion, we need to shift away from the 'having some great ideal for what we expect people [with a substance use disorder] to do,' and simply meet them where they're at and help them take that next healthy choice." — Key Informant

"[A support person in recovery] can then be a really wonderful, safe person for patients who are similarly struggling with [a substance use disorder]. They might identify closer with them rather than identifying with a health care provider who might not personally have that experience and so they'll trust that person more." — Key Informant

Key informants were particularly concerned about young people vaping, smoking marijuana, and using other substances. They spoke about the connection between substance use/misuse and other issues, like a lack of hope and belonging, particularly for young people. They also spoke of substance use disorders (SUDs) contributing to unsafe and unhealthy homes – including domestic violence and child abuse and neglect – if left unaddressed.

Key informants emphasized there is a lack of **access to behavioral health care** in Lewis County. There is a lack of capacity to meet the behavioral health needs in the community, including a lack of organizations or resources to meet the needs.

"We see it day in, day out, whether it be from mental health issues that are caused by drug addiction or just mental health just in general, whether it's with our veterans coming back from either fighting in a war or serving in some [Post-Traumatic Stress Disorder] type of environments. Our mental health issues in our community, I feel, are pretty severe. We don't have the organizations. We don't have the revenue to be able to take care of those needs." — Key Informant

Key informants shared that people with mental health and/or SUD needs cannot access timely care, with many people with a behavioral health need being underserved.

"There are so many people that really, really, really need counseling services. They just need to sit down with a therapist, or they need to sit down with a counselor and work stuff out, and they can't gain access to a counselor. That partly has to do with capacity and other things." — Key Informant

"I think one of our biggest problems, and it's the same problem that a lot of organizations are having right now, is the drug addiction and the mental health care issue. I think a lot of these people are woefully underserved. I think that's real problematic." — Key Informant

A lack of behavioral health providers and provider burnout contributes to a lack of system capacity to meet behavioral health needs. Key informants emphasized that the community needs more counselors, therapists, psychiatrists, and other behavioral health providers. Due to a lack of psychiatrists, some primary care providers (PCPs) may end up managing people's mental health needs. Providers expected to manage unreasonably large, complex patient populations may experience burnout, contributing to provider turnover. Provider turnover makes it difficult for patients to build trust.

"I think that if we look at, for example, mental health specifically, yes, there are some counselors and programs in the community, but there's also a huge turnover of those counselors and behavioral health providers. That's really challenging for patients who already have difficulty trusting the medical system and then opening up about all of their personal things that have happened. Right when they start feeling comfortable, they have to switch to a new counselor. That's really hard, the turnover of providers. Similarly, there's not a lot of psychiatric providers in the community." — Key Informant

A lack of system capacity and providers contributes to long wait times for behavioral health appointments. Patients may have to wait a long time to speak with a counselor for mental health concerns and may experience difficulty scheduling SUD treatment services. For example, patients may need to enter a detox center and then an inpatient treatment program, but depending on availability, there may be a gap in time between these services.

"It's just really difficult to schedule appointments with counselors and whatnot, right? … Moving people, say with a substance use disorder diagnosis into detox, and then into subsequent inpatient treatment is extremely challenging, especially when you couple it with something like struggling with housing or not having a home to live in. Where do you go in the interim if there's a gap between detox and inpatient?" — Key Informant

A lack of funding towards behavioral health care in the community can also contribute to a lack of services and system capacity to meet community needs.

"Well, the first one is right there, at number one, access to behavioral health care. That without question is the number one priority that we need because it's, by just in the terms of dollars, that is the least funded but one of the major needs that we need." — Key Informant

The following gaps in services contribute to behavioral health access challenges:

- Lack of inpatient SUD treatment services.
- Lack of adequate detox centers.

> *"I also don't think we have a detox center that is adequate for our area. Jail's not a detox." — Key Informant*

- Crisis response and stabilization: The Emergency Departments (EDs) are stretched thin with people in behavioral health crisis. There are very few beds dedicated to patients with a mental health need and not enough capacity in the ED to respond to high-intensity behavioral health patients. There is a need for more crisis response options for people in a behavioral health crisis, as well as Designated Crisis Responders (DCRs) to support moving people into inpatient treatment.

> *"All the mental health care that we have, even the addiction issues that we have, to get people into inpatient treatment is still incredibly difficult. There's not enough [Designated Crisis Responders (DCRs)] out there to do the processing that they need. We're having a huge issue with that." — Key Informant*

- Community-based mental health care that is a step-down from hospitalization: There are a lack of mental health services for people who do not necessarily need to be hospitalized, but also cannot be released without some type of care and supportive services.

> *"If we were going to put the number one piece, it would be the mental health component. We have people that sit in our hospitals that need mental health treatment. They don't necessarily need a bed in the ER or even in our hospital, but they take up capacity because we can't just allow them to go back on the streets and to be in harm's way. If we had proper mental health organizations or companies to be able to provide those services, I think that would help alleviate some of the pressure with the hospitals, but it would also give the quality care that is needed in our community." — Key Informant*

- Reunification support services for people with behavioral health conditions: Key informants spoke about the importance of people being reunited with their families and having strong support systems when in recovery.

> *"If you have people that are suffering or struggling [with a behavioral health condition], the one thing that they need is a support network. Without that support network, it's very difficult to get them back on track and back to living their life as it once was, or hopefully once was." — Key Informant*

Transportation can also be a barrier to people accessing services. Lewis County is geographically expansive with some very rural areas, making it more difficult to get services out to those areas, as well as to get people into services.

Specific populations may experience unique or additional barriers to accessing services:

- Young people: Key informants were particularly concerned about young people, including children and teenagers, and increasing mental health and substance use/misuse challenges. There is a lack of behavioral health providers to serve youth and children, making accessing services more difficult for this group.

  "Then the last one, access to behavioral health. We know that we have a lot of needs in that area specifically with youth and children. We don't have providers or many providers down here who are trained to serve that population. That's something that parents are routinely having to travel outside the area to gain access for their kids." — Key Informant

  They shared that they are seeing young people use substances, including marijuana, as a coping mechanism for a lack of belonging and inclusion. They noted that children and their guardians may not understand the effects of smoking marijuana.

  "I see lots of kids using substances in order to manage stress or to numb issues. They'll say that to me it's numbing. Then, I probably would say that isn't a result just of substance abuse. The real result is they don't feel the sense of belonging or hope, so I would go to diversity, inclusion, and hope." — Key Informant

  Young people are exposed to negative information on social media, affecting mental health and behaviors. Many young people experience high levels of stress, suicidal ideation, and a lack of coping skills. There can also be a lack of hope and the support to think positively about the future, like pursuing higher education.

  "Then, that leads to another area that we continue to see. It has leveled off but continue to see higher than maybe three or four years ago, the levels of stress in kids and the level of suicidal ideations, especially at all ages. Then, the lack of coping to manage even stress. It escalates instead of having good coping skills." — Key Informant

  Key informants were concerned about behavioral health challenges exacerbated when children and youth are left home alone frequently or with an older sibling. The high cost of after-school and summer activities prevents many children from engaging. Offering free opportunities can help alleviate some stress and create fun opportunities for building community and helping children build a sense of belonging.

- Older adults: Key informants were concerned about older adults living alone with mental health issues and not receiving care or support because organizations do not know they need help. There is a need for more mental health services specifically to support this population.
- People experiencing homelessness: Key informants spoke about the connection between homelessness and behavioral health conditions, with behavioral health issues contributing to housing instability and homelessness.
- Latino/a/x population: There are a lack of bilingual and bicultural behavioral health providers to serve the Latino/a/x population.
- Veterans: There is a need for more mental health services to specifically serve veterans.

Affordable housing and homelessness

Key informants emphasized that housing is a complex issue that needs engagement and collaboration from multiple sectors.

> *"I think we're seeing this throughout the country, that affordable housing, homelessness these are really big problems and there aren't easy answers. If there were easy straightforward things that communities could do, they would've done it by now. I think it's going to be a long road ahead to really address these issues." — Key Informant*

They shared there is a lack of housing supply, particularly safe and healthy housing, and even fewer options for housing in east Lewis County.

> *"There's just such a lack of adequate – in any regard to housing – just safe, clean housing. Certainly, there's that issue." — Key Informant*

Employees and families cannot find housing in Lewis County and end up having to look in other areas. This makes hiring people difficult if they will not be able to find an affordable place to live. Some employees live outside of Lewis County, like in Olympia or Lacey, and commute in for work, despite preferring to live in Lewis County.

> *"I would definitely put affordable housing and homelessness at the top of the list. We have a lot of employees who cannot find housing here. We have lots of employees who end up living in Tumwater/Olympia/Lacey because that's where they can find housing, even though they would rather live here locally. Then a lot of employees who have seen rents go up precipitously over the last year, year and a half, or however long it's been since rent controls in COVID were stopped. That's definitely a problem." — Key Informant*

The cost of housing is a major barrier for many people. There is a need for more affordable housing to be developed. Particularly for people with low incomes, rent has become "almost impossible" to afford, especially as Supplemental Nutrition Assistance Program (SNAP) benefits have decreased recently. The cost of rent and property taxes have increased, particularly since rent control during the COVID-19 pandemic was stopped. Key informants shared that wages have not kept pace with the cost of housing, which is connected to economic security and a lack of living wage jobs.

> *"Our housing market is so expensive that a lot of the wages don't cover or enable people to be able to live in the houses here." — Key Informant*

The high cost of housing puts a great deal of stress on families, with much "affordable housing" still costing between $1,800 to $2,200 a month, which is not affordable for many families. Building more affordable housing is difficult and some people do not want it built close to where they live.

There is also a need for more supportive and transitional housing, particularly for people needing support services to remain stably housed, such as people with behavioral health challenges.

Key informants spoke of a need for more homeless services and shelter beds. Shelter space is very limited, although organizations have been working on developing a night-by-night shelter program in 2023. Having more shelter beds and more outreach to get people connected to services is important for getting people off the street so that they are safe. Beyond shelter, the community needs to ensure there are wraparound support services for stabilization and health, and hygiene services for people living unsheltered. This is specifically needed along the I-5 corridor.

> *"If you put somebody in a shelter for a night, that's one thing, but if you could put them into a service mode, a support network, a navigated network where you have a wraparound service to help create prosperity, now you have a downtown business that doesn't have somebody sleeping in their doorway. It engages everybody and it has meaning to everyone." — Key Informant*

The complexity of the housing system can be difficult for people to navigate. They typically must talk to many people and complete a number of applications to access housing supports. There needs to be more support to address the bottleneck of services due to so many people seeking services.

The following are groups that may experience more barriers to housing stability:

- Older adults: With the increasing cost of housing, some older adults over the age of 60 years are potentially experiencing homelessness and housing instability for the first time. Particularly, older adults living on a fixed income may have difficulty keeping up with rising housing costs. Key informants expressed concern for older adults living alone, not connected to services or known to service organizations, who may be living in unhealthy and unstable housing situations.

- People with behavioral health challenges: Key informants identified behavioral health and homelessness as interconnected needs, noting they must both be addressed to make meaningful progress.

Access to health care services

Key informants spoke of a lack of primary and specialty care. They emphasized it can be especially difficult to establish primary care, with people waiting up to six months to get a new primary care provider.

> *"I would say like with access to health care, it's so difficult for a lot of our clients that don't have a history with primary care to gain access to primary care, especially given the shorter duration of interest in pursuing some of their health care needs. And when folks are having to wait a month or so to be able to schedule an appointment, they're just not all that inclined to even do it." — Key Informant*

Key informants shared that some primary care practices in the community have closed over the years, forcing patients to find a new provider. This change can make it difficult for patients to build a relationship and trust with one provider.

> *"I think that just as far as specifically health-related things, a lot of people find it more difficult to have a long-term relationship with a primary care doctor because people come and go. There are fewer private practices where people have the same doctor their whole life and so forth." — Key Informant*

As primary care clinics close and providers leave the community, potentially thousands of patients are left trying to find a new primary care provider. This puts tremendous strain and stress on those providers left in the community trying to meet the needs and serve those patients. This contributes to provider burnout.

> *"We're, as I'm sure you know, a health care provider shortage area. It's difficult to access primary care here. Just anecdotally, even for me, I had to get a primary care doctor who's up in Thurston County because there was no one here. When the provider that I was established with closed up shop, there were no providers available." — Key Informant*

Key informants emphasized there is a need for more primary care providers to support the aging population, including people on Medicare and people on Medicaid. There is a "large swath of the population" that does not access primary care to manage chronic conditions. This contributes to people using the Emergency Department (ED) as their main form of health care.

> *"I think that managing chronic conditions, it's really difficult because we have the large swath of the population that doesn't get care. We know that they are out there using the [Emergency Room (ER)] as primary care, using the ER when their conditions*

are finally so out of control now, and that just creates a problem in and of itself." — Key Informant

The ED is overwhelmed not only by people with unmanaged chronic conditions, but also people with behavioral health conditions. People are waiting to access care until it becomes an emergency, rather than preventing emergencies. There can be long wait times for ambulances dropping off patients at the ED. There are also people trying to get in to see their primary care provider, but their condition worsens before their appointment, and they seek care at the ED.

"We have rampant abuse of the hospital because they don't have a [primary care] doctor, which slows down everybody else getting seen [whose cases] are severe." — Key Informant

Lewis County needs more urgent care facilities to lessen the burden on the ED and ensure it is reserved for emergent issues.

Accessing specialist care is also difficult, with many people traveling outside of Lewis County to Olympia, Tacoma, or Vancouver to access specialist providers. This creates additional barriers for people who have low incomes or are uninsured or underinsured. Transportation can also be difficult, particularly for older adults.

"It's harder and harder to get a physician and particularly specialists. Most of those things we're going to Olympia for now. Then there are certainly lots of low-income and uninsured or underinsured folks and some of those needs are [not] being met." — Key Informant

"There's not a lot of specialists in the community, so most of our patients have to travel at least to Olympia, often to Tacoma, or south to Vancouver to access specialist care. That's particularly challenging when transportation is not easy. There's no public transportation between those. Then we have, again, a lot of elderly patients, so that makes that more complicated." — Key Informant

Key informants spoke about needing more specialists in gerontology, endocrinology, cardiology, and psychiatry. There are delays in referrals from primary care because of understaffing in hospitals and lack of local specialists.

Key informants discussed the following gaps in health care services in Lewis County:

- Health care providers: Nursing shortages and provider burnout are contributing to fewer providers in the community. There is a need to build more awareness of careers in health care and to support students in pursuing those careers and remaining in Lewis County.
- Lack of hospital capacity: Key informants spoke of local hospitals not having the capacity to meet the needs of Lewis County, with patients being diverted to other areas. The ED is

overcrowded with patients waiting eight to twelve hours to be seen. Key informants spoke of needing larger hospitals to meet community needs.

- In-home health care aids and caregivers: There is a lack of caregivers for older adults and in-home health care aids in general.
- Care coordination: There is a specific need for more care coordination for patients after being discharged from the hospital to support follow-up care, medication management, and more. This is important for preventing future hospitalizations.
- Access to cancer screening: Cancer screening can be difficult to access locally with people sometimes driving two hours to get a mammogram. Colonoscopies for colon cancer screening have a long wait list as there is a backlog of people seeking this screening after not receiving it during the COVID-19 pandemic.

Barriers to accessing care include the following:

- Transportation: Lewis County is expansive with many rural areas, making it hard to get health care resources to those areas and for people to travel to services. Transportation is a major barrier for many people, both within Lewis County and from Lewis County to other areas. Gas prices can be a barrier for people traveling to health care services.

  Transportation is especially difficult for patients seeing specialists because they often have to travel out of Lewis County to Olympia, Tacoma, or Vancouver. Transportation can be especially difficult for older adults.

  "It means that [transportation is] very difficult for people, especially when they're needing to access health care. I know for example – folks who have cancer or older folks who just have chronic health conditions – if they're not able to drive themselves, it's difficult for them to access care physically. Even if it was available here or in Olympia or Seattle, it's quite a trek to get there. That's something that's a major challenge." — Key Informant

- Health literacy: Key informants spoke about the health care system being difficult to navigate and many patients needing support to understand their diagnosis and how to engage with the health system. They emphasized that patients need more than just a brochure; they need to build relationships and trust. There is a need for more health care navigation to support people, particularly those unfamiliar with the system. Community Health Workers (CHWs) can also support patients in making appointments and following up on their care. This may be especially important for patients who have complex needs, such as those experiencing homelessness.

  "I don't know how we expect our patients to navigate [the health care system] when even for us, when we're trying to do it for ourselves personally, it is incredibly challenging. You can see why people just give up on it." — Key Informant

There is also a need for more health education related to chronic conditions. Providers are seeing a lack of health literacy contribute to unmanaged chronic conditions, with rates of diabetes "skyrocketing" and difficulty getting patients to engage in their care and understand how to manage their condition.

"I think that the rates of diabetes in this country are skyrocketing and will continue to for a while. It's just so incredibly difficult. The more under-resourced, the more underserved, the more … lack of medical literacy a community has, the harder it is going to be to try and get them to engage in their care and really understand that these things will have repercussions in the future that are going to make things even worse." — Key Informant

Some patients may not fully understand their diagnosis, including a diagnosis of dementia or a chronic condition. People may have access to misinformation online and on social media. Having access to accurate, understandable information is important for helping patients and their families navigate diagnoses.

"When I worked in the library, a lot of times, people would come in because their doctor didn't explain something to them, and they wanted to know, 'What was the surgery?' or 'What is this thing they just told me I had?' That's not fair that somebody who doesn't understand – I've seen that time and time again – low income or lower education, people just don't understand their diagnoses, so really helping them with that, so they know how to make the best choices." — Key Informant

- Access to and comfort with technology: Telehealth appointments may be beneficial for some patients, but a lack of access to technology and broadband, or comfort with technology, can prevent people from using telehealth appointments.
- Distrust of the medical system: The COVID-19 pandemic worsened some distrust of the medical system. This creates challenges for providers trying to engage with the community and patients.

Specific populations may experience these barriers and more to accessing care:

- Older adults may have difficulty finding a provider that accepts Medicare and accessing specialists, particularly if they have to travel out of the area. There is a lack of in-home caregiver services and a need for more in-home health care. Many older adults' needs go unaddressed because they cannot access that care.
- People living in east Lewis County: East Lewis County is more rural and has fewer health care resources. People have to travel farther to access care and may have difficulty getting the preventive and emergency care needed.
- Latino/a/x community: There is a lack of bilingual and bicultural health care providers and staff that speak Spanish, making accessing care and navigating services difficult. The Latino/a/x community is increasing in Lewis County, but there are few organizations engaging meaningfully

in outreach and services with the community. There needs to be more intentional outreach to understand how best to serve this community and meet their needs.

> *"Like I said, our Spanish-speaking population is growing, or at least our Hispanic population is growing so I think one thing that the community could work on is just having more services available in Spanish. I think we're all facing hiring challenges, but I think that agencies and organizations could prioritize hiring folks who are bilingual or better yet bicultural." — Key Informant*

- People identifying as LGBTQIA+: Accessing care that is responsive to and affirming for LGBTQIA+ health needs is difficult. Key informants spoke of the importance of creating an explicitly welcoming and safe environment for LGBTQIA+ patients. Additionally, providers need to engage in continuing education around care for LGBTQIA+ patients. There are not many resources or support groups for LGBTQIA+ people within Lewis County.
- People without insurance or not Medicaid eligible: There is a lack of health care resources for people without insurance.

Economic security and income inequality

Economic security is important for people's health and well-being; it helps them be happier and contribute to the community, like through volunteering. Key informants emphasized that people cannot be healthy if they cannot meet their basic needs.

> *"When people are financially stable, they're happier. They're more apt to do more things. They're more apt to be healthier. … They're more apt to enjoy life more. They're more apt to volunteer. They're more apt to do a lot of things." — Key Informant*

> *"In order for people to be healthier, one of the prerequisites to that is that they needed to have more money. They needed to be employed. There are so many health outcomes that are linked to income and those are some of the things that we're really challenged with here." — Key Informant*

Lewis County has a lower median wage than Washington state and nearby Thurston County. Some residents of Lewis County go to work in Thurston County because the wages are more competitive.

> *"I would probably pick economic security and income inequality. In general, Lewis County has lower median wages than the rest of the state and particularly a lower [median wage] than Thurston County. We lose a lot of employees to jobs in Thurston County because of wage competition." — Key Informant*

Due to an expensive housing market in Lewis County, wages do cover housing costs for many families.

"Our housing market is so expensive that a lot of the wages don't cover or enable people to be able to live in the houses here." — Key Informant

Addressing economic security is connected to opportunities in education and in job skills and technical training. Key informants spoke about inequity in resources for Lewis County school districts, with opportunities not evenly distributed. Key informants would like to see education more highly valued in the community.

"Number two would be a stronger value set around education. Supporting our schools more would be something I see our community needs to do." — Key Informant

Bachelor's degree attainment is lower in Lewis County than in the state overall. For young people, a lack of hope and lack of conversations at home about the future and educational opportunities may contribute to fewer people wanting to pursue higher education.

Job skills and technical training is important for helping people grow and seek higher paying jobs. The economy in Lewis County has been transitioning away from the industries that have historically been most dominant: farming, forestry, logging, and coal.

"Something that comes up just in talking with the community is the economic depression in the area. We have a higher unemployment rate. We have lower educational attainment rates. There are some structural problems. I think we're still in a way, I think, transitioning from an agriculture extraction economy to more of a service economy." — Key Informant

This transition away from an agricultural economy has contributed to a lack of job opportunities locally and high unemployment. Many young people leave the community for work opportunities and may not return.

While public benefits do help people whose incomes are below a certain threshold, those resources are not fully meeting the need. Supplemental Nutrition Assistance Program (SNAP) benefits have been cut drastically this year, contributing to increased food insecurity.

"A lot of people have lost their SNAP benefits, so for a lot of low-income people, just being able to pay rent and eat is becoming almost impossible." — Key Informant

Key informants shared that public benefits only help people up to a certain income level and then quickly stop (otherwise known as the benefits cliff). Once people start to stabilize, the benefits end and one event or accident can be devastating. This system incentivizes people to pass up promotions or pay raises, keeping them in fear and preventing opportunities for growth.

"Once they start getting their feet under them, everything disappears and it's so easy to drop back down. It scares people to move up because they know that their benefits

are going to disappear, and they don't know what to do if something doesn't work. Not only do you tangibly penalize them, [but] you set them up with a mentality that 'I'm sticking with these benefits because that I know is what I can get and I'm not going to take a chance on myself or anything else to move ahead.'" — Key Informant

Families with low incomes may not be able to afford after-school or summer recreational activities and sports. This means those children are excluded from exercise and social activities because of cost. These activities are important for physical activity, mental health, belonging, community building, and more.

The following groups may experience more barriers to economic security:

- People living in rural areas, including east Lewis County: Key informants shared that access to resources is more difficult in rural areas. There are also fewer jobs and lower incomes in east Lewis County.
- Latino/a/x families: Particularly families that primarily speak Spanish may experience more economic insecurity, even if employed. Key informants shared there is a need for more bilingual staff in schools to communicate with families and share information. There should be more intentional engagement to understand these families' needs and support their children in accessing educational and economic opportunities.
- Older adults: Particularly, older adults living on a fixed income from Social Security or Disability may have difficulty affording housing, food, and other basics. Local organizations may not be aware of the needs of older adults living alone, although there could be resources that could benefit them.
- Women: In Lewis County, women tend to make less money than men. In households with a single female as head of household with children, there is more difficulty being financially secure.

Food security and nutrition

Key informants emphasized that access to nutritious, affordable food is a major issue for many families and individuals living in Lewis County. The need has recently increased with the cuts to SNAP benefits. To make up for the drastically reduced benefits, many people are seeking other food resources, like food banks.

"Access to food resources is a major issue. SNAP accounts have been cut drastically, almost entirely for some households, in just the last couple of months, and so we've seen increases of delivering approximately 600 food boxes a week to over 1,000 food boxes a week in the last couple of months." — Key Informant

"A lot of people have lost their SNAP benefits. So for a lot of low-income people, just being able to pay rent and eat is becoming almost impossible." — Key Informant[6]

Families with low incomes may be especially affected by food insecurity, particularly with the rising cost of housing. Key informants shared that within school districts and colleges, many families and students

[6] Quote also appears in the "Economic security and income inequality" section

are seeking food resources. A high proportion of students qualify for free and reduced lunch in local school districts. Additionally, colleges are being asked to pick up more traditional social service functions, like providing food resources, to meet students' basic needs to help them be successful.

Accessing nutritious, affordable food, as well as food resources, is more difficult in rural parts of the county, including east Lewis County. People may have to travel long distances to the nearest food bank and may experience transportation barriers. Even people with cars may not be able to afford the fuel expense. Families are making spending tradeoffs, deciding on how to best use their money — on gas or on food.

> *"Households are really struggling to put food on the table. Part of that struggle too is that Lewis County is so vast and expansive that individuals even being able to afford to get to their nearest food bank is extremely [difficult]. People are making a real choice to go get some food and spend the gas money, or do without the food and save the gas money, and/or they may not have the gas money even to get there." — Key Informant*

Ensuring families have access to nutritious food is connected to child well-being. A lack of healthy and nutritious food contributes to long-term health challenges, like obesity and diabetes. Key informants suggested more education regarding nutrition and healthy cooking.

Aging adult health and fall prevention

Key informants shared Lewis County has a large population of older adults and needs more resources to support aging adult health and prevent falls. Falls are a major concern because they can lead to hospitalization and death, and they are preventable. There is a strong need for more partnership to address fall prevention and support home modifications and safety. Lewis County has one of the highest rates of falls in Washington state, especially in its remote areas.

> *"Of course, that leads to so many hospitalizations and even deaths, and that's all preventable." — Key Informant*

Falls are especially a concern for older adults living alone without people checking on them. There is the risk that they could fall and not be able to call for help.

There is also a lack of access to good caregiver services. Key informants spoke of needing more in-home health care for older adults. This care should also include support for older adults after discharge from the hospital to ensure that they have help with follow-up appointments, filling prescriptions, and making home modifications (such as installing grab bars) to prevent future falls.

Care for older adults is considered to be underfunded. Key informants advocated for more resources dedicated to caring for older adults and keeping them healthy.

> *"I think our senior care is also massively underfunded as far as getting our seniors the care that they need. They're those that are on fixed incomes. They're seeing the pinch*

even stronger than most people when it comes to our economy, but as far as getting them the proper attention and care that they need, I think that that is another social health issue that we have in our area that we really need to put money in from the legislature." — Key Informant

Accessing care in Lewis County can be particularly difficult for older adults because there is a lack of specialists locally. Older adults may have to travel outside of Lewis County to Olympia, Tacoma, Vancouver, or other areas to access specialists, including gerontology services. Transportation may be especially difficult for older adults who cannot drive themselves or have mobility issues. It can also be difficult to find providers accepting Medicare.

THURSTON COUNTY: FINDINGS FROM KEY INFORMANT INTERVIEWS

COMMUNITY STRENGTHS

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

Community organizations want to collaborate and work together to meet needs more effectively

Key informants spoke of many organizations wanting to work together and partner to better meet community needs.

"One of the things that I see in our community is the desire to collaborate amongst agencies that are providing services to families and children, and that's been an ongoing conversation for as long as I can remember."— Key Informant

They spoke of current relationships working to address behavioral health needs and homelessness, including strong workgroups and coalitions focused on these collective impact efforts.

"While those partnerships formed long before Thurston Thrives did, that's been an asset to have that collaboration of partners thinking on housing and working together on housing or the partners for children, youth, and families to be able to come together and talk about the increase in childhood abuse and neglect." — Key Informant

Relationships between health care providers, including hospitals, community health centers, and public health, all contribute to improved care coordination. Strong relationships and trust between organizations is key for making progress on addressing complex issues.

"I think there is really strong trust and relationships and I think that we are better together … when those exist. I've seen some really amazing work get done and help to people that is getting accomplished because of that trust and those relationships that have been built. I think leveraging those relationships is helpful and good and should continue." — Key Informant

However, key informants were quick to note that the desire to collaborate is not always supported by strong systems that incentivize collaboration, leaving quite a bit of room for more strategic collaboration. The main concern was avoiding siloing of services, which prevents addressing the whole needs of each patient or client.

"I believe in Thurston County that we have a wonderful array of health care providers, and behavioral health providers, and nonprofits, and service organizations, and community resources —a huge array of them. There does not seem to be a coordinated approach amongst those groups, there does not seem to be a coordinated approach within the municipalities, and I think that all of our marginalized, underserved, under-resourced community members are getting caught in the middle of that."—Key Informant

They spoke about the importance of understanding the work that one another are doing, including more communication and a centralized referral system to ensure that they are able to refer to one another effectively. Key informants also spoke of the benefits of sharing funding and co-locating services to improve multi-sector collaboration and wraparound services. They shared that, often times, unique funding sources make it difficult for people to collaborate or think about whole-person care.

"I think the suggestion I would have – I don't know if people would agree with it – is to think more holistically that you cannot have a conversation about housing without including access to food and transportation. We have a community that likes to work together, and yet often because the funding sources are siloed, we end up not thinking across those silos." — Key Informant

To address this, key informants suggested that applying for funding and grants together can help avoid competing for resources. No one organization can solve a community's needs or address a complex need fully; therefore, collaboration is the only answer.

"I think that if there was better collaboration, we could make more of a dent in the issues that our community is experiencing." — Key Informant

"All of these factors are so intertwined and interconnected that it's really important to be able to not have the expectation that any one organization is going to be able to meet all of these things. We have to find ways to really collaborate, work together, and build on the strengths of our community and pull together the experts in each area to be doing the work collectively."— Key Informant

Key informants noted that a multi-disciplinary approach should include grassroots organizations and community-based organizations that have trusted relationships in the community. This will help improve health equity and tighten the safety net.

Community members are engaged and have unique knowledge and wisdom to share to make the community healthier

Key informants described community members as being already engaged and involved in the community, with a desire to help one another and share their opinions. Community members have formed grassroots efforts to address community needs. Young people are engaged in telling organizations how services should look and how organizations should support them. LGBTQIA+ individuals have resources compiled within the community and share those resources with one another. People with lived experience provide peer support and walk alongside others experiencing similar situations.

> *"We have a strong, amazing, vibrant community that is really engaged in activism and social justice in our community, and I think we need to leverage that and be intentional about what we're going to do to transform Thurston County, but it has to start with community." — Key Informant*

Creating intentional space for people to share their voices and be part of solutions is critical. Key informants discussed including people with lived experience on advisory boards regarding funding of programming and addressing needs. Better efforts to be inclusive of all community members is needed, particularly for groups that are historically not included in decision making.

> *"We have some voices that are not at the table. We need to work really hard that we're inclusive of every member of our community and not just those who speak the loudest." — Key Informant*

Organizations, including health care providers, should also ask patients how they want to receive services and learn more about barriers to care.

> *"I think if services could do a little bit more to really engage the actual stakeholders, the actual patients and how do you want to access these services, what is not even most convenient but what makes it possible for you to connect, and really engaging a stronger voice from the people who actually need the services, that would be a good strategy." — Key Informant*

Grassroots organizations are already leveraging important community knowledge and wisdom. Larger organizations can help these smaller grassroots efforts build capacity. Organizations can build upon trusted relationships in the community to gain meaningful information about needs and use the feedback from participants to develop plans and strategies that incorporate community voice.

Community members are resilient and hopeful, working towards improving their lives and the lives of their families

Many of the key informants spoke of the people their organizations serve as resilient. They defined resilience as working really hard, despite obstacles, and being persistent and tenacious. They described strong problem-solving skills and resourcefulness. They also described community members staying rooted in their culture while adapting to change.

> *"Resilience and a problem-solving orientation. If you think about the challenges to accessing services just for any person and then you throw in any sort of curve ball, like, okay, now you have to access the service but you don't have internet or a device that you can … You don't have a phone, you don't have a house, you don't speak the language that the service providers speak. I would say our patients are incredibly resilient in their ability to just continue to persist and try to access services." — Key Informant*

Key informants shared that community members are hopeful and have dreams. They remain determined that life can be better for their children, and they remain committed to improving their situation. They specifically identified immigrants and refugees as remaining hopeful and grounded in their culture.

> *"The greatest thing I see our community have is hope. These families have come here for a reason, and as long as they can keep that hope. As long as our organization and other organizations realizes [sic] that being able to keep their cultural identity is key to them retaining that resilience and keeping themselves strong." — Key Informant*

> *"People just remain so hopeful and remain steadfast that life can be better. It's a really beautiful thing, but I think that it's a double-edged sword because I feel like they shouldn't have to be that resilient, but they are." — Key Informant*

PRIORITIZED UNMET HEALTH-RELATED NEEDS

Key informants were asked to identify their top five health-related needs in the community. The health issues that were highly ranked by key informants are below in order of rank:

1. Access to behavioral health care
2. Affordable housing and homelessness
3. Substance use/misuse and overdose prevention
4. Diversity, inclusion, and belonging
5. Mental health and suicide prevention
6. Access to health care
7. Economic security and income inequality
8. Racism and discrimination

9. Community engagement and involvement

Access to behavioral health care, substance use/misuse, and mental health

Key informants identified "access to behavioral health care" as the most pressing need in Thurston County. They also identified "substance use/misuse and overdose prevention" and "mental health and suicide prevention" as needs 3 and 5, respectively, and spoke of these three needs as interconnected and inseparable. Therefore, they are discussed together in this report.

Key informants emphasized that behavioral health care is a basic need, critical for all people to have to survive and be healthy; it is not a commodity. Regarding, **substance use/misuse and overdose prevention**, key informants were particularly concerned about an increase in fentanyl and resulting deaths by overdose. They spoke about substance use/misuse and overdose deaths as affecting entire communities.

> *"Addressing overdoses, both stimulants and opioids and other substances in our community, is a huge issue as well because we have a rising fatal overdose rate that's contributing not only to the number of deaths in our community, but then also contributes to PTSD and grief and trauma that other folks have to experience whether that's friends, family, or children of folks who have been lost to overdose."*
> *— Key Informant*

They spoke highly of harm reduction programs, including trainings for administering naloxone, although think there is a need for additional low-barrier, supportive services for people with a substance use disorder (SUD).

Mental health and suicide prevention is a pressing concern and is deeply linked to many other needs:

- Diversity, inclusion, and belonging: Having a sense of belonging is foundational to mental health. Social isolation and a lack of inclusion contribute to more mental health challenges.
- Child abuse and neglect: Unaddressed mental health challenges can contribute to child abuse and neglect.
- Climate change and environmental issues: Climate grief and stress from extreme weather and the resulting issues, like food scarcity, can contribute to mental health challenges.
- Access to health care and chronic conditions: Unaddressed mental health conditions can make managing chronic conditions and engaging with preventive health care more difficult.

Key informants spoke about seeing more suicidal ideation and mental health challenges coming out of the COVID-19 pandemic. They shared that addressing suicide is an urgent issue. They also noted that providing follow-up care for people after being discharged from inpatient care for a mental health condition, including medication management, is needed.

"Coming out of COVID, we are different than we were going into COVID. I've seen more suicide ideation in the last year than I've seen in the previous 10 years." — Key Informant

There are a variety of factors that are seriously affecting **access to behavioral health care** in Thurston County. In general, there is a lack of capacity to meet the growing need, leading to long wait times for both mental health and substance use/misuse treatment services. Key informants spoke of people waiting six months for a mental health evaluation.

"The specific areas are that waiting lists for care are extremely long. Even for patients who are insured, being able to find providers who take their insurance is really difficult. Substance use disorder treatment is really difficult to find. We've had many people come in and say, 'I want to go to detox,' or inpatient treatment, or like, 'I need help. I'm worried about what I'm going to do,' and then there are no beds available. That's definitely a huge issue." — Key Informant

The following gaps in services contribute to behavioral health access challenges:

- Residential or inpatient care facilities: There are limited inpatient beds for people with behavioral health challenges, primarily due to a lack of funding.

  "Residential treatment services are something that—there's definitely a lack of those. Most of that's due to funding. … There's not a lot of residential beds out there for people to go into. That's interesting, and something we need to fix." — Key Informant

  For parents or guardians, there are no inpatient options that allow patients to bring their children. This creates a barrier for people with caregiver responsibilities to enter into an inpatient treatment facility.

  "For families that are ready to access substance abuse care, but have kids, there's really not an inpatient option for them that accommodates their need to have their kids with them. We know too that if they have their kids with them while they're receiving their care, they're more likely to be successful with that program as well. That's a big need that I see for our community, particularly when we see the opioid addiction challenges across our community continuing to rise." — Key Informant

- Crisis response and stabilization: There are limited emergency bed options for people with an acute mental health or SUD crisis. There needs to be additional coordination between service providers to ensure that there is adequate capacity to respond to behavioral health crises.
- Treatment services for people with dual diagnoses needing high levels of care: Patients with a mental health need and a SUD often need more intensive support than current facilities can provide. They are often exited from facilities, but there is nowhere else locally to send these patients.

A lack of funding, community coordination, staffing, and alignment between physical and behavioral health care contribute to these gaps in services. Key informants spoke of an "extreme" lack of behavioral health care providers, noting a need for more counselors specifically. They would especially like to see more counselors accepting Medicaid and Medicare, as well as those that can serve people under the age of 18.

Reimbursement models and lack of equity in reimbursements amongst behavioral health providers contribute to the lack of capacity in local services. For example, reimbursement rates for residential treatment for patients with Medicaid are lower than the cost to provide services. These systemic factors limit access for patients.

The following barriers prevent people from accessing needed behavioral health care:

- A lack of providers that are bilingual and bicultural: For Black, Brown, Indigenous, and People of Color (BBIPOC), having a provider that can provide care in a culturally relevant way and understand their experiences is crucial. A lack of culturally informed mental health providers is lacking.

  "There is no connection between providers and patients. More when those patients are looking for services are immigrants or refugees or people of color. They don't feel that the doctors are really relevant to their culture or to their experiences." — Key Informant

  "Honestly, our biggest unmet need is trauma and culturally-informed mental health professionals, all the way from counselors to psychiatrists." — Key Informant

- Cost of care: Even with insurance, copays and meeting deductibles can make behavioral health services unaffordable for families. Families may have to decide between paying bills or seeking behavioral health services.
- Transportation: Patients may need to travel to other areas, like Tacoma, for behavioral health appointments, which can be a barrier. The cost of gas is also high, meaning even people with a car may not be able to afford the expense. To address equity, behavioral health services should be located where people already go and should be embedded in the community.
- Hours of services: People may only be able to engage in behavioral health services outside of business hours or working hours.

Specific populations may experience unique or additional barriers to accessing services:

- Young people: Key informants were particularly concerned about increased depression, substance use/misuse, and behavioral challenges in young people, particularly as a result of the COVID-19 pandemic. They noted seeing more behavioral issues in very young children in childcare centers, as well as more extreme mental health challenges in teenagers.

"As a provider of services to families with kids, we've seen especially in our young adult and teenage population, it's just so prevalent that there is [sic] extreme mental health challenges and depression and a lack of resources to really dig in and support people in becoming healthy when they're in those situations." — Key Informant

There are very few behavioral health providers to support young people with behavioral health needs in Thurston County and it can be difficult to find care. Key informants suggested integrating behavioral health services into schools.

"Typically, kids only have a couple of options when it comes to meeting their behavioral health or mental health needs. Either they have to do something severe enough to require them to have a stay overnight, stay at least in the hospital, sometimes up to seven days, or they end up in the juvenile detention system. There's not a lot in between." — Key Informant

- People experiencing homelessness: Unaddressed behavioral health issues can contribute to engagement with the criminal legal system. A lack of resources to coordinate services across sectors makes meeting needs more difficult. Ideally, behavioral health services would be provided within a shelter or supportive housing setting to support long-term stabilization and individuals remaining housed. More flexibility in behavioral health appointments would also be beneficial for folks who may not have a cell phone or transportation to get to an appointment at a designated time, but who may need services available when they decide they are ready to engage.

"We follow a housing first philosophy, get people in housing as quickly as possible and as a primary goal, and then to lay on those additional services to support the things that impacted their housing stability to begin with. Oftentimes that's domestic violence, substance abuse challenges, mental health issues, but what we experience a lot is we get people into housing, but then we still don't have the resources to provide the level of support to address all of those barriers in a way that really helps to stabilize the family long term." — Key Informant

- People identifying as LGBTQIA+: This population is disproportionately affected by behavioral health needs, including depression. Discrimination and a lack of inclusion and belonging contribute to these challenges and increased isolation.

"If you recognize that there are less risk-taking, or otherwise, self-harm, or self-destructive behaviors going on, that's an indicator of a healthy community. For people to be able to think for the future, and see themselves being here in 10 years, and 20 years, and 30 years down the line, that is a sign of a healthy community. Right now, I would say our entire community is struggling with mental health issues, with

suicidal ideation, and a lot of really heavy things, where our community is drowning a bit." — Key Informant

There is a strong need for more therapists that are affirming and well-educated on the needs of LGBTQIA+ patients. Ignorance, stereotypes, and discrimination make people unwilling to and fearful of accessing services. Older adults identifying as LGBTQIA+ may experience mental health challenges when entering a skilled nursing facility or other living situation where they are not safe and accepted, contributing to isolation and depression.

- BBIPOC communities: BBIPOC communities are disproportionately affected by behavioral health needs and are typically underserved. There was specific concern for BBIPOC young people. In some communities, there may be stigma towards seeking mental health services.
- People living in more rural areas of Thurston County: In more rural areas of Thurston County, including south Thurston County, there are fewer behavioral health resources available, and less outreach related to substance use/misuse. There are also fewer providers available and more transportation barriers.
- Military families: There are many military families in Thurston County and some experience mental health challenges that may result from trauma, frequent moves, or parents having to spend substantial time outside of the home.

"One of the things that we have in our community … is the impacts of having military in our community and what that means to frequent moves. It's tied to mental health. It's tied to parents being outside of the home. It's out there." — Key Informant

Affordable housing and homelessness

Key informants identified affordable housing and homelessness as one of the most pressing needs. Housing is a foundational need, meaning addressing housing needs will support addressing other needs like behavioral health challenges, physical health, and domestic violence. Without housing, other needs cannot be met.

"I would say that the most pressing [issue] is access to housing. We believe strongly that housing is a health care intervention, and that without having that resource, every other health-related outcome is negatively exacerbated, so management of chronic illness, ability to heal from acute illness or acute injury, stabilization of mental illness, and opportunity for recovery from substance use disorder, however someone might define recovery for themselves." — Key Informant

The need for safe, affordable housing is only growing in Thurston County. The cost of living has increased and is very expensive for many families. Many families spend a great deal of their income on housing. It can be particularly difficult for people to afford housing if they have a low income or are on a fixed income from disability or social security. There is a specific lack of low-income housing in south Thurston County.

Particularly in some areas of the county, people live in unhealthy housing where there is mold and other hazards. There needs to be a deeper investment towards affordable housing, recognizing that safe, healthy, affordable housing is a human necessity. Affordable housing is connected to creating a safe living environment for children. Unstable and unsafe housing contribute to further unmet health needs for children.

> *"The mental shift that I think we have to make is away from a place where housing is a commodity, a [sic] investment strategy, a retirement plan for many people, and to a place where housing is a necessity for any individual to have any opportunity to not die. It's a fundamental human necessity." — Key Informant*

Key informants spoke about needing more housing across the spectrum to support people experiencing homelessness and housing instability.

> *"One of the biggest things that I would say is a lack of available and affordable housing on the complete spectrum. Everything from a spot for sanctioned encampments, to overnight shelters, to long-term shelters, to permanent supportive housing, really housing all across the spectrum, because it's not a one-size-fits-all package. Some folks are going to fail in certain housing options. Then you also have folks who cannot get into housing because of our current housing cost in Thurston County being astronomically high." — Key Informant*

Specific housing needs include the following:

- Permanent supportive housing: This type of housing is specifically needed to support folks in gaining long-term stability, especially for people who may have experienced chronic homelessness. It is also important for people with behavioral health challenges. Key informants spoke of permanent supportive housing as important because it creates a wraparound community for the residents, where people can know their neighbor, build a sense of belonging, and have services co-located to support them. Key informants emphasized that addressing housing-related needs is critical and there is a lack of resources to provide the support needed to keep people stabilized and housed long term.
- Emergency, short-term, and long-term shelters: Key informants shared there is a need for more shelter beds, both just for a night and for longer-term stays. There is also a need for emergency shelter beds for people leaving a domestic violence situation. Currently, people in a domestic violence situation may not be able to find a shelter with space for them, leaving them to remain in an unsafe situation.

> *"We have a lack of shelter spaces in our community. We're not able to provide even a temporary safe place for people, both for domestic violence and within the homeless system as well and even within the greater community for people who are living outdoors." — Key Informant*

To support people living unsheltered, there is a need to provide more homelessness services. Key informants noted a need for a safe spot for a sanctioned encampment, rather than having people searching for a place to put their tent for the night. They also noted a need for more hygiene services for people living unhoused and a need for bringing medical care to where people are living or sleeping. People experiencing homelessness often have significant health needs with limited outreach medical care or respite beds. In addition, outreach related to other determinants of health are needed. Key informants were concerned about the discrimination people experiencing homelessness face and how they are often not treated well in health care.

Some communities or people may experience specific barriers to safe, stable housing:

- Older adults: More older adults are entering homelessness for the first time because of the rising cost of housing and inability to afford their rent. There is a lack of programs and services for older adults related to homelessness and affordable housing.
- BBIPOC communities, particularly Latino/a/x communities and Indigenous peoples: BBIPOC communities are overrepresented in the homeless system and underrepresented in the shelter system, which could point to barriers for these families in accessing services.
- LGBTQIA+ community: People identifying as LGBTQIA+ are overrepresented in the houseless community, particularly among youth. Key informants were concerned about young people who are thrown out of their homes or forced to flee because of their gender identity or sexual orientation, particularly for transgender youth. Discrimination contributes to the higher rate of homelessness for LGBTQIA+ people.
- Young people. There are very limited support services for unaccompanied minors and those experiencing homelessness in Thurston County. Of particular concern are those identifying as LGBTQIA+.

> *"The LGBTQ community is over-represented in the houseless community, particularly among youth. Many, many youths are kicked out of their homes or run away because they are queer. This is particularly true for transgender youth. This puts their health at risk as they lack resources to get medical attention when needed and it can also lead to things like drug addiction or sex work or things that put them at risk." — Key Informant*

- People with behavioral health challenges: There is a lack of low-barrier supportive housing for people with behavioral health challenges. Housing is critical for addressing behavioral health, but often times housing is contingent on people being in recovery or other factors. Therefore, there can be many barriers to engaging in housing programs, which makes addressing the behavioral health needs difficult.

> *"I think permanent housing, number one, and then also low-barrier emergency housing options for people. I think that one of our biggest gaps right now is not only*

the number of emergency bed options for people to be able to go to, but also the lack of treatment bed options for both people who are in acute crisis for mental health and substance use disorder. It's the intersection of homelessness, mental health, and substance use, and options to meet the immediate needs, but we cannot focus only on that as a community; we have to also in tandem focus on permanent housing solutions for people. If we focus on one or the other, we will always have a continuously incomplete system." — Key Informant

Diversity, inclusion, and belonging

Diversity, inclusion, and belonging is closely connected to racism and discrimination and is a driver of most other needs. Key informants spoke about the importance of embedding a focus on diversity, inclusion, and belonging into all systems and programs.

Diversity, inclusion, and belonging connect to a variety of other needs, including economic insecurity and income inequality. BBIPOC communities experience barriers to accessing programs and services, contributing to more economic insecurity and housing instability. It is also connected with safety. Key informants spoke of the importance of feeling safe and accepted in the community, which means people will be comfortable seeking help and reaching out.

"The community needs to feel safe and accepted wherever they go. … If you don't feel safe, you won't seek out the help you need. That can lead to a lot of other problems down the road for people." — Key Informant

Without inclusion and belonging, there are more mental health challenges and social isolation, which can have negative health outcomes. Key informants emphasized the importance of being more supportive and having more empathy and less judgement of people with mental health conditions.

Ensuring students have a sense of belonging in their school community is important for them to be able to learn.

"I feel like in order for students to be ready and able to learn, they have to feel like they're a part of the community that they're in." — Key Informant

When people feel included in the community, they are more likely to be engaged and involved. Because Thurston County is diverse, involvement opportunities need to celebrate that diversity and actively work to include all members of the community. Creating opportunities for people to be involved in the community and grow can change their lives. Key informants shared that healthy communities are ones where people feel supported and believed in.

"Honestly, giving somebody an opportunity and believing in them can change somebody's life. If we could all do that to one person and they do it to one person, we could have a completely different community." — Key Informant

Everyone can benefit from an increased sense of inclusion and belonging. Key informants identified specific populations that are not always made to feel like they belong:

- LGBTQIA+ community: There is a need for more safe community spaces for LGBTQIA+ folks. There are parts of Thurston County where LGBTQIA+ individuals do not feel safe. They may also feel fearful of seeing a new provider and not knowing if they will be accepting. There is a need for affirming and respectful health care providers who will make patients feel safe and heard. One way to do that is to include questions regarding pronouns, preferred name, etc. on the intake forms to ensure patients do not have to repeat themselves and ensure that staff use correct names and pronouns when addressing the patient. There is a need for more education and training related to transgender health care services to ensure there are more providers that can provide competent and affirming health care services. LGBTQIA+ community members may have grown up without much trust for authority figures. Ensuring there are community leaders who can be advocates to help build that trust is important and goes hand-in-hand with a sense of belonging.

  "There is a lot of distrust of authority in our community just because a lot of times at a younger age they didn't have authority figures that they could turn to for a lot of LGBTQ issues. … So finding community leaders who are willing to be advocates can go a long way towards building that trust, people that they recognize as trustworthy already. That was probably the biggest thing. The issue is that sense of belonging when it comes to gaining that trust, and that's why one of our big things is we need more mentors and advocates and such." — Key Informant

- Mixed-status families and those with undocumented status: Threat of deportation or having their information shared can make mixed-status families fearful of engaging with community services and the community in general.
- People whose first language is not English: People who primarily speak a language other than English are often served by a limited number of agencies instead of experiencing inclusive services across the county. There is a need to improve access to services for this population.
- People experiencing homelessness: Key informants spoke of inclusion and belonging as foundational for keeping people stably housed. Building community within permanent supportive housing where people know one another and look out for one another helps people be successful in their permanent housing. It can be scary and isolating to move into new housing and be alone.

  "What we hear over and over and over again is that everybody who moved into the apartments was so happy that they moved in knowing that the community of the shelter was still part of the building, knowing that they knew their neighbors when they moved in. It's really scary for people to move into apartments of their own,

especially if they have been experiencing homelessness for a really long time and living around other people or in the public eye for so long. It can be very scary to move into an isolated place." — Key Informant

Access to health care services

Key informants shared there is a lack of capacity to meet everyone's health care needs in Thurston County, particularly people who are uninsured and underinsured. They spoke of people with resources, transportation, and high-quality insurance as being able to access the care they need, but inequities exist in the community.

Locally there can be fairly long wait lists for specialists, with people traveling to other areas for quicker access. They specifically identified specialists in endocrinology, rheumatology, pulmonology, gerontology, and speech therapy as having longer wait lists. Some wait lists to see specialists can take up to six months, leading some people to travel to Tacoma or Seattle.

Primary care can also have long wait lists with people waiting two or three months to get a health care appointment. There is a specific need for more primary care providers that accept Medicaid and accept patients who are uninsured and underinsured.

"At least in the community that we serve, there are always waiting lists. There are never enough providers, so that goes back to that recruitment piece. There's just never enough. Not even always depending on where you live. It can be based on where you live, your income, a whole host of things that there's just not enough providers. … We have quite a few providers in our community, but not everybody takes Medicaid, for example." — Key Informant

Often, the primary safety net for these patients is the Emergency Department. Key informants call for more collaboration within health care to support these patients. Lower reimbursement rates for Medicaid patients mean there are fewer providers, less quality of care, and less access for these patients.

"I think the gap that I'm seeing from my perspective is that those without good insurance either through their employer or through the state or are uninsured altogether, there are far fewer options. … We need, of course, more access to primary care for uninsured and underinsured patients…. The system that's available for uninsured and underinsured community members is not yet adequate." — Key Informant

Key informants also spoke about hospitals being very busy and shared that an additional hospital in south Thurston County would be beneficial.

Long wait lists could partly be due to the nursing shortage, with health care in general experiencing staffing shortages. Provider burnout could also contribute to health care providers leaving the profession. Key informants would like to see a Thurston County training program for Nurse Practitioners (NP), Physician Assistants (PA), and Medical Doctors in the community.

> *"We need a third hospital in Tumwater. You know this. Or at least South Thurston County needs its own hospital. … We need an NP program in-county, we need a PA program in-county or both. … Something that would train the next [mid-level staff]. Why can't you put a med school campus down here?... If we train the doctors, maybe we can keep a percentage of them here. Preventing provider burnout is going to be huge because that's what we're seeing in droves right now, providers leaving."—Key Informant*

Specific barriers to accessing timely and appropriate care include the following:

- Transportation: Transportation to appointments and services can be more difficult for people living in south Thurston County or other rural areas. In some areas, people may live far from a bus line or have no access to public transportation. Older adults may also have more difficulty using public transportation to get to appointments. Public transportation may also not be a practical option because of the length of time it takes to get to an appointment, meaning people have to dedicate an entire day for an appointment. For people with cars, the cost of gas may be prohibitively expensive.

> *"Another quality-of-life issue we have is lack of transportation, and specifically, transit outside of the Tumwater, Lacey, and Olympia area – public transit existing at all – but then also transit barriers for where it does exist; it takes a long time to commute between any of those three cities. It's not practical if you're looking to get to appointments or jobs or anything like that in a timely manner where you don't have all day to spare." — Key Informant*

- Hours of appointments: Some people may need more flexibility in appointment hours, either because of the hours they work or because they have barriers to following a rigid schedule. Offering more services during the evening and weekend hours, as well as more flexibility such as drop-in hours, could help.
- Lack of broadband access: Telehealth services help address barriers to care for some people, but a lack of broadband access and comfort with technology can prevent people from successfully engaging in telehealth appointments.
- Stigma and discrimination: People with a behavioral health issue, people experiencing homelessness, and people identifying as LGBTQIA+ may avoid engaging with health care for fear of not being treated with care and respect. For transgender patients specifically, it can be scary

to see a provider and not know if they will be accepting. Provider ignorance, stereotyping, and a lack of competence in serving this community can harm patients.

"Going to a new doctor is scary. Is that doctor accepting [of LGBTQIA+ patients]?" — Key Informant

"There's a lot of ignorance about what being trans means or a lot of stereotypes or discrimination that people will face just walking in the door. A lot of people will not go get their yearly checkup or they won't get their pap smears done because of whether it's dysphoria or knowing that the staff there are going to misgender them and treat them in a way that is really difficult to go through, especially coming from a professional, coming from someone who you have to be very vulnerable with in order to get what you need." — Key Informant

- Lack of providers that are bilingual and bicultural: There is a need for more providers that are from the communities they are serving and understand their patients' cultures and languages.

Specific populations may experience these barriers and more to accessing responsive care:

- People experiencing homelessness: Key informants spoke of the importance of bringing medical care to where people are, including homeless camps and shelters. This includes wound care and preventive care. They also shared there is a lack of resources to address the significant medical needs of folks experiencing homelessness. People end up using the Emergency Department for care if they cannot get to a clinic or receive the preventive care they need. People experiencing homelessness may die from a lack of shelter and unaddressed medical needs.

  "We do as a community have a strong group of outreach providers, but the capacity to be able to provide the level of services that people need when they don't have homes is really, really low. We have a lot of people within our homeless population that have significant illnesses or medical needs, and very limited respite-type beds that can accommodate that. Just last week we had a person who passed away and he had tried to access shelter." — Key Informant

  There is also a lack of respite beds to accommodate people who have significant health needs post-discharge from the hospital. The beds that are operating are working well, but there are not nearly enough to serve everyone who needs them.

  Of particular concern are youth identifying as LGBTQIA+ who have been kicked out of their homes and may be seeking anonymous and free medical care. Patients experiencing homelessness may avoid seeking care for fear of not being treated well and with respect.

- BBIPOC community members: Racism contributes to poorer health outcomes for BBIPOC communities. High comorbidities and unmanaged chronic conditions can also contribute to brief hospitalizations.
- LGBTQIA+ community members: Key informants spoke about a variety of factors that prevent LGBTQIA+ patients from receiving high-quality care. There is a lack of providers for some gender affirming procedures like electrolysis that are covered by health care. Additionally, hormone replacement therapy (HRT) is only offered at a limited number of places that are overloaded. Fertility care and gender affirming care can be extremely expensive and can affect people's ability to meet other needs, like affording nutritious foods. Transgender patients specifically need care that covers assigned-at-birth medical needs and transgender medical needs.

  If able to access needed care, finding an accepting provider can be difficult and it can be very scary to see a new provider not knowing if they will be accepting. Key informants shared that there is a great deal of ignorance around what it means to be trans, and that trans patients face discrimination in health care. Many trans patients are burdened with educating their own provider with how to care for them. There needs to be more required education and training for providers to better care for LGBTQIA+ patients, ensuring providers are competent at providing care for this community.

  > *"At this point, really what we need is for health care providers to take on that responsibility of listening to what the [LGBTQIA+] community has had to say about how to best respect us and how to meet our health care needs." — Key Informant*

  Older adults who identify as LGBTQIA+ need access to skilled nursing facilities that are safe and accepting, and young people identifying as LGBTQIA+ need access to free and anonymous medical care if they are seeking safety away from their home.

- Mixed-status families and individuals with undocumented status: Mixed-status families, or those with a mix of immigration statuses (including undocumented) may not access services for fear of being asked about documentation status. Lack of insurance may also be a barrier.

Economic insecurity and income inequality

The cost of living in Thurston County, including housing, food, gas, etc. have all increased substantially. Key informants shared concern for people with low incomes being able to afford their basic needs. Families are forced to make spending tradeoffs, choosing between food and health care services. Other basic needs, including baby formula, car seats, etc. are all expensive and difficult for families to afford to keep their families safe.

> *"Everything's getting so much more expensive. Very basic needs such as being able to afford the roof over your head, the formula for your children. Items such as safe sleep*

items like a proper crib, sleepers, when you get a little older, that bike helmet. Although they're small purchases, it's too much for parents." — Key Informant

Many families would have difficulty financially recovering from one event, like a car accident. Key informants spoke about the importance of ensuring that even with rising costs of gas and food, families still have enough money to meet their basic needs, like a basic minimum income strategy.

Key informants were most concerned about people with incomes slightly above the threshold for qualifying for public benefits, but without enough money to afford those basics without the assistance. For example, a slight raise in income could mean people no longer qualify for their Supplemental Nutrition Assistance Program (SNAP) benefits or childcare benefits. This is called the "benefits cliff" and means benefits drop off sharply with a small increase in income.

"I have several people we're trying to help navigate through housing. They make just too much or just not enough to qualify for assistance. … There's [sic] all kinds of resources for you if you're at the very top or the very bottom of the economic scale, but not if you're in the middle." — Key Informant

Economic insecurity is connected to education and employment opportunities. Key informants spoke of the importance of investing in young people's education. They were particularly concerned about BBIPOC students and those with low incomes because they can have less access to high-quality education and programs like music and arts. The school-to-prison pipeline also contributes to poverty. To support students' learning, key informants spoke about ensuring students feel part of the community and have a sense of belonging so they can be ready to learn.

Employment opportunities are also needed in Thurston County to address economic insecurity and income inequality. There are limited employment opportunities paying a living wage for people in Thurston County without higher education.

"There's [sic] limited opportunities for folks who, for instance, don't have a GED or a high school diploma. Specifically, the ability to access a job market where they can make a living wage when they do not have access to higher education." — Key Informant

There is also a need for job skills and technical training to help people increase their economic security and access housing, health care, and more.

"The other thing that I think is missing and have thought for a number of years is really job-skill and technical training. We have folks that at times would really love to be employed, but because of other social determinants, they are not viewed as good risks to employers, which just keeps them in oftentimes the situation they're in or prevents them from being able to access housing or access care that, if they had a job, they would have the ability to do so." — Key Informant

Employment opportunities for people experiencing behavioral health issues are also important for stability.

> *"I think that there is a lack of low-barrier employment for individuals that are experiencing behavioral health issues. I think that that would have an impact on people being able to have income and be able to be more stable from that income. … The way it would manifest is that we would potentially have less property crime because people would have other legal sources of income." — Key Informant*

BBIPOC communities are affected by economic insecurity because of racism and a lack of opportunities. Barriers to accessing programs and services may contribute to more economic insecurity.

Racism and discrimination

Key informants discussed how racism and discrimination contribute to most needs and are closely connected to diversity, inclusion, and belonging. They shared that they are foundational to all other needs and are very much an issue. To address community needs, racism and policies that prevent people from living healthy lives must be addressed.

> *"I think racism and discrimination is still huge for our communities." — Key Informant*

Racism contributes to BBIPOC communities having fewer educational and economic opportunities, leading to more economic insecurity. It also contributes to barriers that prevent people from accessing support services. The school-to-prison pipeline pushes BBIPOC children and those with low incomes out of education and into the criminal legal system. Key informants spoke of the need for preventing students from entering the criminal legal system in the first place.

> *"There is a need to change the conditions created by systemic and structural racism. … I will put the example of the school-to-prison pipeline that had been created to increase the number of BIPOC and low-income students that goes [sic] into that pipeline, directly from the school to prison. There are not policies in place to change that. There is no intervention that prevents a student to go [sic] into that pipeline." — Key Informant*

It was noted by key informants that racism contributes to poorer health outcomes for BBIPOC communities.

> *"It was very heartbreaking to see some of the statistics related to mothers, specifically brown mothers, and how they're three times as likely to either have babies that are born early or that don't make it. To me, that was very impactful." — Key Informant*

LGBTQIA+ community members experience discrimination and a lack of safety. Providers may not be respectful of transgender patients or provide gender-affirming care. This can create fear for transgender patients, as well as lead some LGBTQIA+ patients to avoid engaging with health care. LGBTQIA+ individuals also experience fear in the community and may avoid being alone in certain areas for fear of being attacked, assaulted, or killed. This affects mental and physical health.

> *"There's a lot of ignorance about what being trans means or a lot of stereotypes or discrimination that people will face just walking in the door. A lot of people will not go get their yearly checkup or they won't get their pap smears done because of whether it's dysphoria or knowing that the staff there are going to misgender them and treat them in a way that is really difficult to go through, especially coming from a professional, coming from someone who you have to be very vulnerable with in order to get what you need." — Key Informant*[7]

People with behavioral health conditions and people experiencing homelessness also experience discrimination from providers. Patients that are actively using substances may not be treated with the same care and respect as other patients. Patients experiencing homelessness may not be taken seriously when they seek care in the Emergency Department.

Racism also affects where people live. BBIPOC communities and families with low incomes are more likely to live in areas where they are affected by climate change and its harmful health effects.

> *"Climate change, basically, it targets everybody, but especially folks that are in the lower-income brackets, people that have health issues like respiratory issues. Then, of course, the BIPOC communities, which often fall into those communities as well." — Key Informant*

Community engagement and involvement

Community engagement and involvement is a driver for addressing most other needs. Key informants shared that to have engagement and involvement from community members, people need to have a sense of belonging and inclusion. Because the community itself is diverse, there needs to be acceptance and acknowledgement of diversity of opinions and experiences when seeking community engagement.

Key informants shared that a community strength is that people are engaged in activism and have much knowledge and wisdom to share. However, organizations do not always create the space for community members to share their voice. Community members have formed grassroots efforts to address community needs. Young people are engaged in telling organizations how services should look and how organizations should support them. LGBTQIA+ individuals have resources compiled within the community and share those with one another. People with lived experience provide peer support and walk alongside others experiencing something similar.

> *"We have a strong, amazing, vibrant community that is really engaged in activism and social justice in our community, and I think we need to leverage that and be*

[7] Quote also appears in the "Access to health care services" section

intentional about what we're going to do to transform Thurston County, but it has to start with community." — Key Informant[8]

Creating intentional space for people to share their voices and be part of solutions is critical. Key informants discussed including people with lived experience on advisory boards regarding funding for programming and addressing needs. Better efforts to be inclusive of all community members is needed, particularly for groups that are historically not included in decision making.

"We have some voices that are not at the table. We need to work really hard that we're inclusive of every member of our community and not just those who speak the loudest." — Key Informant[9]

Organizations, including health care, should also ask patients how they want to receive services and learn more about barriers to care.

"I think if services could do a little bit more to really engage the actual stakeholders, the actual patients and how do you want to access these services, what is not even most convenient but what makes it possible for you to connect and really engaging a stronger voice from the people who actually need the services, that would be a good strategy." — Key Informant[10]

Grassroots organizations are already leveraging important community knowledge and wisdom. Larger organizations can help these smaller, grassroots efforts build capacity.

"[We need] programs and services to help buy-in for organizations that are coming from grassroots efforts and they may have a huge strength, and they do have a huge strength, in serving the population that they're serving, because they're a part of that population and understand the cultural and physical needs of that group. I think we're just missing the piece of giving the capacity and the structure for those organizations to fully move from a small organization to an organization that can take on a federal grant and [that] provides services to their population under that grant." — Key Informant

Key informants also spoke about the importance of health care providers connecting and engaging with community organizations and groups, particularly those that have trusted relationships with specific communities. This engagement could help health care organizations better meet the needs of specific groups and improve health equity.

"I think that there is a healthy relationship between health care providers across different strata of the industry. We have regular and frequent interactions between community health centers, public health departments, and large integrated health systems like MultiCare and Providence. I think where we're missing connections is

[8] Quote also appears in the "Community strengths" section

[9] Quote also appears in the "Community strengths" section

[10] Quote also appears in the "Community strengths" section

into community organizations that have a better connection with individual community groups. … We as an organization struggle to find the right organizations in the community that serve a particular demographic, whether it's Spanish-speaking populations or new mothers or church groups, people that are doing a lot of good work on their own – those organizations are not as well and uniformly connected to the consortium of health care organizations that exist." — Key Informant

School districts are also important hubs for bringing together organizations and the community to better provide resources and improve access to services. Because many families are already engaged with school districts, they have built trust with families and can help connect them to other services that will meet families' needs.

"I really feel like something we could do better is to work with our local school districts to leverage our school buildings and school district-related resources into better creating community hubs within those structures. … I think that having our schools become a really easily accessible, almost coordinated entry for social determinant needs of our kiddos would be fantastic." — Key Informant

Appendix 3: Community Resources Available to Address Significant Health Needs

Providence St. Peter and Centralia Hospitals cannot address all significant community health needs by working alone. Improving community health requires collaboration across sectors and with community engagement.

Our communities have many valuable partners and service agencies working to meet identified health needs for residents. Comprehensive lists of available resources may be found online on the websites of the Thurston County Public Health and Social Services Department, The Crisis Clinic of Thurston and Mason Counties, United Way of Lewis County, and Washington 211. Washington 211 may also be accessed toll-free by dialing 211 on the telephone (or 800-572-4357).

Appendix 4: CHNA Advisory Council, Providence Swedish South Puget Sound

Table_Apx 8. Community Health Needs Assessment Advisory Council Members

Name	Title	Organization	Sector
JP Anderson	Chief Executive Officer	CHOICE (Community Health Organization Improving Care and Equity)	Community-Based Health; Accountable Community of Health
Gabe Ash	Director of Housing and Homeless Services	Catholic Community Services Southwest Washington	Nonprofit Community-Based Organization
David Bayne	Director	Thurston County Public Health and Social Services Department	Public Health
Tracy Brown	Chief Mission Officer	Providence St. Peter Hospital	Health Care
Melissa Grant, MD	Chief Medical Officer	Providence Swedish South Puget Sound	Health Care
Meja Handlen	Director	Lewis County Public Health and Social Services	Public Health
Mercy Mvundura, PhD	Health Economics Technical Advisor Board Member	PATH Community Mission Board, Providence Swedish South Puget Sound	Global Health Nonprofit Health Care
Gaelon Spradley	Chief Executive Officer	Valley View Health Center	Health Care, Federally Qualified Health Center (FQHC)
Chris Wells	Executive Director	United Way of Thurston County	Nonprofit Community-Based Organization

Appendix 5: Community Mission Board, Providence Swedish South Puget Sound

- Jonathan Babbitt, MD
- Jennifer Groberg, JD
- Susan Hettinger, JD
- Joann Hutchinson
- Eileen McKenzie Sullivan
- Brian Mittge
- Mercy Mvundura, PhD
- Ruben Ramirez
- Fanny Roberts, PhD
- Richard Stride, PsyD, MBA, LMHC
- Laurie Tebo
- Ian Timms, MD
- Daidre West
- Rachel Wood, MD, MPH - Board Vice Chair
- Steve Ward - Board Chair