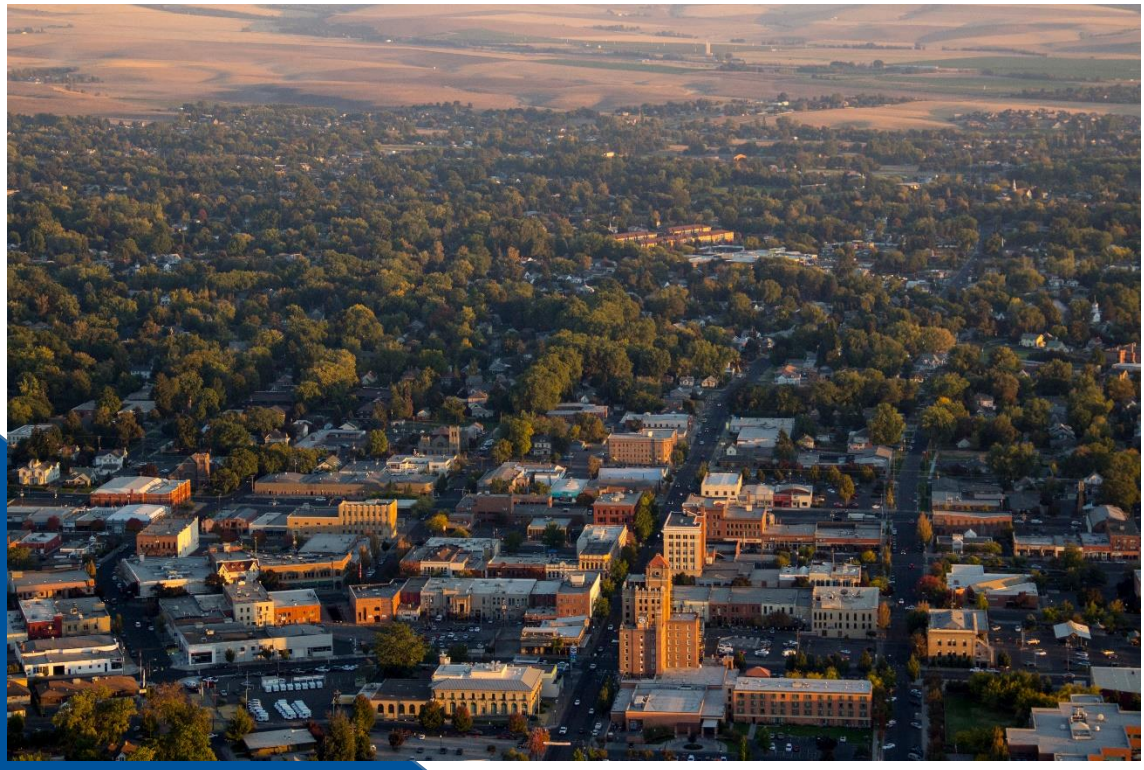
2021

COMMUNITY HEALTH NEEDS ASSESSMENT

Providence St. Mary Medical Center

Walla Walla, Washington



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Providence

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MESSAGE TO THE COMMUNITY

To our communities:

Community Benefit is a core aspect of Providence St. Mary Medical Center's mission to serve the poor and vulnerable. Each year we dedicate a portion of our budget to free and discounted care, subsidizing health services, covering the unpaid costs of Medicaid, and providing other services to improve the health and welfare of the people in this area.

In 2020, our Community Benefit Investment totaled over $17million dollars.

The work is guided by our Community Healthy Needs Assessment (CHNA). The assessment is conducted every three years in concert with our many community partners who also seek to improve the health and welfare of the community. Together, we identify the most urgent needs and determine those that Providence St. Mary may be able to impact.

As outlined in our **2021 CHNA,** the following health needs emerged during the assessment process:

- **BEHAVIORAL HEALTH CHALLENGES AND ACCESS TO CARE**
- **ACCESS TO HEALTHCARE SERVICES**
- **HOMELESSNESS / LACK OF SAFE, AFFORDABLE HOUSING**

These three health-related needs will be addressed using a **health and racial equality** framework. With this understanding, we will develop the Community Health Improvement Plan (CHIP) to specifically address many of these barriers to improve health in our community. The CHIP will outline a process for strengthening existing programs, identify new programs that will have a greater impact, and identify further opportunities for partnering with our community.

Providence St. Mary will continue to focus on some of the greatest needs in the community we serve as we seek to improve health for everyone.

Susan Blackburn, Chief Executive
Providence St. Mary Medical Center

EXECUTIVE SUMMARY

Understanding and Responding to Community Needs

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

The 2021 CHNA was approved by the Community Mission Board on December 17, 2021 and made publicly available by December 28, 2021.

Responding to the COVID-19 Pandemic

The 2021 Community Health Needs Assessment process was disrupted by the SARS-COV-2 virus and COVID-19, which has impacted our nation and communities. The focus of our communities has been one of crisis response; it has required concentration of resources associated with the pandemic response. Our intention is to further engage the community as we address the identified priorities in the CHNA.

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

Gathering Community Health Data and Community Input

Through a mixed-methods approach using quantitative and qualitative data, the CHNA process used several sources of information to identify community needs. Information collected includes U.S. Census American Community Survey data, County Health Rankings, hospital prevention quality indicators and Emergency Department utilization. Stakeholder interviews were conducted with representatives from organization that serve low-income, and/or are medically underserved populations. Some key findings include the following:

- Lack of easy access to Behavioral Health Services
- Need for affordable housing
- Lack of access to healthcare for non-English speaking individuals
- Lack of childcare providers
- Population below 200% of the Federal Poverty Level (FPL) in the following counties: Walla Walla 34.2%, Columbia 38.1%, Umatilla 42.1%. (WA State average: 28.2%)

Identifying Top Health Priorities Together

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

Prioritized Need	Definition	Rationale
PRIORITY 1: BEHAVIORAL HEALTH CHALLENGES AND ACCESS TO CARE	Barriers to mental health and substance use disorder services significantly impact youth and people whose primary language is not English. "Youth in Washington are experiencing a disaster cascade and feelings of despair." WA State DOH	• In 2020, the Walla Walla County Coroner's Office reported a total of 16 drug overdoses and 7 deaths by suicide (one individual is included in both counts). In 2019, they reported 10 drug overdoses and 14 suicides. However, in 2021 there were 11 deaths by suicide YTD (through October) showing a trend in increase in females, increase in use of firearms and decrease in average age from 40 to 33. *Resource – Walla Walla County Department of Community Health. • Substance use disorders accounted for 5.8% of all Avoidable Emergency Department visits (AED) in **2020** at PSMMC. Anxiety and personality disorders accounted for 5.7% of AED visits. • In Walla Walla County in 2018, 36% of 8th graders reported depressive feelings, compared to 32% statewide (Healthy Youth Survey). • Stakeholders identified behavioral health as the most important unmet need in the community, noting challenges to hiring mental health professionals, particularly those to serve youth and those who are bilingual and bicultural. • According to stakeholder interviews, the COVID-19 pandemic has increased levels of stress, anxiety, and substance use. Educators are seeing an increased need for mental health services for young people, although schools have insufficient capacity to meet those needs.

Prioritized Need	Definition	Rationale
PRIORITY 2: ACCESSS TO HEALTH CARE SERVICES	Barriers to access to health care services include insurance or cost, provider availability, distance to care, and transportation. In addition, those without technology access for healthcare messaging on social media, online appointments, and online test resulting have additional barriers. These barriers significantly impact the aging population, those living with disabilities, and those who are Black, Brown, Indigenous, and People of Color (BBIPOC).	• In Umatilla and Walla Walla Counties, more than 7% of the population is without health insurance, compared to 4.8% in Columbia County (American Community Survey (ACS), 2015-2019). • PSMMC is in a primary care, mental, and dental health; Health Professional Shortage Area (HPSA). Large portions of the service area are designated as shortage areas (Health Resources and Services Administration (HRSA), 2021). • Due to differences in access to care and Social Determinants of Health (SDOH), individuals identifying as American Indian or Alaska Native and Black or African American had higher than average percentages of avoidable ED visits at PSMMC. • In 2018, 73.9% of adults reported having a primary healthcare provider, reduced from 79.0% in 2012 (WA State DOH: CHAT). • Stakeholders shared there are a lack of specialists in the community, particularly geriatric specialists to meet the needs of the aging population and those to support people living with disabilities. • Stakeholders and listening session participants emphasized transportation as a barrier to care, noting people often have to travel to the Tri-Cities for care. • Lack of technology access identified during the pandemic response as a key barrier to access to needed services.

Prioritized Need	Definition	Rationale
PRIORITY 3: HOMELESSNESS / LACK OF SAFE, AFFORDABLE HOUSING	Barriers to addressing homelessness include the lack of affordable housing and economic insecurity.	• Almost one in four renter households in Walla Walla County are considered severely housing cost burdened, meaning they spend 50% or more of their income on housing costs (ACS, 2013-2017). • In Walla Walla County, 17% of households have severe housing problems, meaning there is overcrowding, high costs, lack of adequate kitchen, or lack of plumbing facilities (HUD Comprehensive Housing Affordability Strategy, 2013-2017). • In 2018, there were 181 individuals experiencing homelessness (Walla Walla Point in Time Count). • Listening session participants shared that the basic needs of many people experiencing homelessness are still not being met, especially the need for safety. • Community stakeholders noted a lack of affordable housing as a major community issue due to rapidly increasing rent, a lack of housing stock, and vacation rental properties.

Next Steps: Making a Community Health Improvement Plan

Providence St. Mary Medical Center will develop a three-year Community Health Improvement Plan (CHIP) to respond to these prioritized needs in collaboration with community partners considering resources, community strengths, and capacity. The 2022-2024 CHIP will be approved and made publicly available no later than May 15, 2022.

INTRODUCTION

Mission, Vision and Values

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

Our Vision Health for a Better World

Our Values Compassion – Dignity – Justice – Excellence – Integrity

Who We Are

Providence St. Mary Medical Center serves the Southeast Washington Service Area in the Eastern Washington/Montana Region, employing approximately 1,400 caregivers.

The medical Center, located in Walla Walla, WA is an acute-care hospital that was founded in 1880. Licensed for 142 beds, the Major programs and services offered to the community include the following: Level 1 Cardiac Center, Regional Cancer and Spine Center, Level 3 Trauma Center, hospitalist services/internal medicine, critical care, neurosurgery, general surgery, orthopedic surgery, rehabilitation, cardiology, nephrology, emergency medicine, ambulatory care, Family Birth Center.

Providence Medical Group – Walla Walla operates several primary and specialty care clinics and has more than 80 employed physicians and 30+ advanced practitioners.

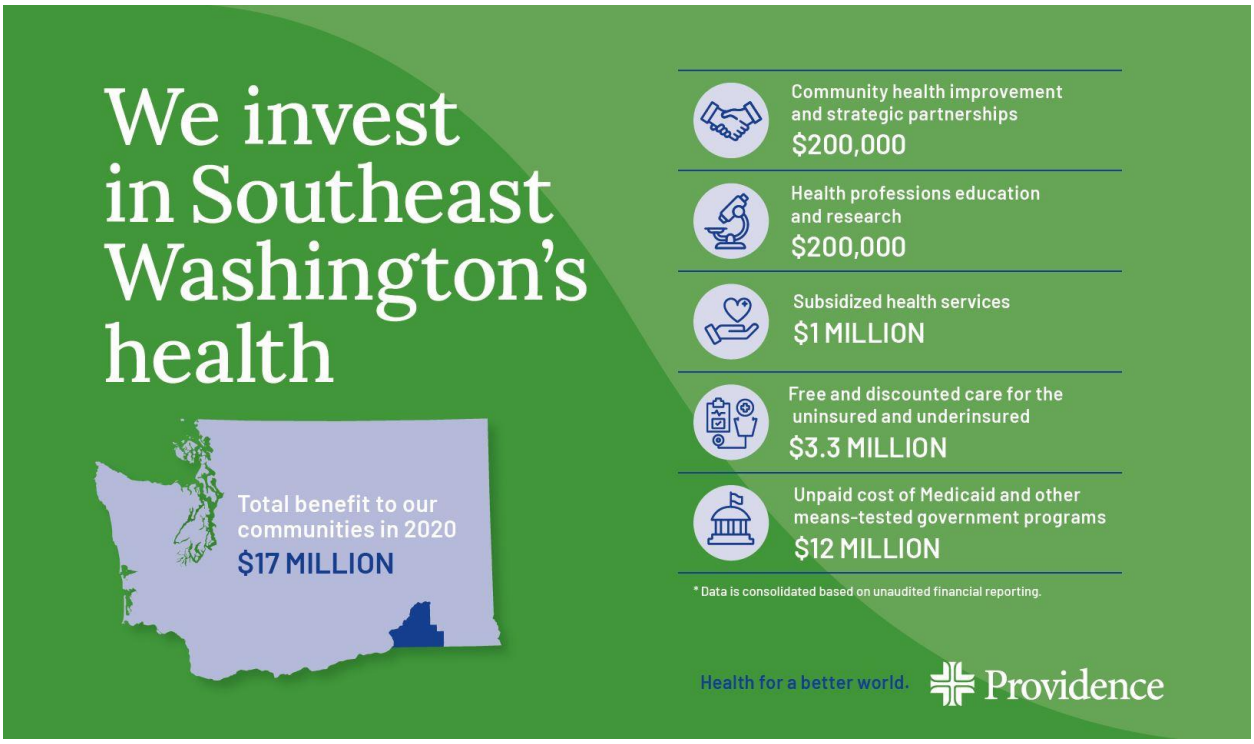
Our Commitment to Community

Providence St. Mary Medical Center dedicates resources to improve the health and quality of life for the communities we serve, with special emphasis on the needs of the poor and vulnerable. During 2020, PSMMC provided $17M in Community Benefit in response to unmet needs and improved the health and well-being of those we serve in Southeast Washington.

Providence Southeast Washington further demonstrates organizational commitment to the Community Needs Assessment (CHNA) through the allocation of staff time, financial resources, participation and collaboration to address community identified needs.

The Providence Eastern WA/MT Regional Director of Community Health Investment is responsible for ensuring the compliance of State and Federal 501r requirements as well as providing the opportunity for St. Mary Leadership and other community leaders to work together in planning and implementing the resulting Community Health Improvement Plan (CHIP).

Figure 1. Providence Community Benefit in Southeast Washington State in 2020



Health Equity

At Providence, we acknowledge that all people do not have equal opportunities and access to living their fullest, healthiest lives due to systems of oppression and inequities. We are committed to ensuring health equity for all by addressing the underlying causes of racial and economic inequities and health disparities. Our Vision is "Health for a Better World," and to achieve that we believe we must address not only the clinical care factors that determine a person's length and quality of life, but also the social and economic factors, the physical environment, and the health behaviors that all play an active role in determining health outcomes (see Figure 1[1]).

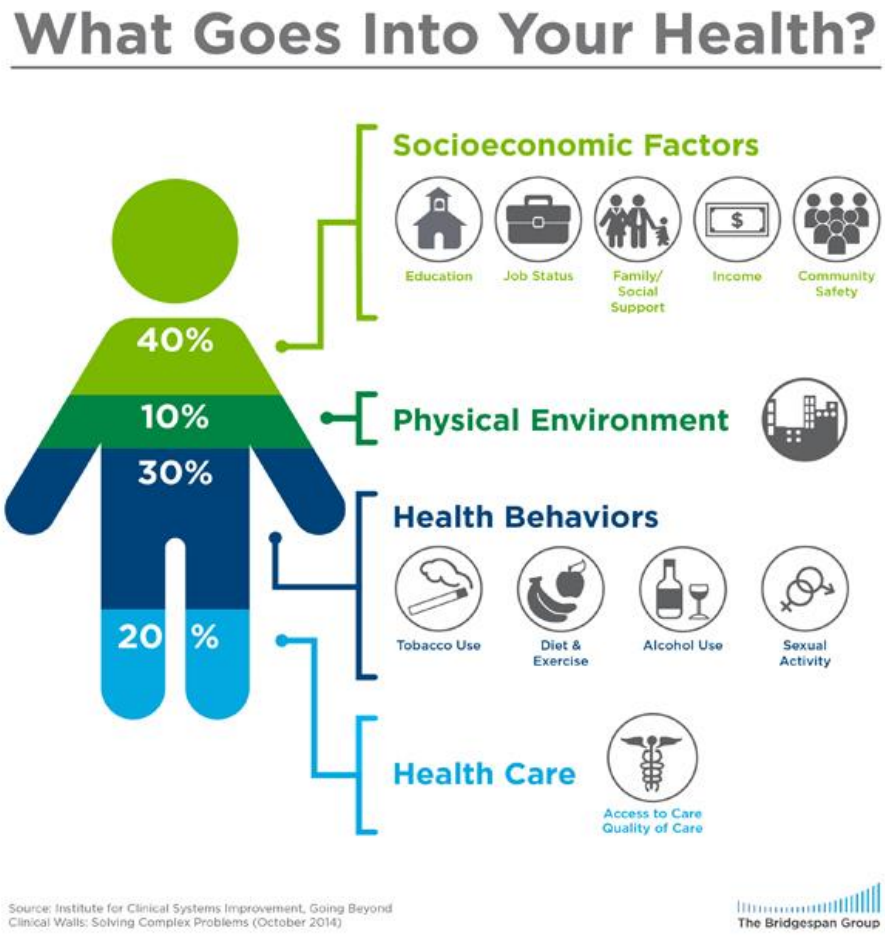


Figure 2. Factors contributing to overall health and well-being

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

The CHNA is an important tool we use to better understand health disparities and inequities within the communities we serve, as well as the community strengths and assets (see Figure 3 for definition of terms[2]). Through the literature and our community partners, we know that racism and discrimination have detrimental effects on community health and well-being. We recognize that racism and discrimination prevent equitable access to opportunities and the ability of all community members to thrive. We name racism as contributing to the inequitable access to all the determinants of health that help people live their best lives, such as safe housing, nutritious food, responsive health care, and more.

Health Equity

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

Health Disparities

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

Figure 3. Definitions of key terms

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

Approach

Explicitly name our commitment to equity

Take an asset-based approach, highlighting community strengths

Use people first and non-stigmatizing language

Community Engagement

Actively seek input from the communities we serve using multiple methods

Implement equitable practices for community participation

Report findings back to communities

Quantitative Data

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

Disaggregate data when responsible and appropriate

Acknowledge inherent bias in data and screening tools

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

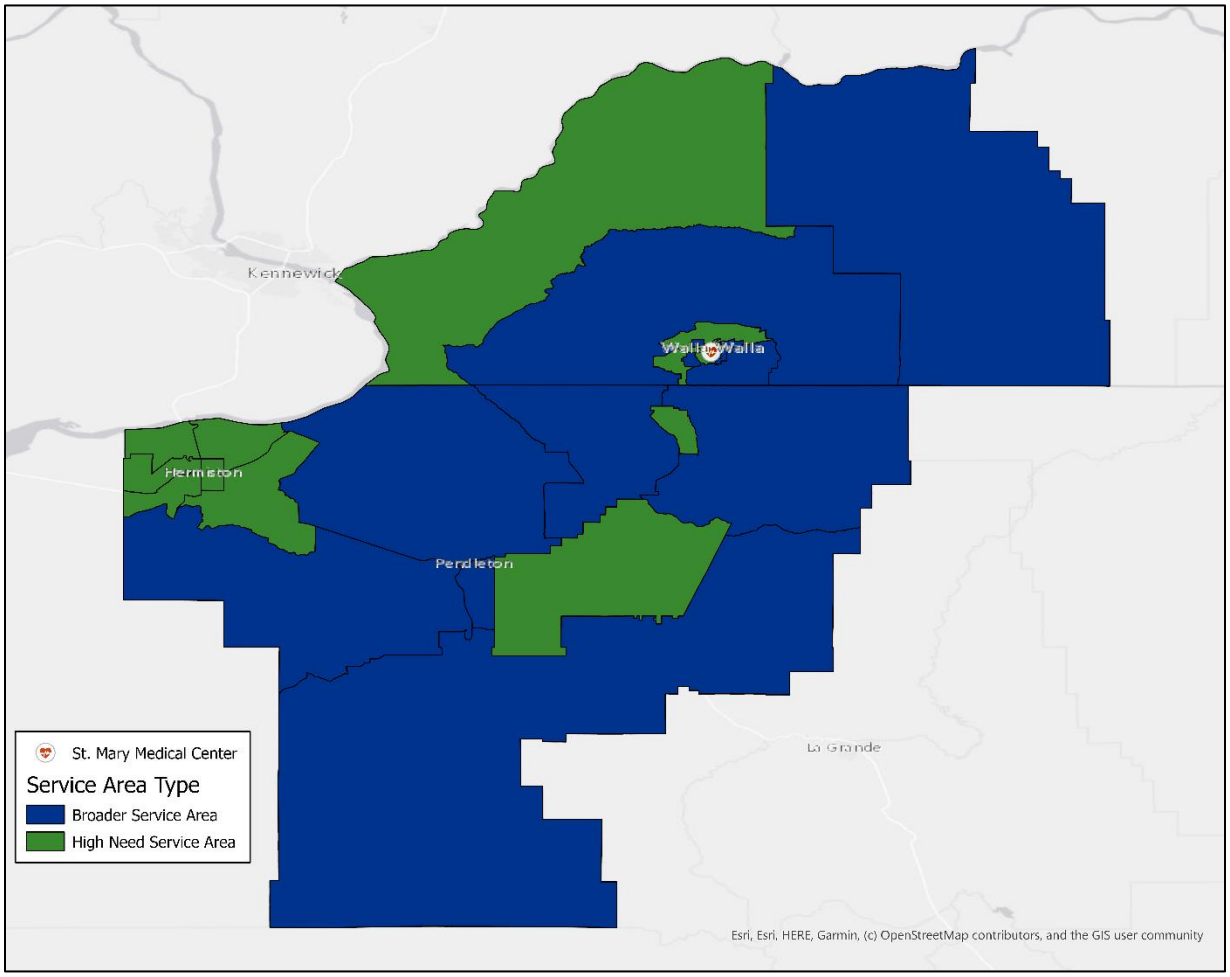
Efforts taken to center equity in community engagement included interviewing stakeholders who represent organizations serving various demographic groups that are historically marginalized. Some of these populations that were intentionally included were older adults, people experiencing homelessness, Spanish-speaking communities, and Black, Brown, Indigenous, and People of Color. Listening sessions were designed to include participants from under-represented groups and included family members and caregivers of those living with disabilities, aging community members, and people experiencing homelessness. The community survey was distributed in English and Spanish.

OUR COMMUNITY

Hospital Service Area and Community Served

Providence St. Mary Medical Center provides care to Walla Walla, Umatilla, and Columbia Counties which includes a population of approximately 144,442 people. Based on the availability of data, geographic access to these facilities and primary care, and other hospitals in neighboring counties, Walla Walla, Umatilla, and Columbia County serve as the boundary for the hospital service area. See map below for further detail, including communities identified as higher need. There are 13 census tracts in the high need service area and 15 census tracts in the broader service area.

Figure 4. PSMMC Service Area including Walla Walla, Columbia, and Umatilla Counties



Providence Need Index

Within a medical center's service area is a high need service area based on social determinants of health related to the inhabitants of that census tract. Based on work done by the Public Health Alliance of Southern California and their Healthy Places Index (HPI) tool the following variables were used in the calculation of a high need census tract:

1. Population Below 200% the Federal Poverty Level (2019, American Community Survey)
2. Percent of Population with at least a high school education (2019, American Community Survey)
3. Percent of population Age 5 Years and over in Limited English Households (2020, American Community Survey)
4. Life Expectancy at Birth (Estimates based on 2010 – 2015 data, CDC)

For this analysis, census tracts with more people below 200% federal poverty level, less people without least a high school education, more people in limited English household and a lower life expectancy at birth were identified as "high need."

A census tract given a score between 0 and 1 where 0 represents the best performing and census tract and 1 would be the worst performing according to criteria.

Census tracts that scored higher than the average are classified as high need service area and are depicted in green (see Figure 4). In the Walla Walla service area, **13 of 28 census tracts** scored above the **average of 0.45** on the Providence Need Index.

Community Demographics

The tables and graphs below provide basic demographic and socioeconomic information about the service area and about how the high need area compares to the broader service area. The high need area includes census tracts identified based upon lower life expectancy at birth, a lower percent of the population with at least a high school diploma, more households which are linguistically isolated and more households at or below 200% of the Federal Poverty Level (FPL) compared to county averages. For reference, in 2019, 200% FPL represents an annual household income of $51,500 or less for a family of four.

For the socioeconomic indicators, the broader service area and high need area values are calculated based on the average of the census tracts within each service area classification.

We have developed a dashboard that maps each CHNA indicator at the census tract level.
The dashboard can be found here: https://arcg.is/HfWGm

POPULATION AND AGE DEMOGRAPHICS

Table 1. Population Totals for Walla Walla Service Area

Indicator	Columbia County	Umatilla County	Walla Walla County	Broader Service Area	High Need Service Area
2019 Total Population	4,138	78,401	61,903	72,449	71,993
Female Population	2,074	37,468	30,284	34,750	35,076
Male Population	2,064	40,933	31,619	37,699	36,917

Source: U.S. Census, 2019

POPULATION BY RACE AND ETHNICITY

Table 2. Population by Race in the PSMMC Service Area

Indicator	Columbia County	Umatilla County	Walla Walla County	Broader Service Area	High Need Service Area
American Indian Population	1.5%	3.6%	1.1%	1.8%	3.2%
Asian Population	1.3%	1.0%	1.5%	1.4%	1.0%
Black Population	0.9%	1.1%	2.2%	2.0%	1.1%
Other Race Population	2.5%	14.5%	8.9%	5.0%	18.6%
Pacific Islander Population	0.3%	0.2%	0.3%	0.3%	0.2%
Population of Two or More Races	4.0%	3.6%	3.6%	3.6%	3.6%
White Population	89.5%	76.1%	82.5%	86.1%	72.3%

Source: U.S. Census, 2019

MEDIAN INCOME

Table 3. Median Income in the PSMMC Service Area

Indicator	Columbia County	Umatilla County	Walla Walla County	Broader Service Area	High Need Service Area
Median Household Income Data Source: American Community Survey Year: 2019	$53,423	$53,013	$50,140	$50,674	$48,903

The median household income for the three counties is similar, with Walla Walla County having a median income slightly below Columbia and Umatilla Counties.

SEVERE HOUSING COST BURDEN

Table 4. Severe Housing Cost Burden in the PSMMC Service Area

Indicator	Columbia County	Umatilla County	Walla Walla County	Broader Service Area	High Need Service Area
Percent of Renter Households with Severe Housing Cost Burden Data Source: American Community Survey Year: Estimates based on 2013 – 2017 data	16.5%	16.1%	24.5%	16.2%	21.4%

Severe housing cost burden is defined as households spending 50% of more of their income on housing costs. Walla Walla County has a substantially higher amount of renter households that are considered severely housing cost burdened compared to Columbia and Umatilla Counties. Walla Walla County's percent of renter households with severe housing cost burden is about 50% higher than that of Umatilla County and the broader service area.

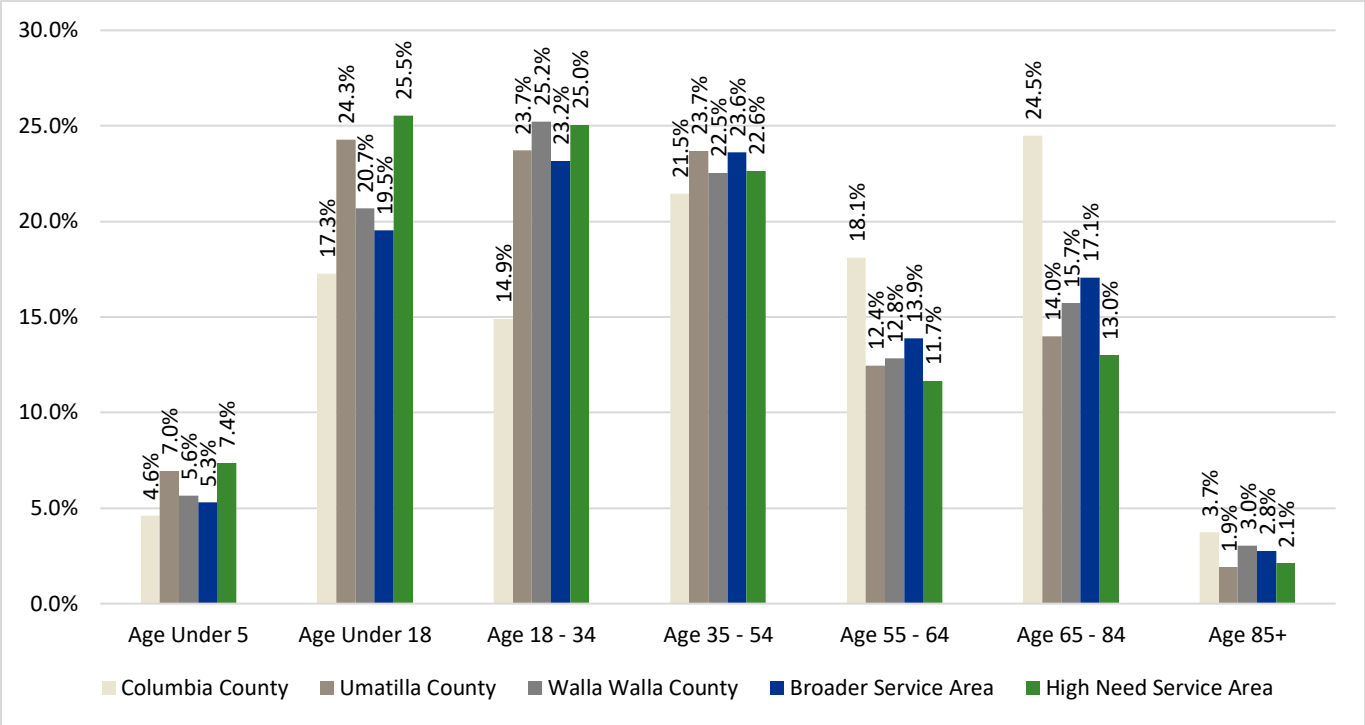
PERCENT OF LABOR FORCE UNEMPLOYED

Table 5. Percent of Labor Force Unemployed in the PSMMC Service Area

Indicator	Columbia County	Umatilla County	Walla Walla County	State of Washington	United States
Percent of Labor Force Unemployed Data Source: U.S Bureau of Labor Statistics Year: April 2021	6.0%	5.6%	4.8%	5.5%	6.1%

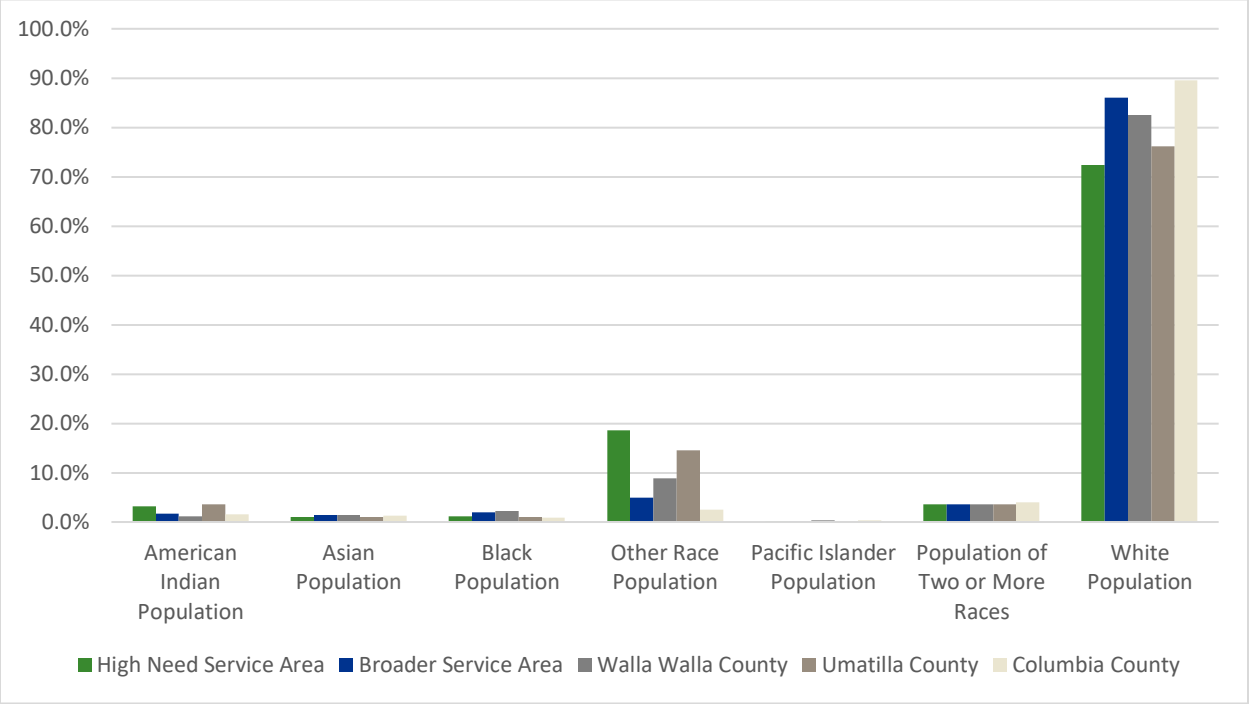
POPULATION AND AGE DEMOGRAPHICS

Figure 5: Age Group by Geography



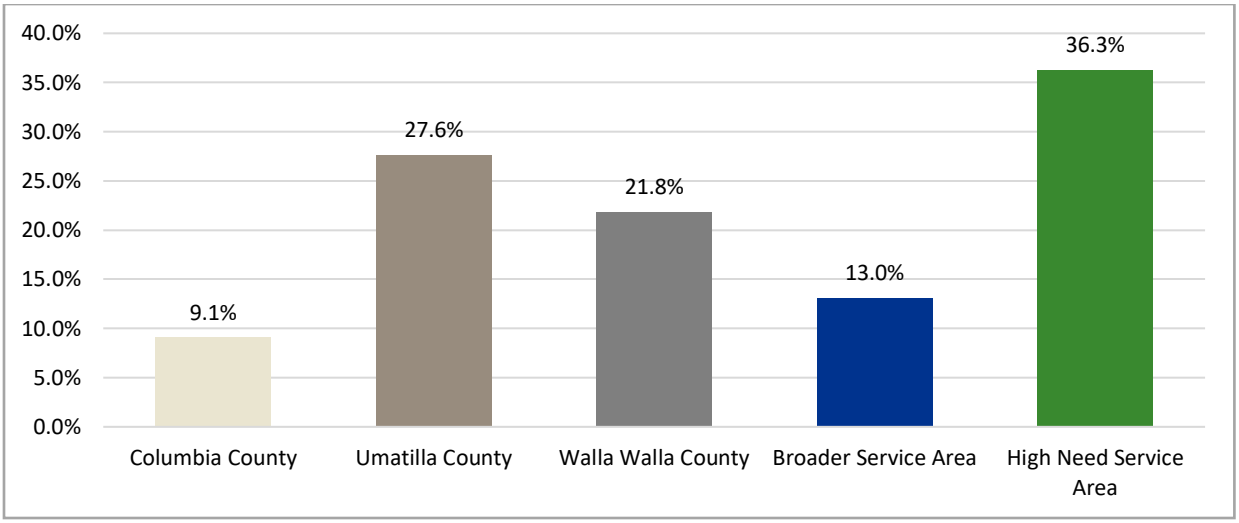
Source: U.S. Census, 2019

Figure 6. Race by Geography



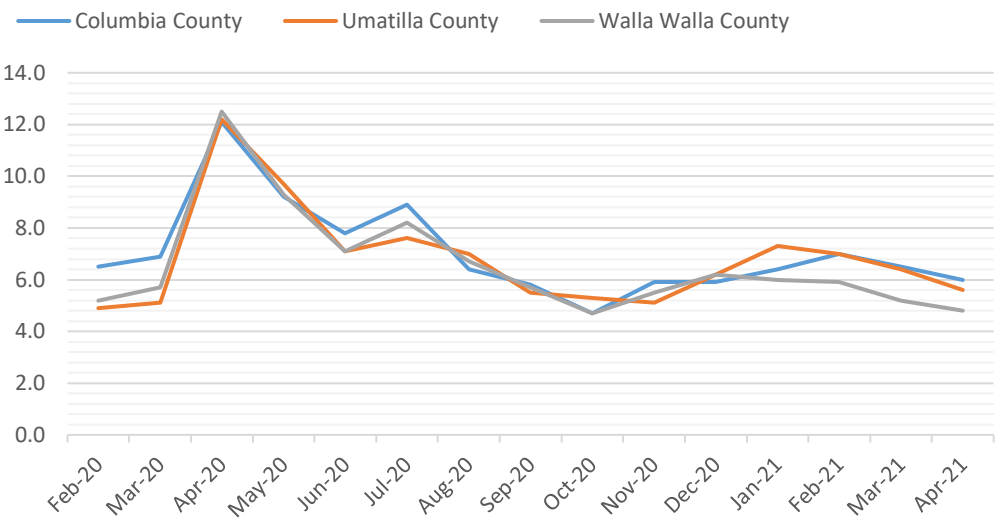
Source: U.S. Census, 2019

Figure 7. Hispanic Population by Geography



Source: U.S. Census, 2019

Figure 8. Rate of Unemployment by County, February 2020-April 2021



	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21
Columbia County	6.5	6.9	12.1	9.2	7.8	8.9	6.4	5.8	4.7	5.9	5.9	6.4	7.0	6.5	6.0
Umatilla County	4.9	5.1	12.2	9.7	7.1	7.6	7.0	5.5	5.3	5.1	6.2	7.3	7.0	6.4	5.6
Walla Walla County	5.2	5.7	12.5	9.3	7.1	8.2	6.7	5.7	4.7	5.5	6.2	6.0	5.9	5.2	4.8

Source: U.S. Bureau of Labor Statistics, Local Area Unemployment Statistics

As of April 2021, the percent of people unemployed in Walla Walla was lower than that of Washington State (4.8% in Walla Walla compared to 5.5% in Washington). Columbia and Umatilla Counties had slightly higher unemployment rates than the state of Washington, but lower than the nation.

Like many areas, Walla Walla, Umatilla, and Columbia Counties experienced a drastic increase in unemployment rates between March 2020 and April 2020 with rates increasing by 75% in Columbia County, 139% in Umatilla County and 119% in Walla Walla County.

OVERVIEW OF CHNA FRAMEWORK AND PROCESS

The CHNA process is based on the understanding that health and wellness are influenced by factors within our communities, not only within medical facilities. In gathering information on the communities served by Providence St. Mary Medical Center, we looked not only at the health conditions of the population, but also the socioeconomic factors, the physical environment, and health behaviors. Additionally, we invited key stakeholders and community members to provide additional context to the quantitative data through qualitative data in the form of interviews and listening sessions. As often as possible, equity is at the forefront of our conversations and presentation of the data, which often have biases based on collection methodology.

In addition, we recognize that there are often geographic areas where the conditions for supporting health are substantially poorer than nearby areas. Whenever possible and reliable, data are reported at the ZIP Code or census 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 American Community Survey and local public health authorities. In addition, we include hospital utilization data to identify disparities in utilization by income and insurance, geography, and race/ethnicity when reliably collected.

Data Limitations and Information Gaps

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

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

Written comments were solicited on the 2018 CHNA and 2019-2021 CHIP reports, which were made widely available to the public via posting on the internet in December 2018 (CHNA) and May 2019 (CHIP), as well as through various channels with our community-based organization partners. No comments were received.

HEALTH PROFESSIONAL SHORTAGE AREA

The federal Health Resources and Services Administration (HRSA) designates Health Professional Shortage Areas (HPSA) as areas with a shortage of primary care, dental care, or mental health disciplines. They are designated according to geography, demographics, or institutions. PSMMC is in a primary care, mental, and dental health HPSA. Large portions of the service area are designated as shortage areas. Other designations within Walla Walla County, Columbia County, and Umatilla County include Federally Qualified Health Centers (FQHC), correctional facilities, and low-income, homeless, migrant farmworker populations.[3]

MEDICALLY UNDERSERVED AREAS/POPULATIONS

Walla Walla County is not designated as a Medically Underserved Area (MUA) or designated as having Medically Underserved Populations.

Columbia County is designated as a MUA for primary care. There is no MUP for Columbia County.

Parts of Umatilla County are designed as a MUA for primary care: the Umatilla Reservation and the Hermiston-Umatilla areas. There is no MUP in Umatilla County.[4]

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

[3] Sources: https://data.hrsa.gov/tools/shortage-area/by-address and https://data.hrsa.gov/tools/shortage-area/hpsa-find

[4] Source: https://data.hrsa.gov/tools/shortage-area/mua-find

HEALTH INDICATORS

Access to Health Care

Table 6. Percent of Population without Health Insurance in the PSMMC Service Area

Indicator	Columbia County	Umatilla County	Walla Walla County	Broader Service Area	High Need Service Area
Percent of Population Without Health Insurance Data Source: American Community Survey, 2015-2019 estimates	4.8%	7.3%	7.2%	5.2%	9.7%

Both Umatilla and Walla Walla Counties have a higher percent of population without health insurance compared to Washington State, in which 6.3% of the population lacks insurance.

Table 7. Influenza Vaccine Coverage for Adults Over 18 Years

Indicator	Walla Walla County	Umatilla County	Columbia County
Influenza Vaccine Coverage for Adults over 18 years Source: CDC, Influenza Vaccination Coverage for All Ages (6+ Months), 2019-2020	43.4%	36.4%	48%

Walla Walla County had about 43% of adults over 18 years receive the influenza vaccine in 2019-2020, compared to 48% in Columbia County. In Umatilla County, 36.4% of adults received the influenza vaccine according to the CDC.

Table 8. Percent of Total Population Fully Vaccinated for COVID-19

Indicator	Walla Walla County	Columbia County	Washington State
Percent of Total Population Fully Vaccinated Source: COVID-19 Data Dashboard :: Washington State Department of Health, Data as of 11/24/2021	58.2%	40.2%	60.7%
Percent Fully Vaccinated by Age Group in Walla Walla County Source: Walla Walla County Department of Community Health,	65+ years old 84%	18+ years old 68.8%	12+ years old 67.2%

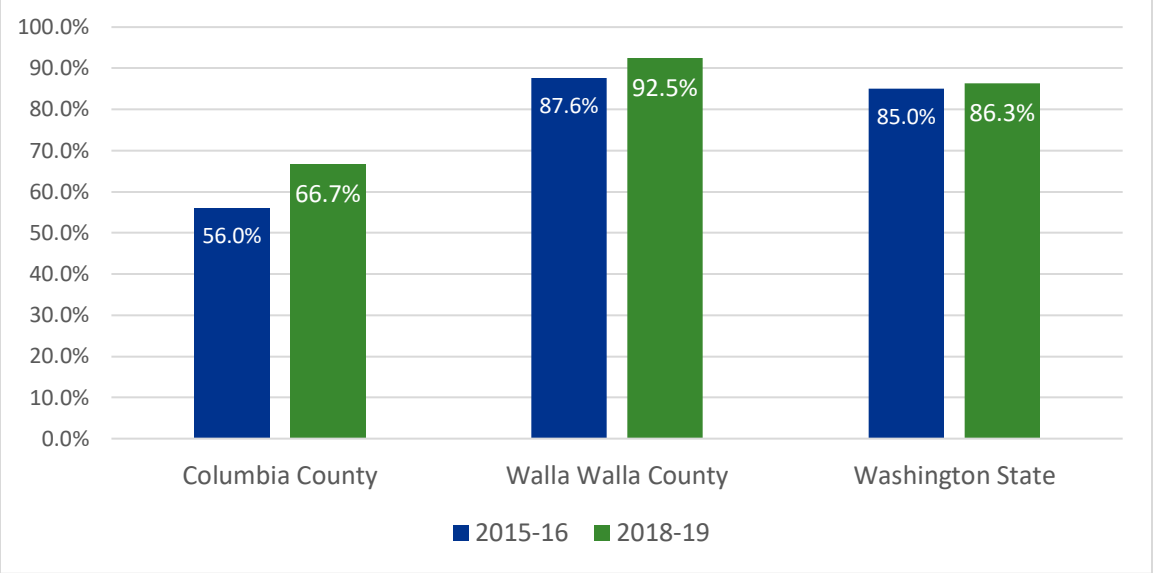
Walla Walla County ranks 14th out of 39 Washington Counties for fully vaccinated population 18 years of age and older and ranks 16th for the population 12 years and older (11/24/2021). Vaccination for children ages 5 through 11 years of age is just beginning in Walla Walla County (November 2021).

Table 9. Kindergarten Vaccination Status for 2018-2019 School Year

Indicator	Complete	Exempt	Conditional	Out of Compliance
Columbia County—Kindergarten Vaccination Status	66.7%	7.4%	3.7%	22.2%
Walla Walla County—Kindergarten Vaccination Status	92.5%	4.1%	1.1%	2.3%
Washington State—Kindergarten Vaccination Status	86.3%	5.0%	1.7%	7.0%

Data Source: County School Immunization :: Washington State Department of Health, 2018-19

Figure 9. Complete Vaccination Status for Kindergarteners, 2015-2016 compared to 2018-2019 school year

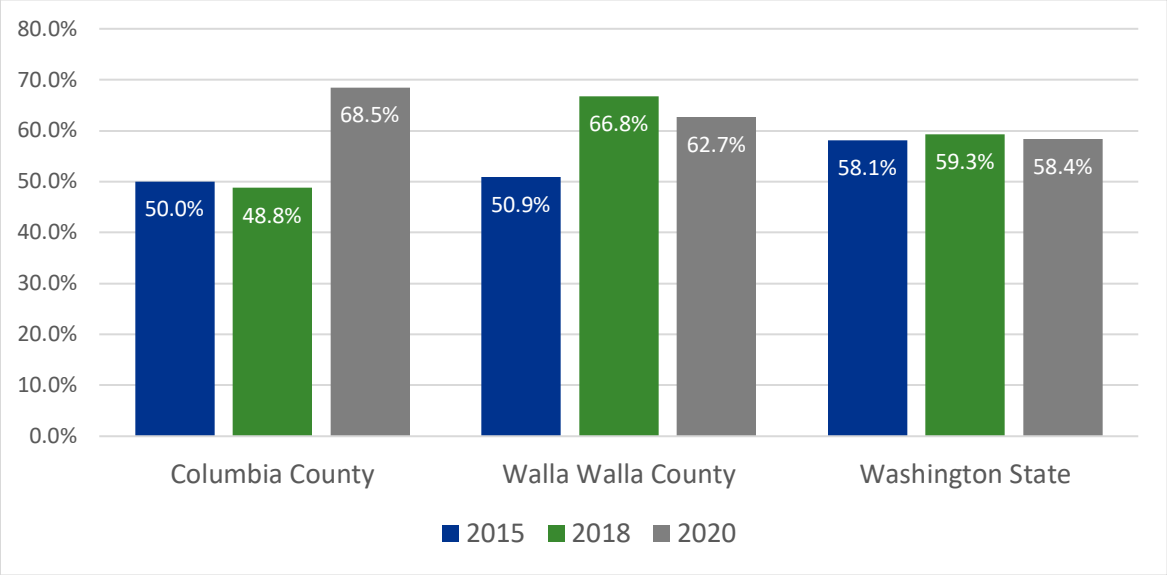


Source: 2015-2016 data, Washington DOH, Historical immunization data for state and county, 1998-2018

Source: 2018-2019 data, Washington DOH, County School Immunization Dashboards, 2018-19

For the 2018-2019 school year, 92.5% of kindergarteners had completed all of their immunizations in Walla Walla County, compared to 66.7% in Columbia County and 86.3% in Washington State. Since the 2015-2016 school year, Walla Walla County saw about a 5% increase in the percentage of kindergarteners with complete vaccinations.

Figure 10. Childhood Series Immunization Rates at 2 years-of-age



Source: [Public Health Measures – County :: 19-35 Month-Olds Immunization Coverage](), 2015, 2018, and 2020

A child should complete the 4:3:1:3:3:1:4[5] immunization series by 19 months. In 2020, 62.7% of 2-year-old children in Walla Walla County had completed their childhood series immunizations, which is higher than the state average of 58.4%. In Columbia County in 2020, 68.5% of 2-year-olds had completed the childhood series immunizations, a 40% increase from 2018.

Mental Health and Substance Use

Indicator	8th Graders	Statewide
Substance Use		
Smoked cigarettes in past 30 days	5.2%	2.7%
Drank alcohol in past 30 days	10.6%	8.4%
Used marijuana or hashish in past 30 days	10.6%	7.2%

[5] The 4:3:1:3:3:1:4 series consists of ≥4 doses of DTaP vaccine, ≥3 doses of polio vaccine, ≥1 dose of MMR vaccine, ≥3 doses of hepatitis B vaccine, ≥3 doses of Haemophilus influenzae type B vaccine, ≥1 dose of varicella (chickenpox_ vaccine, and ≥4 doses of PCV vaccines.

In 2020, the Walla Walla County Coroner's Office reported 16 deaths by drug overdoses and 7 deaths by suicide (one individual is included in both counts). The overdoses involved the following substances: fentanyl, methamphetamine, oxycodone, alcohol, and heroin. The average age of the individuals who died by overdose and by suicide was 43 and 50 years, respectively. In 2021 YTD (through October) the deaths by suicide were 11. Trending shows an increase in females use of firearms, and a decrease in average age to 33 years.

*Source: Walla Walla County Department of Community Health

Data from PSMMC Emergency Department visits shows number of ED encounters associated with mental health or overdose diagnosis from 2019-2021 YTD (as of Nov 11):

2019		**2020**		**2021 through November 11**	
Mental Health	456	Mental Health	391	Mental Health	328
Overdose	37	Overdose	33	Overdose	53

Chronic Conditions and Healthy Lifestyle

Table 10. Chronic Conditions and Healthy Lifestyle Indicators in PSMMC Service Area

Indicator	Columbia County	Umatilla County	Walla Walla County	Broader Service Area	High Need Service Area	Washington
Obesity, crude prevalence (%)	29.6%	34.6%	18.4%	17.0%	34.9%	28.5%
Physical inactivity, crude prevalence (%)	20.5%	24.0%	18.4%	19.2%	23.3%	17.6%
Binge drinking, crude prevalence	13.7%	16.6%	15.9%	17.2%	16.3%	14.7%
Asthma, crude prevalence (%)	10.3%	11.1%	10.2%	10.6%	11.3%	9.6%
Diabetes, crude prevalence (%)	13.0%	12.4%	10.3%	10.2%	11.5%	9.9%

Data Source: Behavioral Risk Factor Surveillance System
Year: 2018

See Appendix 1: Quantitative Data for additional health indicators

Hospital Utilization Data

In addition to public health surveillance data, our hospitals can provide timely information regarding access to care and disease burden across Walla Walla, Umatilla, and Columbia Counties. We were

particularly interested in studying potentially avoidable Emergency Department visits and Prevention Quality Indicators. Avoidable Emergency Department (AED) use is reported as a percentage of all Emergency Department visits over a given time period, which are identified based on an algorithm developed by Providence's Population Health Care Management team based on NYU and Medi-Cal's definitions.

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

Table 11. Avoidable Emergency Department Visits for Providence Washington and Montana Ministries

Facility	Non-AED Visits	AED Visits	Total ED Visits	AED %
Kadlec Regional Medical Center	43,906	19,150	63,056	30.4%
Providence Centralia Hospital	18,627	7,792	26,419	29.5%
Providence Holy Family Hospital	27,821	11,278	39,099	28.8%
Providence Mount Carmel Hospital	6,237	2,337	8,574	27.3%
Providence Regional Medical Center Everett	34,442	14,382	48,824	29.5%
Providence SHMC And Children's Hospital	34,228	16,392	50,620	32.4%
Providence St Joseph's Hosp Chewelah	2,848	1,128	3,976	28.4%
Providence St Mary Medical Center	14,451	6,094	20,545	29.7%
Providence St Peter Hospital	29,777	12,450	42,227	29.5%
St Joseph Hospital Polson	3,355	1,256	4,611	27.2%
St Patrick Hospital	14,364	6,242	20,606	30.3%
Grand Total	**230,056**	**98,501**	**328,557**	**30.0%**

Across Providence's Washington and Montana region, PSMMC's percent of avoidable ED visits was about average in 2020. At PSMMC, individuals identifying as American Indian or Alaska Native and Black or African American had higher than average percentages of avoidable ED visits.

ZIP Code 99362 produced the greatest number of potentially avoidable ED visits, accounting for about half of all avoidable visits in 2020. The top 3 causes of avoidable visits were urinary tract infection, bronchitis and other upper respiratory disease, and skin infection. Substance use disorders accounted for 5.8% of all avoidable ED visits.

Table 12. Avoidable Emergency Department Visits by Ministry and Patient ZIP Code

Facility and Top 10 Patient ZIP Codes	Non-AED Visit	AED Visits	Total ED Visits	AED %
Providence St Mary Medical Center	**14,451**	**6,094**	**20,545**	**29.7%**
99362	8,269	3,585	11,854	**30.2%**
97862	2,300	940	3,240	**29.0%**
99324	1,887	764	2,651	**28.8%**
99328	184	88	272	**32.4%**
99361	198	70	268	**26.1%**
97886	191	70	261	**26.8%**
97813	183	71	254	**28.0%**
99360	187	60	247	**24.3%**
97801	147	59	206	**28.6%**
99348	124	46	170	**27.1%**

See Appendix 1: Quantitative Data for more information on PQIs and AEDs

Potential Resources Available to Address Significant Health Needs

Understanding the potential resources to address significant health needs is fundamental to determining current state capacity and gaps. The organized health care delivery systems include the Walla Walla County Department of Public Health, Family Medical Center, The Walla Walla Clinic, Jonathan M. Wainwright Memorial VA Medical Center, Columbia County Health System that includes Dayton General Hospital. In addition, there are numerous social service non-profit agencies, faith-based organizations, and private and public-school systems that contribute resources to address these identified needs. For a list of potentially available resources available to address significant health needs see Appendix 3.

The cities of Walla Walla and College Place are on the way to becoming a Blue Zones Community® to help make healthier choices easier for everyone in the Walla Walla Valley. Their goals are to improve community health and well-being, lower obesity rates, and reduce smoking and chronic disease to create a healthier, happier place to live, work, and play. They believe that small changes contribute to significant benefits, such as, lowered healthcare costs, improved productivity, and a higher quality of life. PSMMC participated in the original campaign to bring the Blue Zones Project to the Walla Walla Valley and continues to be supportive of the project.

https://wwvalley.bluezonesproject.com/home

Appendix 3: Resources potentially available to address the significant health needs identified through the CHNA

COMMUNITY INPUT

Summary of Community Input

To better understand the unique perspectives, opinions, experiences, and knowledge of community members, representatives from Providence St. Mary Medical Center conducted 15 stakeholder interviews, including 21 participants, and 3 listening sessions with 15 community members. Full details on the protocols, findings, and attendees are available in **Appendix 2.**

Below is a high-level summary of the **high-priority health related needs** based on findings from these sessions:

Behavioral Health challenges (includes both mental health and substance use disorders)

The majority of stakeholders were very concerned about a lack of mental health and Substance Use Disorders (SUD) treatment services. The community lacks a detox facility, SUD treatment facility and inpatient mental health services. Stakeholders were concerned about many groups of people who may have difficulty accessing mental health services due to a **lack of providers, lack of Spanish-speaking providers, long wait times, and transportation barriers.** Other concerns expressed include **loss of insurance due to COVID-19, or** the provider will **not accept Medicaid and/or Medicare.**

Educators indicate they are seeing increased mental health needs for **young people** and **insufficient capacity to meet those needs.**

The COVID-19 pandemic has only exacerbated these challenges and concerns which has further limited access to Behavioral Health care for many.

Homelessness/lack of safe, affordable housing

Stakeholders emphasized a lack of affordable housing as a community issue due to rapidly **increasing rent**, a **lack of housing stock**, and **vacation rental properties**. Housing vouchers are not close enough to market rent to be attractive to landlords and listening session participants emphasized few housing options for people with poor credit, history of evictions, etc. **Homelessness**, while still an issue, is something that stakeholders shared many community organizations are addressing. Despite this, listening session participants shared that the **basic needs** of many people experiencing homelessness are still not being met, especially the need for **safety**. Stakeholders were primarily concerned about the following populations: **older adults** unable to afford their housing; **multi-family households; BBIPOC** (Black, Brown, Indigenous, and People of Color) and those who identify as **LGBTQ+** who are disproportionately affected by homelessness; and **mixed status families** (those with a mix of documentation statuses).

During the COVID-19 pandemic, community organizations have received funding to keep people in housing, but that may not last. Additionally, while **eviction moratoriums** have prevented people from losing housing, there have been fewer rental openings for people seeking housing.

Economic Insecurity

Stakeholders were concerned with the rising unemployment as a result of COVID-19. The current rate for Walla Walla is 4.8% compared to the state average of 5.5%. They noted a **lack of living wage jobs,** specifically in the agricultural and service sector that do not pay a sufficient amount, requiring people to work multiple jobs. They named economic security as foundational to secure **housing, food security,** and **access to health care.**

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

Affordable childcare and preschools

Stakeholders shared there are a **lack of childcare providers** in Walla Walla and no licensed childcare providers in Columbia County. This is especially an issue because **childcare subsidies** can only be applied to licensed programs. Affordable childcare allows parents to **work** and access **health care services** and ensures older siblings can focus on their education. COVID-19 caused a **childcare crisis** when many centers shut down, forcing some parents to take their children to the Tri-Cities for care. There was a disparity, as some parents were able to care for their children while working from home and others were left with few options.

Access to healthcare services

Stakeholders discussed a lack of low-barrier clinics that provide **complex case management.** They shared there's a lack of some **specialists** in the community (in particular, geriatrics and care for people with certain disabilities). Participants emphasized **transportation** as a barrier to care.

Stakeholders also expressed concern that certain populations *may experience* increased barriers to care: **Medicaid patients, patients in correctional facilities, Spanish-speaking patients, migrant populations, homeless, and LGBTQ+ youth.**

COVID-19 caused many people to **delay seeking care** which has led to more severe issues for some. Public **transportation** became more challenging during the pandemic making it difficult to get to medical

appointments. While **telehealth** helps some, it is especially challenging for those with limited technical skills or language barriers.

Aging Issues

Stakeholders shared there is a large aging population in the Walla Walla area that experiences challenges with housing, access to care, economic insecurity, and transportation. Some older adults are **unable to afford an assisted living center** and there **are limited in-home elder care options. Prescription drug costs** are difficult for those with low incomes (for some it means not being able to take the medication).

SIGNIFICANT HEALTH NEEDS

Effects of COVID-19

Stakeholders discussed how the pandemic has prevented their clients from accessing health care and behavioral health services, stating that while telehealth has increased access for some individuals, it has prevented others from receiving the care they need. People are delaying care, including well **child visits**, **vaccinations**, **dental care**, **chronic disease management**, and **mental health services**, which may have lasting effects. Stakeholders shared some clients would prefer to delay care until they can be seen in person and others lack the **technology**, **internet**, and/or **privacy** for telehealth appointments.

They shared they have not been able to contact some of the hardest to serve individuals, particularly **clients experiencing homelessness**. Stakeholders noted increased isolation for **older adults** and added stress on **families** with children.

Challenges in Obtaining Community Input

Obtaining robust community input during the COVID-19 pandemic was especially challenging and prevented PSMMC from completing many in-person conversations. Stakeholder interviews and listening sessions were adapted to be conducted virtually. While video conferencing does facilitate information sharing, there are challenges creating the level of dialogue that would take place in person. Additionally, due to many community organizations engaging in COVID-19 response, some organizations had limited capacity and were not able to participate in interviews. Reaching community members, particularly Spanish-speaking community members, was also a challenge. While efforts were made to distribute the survey through community partners and community health workers, limited capacity, COVID-related closures, and survey fatigue may have affected distribution and willingness to participate.

Opportunities to Support Community Needs

The Covid-19 pandemic also provided new opportunities to pivot from previous priorities to develop community collaborations to meet the newly prioritized critical healthcare needs and receive input from multiple community groups. A Walla Walla County Covid Joint Command team was implemented in March 2020 and still meets on a regular basis.

This interagency collaborative team was formed to strategically plan for and take action for the needs of the pandemic. Agencies include a broad spectrum of stakeholders representing various populations within Walla Walla County:

- Department of Community Health (Public Health), County EMS, County Emergency Management, and County Commissioners
- Municipal authorities from City of Walla, College Place and Waitsburg
- Healthcare facilities including Providence, Walla Walla Clinic, Family Medical Center, and the Johnathon Wainwright VA Medical Center
- Long term care facilities
- School Districts

- Port of Walla Walla
- Chamber of Commerce
- Law Enforcement
- Valley Transit Public Transport
- Other related social service agencies
- Walla Walla University
- Population Health

Examples of significant action planning occurred for:

- Development of free community Covid-19 testing strategies addressing needs of populations such as the elderly, those with limited mobility, the Hispanic community, and high risk work environments including prevalence of non-English speaking workforce.
- Implementation of Mass Covid-19 Vaccination venues starting in December 2020with PSMMC and Public Health collaborating on priority vaccination for healthcare workers, EMS, and law enforcement. Then expanding in March 2021 to mass vaccinations at the Walla Walla County Fairgrounds for the broader population. PSMMC assisted in the collaboration to provide vaccine control support, pharmacy support, security, vaccinators, and Incident Command team support. Multiple other agencies and private citizens also assisted for a total of 3,562 volunteer base established with 263 of these qualified as 'medical' and able to administer vaccinations. A total of 58,000 shots were given from February 28 through May at the fairgrounds with 29,000 people fully vaccinated. These volunteers continue to assist with the smaller vaccination venues scheduled since May, mobile vaccination teams going to high-risk populations or work settings, and the recent start of pediatric vaccinations held at the schools. Again, populations were sought out that traditionally may be underserved as listed under Covid testing. Creative strategies were developed to communicate with those who do not have online access to obtain appointments and translators were present at the vaccination sites.
- Implementation of County Isolation Housing facility at our Providence Southgate campus where Covid positive individuals without a safe or adequate place can shelter while needing to be in quarantine. Many of the guests have been homeless, women seeking shelter from abusive homes, or individuals recently furloughed from prison.

Through the work of the County Joint Command, many needs came to light and were addressed for populations that have been identified as underserved in the past.

See Appendix 2: Community Input

Prioritization Process

Using the process of engaging community leaders in stakeholder interviews was essential in identifying what they see as the top health-related needs of the community they serve. Data gathering and analytics was also paramount to objectively determine areas of focus. The PSMMC Mission Committee, which includes community members, hospital leaders and executives, reviewed the materials and prioritized the needs based on the stakeholder input and data resources.

2021 Priority Needs

The list below summarizes the significant health needs identified through the 2021 Community Health Needs Assessment process:

PRIORITY 1: BEHAVIORAL HEALTH CHALLENGES AND ACCESS TO CARE

Barriers to mental health and substance use disorder services significantly impact youth and those who speak a language other than English.

PRIORITY 2: ACCESS TO HEALTH CARE SERVICES

Barriers to access to health care services are related to insurance or cost, provider availability, distance to care, or transportation and significantly impact the aging population, those living with disabilities, and those who are Black, Brown, Indigenous, and People of Color (BBIPOC).

PRIORITY 3: HOMELESSNESS / LACK OF SAFE, AFFORDABLE HOUSING

Barriers to addressing homelessness include the lack of affordable housing and economic insecurity.

EVALUATION OF 2019-2021 CHIP IMPACT

This report evaluates the impact of the 2019-2021 Community Health Improvement Plan (CHIP). Providence St. Mary Medical Center responded to community needs by making investments of direct funding, time, and resources to internal and external programs dedicated to addressing the previously prioritized needs using evidence-based and leading practices. The Mission Committee prioritized, and the Community Board approved, the following three priorities listed in no particular order.

Table 13. Outcomes from 2019-2021 CHIP

Priority Need	Program or Service Name	Program or Service Description	Results/Outcomes
Youth at Risk – Homeless Youth and Young Adults (ages 12-24)	Count of "Youth Homeless" in Walla Walla County	Anchor Community Initiative Walla Walla Core Team	Anchor Community Initiative reported a 20% reduction in the number of actively homeless YYA in their system April–September 2021 compared to the prior six-month period.
	By-Name List (BNL) Scorecard of Youth & Young Adults (YYA)	Develop BNL of YYA experiencing homelessness in real time by FY2019.	BNL completed in 2019. In 2020 Walla Walla achieved reliable data for the YYA BNL (actively homeless, inflow and outflow numbers balanced within 15% margin of error).
	Policies and procedures	Develop policies and procedures to capture YYA experiencing homelessness	Walla Walla Anchor Community Initiative identified methodology for capturing and tracking YYA homelessness.
Behavioral health (mental health and substance abuse)	Aligned county behavioral health system of care	Council on behavioral health – cross sector behavioral health oversight body analyzes data, determines or how to best align systems of care and resources to meet community need will be implemented.	Walla Walla County Department of Community Health (WWDCH) contracted with the Human Services Research Institute for a comprehensive needs assessment to evaluate gaps in services and their role in behavioral health. Council on Behavioral Health implemented in 2018.

	Reduction in access to lethal means	Reduction in suicide and overdose deaths	Overdose deaths in 2017: 20 Suicide deaths in 2017: 12 Overdose deaths in 2020: 16 (20% reduction; 2017 goal of 25% reduction) Suicide deaths in 2020: 7 (42% reduction from 2017; exceeding goal of 25%) *1 case in both numbers overdose as well as suicide. 2020 numbers provided by Walla Walla County Coroner's Office*
	Implement population health department to provide integrated behavioral health into Providence Medical Group (PMG) primary care	Recruit and hire new positions for population health department	Population health positions filled: • Population health Coordinator • Outpatient Care Manager • MA Clinical Analyst • MA Case manager ED, 1.5 FTEs • Community Health Workers, 3 FTEs (COVID response) • Promotore de Salud
1. Childhood immunization rate in Walla Walla County as defined by Washington State as ready for kindergarten (Healthy People goal 80%)	Conduct innovative community coordinated public education	Public health information and messaging program	1. For the 2018-2019 school year, 92.5% of kindergarteners had completed all of their immunizations in Walla Walla County, compared 86.3% in Washington State. Since the 2015-2016 school year, Walla Walla County saw about a **5% increase** in the percentage of kindergarteners with complete vaccinations. Source for 2015-16 data: Washington DOH, Historical immunization data for state and county, 1998-2018 Source for 2018-19 data: Washington DOH, County School Immunization Dashboards, 2018-19

2. Adult influenza immunization rate in Walla Walla County (Healthy People goal 80%)	Conduct flu vaccination clinic to underserved	Flu vaccination clinics at convenient times and locations without need for appointment	2. Walla Walla County had about 43% of adults over 18 years receive the influenza vaccine in 2019-2020. Source: CDC, Influenza Vaccination Coverage for All Ages (6+ Months), 2019-2020

PSMMC, in collaboration with the Walla Walla County Department of Community Health, continued to collaborate on free drive-through influenza vaccinations for community benefit in the month of October during 2019, 2020, and 2021 where 500-600 doses were administered at each clinic. The exercising of these free clinics over the last 12 years most certainly helped us to quickly stand up to conduct the larger Covid mass vaccinations clinics where we administered up to 1500-2000 plus vaccinations per clinic with only community support. It should be noted there was a historic low prevalence of influenza during the winter of 2020-2021 – almost non-existent in Walla Walla County. A pivot was made with all hands-on-deck to provide Covid-19 mass vaccinations with the outcomes as previously listed under **"Opportunities to Support Community Needs"** as the higher priority. Ongoing needs continue to be vaccinations in the younger population where most new cases of Covid-19 are occurring.

Population Health

One of the strategies identified to address behavioral health in the 2019-2021 CHIP resulted in the implementation of the Population Health Department. In 2019, the Population Health Manager was assigned to lead Population Health for Providence's Southeast Washington region in Walla Walla. The department has grown to a team that includes nurses, community health workers, social workers, and a pharmacist.

Behavioral health accomplishments:

- As a component of Population Health's regional Mental Health Improvement Plan (MHIP) Providence SEQA was the first WA/MT service area to pilot Community Health Workers. On-boarding at the height of the pandemic of Community Paramedic Program pilot was implemented in Walla Walla in May of 2021. This quickly proved to be an essential workforce in our fight to keep the community safe. The Community Paramedic assists with case management of some of our most medically and socially complex patients in the Walla Walla Valley. They round weekly at the area homeless shelters, jail, and emergency department. They work closely with our community partners, linking patients to vital services. They assist with Covid-19 Care Coordination, partnering with the Walla Walla Department of Community Health. At the height of our county's surge, they would drive hundreds of miles per day delivering food boxes, thermometers, oximeters, and supplies to doorsteps. Most of the patients on the patients on their panels have active behavioral health diagnosis. Assigning a Community Health Worker to our most vulnerable populations has been a game changer in healthcare and is helping to reduce avoidable Emergency Department visits.

- In partnership with Walla Walla University and Anchor Point Counseling, Blue Mountain Health Cooperative (BMHC) opened their doors in February 2021, sharing space with the Population Health team. This student-run mental health clinic is the first of its kind in Walla Walla and is free and open to the public. In addition to the mental health clinic, BMHC offers behavioral health navigation services.
- Population health staff provides community education on mental health and are trained in Mental Health First Aid (MHFA), eCPR (Emotional CPR), and QPR (Question, Persuade, and Refer).
- Population Health involved in **A Way Home Anchor Community Initiative,** a diverse coalition partnering to functionally end youth homelessness. Our Community Health Workers have Centralized Diversion Fund Training, a young person centered solution to prevent or divert youth and young adults from entering homelessness which may be driven by behavioral health or substance abuse challenges.

Health equity accomplishments:

- Hired four Community Health Workers for COVID response.
- MOST is mobile, multi-agency, multidisciplinary outreach program which is dispatched to communities and areas where vulnerable, poor, and homeless people live and /or congregate. Population Health provides a Nurse Practitioner (with a mental health background), a Promotora (Spanish speaking community health worker), and other health specialists depending on the need.
- Vital Wines/Promotore de Salude – Covid-19 disproportionally impacted People of Color. Walla Walla County was not an exception. In 2020, 60% of our covid related outreach was to LatinX households, 38% Spanish speaking only. A high percentage was in the agricultural/vineyard industries. We recognized the value of having bilingual, bicultural Community Health Workers – a Promotore de Salud. The ability to penetrate these tight knit communities with education and trusted information is crucial for LatinX populations at higher risk not only for Covid but for other chronic diseases. In the summer o f2021, we partnered with Vital Wines to launch a Promotora program.
- Hired Promotore de Salud for COVID outreach to the Latinx population.
- In partnership with the Walla Walla Department of Community Health, Population Health operates the Southgate COVID Isolation and Quarantine Shelter. The 17-bed wing provides a safe place for people who are unsheltered to safely isolate. They receive supervision, meals, medical support, and case management, free of charge.
- The Population Health department is contracting with the Children's Home of Washington and will provide a bilingual Health Equity RN to provide clinical support for their Early Head Start program.

The Population Health team participated in the PSJH inaugural Age-Friendly Innovation Challenge Pitch Fest in August 2021 and was one of four winning project proposals. The challenge was initiated to encourage PSJH caregivers to bring their innovative ideas forward and jumpstart the journey to becoming an age-friendly health system. The successful project, Southeast Washington Fall Prevention Community Partnership Project, will focus on fall prevention and after falls targeting the aging population. The project was developed in response to the local crisis of in-home falls resulting in over 1100 EMS responses for lift assists in 2020.

Example of Addressing Health Needs for High-Risk Workforce Populations

On April 15, 2020 a cluster of 47 Covid-19 cases were identified to workers spanning three counties at a meat processing plant in Walla Walla County that employed approximately 1,400 workers of thirteen ethnicities, many of which were non-English speaking. This was identified by Public Health as an environmentally high-risk workplace of covid surge with workers in close contact, limited cafeteria/break room space, and shared carpooling.

On April 21, PSMMC received a request from Walla Walla County Department of Community Health to assist with mass Covid-19 swab testing of all employees at this plant. PSMMC responded to provide caregivers from Infection Prevention, Emergency Preparedness, Cardiac Cath Lab, and Population Health departments. This was a the first 'mass testing' to be conducted in the County. Testing was done over 1.5 days with a throughput rate of approximately 150 tests completed hourly with over 200 additional positive cases identified resulting in the plant temporarily being closed while additional environmental mitigation strategies and education provided for its workers. No further significant outbreaks have occurred at this facility after precautions and health education were in place. This set the pace for additional testing at other congregate settings and later with vaccinations taken into high-risk workplaces. This is another example of the need to be nimble and pivot when the priority needs change working in multi-agency collaboratives and not in a silo for the benefit of the entire community Go where the need is, the over-riding lessons over the last two years.

Addressing Identified Needs

Lessons learned during 2020-2021 in addressing community health needs during a pandemic quickly became apparent that it is essential to develop and maintain tight-knit community, multi-agency, and private citizen liaisons for collaborations to overcome barriers with creative ideas, action planning, and volunteerism. The true meaning of a 'community-based healthcare workforce' was revealed. We have to leave behind our traditional 'brick and mortar' mentality. If up to 80% of health outcomes are determined by Social Determinants of Health, we need to continue to invest in such community workers and programs to address the complex needs.

A community-based workforce also provides great value to our aged population, those that have marginalized healthcare access through lack of mobility, language or technology access, as well as homelessness. Other lessons included the need to work with certain vulnerable populations in their work setting – go to where they are to provide health screening and education, testing, or vaccination. Finally, the need for 'seamless' behavioral health (including substance abuse) navigation (No wrong door) is

echoed as a primary need by our community stakeholder agencies and vulnerable populations. The current system is still too fragmented, fraught with cracks in service leaving patients dangling, unserved, suffering. The prolonged pandemic, social distancing, significant changes in how students attend school or participate in extracurricular activities between virtual to on-site is uncharted territory and has exacerbated the stressors of youth.

2021 CHNA GOVERNANCE APPROVAL

This Community Health Needs Assessment was adopted by the Providence St. Mary Medical Center Community Mission Board[6] of the hospital on December 17, 2021. The final report was made widely available by December 28, 2021.

Susan Blackburn 12.17.2021

Susan Blackburn Date
Chief Executive, PSMMC

Anne-Marie Zell Schwerin 12/17/2021

Anne-Marie Zell Schwerin Date
Chair, Providence St. Mary Community Board

Justin Crowe 12-20-2021

Justin M. Crowe Date
Senior Vice President, Community Partnerships
Providence

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

[6] **See Appendix 4: Advisory Committees**

APPENDICES

Appendix 1: Quantitative Data

POPULATION LEVEL DATA

Economic Indicators

Indicator	Columbia County	Umatilla County	Walla Walla County	Broader Service Area	High Need Service Area
Percent of Population Below 200% Federal Poverty Level Year: 2019	38.1%	42.1%	34.2%	30.5%	45.7%
Percent of Households Receiving SNAP Benefits Year: 2013-2017 estimates	17.3%	22.5%	13.5%	16.0%	20.9%

Data Source: American Community Survey

Indicator	Walla Walla County	Washington State
Overall average annual wage (using nominal dollar values) Data Source: Walla Walla Trends, Washington State Employment Security Department: Labor Market Report Library—Covered Employment, Quarterly Census of Employment and Wages Year: 2019 compared to 2017 and 2000	2019: $46,219 2017: $42,999 2000: $25,996	2019: $69,615 2017: $62,077 2000: $37,101
Share of K-12 students enrolled in USDA free & reduced lunch program Data Source: Walla Walla Trends, State of WA Office of Superintendent of Public Instruction: Child Nutrition—Reports Year: 2020-2021 compared to 2016-2017	2020-2021: 55.5% 2016-2017: 55.3%	2020-2021: 45.8% 2016-2017: 44.4%

The overall annual wage has increased by 77.8% in Walla Walla County and 87.6% in Washington State since 2000.

Indicator	Walla Walla County	Columbia County	Umatilla County	Washington State
Children in single parent households	2019: 20% 2016: 30%	2019: 6% 2016: 20%	2019: 23% 2016: 39%	2019: 20% 2016: 29%

Data Source: County Health Rankings, American Community Survey, 2015-2019 estimates for 2019 and 2012-2016 estimates for 2016				
Income inequality: ratio of household income 80th percentile to 20th percentile (a higher ratio indicates greater division between the top and bottom ends of the income spectrum) Data Source: County Health Rankings, American Community Survey, 2015-2019 estimates for 2019	4.6	6.3	4.4	4.4
Food Environment Index (0-10 scale with 10 being the best) Data Source: County Health Rankings, United States Department of Agriculture, The Atlas, 2015 and 2018 data	8.1	7.1	7.1	8.2

Housing Instability and Homelessness

Indicator	Walla Walla County	Columbia County	Umatilla County	Washington State
Number of individuals experiencing homelessness Data Source: Walla Walla County Point in Time Count, 2018	181	N/A	N/A	N/A
Severe housing problems (factored for overcrowding, high costs, lack of adequate kitchen or lack of plumbing facilities) Data Source: County Health Rankings, HUD Comprehensive Housing Affordability Strategy data, 2013-2017 average for 2017 and 2010-2014 for 2014 data	2017: 17% 2014: 17%	2017: 13% 2014: 17%	2017: 16% 2014: 17%	2017: 17% 2014: 18%
Rental vacancy rate Data Source: Walla Walla Trends, American Community Survey, 2019 and 2013	Walla Walla & Columbia Counties combines 2019: 2.9% 2013: 3.4%		N/A	2019: 3.6% 2013: 4.7%

Language Proficiency

Indicator	Columbia County	Umatilla County	Walla Walla County	Broader Service Area	High Need Service Area
Percent of Population Age 5+ Who Do Not Speak English Very Well Data Source: American Community Survey Year: 2015 – 2019 Estimate	1.6%	4.1%	3.4%	0.8%	7.0%

Educational Attainment

Indicator	Columbia County	Umatilla County	Walla Walla County	Broader Service Area	High Need Service Area
Percent of Population Age 25+ With A High School Diploma Data Source: American Community Survey Year: 2019	91.0%	83.6%	89.3%	91.6%	80.7%

Indicator	Walla Walla & Columbia Counties combined	Washington State
Share of the population ages 25+ with a high school diploma, GED or less	2019: 21.1%* 2013: 25.4%	2019: 22.1%* 2013: 23.3
Share of the population ages 25+ with at least some college or an associate's degree	2019: 12.9% 2013: 11.6%	2019: 10%* 2013: 9.5%
Share of the population ages 25+ with at least a bachelor's degree	2019: 18.9% 2013: 16.9%	2019: 22.8%* 2013: 20.9%

Data Source: Walla Walla Trends, American Community Survey
Year: 2019 compared to 2013
*Statistically significant change

Access to Health Care

Indicator	Walla Walla County	Columbia County	Umatilla County	Washington State
Primary Care Physicians Ratio per 100,000 people Data Source: County Health Rankings, Area Health Resource File/ American Medical Association, 2018 and 2015 data	2018: 820:1 2015: 820:1	2018: 1,350:1 2015: 1,310:1	2018: 2,350:1 2015: 1,960:1	2018: 1,180:1 2015: 1,200:1
Share of adults with a primary healthcare provider Data Source: Walla Walla Trends, WA State DOH: Community Health Assessment Tool, 2018 and 2012 data	2018: 73.9% 2012: 79.0%	Not Available	Not Available	2018: 74.5% 2012: 75.5%
Dentists ratio per 100,000 people Data Source: County Health Rankings, Area Health Resource File/ National Provider Identification File, 2019 and 2016 data	2019: 1,240:1 2016: 1,260:1	2019: 1,330:1 2016: 1,310:1	2019: 1,770:1 2016: 1,700:1	2019: 1,200:1 2016: 1,250:1
Share of adults visiting a dentist, hygienist, or dental clinic in last year Data Source: Walla Walla Trends, WA State DOH: Community Health Assessment Tool, 2018 and 2012 data	2018: 65.1% 2012: 65.1%	Not Available	Not Available	2018: 68.9% 2012: 67.4
Mental health provider ratio per 100,000 people Data Source: County Health Rankings, CMS, National Provider Identification, 2020 and 2017	2020: 340:1 2017: 440:1	2020: 330:1 2017: 440:1	2020: 250:1 2017: 340:1	2020: 250:1 2017: 330:1

Digital Divide

Indicator	Columbia County	Umatilla County	Walla Walla County	Broader Service Area	High Need Service Area
Percent of households without internet access Data Source: American Community Survey Year: 2019	18.9%	17.1%	11.2%	13.7%	15.7%

Mental Health and Substance Use

Indicator	Walla Walla County	Columbia County	Umatilla County	Washington State
Suicide rate per 100,000 deaths Data Source: County Health Rankings, National Center for Health Statistics—Mortality Files, 2015-2019	14	Not Available	19	16
Adult smoking Data Source: County Health Rankings, BRFSS, 2018	14%	16%	21%	12%

2018 Healthy Youth Survey

The Washington State Healthy Youth Survey is an effort to measure health risk behaviors that contribute to morbidity, mortality, and social problems among young people. These behaviors include substance use, those that result in intentional and unintentional injuries, and dietary behaviors and physical activities. The survey also reports on mental health, school climate, and other related risk and protective factors. Students are surveyed in the 6th, 8th, 10th, and 12th grade every 2 years. In 2018, the most recent survey data available, survey results for 10th and 12th grade are suppressed due to insufficient reporting from students. Therefore, only grade 8th grade data are reported and compared to the statewide data. In Walla Walla County, 72% of 8th graders participated.

PMG data shows 70% of our Medicaid covered paneled youth are behind on annual wellness visits and immunization schedules. The Washington DOH recently published a report correlating that falling childhood vaccination rates since 2020 are a concerning trend.

Indicator	8th Graders	Statewide
Dietary Behaviors		
Drinking at least one sweetened drink in the past 7 days	80.9%	74.8%
Students who ate breakfast today	62.8%	64.7%
Students who rarely or never eat dinner with family	39%	33%
Weight and Exercise		
Obese or overweight	27%	26%
Students who walk to or from school at least one day a week	45.7%	35.0%
Students who did not meet the recommendation for 60 minutes of physical activity 7 days a week	67%	72%
Substance Use		
Smoked cigarettes in past 30 days	5.2%	2.7%
Drank alcohol in past 30 days	10.6%	8.4%
Used marijuana or hashish in past 30 days	10.6%	7.2%
Binge drinking in past 2 weeks	7.2%	4.6%
Bullying and School Climate		
Carried a weapon at school in the past 30 days	5.0%	3.4%
Bullied in the past 30 days	31.6%	27.4%
Enjoyed being at school over the past year	39.3%	38.4%
Felt safe at school	76.5%	79.8%
Mental Health		
Depressive feelings	36%	32%

Life Expectancy and Mortality

Indicator	Columbia County	Umatilla County	Walla Walla County	Broader Service Area	High Need Service Area
Life Expectancy at Birth Data Source: CDC/National Center for Health Statistics, 2010-2015	79.7	78.6	80.3	80.6	77.9

Indicator	Walla Walla County	Columbia County	Umatilla County	Washington State
Years of potential life lost before age 75 per 100,000 population (age-adjusted) Data Source: County Health Rankings, National Center for Health Statistics—Mortality Files, 2017-2019 data	5,800	Not Available	7,300	5,600
Number of deaths among residents under age 75 per 100,000 population (age-adjusted) Data Source: County Health Rankings, National Center for Health Statistics—Mortality Files, 2017-2019 data	300	390	360	290
Top 7 causes of death in order Data Source: WA State Death Dashboard, 2019 data	1. Malignant Neoplasms 2. Diseases of Heart 3. Alzheimer's Disease 4. Accidents 5. Cerebrovascular diseases 6. Diabetes			1. Malignant Neoplasms 2. Diseases of Heart 3. Accidents 4. Alzheimer's Disease 5. Cerebrovascular diseases 6. Chronic lower respiratory diseases

	7. Chronic lower respiratory diseases			7. Diabetes

Safety

Indicator	Walla Walla County	Columbia County	Umatilla County	Washington State
Violent crime rate (offenses per 100,000) Data Source: County Health Rankings, Uniform Crime Reporting—FBI, 2014 and 2016 data	239	38	223	294
Domestic violence offence rate per 1,000 residents Data Source: Walla Walla Trends, WA State DSHS: Risk and Protection Profiles for Substance Abuse Prevention Planning, 2019 data	8.3	Not Available	Note Available	8.4
Number of deaths due to injury per 100,000 population Data Source: County Health Rankings, National Center for Health Statistics—Mortality Files, 2015-2019 data	79	120	76	67
Percentage of driving deaths with alcohol involvement Data Source: County Health Rankings, Fatality Analysis Reporting System, 2015-2019 data	26%	75%	27%	33%

Environmental Factors

Indicator	Walla Walla County	Columbia County	Umatilla County	Washington State
Air pollution (particulate measured rate) Data Source: County Health Rankings, CDC's National Environmental Public Health Tracking Network, 2016 and 2012 data	2016: 8.1 2012: 7.2	2016: 6.5 2012: 6.1	2016: 8.8 2012: 7.6	2016: 6.4 2012: 7.0

2018 vs. 2021 County Health Rankings – Walla Walla County

	Washington - 2021	Walla Walla - 2021	Walla Walla - 2018
Health Outcomes			
Length of Life			
Premature death	5,600	5,800	6,300
Quality of Life			
Poor or fair health	15%	18%	15%
Poor physical health days	3.7	4.1	3.9
Poor mental health days	4.0	4.4	4.0
Low birthweight	6%	6%	5%
Health Factors			
Health Behaviors			
Adult smoking	12%	14%	15%
Adult obesity	29%	29%	28%
Food environment index	8.2	8.1	8.1
Physical inactivity	16%	16%	18%
Access to exercise opportunities	86%	83%	83%
Excessive drinking	17%	18%	18%
Alcohol-impaired driving deaths	33%	26%	19%
Sexually transmitted infections	465.2	351.7	397.7
Teen births	16	19	25
Clinical Care			
Uninsured	7%	9%	9%
Primary care physicians	1,180:1	820:1	820:1
Dentists	1,200:1	1,240:1	1,260:1
Mental health providers	250:1	340:1	440:1
Preventable hospital stays*	2,853	2,724	28
Mammography screening	40%	43%	63%
Flu vaccinations	47%	48%	Not listed
Social & Economic Factors			
High school graduation	92%	89%	80%
Some college	71%	69%	65%
Unemployment	4.3%	4.9%	5.6%
Children in poverty	12%	15%	17%
Income inequality	4.4	4.6	4.5
Children in single-parent households	20%	20%	30%
Social associations	8.5	8.0	8.9
Violent crime	294	239	215
Injury deaths	67	79	74
Physical Environment			
Air pollution - particulate matter	6.4	8.1	7.2
Drinking water violations	Not Listed	No	Yes
Severe housing problems	17%	17%	17%
Driving alone to work	72%	73%	69%

Long commute - driving alone	37%	12%	10%
Length of Life			
Life expectancy	80.4	80.3	Not listed
Premature age-adjusted mortality	290	300	320
Child mortality	40	20	50
Infant mortality	4	Not Listed	6
Quality of Life			
Frequent physical distress	11%	13%	12%
Frequent mental distress	12%	13%	12%
Diabetes prevalence	9%	12%	10%
HIV prevalence	215	124	104
Health Behaviors			
Food insecurity	11%	12%	12%
Limited access to healthy foods	6%	5%	5%
Drug overdose deaths	16	21	20
Motor vehicle crash deaths	8	10	10
Insufficient sleep	32%	33%	27%
Clinical Care			
Uninsured adults	9%	11%	11%
Uninsured children	3%	3%	4%
Other primary care providers	1,020:1	920:1	1,138:1
Social & Economic Factors			
Disconnected youth	6%	7%	10%
Reading scores	3.0	2.7	Not listed
Math scores	3.0	2.5	Not listed
Median household income	$78,700	$60,200	$53,600
Children eligible for free or reduced price lunch	43%	56%	58%
Residential segregation - Black/White	59	34	36
Residential segregation - non-white/white	38	28	22
Homicides	3	3	3
Suicides	16	14	Not listed
Firearm fatalities	11	13	11
Juvenile arrests	25	32	Not listed
Physical Environment			
Traffic volume	601	236	Not listed
Homeownership	63%	65%	Not listed
Severe housing cost burden	14%	14%	Not listed
Broadband access	88%	85%	Not listed

*The 2021 indicator for preventable hospital stays is the rate of hospital stays for ambulatory-care sensitive conditions per 100,000 Medicare enrollees, while the 2018 indicators is the rate per 1,000 Medicare enrollees.

HOSPITAL LEVEL DATA

Avoidable Emergency Department (AED) Visits

Emergency department discharges for the year 2020 were coded as "avoidable" per the Providence definition for Providence St. Mary Medical Center and nearby Providence hospitals. Avoidable Emergency Department (AED) visits are based on the primary diagnosis for a discharge and includes diagnoses that are deemed non-emergent, primary care treatable or preventable/avoidable with better managed care.

Avoidable Emergency Department Visits by Providence Hospitals in Washington Montana

Facility	Non-AED Visits	AED Visits	Total ED Visits	AED %
Kadlec Regional Medical Center	43,906	19,150	63,056	30.4%
Providence Centralia Hospital	18,627	7,792	26,419	29.5%
Providence Holy Family Hospital	27,821	11,278	39,099	28.8%
Providence Mount Carmel Hospital	6,237	2,337	8,574	27.3%
Providence Regional Medical Center Everett	34,442	14,382	48,824	29.5%
Providence SHMC And Children's Hosp	34,228	16,392	50,620	32.4%
Providence St Joseph's Hospital Chewelah	2,848	1,128	3,976	28.4%
Providence St Mary Medical Center	14,451	6,094	20,545	29.7%
Providence St Peter Hospital	29,777	12,450	42,227	29.5%
St Joseph Hospital Polson	3,355	1,256	4,611	27.2%
St Patrick Hospital	14,364	6,242	20,606	30.3%
Grand Total	**230,056**	**98,501**	**328,557**	**30.0%**

Avoidable Emergency Department Visits at Providence St. Mary Medical Center by Patient Zip Code

Facility and Top 10 Patient Zip Codes	Non-AED Visits	AED Visit	Total ED Visits	AED %
Providence St Mary Medical Center	**14,451**	**6,094**	**20,545**	**29.7%**
99362	8,269	3,585	11,854	**30.2%**
97862	2,300	940	3,240	**29.0%**
99324	1,887	764	2,651	**28.8%**
99328	184	88	272	**32.4%**
99361	198	70	268	**26.1%**
97886	191	70	261	**26.8%**
97813	183	71	254	**28.0%**
99360	187	60	247	**24.3%**
97801	147	59	206	**28.6%**
99348	124	46	170	**27.1%**

Avoidable Emergency Department Visits by Race at Providence St. Mary Medical Center

Facility and Race	Non-AED Visits	AED Visit	Total ED Visits	AED %
Providence St Mary Medical Center	**14,451**	**6,094**	**20,545**	**29.7%**
American Indian or Alaska Native	172	87	259	**33.6%**
Asian	72	33	105	**31.4%**
Black or African American	197	101	298	**33.9%**
Native Hawaiian or Other Pacific Islander	34	13	47	**27.7%**
Other	2,839	1,193	4,032	**29.6%**
Patient Refused	208	96	304	**31.6%**
Unknown	243	100	343	**29.2%**
White or Caucasian	10,681	4,469	15,150	**29.5%**
(Blank)	5	2	7	**28.6%**

Avoidable Emergency Department Visits by Ethnicity at Providence St. Mary Medical Center

Facility and Ethnicity	Non-AED Visits	AED Visit	Total ED Visits	AED %
Providence St Mary Medical Center	**14,451**	**6,094**	**20,545**	**29.7%**
Hispanic or Latino	2,888	1,243	4,131	30.1%
Not Hispanic or Latino	11,217	4,702	15,919	29.5%
Patient Refused	144	67	211	31.8%
Unknown	197	80	277	28.9%
(Blank)	5	2	7	28.6%

Top 20 Diagnosis Groups for Avoidable Emergency Department Visits at Providence St. Mary Medical Center

Top 20 Diagnosis Groups* for AED Visits	Avoidable Visits	Percent of Total Avoidable Visits
Providence St Mary Medical Center	**6,094**	**-**
Urinary Tract Infection	617	10.1%
Bronchitis and Other Upper Respiratory Disease	501	8.2%
Skin Infection	439	7.2%
Nonspecific Back and Neck Pain	417	6.8%
Substance Use Disorders	353	5.8%
Anxiety and Personality Disorders	345	5.7%
Headache/Migraine	210	3.4%
Tonsillitis	209	3.4%
Dizziness	189	3.1%

Inflammatory Bowel Disease	184	3.0%
Asthma	157	2.6%
Chronic Obstructive Pulmonary Disease	152	2.5%
Acute Otitis Media and Sinusitis	148	2.4%
Oral and Dental Disease	145	2.4%
Pneumonia Including Aspiration Pneumonia	136	2.2%
Mood Disorders, Episodic	120	2.0%
Diabetes Mellitus	119	2.0%
Psychosis	113	1.9%
Unclassified**	103	1.7%
Hypertension	102	1.7%

**Diagnoses are grouped by Care Family; method is Sg2 CARE Grouper. For example, for this data set, 56 diagnoses are grouped together as "Substance Use Disorders."*

Prevention Quality Indicators

Prevention Quality Indicators were developed by the Agency for Healthcare Research and Quality to measure potentially avoidable hospitalizations for Ambulatory Care Sensitive Conditions (ACSCs). ACSCs are conditions for which hospitalizations can potentially be avoided with better outpatient care and which early intervention can prevent complications.

More info on PQIs can be found on the following links:
https://www.qualityindicators.ahrq.gov/modules/pqi_overview.aspx
https://www.qualityindicators.ahrq.gov/modules/pqi_resources.aspx
PQIs were calculated using inpatient admission data for the years 2018, 2019 and 2020.

Prevention Quality Composite Rates at Providence St. Mary Medical Center

PQI 90 Description:
Prevention Quality Indicators (PQI) overall composite per 100,000 population, ages 18 years and older. Includes admissions for one of the following conditions: diabetes with short-term complications, diabetes with long-term complications, uncontrolled diabetes without complications, diabetes with lower-extremity amputation, chronic obstructive pulmonary disease, asthma, hypertension, heart failure, bacterial pneumonia, or urinary tract infection.

PQI 90 Numerator:

Discharges, for patients ages 18 years and older, that meet the inclusion and exclusion rules for the numerator in any of the following PQIs:
- PQI #1 Diabetes Short-Term Complications Admission Rate
- PQI #3 Diabetes Long-Term Complications Admission Rate
- PQI #5 Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate
- PQI #7 Hypertension Admission Rate
- PQI #8 Heart Failure Admission Rate

- PQI#11 Community-Acquired Pneumonia Admission Rate
- PQI #12 Urinary Tract Infection Admission Rate
- PQI #14 Uncontrolled Diabetes Admission Rate
- PQI #15 Asthma in Younger Adults Admission Rate
- PQI #16 Lower-Extremity Amputation among Patients with Diabetes Rate

PQI 90 Denominator:

Discharges, for patients ages 18 years and older, at a hospital.

PQI 90	2018	2019	2020
Numerator	631	615	570
Denominator	5,817	5,500	4,838
Rate per 1,000 Visits	**108.48**	**111.82**	**117.82**

PQI 91 Description:
Prevention Quality Indicators (PQI) composite of acute conditions per 100,000 population, ages 18 years and older. Includes admissions with a principal diagnosis of one of the following conditions: bacterial pneumonia or urinary tract infection.

PQI 91 Numerator:

Discharges, for patients ages 18 years and older, that meet the inclusion and exclusion rules for the numerator in any of the following PQIs:
- PQI #11 Community-Acquired Pneumonia Admission Rate
- PQI #12 Urinary Tract Infection Admission Rate

PQI 91 Denominator:

Discharges, for patients ages 18 years and older, at a hospital.

PQI 91	2018	2019	2020
Numerator	200	201	177
Denominator	5,817	5,500	4,838
Rate per 1,000 Visits	**34.38**	**36.55**	**36.59**

PQI 92 Description:
Prevention Quality Indicators (PQI) composite of chronic conditions per 100,000 population, ages 18 years and older. Includes admissions for one of the following conditions: diabetes with short-term complications, diabetes with long-term complications, uncontrolled diabetes without complications, diabetes with lower-extremity amputation, chronic obstructive pulmonary disease, asthma, hypertension, or heart failure without a cardiac procedure.

PQI 92 Numerator:

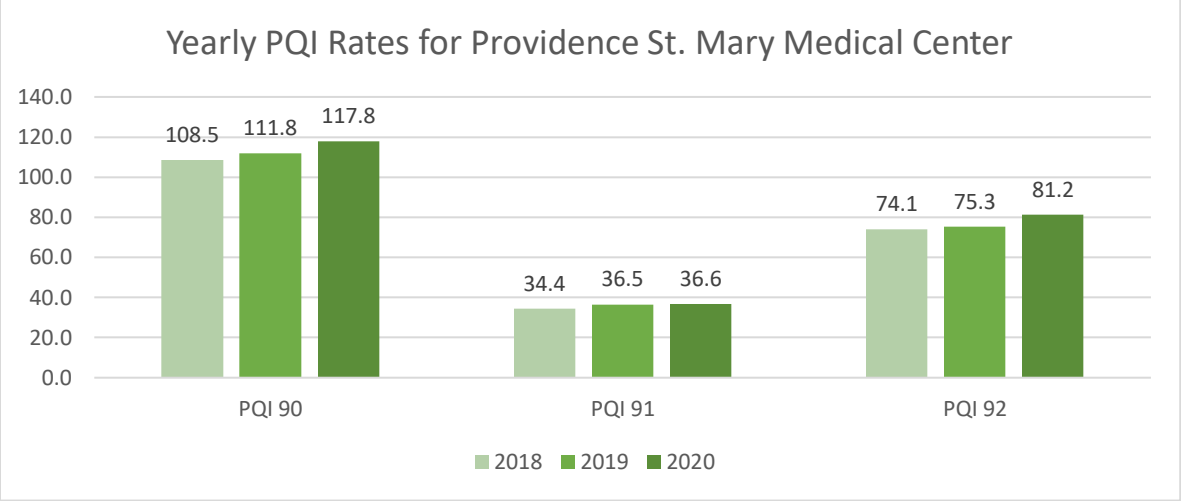
Discharges, for patients ages 18 years and older, that meet the inclusion and exclusion rules for the numerator in any of the following PQIs:

- PQI #1 Diabetes Short-Term Complications Admission Rate
- PQI #3 Diabetes Long-Term Complications Admission Rate
- PQI #5 Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate
- PQI #7 Hypertension Admission Rate
- PQI #8 Heart Failure Admission Rate
- PQI #14 Uncontrolled Diabetes Admission Rate
- PQI #15 Asthma in Younger Adults Admission Rate
- PQI #16 Lower-Extremity Amputation among Patients with Diabetes Rate

PQI 92 Denominator:

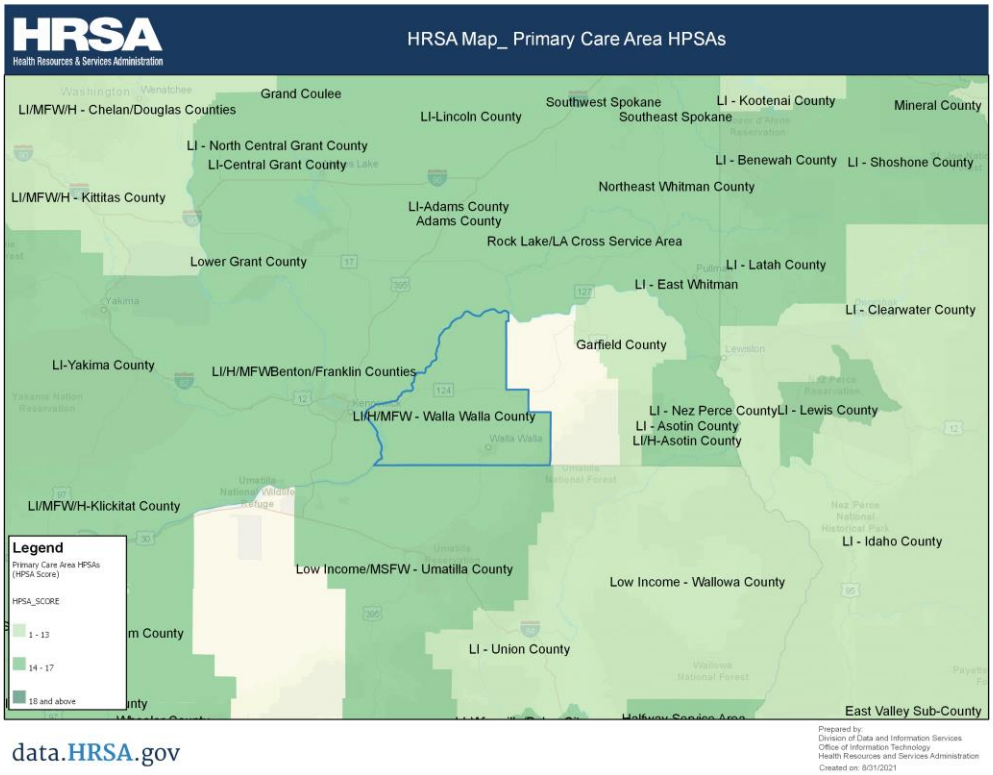
Discharges, for patients ages 18 years and older, at a hospital.

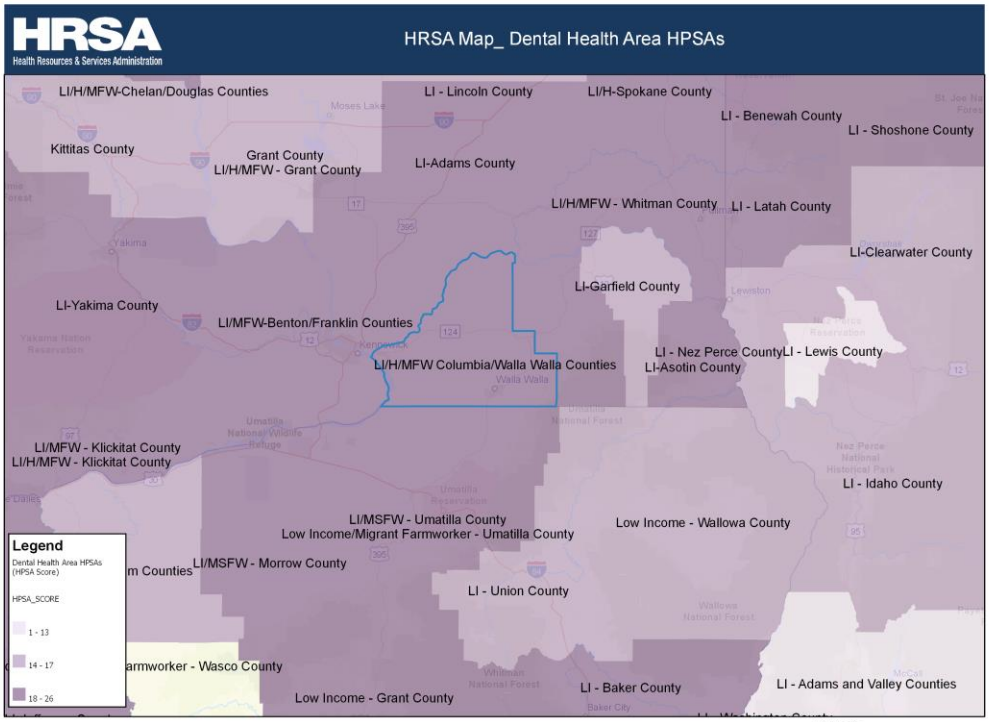
PQI 92	2018	2019	2020
Numerator	431	414	393
Denominator	5,817	5,500	4,838
Rate per 1,000 Visits	**74.09**	**75.27**	**81.23**



HEALTH PROFESSIONAL SHORTAGE AREA

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





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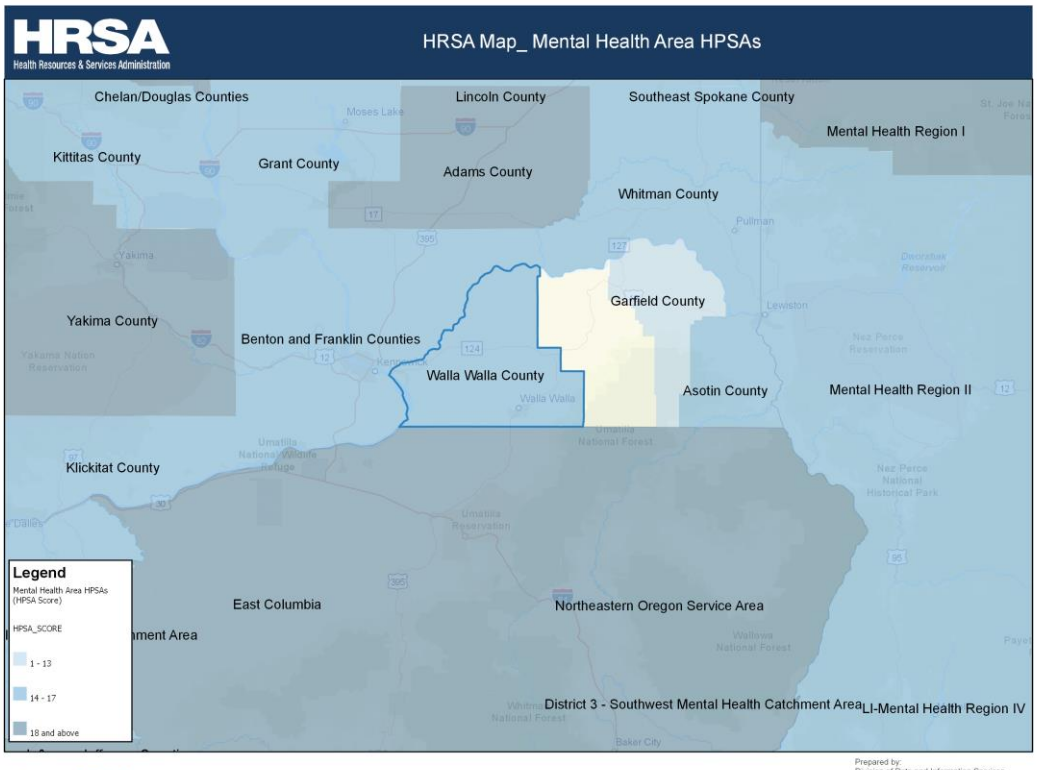

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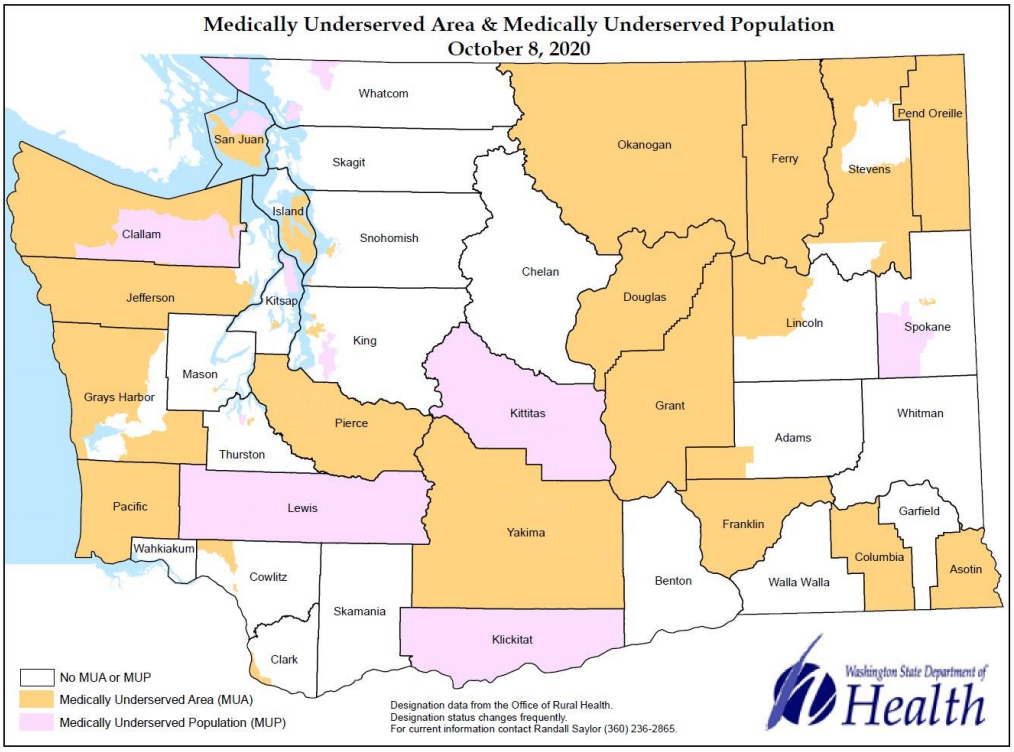
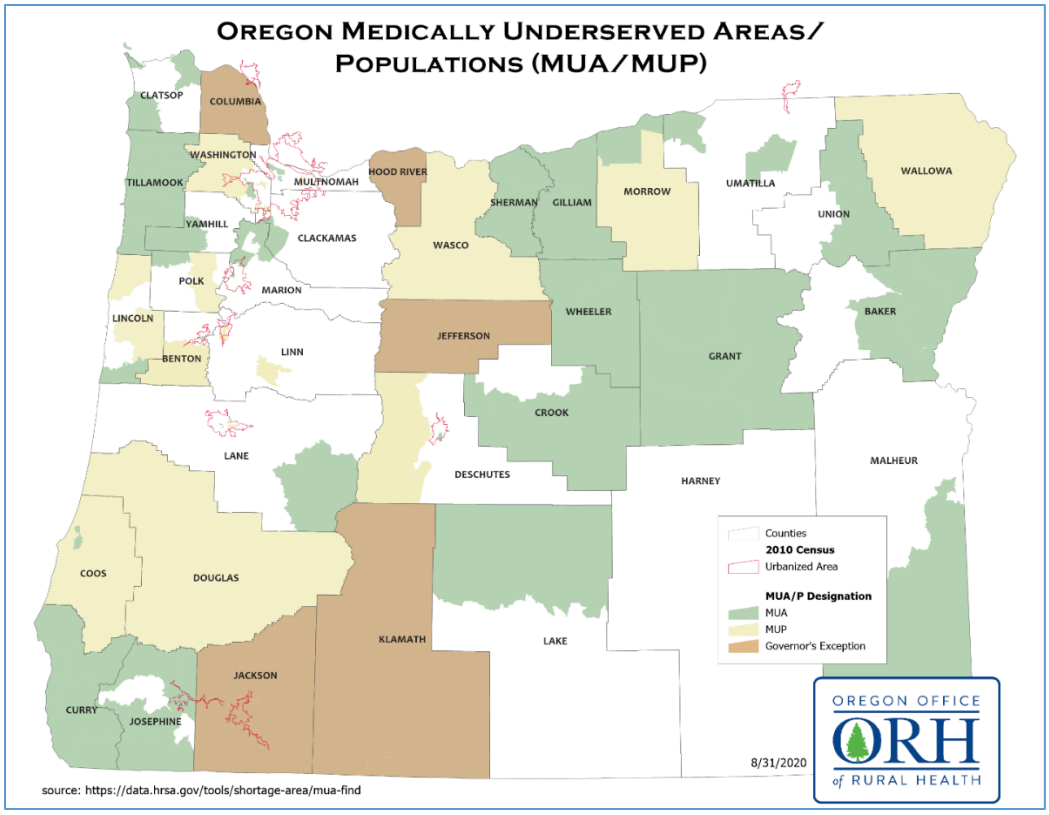
MEDICALLY UNDERSERVED AREA/ MEDICAL PROFESSIONAL SHORTAGE AREA

Medically Underserved Areas (MUAs) and Medically Underserved Populations (MUPs) are defined by the Federal Government to include areas or populations that demonstrate a shortage of health care services. This designation process was originally established to assist the government in allocating the Community Health Center Fund to the areas of greatest need. MUAs are identified by calculating a composite index of need indicators compiled and with national averages to determine an area's level of medical "under service." MUPs are identified based on documentation of unusual local conditions that result in access barriers to medical services. MUAs and MUPs are permanently set, and no renewal process is necessary. The following map depicts the MUAs and MUPs within a 30-mile radius from PSMMC.





Appendix 2: Community Input

INTRODUCTION

Providence St. Mary Medical Center (PSMMC) conducted stakeholder interviews and community listening sessions. Listening to and engaging with the people who live and work in the community is a crucial component of the CHNA, as these individuals have firsthand knowledge of the needs and strengths of the community. PSMMC conducted 15 stakeholder interviews including 21 participants, people who are invested in the wellbeing of the community and have first-hand knowledge of community needs and strengths. They also included 3 listening sessions including 15 community members. The goal of the interviews and listening sessions was to identify what needs are currently not being met in the community and what assets could be leveraged to address these needs.

METHODOLOGY

Selection

A total of 3 listening sessions were completed with 15 community members.

Apx 2_Table 1. Community Input Type and Population

Community Input Type and Population	Location of Session	Date	Language
Listening session at The Sleep Center with people experiencing homelessness	Walla Walla, WA	June 9, 2021	English
Listening session at Aging & Long Term Care with older adults	Online (Zoom)	June 29, 2021	English
Listening session at The Disability Network with mothers of children living with disabilities	Online (Zoom)	June 28, 2021	English

Representatives from PSMMC conducted 15 stakeholder interviews including 21 participants. Stakeholders were selected based on their knowledge of the community and engagement in work that directly serves people who are economically poor and vulnerable. PSMMC aimed to engage stakeholders from social service agencies, health care, education, housing, and government, among others, to ensure a wide range of perspectives. Included in the interviews was the Public Health Officer and Medical Director and the Administrative Director from Walla Walla County Department of Community Health, the local health department.

Apx 2_Table 2. Key Community Stakeholder Participants

Organization	Name	Title	Sector
Blue Mountain Action Council	Kathy Covey	CEO	Social Service
Blue Mountain Heart to Heart	Everett Maroon	Executive Director	Social Service, Public Health
Catholic Charities Walla Walla	Tim Meliah	Director	Non-profit organization
Center for Humanitarian Engagement- Walla Walla University	E. David Lopez	Executive Director	Education

City of College Place	Norma Hernandez	Mayor	Government
City of Walla Walla	Scott Bieber	Chief of Police	Government
Comprehensive Healthcare	Courtney Hesla, Merridy Smith & Rich Simpson	Vice President, Team Lead Outpatient Unit Walla Walla & Team Lead Outpatient Unit 2, Child and Family Services	Healthcare
Dayton Chronicle	Loyal Baker	Co-Publisher	Media
Family Medical Center/Yakima Valley Farm Workers Clinic	Derek Valdez, Marcie Larson, Jessica Herbst, Edgar Diaz	Derek, Interim Clinic Manager; Marcie, Front Office Supervisor; Jessica, Nursing Supervisor, Edgar, CHW	Healthcare
Milton-Freewater Downtown Alliance (MFDA) & Broadway Family Dental Care	Norm Saager, DMD	President (of MFDA) & Dentist	Economic & Healthcare
Providence Medical Group Population Health	Becky Betts	Manager	Population Health
Walla Wall Public Schools	Julie Perron	Director of Equity and Dual Programs	Education
Walla Walla County Department of Community Health	Daniel Kaminsky, MD & Nancy Wenzel	Public Health Officer and Medical Director & Administrative Director	Public health and human services
YMCA	Karen Hedine	CEO	Education, Children's Services
Youth Women and Children's Center	Anne Marie Zell Schwerin	Executive Director	Public health and human services

Facilitation Guide

Providence developed a facilitation guide that was used across all hospitals completing their 2021 CHNAs (see Stakeholder Interview Questions for the full list of questions):

- The community served by the stakeholder's organization

- The community strengths
- Prioritization of unmet health related needs in the community, including social determinants of health
- The COVID-19 pandemic's effects on community needs
- Suggestions for how to leverage community strengths to address community needs
- Successful community health initiatives and programs
- Opportunities for collaboration between organizations

Training

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

Data Collection

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

Analysis

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

The recorded interviews were sent to a third party for transcription. The analyst listened to all audio files to ensure accurate transcription. The stakeholder names were removed from the files and assigned a number to reduce the potential for coding bias. The files were imported into Atlas.ti. The analyst read through the notes and developed a preliminary list of codes, or common topics that were mentioned multiple times. These codes represent themes from the dataset and help organize the notes into smaller pieces of information that can be rearranged to tell a story. The analyst developed a definition for each code which explained what information would be included in that code. The analyst coded nine domains relating to the topics of the questions: 1) name, title, and organization of stakeholder, 2) population served by organization, 3) greatest community strength 4) unmet health-related needs, 5) disproportionately affected population, 6) effects of COVID-19, 7) opportunities to leverage community strengths, 8) successful programs and initiatives, and 9) opportunities to work together.

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

The analyst determined the frequency each code was applied to the dataset, highlighting which codes were mentioned most frequently. The analyst used the query tool and the co-occurrence table to better understand which codes were used frequently together. For example, the code "food insecurity" can

occur often with the code “obesity.” 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.

FINDINGS FROM COMMUNITY LISTENING SESSIONS

Findings are summarized for each listening session below. The themes from the listening session are integrated into the themes from the stakeholder interviews in the Community Input section of the report.

Aging & Long Term Care

Participants from Aging & Long Term Care (ALTC) represent the older adult population. They shared the greatest community strength is that people have time for each other, stating “seniors look after each other, neighbors help neighbors.” A healthy community is a place where older adults have access to home health services, social activities, transportation, and local services. Participants noted needing more of the following: in-home services, resource education, navigation assistance, and “spur of the moment” transportation that does not need to be booked ahead of time. They identified the PSMMC services, Columbia Basin Hearing, the caring nature of people, and collaboration between organizations as what is working well for them.

The Sleep Center

Participants from The Sleep Center shared that they have not experienced a healthy community, but they envision it as a place where people listen to and respect each other, there are opportunities for people, basic needs are met, and there is less trauma. They reported the following needs for people experiencing homelessness:

- **Basic needs**: Safety and security, consistent meals, bathrooms, showers, laundry, and identification.
- **Mental health support**: Opportunity to address unresolved trauma.
- **Housing supports**: Ability to get housing with no/low credit or a conviction, and landlords who provide low-barrier, low-income housing.
- **Transportation**: Ability to access medical appointments, resources, and work.
- **Respect**: Not feeling ignored and sidelined.

They also expressed frustration that organizations are not working well together or communicating. They agreed that The Sleep Center and friendships are working well for them.

The Disability Network

Listening session participants identified fellow mothers, family and friends, and the Disability Network as community strengths. They agreed that in a healthy community all people have a sense of belonging, everyone can meaningfully participate in the community, and there is access to local specialized care. They identified the following needs:

- **Access to specialized care**: Speech therapy, occupational therapy, and other specialists located within the community.
- **Informed and respectful providers**: Participants spoke to wanting providers to acknowledge the education and experience parents have regarding their child's disability. They also need to do more consults with specialists and be more familiar with community resources.
- **Advocacy and inclusion**: Participants emphasized the need to approach people living with disabilities from a strengths-based approach. They shared a need for more disability inclusion in Walla Walla and opportunities for their children to meaningfully engage in the community.

"If you look around your surroundings and do not see anyone with a disability, you are not accessible."—Listening Session Participant

Participants named the Walla Walla Disability Network, Parent to Parent, YMCA, the Walla Walla Parks and Recreation, the police department, and Valley Residential Services as community resources working well for them.

FINDINGS FROM STAKEHOLDER INTERVIEWS

Community Strengths

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

Relationships and Collaborative Nature

Many stakeholders agreed the community's relationships and collaborative nature are Walla Walla's greatest strength. They shared that Walla Walla is a small enough community that everyone needs to work together, but it is also big enough that there are a lot of organizations and talents. There are a lot of non-profits focused on addressing community needs.

"I think Walla Walla is really good about getting together around a need. We are too big to be small and too small to be big. That means we have to really work well together because we're going to see all our community partners throughout the community. If we break a relationship, that doesn't serve us or the people that we serve well… Relationships are really important, and I think our community knows that relationships are important." – Community Stakeholder

To leverage this strength, stakeholders suggested creating forums for case conferencing and discussing client needs. They also suggested building upon some of the key collaborations that formed during the pandemic, particularly between health care organizations, to address needs, including mental health and substance use disorders (SUD). Building upon the collaborative nature of the community will avoid silos and create more "powerful and sustainable" outcomes.

"Everybody wants to do good, everybody wants to be the leader, and everybody has the best idea. Sometimes you've got two or three different entities vying for that same

outcome, they want to help the same population, but we're not stepping back to figure out how we can all work together."- Community Stakeholder

Community Engagement

Many stakeholders shared that community engagement has always been a strength but was especially highlighted during COVID-19 as volunteers came together to help with vaccines. They were excited about developing a Volunteer Corp to continue to utilize engaged community volunteers.

"Community involvement. That's probably where we're thriving." – Community Stakeholder

"I think the mass vaccination clinics highlighted one of our greatest strengths. We developed a roster of 4,000 volunteers. We would have 300 to 700 volunteers a day at these clinics. That's a strength that the community will come together and work together for a common goal." – Community Stakeholder

Stakeholders shared people are motivated to work together and are invested in the health and well-being of other people. To leverage this strength, they also suggested utilizing the knowledge and expertise of community members to develop creative solutions to community needs. This means reaching out to and elevating the voices of community members.

"I'm just a real big believer. If you want people to participate in improving their lives, you have to find out what that means for them, not what that means for us. That whole learning to be at the table, to reach out to families is a struggle for some who are used to setting how the table looks and inviting certain people to the table. You got to throw all that away when you're working with our families and humble yourself to be what they need you to be. I think that's just what we try to emulate, and the table looks different for everybody."- Community Stakeholder

High Priority Unmet Health-Related Needs

Stakeholders were asked to identify their top five health-related needs in the community. Three needs were frequently prioritized and were categorized as high priority. Three additional needs were categorized as medium priority. The effects of the COVID-19 pandemic will be woven throughout the following sections on health-related needs.

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

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

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

Most stakeholders were concerned about accessible mental health and substance use services. They spoke to wanting to see non-punitive, responsive, easy-to-navigate services so that people get the right care at the right time, avoiding unnecessary ED use. For many people, knowing how to navigate these systems is a challenge.

> *"It's not like we don't have mental health care in town. It's just inaccessible. It's hard to understand and the rules and the people always seem to change. I think that when like my long-time advocates can't figure out the system, then if they can't figure it out, who can?" – Community Stakeholder*

Part of making behavioral health services accessible is ensuring that people feel comfortable accessing them. Stakeholders spoke to some providers not having the capacity or desire to work with patients with SUDs or complex social issues.

> *"If they have a history of drug abuse or substance use or complex social issues, providers really don't want to bring them in and accept them on their panel because they're complex. These providers don't have the team-based approach or social network within the clinics to help support that. They're one provider with 15-minute visit. I do understand that." – Community Stakeholder*

Additionally, when providers dismiss or trivialize patients with a SUD, these patients are more hesitant to engage with the medical system for fear of not receiving respectful care.

> *"I think that if we could educate providers in town not to just turn away from these patients, not to just tell them, 'I can't work with you,' not to just fear the liability but to actually engage them as people, give them space to tell them the truth about their risk behavior, we have a chance of pulling them back, of getting them into recovery, which is what I want to see happen." – Community Stakeholder*

Stakeholders spoke to a few specific gaps in services related to behavioral health:

- There is no detox facility nearby
- A lack of inpatient facilities for mental health care and substance use disorder treatments where patients can spend 60+ days: Patients often have difficulty finding an inpatient bed and are sent to Seattle or Spokane. They usually need a coordinator or someone to help navigate this process.
- A lack of culturally responsive and linguistically appropriate care: Stakeholders shared there are a lack of Spanish-speaking providers and a lack of bilingual services to provide social and emotional support to families. This often means Spanish-speaking families are more isolated and not able to access the support they need.

Stakeholders named the following populations as experiencing barriers to accessing responsive and timely behavioral health services:

- **Children and adolescents:** There are a lack of pediatric mental health professionals. There is a need for more mental health services in schools. There are long waiting lists for students and there are schools that want school-based health centers implemented.
- **Spanish-speaking patients**, particularly immigrants with low incomes and agricultural workers: There are not enough bilingual and bicultural behavioral health providers to provide culturally responsive and linguistically appropriate care to Spanish-speaking patients.

"If you're thinking about social determinants of health, we are underserving Latinos across the board. We're certainly underserving them when they have a behavioral health need. It's not just a St. Mary issue. It's everybody."—Community Stakeholder

- **People in Dayton**: Stakeholders reported the community of Dayton does not have a psychiatrist.

The COVID-19 pandemic has affected behavioral health challenges in the community in the following ways:

- **Challenges for young people**: The pandemic has especially affected young people's social and emotional well-being. Many took on new roles during the pandemic, such as caring for younger siblings and many lacked socialization with school closures. Stakeholders reported increased screen time for young people during the pandemic and noted many have been disconnected from peers.

"I use this word stigma on purpose because I hear this constantly, especially with our young people, 'There's nothing wrong with me,' and yet these same kids are the ones who have been deeply disenfranchised during COVID, socially disconnected. We see this every day. They'd rather be on a computer screen than outdoors and being active. Really trying to reconnect youth in our view, which is a big focus, back to engaging them in ways beyond a screen." – Community Stakeholder

Now that young people are returning to schools, stakeholders report schools are not able to meet the mental health needs of their students. There is too great a need and too few pediatric mental health providers. Many young people had unmet mental health needs while they were participating in remote learning.

- **Increased substance use**: Stakeholders reported a spike in people using substances and shared they have not seen a downward trend yet. There has also been an increase in overdoses in the last year compared to the year before.
- **Increased stress and anxiety**: Families have experienced more stress during the last year, particularly those balancing working and parenting from home. Stakeholders reported seeing more mental health challenges as a result of the pandemic.

"I think the stress of COVID has shown up… [with] significantly increased anxiety. Some people have seen their mood destabilized because of the stress. We saw a lot more relapses post-pandemic, most of them got right back into recovery, but it was a shock to the system."- Community Stakeholder

- **Behavioral health hiring challenges**: The pandemic has made hiring licensed mental health professionals even more challenging because people were not as willing to move.

"Here in this area, finding licensed health care, mental health care, it's a premium now. It's like the housing market. It's very difficult to find one and when you do, there's high competition for them and the cost has gone up. A lot of our non-profit health care facilities are struggling to find qualified staff to hire, to care for the community." – Community Stakeholder

- **Lack of in-person health care visits and telehealth challenges**: Some people, particularly young people, lacked privacy in their homes for a behavioral health visit. Many people could no longer get the counseling and SUD support they needed in person.
- **A lack of social-emotional connection**: Many people lacked meaningful connection and did not get sufficient connection from technology.

"I will tell you I watched people when we first had to close due to COVID back in March, a year ago, we watched people in the hallway here cry, adults. This was their social connection. This was their network. This was their sanity. Those were words I heard. It was because of that social-emotional connection which was so essential, and you don't get that by Zoom. We tried to engage, we did everything we could, we did as many outdoor things as we could before it got too cold, but there is something deeply human about that social-emotional connection." – Community Stakeholder

- **A lack of insurance coupled with increased mental health needs**: People who lost their job may have lost their insurance at the same time, creating increased challenges accessing care and increased mental health needs. This group of people may not be able to afford care and may still not be fully engaging with mental health systems.

Homelessness/ lack of safe, affordable housing

Stakeholders discussed how connected housing is to health. They shared the importance of ensuring housing is of good quality, including addressing poor-quality housing that may be linked to asthma and allergies. They also shared stable housing is connected to educational opportunities, job training, employment, and economic security.

Stakeholders were particularly concerned about a lack of affordable housing in the community. They described the following barriers to accessing affordable, good-quality housing:

- **Lack of affordable housing stock and increasing housing prices**: Stakeholders emphasized a lack of affordable housing as the biggest issue in the community. They shared that even families with decent jobs have a hard time finding quality housing. This may be partially attributed to some housing being used for vacation rentals. They spoke to skyrocketing housing prices.

"There's such a lack of housing stock, which is it's not just our community, it's just about every community that's facing that. But our community is in a unique situation as a tourist community where housing has been used for VRBOs and other types of uses and so we've lost some of our housing stock that used to be pretty affordable for people."- Community Stakeholder

- **Challenges applying for and utilizing housing vouchers:** Stakeholders spoke to the challenges of applying for a housing voucher and then the added difficulty of utilizing the voucher. Applying for an apartment is an expensive and time consuming process that requires people to react very quickly. Many landlords do not want to accept the housing voucher because they are not close enough to market rent to be attractive.

"They have to go through the [housing] application process and applications are both expensive and time-consuming, and they need to be paid for very quickly. We've had stories of folks who get the application, fill it out, write their check, take it back, and by the time they bring the application back the next day, the apartment is gone. They might have to do that for five or six different apartments, and that adds up in terms of time and money."—Community Stakeholder

Stakeholders discussed **homelessness** in the community as well. While they shared that homelessness is increasing and is a community issue, there are many organizations working to address the need. Stakeholders shared that many people experiencing homelessness come to Walla Walla to access services from other areas, including Umatilla, that lack those services.

Stakeholders identified the following populations who may experience additional challenges accessing stable, affordable housing:

- **Older adults**: Older adults experiencing economic insecurity may not be able to afford their taxes or utility bills.

"Housing is a concern because our housing prices are going up. We're hearing a lot of concerned citizens including the elderly. 'I can't afford my taxes.' They couldn't afford their water bills." – Community Stakeholder

- **Multi-family households**: Overcrowded homes may lead to poorer living conditions, which is connected to mental health. This challenge was especially highlighted during COVID-19.
- **Black, Brown, Indigenous, and People of Color (BBIPOC) and individuals who identify as LGBTQ+**: These populations are disproportionately affected by homelessness due to racism and discrimination.
- **Mixed status families**: Families with a mix of documentation statuses experience disproportionate challenges accessing and affording good-quality housing.

As a result of the **COVID-19 pandemic**, stakeholders shared there have been fewer evictions, but also fewer openings for people in need of housing. Additionally, fewer people moved out of housing,

creating a slowdown in the typical progression of affordable housing becoming available. Federal and state COVID-relief money helped keep people in housing during the pandemic, but there is uncertainty if that will last. Young people have been able to stay in the youth shelter indefinitely, as opposed to only 30 days, which was the case pre-pandemic.

Economic insecurity

Stakeholders shared there is a disparity in incomes in Walla Walla, describing "two Wallas," one that is higher income and one that is lower income.

"A friend of mine … said, 'There are two Wallas.' What he meant by two Wallas is, there is a socioeconomic level in Walla Walla that is extremely wealthy and there is another socioeconomic level of Walla Walla that is not so fortunate economically and do struggle to find living-wage jobs."—Community Stakeholder

They attributed this disparity in incomes to a lack of living wage jobs, stating that some families work multiple jobs to make ends meet. This may be particularly true for people in the **agricultural and service industries**.

"I would say the last one that concerns me is that economic security, the lack of a living wage, because I think that we have some families that are working this job and that job and taking their kids with them to help with some of the jobs. It's just gets a little crazy."—Community Stakeholder

"I'll clarify that, maybe not as much as unemployment, there's plenty of service type jobs in this community because of the tourism, those really are not living wage jobs per say."-Community Stakeholder

Stakeholders identified **Milton-Freewater** as an area with economic insecurity, despite a lot of people working hard to meet the needs of their families.

They shared that economic insecurity is connected to many other challenges and community needs. Economic security is foundational to secure **housing** and is connected to having steady **employment**, which means having insurance and better access to health care. Educational opportunities and job skill development are important for economic security.

Medium Priority Unmet Health-Related Needs

Three additional needs were often prioritized by stakeholders (in order of priority):

4. Affordable childcare and preschools
5. Access to health care services
6. Discrimination, including racism

Affordable childcare and preschools

Stakeholders discussed the importance of affordable childcare for the overall well-being of families. Without childcare, older siblings may need to stay home and care for their younger siblings. Parents may have difficulty accessing **health care** appointments and meeting other needs. Stakeholders shared they often hear employees speak to difficulty finding childcare.

There is a **lack of licensed childcare providers** in Walla Walla County, and no licensed childcare providers in Columbia County. This is important because families can only use their childcare subsidy for a licensed childcare program and with fewer and fewer licensed programs, it is hard for families to use the benefit.

Stakeholders were particularly concerned with how the **COVID-19 pandemic** has affected childcare, noting that some local childcare facilities have closed. In response, some families are driving their children to the Tri-Cities for care and then returning to work in Walla Walla.

"The other thing that we talked about was the childcare crisis. COVID caused several childcare centers to shut down and not all of them have reopened, especially those that are home-based childcare. There's very, very, very little infant care in the community. In Columbia County, which is the other county that we serve, that is rural and remote, as of June, there will be no licensed childcare in that county at all. Already parents are looking at childcare options and actually taking advantage of childcare options in the Tri-Cities, so they're waking up their kids at 4:00 in the morning, driving them to the Tri-Cities, and then coming back to Walla Walla to work."- Community Stakeholder

While some families have been able to **work from home** and care for their children, many essential workers do not have this option.

"Some parents were concerned about the disease and kept kids home to keep them in a small family cohort. Many families had no alternatives, first responders that needed a place for their children, as with other working parents."- Community Stakeholder

Access to health care services

Stakeholders spoke to a variety of community needs for improving access to health care:

- **Increase low-barrier clinics that have complex case management support:** They shared there is a lack of care coordination between providers in clinics and in the ED, citing a need for more transitional services and hand holding. Investing in a community care management network will help address homelessness, substance use, mental health, and more. Team based case management can also help support providers who are unable to address all of a patient's social determinants of health.

"Then we have low-barrier clinics that can take patients like our FQHC, but they also don't have a case management panel. What's happening is a vast amount of people are left

floundering in the community without primary care, without case management… It's one or the other; we either have high-barrier clinics or low-barrier clinics but not enough complex case management support."- Community Stakeholder

- **Increase the number of specialists in the community**: Stakeholders spoke to a lack of specialists in the community, particularly to meet the needs of the aging population. They shared there is only one geriatric specialist in Walla Walla and none in College Place.

"Specialty, we are lacking specialty physicians and care such as rheumatology, those who treat Alzheimer's or geriatric care. We have a very large elderly community over here, and many have to go to Spokane or Seattle for extra care, which is, of course, difficult when you're elderly so it's a burden on the family to have to try to travel with them."- Community Stakeholder

- **Implement medical advocacy for survivors of sexual assault**

Accessing specialists has been more challenging with the closure of General Hospital. For some community members, this has created some confusion on what services are still available in the community and for which services people need to travel to other communities to access. Stakeholders shared people liked having options for where to seek care. There is some concern that PSMMC may be strained to meet the community need, particularly in light of the COVID-19 pandemic.

Stakeholders named a few barriers to accessing care:

- **Language barrier for Spanish-speaking patients**: Spanish-speaking patients experience greater barriers to making appointments and receiving linguistically appropriate services. There are a lack of bilingual resources in Walla Walla. Spanish-speaking patients may have to wait longer for an interpreter or rely on a family member to help.

"We lack bilingual resources in town sometimes, and it might be that a family is more comfortable working with someone who identifies with them culturally and if we can't provide that, that that's a loss for that family."- Community Stakeholder

- **Cost of care**: Particularly for people without insurance or with high deductibles, the cost of health care makes it inaccessible. This is connected with employment opportunities in the community. This may especially be a barrier for individuals working in the agricultural or service industries, particularly migrant farmworkers who may not have insurance. The fear related to cost of care can prevent people from seeking care until their issue has deteriorated and developed into an emergency.
- **Transportation**: This can be a challenge locally and to access specialists in other communities.
- **Hours of care available for primary care**: Many people who work during the day are not able to go to appointments and may end up using the ED for non-emergency needs.

Stakeholders named the following populations as experiencing challenges accessing timely, responsive care:

- **Spanish-speaking patients**
- **Patients with Medicaid**
- **Jail-based clients** who often lack access to medications in jail and discharge planning
- **Older adults**, particularly those who may not be able to afford their medications or care
- **LGBTQ+ youth** who may experience challenges finding responsive and compassionate care

The **COVID-19 pandemic** led some people to **delay seeking needed medical care**, leading to worsening conditions, particularly for those with chronic conditions. A lot of primary care services were not accessible during the start of the pandemic, leading to an increase in ED visits. There is still some confusion as to which services are available now.

"People were more afraid to see the doctor because they didn't want to be exposed to COVID. Moderate health concerns, some of them turned into severe health concerns by the time they finally went back."—Community Stakeholder

Transportation to care is more challenging for people who use public transportation, especially because the number of riders is limited. Missed appointments or late appointments create some strain between patients and providers when offices have strict no-show and late policies.

"It made it harder for people to travel. A transportation thing again because you'd only have like six riders on a bus. People couldn't make their appointments on time, because the bus would just go by the stop when they were waiting for it, and they'd have to wait for the next bus, and then they'd miss an appointment. Then the doctor would say, 'I can't see you anymore,' or, 'I've got to put you on my list as a naughty patient or something because you were 20 minutes late.'" – Community Stakeholder

Telehealth visits have been very positive for some patients who are able to maintain connection through technology. They give providers the chance to see into patients' homes. For others without technology or privacy at home, utilizing telehealth services is less feasible, particularly for those with language barriers. Stakeholders shared they did not think telehealth are widely used in the community.

"In general, telehealth is not widespread throughout Walla Walla at any level that I'm aware of."- Community Stakeholder

Populations that have an especially hard time accessing health care services during the pandemic are **older adults, people with low incomes, and the Spanish-speaking population**. Those clinics that typically serve migrant farmworkers were closed during part of the pandemic and getting to appointments is hard for those without easy transportation or childcare.

Community Stakeholder Identified Assets

Stakeholders were asked to identify one or two community initiatives or programs that they believe are currently meeting community needs. Six programs were identified by at least 3 stakeholders:

- **Blue Mountain Action Council (BMAC)**: BMAC works to address a variety of community needs, including those related to housing, food insecurity, transportation, employment, and more. Stakeholders were particularly impressed by the housing navigators that help move people from shelters into permanent housing. They also spoke to the importance of the Street Outreach Program that engages with youth experiencing homelessness, building relationships and trust.

- **Blue Mountain Health Cooperative**: This cooperative addresses unmet behavioral health needs through a walk-in clinic and resource navigators. Stakeholders were impressed that the cooperative meets immediate needs through a walk-in clinic.

- **Blue Mountain Heart to Heart**: This community-based organization uses client-centered harm reduction and case management approaches to support people living with HIV/AIDS and SUD. Stakeholders appreciated the wraparound care for clients and the open-door policy, always welcoming back clients that are seeking support.

  "As with any recovery program, there are a lot of folks that drop out in the first two weeks. We're always trying to work on that, but the door is always open."- Community Stakeholder

- **The Blue Zones Project**: Stakeholders were excited by the community engagement in the Blue Zones Project and saw an opportunity for it to holistically address the environment and policies that affect people's well-being and health.

- **Law Enforcement Assisted Diversion (LEAD) Program**: This program addresses people's social determinants of health and behavioral health needs to divert them away from the criminal justice system. These support services include wraparound support to address SUD, housing challenges, food insecurity, etc. This keeps people out of the jails and ED, providing more appropriate interventions.

- **Population Health at PSMMC**: Stakeholders noted the importance of the Community Health Workers (CHW) at PSMMC who are a trusted part of the community and help bridge the communication between the community and the health system. They see the CHW program as fundamental because it meets people where they are and allows for a deeper understanding of people's needs.

  "If you have a trusted community health worker, which is essentially an extended member of their family and their culture and their community, bridging that information back to a

health care system and a provider, there is an improvement in health outcomes." – Community Stakeholder

Other initiatives and programs named by stakeholders include the following (in alphabetical order):

- **Anchor Community Initiative**: Addresses youth and young adult homelessness with the goal of reaching functional zero. Stakeholders were impressed by the effort to engage people with lived experience.
- **Churches**: Churches stepped up during the pandemic to help people experiencing homelessness or food insecurity.
- **Community Paramedic Program**: This newer program dispatches a community paramedic for non-emergent calls to free up the ambulance for true emergencies. This helps by ensuring people get the care they need but also diverts people from the ED and mitigates avoidable ED visits.
- **Family Medical Center**: The Clinical Patient Benefits Coordinator helps provide access to health insurance for many people that would not be able to sign up on their own.
- **Helpline Walla Walla**: Assists clients over the phone in meeting their basic needs by connecting them to resources.
- **Lifesaver Fund with PSMMC**: A program that offers free mammogram services and supports patients with next steps if there are any abnormalities.
- **Reach out Walla Walla**: A suicide prevention program.
- **SonBridge Community Center**: Stakeholders identified it as a safe place for people to access dental and medical care if they do not have insurance.
- **SOS Clinic**: SOS Clinic was named as a clinic serving people without insurance and those fearful of accessing health care services.
- **The Sleep Center**: Supports getting people experiencing homelessness into transitional housing and also addresses mental health and SUD needs.
- **Trilogy Recovery Program**: Addresses SUD and mental health challenges.
- **Walla Walla County Community Health Department**: The health department has responded to the COVID-19 pandemic, getting vaccinations to people, and also provides direct services, such as WIC.
- **Walla Walla Public Schools**: The Walla Walla Public Schools work to remove obstacles for and build bridges with families. They provide a lot of proactive resources and are thoughtful about how to get information to families, particularly those that are Spanish speaking. Stakeholders named the Summer Sol Program, the district's partnership with the Community College, Whitman, and Walla Walla University, and the intentional recruitment of bilingual teachers as strengths. They also shared the importance of the school-based health clinic and supporting the social and emotional needs of students.
- **Walla Walla Volunteer Corps**: This group of volunteers started as a result of the COVID-19 pandemic, but stakeholders are hoping to keep them engaged beyond pandemic response.
- **YWCA**: Addresses domestic violence, child abuse and neglect, among other challenges.

Community Stakeholders: Opportunities to Work Together

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

- **Improve communication and foster ongoing relationship-building between organizations**: This was by far the most common response from stakeholders. They noted that high turnover in social service work and a lot of organizations trying to address the same needs means there is tremendous need for continuous communication, which will hopefully break down silos.

  "Just communication. It's to just have that regular check-in. I check in with all the boards and committees that I sit on. That's helpful for information flow, but then besides that, just a monthly check-in here between directors of organizations, having some of those things facilitated would be and could be helpful for those that aren't as assertive. I think that it's a big communication game."—Community Stakeholder

  They shared wanting to see a more collective and unified response to challenges, avoiding duplicating efforts. They also noted the importance of increasing knowledge around what one another do and what services are already provided. This could be improved by knowing who to contact at which organization.

  "Being curious as to what each of us does, that's my idea around the forum, is if we had more of a mixed bag of people meeting and sharing information, there'd be more understanding of what we do because there's a lot of misunderstanding in our community of what each entity provides, which you would think with a community this size, not all that large, there would be more understanding, but there really isn't. Just becoming more curious, what does such and such do and how can we learn more about it?"—Community Stakeholder

  PSMMC was specifically named as needing to better understand what community partners are doing, noting that this CHNA community engagement must be sustained.

  "You can't just get a snapshot once in a blue moon and really know where things are at. There needs to be an ongoing engagement with other providers. I know it's hard, because [PSMMC] is a really big ship compared to a little org like ours, but we're doing a lot of work to take cases off your hands, and your management needs to know more about that."—Community Stakeholder

- **Better coordination between community- based organizations for shared clients**: Stakeholders shared they want to see organizations working together to support their shared clients through warm hand-offs, updated resource lists, and data sharing agreements. They noted that each organization only has a narrow picture of the clients they serve but could have a more complete picture with shared data.

"If we have some organic, not just artificial, not just point-in-time relationship with each other, we could really break some patterns… If we had an MOU together to work together, I think we could do a lot more, but we have to all get out of this like, 'These are my people, these are my data, this is my organization, you do your thing, I'll do my thing.'"—Community Stakeholder

- **Engage a convenor**: Stakeholders see an opportunity for organizations to serve as a convenor for addressing certain needs. They suggested a convenor that does not have their own agenda but wants to support the community. It is also important to have a paid coordinator to help ensure this work is prioritized and continues to move forward. Examples of areas where a convenor could be beneficial is related to domestic violence and the criminal justice system.

"I'm thinking about that need for a good convener, a convening presence. Somebody who's concerned but may not have a dog directly in every fight. That's what I think the greatest role of Providence St. Mary can be."—Community Stakeholder

- **Consider who has decision-making power and who is invited to the table:** Stakeholders emphasized the importance of having people with lived experience and subject matter experts involved in developing interventions. They also noted that people who are local and know the community should be involved in making decisions for the community.

LIMITATIONS

While stakeholders were intentionally recruited from a variety of types of organizations, there may be some selection bias as to who was selected as a stakeholder. Multiple interviewers may also affect the facilitation.

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

STAKEHOLDER INTERVIEW QUESTIONS

1. How would you define the community that your organization serves?
2. While a Community Health Needs Assessment is primarily used to identify gaps in services and challenges in the community, we want to ensure that we highlight and leverage the community strengths that already exist. Please briefly share the greatest strength you see in the community your organization services.
3. Please identify and discuss specific unmet health-related needs in your community for the persons you serve. We are interested in hearing about needs related to not only health conditions, but also the social determinants of health, such as housing, transportation, and access to care, just to name a few.

4. Using the table, please identify the five most important "issues" that need to be addressed to make your community healthy (1 being most important). [see table below]
5. Has the COVID-19 pandemic influenced or changed the unmet health-related needs in your community? If yes, in what ways?
6. What suggestions do you have for how we can leverage community strengths to address these community needs?
7. Please identify one or two community health initiatives or programs you see currently meeting the needs of the community.
8. What suggestions do you have for organizations to work together to provide better services and improve the overall health of your community?
9. Is there anything else you would like to share?

Question 4: Using the table below, please identify the five most important "issues" that need to be addressed to make your community healthy (1 being most important). Please note, these needs are listed in alphabetical order.			
	Access to health care services		Few community-building events (e.g. arts and cultural events)
	Access to dental care		Food insecurity
	Access to safe, reliable, affordable transportation		Gun violence
	Affordable childcare and preschools		HIV/AIDS
	Aging problems		Homelessness/lack of safe, affordable housing
	Behavioral health challenges and access to care (includes both mental health and substance use disorder)		Job skills training
	Bullying in schools		Lack of community involvement and engagement
	Community violence; lack of feeling of safety		Obesity and chronic conditions
	Disability inclusion		Opportunity gap in education (e.g. funding, staffing, support systems, etc. in schools)
	Domestic violence, child abuse/neglect		Racism and discrimination

	Economic insecurity (lack of living wage jobs and unemployment)		Safe and accessible parks/recreation
	Environmental concerns (e.g. climate change, fires/smoke, pollution)		Safe streets for all users (e.g. crosswalks, bike lanes, lighting, speed limits)
			Other:

LISTENING SESSION QUESTIONS

1. What makes a health community? How can you tell when your community is healthy?
2. What's needed? What more could be done to help your community be healthy?
3. What's working? What are the resources that currently help your community be healthy?
4. Is there anything else related to the topics we discussed today that you think I should know that I haven't asked or that you haven't shared?

Appendix 3: Community Resources Available to Address Significant Health Needs

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

Table_Apx 1. Community Resources Available to Address Significant Health Needs

Organization Type	Organization or Program	Description of services offered	Street Address (including city and zip)	Significant Health Need Addressed
Hospital	Dayton General Hospital (Columbia County Health System)	Public Hospital District with Critical Access Hospital, Level V Trauma Center, and Level III Cardiac and Stroke Center designations. Primary service areas include Dayton, Waitsburg, Starbuck, and surrounding areas. Includes Columbia Family Clinic, Waitsburg Clinic, Booker Rest Home. Services include primary care and behavioral health.	1012 S. 3rd Street Dayton, WA 99328	Mental Health and Substance Abuse Improving Immuniza-tion Rates within the County

Clinic	Family Medical Center	Federally Qualified Health Center (FQHC) services include primary care, behavioral health, women's health, dental, eye and vision care, AIDS/HIV care, Northwest Community Action Center.	1120 West Rose Street Walla Walla, WA 99362	Mental Health and Substance Abuse; Improving Immunization Rates within the County
Medical Center	Jonathan M. Wainwright Memorial VA Medical Center	Services include mental health, Substance use disorder (SUD), pharmacy, visual impairment, suicide prevention.	Main Campus 77 Wainwright Drive Walla Walla, WA 99362	Mental Health and Substance Abuse; Improving Immunization Rates within the County
Clinic	The Walla Walla Clinic	Established in 1936, a multispecialty medical clinic offering more than 60 primary care and specialty providers in most areas of medicine.	55 W. Tietan Street Walla Walla, WA 99362	Improving Immuniza-tion Rates within the County

Appendix 4: Advisory Committees

PROVIDENCE ST. MARY MEDICAL CENTER MISSION COMMITTEE

Table_Apx 2. Providence St. Mary Mission Committee Members

Name	Title	Organization	Sector
Becky Betts	Population Health Manager	Providence St. Mary Medical Center	Healthcare
Susan Blackburn	Chief Executive	Providence St. Mary Medical Center	Healthcare

Frances Chvatal	Mission Committee Chair / Board Member	Providence St. Mary Medical Center	Healthcare
Frank Erickson	Finance Director	Providence St. Mary Medical Center	Healthcare
Kathryn Barron	Board Member	Providence St. Mary Medical Center	Healthcare
Susan Leathers	Manager Trauma / Emergency Preparedness, Security Director	Providence St. Mary Medical Center	Healthcare
Paul McLain, MD	Board Member	Providence St. Mary Medical Center	Healthcare
Meghan DeBolt	Community Member, Executive Director	Blue Zones	Healthcare
Kathleen Obenland	Communication Director	Providence St. Mary Medical Center	Healthcare
Kathie Oreb	Chief Mission Officer	Providence St. Mary Medical Center	Healthcare
Tim Meliah	Board Member	Catholic Charities Walla Walla	Non-profit organization
Jake Kaminsky, MD	Community Member, Public Health Office	Walla Walla County Department of Health	Public health and human services

PROVIDENCE ST. MARY MEDICAL CENTER COMMUNITY MISSION BOARD MEMBERS

Table_Apx 3. Providence St. Mary Community Mission Board Members

Name	Title	Organization	Sector
Peter Allen	Board Member	Providence St. Mary Medical Center	Healthcare

Kathryn Barron	Board Member	Providence St. Mary Medical Center	Healthcare
Leslie Bumgardner	Retired Spiritual Support Counselor, Chaplain, Pastor	Providence St. Mary Medical Center	Healthcare
Frances Chvatal	Board Member, Quality Utilization Review Analyst RN	Providence St. Mary Medical Center	Healthcare
Bertha Clayton	Associate Attorney	Hernandez Immigration Law	Legal
Alan Coffey	Chief Executive Officer	Coffey Communications	Healthcare communications
Paul McLain, MD	Board Member, Family Practitioner	Providence Medical Group	Healthcare
Tim Meliah	Board Member	Catholic Charities Walla Walla	Non-profit organization
Laura Norris	Nurse Practitioner	The Health Center	Healthcare
Gustavo Reyna	Strategic Marketing Manager	Intel Corporation	Technology
Mario Uribe Saldana	Board Member	Providence St. Mary Medical Center	Healthcare
Anne-Marie Zell Schwerin	Board Chair Executive Director	YWCA	Non-profit organization