2025

COMMUNITY HEALTH NEEDS ASSESSMENT

Providence Mount Carmel Hospital

Colville, WA

Providence St. Joseph's Hospital

Chewelah, WA

To provide feedback about this CHNA or obtain a free printed copy, please email Christina Kamkosi Chery at christina.kamkosi@providence.org

Providence

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MESSAGE TO THE COMMUNITY

The health of a community can be measured by the willingness of its members to support those in need. Providence Inland Northwest Washington (INWA) continues a vibrant history of serving our communities' needs for more than 160 years. Our Mission calls us to care for everyone, especially those who are poor and vulnerable. Providence reaches beyond the clinical setting to meet the needs of our communities today, while improving conditions for a better tomorrow.

When the Sisters of Providence arrived in eastern Washington, they partnered with members of the community to provide healing and comfort to thousands of individuals, promote human dignity and improve the communities they served. The Sisters relied on others for help to achieve the Providence Mission.

Similar to those early days, Providence cannot improve the health of our community on our own, which is why we partner with community organizations to identify the greatest areas of unmet need in the communities we serve. We identify these unmet needs through the community health need assessment process; we then create a community health improvement plan to address those unmet needs.

I invite you to learn more about this important work by reading this community health needs assessment, approved October 16, 2025, by the INWA Community Mission Board governing body. It is our calling and privilege to work together to build healthy communities.

Susan Stacey
Chief Executive
Providence INWA

EXECUTIVE SUMMARY

Understanding and Responding to Community Needs

The Community Health Needs Assessment (CHNA) is an opportunity for Providence Mount Carmel and Providence St. Joseph's Hospitals 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.

This report is a joint CHNA and reflects the hospitals' collaborative efforts to identify the significant health-related needs in the community and the community strengths. The hospitals participating in this joint CHNA share a service area and community served. The 2025 CHNA was approved by the INWA Community Mission Board on October 16, 2025, and made publicly available by December 28, 2025.

Gathering Community Health Data and Community Input

Through a mixed-methods approach, using quantitative and qualitative data, we collected information from the following sources: American Community Survey, Behavioral Risk Factor Surveillance System, Environmental Justice Index, local public health data regarding health behaviors; morbidity and mortality; and hospital-level data. To actively engage the community, we conducted three listening sessions with people who have chronic conditions, are from diverse communities, have low-incomes, and are medically underserved. We also conducted 11 key informant interviews with representatives from organizations that serve these populations, specifically seeking to gain deeper understanding of community strengths and opportunities. Some key findings include the following:

- Key informants consistently emphasized the deep interconnection between homelessness, substance use/misuse, and mental health, identifying them as mutually reinforcing issues that contribute to ongoing instability for many individuals in the community.
- Key Informants identified several key challenges in accessing healthcare, particularly in rural areas. These challenges include geographic and economic barriers, long travel times to reach providers, limited appointment availability, and significant wait times for services. A common concern was that residents often do not know what services are available to them, even with efforts like health fairs.
- Most Key informants identified homelessness and housing stability as a need in Stevens County. They discussed significant challenges related to housing affordability and homelessness, which intersect with health and social services.
- Several Key informants highlighted economic security as a need in the community, with impacts felt across age groups and sectors. Key informants described how the rising cost of living, limited local opportunity, and shortages in critical service areas are creating long-term challenges for community stability and growth.

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

Identifying Top Health Priorities

Through a collaborative process engaging the Tri County Advisory Council, the CHNA advisory committee identified the following priority areas:

ACCESS TO HEALTH CARE SERVICES

Challenges in accessing healthcare including dental care and chronic conditions, particularly in rural areas. These challenges include geographic and economic barriers, long travel times to reach providers, limited appointment availability, and significant wait times for services. A common concern was that residents often do not know what services are available to them, even with efforts like health fairs.

BEHAVIORAL HEALTH CHALLENGES AND ACCESS (MENTAL HEALTH AND SUBSTANCE USE/MISUSE)

Community input highlighted the deep interconnection between homelessness, substance use/misuse, and mental health, identifying them as mutually reinforcing issues that contribute to ongoing instability for many individuals in the community. Fragmented care was seen as a barrier to effective recovery, particularly when people are forced to navigate separate systems for help.

SOCIAL DETERMINANTS OF HEALTH

Needs in this category included homelessness and housing stability, food security and transportation.

Homelessness and housing instability includes challenges related to housing affordability and homelessness, which intersect with health and social services.

Food security is a result of interconnected economic, structural, and social challenges.

Transportation is a significant barrier affecting access to essential services and resources within the community.

Providence Mount Carmel and Providence St. Joseph's Hospitals will develop a three-year Community Health Improvement Plan (CHIP) to respond to these prioritized needs in collaboration with community partners considering resources and community strengths and capacity. The 2026-2028 CHIP will be approved and made publicly available no later than May 15, 2026.

Results from the 2022 CHNA and 2023-2025 CHIP

Providence Mount Carmel and Providence St. Joseph's Hospitals responded to community needs by making investments of direct funding, time, and resources to internal and external programs dedicated to addressing the previously prioritized needs using evidence-based and leading practices. In addition, we invited written comments on the 2022 CHNA and 2023-2025 CHIP, made widely available to the public through posting on our website and distribution to community partners. No written comments were received on the most recent CHNA and CHIP. The 2022 CHNA and 2023-2025 CHIP priorities were the following: mental health, access, substance use/misuse and housing instability.

A few of the key outcomes from the previous CHIP are listed below:

- The Libraries of Stevens County received a grant from Providence and launched the Library Prescriptions and Devices program to enhance mental health resources, including telehealth services for residents without internet access. The telemedicine kits included a hotspot and a laptop, expanding access for providers and school counselors to identify and issue 'technology prescriptions. In 2024, the program served 1,000 patrons.
- From 2023 to 2024, the Farm to Food Pantry program delivered over 80,000 pounds of locally grown produce, benefiting 8,434 people in 2023 and 8,880 people in 2024. Equipped about 600 people in Grow Your Own Row program. 8,500 people served in 2025 through a grant from Providence.
- As of 2023, there have been a total of 485 inductions or reinductions in the Medication Assisted Treatment program (171 in 2023, 176 in 2024, and 138 in 2025). Since the inception of the network, there have been 739 unique episodes (distinct clients). According to the latest report from DSHS, there are currently 422 active clients in the program.

INTRODUCTION

Who We Are

Our Mission	As expressions of God's healing love, witnessed through the ministry of Jesus, we are steadfast in serving all, especially those who are poor and vulnerable.
Our Vision	Health for a Better World.
Our Values	Compassion — Dignity — Justice — Excellence — Integrity

Providence Mount Carmel, a 25-bed Critical Access Hospital, was founded in 1919 to meet the health care needs of the small community of Colville. More than a century later, Providence Mount Carmel serves a three-county area, offering services including 24-hour emergency care, surgery, and labor and delivery.

Providence St. Joseph's Hospital was founded by the Dominican Sisters in 1929 to meet the health care needs of the small community of Chewelah and surrounding communities of Stevens County. Services include 24-hour emergency care, acute care/skilled care services, radiology and imaging, rehabilitation, and outpatient day surgery.

Providence Inland Northwest Washington (INWA) in Stevens County includes Providence Northeastern Washington Medical Group, Providence Mount Carmel and Providence St. Joseph's Hospitals. INWA serves the tri-county area of Stevens, Ferry, and Pend Oreille Counties. Clinics include locations in Colville, Chewelah, and Kettle Falls.

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

Joint CHNA

This is a "joint CHNA report," within the meaning of Treas. Reg. § 1.501(r)-3(b)(6)(v), by and for Providence including Providence Mount Carmel and Providence St. Joseph's Hospitals. This report reflects the hospitals' collaborative efforts to identify the significant health-related needs in the community as well the community strengths. The hospitals participating in this joint CHNA share a service area and community served. This CHNA engaged with and sought input from that community.

SECTION I: CHNA FRAMEWORK AND PROCESS

Equity Practices in the CHNA

At Providence, we are committed to addressing the underlying and root causes of health disparities and inequities in the communities we serve. We work to address not only the clinical factors that determine a person's length and quality of life, but also the social and economic dimensions, physical environment, and other factors that play a role in determining health outcomes. Addressing these factors includes leveraging community strengths and utilizing evidence-based, leading practices.

The CHNA is an important process for better understanding health disparities and social inequities, including how racism and discrimination have detrimental effects on community health and wellbeing. Through literature and our community partners, we recognize that long-standing systemic inequities exist and that they can lead to health disparities. To ensure we are taking a holistic approach to understanding the health of the communities we serve, we define health broadly including social, cultural, and environmental factors that affect wellbeing, and engage community members from diverse backgrounds in the CHNA process. We routinely evaluate health disparities in the communities we serve and use qualitative and quantitative data to inform how we enhance access to high-quality, evidence-based care.

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

Share equity practices in the CHNA

Highlight community strengths

Use people first and non-stigmatizing language

Community Engagement

Use multiple methods to engage with community members

Implement equitable practices for community participation

Share findings back with communities

Quantitative Data

Report data at the local level to avoid masking

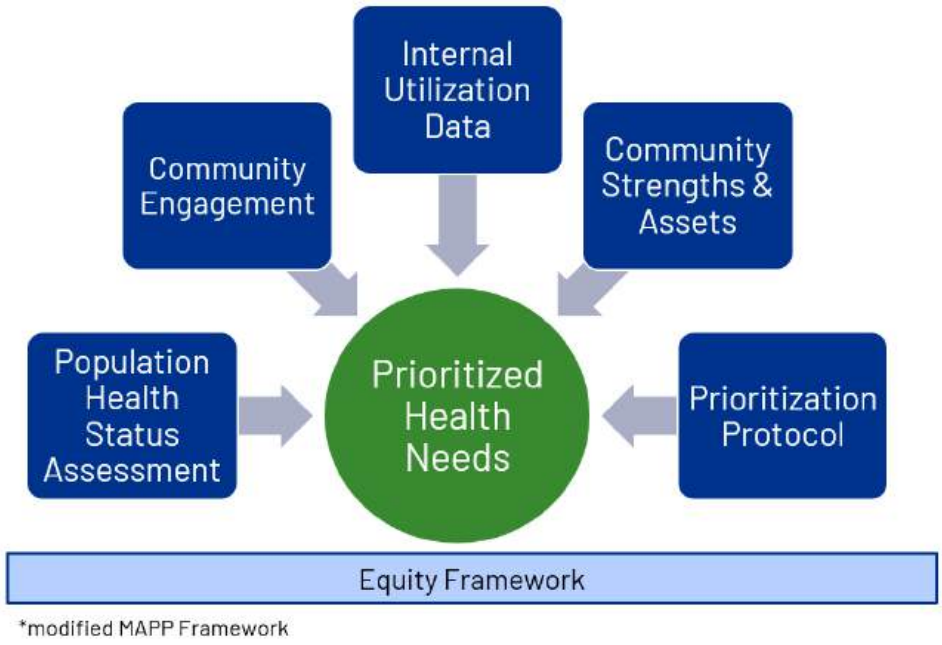
Disaggregate data when responsible

Acknowledge inherent bias in data and screening tools

During the 2025 CHNA process, we engaged members of the Spokane Trible in key informant interviews. We also consulted with the Tri County Advisory committee during our data prioritization process.

CHNA Framework

The equity framework is foundational to our overall CHNA framework, a modified version of the Mobilizing for Action through Planning and Partnerships 2.0 (MAPP 2.0) developed by the National Association of County and City Health Officials (NACCHO). The modified MAPP framework takes a mixed methods approach to prioritize health needs, considering population health data, community input, internal utilization data, community strengths and assets, and a prioritization protocol.



Data Sources

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

We reviewed data from the following sources:

CHNA Data Sources

- Key informant interviews
- Community listening sessions
- Internal hospital utilization data
- American Community Survey from the U.S. Census Bureau
- Behavioral Risk Factor Surveillance System (BRFSS)

- CDC Places
- Environmental Justice Index
- County health rankings
- Tri County Health Departments data

Data Limitations and Information Gaps

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

- Not all desired data were readily available, so sometimes we had to rely on tangential or proxy measures or not have any data at all.
- While most indicators are relatively consistent from year to year, other indicators are changing quickly and the most recent data available are not a good reflection of the current state.
- Reporting data at the county level can mask inequities within communities. This can also be true when reporting data by race, which can mask what is happening within racial and ethnic subgroups. Therefore, when appropriate and available, we disaggregated the data by geography and race.
- Data that are gathered through interviews and surveys may be biased depending on who is willing to respond to the questions and whether they are representative of the population as a whole.
- The accuracy of data gathered through interviews and surveys depends on how consistently the questions are interpreted across all respondents.

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

Written comments were solicited on the 2022 CHNA and 2023-2025 CHIP reports, which were made widely available to the public via posting on the internet in December 2022 (CHNA) and May 2023 (CHIP), as well as through various channels with our community-based organization partners.

No comments were received.

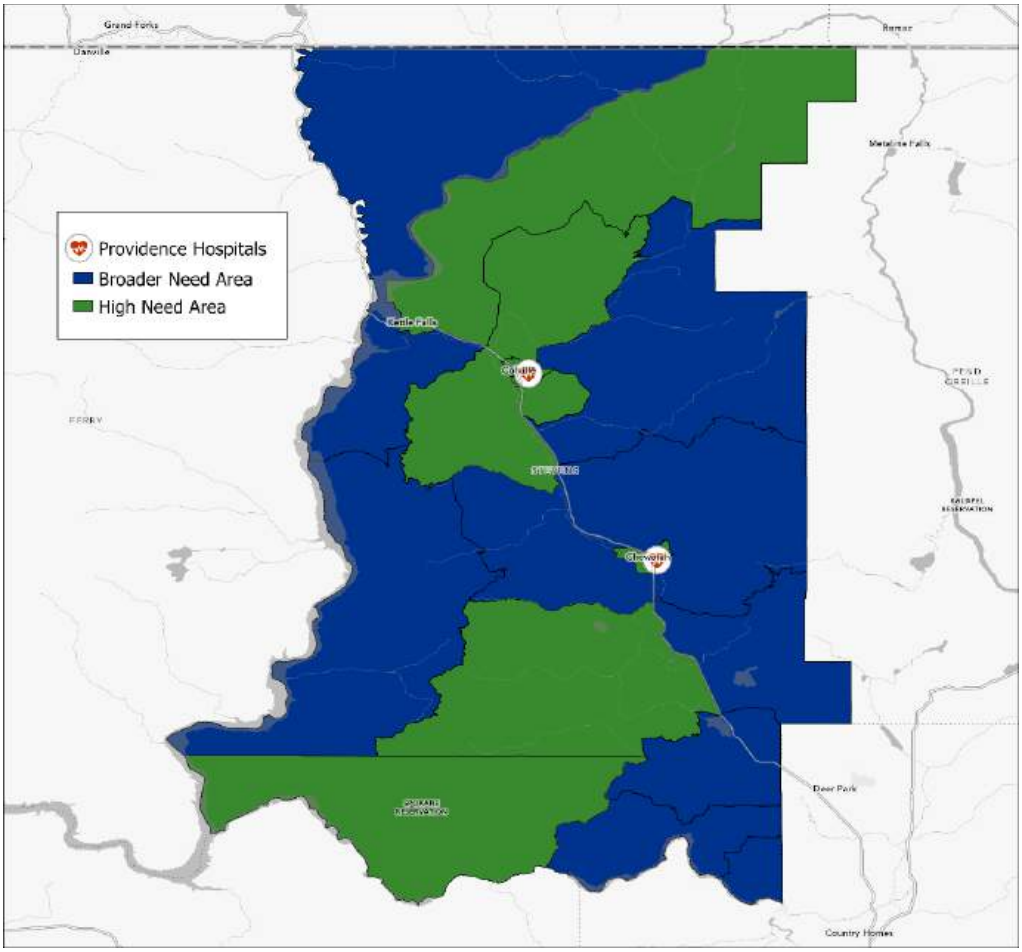
SECTION II: DESCRIPTION OF COMMUNITY

CHNA Service Area

HOSPITAL SERVICE AREA AND COMMUNITY SERVED

Providence Mount Carmel and Providence St. Joseph's Hospitals are situated in Stevens County, in the northeast corner of Washington state. Counties on to the east and west of Stevens County (Pend Oreille and Ferry counties, respectively) make up the Tri County area with Stevens County, sharing similar demographics and rural characteristics. Based on the availability of data, geographic access to these facilities, and other hospitals in neighboring counties, Stevens County serves as the boundary for the service area.

Figure 1. Map of Stevens County highlighted in dark blue and green



Providence's Stevens County Data Hub 2025

Environmental Justice Index

Providence uses CDC's Environmental Justice Index (EJI) to identify communities of higher need within our service areas. Census tracts that score higher than the median EJI score are classified as "high need" and are depicted in green. All other census tracts are labeled "broader need" and are shown in blue. For Stevens County, the median 2024 EJI score for census tracts overall is 0.655.

More information can be found here: Environmental Justice Index | Place and Health - Geospatial Research, Analysis, and Services Program (GRASP) | ATSDR

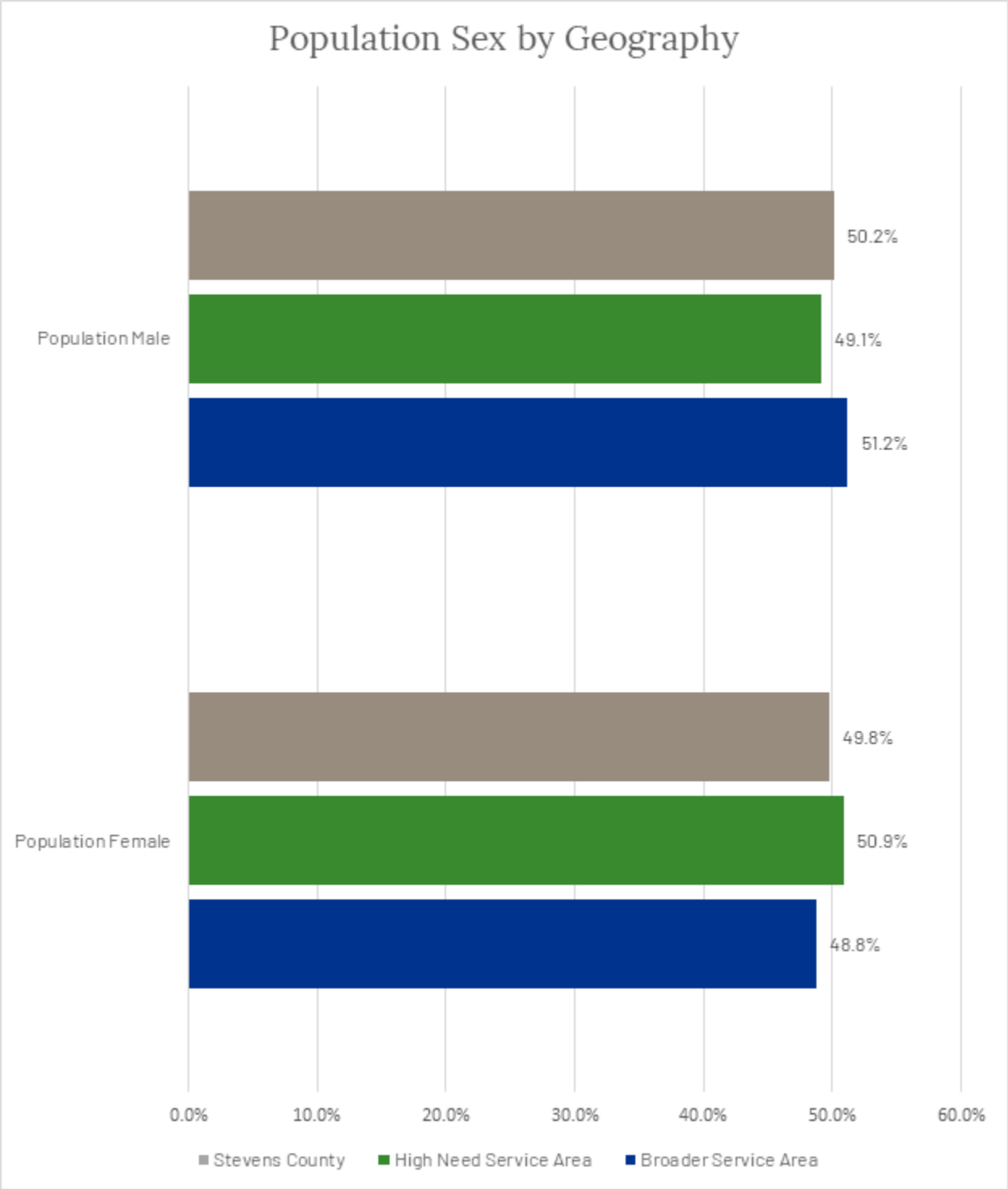
We have developed a data hub that maps each CHNA indicator at the census tract level: 2025 Stevens County CHNA Datahub

Community Demographics

POPULATION

Population demographics used in this CHNA are from the **2023 American Community Survey 5 – Year Estimates**. Graphs below provide basic demographic and socioeconomic information about the service area and how the high need area compares to the broader service area.

Figure 2: Graph of Population sex by Geography

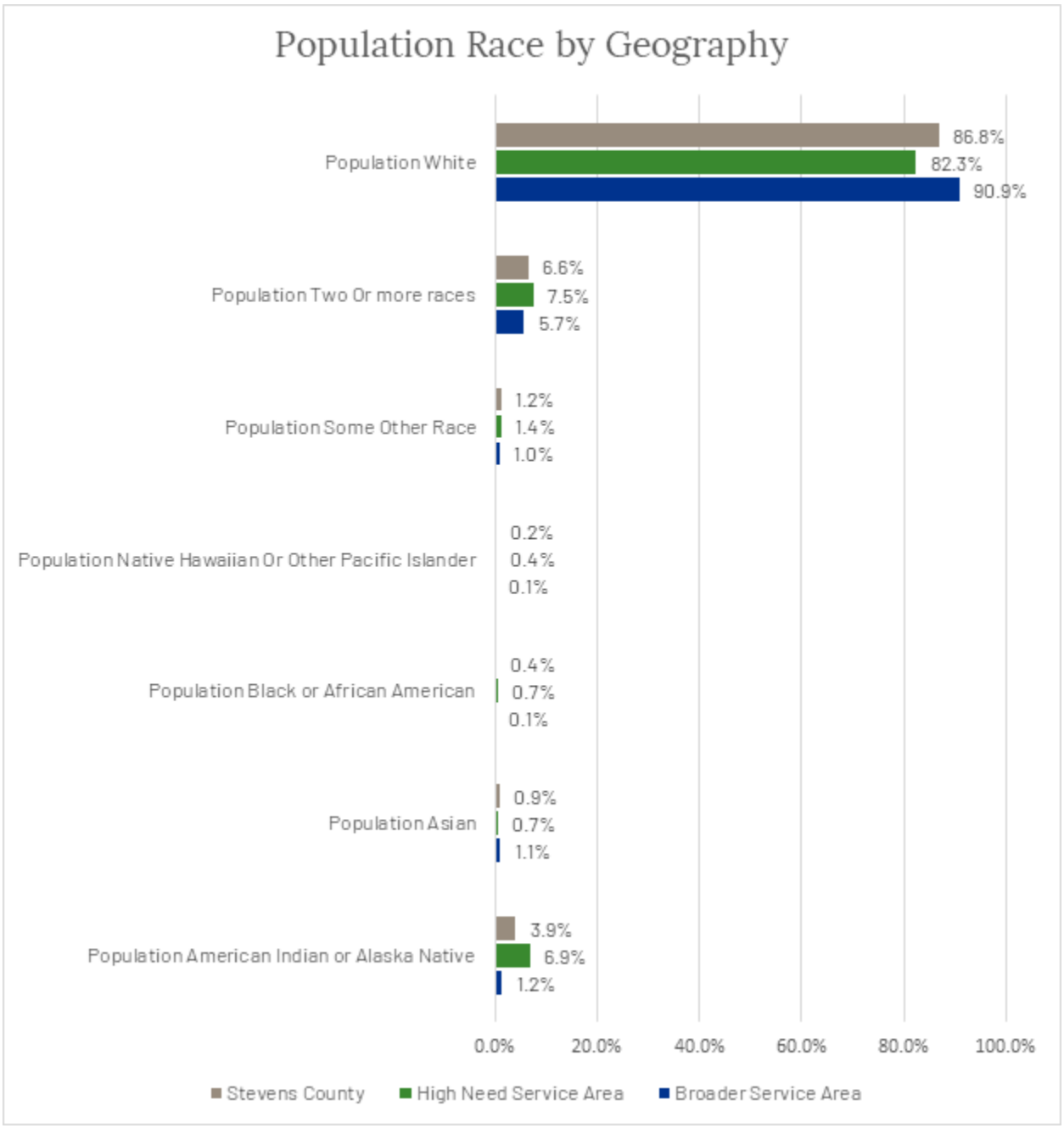


2023 American Community Survey 5-Year Estimates

The population total of Stevens County is estimated to be 47,470, an estimated increase of 7.73% since the last CHNA was completed in 2022. Percentage population by sex is split close to evenly at 50.2% male and 49.8% female. A little over 40% of the population are over 55. Roughly 1 in 5 people in Stevens County are under the age of 18 years.

RACE AND ETHINICITY

Figure 3: Graph of Population Race by Geography

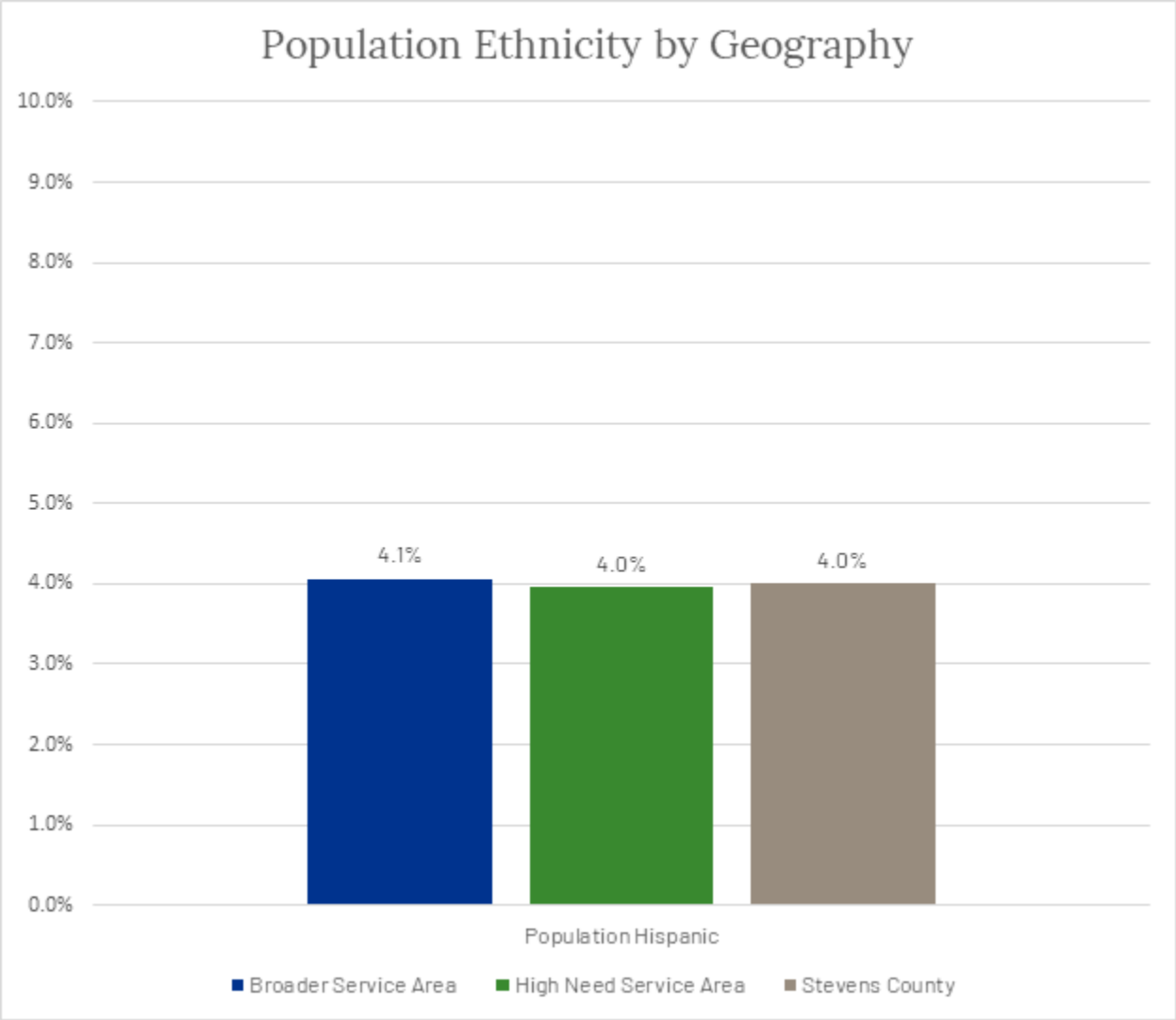


2023 American Community Survey 5-Year Estimates

86.8% of the population in Stevens County is white and disproportionately represented in the broader service area (90.9%). 6.6% of the population identify as two or more races and are disproportionately represented in the high need service area (7.5%). People identifying as American Indian or Alaska Native

are also disproportionately represented in the high need service area (6.9%), compared to the county overall (3.9%).

Figure 4: Graph of Population Ethnicity by Geography



2023 American Community Survey 5-Year Estimates

The proportion of the population identifying as Hispanic represent 4% of the population across total, broader, and high need service areas.

See **Appendix 1** – Community Demographics for additional detail.

MEDIAN INCOME

According to the 2023 American Community Survey 5-year estimates, the median household income in Stevens County was $67,405, over $27,500 lower than the median income for Washington State ($94,952). Within the high need service area, median household income was $56,391.

SEVERE HOUSING COST BURDEN

Despite the overall much lower median household income for households in Stevens County, there are fewer households compared to Washington state that experience a severe housing cost burden of spending 50% or more of income on housing costs, at 10.2% of Stevens County households compared to 13.8% of Washington state households.

County Health Rankings and Roadmaps explains the link between health and housing in the following way: "There is a strong and growing evidence base linking stable and affordable housing to health. As housing costs have outpaced local incomes, households not only struggle to acquire and maintain adequate shelter but also face difficult trade-offs in meeting other basic needs."

See Providence's Stevens County Data Hub 2025 for additional detail

HEALTH PROFESSIONAL SHORTAGE AREA

Stevens County is a HRSA-designated medically Underserved Area, and it has the lowest rating by HRSA for access to Health Professionals.

The Federal Health Resources and Services Administration designates a Health Professional Shortage Area (HPSA) as an area with a shortage of primary medical care, dental care, or mental health providers. They are categorized into three types: geographic, population, and facility.

Stevens County has several geographic areas, population segments, and facilities that are designated as shortage areas. Stevens County is designated as an HPSA for low-income populations for both primary and dental care. The entirety of Stevens County is designated as a mental health geographic HPSA. This information can be used to understand access issues, guide state and local health care planning, determine placement of providers, and influence allocation of limited health care resources.

HPSA facilities for primary, dental, and mental health include New Health Programs Association, David C. Wyncoop Memorial Clinic, Spokane Tribe of Indians Behavioral Health, Providence Family Medicine Chewelah, and Providence Northeast Washington Medical Group.

See Appendix 1 for additional quantitative data.

SECTION III: HEALTH-RELATED INDICATORS

Please refer to Stevens County Data Hub 2025 to review each of the following health indicators mapped at the census tract level.

2025 Stevens County CHNA Datahub

The hub provides data on each indicator in Stevens County, high need and broader need service areas, and Washington.

27 indicators can be viewed by census tract at the above link, including:

- Service area (High Need Service Area vs. Broader Service Area)
- Poverty, income, and housing data
- Demographic data, including education, language, employment, and veteran status
- Health data, including chronic disease, mental health, and substance use disorder

The following table reflects select health indicators of interest for Stevens County. Rows in green indicate where Stevens County performs better than the state, while rows in red indicate where Stevens County performs worse than the state.

Table 1. Select Health Indicators for Stevens County Compared to the State of Washington

Selected Indicator	Stevens County	High Need Service Area	Broader Need Service Area	Washington	Need Area
Population Uninsured*	6.7%	7.4%	6.7%	6.4%	Access
Dental Visit†	61.8%	57.3%	64.3%	67.8%	Access
Households without Internet Access*	12.0%	14.9%	10.8%	4.8%	Access
Diabetes†	12.6%	13.5%	12.4%	9.7%	Chronic Disease
Coronary Heart Disease†	8.8%	9.0%	8.6%	5.7%	Chronic Disease
Physical Inactivity†	20.5%	22.3%	19.2%	17.4%	Chronic Disease, Obesity
Households Receiving SNAP*	15.1%	20.1%	11.5%	11.4%	Food Security
Severe Housing Cost Burden*	10.2%	11.5%	8.9%	13.8%	Housing Stability
Frequent Mental Health Distress†	15.9%	17.9%	15.4%	16.5%	Mental Health
Depression†	25.4%	26.9%	25.1%	25.0%	Mental Health
Binge Drinking†	16.5%	15.9%	16.2%	15.7%	Substance Use/Misuse

**2023 American Community Survey, 5-Year Estimates*

†PLACES. Center for Disease Control and Prevention. Indicator uses crude prevalence for year 2022 estimates

High need areas in Stevens County face greater barriers to healthcare and digital connectivity. The uninsured rate is highest in these areas (7.4%), compared to the broader service area (6.7%) and the state (6.4%). Fewer residents in high need areas had a dental visit in the past year (57.3%) than those in the broader area (64.3%) or statewide (67.8%), indicating gaps in oral health access. Additionally, 14.9%

of households in high need areas lack internet access, which is significantly higher than the broader service area (10.8%) and the state (4.8%). This digital divide can limit access to telehealth, education, and essential services.

Chronic disease burden is notably higher in high need areas. Diabetes prevalence is 13.5% in high need areas, compared to 12.4% in the broader service area and 9.7% statewide. Coronary heart disease rates follow a similar pattern (9.0% in high need areas vs. 8.6% broader, 5.7% state). Physical inactivity is also more common in high need areas (22.3%), which can contribute to higher rates of chronic disease and obesity, compared to 19.2% in the broader area and 17.4% statewide.

Food insecurity is a pronounced challenge in high need areas. Households receiving SNAP benefits—a marker of economic vulnerability—make up 20.1% of the high need area, nearly double the broader service area (11.5%) and the state (11.4%). This suggests that residents in high need areas are more likely to struggle with food access and affordability.

Housing affordability remains a concern, with 11.5% of households in high need areas experiencing severe housing cost burden, compared to 8.9% in the broader service area. While this is slightly lower than the state average (13.8%), it still highlights the financial pressures faced by vulnerable populations in high need communities.

Mental health challenges are more prevalent in high need areas. Frequent mental health distress affects 17.9% of residents in high need areas, compared to 15.4% in the broader service area and 16.5% statewide. Depression rates are also higher (26.9% in high need areas vs. 25.1% broader, 25.0% state), underscoring the need for expanded mental health resources and support.

Rates of binge drinking are similar across all areas, with high need areas at 15.9%, the broader service area at 16.2%, and the state at 15.7%. This suggests that substance use challenges are widespread and not concentrated in any one area but still warrant attention as part of community health improvement efforts.

Leading Causes of Death

The mortality data available on CDC WONDER are national mortality and population data produced by National Center for Health Statistics (NCHS) at the Centers for Disease Control and Prevention (CDC). Mortality information is collected by state registries and provided to the National Vital Statistics System. Data are based on death certificates for U.S. residents. Each death certificate contains a single underlying cause of death, and demographic data. The number of deaths and death rates can be obtained by place of residence (United States national, state, and county when available), age group, race, Hispanic ethnicity, sex, and cause of death (4-digit ICD-10 codes, 113 selected causes of death, 130 selected causes of death for infants, and categories for injury intent and mechanism, or drug / alcohol induced causes of death, when available). For more information, refer to National Vital Statistics System - Mortality Data.

Stevens County exhibits higher crude death rates for all the major causes of death listed compared to Washington state. The top two leading causes of death in both Stevens County and Washington State are cancer and heart disease.

Table 2. Leading Causes of Death Ranked by Stevens county Compared to Washington State (Crude Rates, per 100,000)

	Cause of Death	Stevens County (Crude Rate)	Washington (Crude Rate)
1st	Malignant neoplasms	260.4	171.6
2nd	Diseases of heart	256.5	60.4
3rd	Accidents (unintentional injuries)	77.7	60.8
4th	Chronic lower respiratory diseases	65.3	37
5th	COVID-19	61.4	27.3
6th	Alzheimer disease	51.8	47

7th	Cerebrovascular diseases	50.7	40.5
8th	Diabetes mellitus	30.2	26.2
9th	Intentional self-harm (suicide)	26.3	16.2
10th	Chronic liver disease and cirrhosis	20.9	15.8

Centers for Disease Control and Prevention, National Center for Health Statistics. National Vital Statistics System, Mortality 2018-2023 on CDC WONDER Online Database, released in 2024. Data are from the Multiple Cause of Death Files, 2018-2023, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program.

Suicide Deaths

Between 2018 and 2023, the suicide mortality rate in Stevens County (26.3 per 100,000) was notably higher than Washington State (16.2 per 100,000).

Table 3. Suicide Mortality Rates in Stevens County Compared to Washington State (Crude Rates, per 100,000 population)

Region	Deaths	Population	Crude Rate
Washington	7,486	46,181,454	16.2
Stevens County	74	281,835	26.3

Centers for Disease Control and Prevention, National Center for Health Statistics. National Vital Statistics System, Mortality 2018-2023 on CDC WONDER Online Database, released in 2024. Data are from the Multiple Cause of Death Files, 2018-2023, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program.

See Appendix 1 for additional Population Health Data

Hospital Utilization Data

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

The BIPOC (Black, Indigenous, People of Color) population flag includes all patients with a race/ethnicity category that is not "white", "other", "unknown" or "Chose not to Disclose".

In 2024, our data showed the following key insights:

Avoidable Emergency Department Cases

- Overall, 29.7% of ED cases in the combined facilities were considered avoidable

- Common diagnosis groupings among avoidable ED cases were skin infections, urinary tract infections, bronchitis and other upper respiratory diseases, tonsillitis, pneumonia, and acute otitis media and sinusitis.

Behavioral Health Related Emergency Department Cases

- Averaged across both hospitals, 3.0% of all ED visits were primarily for behavioral health needs in 2024.
- At Providence Mount Carmel, the age group 40 to 64 years made up 42.3% of all the behavioral health cases that took place in the ED, followed closely by ages 18 to 39 years (36.6%).
- At Providence St Joseph's Hospital Chewelah, the age group 18 to 39 years had the highest percentage of behavioral health related ED visits (6.9%) compared to the patient population overall, and made up almost half of all of the behavioral health cases that took place in the ED.
- Cases covered by Medicaid had higher percentages of behavioral health related ED visits (4.3% at Mount Carmel Hospital and 4.7% at St. Joseph's Hospital) and made up over half of all the behavioral health cases that took place in both EDs.

SECTION IV: COMMUNITY INPUT

Summary of Community Input

To better understand the unique perspectives, opinions, experiences, and knowledge of community members, Providence conducted 11 key informant interviews with 16 representatives from community-based organizations and agencies serving Stevens County (including five representatives from the Spokane Tribal Network), as well as three listening sessions with community members. All community input was collected from April to June in 2025.

During these interviews and listening sessions, community members and nonprofit and government key informants discussed the issues and opportunities of the people, neighborhoods, and cities of the service area. Below is a high-level summary of the findings of these sessions. Full details on the methodology and participants are available in Appendix 2.

See Appendix 2 for methodology and participant details

Community-Defined Health and Strengths

Key informants were asked to highlight community strengths and describe their vision for a healthy community:

Vision for a Healthy Community
•Belonging, Inclusion and Social Connection •Accessible Health and Social Services •Safe and Healthy Environment •Safe and Accessible Public Infrastructure •Economic Stability and Employment Opportunities •Equity and Support for All Community Members •Shared Values and Collective Well Being •Housing for Everyone •Basic Needs are Met

Community Strengths
•Community Resilience and Support Systems •Community Connection and Support •Leadership and Collaboration •Innovation •Economic Diversity and Resilience •Shared Values and Collective Well Being

Community Needs

HIGH PRIORITY UNMET HEALTH-RELATED NEEDS

Behavioral health challenges and access (mental health and substance use/misuse)	Key informants and community members discussed how mental health and substance use/misuse are deeply interconnected issues that reinforce one another, emphasizing the need for integrated, holistic approaches to addressing behavioral health, as fragmented care often creates barriers to recovery. They also discussed how homelessness contributes to and is affected by behavioral health needs. Stigma and limited resources further hinder access to services and increase provider burnout. Informants voiced strong support for community-led, culturally responsive solutions that reduce stigma, expand access, and promote long term stability. They emphasized the importance of implementing community-wide education and awareness campaigns to help reduce the stigma often experienced by people facing mental health challenges. Populations most impacted by these challenges include people

	experiencing homelessness, older adults, people with disabilities, those with co-occurring disorders, pregnant or parenting individuals, people with criminal legal involvement, and people with low income or who are uninsured.
Access to health care services, including dental care	Key Informants identified significant challenges in accessing healthcare in rural areas, including geographic and economic barriers, limited appointment availability, long travel times, and extended wait periods for services. Key informants discussed not having access locally to prenatal care, acute care, urgent care, and dental care. Residents often lack awareness of available healthcare services, despite efforts to improve communication through health fairs. Key areas needing improvement include expanded healthcare resources, enhanced urgent and preventive care options, improved staffing, locally available specialized healthcare services, and solutions to reduce healthcare disparities. Community members expressed a strong need for improved access to quality, affordable healthcare. They called for greater investment in facilities, such as clinics, to ensure healthcare services are available and accessible to everyone. Community members also highlighted the need for in-person visits and check-ins with older adults to ensure they access necessary resources and support. Populations particularly affected by barriers to accessing health and dental services include older adults, people with low income, people experiencing homelessness, rural residents, Indigenous peoples of the U.S., and people without insurance. These groups face unique challenges such as economic constraints, transportation barriers, shortage of specialty services, geographic isolation, and environmental concerns. Limited dental care access due to few providers accepting state insurance further complicates healthcare accessibility, driving residents to travel to larger cities like Spokane for services.
Homelessness and housing stability	Key informants in Stevens County identified homelessness and housing stability as critical needs, with significant challenges stemming from housing affordability and homelessness intersecting with health and social services. Housing insecurity is closely tied to untreated mental illness, substance use disorders, economic insecurity, and job loss, impacting children, families, and caregivers through cycles that hinder stable housing and recovery support. Community members discussed how rising rents make it increasingly difficult for families and individuals to secure safe housing. Participants also highlighted the need for shelters that provide essential amenities such as laundry and shower facilities. There is a notable shortage of affordable housing, exacerbated by long waitlists for housing vouchers and a lack of entry-level housing developments, compounded by rising costs due to economic changes post-COVID-19 and environmental events like wildfires increasing displacement. Housing instability is further compounded by difficulties accessing healthcare, with stigma towards people experiencing homelessness posing additional barriers. Populations most affected include single adults, older adults on fixed incomes, people with disabilities or chronic illnesses, survivors of domestic violence, and women with children. Key informants expressed the need to expand housing access, reunite families, and support recovery services, with hope that enhanced coordination, investment, and community engagement can lead to sustainable solutions such as permanent supportive housing and mental health services.

Economic Security	Several key informants identified economic security as a pressing need, affecting all age groups and sectors. Rising living costs, limited local opportunities, and shortages in critical service areas pose long-term challenges to community stability and growth. Workforce gaps, particularly in healthcare, are driven by difficulties in developing and retaining local talent, as many individuals leave for education and career opportunities elsewhere, often not returning until later in life, thus undermining early career workforce availability. Strategies are needed to support local education pathways, incentivize residents to stay, and establish a sustainable pipeline of workers, especially in healthcare. The high cost of living and housing has become a major barrier to financial stability, forcing younger adults to move back in with parents and delay life milestones. Essential services like grocery stores, transportation, and affordable healthcare are becoming increasingly inaccessible, particularly in rural areas, due to economic decline and population shifts. Community members expressed concern about the lack of affordable childcare and after-school programs as a barrier for working families striving to balance job responsibilities and family care. Populations most affected include older adults, who face rising costs and reduced access to services, and young adults, who struggle with economic pressures, limited career options, and a feeling of being "stuck," prompting many to seek opportunities outside the community.

MEDIUM PRIORITY UNMET HEALTH-RELATED NEEDS

Food Security	Key informants have highlighted food insecurity as a significant issue, resulting from interconnected economic, structural, and social challenges. Many residents face an unstable food supply, where healthy options are limited, inconsistent in quality, and increasingly expensive. The expansion of large chain grocery stores has not compensated for the decline of smaller, neighborhood stores, making it challenging for households to maintain balanced diets. Limited transportation options further restrict access to grocery stores and food resources, particularly for those living far from retail centers or without personal vehicles, exacerbating difficulties in obtaining fresh, nutritious food. Community members emphasized the need to expand school food programs to effectively address food insecurity experienced by children in the community. Older adults, in particular, encounter additional obstacles due to fixed incomes, reduced mobility, and the inaccessibility of grocery stores, making it especially challenging to access affordable, healthy food.
Obesity and chronic conditions	Key informants have identified obesity and chronic conditions in Stevens County as interconnected issues exacerbated by healthcare access barriers, socioeconomic constraints, and environmental challenges. Residents face high rates of chronic illnesses such as diabetes, COPD, Chronic Kidney Disease, and Congestive Heart Failure, often worsened by delayed medical care, geographic isolation, and transportation limitations. Limited access to nutritious food and physical activity opportunities further contributes to obesity and related diseases. Rural geography hinders access to primary and specialized care, with long travel distances, transportation barriers, and seasonal challenges like wildfires and harsh winters impeding timely and consistent care. Economic insecurity, high food costs, and limited employment opportunities hinder residents' ability to prioritize health, especially in

	isolated areas where fresh produce and preventive care are harder to obtain. Environmental challenges further impact healthcare access and exacerbate conditions like asthma. Despite these obstacles, residents benefit from strong social networks, resilience, and cultural traditions that support health, with initiatives like community gardens and Farm to Food Pantry enhancing access to fresh produce and encouraging community engagement.

Community members also identified **Transportation** and **Communication and Advocacy** as high priority unmet health related needs, and **Childcare Providers and School Programs, Community Gathering and Recreational Spaces, Safety,** and **Care and Support for Older Adults** as medium priority unmet health related needs.

SECTION V: SIGNIFICANT HEALTH NEEDS

Review of Primary and Secondary Data

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

The Tri County Advisory Committee reviewed the quantitative and qualitative data collected for each of the following community health-related needs:

- Access to health care services including dental care
- Behavioral health challenges and access (mental health and substance use/misuse)
- Care and support for older adults
- Childcare providers and school programs
- Communication and advocacy
- Community gathering and recreational spaces
- Economic security
- Food security
- Homelessness and housing stability
- Obesity and chronic conditions
- Safety
- Transportation

Identification and Prioritization of Significant Health Needs

Members of the Tri County Advisory Committee convened September 5, 2025, to discuss qualitative data gathered through community engagement and quantitative data, including hospital utilization and data reflecting health indicators in Stevens County. The following criteria were used in the prioritization process:

The following criteria were used in the prioritization process:

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

The following list was included in the poll for voting to identify priorities:

- Access to health care services including dental care
- Behavioral health challenges and access (mental health and substance use/misuse)
- Care and support for older adults
- Childcare providers and school programs
- Communication and advocacy
- Community gathering and recreational spaces
- Economic security
- Food security
- Homelessness and housing stability
- Obesity and chronic conditions
- Safety
- Transportation

Following discussion of the above data, the participating members of the Tri County Advisory Committee each recommended their three highest priority needs. The aggregate voting results of this process determined the following priority needs:

1. Access to health care services
2. Behavioral health challenges and access (mental health and substance use/misuse)
3. Social determinants of health (homelessness and housing stability, food security and transportation)

The following community health needs identified in the 2025 CHNA will not be directly addressed by the Providence hospitals due to resources constraints and other facilities or organizations in the community are addressing them:

- Care and support for older adults
- Childcare providers and school programs
- Communication and advocacy
- Community gathering and recreational spaces
- Economic security
- Food security
- Homelessness and housing stability
- Safety
- Transportation

2025 Priority Needs

The list below summarizes the priority health needs identified through the 2025 Community Health Needs Assessment process:

ACCESS TO HEALTH CARE SERVICES

Challenges in accessing healthcare including dental care and chronic conditions, particularly in rural areas. These challenges include geographic and economic barriers, long travel times to reach providers, limited appointment availability, and significant wait times for services. A common concern was that residents often do not know what services are available to them, even with efforts like health fairs.

BEHAVIORAL HEALTH CHALLENGES

Community input highlighted the deep interconnection between homelessness, substance use/misuse, and mental health, identifying them as mutually reinforcing issues that contribute to ongoing instability for many individuals in the community. Fragmented care was seen as a barrier to effective recovery, particularly when people are forced to navigate separate systems for help.

SOCIAL DETERMINANTS OF HEALTH

Needs in this category included homelessness and housing stability, food security and transportation.

Homelessness and housing stability includes challenges related to housing affordability and homelessness, which intersect with health and social services.

Food security is a result of interconnected economic, structural, and social challenges.

Transportation is a significant barrier affecting access to essential services and resources within the community.

Alignment with Other Community Health Needs Assessments

To ensure alignment with local public health improvement processes and identified needs, we reviewed the needs of other publicly available sources that engaged the community in setting priorities, including Northeast Tri County Health District 2022-2023 CHNA: 2022_Stevens-CHNA-Report-_FINAL

The Tri County Advisory Committee reviewed this CHNA report to confirm alignment with government and non-profit organizations serving Stevens County.

The following table provides an overview of the priorities identified by the organizations. Both entities share common priorities including the emphasis on the importance of access to healthcare services, behavioral health challenges highlighting the need to address mental health and substance use/misuse and recognize significant needs in the areas of homelessness and housing stability, transportation, communication, economic security, food security and obesity and chronic conditions.

Table 4. Alignment with Other Community Health Needs Assessments

PROVIDENCE MOUNT CARMEL HOSPITAL AND PROVIDENCE ST. JOSEPH'S HOSPITAL CHNA—2025	NORTHEAST TRI COUNTY HEALTH DISTRICT CHNA – 2022 - 2023
• Access to health care services including dental care • Behavioral health challenges and access (mental health and substance use/misuse) • Care and support for older adults • Childcare providers and school programs • Communication and advocacy • Community gathering and recreational spaces • Economic security • Food security • Homelessness and housing stability • Obesity and chronic conditions • Safety • Transportation	• Housing (including affordability and availability • Homelessness • Healthcare (including lack of doctors, lack of emergency care and urgent care, immunizations, colonoscopy, mammogram) • Mental health services (depression in youth, bullying in youth) • Substance use • Transportation • Communication of local information • Overweight • Community services • Infrastructure

Potential Resources Available to Address Significant Health Needs

Understanding the potential resources to address significant health needs is fundamental to determining current state capacity and gaps. The organized health care delivery systems include the Department of Public Health, Providence Mounty Carmel Hospital, Providence St. Joseph's Hospital, and NEW Health. 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.

See Appendix 3 for a full list of resources potentially available to address the significant health needs

SECTION VI: EVALUATION OF 2023-2025 CHIP

The 2022 CHNA and 2023-2025 CHIP priorities were the following: mental health, access, substance use/misuse and housing instability. This report evaluates the impact of the previous Community Health Improvement Plan (CHIP). Providence Mount Carmel and Providence St. Joseph's Hospitals responded to community needs by making investments of direct funding, time, and resources to internal and external programs dedicated to addressing the previously prioritized needs using evidence-based and leading practices. Providence partnered with community organizations via the Tri County Advisory Council, working collaboratively to address identified community health needs and implement solutions that reflect local priorities and resources.

Table 5. Outcomes from 2023-2025 CHIP

Priority Need	Program or Service Name	Program or Service Description	Results/Outcomes
Mental Health	Work2BeWell Mental Health and Wellness Program	Mental health program aimed at empowering teens, educators, and communities through educational resources and initiatives focused on mental health awareness and support	Initial contact made by Providence with Newport High School discussing establishing a Work2BeWell program
	Charlie Health Virtual Intensive Outpatient Program	A structured, personalized approach for individuals who need more support than weekly therapy provides	Engaged with Charlie Health and Providence Stevens County Manager of Clinics to initiate discussion about establishing a formal referral process. Charlie health information is included in Providence's monthly resource guide that is distributed to providers
	NEW Alliance Counseling	Assessment support for patients at Mount Carmel to get connected to mental health resources	Between 2023 and July 2025, there have been a total of 2,465 Mental Health assessments conducted (1,050 in 2023, 835 in 2024, and 580 in 2025) and a total of 1,552 individual therapy counseling sessions (738 in 2023, 548 in 2024, and 266 in 2025)

	Rural Resources (Area Agency on Aging)	Support for aging adults including minor home care/aging in place and gap funding for mobile pantry services	2025 grant awarded from Providence to Rural Resources encompassing transportation support for deliveries, direct client home repairs, and client durable medical equipment. 500 individuals served.
	Integrating Behavioral Health in Primary Care	An approach that allows healthcare providers at Providence to address both medical and behavioral health factors, leading to better health outcomes	-Three Providence licensed social workers provide support to Colville, Kettle and Chewelah for behavioral health through collaborative care model -Access to Telepsychiatry consultation served by Spokane Psych Residency There is same day access (warm handoff) to meet with a behavioral health consultant
Access	Eastern Washington University Student Stipends to Support Travel/Housing	Stipends offered to students doing practicums in Stevens County to offset transportation and housing costs	In the 2022-2023 academic year, eight students were awarded stipends: two in Speech Language Pathology and six in Physical Therapy. In 2024, two awards were given, and four in 2025.
	Telehealth/Broadband Action Team/Libraries of Stevens County to Increase Broadband Access in Stevens County	Library Prescriptions and Devices program to enhance mental health resources, including telehealth services for residents without internet access.	Providence a grant to the Libraries of Stevens County. In 2024, served 1,000 patrons, providing telemedicine kits (a hotspot and a laptop). The program expanding access for providers and school counselors to identify and issue ”technology prescriptions.”
	Stevens County Ambulance: Access to	Ambulance transport service for residents of	A grant from Providence ensured enhanced standard

	Medications, Paramedic Program and Equipment	Stevens County and surrounding areas	of pre-hospital care for the sick residents of rural Washington. Stevens County Ambulance offered training for those working with Advanced Life Support (ALS) and to improve the critical thinking skills of all First Responders, Emergency Medical Technicians (EMTs), Advanced EMTs, and Paramedics. 4,651 people served in 2023 and 2024. Anticipating serving 2,000 in 2025.
	Providence Northeast Washington Hunger Coalition	A collaborative network of food pantries and community partners dedicated to relieving hunger, improving nutrition, and building community food resilience and access to fresh produce in the food desert of the tri county region	From 2023 to 2024, the Farm to Food Pantry program delivered over 80,000 pounds of locally grown produce, benefiting 8,434 people in 2023 and 8,880 people in 2024. Equipped about 600 people in Grow Your Own Row program. Served 8,500 people in 2025.
Substance Use/Misuse	Medication Assisted Treatment	An evidence-based treatment strategy that integrates medications with counseling and behavioral therapies to address substance use disorders (SUDs)	As of 2023, there have been a total of 485 inductions or reinductions at Providence Mount Carmel Hospital. (171 in 2023, 176 in 2024, and 138 in 2025). Since the inception of the program, there have been 739 unique episodes (distinct clients). According to the latest report from DSHS, there are currently 422 active clients in the program.

	NEW Alliance Counseling	Assessment support for patients at Mount Carmel Hospital to get connected to substance use disorder resources	There were a total of 886 Substance Use Disorder Intensive Outpatient/Outpatient (SUD IOP/OP) assessments conducted (318 in 2023, 354 in 2024, and 214 in 2025) and 192 individual therapy counseling sessions (61 in 2023, 96 in 2024, and 35 in 2025).
Housing Instability	Catholic Charities of Eastern Washington Housing Project	This is a 71-unit permanent supportive housing community	Providence was the convener during the community planning process to support the project. Leadership at Providence also testified before the Planning Commission to support the project. Dominican Sisters Haven opened in Spring of 2025 to house those experiencing housing insecurity and those with low incomes.

Addressing Identified Needs

The Community Health Improvement Plan developed for the Stevens County service area will consider the prioritized health needs identified in this CHNA and develop strategies to address needs considering resources, community capacity, and core competencies. Those strategies will be documented in the CHIP, describing how Providence Mount Carmel and Providence St. Joseph's Hospitals plan to address the health needs. If the hospital does not intend to address a need or plans to have limited response to the identified need, the CHIP will explain why. The CHIP will not only describe the actions Providence Mount Carmel and Providence St. Joseph's Hospitals intends to take, but also the anticipated impact of these actions and the resources the hospital plans to commit to address the health need.

Because partnership is important when addressing health needs, the CHIP will describe any planned collaboration between Providence Mount Carmel and Providence St. Joseph's Hospitals and community-based organizations in addressing the health need. The CHIP will be approved and made publicly available no later than May 15, 2026.

2025 CHNA GOVERNANCE APPROVAL

This Community Health Needs Assessment was adopted by the INWA Community Mission Board[1] of the hospital on October 16, 2025. The final report was made widely available by December 28, 2025.

Susan Stacey — Date: 10/31/25
Chief Executive, Providence Inland Northwest Washington

Mary Koithan — Date: 11/3/25
Chair, Providence INWA Community Mission Board

Scott O'Brien — Date: 11/18/25
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[1] See Appendix 4: Tri County Advisory Committee

APPENDICES

Appendix 1: Quantitative Data

POPULATION LEVEL DATA

The following population demographics are from the 2023 American Community Survey 5-Year Estimates.

Indicator	Stevens County	Broader Service Area	High Need Service Area
Population by Age Groups			
Total Population	47,470	24,857	22,613
Population Under Age 5	4.9% (2,340)	4.2% (1,051)	5.7% (1,289)
Population Under Age 18	21.3% (10,104)	19.6% (4,874)	23.1% (5,230)
Population Ages 18 to 34	15.8% (7,501)	15.6% (3,876)	16.0% (3,625)
Population Ages 35 to 54	22.3% (10,586)	22.7% (5,654)	21.8% (4,932)
Population Ages 55 to 64	15.9% (7,562)	16.1% (4,010)	15.7% (3,552)
Population Ages 65 and Over	24.7% (11,717)	25.9% (6,443)	23.3% (5,274)
Population by Sex			
Female	49.8% (23,639)	48.8% (12,134)	50.9% (11,505)
Male	50.2% (23,831)	51.2% (12,723)	49.1% (11,108)
Population by Race			
American Indian and Alaska Native	3.9% (1,864)	1.2% (305)	6.9% (1,559)
Asian Population	0.9% (431)	1.1% (270)	0.7% (161)
Black or African American Population	0.4% (186)	0.1% (20)	0.7% (166)
Native Hawaiian and Other Pacific Islander Population	0.2% (112)	0.1% (16)	0.4% (96)
Other Race Population	1.2% (567)	1.0% (246)	1.4% (321)
Two or more Races Population	6.6% (3,116)	5.7% (1,411)	7.5% (1,705)
White Population	86.8% (41,194)	90.9% (22,589)	82.3% (18,605)
Population by Ethnicity			
Hispanic Population	4.0% (1,904)	4.1% (1,010)	4.0% (0,894)

COUNTY HEALTH RANKINGS—2025 DATASET

Indicator	Stevens	Ferry	Pend Oreille	Washington
Population Health - *Note: Blank values reflect unreliable or missing data*				
Length of Life				
Premature Death	9,100	13,000	13,800	6,800
Quality of Life				
Poor Physical Health Days	4.7	5.3	4.6	3.9
Low Birth Weight	7%	6%	7%	7%
Poor Mental Health Days	5.5	6.1	6.1	5.4
Poor or Fair Health	17%	21%	17%	15%
Health Infrastructure				
Flu Vaccinations	26%	11%	26%	46%
Access to Exercise Opportunities	48%	75%	62%	86%
Food Environment Index	7.0	4.9	7.1	8.5
Primary Care Physicians	1,440:1	910:1	1,740:1	1,200:1
Mental Health Providers	210:1	310:1	300:1	190:1
Dentists	2,010:1	1,240:1	3,540:1	1,150:1
Preventable Hospital Stays	1,179	1,477	1,713	1,842
Mammography Screening	35%	22%	36%	39%
Uninsured	8%	9%	8%	7%
Physical Environment				
Severe Housing Problems	14%	16%	13%	17%
Driving Alone to Work	79%	67%	74%	65%
Long Commute - Driving Alone	45%	23%	45%	37%
Air Pollution: Particulate Matter	13.5	11.8	12.6	10.3
Drinking Water Violations	Yes	Yes	No	
Broadband Access	85%	77%	86%	93%
Library Access	2	2	4	2
Social & Economic Factors				
Some College	57%	55%	57%	72%
High School Completion	92%	92%	94%	92%
Unemployment	6.0%	8.4%	6.0%	4.1%
Income Inequality	4.4	4.9	4.2	4.5
Children in Poverty	18%	29%	22%	12%
Injury Deaths	100	151	148	79
Social Associations	8.3	8.1	8.5	8.3
Child Care Cost Burden	37%	43%	39%	37%

Stevens, Washington | County Health Rankings & Roadmaps – Data released 03/19/2025

Appendix 2: Community Input

METHODOLOGY

Participants

The hospital completed three listening sessions that included a total of 26 participants. The sessions took place between April and June 2025.

Table_Apx 1: Community Input

Community Input Type	Population	Community Partner	Location	Date	Language
Listening Session	Individuals volunteering in the community and seniors	Rotary Club of Colville, WA	Providence Mt. Carmel Hospital, Colville	June 13, 2025	English
Listening Session	Individuals serving those facing food insecurity	Providence Northeast Washington Hunger Coalition	Virtual	June 13, 2025	English
Listening Session	Individuals experiencing homelessness, in recovery and service providers	Bridges of Hope Men's Recovery Center	Bridges of Hope Recovery House, Colville	June 13, 2025	English

The hospital completed 11 key informant interviews that included a total of 16 participants. The interviews took place between April and June 2025.

The goal was to engage representatives from social service agencies, health care, education, housing, and government, among others, to ensure a wide range of perspectives. The hospital included the Administrator from Northeast Tri County Health District and five staff including the Executive Director of Spokane Tribal Network as a key informants to ensure the input from a state, local, tribal, or regional governmental public health department.

Table_Apx 2. Key Community Key Informant Participants

Organization	Name	Title	Sector
Food Bank	Ann Alhstrom	Community Member	Nonprofit
Heartland Medicine Colville Clinic	Barry Bacon	Family Practice Physician	Healthcare

Colville Community Church	Dave McCue	Pastor	Religious
NAMI	Deanna Roy	Senior Education Manager	Nonprofit
Northeast Family Counseling	Emily Danekas	Marriage and Family Therapist	Health
Spokane Tribal Network	Jamie Lovato	Indigenous Birth Justice Advocate	Tribal, Nonprofit
Stevens County Sheriff's Ambulance	Liam Stevens-Holeman	Lead Training Officer and Active Field Paramedic	Public
Spokane Tribal Network	Lynettte Pflueger	Tribal Food Sovereignty and Indigenous Birth Justice Program Manager	Tribal, Nonprofit
Northeast Tri County Health District	Matt Schantz	Administrator	Public Health
Spokane Tribal Network	Melodi Wynne	Community and Cultural Psychologist	Tribal, Nonprofit
Community Member	Nicholas Baldwin	Community Member	Community Member
Spokane Tribal Network	Penny Spencer	Director	Tribal, Nonprofit
Hope Street Restoration	Shelley Bacon	CEO	Nonprofit
Providence Northeast Washington Hunger Coalition	Stephani Smith	Director	Nonprofit
Food Bank	Susan Kelly	Community Member	Nonprofit
Spokane Tribal Network	Will Dennison	Manager & Marketing Coordinator	Tribal, Nonprofit

Facilitation Guides

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

- Community members' definitions of health and well-being
- The community needs
- The community strengths

For the key informant interviews, Providence developed a facilitation guide that was available for use across all hospitals completing their 2025 CHNAs:

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

Training

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

Data Collection

Key informant interviews were conducted virtually, and information was collected in one of two ways: 1) recorded with the participant's permission or 2) a note taker documented the conversation. Two note takers documented the listening session conversations.

Analysis

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

If applicable, the recorded interviews were sent to a third party for transcription, or the notes were typed and reviewed. The key informant names were removed from the files and assigned a number to reduce the potential for coding bias. The files were imported into Atlas.ti. The analyst used a standard list of codes, or common topics that are mentioned multiple times. These codes represent themes from the dataset and help organize the notes into smaller pieces of information that can be rearranged to tell a story. The analyst developed a definition for each code which explained what information would be included in that code. The analyst coded eight domains relating to the topics of the questions: 1) name, title, and organization of key informant, 2) population served by organization, 3) greatest community strength and opportunities to leverage these strengths 4) unmet health-related needs, 5)

disproportionately affected population, 6) effects of COVID-19, 7) successful programs and initiatives, and 8) opportunities to work together.

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

The analyst determined the frequency each code was applied to the dataset, highlighting which codes were mentioned most frequently. Codes for unmet health-related needs were cross-referenced with the domains to better understand the populations most affected by a certain unmet health-related need. The analyst documented patterns from the dataset related to the frequency of codes and codes that were typically used together.

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

Limitations

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

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

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

FINDINGS FROM COMMUNITY LISTENING SESIONS

Vision for a Healthy Community

Community members shared their vision for a thriving community that promotes overall well-being. At the heart of this vision is the belief that everyone deserves a home, as housing is essential to health. A vibrant community is characterized by smiling faces, a feeling of belonging, and a commitment to safety, where everyone is valued and included.

"Housing is health." – Listening Session Participant

Mental health awareness and easy access to services are highlighted, with the community working together supportively. Participants underscored the importance of basic health care and affordable, quality medical care for everyone, including mental health services, facilitated by reliable transportation systems. Welcoming public spaces, like libraries and safe areas for families and children, are seen as crucial for socializing and recreation.

"Every person has a vision, doing what makes them happiest and the influence of this is spreading throughout community."- Listening Session Participant

In challenging times, the community comes together to help each other, with volunteerism playing a key role in filling service gaps and supporting those in need. Ensuring children have hopeful adults in their lives and access to safe after-school activities is essential for their growth and development.

"Adults are hope filled which gives children hope." – Listening Session Participant

The community has well thought out infrastructure, such as walkable cities and bike routes, along with enhanced food programs and cold storage facilities to improve food security. There is clean air and water, preventative healthcare, and personalized care to meet diverse needs.
Community members want a media presence that encourages diverse perspectives beyond social media. A healthy community nurtures mental, social, financial, and medical well-being, creating spaces where people care for one another, especially older adults, and making sure everyone has access to healthy food and safe shelter.

Unmet Health-Related Needs

Community members were asked to discuss community health-related needs. Needs that were talked about in detail in a majority of the sessions were prioritized as high priority. The following themes emerged:

High priority unmet health-related needs

Homelessness and housing stability: Community members emphasized that affordable housing and stable living conditions are urgent needs within the community. Rising rents make it increasingly difficult for families and individuals to secure safe housing. Participants also highlighted the need for shelters that provide essential amenities such as laundry and shower facilities. They stressed the importance of developing strategies that not only address immediate needs but also help people experiencing homelessness work towards long-term self-sufficiency.

Access to Healthcare Services: Community members expressed a strong need for improved access to quality, affordable healthcare. They called for greater investment in facilities, such as clinics, to ensure healthcare services are available and accessible to everyone.

Transportation: Community members emphasized that transportation is a significant barrier affecting access to essential services and resources within the community. They underscored the urgent need for enhanced public transportation solutions that would more effectively connect individuals with resources and opportunities.

Behavioral Health challenges and access: Community members highlighted the essential need for increased funding and expanded facilities to support individuals seeking mental health counseling, including more mental health support in high schools. They emphasized the importance of implementing community-wide education and awareness campaigns to help reduce the stigma often experienced by people facing mental health challenges. Community members also noted the difficulties faced by individuals living with substance use disorders and expressed an urgent need for

comprehensive recovery services and supportive systems. Furthermore, they underscored the necessity of educational efforts aimed at fostering understanding and empathy toward those with substance use disorders.

Food Security: Community members noted that food insecurity is present, especially for children. They emphasized the need to expand school food programs to effectively address food insecurity experienced by children in the community.

Communication and Advocacy: Community members emphasized the need for improved communication across various sectors to bolster community engagement and participation, as well as connect people with resources. They advocated efforts that connect people with social services and ensure effective resource distribution. Participants noted that distrust and limited internet access pose challenges to sharing resource information. To address this, they suggested posting flyers and notices in community spaces such as churches and schools to raise awareness and reach more residents.

"If needs are communicated, people will respond.'' – Listening Session Participant

Medium priority unmet health-related needs

Childcare Providers and School Programs: Community members expressed concern about the lack of affordable childcare and after-school programs, which create significant challenges for working families striving to balance job responsibilities and family care.

Community Gathering and Recreational Spaces: Community members highlighted the need for more gathering spaces to enhance social connections and engagement among residents. They stressed the importance of developing infrastructure that supports recreational activities, such as aquatic centers, walkable cities, and bike trails, to foster a vibrant and cohesive community environment.

Safety: Community members recognized that, despite the low rates of violent crime, theft contributes to insecurity in certain neighborhoods. They further emphasized that challenges related to substance use intensify safety concerns, especially in rural areas where emergency response times are slower.

Care and Support for Older Adults: Community members highlighted the need for in-person visits and check-ins with older adults to ensure they access necessary resources and support. They emphasized strengthening outreach efforts to better connect older adults who feel isolated with available services.

FINDINGS FROM KEY INFORMANT INTERVIEWS

Vision for a Healthy Community

Key informants envisioned a healthy community as one where people feel connected, supported, and able to thrive physically, socially, and economically. Their vision includes:

- **Belonging, Inclusion and Social Connection:** Key informants emphasized that a healthy community is welcoming to all, where people feel a true sense of belonging and are not treated as outsiders. Strong social ties, across generations and backgrounds, are key to emotional well-being and to preventing isolation or loneliness. Community engagement,

opportunities to gather, and spaces for laughter and celebration all contribute to this connectedness.

- **Accessible Health and Social Services**: Easy access to healthcare and essential services were seen as very important in a healthy community. Key informants envisioned communities that reduce barriers to care by providing resources such as telemedicine and care navigators, ensuring that health and social supports are available when and where people need them.
- **Safe and Healthy Environments:** A healthy community protects physical and emotional well-being through its environment. Clean air, safe streets, and well-maintained neighborhoods allow residents to feel secure and supported in their daily lives.
- **Economic Opportunity and Stability**: Key informants described economic stability as essential for community health. Access to jobs, education, and other opportunities allows residents to meet their needs without leaving the community. The ability to grow food locally and achieve financial security was seen as a foundation for collective prosperity.
- **Equity and Support for All Community Members**: Key informants discussed how a healthy community supports all of its community members, including people experiencing homelessness. They highlighted the importance of social and economic inequality, as well as advocacy efforts that ensure all residents can thrive.
- **Shared Values and Collective Well Being:** Key informants envisioned a community grounded in shared values such as kindness, respect, and service to others. A values driven approach to community life fosters meaningful interactions, encourages neighbors to support one another, and strengthens a collective sense of purpose and well-being.

Community Strengths

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

- **Community Resilience and Support Systems:** Key Informants emphasized the importance of strong healthcare and social service systems, especially in a rural setting where distance and geography often limit access. Emergency medical teams frequently go above and beyond to close gaps in care, helping residents reach urgent healthcare services even in remote areas. Alongside healthcare, the community offers libraries and schools, as well as social services for veterans, people seeking jobs, and people experiencing homelessness. While these resources may not reach everyone, they are a critical support for those navigating challenging circumstances.
- **Community Connection and Support:** A strong sense of unity runs through the community, with neighbors often stepping in to help one another. Residents volunteer their time, provide financial support to one another, and share resources to meet collective needs. This culture of mutual aid strengthens community ties and helps residents face local challenges together. Social and cultural activities such as farmers markets, art fairs, and social clubs also create opportunities for connection, making the community feel more cohesive and supportive.
- **Leadership and Collaboration:** Local initiatives benefit from the presence of leaders who organize efforts, mobilize resources, and bring people together. Their leadership helps

coordinate volunteers and sustain projects that might otherwise lose momentum. Collaboration across different community groups enhances the impact of these efforts, making it possible to address challenges that no single organization could take alone.

- **Innovation:** Community members are resourceful and creative. Residents often find inventive ways to generate support, such as hosting local events to fund programs and resources, including the food bank. This problem-solving mindset helps the community adapt to change and maintain stability, even when facing economic uncertainty.
- **Economic Diversity and Resilience:** The community's economy benefits from a mix of industries, including logging, which provides stability by reducing reliance on a single sector. Residents demonstrate self-sufficiency and resourcefulness, supporting both household and community needs through varied work and skill sharing. Social and cultural enterprises, such as farmers markets and artisan crafts, along with digital platforms for trade, further strengthen local economic activity and long-term resilience.
-

Key informants identified several ways to build on existing strengths to improve health, housing, and overall community resilience:

- **Expand collaborative healthcare**: Strengthen coordination among healthcare providers and scale innovate models, like hybrid clinics, which improve access for uninsured and underinsured residents.
- **Prioritize housing solutions:** Support development of affordable and entry level housing, following examples like Catholic Charities low-income housing complex, to address homelessness and housing shortages.
- **Improve transportation access:** Invest in non-emergency transportation and infrastructure to reduce barriers to healthcare and other essential services.
- **Strengthen partnerships:** build trust and share resources among local organizations to reduce siloed efforts and sustain community programs
- **Use digital tools strategically:** Leverage social media and online platforms for outreach, service connection, and resource allocation, especially for transportation and healthcare access.

High Priority Unmet Health-Related Needs

Four needs were talked about in detail or ranked highly by a majority of key informant interview participants. Two additional needs were categorized as medium priority because they were discussed less frequently and in less detail. Key informants were most concerned about the following health-related needs:

1. Behavioral health challenges and access (mental health and substance use/misuse)
2. Access to health care services
3. Homelessness and housing stability
4. Economic Security

Behavioral health challenges and access (mental health and substance use/misuse)

Most key informants identified addressing behavioral health challenges and access as an important need in the community.

Intersection of Homelessness, Mental Health, and Substance Use/Misuse: Key informants consistently emphasized the deep interconnection between homelessness, substance use/misuse, and mental health, identifying them as mutually reinforcing issues that contribute to ongoing instability for many individuals in the community. Informants mentioned the need for integrated treatment options that address mental health conditions and substance use disorders together. Fragmented care was seen as a barrier to effective recovery, particularly when people are forced to navigate separate systems for help.

Untreated mental illness and substance use disorder was described as a major driver of homelessness and housing insecurity, disrupting people's ability to maintain employment, relationships, and consistent shelter. At the same time, participants noted that the experience of homelessness often worsens mental health conditions and exacerbates substance use/misuse, particularly when people are disconnected from services, family, and community support. Several informants referred to this as a "cycle" that is difficult to break.

Stigma and Public Perception: Stigma was identified as a persistent barrier to addressing behavioral health in the community. Some people in the community oppose behavioral health initiatives or view homelessness as mental illness issues of personal failure rather than structural inequity. This contributes to limited public support for evidence-based interventions and adds pressure to service providers, many of whom face burnout.

> *"My favorite description is that it's not a character trait. I was raised to believe it was a character trait, and that there was something wrong with me. Now, in my 50s, my parents are finally catching on. Change comes very slowly." – Key Informant*

Limited Resources and Access to Care: Key informants discussed how access to behavioral health services is also constrained by limited resources. With limited options for mental healthcare and substance use/misuse care available locally, people in crisis often must travel long distances for treatment. This obstacle often leads to delays or complete disengagement from care. Informants underscored that these service gaps are especially detrimental for people who already face challenges from structural inequities or are disconnected from their social networks.

Key informants identified several populations in the community who face heightened risk of behavioral health challenges and barriers to care:

- **People experiencing homelessness**: People experiencing homelessness are often unable to access consistent care or maintain treatment plans due to lack of shelter, transportation, or insurance.
- **Older adults**: Especially those living alone or with disabilities, who may experience isolation, untreated mental health conditions, or co-occurring substance use/misuse challenges.
- **People with disabilities**: People with disabilities, including those with cognitive, physical, and developmental disabilities, face additional barriers navigating fragmented systems of care.

- **People with co-occurring mental health and substance use disorders**: People with co-occurring disorders often fall through the cracks due to a lack of integrated treatment options.
- **People who are pregnant or parenting:** People who are pregnant and/or parenting face high levels of stigma and limited access to supportive services

"How can we get her a different life? …So mothers, absolutely children, [are] very much affected by what we're seeing in our community because when mom and dad are in an unstable situation and their life is spun out of control, it traumatizes them and they don't know what to do with that trauma and that grief. So, we talk about including the children in our recovery houses and reuniting families as a big, important component of what we're doing."-Key Informant

- **People with Criminal Legal System Involvement**: People with criminal legal system involvement, especially those re-entering the community without stable housing or connection to behavioral health support are disproportionately impacted.
- **People with low income/uninsured:** People with low income or who are uninsured are less likely to receive early or preventative mental healthcare due to cost, access, or systemic inequities.

Strengths of Community Led Solutions: Key informants expressed strong support for grassroots, community-led efforts that provide mental health education, reduce stigma, and empower individuals to advocate for themselves. Locally developed, culturally responsive approaches were seen as more sustainable and trusted than externally imposed programs.

Need for Integrated, Holistic Approaches: There was strong agreement among informants that effective solutions must be holistic. Addressing mental health, substance misuse, and housing needs together rather than in isolation was described as essential for long term stability. Informants called for community driven, stigma-free strategies that expand access to treatment, integrate wraparound efforts, and build healthier pathways forward for individuals and families experiencing these overlapping challenges.

"Just because we have mental illnesses doesn't mean life is over. We still get to be moms, sisters, aunties, godmothers, and even go on to be lawyers and judges."- Key Informant

Access to health care services, including dental care

Key Informants identified several key challenges in accessing healthcare, particularly in rural areas. These challenges include geographic and economic barriers, long travel times to reach providers, limited appointment availability, and significant wait times for services. A common concern was that residents often do not know what services are available to them, even with efforts like health fairs.
Key informants pointed to a need for:

- Expanded healthcare resources
- More urgent and preventive care options, including dental care
- Improved staffing

- Locally available specialized healthcare services
- Solutions that reduce disparities in healthcare access and outcomes

Awareness and Education: Many people in the community are unaware of what services and resources are available to them. While health fairs and community events try and address this, the information doesn't always reach those who need it most.

Lack of Essential and Specialty Services: Key informants discussed not having access locally to prenatal care, acute care, urgent care, and dental care. There are not enough healthcare facilities, providers, and services to meet the needs of the community, especially specialty care services. There is also a shortage of healthcare workers. Patients often travel to large cities like Spokane for treatment. Residents have difficulty in making timely doctor's appointments and finding offices accepting new patients. Community members report long delays for appointments, sometimes booking as far out as nine months.

"It should be mentioned that as a rural community it's harder to access services here. We just don't have much to pull from. It's easier when you live in Spokane." – Key Informant

Transportation: Limited, rigid transportation options create challenges for residents without a personal vehicle and people who rely on public transportation.

Availability of Dental Services: Key informants noted a scarcity of dental offices in the area that accept state insurance, making it difficult for low-income residents to access necessary dental care. This forces people to travel to larger cities like Spokane for dental services, which is not feasible for everyone, especially those without reliable transportation.

"We know through research that dental problems can carry over into medical problems. And if you take care of your teeth, there are medical problems you can avoid because of that…these guys just don't have access to that." – Key Informant

Environmental Concerns: Key informants described how environmental challenges like power outages disrupt residents' ability to access healthcare services.

"There's a large distance between them and essential health services, as well as feasibility of actually accessing those services. So being able to afford that care, being able to afford their medications, or being able to just afford the transit to get there, whether that's gas, money, vehicle maintenance." – Key Informant

Certain populations are especially impacted by access to care challenges:

- **Older Adults:** Older adults often face significant barriers to care due to economic constraints from fixed incomes, and Medicare limitations. A shortage of specialty services and the long distances required to reach care further compound these challenges.
- **People with Low-Income:** Individuals with limited financial resources have difficulty affording healthcare, medications, and transportation. A large portion of the population is reliant on Medicaid, Social Security, and Medicare.

- **People Experiencing Homelessness:** This group faces severe health disparities, including reduced life expectancy and social stigma that can discourage community support. Limited access to consistent healthcare exacerbates these disparities.
- **Rural Residents:** People living in the most remote areas experience significant challenges due to geographic isolation, transportation barriers, and limited healthcare infrastructure, all of which hinder timely access to care.
- **Indigenous Peoples of the U.S.:** Key informants noted that Indigenous peoples of the U.S. may experience unique health challenges and higher prevalence of certain conditions, underscoring the need for culturally responsive healthcare and improved access to services.
- **People without insurance:** Those who earn too much to qualify for state insurance but cannot afford private coverage are often left without adequate medical or dental care, leaving critical health needs unmet.

Homelessness and housing stability

Most Key informants identified homelessness and housing stability as a need in Stevens County. They discussed significant challenges related to housing affordability and homelessness, which intersect with health and social services.

Housing insecurity and Behavioral Health: Key informants discussed how housing insecurity is closely tied to untreated mental illness, substance use disorders, economic insecurity, and job loss. Key informants discussed how housing loss can quickly impact anyone—including those seen as capable and working. Mental health conditions and substance use disorders often coincide with or are directly related to housing instability, which in turn affects children, families, and caregivers. Many noted concerns around the emotional and developmental toll housing insecurity has on children. These intersecting challenges create cycles that make it difficult for people to maintain stable housing or access the support needed to recover.

> *"Poverty, homelessness, untreated mental illness, and chemical dependency tend to run together. And I mean, it's understandable why that would be. If you have an untreated mental illness, you're going to lose your job. Your life is going to spiral out of control. You're going to lose your relationships and your support, and you're going to end up on the streets."—Key Informant*

Limited Affordable Housing: There is a significant shortage of affordable and supportive housing. Long waitlists for housing vouchers and a lack of entry-level housing development were frequently cited. Some key informants expressed frustration that affordable housing projects are often not prioritized.

Economic Insecurity: Economic changes since the COVID-19 pandemic have led to rising housing costs, particularly with remote workers moving into the region. This has made it increasingly difficult for long-term residents, especially young adults and older adults on fixed incomes, to afford housing.

Environmental Concerns: Wildfires, droughts, and other natural disasters have increased displacement, with few resources available for those in need of emergency shelter. These events have further strained the limited housing options in the area.

Access to Healthcare: Housing instability is often compounded by difficulty accessing healthcare. Long wait times and limited preventive care contribute to worsening health outcomes, particularly for people living without stable housing.

Stigma: Some informants pointed to ongoing stigma and negative attitudes toward people experiencing homelessness. These perceptions can hinder public support for housing initiatives and social services, creating an additional barrier to progress.

> *"Research says that people without housing live on average 27 years less than the average population. I don't know that there's any single other health disparity in our community or in our nation that is as significant as that one number. There's just nothing like it. Cancer doesn't do that, you know. Kidney disease, diabetes—whatever…and it is a solvable problem. That's what makes it so difficult to realize. A corresponding problem to that, which isn't necessarily a health problem, but is a barrier to solving that health problem."—Key Informant*

Populations Most Impacted

Several groups were identified as being most affected by housing instability and the challenges surrounding it:

- **Single Adults, Especially Men:** A large portion of those without stable housing are single men, often facing isolation and limited access to services.
- **Older Adults**: Many older residents live on fixed incomes and are being priced out of the housing market.
- **People with Disabilities or Chronic Illnesses:** Individuals with physical or mental health conditions face added barriers when trying to secure and maintain housing.
- **Survivors of Domestic Violence**: People fleeing domestic violence often face sudden housing loss and safety concerns.
- **Women and Children:** Families, especially single mothers with young children, are disproportionately impacted due to a lack of safe, stable housing options.
-

> *"We have old people showing up at the rest stop, meaning that old people are experiencing homelessness…We see people with mental illness, people dealing with addiction, and people who are just struggling with life, such as victims of natural disasters, domestic violence, and all of the above. Homelessness is very complex in terms of the causes." —Key Informant*

Despite the challenges, key informants emphasized a strong desire to expand housing access, reunite families, and support recovery services. There is a shared sense of hope that with better coordination, investment, community engagement, and long-term solutions such as permanent supportive housing and mental health services can be developed and sustained.

Economic Security

Several key informants highlighted economic security as a need in the community, with impacts felt across age groups and sectors. Key informants described how the rising cost of living, limited local

opportunity, and shortages in critical service areas are creating long-term challenges for community stability and growth.

Education and Workforce Gaps: The community faces a shortage of healthcare professionals, which is driven in part by challenges in developing and retaining a local workforce. Although some education and training opportunities exist within the community, many people leave the area to pursue opportunities and education elsewhere and do not return. This undermines local capacity. Those who do come back often return later in life, limiting early career workforce availability. Key informants discussed the need for strategies that support local education pathways, create incentives to stay, and build a sustainable pipeline of workers, especially in healthcare, within the community.

Cost of Living and Housing Availability: The high cost of living, especially housing, is a major barrier for financial stability. Key Informants described how younger adults are increasingly unable to afford living independently, often moving back with parents or delaying major life milestones.

Declining Access to Essential Services: Essential services, such as grocery stores, transportation, and affordable healthcare are becoming less accessible, especially in rural or remote parts of the county. Economic decline and population shifts have made it harder for many residents to meet basic needs without leaving the area.
Populations Most Impacted:

- **Older adults**: Older adults, especially those who rely on Social Security and Medicare, face increasing costs and reduced access to services.
- **Young adults:** Economic pressures, including rising housing costs, limited career options, and a sense of being "stuck," make it difficult for younger residents to establish financial independence, resulting in young people choosing to leave the community to seek opportunity elsewhere.

Medium Priority Unmet Health-Related Needs

Two additional needs were often discussed by key informants:

5. Food Security
6. Obesity and chronic conditions

Food Security

Key informants described food insecurity as a result of interconnected economic, structural, and social challenges.

Availability, Quality, and Affordability of Food: Many residents face an unstable food supply, where healthy options are limited, inconsistent in quality, and increasingly expensive. The growth of large chain grocery stores has not filled the gap left by the decline of smaller, more accessible neighborhood stores, making it harder for households to maintain balanced diets.

Transportation Barriers: Limited transportation options restrict access to grocery stores and other food resources, particularly for those living far from retail centers or without personal vehicles. This lack of physical accessibility compounds the challenge of securing fresh, nutritious food.

Impact on Older Adults: Older adults experience added challenges due to fixed incomes, reduced mobility, and the inaccessibility of grocery stores, making it especially difficult to obtain affordable, nutritious food.

Obesity and chronic conditions

Key informants described obesity and chronic conditions as interconnected issues driven by healthcare access barriers, socioeconomic constraints, and environmental challenges.

Chronic Health Conditions and Contributing Factors: Residents experience high rates of chronic illnesses such as diabetes, COPD, chronic kidney disease, and Congestive Heart Failure. These conditions are often made worse by delayed or inconsistent medical care, geographic isolation, and limited transportation. Poor access to nutritious food and opportunities for physical activity further contribute to obesity and related diseases.

Healthcare Access and Geographic Isolation: The rural geography of Stevens County limits residents' ability to access both primary and specialized care. Long travel distances, transportation barriers, and seasonal challenges such as wildfires and harsh winters make it difficult for people to receive timely and consistent care, particularly for managing chronic conditions.

Economic and Social Determinants of Health: Economic insecurity, high costs of healthy food, and limited employment opportunities affect residents' ability to prioritize health. For many, geographic isolation compounds these barriers, making fresh produce and preventive care harder to obtain.

Environmental Challenges: Weather events, including wildfires and harsh winters, impact access to healthcare and exacerbate chronic conditions like asthma. These environmental challenges, coupled with transportation issues, pose significant barriers to accessing services and maintaining community well-being.

Despite these challenges, residents benefit from strong social networks, resilience, and cultural traditions that support health and well-being. Initiatives such as community gardens, Farm to Food Pantry, and master gardener programs increase access to fresh produce while fostering physical activity and community engagement.

Appendix 3: Community Resources Available to Address Significant Health Needs

Providence Mount Carmel Hospital and Providence St. Joseph's Hospital cannot address all of the significant community health needs by working alone. Improving community health requires

collaboration across community key informants and with community engagement. Below outlines a list of community resources potentially available to address identified community needs.

Table_Apx 3. Community Resources Available to Address Significant Health Needs

Organization or Program Name	Description of Services Offered	Address	Website	Significant Need(s) Addressed
Aloha Integrative Medicine	Primary medical care services	325 E 3rd Ste. C Kettle Falls, WA 99141	Aloha INTEGRATIVE MedicINE - Home	Access to Health Care Services Obesity and chronic conditions
Bridges of Hope Men's Recovery	Homelessness and substance use support	282 W Astor Ave, Colville, WA 99114	About — Bridges of Hope Men's Recovery Center	Homelessness, Behavioral Health Challenges and Access
Catholic Charities Eastern Washington – Dominican Sisters Haven	72-unit permanent supportive housing community, including access to support services	171 Buena Vista Drive, Colville, WA 99114	Dominican Sisters Haven (Colville)	Homelessness and Housing Instability, Access to Health Care Services
Catholic Charities – Volunteer Chore Services – Colville Senior Services	Provides a wide range of household tasks and assistance to low-income elderly and disabled clients including transportation	525 S Main St #1 Colville, WA 99114	Senior Services | Catholic Charities Eastern Washington	Care and support for older adults Transportation Safety
Chamber of Commerce	Both Chewelah and Colville Chamber of Commerce focuses promoting growth and	**Chewelah Chamber of Commerce** 401 S Park St Suite G P. O. Box 94	About Chewelah - Chewelah Chamber of Commerce Colville Chamber	Economic Security Community gathering and recreational spaces

	stability of local economy, business community and area tourism	Chewelah, WA 99109 **Colville Chamber of Commerce** 986 S Main, Suite B, Colville, WA 99114		
Chewelah Community Health Center	Primary medical care services	518 E Clay Ave, Chewelah, WA 99109	Chewelah Medical – NEW Health	Access to Care Medical Care Obesity and chronic conditions
Colville Community Health Center	Primary medical care services	358 N Main St, Colville, WA 99114	Colville Medical – NEW Health	Access to Care Medical Care Obesity and chronic conditions
Colville Dental	Dental services	161 E. 3rd Avenue Colville, WA 99114	Colville Dental – NEW Health	Access to Health Care Services - Dental
Colville Senior Center – The Hub	Hosts engaging events and serves food	231 W. Elep Avenue Colville, WA 99114-5104	Home | Colville Community Senior Center	Community gathering and recreational spaces Care and support for older adults
Colville Together	A partnership of the City of Colville, Colville Chamber of Commerce and Tri County Economic Development District	115 W Astor Ave, Suite 206 Colville , WA 99114	Our Story	Communication and advocacy
David C. Wynecoop Memorial Clinic	Primary medical care services	6203 Agency Loop Rd, Wellpinit, WA 99040	David C Wynecoop Memorial Clinic	Access to Health Care Services

aka Wellpinit Service Unit, Indian Health Services			Dhhs Ihs Wellpinit Service Unit in Wellpinit, WA - Medicare Clinic/Center	Obesity and chronic conditions
ECEAP and HeadStart in Chewelah, Colville, Kettle Falls and Spokane Tribe of Indians	Early learning and child care or preschool support	956 S Main St, Colville, WA 99114 600 N 3rd St E Chewelah, WA 99109 E 347 Aster St Colville, WA 99114 700 Oak St Kettle Falls, WA 99141 6195 Ford-Wellpinit Rd, Wellpinit, WA 99040	Early Childhood Education - Rural Resources Headstart – Spokane Tribe of Indians	Childcare providers and school programs
Heartland Medicine Colville Clinic Direct Care and Urgent Care	Direct Care Clinic and Urgent Care Center that provides access to high quality healthcare services	250 S Main Colville, WA 99114	Barry Bacon, MD – Heartland Medicine Colville Clinic Direct Care and Urgent Care	Access to Health Care Services Obesity and chronic conditions
Hope Street Project		528 S Wynne St Colville, WA 99114	Contact – Hope Street Project	Homelessness and Housing Instability
Kettle River Community Health Center	Primary medical care services	141 Third Ave, Orient, WA 99114	Kettle River Community Health - Orient, WA, 99160	Access to Health Care Services
Lake Spokane Community Health Center	Primary medical care services	5952 Blackstone Way, Nine Mile Falls, WA 99026	Lake Spokane Medical – NEW Health	Access to Health Care Services
Loon Lake Community Health Center	Primary medical care services	3994 Colville Rd, Loon Lake, WA 99148	Loon Lake Medical – NEW Health	Access to Health Care Services
NEW Health Northport	Primary medical care services	411 Summit Ave, Northport, WA 99157	TEMPORARILY CLOSED - Northport	Access to Health Care Services

Community Health Center			Medical – NEW Health	
Selkirk Community Health Center	Primary medical care services	208 Cedar Creek Terrace, Ione, WA 99139	Selkirk Medical – NEW Health	Access to Health Care Services
Northeast Washington Alliance Counseling Services	Behavioral Health services, employment and housing services	165 E. Hawthorne Avenue Colville, WA 99114 E. 301 Clay Ave, Room 201 Chewelah Municipal Bldg Chewelah, WA 99109	NEWABH - Stevens County WA	Behavioral Health Challenges and Access, Homelessness and Housing Instability
Northwest Justice Project	Legal Aid	132 W 1st Ave, Colville, WA 99114	About Us | Northwest Justice Project	Housing and Homelessness
N.E.W. Hunger Coalition	Food banks and food pantries	374 W 2nd St, Ste G, Colville, WA 99114	NEW Hunger Coalition – Together, we can end hunger!	Food Security
Rural Resources Community Action	Resource support including rental assistance, emergency shelter, housing vouchers and transportation	956 S Main St, Colville, WA 99114 600 N 3rd St E, Chewelah, WA 99109	Home Page - Rural Resources	Homelessness and Housing Instability Care and support for older adults Communication and advocacy Childcare providers and school programs Transportation
Spokane Tribal Network	Services for Spokane Tribal people, families and communities	6230 Old School Rd Wellpinit, WA 99040	Home - Spokane Tribal Network	Access to Health Care Services
Springdale Dental	Dental care	105 N Second, Springdale, WA 99173	Springdale Dental – NEW Health	Access to Health Care Services - dental

Springdale Community Health Center	Primary medical care services	114 S Main St, Springdale, WA 99173	Springdale Medical – NEW Health	Access to Health Care Services
Stevens County Emergency Management	Coordination of information between the public and emergency services	215 South Oak Street Colville, WA 99114	Stevens County WA - Official Website	Safety
Stevens County Sheriff's Ambulance	Medical emergency services	425 N Hwy, Colville, WA 99114	Sheriff's Ambulance - Stevens County WA	Access to Health Care Services
Tri County Economic Development District	Lead agency for Northeast Washington Regional Transportation Planning Organization. Also offers a local business loan fund	986 South Main Street, Suite A Colville WA 9911	Home Page • Tri County Economic Development District	Economic Security

Appendix 4: Tri County Advisory Council

Table Apx 4. Tri County Advisory Council Members

Name	Title	Organization	Sector
Bill Buscher	Operations Manager	Stevens County Sherriff's Ambulance	Public, Emergency Services
Bryan Raines	Chief Executive Officer	Rural Resources Community Action	Community Based Organization
Caleb Holtzer, MD	Physician	Providence	Healthcare
Crystal Harper	Chief Nursing Officer	Providence	Healthcare

David Nielsen, Ph.D	Executive Director	Northeast Washington alliance Counseling Services	Community Based Organization
Debra Hansen	County Director	WSU Stevens County Extension	Education
Dorothy Knauss	Interim Mayor	City of Chewelah	Government, Public
Edward Johnson, MD	Chief Medical Officer	Providence	Healthcare
Heidi Brown	Director Business Development	Providence	Healthcare
Janessa Graves, Ph.D, MPH	Associate Professor/Health Data Analyst	University of Washington	Education
Jason Perrins	Superintendent	Chewelah School District	Education
Kelley Robertson	Executive Assistant	Providence	Healthcare
Kelley Zema	CSO Administrator	DSHS/ESA/CSD	Social and health services
Kelly Corcoran	Chief Mission Officer	Providence	Healthcare
Kevin Knight	Superintendent	Colville School District	Education
Klinton Kilgore	Physician	Providence	Healthcare
Matt Schanz	Administrator	Northeast Tri County Health District	Public Health
Michael Olsen	Superintendent	Kettle Falls School District	Education
Michelle Wasco	Associate Caregiver health	Providence	Healthcare

Ozzie Wilkinson	Past Board Member	Providence	Healthcare
Patrick Shannon, MD	Physician	Providence	Healthcare
Paul Larsen, MD	Physician	Providence	Healthcare
Phil Stalp	Past Board Member	Providence	Healthcare
Ramon Canto, MD	Physician	Providence	Healthcare
Ron Rehn	Chief Administrative Officer	Providence	Healthcare
Susan Stacey	Chief Executive	Providence	Healthcare