2023

COMMUNITY HEALTH NEEDS ASSESSMENT

Providence St. Joseph Medical Center

Polson, Montana

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Providence

CONTENTS

MESSAGE TO THE COMMUNITY AND ACKNOWLEDGEMENTS

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

Providence's vision of "Health for a Better World" starts with our commitment to understanding and serving the needs of the community, especially those who are poor and vulnerable. With each investment we make and partnership we develop, we find ways to best address and prioritize our region's most challenging needs as identified through our CHNA. In 2022, driven by our Mission to care for our community, Providence Montana, which includes Providence St. Joseph Medical Center, Providence Medical Group, as well as St. Patrick Hospital in Missoula, invested more than $22 million in Community Benefit[1] in our communities. Together with our partners, we are building communities that promote and transform health and well-being.

With input and guidance from many of our community partners we complete a CHNA every three years to identify the greatest unmet needs in our community. The objectives of the CHNA are to understand the greatest needs in the community, determine how Providence St. Joseph Medical Center can respond to those needs in partnership with other community organizations, and develop implementation strategies that will lead to health improvement. We are grateful for the time our community partners and community members spent sharing their thoughts and ideas about the most significant needs in Lake County. These conversations allow us to create a rich, meaningful assessment of our community's strengths and needs.

In the coming years, we will focus our efforts on supporting and growing programs that address mental health care, substance use /misuse, housing instability and food insecurity.

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

Sincerely,

Kirk Bodlovic
Interim Chief Executive and Chief Operating Officer
Providence Montana

[1] Per federal reporting and guidelines from the Catholic Health Association.

EXECUTIVE SUMMARY

Understanding and Responding to Community Needs

The Community Health Needs Assessment (CHNA) is an opportunity for Providence St. Joseph Medical Center 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.

The 2023 CHNA was recommended for approval by the Providence St. Joseph Advisory Council on September 27, 2023. The CHNA was approved by the Montana Service Area Community Mission Board on October 24, 2023 and made publicly available by December 28, 2023.

Gathering Community Health Data and Community Input

Through a mixed-methods approach, using quantitative and qualitative data, we collected information from the following sources: American Community Survey, Behavioral Risk Factor Surveillance System, local public health data, and hospital-level data. To actively engage the community, we conducted listening sessions that included people who are from diverse communities, who have lived experience with substance use disorder, have low-incomes, and/or 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 found addressing behavioral health challenges and improving access to care, specifically for mental health and substance use/misuse to be the primary need in Lake County
- Populations most affected by housing instability include elderly individuals, people relying on fixed incomes, and American Indians
- Community members are concerned about racism and discrimination leading to disparities in care based on an individual's perceived background, appearance, and social connections

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 Providence St. Joseph Medical Center Advisory Council, the following priority areas were identified (listed by order of priority):

MENTAL HEALTH

Mental health programs include the prevention, screening, assessment, and treatment of mental disorders and behavioral conditions. Mental health is an important part of overall health and well-being. Mental health includes our emotional, psychological, and social well- being. In Lake County, key informants emphasize the need for increased resources, improved collaboration among healthcare

providers, enhanced funding for crisis services, and the development of residential and step-down facilities.

SUBSTANCE USE/MISUSE

Substance use/misuse occurs when the recurrent use of alcohol and/or drugs causes clinically significant impairment, including health problems, disability, and inability to meet major responsibilities at work, school, or home. Substance use/misuse includes the use of illegal drugs and the inappropriate use of legal substances, such as alcohol, prescription drugs and tobacco. In Lake County, key informants noted decreased social connections, increased substance use (particularly drinking), and limited resources for individuals with substance use disorders; people seeking help for addiction are unable to find appropriate services, indicating a need for improved accessibility and availability of addiction treatment options.

HOUSING INSTABILITY

Housing instability encompasses several challenges such as having trouble paying rent, overcrowding, moving frequently, staying with relatives, or spending the bulk of household income on housing. Households are considered “cost burdened” if spending more than 30% of household income on housing, and "severely cost burdened” if spending more than 50% of household income on housing. Cost-burdened households have little left over each month to spend on other necessities such as food, clothing, utilities, and health care. Key informants in Lake County identified populations affected by housing instability in particular to be elderly individuals, people relying on fixed incomes, and American Indians and the rising cost of housing to be a major challenge in the community.

FOOD INSECURITY

Food insecurity refers to uncertainty surrounding access to and availability of nutritious food because of lack of money and other resources. Food insecurity may be long term or temporary. It may be influenced by a number of factors including income, employment, race/ethnicity, and disability. In Lake County, the high cost of healthy food, limited access to nutritious options, existence of food deserts, and affordability challenges affect the indigenous population, seniors, and residents of rural Lake County.

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

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

This report evaluates the impact of the 2021-2023 CHIP. Providence St. Joseph Medical Center responded to community needs by making investments of direct funding, time, and resources to internal and external programs dedicated to addressing the previously prioritized needs using evidence-based and leading practices. In addition, we invited written comments on the 2020 CHNA and 2021-2023 CHIP, made widely available to the public through posting on our website and distribution to community

partners. No written comments were received on the 2020 CHNA and 2021-2023 CHIP. The 2020 CHNA and 2021-2023 CHIP priorities were the following:

Priority 1: Access to Mental Health Services

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

Priority 2: Access to Substance Abuse Disorder Treatment Services

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

Priority 3: Safe and Affordable Housing

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

A few of the key outcomes, key initiatives and strategies from the previous CHIP are listed below:

- Integrated mental health care in the primary care setting
- Increased regional coordination for acute mental health services
- Integrated medication-assisted treatment
- Continuation of the Journey of Hope work into longer-term Meadowlark Initiative in support of people with substance use disorders in the perinatal period
- Collaboration with community-based organizations to increase access to peer support services

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 St. Joseph Medical Center is a critical access hospital founded in 1916 and located in Polson, Montana; the Sisters of Providence took responsibility of the hospital in 1990. It is one of nine critical access hospitals in western Montana and has 22 licensed beds. Providence St. Joseph Medical Center has a staff of more than 270.

Under the sponsorship of Providence, St. Joseph Medical Center participates as a member of a system of hospitals and an affiliate of Providence St. Patrick Hospital in Missoula. Expansion of services, shared purchasing and management expertise provide fundamental value to the community. Together, Providence St. Joseph Medical Center, Providence St. Patrick Hospital and Providence Medical Group form Providence Montana. Major programs and services offered by Providence St. Joseph Medical Center to the community include acute inpatient care, primary care, specialty clinics, outpatient diagnostics, surgical services, as well as an assisted living facility.

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.

OVERVIEW OF CHNA FRAMEWORK AND PROCESS

Equity Framework

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

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

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

Approach

Explicitly name our commitment to equity

Take an asset-based approach, highlighting community strengths

Use people first and non-stigmatizing language

Community Engagement

Actively seek input from the communities we serve using multiple methods

Implement equitable practices for community participation

Report findings back to communities

Quantitative Data

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

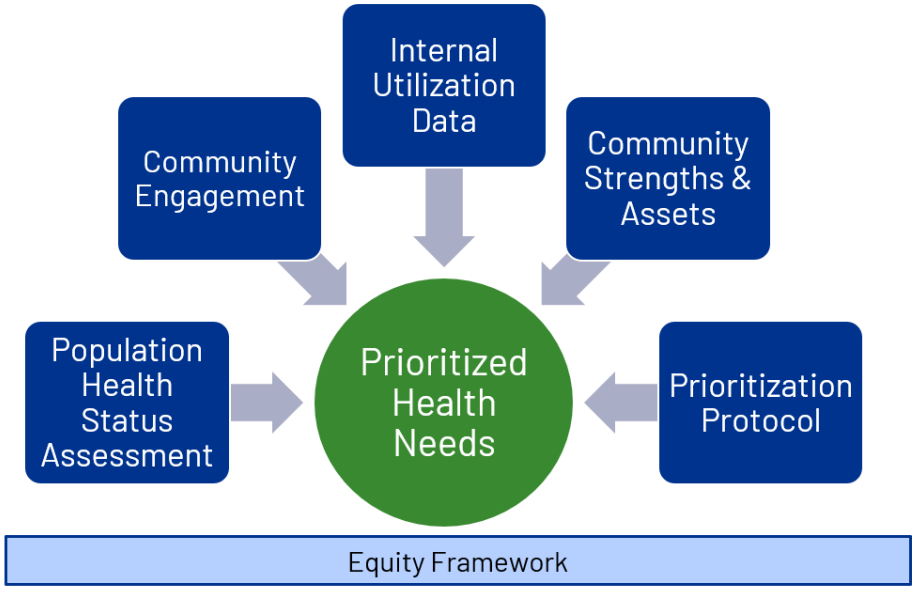
Disaggregate data when responsible and appropriate

Acknowledge inherent bias in data and screening tools

Providence St. Joseph Medical Center is located within the Flathead Indian Reservation, which is the ancestral home of the Bitterroot, Salish, Kootenai, and Pend d'Oreille tribes, organized as the Confederated Salish and Kootenai Tribes of the Flathead Nation (CSKT). In the course of this assessment, we made particular effort to engage members of CSKT, as well as American Indian descendants who live in Lake County. CSKT Tribal Health Department completed a community health assessment in 2022, the results of which helped to inform our own CHNA.

CHNA Framework

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



*modified MAPP Framework

Data Sources

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

We reviewed data from the following sources:

Primary Data Sources	Secondary Data Sources
• Key informant interviews • Community listening sessions • Internal hospital utilization data	• American Community Survey • Behavioral Risk Factor Surveillance System (BRFSS) • U.S. Census Bureau • Montana Index for Health Communities • County Health Rankings • Other recent needs assessments (CSKT Tribal Health, Clark Fork Valley Hospital)

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:

- While most indicators are relatively consistent from year to year, other indicators are changing quickly (such as percentage of people uninsured) and the most recent data available are not a good reflection of the current state.
- Reporting data at the county level can mask inequities within communities. This can also be true when reporting data by race, which can mask what is happening within racial and ethnic subgroups. Therefore, when appropriate and available, we disaggregated the data by geography and race.
- Data that are gathered through interviews and surveys may be biased depending on who is willing to respond to the questions and whether they are representative of the population as a whole.
- The accuracy of data gathered through interviews and surveys depends on how consistently the questions are interpreted across all respondents and how honest people are in providing their answers.

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

Written comments were solicited on the 2020 CHNA and 2021-2023 CHIP reports, which were made widely available to the public via posting on the internet in December 2020 (CHNA) and May 2021 (CHIP), as well as through various channels with our community-based organization partners.

No comments were received for the previous CHNA or CHIP documents.

OUR COMMUNITY

Hospital Service Area and Community Served

Providence St. Joseph Medical Center serves as a critical access hospital to Lake County and surrounding communities, including the Flathead Indian Reservation, which is the ancestral home of the Bitterroot, Salish, Kootenai, and Pend d'Oreille tribes, organized as the Confederated Salish and Kootenai Tribes of the Flathead Nation.

Figure 1. Map of Western Montana with Lake County highlighted in yellow

Lake County, as well as the immediate surrounding area, is rural. Flathead County (to the north and northeast) and Missoula County (to the south and southeast) include the cities of Kalispell and Missoula, respectively, which each have larger hospitals. Sanders County, to the west, is rural, and is home to another critical access hospital. Lake County's population is 32,853[2], 7.8% higher than at the time of the previous CHNA.

Based on the availability of data and the service area being situated between the more populated Missoula and Flathead counties, Lake County serves as the boundary for the hospital service area.

[2] U.S. Census Bureau. QuickFacts Population Estimates, July 1, 2022

Providence Need Index

To facilitate identifying health disparities and social inequities by place, we designated a "high need" service area and a "broader" service area, which together make up the Providence St. Joseph Medical Center Service Area. Based on work done by the Public Health Alliance of Southern California and their Healthy Places Index (HPI) tool, we identified the high need service area based on income, education, English proficiency, and life expectancy.[3]

For this analysis, census tracts with more people below 200% Federal Poverty Level (FPL), more people without a high school diploma, more limited English households, and a lower life expectancy at birth were identified as "high need." The mean value of nearest neighbors was used to insert missing data for variables by way of the Neighborhood Summary Statistics geoprocessing tool in ArcGIS Pro 3.1. All variables were weighted equally. The census tracts were assigned a score between 0 and 100 where 0 represents the census tract with the lowest need and 100 represents the highest need, according to the criteria. Census tracts that scored higher than the average were classified as a high need service area and are depicted in green. In the Providence St. Joseph Medical Center Service Area, 7 of 10 census tracts (70%) scored above the average of 71.9, indicating a high need.

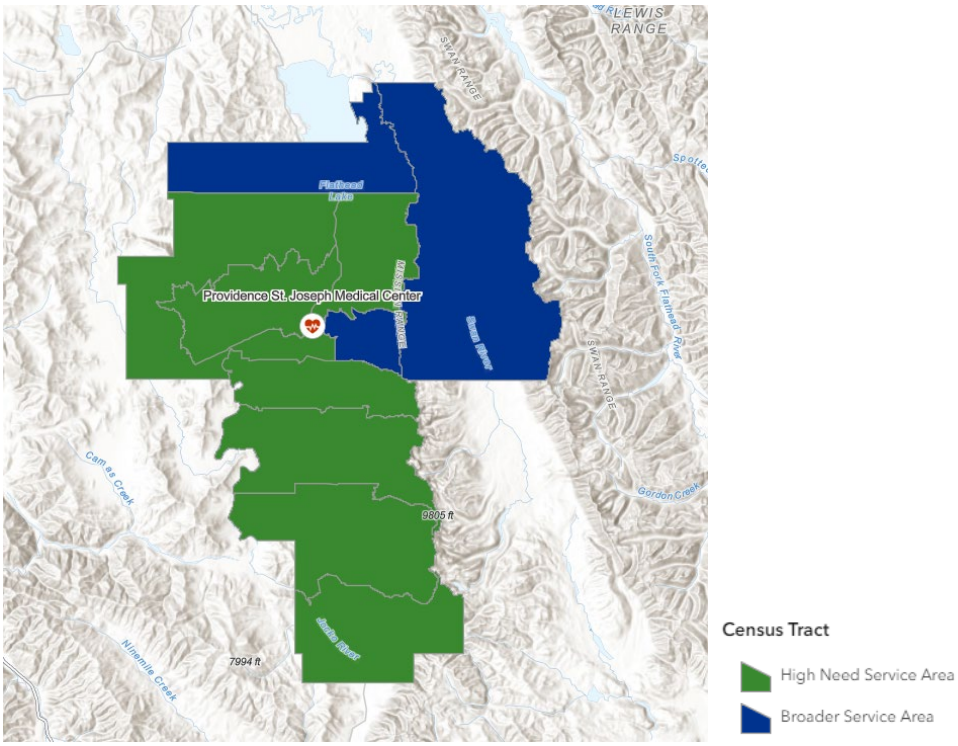


Figure 2. Providence St. Joseph Medical Center Service Area

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

Community Demographics

The tables and graphs below provide basic demographic and socioeconomic information about the service area and how the high need area compares to the broader service area. The high need area includes census tracts identified based upon lower life expectancy at birth, a lower percent of the population with at least a high school diploma, more households which are linguistically isolated and more households at or below 200% of the Federal Poverty Level (FPL) compared to county averages. For reference, in 2023, 200% FPL represents an annual household income of $60,000 or less for a family of four.

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

Lake County Datahub 2023 CHNA (arcgis.com)

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

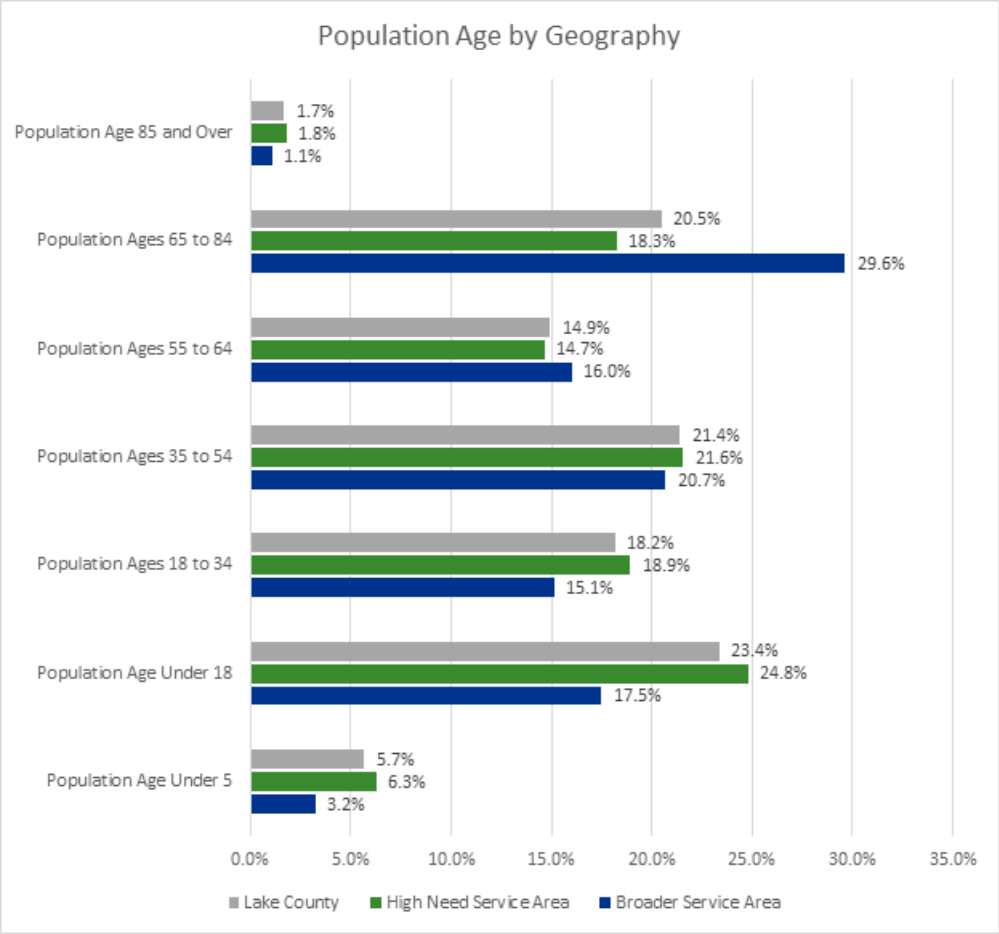


Figure 3: Population Age Groups by Geography

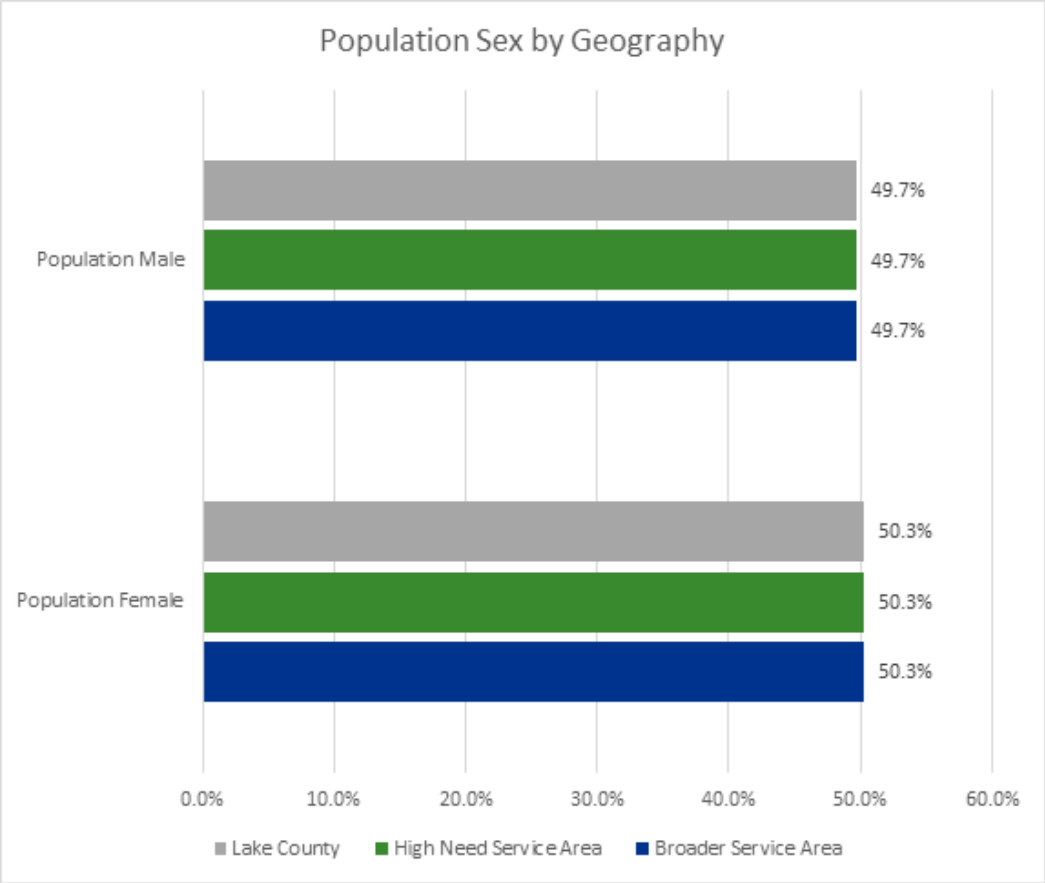


Figure 4: Population Sex by Geography

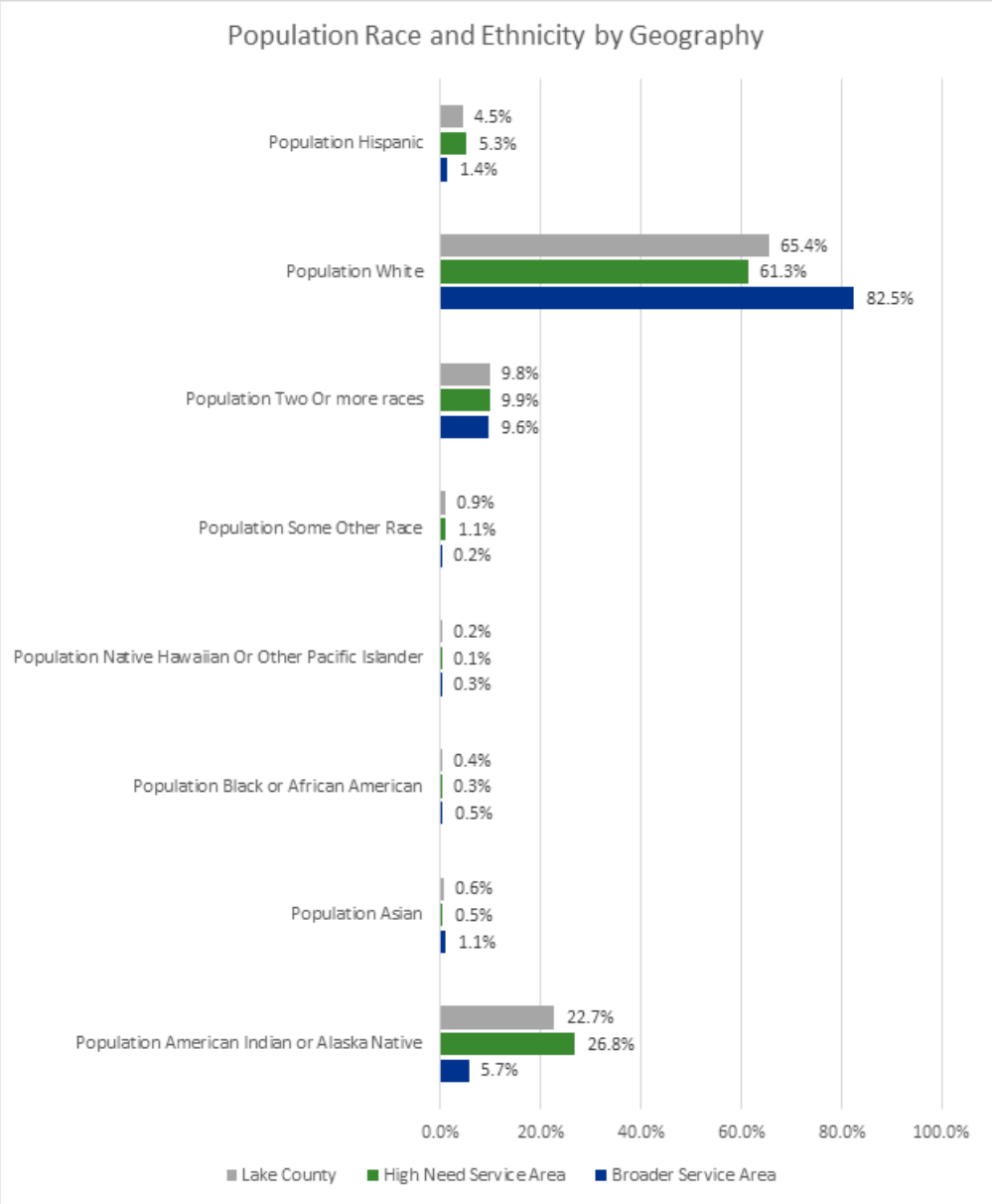


Figure 5: Population Race and Ethnicity by Geography

In Lake County, people who are younger have the most representation in the High Need Area (up to age 54); people who are ages 65-84 are more likely to live in the Broader Need Area. People up to age 34 are over-represented in the High Need Area. People identifying as American Indian or Alaska Native are disproportionately represented in the high need service area, comprising 26.8% of the high need service area, compared to 22.7% of the total population. White people more likely to live in the broader service area, comprising 82.5% of the broader service area compared to 65.4% of the total population. People who identify as Hispanic have more representation in the High Need Area (5.3%) compared to the Broader Need Area (1.4%) and the overall population (4.5%). Population by sex is equally distributed across the service areas.

HEALTH PROFESSIONAL SHORTAGE AREA

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

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

HEALTH INDICATORS

Lake County Data Hub

Please refer to Lake County Data Hub 2023 to review each of the following health indicators mapped at the census tract level:

https://experience.arcgis.com/experience/0ab60e135e7a42ecbf5b84662e127683/

The hub provides data on each indicator in the Lake County high need and broader need service areas, and Montana, as well as information about the importance of each indicator.

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 Lake County; rows in green indicate the Lake County measure is better than the state measure; rows in red indicators where Lake County has worse measures than the broader state measures.

Table 1. Select health indicators[4] for Lake County and state of Montana

Selected Indicator	Lake County	Montana	Need Area
Severe Housing Cost Burden (renter households spending >50% income on housing)	17.8% *(High Need Service Area 19.2%)*	19.3%	Housing Instability
Binge Drinking	21.4%	21.8%	Substance Use/Misuse
Depression	22.3%	23.4%	Mental Health
Coronary Heart Disease	6.1%	2.8%	Chronic Disease
Frequent Mental Health Distress	14.9%	13.8%	Mental Health
Population Uninsured	14% *(High Need Service Area 14.6%; Broader Service Area 7%)*	8.6%	Access
Households Receiving SNAP	14% (*High Need Area 16.3%; Broader Service Area 4.4%)*	9%	Food Insecurity

See Appendix 1 for additional Population Health Data

[4] Source for severe housing cost burden, population uninsured, and households receiving SNAP: American Community Survey (ACS), 2021, 5-year estimate

Source for binge drinking, depression, coronary heart disease, and frequent mental health: Behavioral Risk Factor Surveillance System Survey (BRFSS), 2020

Hospital Utilization Data

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

In 2022, our data showed the following key insights:

- 25.7%; of ED visits were considered avoidable; this represents a decrease of 3 percentage points from the prior CHNA (28.7% in 2019)
- There was a higher percentage of AED visits for patients aged 40-64 years (28.4%) and 18-39 years (27.9%) compared to the total patient population (25.7%)
- 6.4% of all ED visits were behavioral health-related and over half of those were from patients aged 18-39 years; 12.6% of ED visits for patients aged 18-39 years were behavioral health-related, higher than any other age group
- The most common diagnoses for all avoidable ED visits in 2022 were Urinary Tract Infection, Substance Use Disorder and Skin Infection; these diagnoses were the most common avoidable ED visit diagnoses in the prior CHNA, as well

For additional information regarding these findings, please contact Hollie Timmons at hollie.timmons@providence.org.

Montana Index for Healthy Communities

The Montana Index for Healthy Communities (IHC) is a health and social needs index that quantifies social, economic, and health care-related factors that influence the health of Montanans. The IHC shows the health care and socio-economic domains (such as provider supply or housing & transportation) with the most need, as well as the geographic areas that could benefit most from investments in these social drivers of health (SDOH).

Highest need areas in common for Polson and Ronan communities include:

- Treated Prevalence
- Insurance Coverage
- Historically Marginalized
- Income
- Household Structure
- Disease Prevalence

See Appendix 1 for need areas with highest score for Polson and Ronan and definitions of need areas.

County Health Rankings

The County Health Rankings are based on a model of population health that emphasizes the many social, economic, physical, clinical, and other factors that influence how long and how well we live. Countyhealthrankings.org helps counties understand what influences how healthy their residents are and the factors that could determine how long they will live. The Rankings measure the current health of each county and show the differences in health and opportunity by place. They then assess the future health of communities with measures that look at factors such as children living in poverty, access to nutritious foods, smoking rates, obesity rates, and teen births. Finally, selected measures and strategies highlight the intersection of racism, discrimination, and disinvestment to support actions toward equity. [5]

Review measures for Lake County at Countyhealthrankings.org:
https://www.countyhealthrankings.org/explore-health-rankings/montana/lake?year=2023

In 2023, measures in Lake County that show improvement include: Uninsured rate, Dentists, Preventable Hospital Stays, Unemployment, Children in Poverty. Mammography Screening shows a worsening trend.

See Appendix 1 to view the Lake County Snapshot for 2023.

[5] University of Wisconsin Population Health Institute. County Health Rankings & Roadmaps 2023. www.countyhealthrankings.org

COMMUNITY INPUT

Summary of Community Input

To better understand the unique perspectives, opinions, experiences, and knowledge of community members, representatives from Providence St. Joseph Medical Center conducted 11 key informant interviews with representatives from community-based organizations and 2 listening sessions with service providers and people with lived experience. All community input was collected between May and June 2023.

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.

Community-Defined Health and Strengths

Listening session participants were asked to describe their vision of a healthy community and key informants were asked to highlight community strengths. These questions are important for understanding what matters to community members and leveraging what is already working:

Vision for a Healthy Community
•Access to comprehensive services and integrated/collaborative care •Safe and supportive environment •Housing is available for everyone •Social well-being is prioritized •Strong economy

Community Strengths
•Community members embrace sense of community and the communal perspective •Community values cultural preservation and incorporates it into programming •Community demonstrates unity and resilience

Community Needs

HIGH PRIORITY UNMET HEALTH-RELATED NEEDS

Behavioral health challenges and access to care (mental health and substance use/misuse)	Key informants found addressing behavioral health challenges and improving access to care, specifically for mental health and substance use/misuse to be the primary need in Lake County. This requires a comprehensive approach involving increased resources, improved collaboration among healthcare providers, enhanced funding for crisis services, and the development of residential and step-down facilities. The impact of COVID-19 has led to decreased social connections, increased substance use (particularly drinking), and limited resources for individuals with substance use disorders. Barriers to accessing services include the loss of crisis centers and mental health providers, limited supportive services for those returning from treatment or jail, and a shortage of residential treatment facilities. There is a concern that people seeking help for addiction are unable to

	find appropriate services, indicating a need for improved accessibility and availability of addiction treatment options. Furthermore, there is a need for increased mental health support in schools, both at the high school and elementary school levels. Smaller communities also require more community support for mental health resources, particularly for young children. The community is seeing an increase in the number of individuals requiring involuntary commitment and hospitals often face limitations in terms of space and resources to accommodate them. Key informants emphasized that funding and collaboration among healthcare providers are essential to address these challenges.
Homelessness and housing instability	Key informants identified affordable housing and homelessness as a significant concern within the community. Populations identified as particularly affected include elderly individuals, people relying on fixed incomes, and American Indians. It was noted that homelessness may be more widespread than commonly realized. Community members highlighted the lack of shelter and services for people experiencing homelessness and noted that this issue worsened during and after the COVID-19 pandemic. Rising housing costs were identified as a major challenge faced by residents. Key informants suggested that government intervention may be necessary to address the housing issues in the community.

MEDIUM PRIORITY UNMET HEALTH-RELATED NEEDS

Access to health care services	Key informants discussed various challenges related to access to healthcare in the community. These include the need for patient autonomy, in-home care, expanded provider accessibility, patient advocacy, education, and affordability. Additionally, there is a need for improved equipment availability, in-home services for seniors, collaboration among healthcare providers, staffing considerations, geographic distribution of services, and transportation options. Improving access to healthcare services involves educating individuals about available resources and how to access them. Collaboration between critical access hospitals in Lake County and nearby communities, like Missoula and Kalispell, strengthens healthcare resources and relationships. Key informants noted addressing these issues will contribute to better healthcare access and outcomes for the community.
Racism and discrimination	Key informants discussed the presence of racism and discrimination within the community. Highlighted issues include the need for education among healthcare providers on traditional healing practices and systemic racism, the importance of cultural healing and understanding, recognition of tribal affiliation, and addressing the effects of colonialism. Key informants emphasized that embedding diversity, equity, and inclusion (DEI) practices within healthcare is essential. Community members raised concerns regarding potential disparities in care based on an individual's perceived background, appearance, and social connections. It was mentioned that individuals from certain classes may receive different levels of care. The community seeks to create a more inclusive and equitable environment.
Food insecurity and	Key informants emphasized the need to address food insecurity and chronic conditions within the community. The high cost of healthy food, limited access to

chronic diseases	nutritious options, existence of food deserts, and affordability challenges affect the indigenous population, seniors, and residents of rural areas. The COVID-19 pandemic further worsened these issues by causing grocery store closures and job losses. Considering cultural practices, increasing food access, and embracing indigenous foods are identified as potential strategies to improve the health and well-being of the community, particularly for those with chronic conditions.
Economic Insecurity	Key informants discussed economic challenges faced by the community. The pandemic contributed to increased isolation, limited service access, and job losses resulting from grocery store closures and decline in homemaking services. Key informants noted that although job opportunities exist, the cost of living in the community is high, and there is a scarcity of living wage jobs. These factors collectively contribute to economic insecurity within the community.

SIGNIFICANT HEALTH NEEDS

Identification and Prioritization of Significant Health Needs

The Providence St. Joseph Medical Center Advisory Council reviewed the quantitative data and community input and met July 26, 2023 to discuss the findings. The Council voted by online poll to prioritize need areas for the 2023 CHNA, with each participant selecting their three highest priority need areas. The full list of need areas for the voting process is below; bolded need areas indicate those that were identified as high and medium-priority needs through the Community Input process:

Access	Education	**Housing Instability**	**Substance**
Chronic Disease	Environmental Justice	**Mental Health**	**Use/Misuse**
COVID-19	Equity	Obesity	
Disasters	**Food Insecurity**	Physical Activity	
Economic Security	**Homelessness**	Safety	

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 need areas in order of highest number of votes include Mental Health, Substance Use/Misuse, Housing Instability, Food Insecurity, Access, Homelessness, Economic Security, Environmental Justice, and Equity.

2023 Priority Needs

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

MENTAL HEALTH

Mental health programs include the prevention, screening, assessment, and treatment of mental disorders and behavioral conditions. Mental health is an important part of overall health and well-being. Mental health includes our emotional, psychological, and social well- being. In Lake County, key informants emphasize the need for increased resources, improved collaboration among healthcare providers, enhanced funding for crisis services, and the development of residential and step-down facilities.

SUBSTANCE USE/MISUSE

Substance use/misuse occurs when the recurrent use of alcohol and/or drugs causes clinically significant impairment, including health problems, disability, and inability to meet major responsibilities at work, school, or home. Substance use/misuse includes the use of illegal drugs and the inappropriate use of legal substances, such as alcohol, prescription drugs and tobacco. In Lake County, key informants noted decreased social connections, increased substance use (particularly drinking), and limited resources for individuals with substance use disorders; people seeking help for addiction are unable to find appropriate services, indicating a need for improved accessibility and availability of addiction treatment options.

HOUSING INSTABILITY

Housing instability encompasses several challenges such as having trouble paying rent, overcrowding, moving frequently, staying with relatives, or spending the bulk of household income on housing. Households are considered “cost burdened” if spending more than 30% of household income on housing, and "severely cost burdened” if spending more than 50% of household income on housing. Cost-burdened households have little left over each month to spend on other necessities such as food, clothing, utilities, and health care. Key informants in Lake County identified populations affected by housing instability in particular to be elderly individuals, people relying on fixed incomes, and American Indians and the rising cost of housing to be a major challenge in the community.

FOOD INSECURITY

Food insecurity refers to uncertainty surrounding access to and availability of nutritious food because of lack of money and other resources. Food insecurity may be long term or temporary. It may be influenced by a number of factors including income, employment, race/ethnicity, and disability. In Lake County, the high cost of healthy food, limited access to nutritious options, existence of food deserts, and affordability challenges affect the indigenous population, seniors, and residents of rural Lake County.

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 Confederated Salish and Kootenai Tribes (CSKT) Tribal Health Community Health Assessment (2022) and Clark Fork Valley Hospital Community Health Needs Assessment (2023).

The Providence St. Joseph Medical Center Advisory Council reviewed these CHNA reports to confirm alignment with government and non-profit organizations serving Lake County. The following summary provides an overview of the priorities identified by the organizations. The findings of these assessments are consistent with community input received in our CHNA process as well as with quantitative data.

CSKT TRIBAL HEALTH COMMUNITY HEALTH ASSESSMENT (2022)

Results

CSKT Tribal Health Department volunteers recruited and surveyed a total of 210 participants from across 30 community neighborhoods in the from July 12-16, 2022.

Disparities observed commonly occurred by gender, low education attainment, unemployed but looking for work, poor physical and mental health, and younger age groups.

Most participants reported strong community cohesion in terms of attitudes on safety, being a good place to grow old and have children, knowing the first names of their neighbor(s), access to healthcare, etc. A top concern was having affordable housing. Nearly half were concerned about illegal drug use and over a third were worried about suicide in their communities. Over half attended the local powwows and nearly half reported having access to cultural support in their community. (*Excerpted from report, page 9*)

Significant Findings

Mental health (risk factor for suicide)

Unemployment

Food insecurity

Link to document

CLARK FORK VALLEY HOSPITAL COMMUNITY HEALTH NEEDS ASSESSMENT (2023)

Key Findings of Health Concerns in Sanders County

1. Mental Health
2. Substance Abuse
3. Access to Care
4. Assisted Living Facilities
5. Social Determinants of Health

Link to document

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 Lake County Public Health, CSKT Tribal Health, and St. Luke Community Healthcare. 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

EVALUATION OF 2021-2023 CHIP

The 2020 CHNA and 2021-2023 CHIP priorities were the following: Access to Mental Health Services, Access to Substance Abuse Disorder Treatment Services and Safe and Affordable Housing. This report evaluates the impact of the 2021-2023 Community Health Improvement Plan (CHIP). Providence St. Joseph Medical Center responded to community needs by making investments of direct funding, time, and resources to internal and external programs dedicated to addressing the previously prioritized needs using evidence-based and leading practices.

Table 1. Results and Outcomes from 2021-2023 CHIP

Priority Need	Program or Service	Results/Outcomes
Access to Mental Health Services	Integrated mental health care in primary care setting	5% improvement in rate of patients with depression treatment response
Access to Mental Health Services	Increase inpatient treatment access; Increased regional coordination for acute mental health services; Improved mental health crisis response	Increase of 13 patients admitted to inpatient mental health in 2022 at Providence St. Patrick Hospital from Lake County over 2020 baseline
Access to Mental Health Services	Trauma-informed care for rural youth	Strategic Alliance (includes CSKT, Shodair, schools, jail, health care) in ongoing strategy meetings, including potential grant funding of mental health coordinator for Lake County Providence SJMC contribution to support new Youth Dynamic office in Polson
Access to Substance Abuse Disorder Treatment Services	IMAT (Integrated Medication-Assisted Treatment)	6 Providence Medical Group providers with IMAT training in Polson and Ronan as of January 2023
Access to Substance Abuse Disorder Treatment Services	Community partnerships in support of substance use disorder services; Journey of Hope	Original Journey of Hope work to be integrated into longer-term Meadowlark Initiative to maintain and improve access to SUD treatment 2022: 155 obstetrics patients screened, with patients who screen positive referred for additional resources
Access to Substance Abuse Disorder Treatment Services	Improved access to chemical dependency evaluations	All PMG patients screened for alcohol use disorder at annual wellness visits starting April 2023 CSKT Tribal Health has 4 Licensed Alcohol Counselors (LACs) as of February 2022

Access to Substance Abuse Disorder Treatment Services	Collaborate with community-based organizations to increase access to peer support services	Never Alone Recovery Support Services (NARSS) based in Ronan offers individual peer and group support Community Health Worker provides peer support within PMG clinic
Safe and Affordable Housing	Collaborate with SKC Tribal Housing Authority and COC representative to assess community need	2013-2017 ACS baseline severe cost burden for housing: 14.2% vs. 14% 2017-2021. The Tribal Housing Authority completed a housing needs assessment with support from the Montana Healthcare Foundation, National Indian Housing Council and the Office of Public & Indian Housing.
Safe and Affordable Housing	Community partnerships in support of housing stability	Medical-Legal Partnership with Montana Legal Service Association launched in May 2020; 40% of initial reason for patient referral to program related to housing Community Solutions Built for Zero initiative/technical assistance to end homelessness potential in Lake County in future

Addressing Identified Needs

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

Because partnership is important when addressing health needs, the CHIP will describe any planned collaboration among Providence St. Joseph Medical Center and community-based organizations in addressing the health need. The CHIP will be approved and made publicly available no later than May 15, 2024.

2023 CHNA GOVERNANCE APPROVAL

This Community Health Needs Assessment was recommended for approval by the Providence St. Joseph Medical Center Advisory Council[6] on September 27, 2023 and approved by the Montana Service Area Community Mission Board[7] on October 24, 2023. The final report was made widely available by December 28, 2023.

Kirk Bodlovic 10-26-2023
Kirk Bodlovic Date
Interim Chief Executive and Chief Operating Officer, Montana Service Area
Providence

11/16/23
Mark Williams Date
Chair, Providence Montana Service Area Community Mission Board

11/20/23
Joel Gilbertson Date
Chief Executive, Central Division
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[6] **See Appendix 4:** Providence St. Joseph Medical Center Advisory Council

[7] **See Appendix 5:** Providence Montana Service Area Community Mission Board and Executive Team Representatives

APPENDICES

Appendix 1: Quantitative Data

POPULATION LEVEL DATA

Please refer to Lake County Data Hub 2023 to review each of the following health indicators mapped at the census tract level:

https://experience.arcgis.com/experience/0ab60e135e7a42ecbf5b84662e127683/

Lake County Demographics

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

Indicator	Lake County	Broader Service Area	High Need Service Area
Population by Age Groups			
Total Population	31,030	6,069	24,961
Population Age Under 5	5.7% (1,757)	3.2% (196)	6.3% (1,561)
Population Age Under 18	23.4% (7,253)	17.5% (1,061)	24.8% (6,192)
Population Ages 18 to 34	18.2% (5,637)	15.1% (918)	18.9% (4,719)
Population Ages 35 to 54	21.4% (6,636)	20.7% (1,256)	21.6% (5,380)
Population Ages 55 to 64	14.9% (4,632)	16.0% (971)	14.7% (3,661)
Population Ages 65 to 84	20.5% (6,357)	29.6% (1,799)	18.3% (4,558)
Population Age 85 and Over	1.7% (515)	1.1% (64)	1.8% (451)
Population by Gender			
Female	50.3% (15,602)	50.3% (3,050)	50.3% (12,552)
Male	49.7% (15,428)	49.7% (3,019)	49.7% (12,409)
Population by Race			
American Indian and Alaska Native	22.7% (7,038)	5.7% (346)	26.8% (6,692)
Asian Population	0.6% (197)	1.1% (68)	0.5% (129)
Black or African American Population	0.4% (112)	0.5% (30)	0.3% (82)
Native Hawaiian and Other Pacific Islander Population	0.2% (48)	0.3% (18)	0.1% (30)
Other Race Population	0.9% (279)	0.2% (14)	1.1% (265)
Two or more Races Population	9.8% (3,048)	9.6% (585)	9.9% (2,463)
White Population	65.4% (20,308)	82.5% (5,008)	61.3% (15,300)

Population by Ethnicity			
Hispanic Population	4.5% (1,396)	1.4% (0,085)	5.3% (1,311)

Table 1_Apx 1. Additional Selected Health Indicators from Lake County Data Hub

Health Indicator[8]	Montana	Lake County	Lake County High Need Area	Lake County Broader Need Area
Population Below 200% Federal Poverty Level	31.1%	37.9%	40.0%	26.7%
Population with at Least a High School Education	94.4%	92.3%	90.8%	97%
Household Median Income	$60,456	$53,481	$51,210	$68,845
Percent of Labor Force Unemployed	4.1%	6.1%	7.0%	3.2%
Percent of Households Receiving SNAP Benefits	9.0%	14.0%	16.3%	4.4%

[8] 2021 American Community Survey, 5-Year Estimate

Montana Index for Healthy Communities

The Montana Index for Healthy Communities (IHC) is a health and social needs index that quantifies social, economic, and health care-related factors that influence the health of Montanans. It was developed by Montana Health Research and Education Foundations and Cynosure Health. Many health outcomes are associated with non-clinical factors, such as access to housing or healthy food. A social needs index like the IHC can identify opportunities to improve health through investing both within and beyond the health care delivery system.

The IHC shows the health care and socio-economic domains (such as provider supply or housing & transportation) with the most need, as well as the geographic areas that could benefit most from investments in these social drivers of health (SDOH). With insights from the index, hospitals and their partners can imagine new ways to collaborate and support the communities with the greatest need.

Higher scores indicate higher levels of need (closer to 100) and lower scores indicate lower need (closer to zero). The IHC includes the most recent data available for each metric as of June 2022.

Highest need areas by index score: Polson

Overall IHC Score: 72

Treated Prevalence (88)

Measure of the conditions for which patients are seeking care, especially for conditions that may be undertreated due to lack of access to care, such as mental health or substance use disorders.

Insurance Coverage (86)

Indicator of the type of health insurance most prevalent in the community, including both the proportion of uninsured and the proportion of individuals with public-only health insurance.

Historically Marginalized (81)

Measure of the proportion of the community who identify as one or more historically marginalized population, which may be at greater risk for adverse health outcomes.

Income (76)

Indicator of overall levels of poverty within the community.

Household Structure (76)

Indicator of increased risk for adverse health outcomes associated with family structure.

Highest need areas by index score: Ronan

Overall IHC Score: 81

Insurance Coverage (89)

Indicator of the type of health insurance most prevalent in the community, including both the proportion of uninsured and the proportion of individuals with public-only health insurance.

Treated Prevalence (88)

Measure of the conditions for which patients are seeking care, especially for conditions that may be undertreated due to lack of access to care, such as mental health or substance use disorders.

Household Structure (85)

Indicator of increased risk for adverse health outcomes associated with family structure.

Historically Marginalized (84)

Measure of the proportion of the community who identify as one or more historically marginalized population, which may be at greater risk for adverse health outcomes.

Disease Prevalence (84)

An indicator of how common chronic diseases are in the community, as compared with others across the state. Includes measures of medical and dental conditions.

Income (83)

Indicator of overall levels of poverty within the community.

County Health Rankings

Table 2_Apx 1. County Health Rankings County Snapshot 2023: Lake County

County Snapshot 2023: Lake County[9]

Areas to Explore | Areas of Strength | Trends Available

Health Outcomes			
Length of Life	**Lake County**	**Montana**	**United States**
Premature Death	10,400	7,500	7,300
Quality of Life	**Lake County**	**Montana**	**United States**
Poor or Fair Health	14%	12%	12%
Poor Physical Health Days	3.4	3.3	3.0
Poor Mental Health Days	4.7	4.5	4.4
Low Birthweight	8%	8%	8%
Additional Health Outcomes (not included in overall ranking)	**Lake County**	**Montana**	**United States**
Life Expectancy	77.1	78.4	78.5
Premature Age-Adjusted Mortality	420	350	360
Child Mortality	90	50	50
Infant Mortality		5	6
Frequent Physical Distress	11%	10%	9%
Frequent Mental Distress	15%	14%	14%
Diabetes Prevalence	10%	8%	9%
HIV Prevalence	96	75	380
Health Factors			
Health Behaviors	**Lake County**	**Montana**	**United States**
Adult Smoking	20%	18%	16%
Adult Obesity	32%	29%	32%
Food Environment Index	8.3	7.7	7.0
Physical Inactivity	21%	18%	22%
Access to Exercise Opportunities	51%	73%	84%
Excessive Drinking	24%	24%	19%
Alcohol-Impaired Driving Deaths	54%	46%	27%
Sexually Transmitted Infections	472.8	386.7	481.3
Teen Births	32	20	19
Additional Health Behaviors (not included in overall ranking)	**Lake County**	**Montana**	**United States**
Food Insecurity	12%	9%	12%
Limited Access to Healthy Foods	2%	7%	6%
Drug Overdose Deaths	14	13	23

[9] University of Wisconsin Population Health Institute. County Health Rankings & Roadmaps 2023. www.countyhealthrankings.org

Insufficient Sleep		33%	30%	33%
Clinical Care		**Lake County**	**Montana**	**United States**
Uninsured		19%	11%	10%
Primary Care Physicians		1,410:1	1,210:1	1,310:1
Dentists		1,230:1	1,350:1	1,380:1
Mental Health Providers		380:1	280:1	340:1
Preventable Hospital Stays		2,525	1,926	2,809
Mammography Screening		35%	38%	37%
Flu Vaccinations		36%	45%	51%
Additional Clinical Care (not included in overall ranking)		**Lake County**	**Montana**	**United States**
Uninsured Adults		22%	12%	12%
Uninsured Children		10%	7%	5%
Other Primary Care Providers		970:1	680:1	810:1
Social & Economic Factors		**Lake County**	**Montana**	**United States**
High School Completion		92%	94%	89%
Some College		61%	69%	67%
Unemployment		3.8%	3.4%	5.4%
Children in Poverty		21%	15%	17%
Income Inequality		5.2	4.4	4.9
Children in Single-Parent Households		30%	20%	25%
Social Associations		9.4	13.8	9.1
Injury Deaths		104	94	76
Additional Social & Economic Factors (not included in overall ranking)		**Lake County**	**Montana**	**United States**
High School Graduation		90%	85%	87%
Disconnected Youth		13%	8%	7%
Reading Scores			3.1	3.1
Math Scores			3.0	3.0
School Segregation		0.10	0.26	0.25
School Funding Adequacy		-$1,702	$2,692	$1,062
Gender Pay Gap		0.75	0.77	0.81
Median Household Income		$51,000	$63,400	$69,700
Living Wage		$43.89	$44.83	$45.00
Children Eligible for Free or Reduced Price Lunch				53%
Residential Segregation - Black/White		61	80	63
Child Care Cost Burden		37%	36%	27%
Child Care Centers		4	4	7
Homicides		8	4	6
Suicides		35	26	14
Firearm Fatalities		23	20	12

Motor Vehicle Crash Deaths	20	17	12
Juvenile Arrests	33	38	24
Voter Turnout	72.6%	73.3%	67.9%
Census Participation	44.5%		65.2%
Physical Environment	**Lake County**	**Montana**	**United States**
Air Pollution - Particulate Matter	7.9	4.6	7.4
Drinking Water Violations	No		
Severe Housing Problems	15%	14%	17%
Driving Alone to Work	73%	74%	73%
Long Commute - Driving Alone	23%	18%	37%
Additional Physical Environment (not included in overall ranking)	**Lake County**	**Montana**	**United States**
Traffic Volume	70	193	505
Homeownership	72%	69%	65%
Severe Housing Cost Burden	14%	12%	14%
Broadband Access	80%	85%	87%

Note: Blank values reflect unreliable or missing data.

HEALTH PROFESSIONAL SHORTAGE AREA

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

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

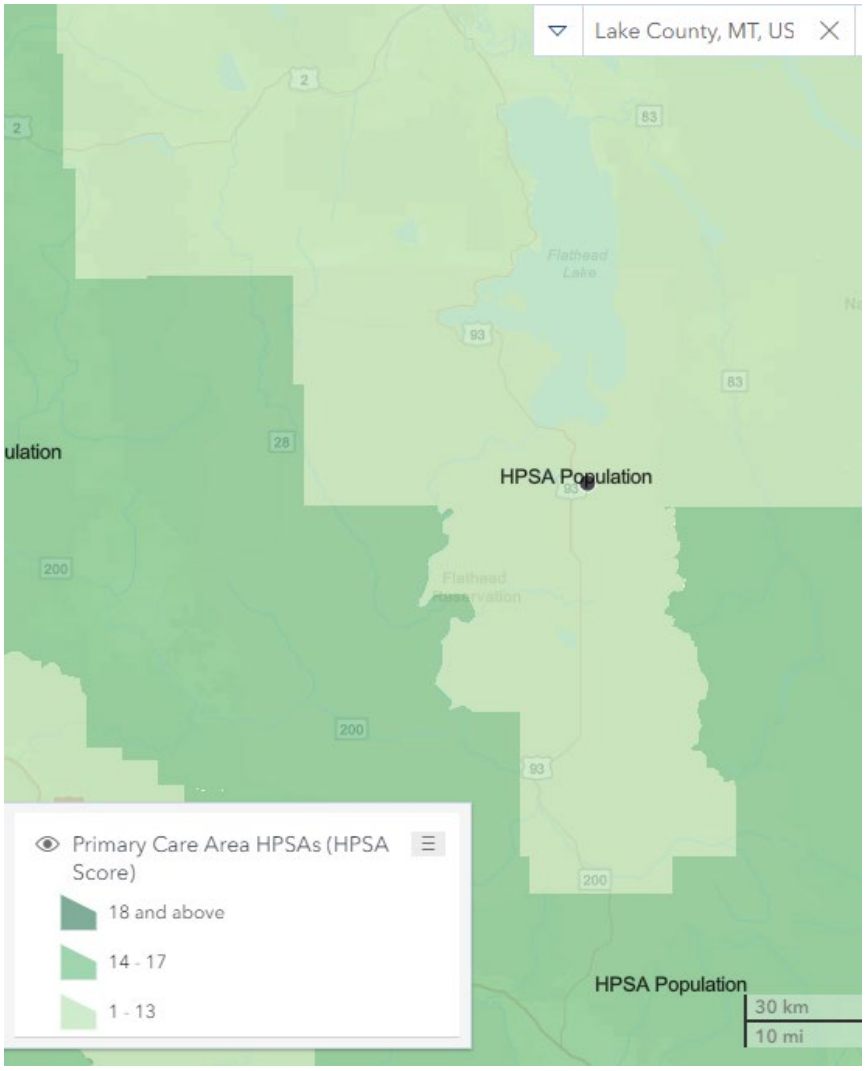

Figure 1_Apx 1. Primary Care Area HPSA

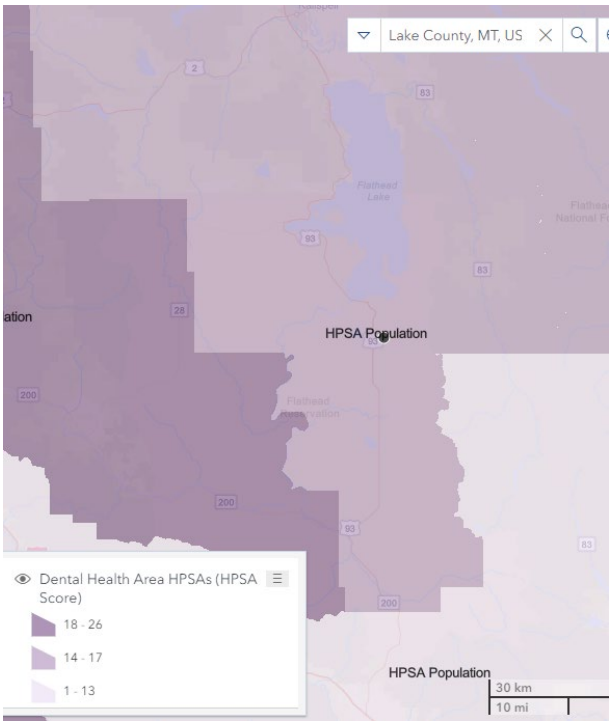

Figure 2_Apx 1. Dental Health Area HPSA

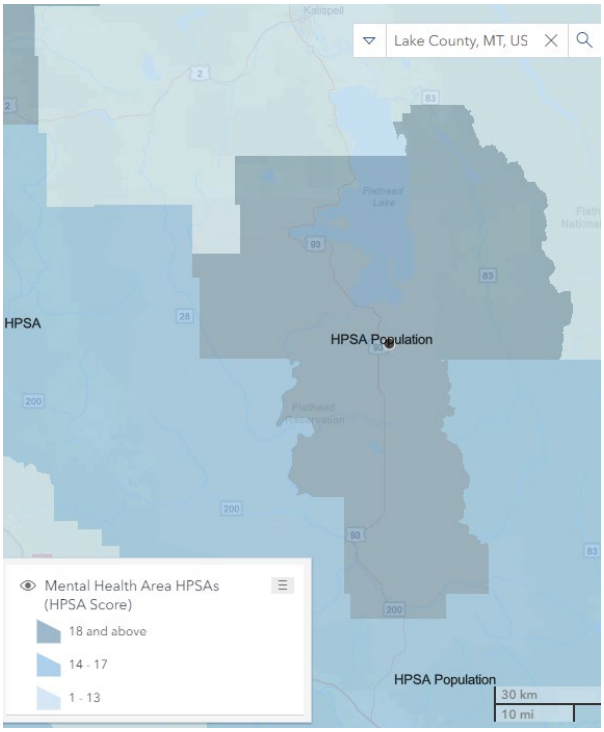

Figure 3_Apx 1. Mental Health Area HPSA

MEDICALLY UNDERSERVED AREA/ MEDICAL PROFESSIONAL SHORTAGE AREA

Medically Underserved Areas (MUAs) and Medically Underserved Populations (MUPs) are defined by the Federal Government to include areas or populations that demonstrate a shortage of health care services. This designation process was originally established to assist the government in allocating the Community Health Center Fund to the areas of greatest need. MUAs are identified by calculating a composite index of need indicators compiled and with national averages to determine an area's level of medical "under service." MUPs are identified based on documentation of unusual local conditions that result in access barriers to medical services. MUAs and MUPs are permanently set and no renewal process is necessary. The following map depicts the MUAs in the Providence St. Joseph Medical Center service area. The service area does not have any MUPs.

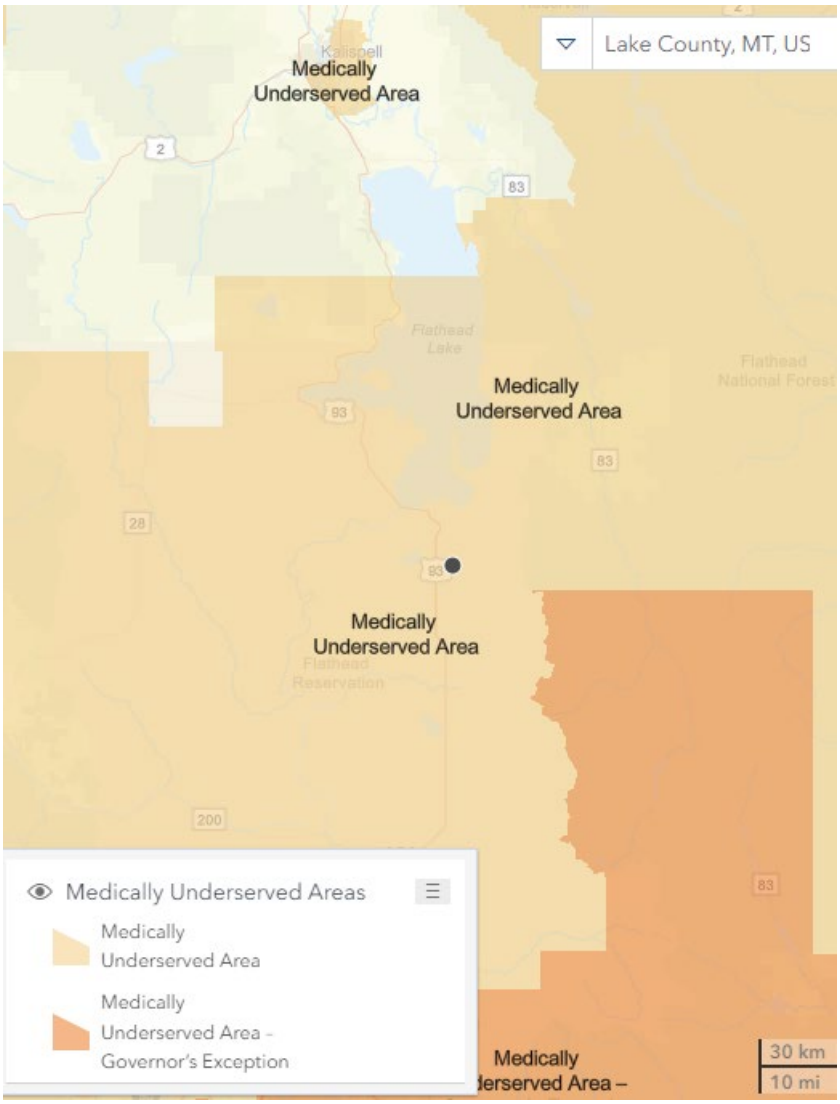

Figure 4_Apx 1. Medically Underserved Area

Appendix 2: Community Input

METHODOLOGY

Participants

The hospital completed two listening sessions that included a total of 19 participants. The sessions took place in June 2023.

Table_Apx 1: Community Input

Community Input Type	Population	Community Partner	Location	Date	Language
Listening Session	Service providers in public health and youth mental health	Youth Dynamics, Lake County Health Department, Providence Community Health Worker	Providence St. Joseph Medical Center, Polson, MT	6/6/23	English
Listening Session	People with lived experience with addiction; people in recovery from substance misuse	NARSS (Never Alone Recovery Support Services)	NARSS Recovery Hall, Ronan, MT	6/13/23	English

The hospital completed 11 key informant interviews that included a total of 13 participants. The interviews took place between May and June 2023.

The goal was to engage representatives from social service agencies, health care, education, housing, and government, among others, to ensure a wide range of perspectives. The hospital included the Health Services Director from Lake County Public Health and CSKT Tribal Health Community Health Division Director as 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
Cherry Valley Elementary	Terez'a Hanson	School Counselor	Education
Confederated Salish & Kootenai Tribes Tribal Health	Chelsea Kleinmeyer	Division Leader	Public Health
Family Medicine Residency of Western Montana, University of Montana	Drew Babcock	American Indian Outreach & Project Coordinator	Health Care / Education

Lake County Attorney's Office	James Lapotka	County Attorney	Government
Lake County Council on Aging	Bev Dalke	Office Manager	Agency on Aging
Lake County Council on Aging	Zayna Irish	Administrative Assistant	Agency on Aging
Lake County Health Department	Emily Colomeda	Health Services Director	Public Health
Montana Food Bank Network	Gayle Carlson	President and CEO	Food Access
Polson High School	Andy Fors	Principal	Education
SAFE Harbor	Brandi Clark	Executive Director	Domestic Violence
SAFE Harbor	Dana Grant	Director of Development	Domestic Violence
Salish Kootenai College	Alana Bahe	Director, Community Health Development	Health care / Education
Western Montana Area Health Education Center, University of Montana	Chelsea Bellon	Health Equity & Community Engagement Specialist	Health care / Education

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 used across all hospitals completing their 2023 CHNAs:

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

Training

The facilitation guides provided instructions on how to conduct a key informant interview 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 SESSIONS

Vision of a Healthy Community

Listening session participants were asked to share their vision of a healthy community. The following themes emerged:

Access to comprehensive services and integrated/collaborative care: Wraparound services, including housing and mental health, medical detox, treatment, mental health services, harm reduction, and crisis psychiatric services, are essential components of a healthy community. Community members suggested the community-wide Recovery-Oriented System of Care (ROSC) model ensures an open-door approach to recovery and collaboration among service providers, preventing siloed services and systems. Additionally, adequate access to healthcare services for the older population and affordable, accessible long-term care are crucial for a healthy community.

Safe and supportive environment: A healthy community provides a safe environment for individuals, access to resources for those experiencing abuse or domestic violence, and opportunities for community support groups. Additionally, there is decreased travel distances and better transportation to access help. Lower crime rates, decreased rates of suicide and overdoses signify a healthy community.

"If you feel like you're on an island, it makes it a lot harder to obtain what you need."- Community member

Housing is available for everyone: Availability of emergency shelter year-round, reduced barriers to housing, and presence of more affordable housing options help contribute to a healthy community.

"People don't worry about their physical health until their base needs are met. - Community member

Social well-being is prioritized: Intergenerational activities that bring different age groups together, support from people instead of relying solely on digital interfaces, and adequate access to mental health care and crisis services promote social connections and well-being.

Strong economy: A good economy with low unemployment, living wages, purchasing power, and food and housing security are indicators of a healthy community.

In summary, listening session participants described a healthy community as one with access to comprehensive services, including wraparound services, mental health care, and housing. It provides a safe environment and support through community groups, while also implementing a collaborative and integrated approach to care. The presence of emergency shelter, reduced barriers to housing, and shorter travel distances for assistance contribute to community well-being. Social well-being is promoted through intergenerational activities and support from people rather than relying solely on digital interfaces. A healthy community also ensures economic stability, food, and housing security, along with adequate support for underserved populations and access to mental health care and crisis services. Positive indicators include lower crime rates, and decreased rates of suicide and overdoses.

Community Needs

Community needs identified from listening sessions

Mental health and substance use/misuse: Community members identified a need for improved detox services, including treatment and case management, to support individuals in their journey towards recovery from addiction. The community expressed concerns about the lack of a dedicated mental health crisis stabilization facility. There is a concern that people seeking help for addiction are unable to find appropriate services, indicating a need for improved accessibility and availability of addiction treatment options. Participants highlighted the lack of local options for addressing behavioral crises in youth, leading to redirection to distant facilities. There is a need for more accessible behavioral crisis intervention services for youth within the community. Community members expressed a desire for more resources, similar to the Recovery Hall, to support individuals in their recovery from addiction. Participants emphasized the need for improved community awareness of available mental health/substance use/misuse resources, such as community events, outreach programs, and networking opportunities, to ensure individuals can easily access the support they need. Participants also mentioned that there is a shortage of therapists in the area, and some therapists struggle to afford living in the community due to relatively low pay. Increasing the number of available therapists and addressing the financial challenges they face are important.

Discrimination and Stigma: Community members discussed experiencing stigma associated with seeking public health resources, such as STI testing. Participants also highlighted instances where healthcare staff's attitudes and biases negatively impacted the quality of care received by individuals, emphasizing the need for healthcare providers to treat patients with respect and dignity. Participants mentioned the importance of a warm hand-off process, particularly after an emergency department visit, to ensure individuals can easily access the next service provider. There is a need to challenge and overcome negative stereotypes and biases associated with addiction and recovery. Participants emphasized that people can and do recover, and healthcare providers should approach them with empathy and support. Some emergency healthcare providers were mentioned as having a negative attitude toward individuals on medications like suboxone, which can impact the quality of care provided. Additionally, concerns were raised regarding disparities in care based on an individual's background, appearance (such as tattoos),

and social connections. It was mentioned that individuals perceived to be 'lower class" may receive different levels of care.

"I think a lot of people think we don't recover. We do. We dynamically recover."- Community member

Access to health care services: There is a need for integrated services that provide comprehensive care, allowing individuals to access multiple services they require from a single location or provider. Concerns were raised about the affordability of healthcare, as some health needs may not be covered by the insurance coverage that individuals qualify for. There is a need for more comprehensive and affordable healthcare options. Participants mentioned that the paperwork process for Medicaid redetermination is not a priority for individuals dealing with housing and food insecurity. Frequent address changes can result in individuals not receiving the necessary paperwork. Streamlining the process and addressing the barriers to redetermination are important. Participants highlighted the need for improved transportation services within Lake County, as well as transportation to services in nearby areas like Missoula and Kalispell, to ensure community members can access necessary healthcare and resources.

Comprehensive and integrated services: The community emphasized the need for services that address all social determinants of health, recognizing that health is influenced by various factors beyond just medical care. There is a need for integrated services that provide comprehensive care, allowing individuals to access multiple services they require from a single location or provider. The community expressed a need for more support group options, particularly for trauma recovery and single fathers, to address specific needs within the community.

Homelessness and housing instability: Community members expressed a need for better cooperation and coordination between different agencies and levels of government to address homelessness and related challenges. It was noted that there is a tendency for each entity to view the issue as someone else's responsibility. Participants highlighted the lack of shelter and services for people experiencing homelessness, and noted that this issue worsened during and after the COVID-19 pandemic. More comprehensive services are necessary. Additionally, the community expressed a need for more affordable housing options, including for individuals on the violent/sexual offender registry, as stable housing plays a crucial role in overall health and well-being.

FINDINGS FROM KEY INFORMANT INTERVIEWS

Community Strengths

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

Key informants highlighted several strengths within the community. These include a sense of community and communal perspective, cultural preservation efforts, unity, responsiveness, diverse population, and resilience. Leveraging existing relationships, partnerships, and community support is crucial for further

collaboration and addressing mental health needs. The community's strengths provide a foundation for continued growth, cultural relevance, and well-being.

Sense of community and communal perspective: There is a strong sense of coming together and embracing a community perspective. The community values the ability to maintain an indigenous way of life, supported by tribal council resolutions that integrate cultural values and language into daily life. Organizations work collaboratively to serve the community. Key informants suggested existing relationships within the community should be strengthened and leveraged.

"People know each other, people want to support each other; people are here to take care of each other." – Key Informant

Cultural preservation and programming congruence: The community has prioritized culture and language through resolutions and efforts to ensure programming aligns with cultural values. Traditional culture is valued and highlighted by organizations.

Unity and community responsiveness: The community has demonstrated great cohesion, with strong ties and connections. People are very resilient, and willing to help each other. There is a community-wide responsiveness to problems or challenges that arise.

"It's like a family community…everybody watches out for everybody else. It's tight-knit."- Key Informant

Key informants discussed how leveraging community strengths to meet the needs in their community involves collaboration among all organizations within the community and sharing common goals. Partnering with Tribal entities can ensure culturally relevant and appropriate programs. Continuing to strengthen collaboration is crucial, as different communities possess unique resources that can be shared for the collective benefit. Recognizing the interconnectedness of various areas and persisting in efforts to enhance collaboration will contribute to overall improvement.

High Priority Unmet Health-Related Needs

Key informants were asked to identify their top five health-related needs in the community. Two needs were prioritized by most key informants and with high priority. Four additional needs were categorized as medium priority. Key informants were most concerned about the following health-related needs:

1. Behavioral health challenges and access to care (mental health and substance use/misuse)
2. Homelessness and housing instability

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

Most key informants spoke to Behavioral health challenges and access to care (mental health and substance use/misuse) as a big issue in Lake County and the primary need. Key informants suggested addressing these behavioral health needs requires a comprehensive approach, including increased resources, improved collaboration among healthcare providers, enhanced funding for crisis services, and the development of residential and step-down facilities within the community. Additionally, efforts should focus on increasing mental health support within schools, particularly for

college students and young children, and providing timely access to substance use evaluation and counseling services.

Impact of COVID-19: Lockdowns and isolation during the pandemic have affected social connections and socializing, particularly among college students. Substance use, specifically drinking, has increased during this period.

Insufficient resources for substance use issues: There is a lack of resources for individuals with substance use disorders. Access to services like chemical dependency evaluations and counseling is limited, and there is uncertainty about where to send people in need of these services in a timely manner. Additionally, there is a shortage of residential inpatient treatment and step-down facilities in the community. People are being sent to other communities for residential care, and the services available upon their return are insufficient to support recovery. Key informants discussed how retaining certified providers in the community is difficult.

"Inpatient treatment is very resource-intensive, but we don't have the environment for people to succeed afterwards."- Key Informant

Additionally, key informants discussed how when an individual requires involuntary commitment, hospitals often face limitations in terms of space and resources to accommodate them until their court hearing. As a result, the state hospital ends up being the default option, rather than serving as a last resort as intended. To address these needs, key informants called for better funding for behavioral health crises services as well as a need for further collaboration among healthcare providers.

"The most urgent unmet health need is mental health care. We don't have an effective emergency detention health care solution in either hospital. We're seeing a significant increase in the need to do involuntary commitments."- Key Informant

Barriers to accessing behavioral health services: The loss of crisis centers and mental health providers poses a challenge. While some services are available through tribal health services, more resources are needed for both tribal and general populations, especially for children living on the Flathead Reservation. There is also a lack of supportive services for individuals returning to the community from treatment or jail.

Mental health support in within schools: High schools have witnessed an increase in anxiety and attendance issues, exacerbated by the COVID-19 pandemic. Key informants discussed how both teachers and students are in need of more mental health support. However, the availability of mental health resources within schools has decreased, with only a limited number of guidance counselors available. Despite the presence of some mental health resources within the community, connecting families in the school system to these services has proven challenging. The primary obstacle is the absence of a dedicated mental health support structure within schools. There is also a need for behavioral health services in elementary schools. Outside counseling resources have been lost, and waitlists exist for accessing therapy. There is a need for more mental health support within schools.

Smaller-scale efforts and community support: There is a need for more community support for mental health resources, particularly for young children, in smaller communities. There are limited recovery services, including a shortage of service providers, especially for the younger population.

Key informants shared certain populations have been especially impacted:

- **Adolescents:** Adolescents in high school are experiencing a rise in anxiety and attendance issues, particularly exacerbated by the COVID-19 pandemic. Additionally, substance use, especially drinking, increased among college students.
- **People involved in the criminal legal system:** Upon reintegration into the community from treatment or jail, individuals face a lack of adequate supportive services. It is necessary for the hospitals to financially support the providers of these services to address the existing gap.
- **American Indians:** American Indians in Lake County face significant challenges related to intergenerational poverty, trauma, limited opportunities from colonialism that contributed to multigenerational struggles with substance use/misuse and addiction.

Homelessness and housing instability

Key informants identified affordable housing and homelessness as a significant concern within the community. Populations identified as particularly affected include elderly individuals, people relying on fixed incomes, and American Indians. It was noted that homelessness may be more widespread than commonly realized. Rising housing costs were identified as a major challenge faced by residents. Key informants suggested that government intervention may be necessary to address the housing issues in the community.

Key informants shared housing needs of specific populations:

- **Older adults:** There is a lack of available housing options for the elderly. Existing options are struggling with scarcity of homemaking services, primarily due to insufficient personnel to meet the demand. These services encompass various tasks such as housekeeping, meal preparation, laundry, respite care, and companionship. Even when positions are approved, it may take months to find a suitable candidate.
- **American Indians:** American Indians are experiencing disproportionate impact from intergenerational poverty, limited opportunities, and exposure to unstable housing conditions.

Medium Priority Unmet Health-Related Needs

Four additional needs were often prioritized by key informants:

1. Access to health care services
2. Racism and discrimination
3. Economic insecurity
4. Food insecurity and chronic diseases

Access to health care services

Key informants identified several needs to improve access to health care services within the community.

Cultural competency and patient advocacy: Key informants indicated healthcare providers need more education on traditional healing systems and an understanding of how systemic racism and socioeconomic barriers impact health. Key informants emphasized that native people should have ownership over their own health and be allowed to make their own healthcare decisions. Greater access to patient advocacy is needed, along with the ability to explain healthcare processes to individuals who may not understand the Westernized medicine approach. Key informants called for cultural competence and awareness of broader social factors influencing health outcomes.

In-home care and accessibility: There is a need for more opportunities for in-home care, as well as increased accessibility to healthcare providers beyond brief face-to-face encounters. People with disabilities and elderly people in particular lack adequate access to necessary equipment (e.g., wheelchairs, walkers) and in-home services. Key informants emphasized the need for improved support and resources in these areas.

Impact of the pandemic on access to healthcare: The COVID-19 pandemic has created increased isolation and barriers to accessing healthcare services, which may persist. This highlights the need to address ongoing challenges stemming from the pandemic.

Affordability of healthcare coverage: Affordable healthcare coverage is identified as an issue, as some individuals may not qualify for Medicaid, and Medicare can be expensive. This suggests a need for accessible and affordable insurance options for all community members.

Collaboration among healthcare providers: There is a call for greater collaboration among healthcare providers, including services related to sexual assault and adolescent health.

Staffing and geographic concentration of healthcare services: Staffing issues and the concentration of healthcare services in certain areas of the county are identified as barriers. Suggestions include leveraging the resources of larger neighboring communities and partnering with other healthcare providers to deliver care more effectively.

Transportation as a barrier: Transportation is highlighted as a barrier to accessing healthcare, although there are tribal transportation systems and satellite clinics in smaller communities. This emphasizes the need for improved transportation options to ensure equitable access to care.

Outreach and collaboration: Key informants identified that improving access to healthcare services involves educating individuals about available resources and how to access them, ensuring information reaches young people who may not receive it from their parents. Leveraging services from neighboring areas and bringing them to underserved regions can enhance access and convenience. Collaboration between critical access hospitals in Lake County and nearby communities, like Missoula and Kalispell, strengthens healthcare resources and relationships.

Key informants highlighted the needs of specific populations:

- **Adolescents:** Adolescents need expanded access to family planning, addressing STDs, providing contraceptive services, educating them about the reproductive system, promoting healthy relationships, and supporting their identity exploration as they navigate through this developmental stage.

- **People with disabilities:** Individuals with disabilities face challenges in accessing necessary equipment such as wheelchairs and walkers.
- **Older adults:** Insufficient in-home services are available for elderly individuals needing assistance. It is crucial for hospitals to assess individuals' situations thoroughly before they are discharged to ensure appropriate support upon their return home.

Racism and discrimination

Key informants spoke to the presence of racism and discrimination within the community. The highlighted issues include the need for education on traditional healing practices and systemic racism, the importance of cultural healing and understanding, recognition of tribal affiliation, addressing the effects of colonialism, and embedding diversity, equity, and inclusion (DEI) practices within healthcare. By fostering cultural competence and bridging tribal/non-tribal divides, the community seeks to create a more inclusive and equitable environment.

Increasing cultural competency, DEI education, and knowledge about traditional healing practices among healthcare providers: There is a need for increased education among healthcare providers regarding traditional healing practices. Key informants spoke to a lack of understanding or appreciation for indigenous healing methods within the healthcare system and need for greater cultural sensitivity and respect within the community. Embedding diversity, equity, and inclusion (DEI) practices within healthcare is essential. Key informants noted that DEI education and knowledge should be standard across all staff training, rather than limited to a DEI board or surface-level gestures like website land acknowledgements. Comprehensive DEI practices can create a transformative change in promoting inclusion.

Awareness of systemic racism and socioeconomic barriers: Healthcare providers should receive education about how systemic racism and socioeconomic barriers impact health outcomes. This highlights the need for healthcare professionals to be aware of the broader social factors that contribute to health disparities. Key informants emphasized that addressing historical treatment disparities is vital. It is necessary to respect and support the knowledge shared by community members, especially elders, as part of reparation efforts. Cultural sensitivity training, respect, and reparation for past harm are crucial for building trust and fostering meaningful partnerships.

Holistic view of healthcare: A holistic approach to healthcare is advocated, including the incorporation of traditional foods that have healing properties for indigenous populations. This recognizes the cultural and medicinal significance of traditional foods. Key informants also noted that it is important to provide comprehensive training and understanding to system-wide staff, ensuring they have the knowledge and skills to effectively engage with patients. Taking time with patients, particularly elders, to build relationships and honor their needs is crucial.

Importance of tribal affiliation: It is crucial to recognize the importance of tribal affiliation and not generalize or lump all indigenous people together. Different tribes have distinct beliefs and practices concerning healing, deaths, and births. Healthcare providers should be aware of these cultural variations and show understanding and differentiation.

Effects of colonialism and bridging the tribal/non-tribal disconnect: The community notes that Lake County is predominantly a reservation, but development has excluded the tribal community.

The effects of colonialism are still present, and there is a need to bridge the disconnect between tribal and non-tribal communities. This highlights the ongoing impacts of historical colonization and the importance of fostering understanding and inclusivity.

Economic insecurity

Pandemic-related isolation and service access difficulties: The COVID-19 pandemic has led to increased isolation and challenges in accessing services within the community. This suggests that the restrictions and safety measures implemented during the pandemic affected residents' ability to connect with support networks and necessary resources.

Job losses due to grocery store closures: The closure of grocery stores in rural communities during the pandemic resulted in job losses. Unfortunately, these stores did not reopen, exacerbating economic insecurity in the community. This highlights the negative impact of these closures on employment opportunities.

Decline in homemaking services: Key informants indicated a decline in homemaking services as people were reluctant to have homemakers enter their homes during the pandemic. This hesitation may be due to concerns about the risk of exposure to the virus. Consequently, individuals working in the homemaking services sector had to find alternative employment when their offices were shut down.

Lack of living wage jobs: Key informants noted that although job opportunities exist, the cost of living in the community is high, and there is a scarcity of living wage jobs.

Food insecurity and chronic diseases

The key informant interview notes highlight the need to address food insecurity and chronic conditions in the community.

High cost of healthy food: The affordability of food is raised as an issue, particularly impacting the indigenous population and seniors. Financial constraints may hinder their ability to access affordable and healthy foods. Healthy food in particular was identified as being expensive, particularly in reservations and rural areas. Residents face difficulties in affording nutritious food options. Nutritious food is recognized as playing a crucial role in overall health. There is a need to work towards increasing access to nutritious foods within the community.

Linking health and food insecurity: Key informants spoke about the need to reinforce the link between food insecurity and health. Ways to address this could include collaboration with healthcare providers to incorporate screening questions related to food insecurity that will help identify individuals in need and facilitate their referral for necessary support. Key informants emphasized the need for stronger screening protocols and more comprehensive follow-up procedures.

Embracing of traditional food and culture: Key informants emphasized the importance of incorporating traditional foods into residents' lives, as these foods are believed to have healing properties. There is a need to prioritize food access, and embracing indigenous food is seen as a potential solution to help individuals with chronic conditions. Key informants discussed the

importance of incorporating culture, language, and recognizing individual differences in addressing the dimensions of wellness effectively.

Limited access to food: In some small rural communities, access to food may be limited to convenience stores, indicating a lack of diverse and healthy food options. The COVID-19 pandemic resulted in the closure of grocery stores in rural communities, leading to a loss of jobs and reduced access to food. This exacerbated existing food security challenges in these areas. Two areas, Elmo and Dixon, are identified as food deserts, where residents have limited access to affordable and healthy food options.

Impact of COVID-19 pandemic: The pandemic resulted in the closure of grocery stores in rural communities, leading to a loss of jobs and reduced access to food. This exacerbated existing food security challenges in these areas.

Technological impact on movement: The increasing reliance on technology has reduced physical movement, resulting in less daily activity. This observation suggests a potential impact on overall health and well-being.

Key informants emphasized the need to address food insecurity and chronic conditions within the community. The high cost of healthy food, limited access to nutritious options, existence of food deserts, and affordability challenges affect the indigenous population, seniors, and residents of rural areas. The COVID-19 pandemic further worsened these issues by causing grocery store closures and job losses. Considering cultural practices, increasing food access, linking food insecurity with health, and embracing indigenous food are identified as potential strategies to improve the health and well-being of the community, particularly for those with chronic conditions.

Appendix 3: Community Resources Available to Address Significant Health Needs

Providence St. Joseph Medical Center 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 Type	Organization or Program	Description of services offered	Street Address	Significant Health Need Addressed
Agency on Aging	Area IV Agency on Aging	Serves people with the goal of enabling persons 60 years or older to lead independent, meaningful, and dignified lives, by providing direct services, contracting for services, and networking with the community to locate services	110 Main St, Ste 5 Polson, MT 59860	Access to Services
Agency on Aging	Lake County Council on Aging	Public transportation, food program, in-home housekeeping, respite care for caregivers, foot clinic and farmer's market. Senior Centers in Arlee, Charlo, Polson, Ronan, St. Ignatius. Tribal Centers in Arlee, Elmo, Polson, Ronan, and St. Ignatius	528 Main Street SW Ronan, MT 59864	Access to Services
Community Development	Arlee CDC	Food sovereignty programming; business development	92555 US Hwy 93 PO Box 452 Arlee, MT 59821	Food Insecurity, Economic Insecurity
Disability Services	Summit Independent Living	Provides consumer and advocacy services to people with mobility, neurological, hearing, visual and other disabilities	124 Main St P.O. Box 434, Ronan, MT 59864	Advocacy
Domestic Violence	SAFE Harbor	Domestic and sexual violence services, including emergency shelter	PO Box 497 Ronan, MT 59864	Emergency Shelter
Food Pantry	Ronan Bread Basket	Provides emergency food services (3-4 days' worth of food, once a month) to needy families in Ronan, Charlo, and Moiese areas	10 6th Ave SW P.O. Box 346, Ronan, MT 59864	Food Insecurity
Food Pantry	Food Distribution	Restricted to those who live on the Reservation	410 Mountain View Dr. St. Ignatius, MT 59865	Food Insecurity
Food Pantry	West Shore Food Bank	Emergency food services	7150 Hwy 93 S P.O. Box 192 Lakeside, 59922	Food Insecurity
Food Pantry	Mission Valley Food Pantry	Food Service for needy families at or below 200% of the poverty level	203 Blaine Street St. Ignatius, MT 59865	Food Insecurity

Food Pantry	Polson Loaves and Fish Pantry	Food service for needy families	904 1st Street E Polson, MT 59860	Food Insecurity
Hospital and Outpatient Clinics	Providence St. Joseph Medical Center	Critical access hospital and outpatient medical care	6 13th Ave E Polson, MT 59860	Access to Care Medical Care
Hospital and Outpatient Clinics	St. Luke Community Healthcare	Critical access hospital and outpatient medical care	107 6th Ave SW Ronan, MT 59864	Access to Care Medical Care
Housing Authority	Ronan Housing Authority	Affordable housing for residents of Lake County	111 2nd Ave SW Ronan, MT 59864	Housing
Legal Aid	Montana Legal Services Association	Attorneys who work with low-income people by providing legal information, advice, and other services free of charge. MLSA works to help low-income people escape domestic violence, keep their housing, preserve their public benefits, protect their finances, and more	1535 Liberty Ln, #110D Missoula, MT 59808	Legal, Individual and Community Advocacy
Mental Health	Youth Dynamics	Mental and behavioral health services for youth and families	410 1st St E Polson, MT 59860	Access to Mental Health Care
Peer Support and Support Groups	Never Alone Recovery Support Services	Peer support; support groups	122 Main St W Ronan, MT 59864	Substance Use / Misuse
Public Benefits	Office of Public Assistance	Administers programs for low-income Montanans including SNAP, Medicaid, medical assistance, emergency aid for dependent children, and TANF	49627 Hwy 93, Polson, MT 59860	Food Insecurity Housing Stability
Public Benefits	WIC (Women, Infants, and Children)	Supplemental nutrition program for women, infants, and children, providing short term, low cost, preventative health services to families who are at risk due to nutrition related health conditions	802 Main St Polson, MT 59860	Food Insecurity
Public Housing Agency	Community Action Partnership of Northwestern Montana (CAPNM)	Offers services for several housing specific needs, including a Section 8 Voucher program for very low-income people, a low income home ownership program (Community Land Trust), and some emergency housing and utility solutions.	110 Main Suite M-1 Mezzanine Level Polson, MT 59860	Housing, Economic Security
Tribal Health	CSKT Tribal Health	Services include medical, dental, behavioral health, community health	35401 Mission Dr PO Box 880 St. Ignatius, MT 59865	Access to Care

Appendix 4: Providence St. Joseph Medical Center Advisory Council

Table_Apx 4. Providence St. Joseph Medical Center Advisory Council Members

Name	Title	Organization	Sector
Brodie Moll	Director (Retired)	Mission Mountain Enterprises	Private Business
Caryl Cox, Council Chairperson	Board Member (Retired)	Polson School Board	Education
Devin Hunt	Chief Operations Officer	Providence St. Joseph Medical Center	Health Care
Gale Decker	County Commissioner	Lake County	Local Government
Josh Maki	Chief Administrative Officer	S&K Technologies	Private Business
Mary Martin	Director	Polson Food Bank	Community Organization
Rob McDonald	Communications Director	Confederated Salish & Kootenai Tribes	Tribal Government
Shauna Rubel	Vice President	Glacier Bank	Business
Tracie McDonald	Dean of Students (Retired)	Salish Kootenai College	Education
Vince River	Psychologist	Self Employed	Mental Health

Appendix 5: Providence Montana Service Area Community Mission Board and Executive Team Representatives

Table_Apx 5. Providence Montana Service Area Community Mission Board Members and Executive Team Representatives

Name	Title	Organization	Sector
Kirk Bodlovic (Providence executive team)	Interim chief executive and chief operating officer	Providence Montana	Hospital
Bruce Bollen, MD	Physician	Missoula Anesthesiology	Healthcare
Damian Chase-Begay	Health Officer	Missoula City-County Health Department	Public Health
Ben Davis	Executive Director	Friends of the Children Western Montana	Community-based Organization
Reed Humphrey, PhD	Dean for College of Health	University of Montana	Education
Josh Maki (representative from SJMC Advisory Council)	Chief Administrative Officer	S&K Technologies	Business
Dale Mayer, PhD RN	Retired Assistant Professor, Montana State University College of Nursing	Retired	Education
Skye McGinty	Executive Director	All Nations Health Center	Healthcare
James McKay, MD (Providence executive team)	Chief Medical Officer	Providence Montana	Hospital
Karen Myers (Providence executive team)	Chief Mission Officer	Providence Montana	Hospital
Krissy Peterson (Providence executive team)	Chief Nursing Officer	Providence Montana	Hospital
Kaia Peterson	Executive Director	NeighborWorks Montana	Community-based Organization
Marc Racicot	Former Montana Governor	Retired	General
Mark Williams, Chair	Attorney	Williams Law Firm	Legal