COMMUNITY HEALTH NEEDS ASSESSMENT 2020

Providence St. Patrick Hospital

This CHNA was conducted by
Providence St. Patrick Hospital in Missoula, Montana

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

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MESSAGE TO THE COMMUNITY AND ACKNOWLEDGEMENTS

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

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

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

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

Sincerely,

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

EXECUTIVE SUMMARY

Understanding and Responding to Community Needs, Together

Improving the health of our communities is foundational to our Mission and a commitment deeply rooted in our heritage and purpose. Our Mission calls us to be steadfast in serving all, with a special focus on our most economically poor and vulnerable neighbors. This core belief drives the programs we build, investments we make, and strategies we implement.

Knowing where to focus our resources starts with our Community Health Needs Assessment (CHNA), an opportunity in which we engage the community every three years to help us identify and prioritize the most pressing needs, assets, and opportunities. The 2020 CHNA was approved by the Providence Montana Service Area Community Mission Board on October 27, 2020.

Our Starting Point: Gathering Community Health Data and Community Input

Through a mixed-methods approach using quantitative and qualitative data, the CHNA process used several sources of information to identify community needs. Across Missoula County, information collected includes public health data regarding health behaviors, hospital utilization data, input from key community stakeholders, and surveys of target neighborhoods. Stakeholder interviews were conducted with representatives from organizations that serve these populations. Some key findings include the following:

- Stakeholders interviewed consistently expressed the need for affordable housing, services for people who are experiencing homelessness, access to health care, including behavioral health care, and low-barrier substance use treatment
- Of individuals who responded to our community survey, 48% of responses called for more or improved mental health services, 21% called for more substance use disorder treatment options, and 18% discussed homelessness and affordable housing
- Compared to other counties in Montana, Missoula County dropped substantially in its ranking in “Health Outcomes” from 2017 (6) to 2020 (13). Conversely, Missoula County’s ranking for Health Factors improved from 13 in 2017 to 7 in 2020. The most improved measure is a 9% decrease in alcohol-impaired driving deaths, as well as an 11% decrease in preventable hospital stays.
- Median household income increased by nearly 25%; still, almost half of children are eligible for a free or reduced-price lunch.

Identifying Top Health Priorities, Together

Through a collaborative process engaging the Providence Montana Community Mission Board Ad Hoc CHNA Committee, the following priority areas were agreed as strategic to improving the health of the community:

Prioritized Need	Definition	Rationale

PRIORITY 1: ACCESS TO MENTAL HEALTH SERVICES	Access to mental health and behavioral health services, including for children and adolescents, regardless of payer source or ability to pay for services, as well as rapid access for people experiencing a mental health crisis.	• Montana consistently ranks in the top three states for rate of suicide; 2018 was the first year Montana dropped out of the top three states for suicide in ten years, ranking fourth *(https://suicidology.org/facts-and-statistics/)*
		• Residents of Missoula County experience an average of 3.8 poor mental health days per month; since 2016, this number has been increased yearly (*countyhealthrankings.org/app/montana/2020/overview)*
		• Percentages of people with depression in Missoula County neighborhoods range from 22.5% to 26.7% *(gis.missoulacounty.us/mcchd/healthmap)*
		• In Montana, Major Depressive Episode (MDE) among youth aged 12-17 in the prior year:
		  o Increased to 11.4% (2013-2017) from 8.9% in 2004-2008
		  o 41.1 % received care for depression in the past year *(samhsa.gov)*
		• In the Montana service area:
		  o Economically-vulnerable patient groups (people who are disabled; people who are experiencing homelessness or have unstable housing) have high rates of mental health diagnosis and/or substance use disorder
		  o Minority populations, including the American Indian population, LGBTQ+, and the Black population have high rates of mental health diagnosis and/or substance use disorder

PRIORITY 2: SAFE AND AFFORDABLE HOUSING	Safe and affordable housing allows households to pay for other nondiscretionary expenses that are integral to good health, like healthy food, health care, and education	• Health and safe, stable housing are inextricably linked, but the community faces an ongoing challenge in its low stock of affordable housing units and a functionally-zero vacancy rate. • Missoula County's cost of living, including cost of housing, is high compared to the minimum wage of $8.50/hour. The living wage for one adult working full time is $11.47; if that adult is supporting a child, the living wage is $24.96. (*livingwage.mit.edu)* • In some Missoula neighborhoods, 70% or more of households are "rent burdened"; the highest rate of "homeowner burdened" housing costs is 38.7% *(gis.missoulacounty.us/mcchd/healthmap)*

		• Not being able to pay rent is the most common reason an individual or family became homeless in Missoula in 2019 (*Reaching Home, City of Missoula)*
PRIORITY 3: ACCESS TO SUBSTANCE USE DISORDER TREATMENT SERVICES	Access to both outpatient and inpatient alcohol and drug treatment and detox, regardless of payer source or ability to pay, as well as expanded treatment models, such as medication-assisted treatment and peer support programs.	• At Providence St. Patrick Hospital, ○ Substance Use Disorders were the top reason for avoidable emergency department encounters in 2019, accounting for 12% of all avoidable ED encounters ○ Two-thirds of avoidable ED encounters and inpatient admissions for Substance Abuse Disorders were by patients with Medicaid; treatment options are limited and waiting times for services are prohibitive for patients covered through Medicaid • Rates of binge drinking in Missoula County neighborhoods range from 20.4% to 24.6%, with the highest rate of depression and binge drinking being in the same neighborhood *(gis.missoulacounty.us/mcchd/healthmap)*
PRIORITY 4: ADDRESSING HOMELESSNESS	Collaborate with community partners to work toward ending homelessness, including housing retention support services for people housed following a period of homelessness.	• As of the 2019 Point in Time Count of homeless households, 325 people in Missoula were homeless, 63 of whom were unsheltered *(http://mthomelessdata.com/2019/)* • People who experience chronic homelessness are significantly more likely than the general population to have serious mental illness and/or substance use disorders • Emergency shelter service providers have reduced the number of people they can shelter each night due to the COVID-19 pandemic, with emergency shelter capacity remaining at about half of pre-pandemic levels for the foreseeable future

Next Steps: Making a Community Health Improvement Plan

Providence St. Patrick Hospital will develop a three-year Community Health Improvement Plan (CHIP) to respond to these prioritized needs in collaboration with community partners in early 2021 considering resources, community capacity, and core competencies. The 2021-2023 CHIP will be approved and made publicly available no later than May 15, 2021.

RESPONDING TO THE COVID-19 PANDEMIC

The 2020 Community Health Needs Assessment process was disrupted by the SARS-COV-2 virus and COVID-19, which has impacted all of our communities. While our communities have focused on crisis response, it has required concentration of resources and reduced community engagement, which impacted survey fielding and community listening sessions. Additionally, the impacts of COVID-19 are likely to affect community health and well-being beyond what is currently captured in secondary and publicly available data. We will seek to engage the community as directly as possible in prioritizing needs and through the community health improvement process.

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

INTRODUCTION

Mission, Vision, and Values

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

Who We Are

Providence St. Patrick Hospital is a regional tertiary care hospital founded in 1873 and located in Missoula, Montana. The hospital has 253 licensed beds, serving 17 counties in western Montana. Providence St. Patrick Hospital employs 2,200 employee caregivers, over 200 of who are Providence Medical Group providers. Major programs and services offered to the community include the International Heart Institute, the Montana Cancer Center, da Vinci Surgical System, a Level II trauma center, inpatient neurobehavioral health, and many specialty areas of medicine.

Our Commitment to Community

Providence St. Patrick Hospital dedicates resources to improve the health and quality of life for the communities it serves, with special emphasis on the needs of the economically poor and vulnerable. During 2019, Providence Montana provided $31.3 million in Community Benefit[1] in response to unmet needs and to improve the health and well-being of those we serve in western Montana, including $7.1 million in free and low-cost care for people who are underinsured or uninsured. Our region includes Providence St. Patrick Hospital, Providence Medical Group, including 11 outpatient primary care clinics

[1] A community benefit is an initiative, program or activity that provides treatment or promotes health and healing as a response to identified community needs and meets at least one of the following community benefit objectives: a. Improves access to health services; b. Enhances public health; c. Advances increased general knowledge; and/or d. Relieves government burden to improve health. Note: Community benefit includes both services to the economically poor and broader community. To be reported as a community benefit initiative or program, community need must be demonstrated. Community need can be demonstrated through the following: 1) community health needs assessment developed by the ministry or in partnership with other community organizations; 2) documentation that demonstrates community need and/or a request from a public agency or community group was the basis for initiating or continuing the activity or program; 3) or the involvement of unrelated, collaborative tax-exempt or government organizations as partners in the community benefit initiative or program.

and 14 specialty clinics, as well as Providence St. Joseph Medical Center in Polson, a critical access hospital.

Figure 1. PSJH Community Benefit in Montana in 2019

Providence St. Patrick Hospital further demonstrates organizational commitment to the CHNA through the allocation of staff time, financial resources, participation and collaboration to address community identified needs. Providence St. Patrick Hospital is responsible for ensuring compliance to the Federal 501(r) requirements as well as providing the opportunity for community leaders and internal hospital leadership, physicians, and others to work together in planning and implementing the resulting Community Health Improvement Plan (CHIP).

Health Equity

At Providence, we acknowledge that all people do not have equal opportunities and access to living their fullest, healthiest lives due to systems of oppression and inequities. We are committed to ensuring health equity for all by addressing the underlying causes of racial and economic inequities and health disparities. Our Vision is "Health for a Better World," and to achieve that we believe we must address not only the clinical care factors that determine a person's length and quality of life, but also the social and economic factors, the physical environment, and the health behaviors that all play an active role in determining health outcomes (see Figure 1[2]).

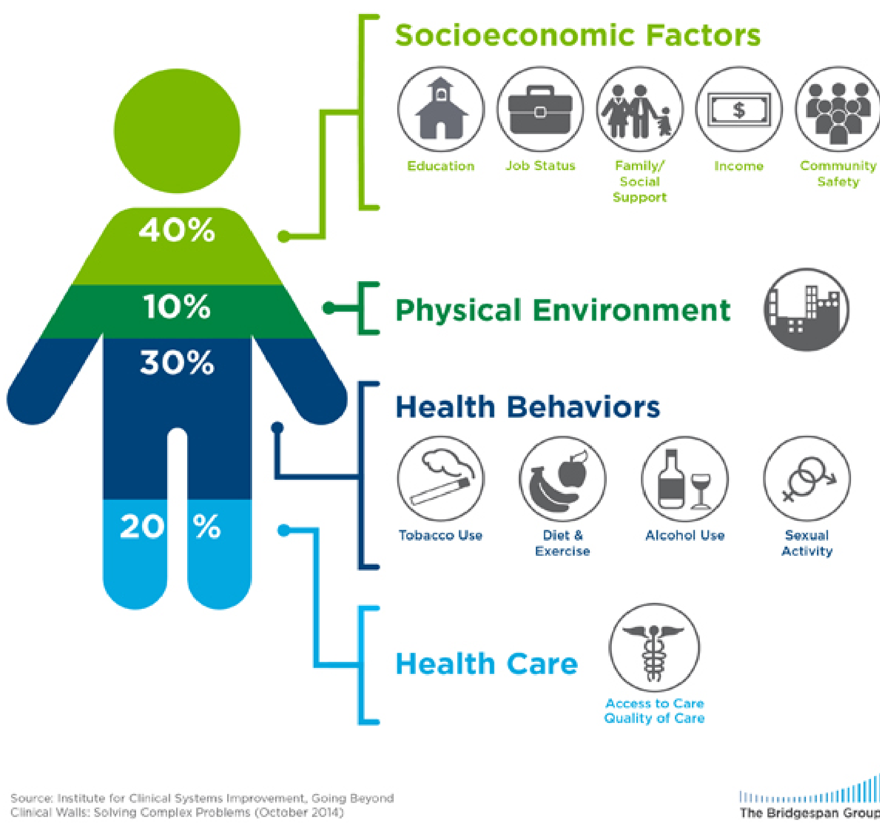

Figure 2. Factors Contributing to Overall Health and Well-being

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

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

Health Equity

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

Health Disparities

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

Figure 3. Definitions of Key Terms

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

Approach

Explicitly name our commitment to equity

Take an asset-based approach, highlighting community strengths

Use people first and non-stigmatizing language

Community Engagement

Actively seek input from the communities we serve using multiple methods

Implement equitable practices for community participation

Report findings back to communities

Quantitative Data

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

Disaggregate data when responsible and appropriate

Acknowledge inherent bias in data and screening tools

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

OUR COMMUNITY

Description of Community Served

Providence St. Patrick Hospital provides communities in western Montana with access to advanced care and advanced caring. Due to the level of care provided at this hospital, Providence St. Patrick Hospital sees patients from surrounding counties, although for the purposes of this CHNA, the hospital service area is Missoula County. Those surrounding areas extend from Lake and Sanders Counties in the north, Ravalli, Granite, Deer Lodge and Silver Bow counties in the south, Powell and Lewis and Clark counties in the east and Mineral county in the west. The total service area, Missoula County, includes a population of approximately 122,000 people.

Hospital Service Area

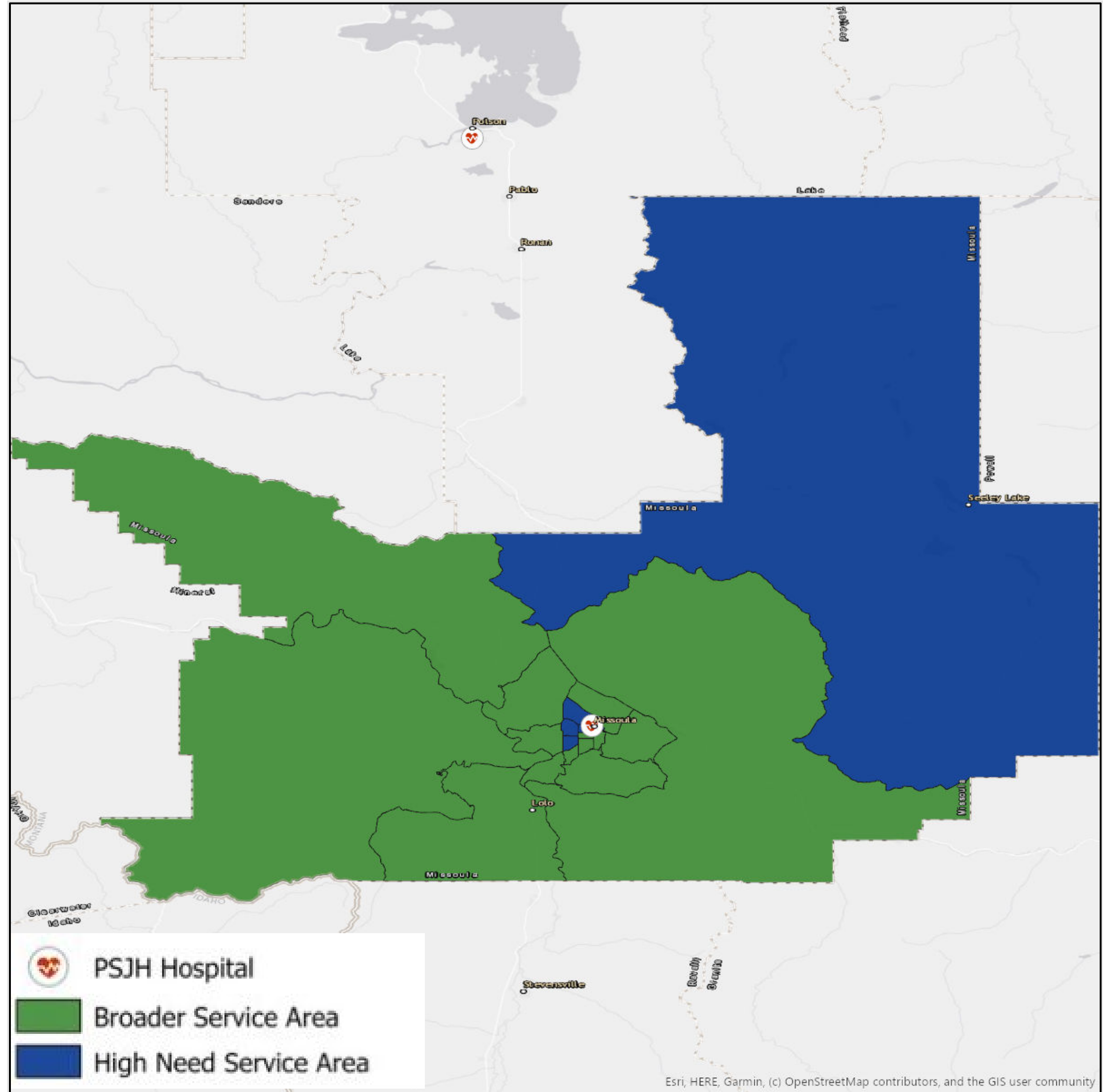
The table and map below are representative of the hospital service area, Missoula County.

Table 1. Cities and ZIP Codes Included in Service Area

Cities/ Communities	ZIP Codes
Missoula	59801, 59802, 59803, 59804, 59806, 59807, 59808, 59812
Bonner	59823
Clinton	59825
Condon	59826
Frenchtown	59834
Huson	59846
Lolo	59847
Milltown	59851
Seeley Lake	59868

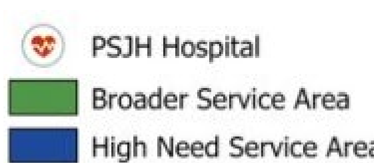
The blue portions of the map below are considered “high need” census tracts, and the green portions are the broader service area. Together, these areas make up the total service area, Missoula County.

Figure 4. Providence St. Patrick Hospital Total Service Area



The following map provides a zoomed in view of the central portion of the service area with Providence St. Patrick in the center.

Figure 5. Providence St. Patrick Hospital Service Area Zoomed In



Community Demographics

The tables and graphs below provide basic demographic and socioeconomic information about Providence St. Patrick service area and how the high need area compares to the broader service area. The service area of Providence St. Patrick Hospital includes approximately 122,000 people and encompasses the entire county of Missoula. The high need area includes census tracts identified based upon lower life expectancy at birth, lower high school graduation rates, and more households at or below 200% FPL (annual household income of $51,500 or less for a family of 4) compared to county averages.

POPULATION AND AGE DEMOGRAPHICS

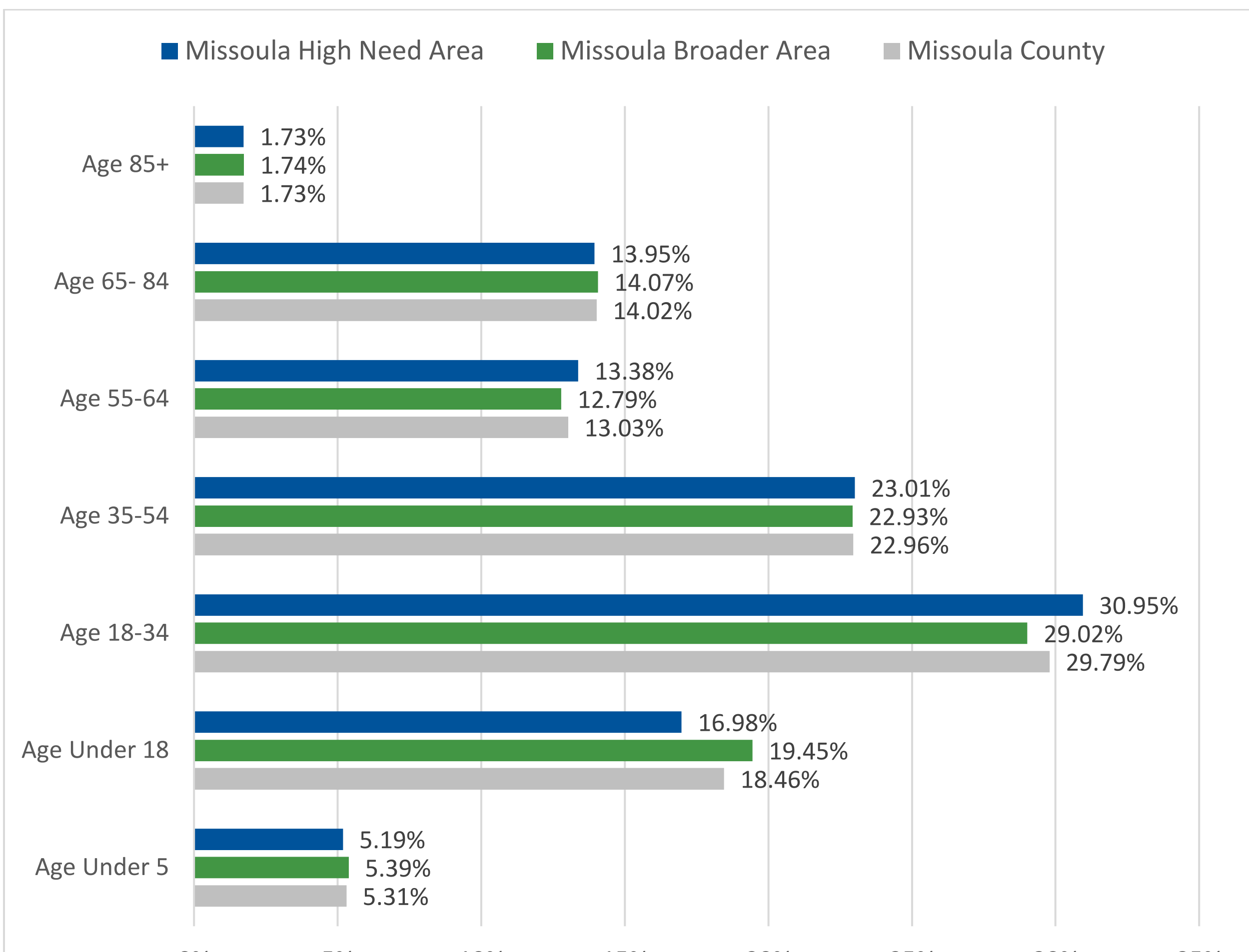
Table 2. Population Demographics for Missoula County Service Area

Indicator	Missoula County	Broader Service Area	High Need Service Area
2019 Total Population	122,370	73,648	48,722
Female Population	49.68%	50.18%	48.91%
Male Population	50.32%	49.82%	51.09%

For the most part, the age distribution is roughly proportional across Missoula County geographies, with those aged between 18 and 34 slightly more likely to live in a high need area, likely young families and those in and around college towns.

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

Figure 6. Age Groups by Geography in Missoula County Service Area



POPULATION BY RACE AND ETHNICITY

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

Indicator	Missoula County	Broader Service Area	High Need Service Area
Hispanic Population	3.38%	3.13%	3.77%

The American Indian population is more likely to live in a high need area, while the white population is less likely to live in a high need area.

Figure 7. Race by Geography in Missoula County Service Area

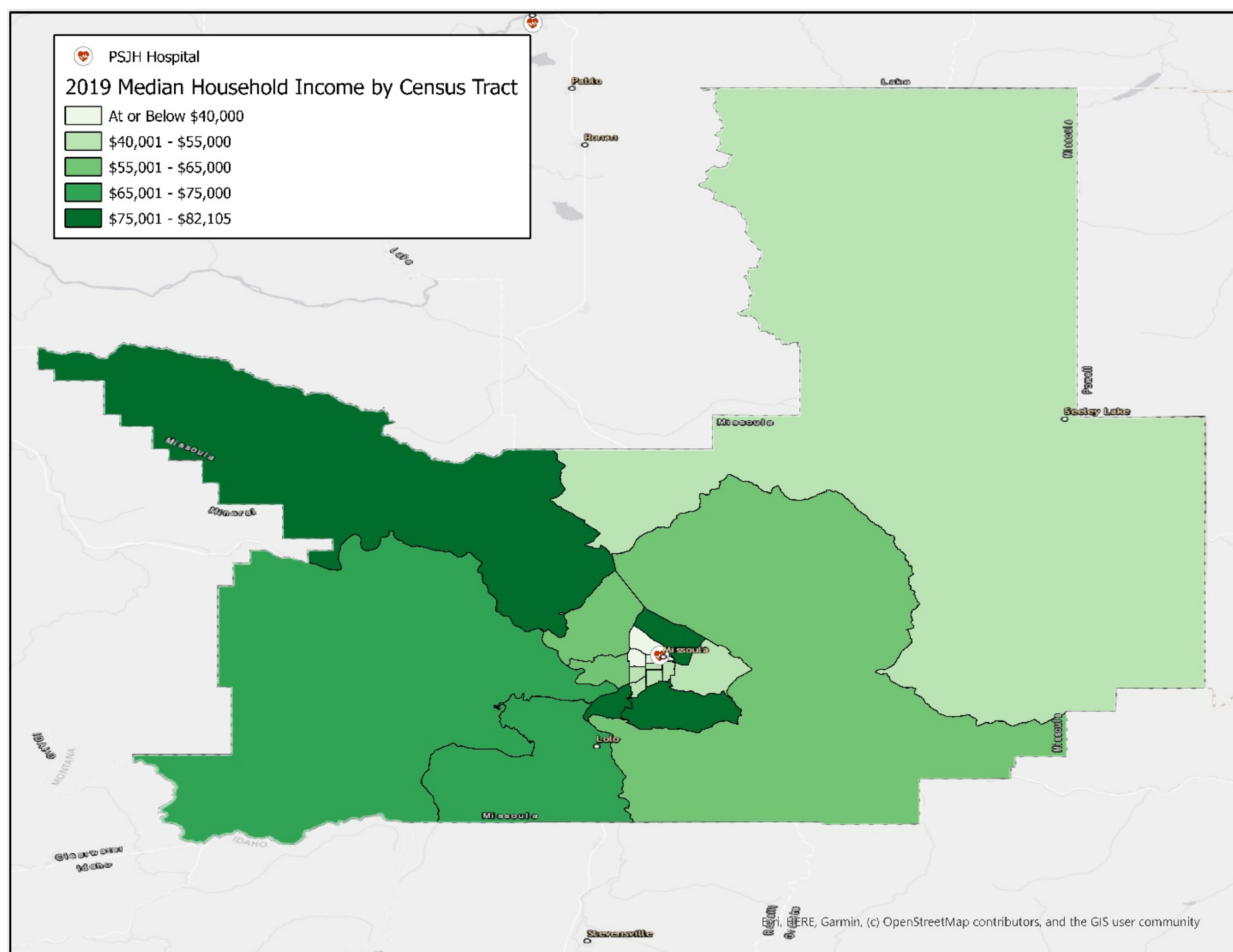
	Missoula High Need Area	Missoula Broader Area	Missoula County
Population of Two or More Races	3.73%	3.15%	3.38%
Other Race Population	0.64%	0.56%	0.59%
Pacific Islander Population	0.11%	0.07%	0.08%
Asian Population	1.34%	1.97%	1.72%
American Indian Population	3.88%	1.75%	2.60%
Black Population	0.58%	0.45%	0.51%
White Population	89.72%	92.05%	91.12%

MEDIAN INCOME

Table 4. 2019 Median Income for Missoula County Service Area

Indicator	Missoula County	Broader Service Area	High Need Service Area
Median Household Income Data Source: American Community Survey Year: 2019	$53,890	$65,203	$41,081

Figure 8. 2019 Median Household Income in Missoula County Service Area



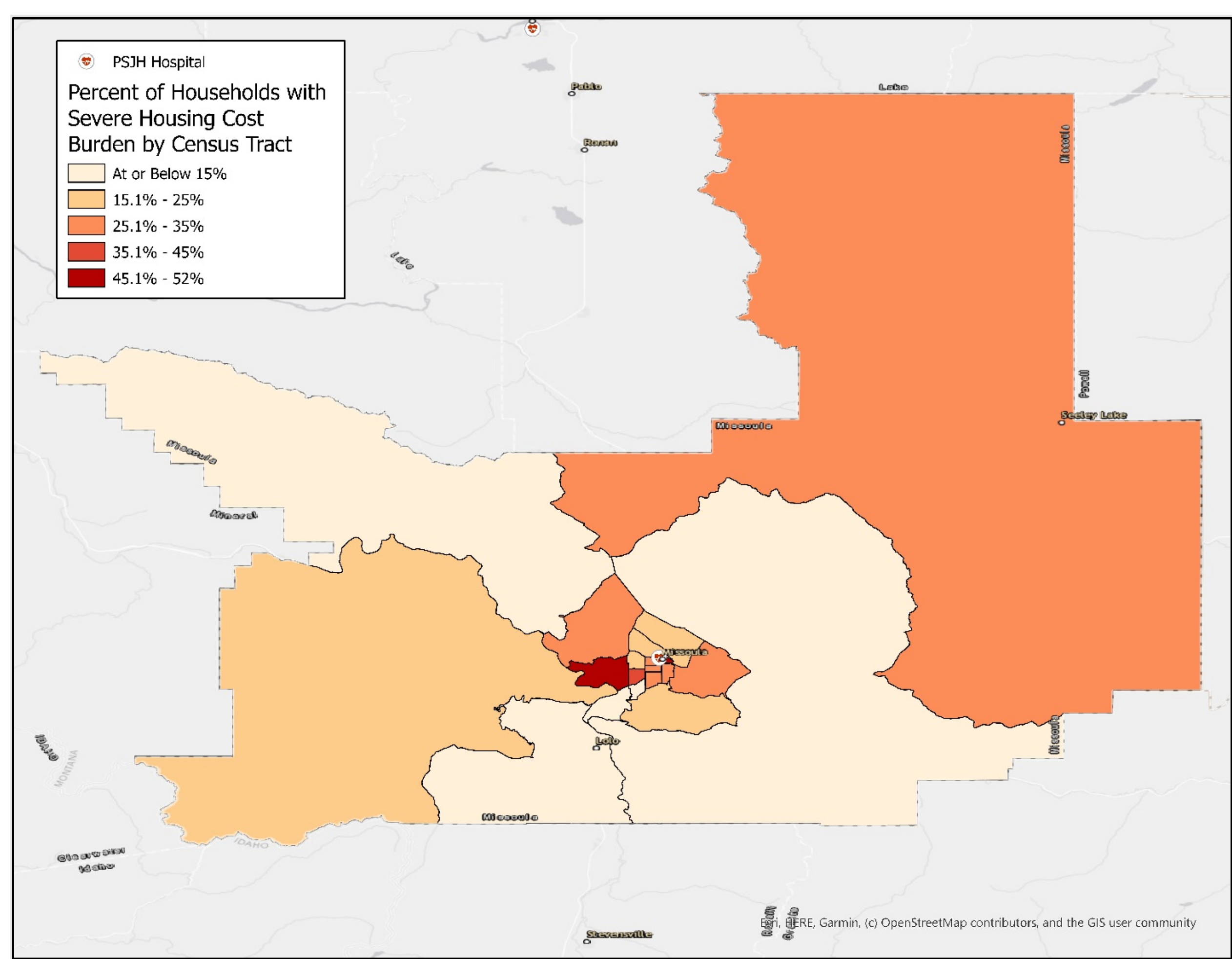
- The median household income in the high need service area is substantially lower than Missoula County overall, with the high need service area being almost $13,000 lower.
- The difference in median household income between the broader service area and the high need service area is even greater, with the high need service area being over $24,000 lower.

SEVERE HOUSING COST BURDEN

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

Indicator	Missoula County	Broader Service Area	High Need Service Area
Percent of Renter Households with Severe Housing Cost Burden Data Source: American Community Survey Year: Estimates based on 2013 – 2017 data	27.07%	23.87%	29.74%

Figure 9. Percent of Households with Severe Housing Cost Burden in Missoula County Service Area



Severe housing cost burden is defined as households that are spending 50% or more of their income on housing costs. On average, approximately 27% of households in Missoula County are severely housing cost burdened. This is slightly lower than the high need areas in which 30% of renter households are severely housing cost burdened.

RURAL HOUSEHOLDS

Compared to Montana, Missoula County has substantially fewer people living in rural areas.

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

Indicator	Missoula County	Montana
Percent of Population Living in a Rural Area Data Source: County Health Rankings, 2010	22.3%	44.1%

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

HEALTH PROFESSIONAL SHORTAGE AREA

Missoula 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 all have HPSA designations, except for Lewis and Clark County. See Appendix 2 “Quantitative Data” for maps by HPSA category.

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

OVERVIEW OF CHNA FRAMEWORK AND PROCESS

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

In addition, we recognize that there are often geographic areas where the conditions for supporting health are substantially poorer than nearby areas. Whenever possible and reliable, data are reported at the ZIP Code or census block group level. These smaller geographic areas allow us to better understand the neighborhood level needs of our communities and better address health disparities within and across communities.

We reviewed data from the American Community Survey and local public health authorities. In addition, we include hospital utilization data to identify disparities in utilization by income and insurance, geography, and race/ethnicity when reliably collected. A glossary of terms from the CHNA can be found in **Appendix 1**.

Data Limitations and Information Gaps

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

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

Written comments were solicited on the 2017 CHNA and 2018-2020 CHIP reports, which were made widely available to the public via posting on the internet in December 2017 (CHNA) and May 2018 (CHIP), as well as through various channels with our community-based organization partners. To date, no public comments have been received.

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

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Hollie.Timmons@providence.org
Providence St. Patrick Hospital
Community Health Investment
PO Box 4587
Missoula, MT 59806

HEALTH INDICATORS

County Health Rankings

Compared to other counties in Montana, Missoula County dropped substantially in its ranking in "Health Outcomes" from 2017 (6) to 2020 (13). The measures in the Health Outcomes category include premature death and quality of life indicators, all of which declined. Premature deaths, measured in years of potential life lost, increased by almost 9%.

Conversely, Missoula County's ranking for Health Factors improved from 13 in 2017 to 7 in 2020. The most improved measure is a 20% decrease in alcohol-impaired driving deaths (from 44% in 2017 to 35% in 2020), as well as an 11% decrease in preventable hospital stays. Median household income increased by nearly 25%; still, almost half of children are eligible for a free or reduced-price lunch.

Compared to the state, Missoula County's adult obesity rate is slightly lower (26% in Montana and 22% in Missoula County), and substantially lower than the state in alcohol-impaired driving deaths (45% in Montana and 35% in Missoula County). Missoula County's percentage of homes with severe housing problems[4] is higher than the state average (15% in Montana compared to 19% in Missoula County) and has the third-highest percentage in the state in that category.

Missoula County has a higher percentage of children eligible for free or reduced lunch compared to Montana. Although, the county percentages of uninsured adults and children are lower than the state.

Table 7. Key Health Factors from County Health Rankings

Indicator	Missoula County	Montana
Children eligible for free or reduced lunch	48%	45%
Uninsured adults	10%	12%
Uninsured children	4%	6%

Source: Community Health Rankings

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

[4] According to County Health Rankings, severe housing problems means percentage of households with at least 1 of 4 housing problems: overcrowding, high housing costs, lack of kitchen facilities, or lack of plumbing facilities

Hospital Utilization Data

In addition to this public health surveillance data, our hospitals can provide timely information regarding access to care and disease burden across Missoula County. We were particularly interested in studying potentially avoidable Emergency Department visits and Prevention Quality Indicators. Avoidable Emergency Department (AED) is reported as a percentage of all Emergency Department visits over a given time period and are identified based on an algorithm developed by PSJH's Population Health Care Management team based on NYU and Medi-Cal's definitions.

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

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

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

Across PSJH's Washington and Montana service area, Providence St. Patrick Hospital had approximately average percentage of potentially avoidable ED utilization in 2019. Individuals identifying as Native American were most likely to have an avoidable ED visit at Providence St. Patrick Hospital.

Potentially avoidable utilization is relatively consistent across age groups, with ZIP Codes 59802, 59801, and 59808 producing the greatest number of potentially avoidable visits at Providence St. Patrick

Hospital. These three ZIP Codes were responsible for approximately 59% (4,342) of all potentially avoidable visits in 2019.

Table 9. Top Three Patient ZIP Codes for Avoidable Emergency Department Visits at Providence St. Patrick Hospital

Encounters by Patient Zip Code	Non-AED Visits	AED Visit	Total ED Visits	AED %
Providence St. Patrick Hospital—Missoula	**15,832**	**7,394**	**23,227**	**31.8%**
59802	3,142	1,745	4,887	35.7%
59801	3,080	1,586	4,666	34.0%
59808	2,352	1,011	3,363	30.1%

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

Social and Economic Effects of COVID-19 Pandemic

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

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

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

(Source: U.S. Census Bureau)

COMMUNITY INPUT

Summary of Community Input

STAKEHOLDER INTERVIEWS

To better understand the unique perspectives, opinions, experiences, and knowledge of community members, representatives from Providence St. Patrick Hospital—Missoula conducted 10 stakeholder interviews, including 12 participants. During these interviews, nonprofit and government stakeholders discussed the issues and opportunities of the people, neighborhoods, and cities of the service area. Below is a high-level summary of the findings of these sessions; full details on the protocols, findings, and attendees are available in **Appendix 3.**

The following findings represent the **high priority health-related needs**, based on community input:

Homelessness/ lack of safe, affordable housing	Stakeholders shared a lack of living wage jobs combined with the high cost of housing contribute to **poor living conditions**, **overcrowding**, and **unstable housing**. They noted housing as being foundational to wellbeing; people who are stably housed are better able to care for their **physical and mental health**. Stakeholders spoke to the need for more **permanent supportive housing** that promotes a positive lifestyle to meet the needs of people with behavioral health challenges or disabilities, noting that these needs can compromise housing stability. They also shared there needs to be more housing options that are not just affordable, but actually **match what people are able to pay**. Stakeholders described the systems in place to help people with housing as uninviting and challenging for people in crisis to navigate. The system itself acts as a barrier for people by not meeting them where they are, emphasizing the need for more **case management** and navigation supports. **Housing discrimination** contributes to Native American and Black people, as well as people identifying as LGBTQ+ having more difficulty accessing good-quality, affordable housing. Other groups who may have challenges accessing quality housing are people with criminal backgrounds, poor credit, or negative housing histories, and young people. Multiple stakeholders emphasized the need to engage **individuals with lived experience** with homelessness and housing discrimination in conversations around housing solutions.

Behavioral health challenges and access to behavioral health care (includes both mental health and substance use disorder)	Stakeholders identified a history of **inter-generational trauma, child abuse/neglect,** and **poverty** as contributors to both mental health challenges and substance use disorders (SUD). They emphasized a need for more mental health services with **easier access points** and **peer mental health case managers**. They noted a need for improved **integration of behavioral health** into primary care and better mental health **assessment tools** to accurately assess psychosocial needs. Stakeholders also said there is a need for improved **gun safety** to reduce suicides and for **crisis services** for people needing immediate, but short-term support, besides the Emergency Department. Stakeholders spoke to challenges accessing appropriate SUD treatment services, noting a need for a **wraparound, low-barrier, transitional SUD treatment facility** that meets people where they are in their process, as well as more **harm reduction services**. They shared **stigma** and a lack of **education** and comfort talking about behavioral health are barriers to people receiving support. Additionally, lack of **insurance** and the **criminalization** of substance use are barriers to addressing these needs. Stakeholders were concerned about people with co-occurring behavioral health and medical needs, Native American communities, young people, people identifying as LGBTQ+, and veterans accessing affordable and responsive services.

The following findings represent **medium-priority health-related needs**:

Access to health care services	Stakeholders emphasized many people may experience **challenges navigating the complexity of the health care system**, especially refugee families, people with disabilities, people with behavioral health needs, and older adults. Other barriers to accessing health care include **cost of care**, especially for people who are uninsured, underinsured, and low income; **transportation**, especially for older adults; and **appointment times** during work hours. People with **behavioral health needs** may be deterred from seeking health care services because of negative experiences being shamed and turned away for their behavior. Stakeholders shared there is a lack of **culturally responsive care** for Native American communities who may not trust non-Native health systems due to **racism** and **historical trauma**. Native veterans and Native university students can experience additional barriers to care.
Unemployment and lack of living wage jobs	Stakeholders were particularly concerned about a **lack of living wage jobs** in Missoula County, contributing to families being unstably housed and food insecure. They noted that a lack of a living wage can put people in the challenging position of making too much money for public benefits, but not enough to meet their basic needs. They also shared a need to increase the **fixed income** amount. Stakeholders noted particular concern for how **racism** contributes to Native American people being disproportionately unemployed or underemployed, and more likely to work in the service industry which are typically lower-wage jobs with fewer benefits.
Domestic violence and child abuse/neglect	Stakeholders described **Adverse Childhood Experiences** (ACEs), such as child abuse and neglect, as major contributors to negative adult physical and mental health outcomes, as well as substance use. They shared particular concern for **young people experiencing homelessness** who may choose not to engage with systems for fear of being returned to abusive and unsafe homes.

Racism and discrimination	Stakeholders spoke to how embedded racism is in all our systems and the many ways these systems of oppression harm Native American communities in Missoula County. They shared that racism and historical trauma and abuse prevent Native American people from receiving high-quality, respectful, and responsive **health care services**. Discriminatory **housing** practices prevent Native American people and people identifying as LGBTQ+ from accessing good-quality, affordable housing. Racism contributes to Native American people being disproportionately **unemployed and underemployed**, keeping people in **poverty** and preventing **access to opportunities**.

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

Racism and discrimination	Stakeholders spoke to how embedded racism is in all our systems and the many ways these systems of oppression harm Native American communities in Missoula County. They shared that racism and historical trauma and abuse prevent Native American people from receiving high-quality, respectful, and responsive **health care services**. Discriminatory **housing** practices prevent Native American people and people identifying as LGBTQ+ from accessing good-quality, affordable housing. Racism contributes to Native American people being disproportionately **unemployed and underemployed**, keeping people in **poverty** and preventing **access to opportunities**.

COMMUNITY SURVEY

In July 2020, the hospital invited households in Missoula County to respond to an anonymous online survey. Postcards with the survey link were mailed to households with an annual income of $35,000 or less in zip codes 59801 and 59802. The survey link was also shared by Providence staff and partner organizations in the community. The survey was open from July 8 – July 26 and September 5 – September 29, with a total of 227 responses received. See Appendix 3 for a summary of the survey responses, as well as a comparison to 2017 survey responses.

See Appendix 3: Community Input: Qualitative Data

Challenges in Obtaining Community Input

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

SIGNIFICANT HEALTH NEEDS

Prioritization Process and Criteria

The SPH CHNA committee met online August 17, 2020 to review and prioritize community needs for 2020 – 2022 Community Health Needs Assessment. The committee reviewed the data packet, including the quantitative and qualitative data included in this document. Following discussion, the committee voted to determine the four highest priority needs.

See Appendix 4: Prioritization Protocol and Criteria

2020 Priority Needs

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

PRIORITY 1: ACCESS TO MENTAL HEALTH SERVICES

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

PRIORITY 2: 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.

PRIORITY 3: ACCESS TO SUBSTANCE USE DISORDER TREATMENT SERVICES

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

PRIORITY 4: ADDRESSING HOMELESSNESS

Collaborate with community partners to work toward ending homelessness, including housing retention support services for people housed following a period of homelessness.

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 Missoula City-County Health Department, Community Medical Center, as well as federally-qualified health centers. 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 5.

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

EVALUATION OF 2018-2020 CHIP IMPACT

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

SOCIAL DETERMINANTS OF HEALTH AND WELL-BEING

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

Focus Area	Program or Service Name	Results / Outcomes	Type of Support
Collaboration with organizations working on affordable housing	Participate in Missoula's At-Risk Housing Coalition	446 affordable units under construction or planned for construction through 2022	In-kind staff time
	Neighborworks Montana	Contribution for low-income housing rehabilitation	Grant
	North Missoula Community Development Corporation (NMCDC)	Contribution toward NMCDC purchase of land that previously had mobile home park	Grant
Collaboration with service providers for people experiencing homelessness to **reduce avoidable emergency department and acute hospital use**	Collaboration with service providers (Poverello Center, Fire Department, MESI, SPH ED and social work staff)	Monthly meetings to coordinate care for high-risk patient groups	In-kind staff time
	FUSE collaboration in support of housing people experiencing chronic homelessness	Care and service coordination for people experiencing chronic homelessness who are the most vulnerable; 42 permanent supportive housing units under construction through 2022	In-kind staff time
	Annual contributions to winter emergency shelter	Overflow shelters up to approximately 70 people per night needed for November – March each year (pre-COVID-19)	Grant
	Contribution to Medical Respite program at Poverello Center	2019: 73 individuals served with average stay of 13 days; most clients stay for 7 nights or less 2018: 40 individuals served with average stay of 13 days; most clients stay for 9 nights or less	Grant
Housing insecurity for transitional-aged youth who age out of foster care	Ongoing participation in Missoula's Coordinated Entry System, including weekly case conferencing	Annual Point in Time Count of people experiencing literal homelessness (as defined by HUD) has roughly tracked with overall population growth: 2019: 365 2018: 293	In-kind staff time

Focus Area	Program or Service Name	Results / Outcomes	Type of Support
		2017: 312 Multi-agency, community-wide collaboration working to achieve functional zero (a standard for ending homelessness).	
Shelter for **homeless families with children**	Family Promise shelters and feeds families in host churches throughout community; community groups provide meals, stay with families, and set up/take down shelter each week	SPH caregivers volunteered to staff one week of Family Promise in 2019.	Volunteer in-kind staff time
Obesity Prevention	CATCH (Coordinated Approach to Child Health) to prevent childhood obesity	CATCH curriculum integrated throughout Missoula County Public Schools, YMCA and Parks and Recreation summer programs	Program
	Prescription Produce	Expanded access to program and food vendors; participants can purchase vegetables with vouchers at local year-round farmers markets. The Providence Center Garden, in partnership with Garden City Harvest, donated over 900 pounds of food to the Prescription Produce program and to the Missoula Food Bank.	Program In-kind contribution
	Double Supplemental Nutrition Assistance Program (SNAP) Dollars	Financial support to increase matching dollars for program; cap of amount to match per household increased in 2020 from $10 to $20; SNAP dollars can be spent at local farmers markets on fresh produce as well as at grocery stores	Grant
Healthy Environment	4 Good Initiative	In 2019, St. Patrick Hospital reduced white copy paper usage by 7.3%. 53% of all waste was recycled or diverted from the landfill. In collaboration with the hospital's food service partner, food waste was reduced by 37%.	Program

MENTAL HEALTH

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

Focus Area	Program or Service Name	Results / Outcomes	Type of Support
Community mental health support	QPR (Question, Persuade, Refer), Mental Health First Aid, and Crisis Intervention Trainings	Regular trainings provided in hospital and community	In-kind staff time
	Human trafficking awareness	Targeted SPH staff completed human trafficking identification and action training	In-kind staff time
	Support for mental health services at Mountain Home Montana (MHM)	Contribution toward service expansion for additional therapy and case management for young, pregnant or parenting mothers between the ages of 16 and 29; MHM offered mental health care, education, and employment services to 20% more families	Grant
	Support for the Strategic Alliance for Behavioral Health and Wellbeing	Organization obtained grant funding through Montana Healthcare Foundation to support a county Mental Health Coordinator, as well as to expand ED use tool to partner mental health care providers in Missoula	Grant
Telehealth	Telepsychiatry	Significant telepsychiatry service expansion through 2019, including rural-focus programming in Ravalli, Beaverhead, Sanders, Deer Lodge, and Mineral counties.	Program
Increase post discharge linkages to community resources from acute (hospitalization, emergency department) care settings	Integrated Behavioral Health	Providence Medical Group added behavioral health care managers to nine primary care clinics with funding from Montana Healthcare Foundation	Program
	Missoula Aging Services Care Transitions Program	Post-care transition visit, patients self-reported an average 10% improvement in confidence to prevent or reduce health problems, increased knowledge of their prescriptions, and ability to determine whether they need to be seen by their provider 120 client interventions provided from July 2019 – June 2020	Grant

Focus Area	Program or Service Name	Results / Outcomes	Type of Support
Increase the capacity of the youth diversion program to meet the needs of **youth in mental health crisis**	Youth Crisis Diversion Project	Program transitioned from initial grant-sponsored stage to full integration in behavioral health services	Program
	Shodair Outpatient Services	Colocation of clinic with Providence outpatient mental health clinics planned for 2021 to increase access	Program
Collaborate with and support community partners to **reduce suicides**	Project Tomorrow	Montana dropped out of the top three states for suicide in the United States in 2019 for the first time in a decade Regular community trainings of Question, Persuade, Refer	Grant
Trauma-Informed care for **children who experience neglect or abuse**	SPH sponsored CASA Light of Hope benefit in support of abused and neglected children in Missoula and Mineral Counties	July 2019 – July 2020, CASA (Court Appointed Special Advocates) volunteers represented 312 children in Missoula and Mineral Counties, providing 4,380 hours of volunteer representation	Grant
	Expanded outpatient mental health services at First Step for children and families who have experienced abuse	First Step LCSW client volume doubled from 2018 to 2019. First Step family advocacy services expanded through addition of MSW practicum student.	Program

ACCESS TO CARE

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

Focus Area	Program or Service Name	Results / Outcomes	Type of Support
Improved Access	Enrollment Assistance	Year-round assistance for enrollment in Medicaid and Marketplace plans; assistance for applying for SSDI. Annual open enrollment assistance for Medicare Part D plan selection. Sponsorship of Cover Montana coalition	Program Grant
	Medication Assistance Program	In 2019, 794 people provided with assistance in obtaining affordable prescription medication, including saving patients over $14 million (based on average wholesale price).	Program

Focus Area	Program or Service Name	Results / Outcomes	Type of Support
	Providence Express Care	Virtual care option launched for patients and the public; service is at a flat-rate, billable to insurance	Program
	Mountain Line Zero Fare	Zero-fare public transportation project began in 2015 and continues as of 2020. 26% of riders are under 25, and 28% are over 50. Ridership has increased by 72% since zero-fare was implemented.	Grant
	Telehealth	Telehealth programming expanded to specialties including Telestroke, bariatric support, and diabetes education	Program

SUBSTANCE ABUSE

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

Focus Area	Program or Service Name	Results / Outcomes	Type of Support
Promote treatment and support services in the community	Western Montana Addiction Services	Established protocol to refer patients to peer-to-peer support program	In-kind staff time
	Eat, Sleep, Console / Bridge to Hope	Protocol for neonatal abstinence syndrome established with initial support from Montana Healthcare Foundation	Program
Collaborate with and support area schools in implementation of **mental health and substance use education and prevention**	Contribution to the PAX "Good Behavior Game" in Missoula County Public Schools to promote self-regulation, mental health, social and emotional learning, and substance abuse prevention in K-5 students	Teachers note increased student self-regulation and improved classroom culture; Longitudinal results show decreased substance use, improved mental health and decreased suicidality	Grant

Addressing Identified Needs

The Community Health Improvement Plan developed for the Providence St. Patrick Hospital community 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. Patrick Hospital 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. Patrick Hospital intends

to take, but also the anticipated impact of these actions and the resources the hospital plans to commit to address the health need.

Because partnership is important when addressing health needs, the CHIP will describe any planned collaboration between Providence St. Patrick Hospital and community-based organizations in addressing the health need. The CHIP will be approved and made publicly available no later than May 15, 2021.

2020 CHNA GOVERNANCE APPROVAL

This Community Health Needs Assessment was adopted on October 27, 2020 by the Providence Montana Community Mission Board of the hospital.[5] The final report was made widely available[6] by December 28, 2020.

10/28/2020

Joyce Dombrouski — Date
Chief Executive, Providence Montana

11/2/2020

William Bekemeyer, MD — Date
Chair, Providence Montana Community Mission Board

12/01/2020

Joel Gilbertson — Date
Executive Vice President, Community Partnerships
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To request a copy free of charge, provide comments, or view electronic copies of current and previous Community Health Needs Assessments, please email CHI@providence.org.

[5] **See Appendix 6: Providence Montana Community Mission Board Ad Hoc CHNA Committee**

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

APPENDICES

Appendix 1: Definition of Terms Related to Community Input

Access to health care services: The timely use of personal health services to achieve the best health outcomes (excluding oral health and behavioral health care services, which are included in other categories). Health care services include primary care providers, pediatricians, OB/GYN, and specialists. Access encompasses issues around insurance coverage, cost of care, timing and availability of appointments, geographic availability, availability of culturally responsive and linguistically appropriate providers, and navigating the complexities of the health care system.

Access to oral health care services: The timely use of oral health care services to achieve the best health outcomes related to dental care, tooth loss, oral cancer, and gum disease. Access encompasses issues around insurance coverage, cost of care, timing and availability of appointments, geographic availability, availability of culturally responsive and linguistically appropriate providers, and navigating the complexities of the health care system. Access to safe, nearby transportation

Accessibility for people with disabilities: The ease with which a person with a disability can utilize or navigate a product, device, service, or environment.

Affordable daycare and preschools: All families, regardless of income, can find high-quality, reasonably priced, convenient childcare options for their children birth to five. This includes free or reduced cost daycare and preschools for families that meet certain income requirements.

Aging problems: The challenges faced by adults as they age, specifically those over the age of 65, who may experience memory, hearing, vision, and mobility challenges. Adults over the age of 65 make up a larger percentage of the U.S. population than ever before and require specific supportive services related to health care, housing, mobility, etc.

Air quality: The degree to which the air is pollution and smoke-free.

Avoidable Emergency Department Utilization (AED): Based on algorithms by Medi-Cal and NYU, PSJH Healthcare Intelligence developed an “AED” flag. This is a list of conditions by diagnostic code that should not require Emergency Department care and are better treated at a more appropriate level of care. Reported at the hospital level and by payor group.

Behavioral health challenges and access to care: Includes challenges related to both mental health and substance use disorders, as well as difficulties getting the support services and care to address related challenges. Covers all areas of emotional and social well-being for all ages, including issues of stress, depression, coping skills, as well as more serious health conditions such as mental illness and Adverse Childhood Experiences. Access encompasses issues around insurance coverage, cost of care, timing and availability of appointments, geographic availability, availability of culturally responsive and linguistically appropriate providers, and navigating the complexities of the health care system.

Bullying and verbal abuse: Put downs and personal attacks that cause a person emotional harm. Examples include name calling, shaming, jokes at the expense of someone else, excessive criticism,

yelling and swearing, and threats. Specifically referring to instances taking place outside of the home, in places in the community such as school and the workplace.

Child abuse and neglect: “Injury, sexual abuse, sexual exploitation, negligent treatment or maltreatment of a child by any person under circumstances which indicate that the child’s health, welfare, and safety is harmed.”[7]

Discrimination: Treating a person unfairly because of who they are or because they possess certain characteristics or identities. Examples of characteristics or identities that are discriminated against include the following: age, gender, race, sexual orientation, disability, religion, pregnancy and maternity, gender reassignment, and marriage and civil partnership.[8]

Domestic violence: Also called intimate partner violence, “a pattern of abusive behavior in any relationship that is used by one partner to gain or maintain control over another intimate partner.”[9]

Economic Insecurity: Lacking stable income or other resources to support a standard of living now and in the foreseeable future.

Few arts and cultural events: A lack of representation of different cultures and groups in the community demonstrated through music, dance, painting, crafts, etc.

Firearm-related injuries: Gun-related deaths and injuries.

Food insecurity: A lack of consistent access to enough good-quality, healthy food for an active, healthy life.

Gang activity/ violence: Encompasses the incidence of crime and violence in the community as well as the fear of it, which prevents people from using open space or enjoying their community.

Health Equity: A principle meaning that “everyone has a fair and just opportunity to be as healthy as possible. This requires removing obstacles to health such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care. For the purposes of measurement, health equity means reducing and ultimately eliminating disparities in health and its determinants that adversely affect excluded or marginalized groups.”[10]

HIV/AIDS: Acquired immunodeficiency syndrome (AIDS), a chronic potentially life-threatening condition caused by the human immunodeficiency virus (HIV). Refers to challenges addressing the spread of HIV in the community and challenges providing treatment, support, and health education related to HIV and AIDS.

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

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

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

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

Homelessness/ lack of safe, affordable housing: Affordability, availability, overcrowding, and quality of housing available in the community. Includes the state of having no shelter or inadequate shelter.

Job skills training: Occupational training with an emphasis on developing the necessary skills to support and guide individuals in finding jobs that meet their interests and pay a livable wage.

Lack of community involvement: Individuals in a defined geographic area do not actively engage in the identification of their needs, nor do they participate in addressing those needs.

Obesity: Primarily defined as the health condition in which individuals are sufficiently overweight as to have detrimental effects on their overall health. This does not include issues of exercise or food choices, which are listed as separate issues.

Poor quality of schools: Schools that do not provide a quality education to all students regardless of race, ethnicity, gender, socioeconomic status, or geographic location. A quality education is defined as one that "provides the outcomes needed for individuals, communities, and societies to prosper. It allows schools to align and integrate fully with their communities and access a range of services across sectors designed to support the educational development of their students."[11]

Racism: "Prejudice against someone based on race, when those prejudices are reinforced by systems of power."[12]

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

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

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

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

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

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

Appendix 2: Quantitative Data

POPULATION LEVEL DATA

2017 vs. 2020 County Health Rankings – Missoula County

Numbers in **bold** are the county's rank for that measure compared to the rest of the state's 56 counties.

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

	Montana - 2020	Missoula - 2020	Missoula - 2017
Health Outcomes		**13**	**6**
Length of Life		*8*	*2*
Premature death	7,200	6,100	5,600
Quality of Life		***22***	***22***
Poor or fair health	15%	14%	13%
Poor physical health days	3.8	3.8	3.5
Poor mental health days	3.7	3.8	3.4
Low birthweight	7%	7%	7%
Health Factors		**7**	**13**
Health Behaviors		***16***	***18***
Adult smoking	17%	17%	18%
Adult obesity	26%	22%	22%
Food environment index	7.3	7.7	7.1
Physical inactivity	22%	17%	15%
Access to exercise opportunities	75%	93%	89%
Excessive drinking	21%	25%	24%
Alcohol-impaired driving deaths	45%	35%	44%
Sexually transmitted infections	434.1	474.3	491.9
Teen births	24	13	18
Clinical Care		***2***	***2***
Uninsured	10%	9%	15%
Primary care physicians	1,250:1	980:1	1,070:1
Dentists	1,390:1	1,140:1	1,120:1
Mental health providers	330:1	210:1	270:1
Preventable hospital stays	3,142	2,670	3,000
Mammography screening	42%	47%	69%
Flu vaccinations	42%	50%	
Social & Economic Factors		***10***	***16***
High school graduation	86%	89%	90%
Some college	68%	77%	79%
Unemployment	3.70%	3.30%	3.90%
Children in poverty	16%	13%	17%
Income inequality	4.5	4.9	4.7
Children in single-parent households	27%	26%	30%
Social associations	14.3	11.4	12.5

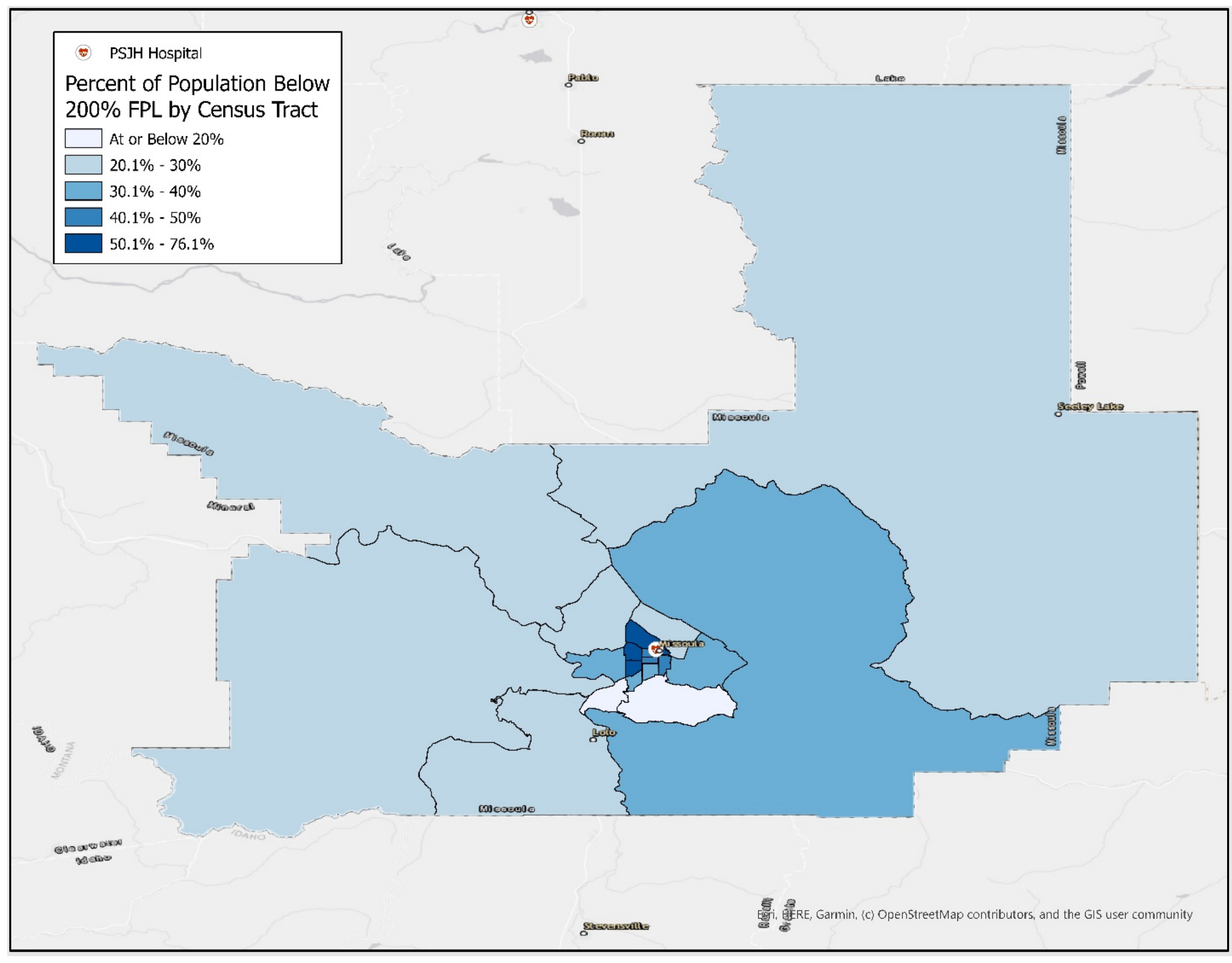
Violent crime	346	345	293
Injury deaths	91	78	79
Physical Environment		***48***	***46***
Air pollution - particulate matter	6	8.6	7.6
Drinking water violations		Yes	Yes
Severe housing problems	15%	19%	19%
Driving alone to work	76%	72%	72%
Long commute - driving alone	16%	13%	11%
Length of Life			
Life expectancy	78.8	79.5	
Premature age-adjusted mortality	340	300	290
Child mortality	60	50	40
Infant mortality	6	5	4
Quality of Life			
Frequent physical distress	12%	11%	10%
Frequent mental distress	12%	12%	11%
Diabetes prevalence	8%	6%	5%
HIV prevalence	68	118	73
Health Behaviors			
Food insecurity	11%	13%	14%
Limited access to healthy foods	8%	7%	8%
Drug overdose deaths	12	11	14
Motor vehicle crash deaths	19	13	14
Insufficient sleep	28%	27%	28%
Clinical Care			
Uninsured adults	12%	10%	18%
Uninsured children	6%	4%	7%
Other primary care providers	803:1	660:1	827:1
Social & Economic Factors			
Disconnected youth	7%	3%	11%
Reading scores	3.1	3.3	
Math scores	3		
Median household income	$55,200	$56,200	$45,000
Children eligible for free or reduced price lunch	45%	48%	44%
Residential segregation - Black/White	77	68	73
Residential segregation - non-White/White	50	26	18
Homicides	3	3	2
Suicides	26	25	
Firearm fatalities	19	20	18
Juvenile arrests	42	57	
Physical Environment			
Traffic volume	146	244	
Homeownership	68%	59%	
Severe housing cost burden	13%	17%	

Population Below 200% Federal Poverty Level

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

Indicator	Missoula County	Broader Service Area	High Need Service Area
Percent of Population Below 200% Federal Poverty Level **Data Source: American Community Survey** **Year: 2019**	34.43%	26.50%	46.08%

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



- The high need service area has a substantially larger proportion of population living below 200% FPL, 46%, compared to Missoula County, 34%.

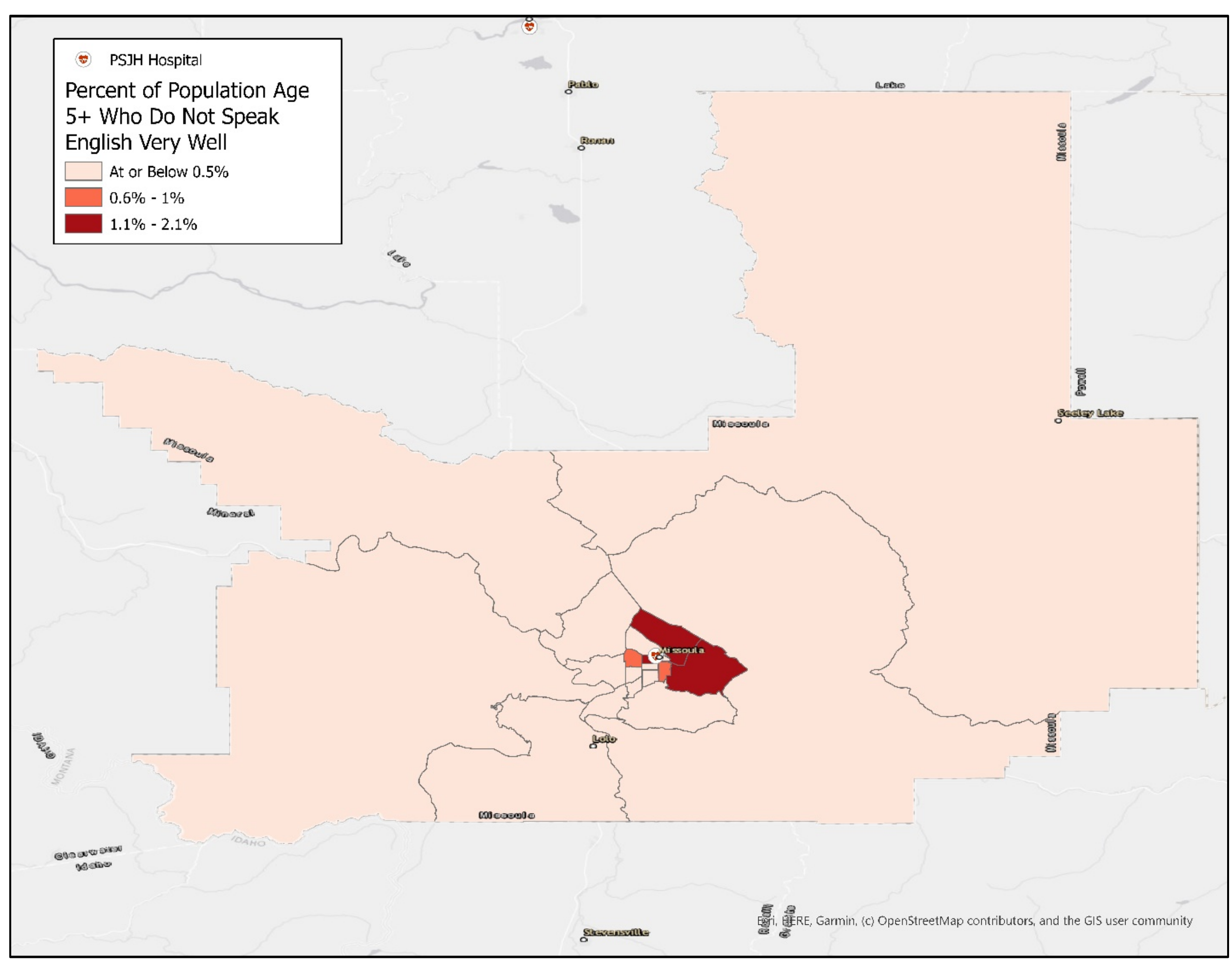
- The gap is even wider between the high needs service area, 46%, and the broader service area, 27%, when comparing percent of population living below 200% FPL.

Language Proficiency

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

Indicator	Missoula County	Broader Service Area	High Need Service Area
Percent of Population Age 5+ Who Do Not Speak English Very Well **Data Source: American Community Survey Year: 2019**	0.37%	0.38%	0.36%

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



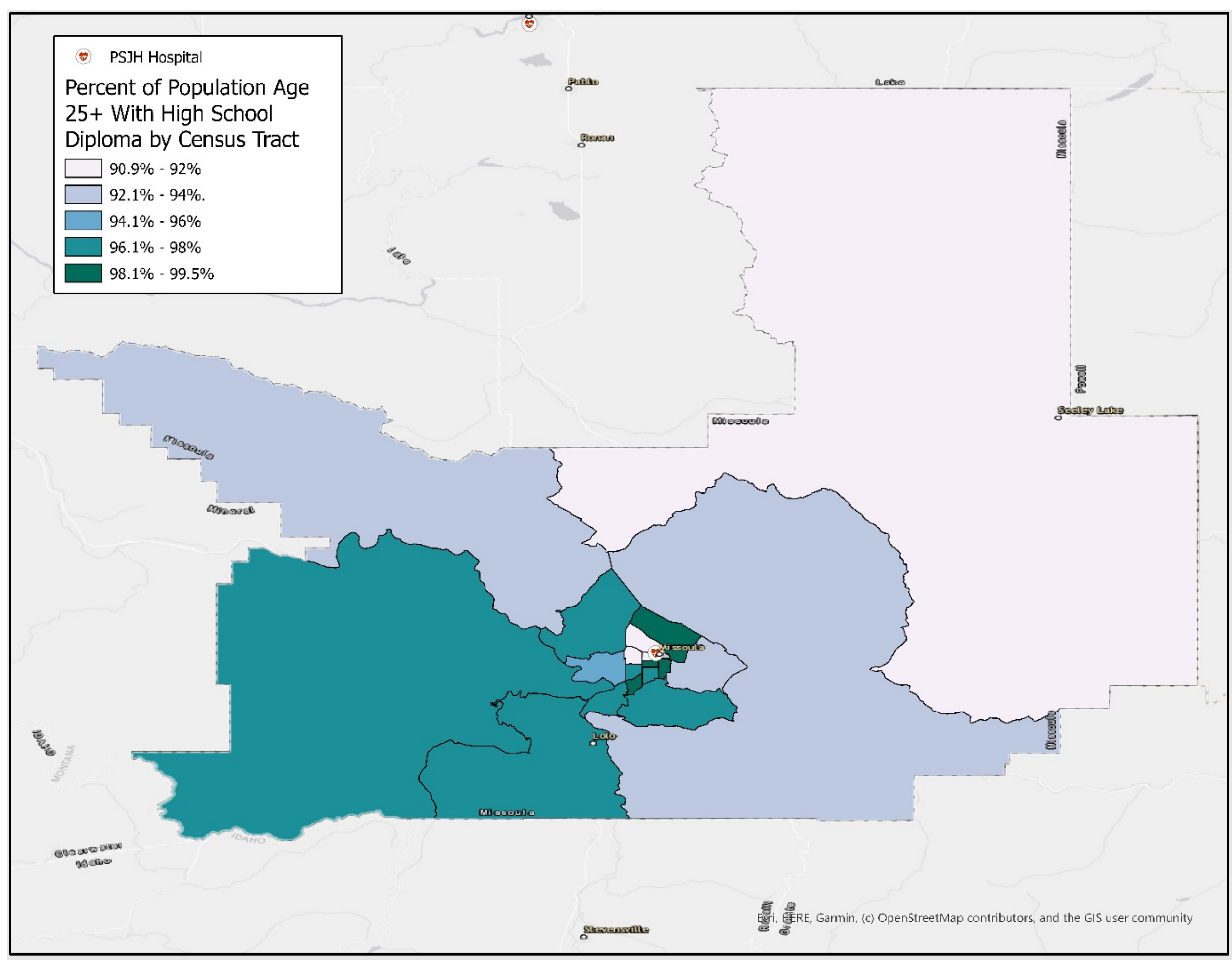
- There is little variation between the high need service area and broader service area for percent of population over 5 who do not speak English very well. There were few census tracts with above 0.5% of the population over 5 who do not speak English very well.

Percent of Population with A High School Education

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

Indicator	Missoula County	Broader Service Area	High Need Service Area
Percent of Population Age 25+ With A High School Diploma **Data Source: American Community Survey Year: 2019**	95.33%	97.00%	92.95%

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



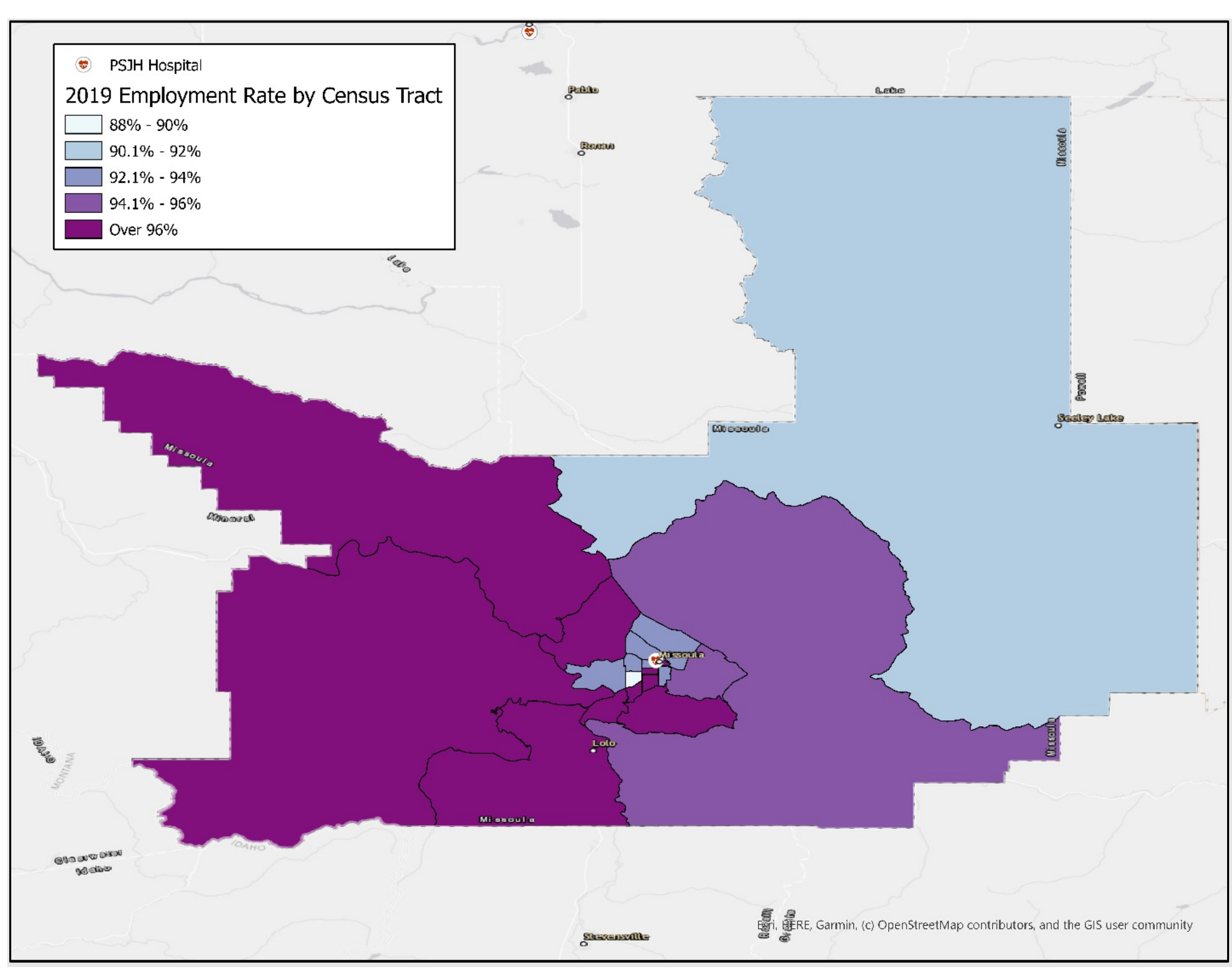
- About 93% of people living in the high need service area who are over 25 years have a high school diploma compared to 97% in the broader service area.
- The proportion of people with a high school diploma in Missoula County overall falls in the middle of the two service areas at 95%.

Percent of Labor Force Employed

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

Indicator	Missoula County	Broader Service Area	High Need Service Area
Percent of Population Age 16+ Who Are Employed Data Source: American Community Survey Year: 2019	94.85%	96.13%	92.94%

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



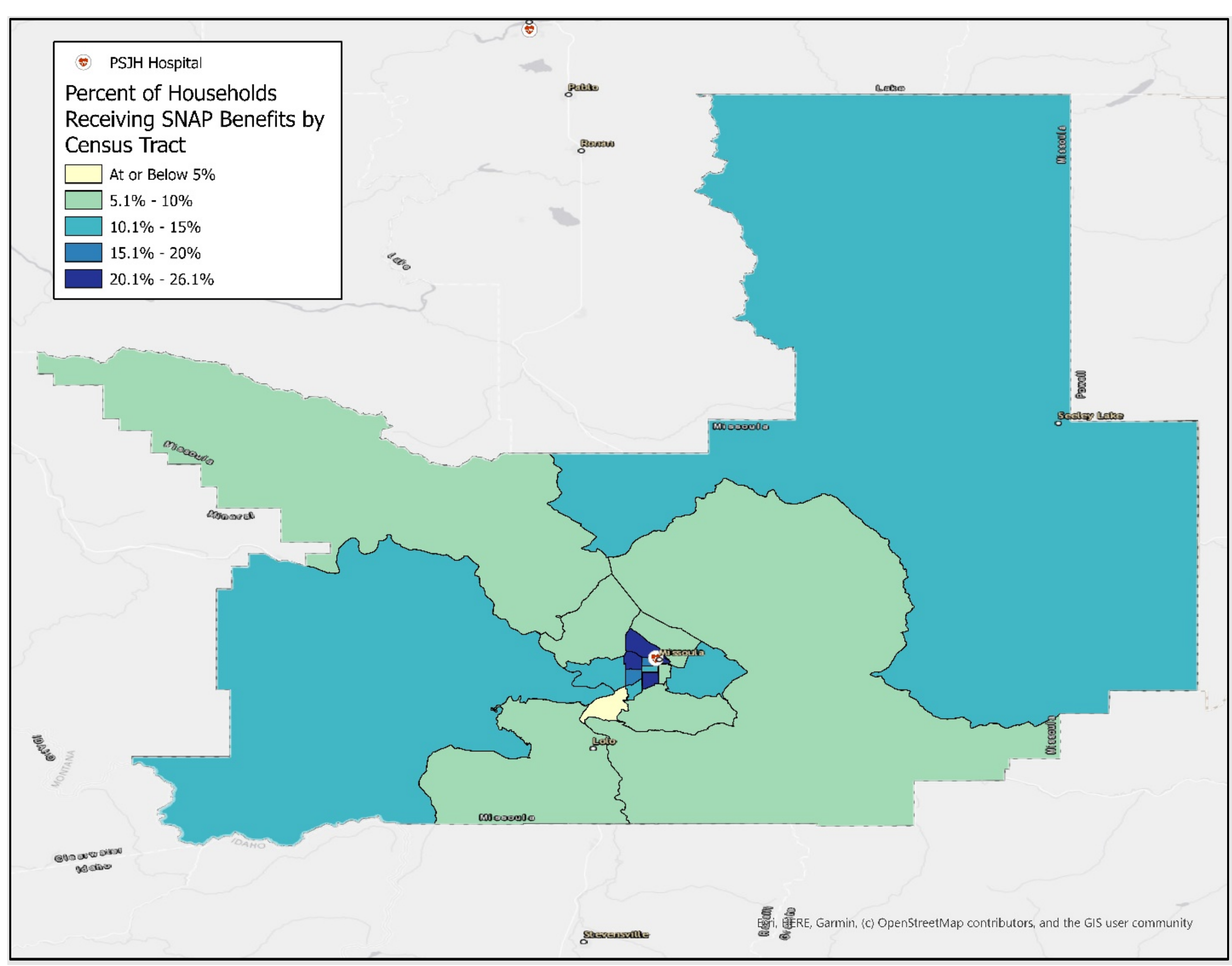
- Over 96% of the population is employed in the broader service area compared the 93% in the high need service area.
- These data are from 2019 and do not yet represent the economic effects of the COVID-19 pandemic.

Percent of Households Receiving SNAP Benefits

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

Indicator	Missoula County	Broader Service Area	High Need Service Area
Percent of Households Receiving SNAP Benefits **Data Source: American Community Survey** **Year: Estimates based on 2013 – 2017 data**	12.77%	9.17%	17.52%

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



- The high need service area has almost twice the percentage of households receiving SNAP benefits compared to the broader service area.
- The highest percentages of households enrolled in SNAP are in the center of Missoula County, closest to St. Patrick Hospital.

HOSPITAL LEVEL DATA

Avoidable Emergency Department (AED) Visits

Emergency department discharges for the year 2019 were coded as "avoidable" per the Providence St. Joseph Health definition for Providence St. Patrick Hospital and nearby PSJH hospitals. Avoidable emergency department (AED) are based on the primary diagnosis for a discharge and includes diagnoses that are deemed non-emergent, primary care treatable or preventable/avoidable with better managed care.

Apx 2_Table 7. Avoidable Emergency Department Visits by PSJH Hospital in Washington and Montana

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

Apx 2_Table 8. Avoidable Emergency Department Visits by Race at Providence St. Patrick Hospital

Facility and Race	Non-AED Visits	AED Visit	Total ED Visits	AED %
Providence St. Patrick Hospital- Missoula	**15,832**	**7,394**	**23,227**	**31.8%**
American Indian or Alaska Native	1,017	728	1,745	41.7%
Asian	77	32	109	29.4%
Black or African American	185	126	311	40.5%
Native Hawaiian or Other Pacific Islander	29	11	40	27.5%
Other	194	127	321	39.6%
Patient Refused	83	26	109	23.9%
Unknown	763	340	1,103	30.8%
Unspecified	69	25	94	26.6%
White or Caucasian	13,397	5,966	19,363	30.8%
(Blank)	19	12	31	38.7%

Apx 2_Table 9. Avoidable Emergency Department Visits by Ethnicity at Providence St. Patrick Hospital

Facility and Ethnicity	Non-AED Visits	AED Visit	Total ED Visits	AED %
Providence St. Patrick Hospital-Missoula	**15,832**	**7,394**	**23,227**	**31.8%**
Hispanic or Latino	308	196	21,196	38.9%
Not Hispanic or Latino	14,466	6,730	120	31.8%
Patient Refused	86	34	1,267	28.3%
Unknown	873	394	94	31.1%
Unspecified	69	25	45	26.6%
(Blank)	31	14	504	31.1%

Apx 2_Table 10. Avoidable Emergency Department Visits by ZIP Code at Providence St. Patrick Hospital

Encounters by Patient Zip Code	Non-AED Visits	AED Visit	Total ED Visits	AED %
Providence St. Patrick Hospital-Missoula	**15,832**	**7,394**	**23,227**	**31.8%**
59802	3,142	1,745	4,887	35.7%
59801	3,080	1,586	4,666	34.0%
59808	2,352	1,011	3,363	30.1%
59803	977	370	1,347	27.5%
59804	492	234	726	32.2%

- Of ED visits by people who identify as Hispanic/Latino, 39% of visits were potentially avoidable.
- Of ED visits by people who identify as American Indian/Alaska Native, 42% of visits were potentially avoidable.
- The most common diagnoses associated with Avoidable ED use were acute upper respiratory infection (4.9%), headache (4.8%), dizziness and giddiness (4.0%), alcohol abuse with intoxication, unspecified (3.6%), and major depressive disorder, single episode (3.4%).
- If the 4th most common diagnosis (alcohol abuse with intoxication, unspecified) is combined with the 7th most common diagnosis (alcohol abuse with intoxication, uncomplicated), then alcohol abuse with intoxication jumps to the most common diagnosis for AED (6.6%).
- The ZIP codes with the greatest proportion of AED visits were 59802, 59801, 59808, 59803, and 59804.

Apx 2_Table 11. Top 20 Diagnosis Groups for Avoidable Emergency Department Visits at Providence St. Patrick Hospital

Top 20 Diagnosis Groups* for AED Visits	Avoidable Visits	Percent of Total Avoidable Visits
Providence St. Patrick Hospital- Missoula	**7,394**	
Substance Use Disorders	915	12.4%
Skin Infection	527	7.1%
Bronchitis and Other Upper Respiratory Disease	496	6.7%
Anxiety and Personality Disorders	452	6.1%
Nonspecific Back and Neck Pain	431	5.8%
Urinary Tract Infection	406	5.5%
Headache/Migraine	353	4.8%
Dizziness	295	4.0%
Mood Disorders, Episodic	259	3.5%
Psychosis	176	2.4%
Tonsillitis	153	2.1%
Oral and Dental Disease	148	2.0%
Acute Otitis Media and Sinusitis	147	2.0%
Dermatitis and Rashes	139	1.9%
Asthma	137	1.9%
Diabetes Mellitus	130	1.8%
Pneumonia Including Aspiration Pneumonia	128	1.7%
Chronic Obstructive Pulmonary Disease	127	1.7%
Gastroenteritis and Intestinal Infections	113	1.5%
Musculoskeletal Injury - Shoulder/Elbow/Upper Arm	112	1.5%

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

- The twenty most common AED visits by diagnosis group account for 76.3% of all AED visits.
- Patients with AED Substance Use Disorders visits averaged 1.7 visits per patient; 20 patients had 6+ AED Substance Use Disorder visits, accounting for 25% of all AED visits for Substance Use Disorders
- Mental health-related AED visits (including Anxiety and Personality Disorders, Mood Disorders, Episodic, and Psychosis) combined account for 12% of all AED visits
- Mental health-related AED visits combined with Substance Use Disorders AED visits accounted for 1 in 4 of all avoidable ED use in 2019

Prevention Quality Indicators

Prevention Quality Indicators were developed by the Agency for Healthcare Research and Quality to measure potentially avoidable hospitalizations for Ambulatory Care Sensitive Conditions (ACSCs). ACSCs are conditions for which hospitalizations can potentially be avoided with better outpatient care and which early intervention can prevent complications.
More info on PQIs can be found on the following links:
https://www.qualityindicators.ahrq.gov/modules/pqi_overview.aspx
https://www.qualityindicators.ahrq.gov/modules/pqi_resources.aspx
PQIs were calculated using inpatient admission data for the year 2019.

The most common PQIs for Providence St. Patrick Hospital—Missoula are heart failure, community acquired pneumonia, and dehydration.

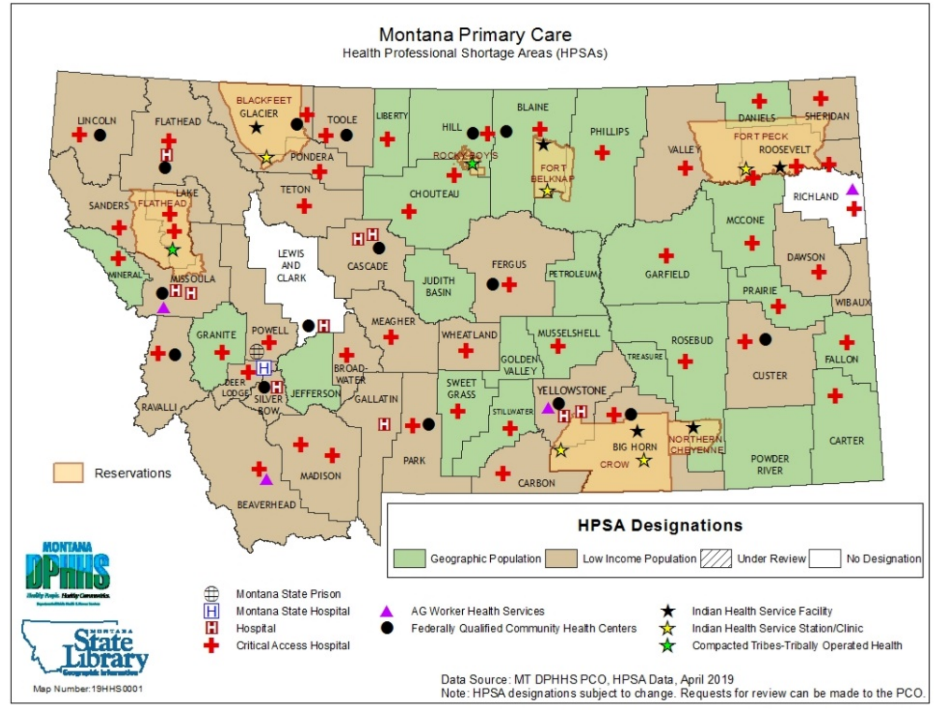
Apx 2_Table 12. Prevention Quality Composite Rates for Providence St. Patrick Hospital

Indicator	Label	Numerator	Denominator	Observed Rate Per 1,000 Visits
PQI 90	**Prevention Quality Overall Composite, per 1,000 visits**			
	ST PATRICK HOSPITAL	677	9,968	67.92
PQI 91	**Prevention Quality Acute Composite, per 1,000 visits**			
	ST PATRICK HOSPITAL	183	9,968	18.36
PQI 92	**Prevention Quality Chronic Composite, per 1,000 visits**			
	ST PATRICK HOSPITAL	494	9,968	49.56

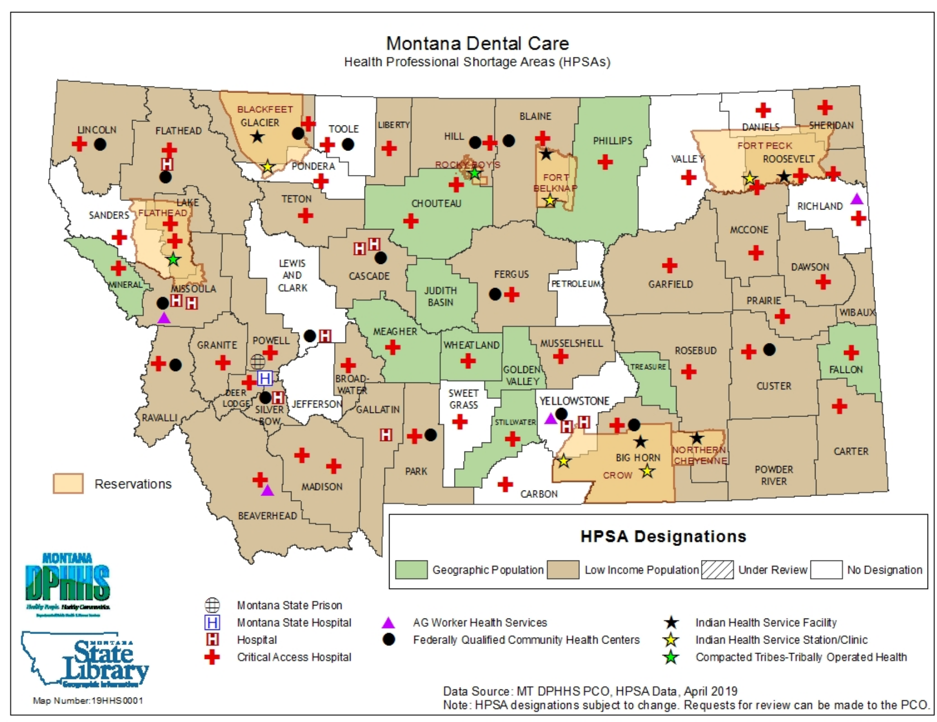
HEALTH PROFESSIONAL SHORTAGE AREA

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). Missoula County is a designated HRSA Health Professional Shortage Area (HPSA) for low-income populations for primary, dental and mental health care. Surrounding counties in the greater service area all have HPSA designations, except for Lewis and Clark County.

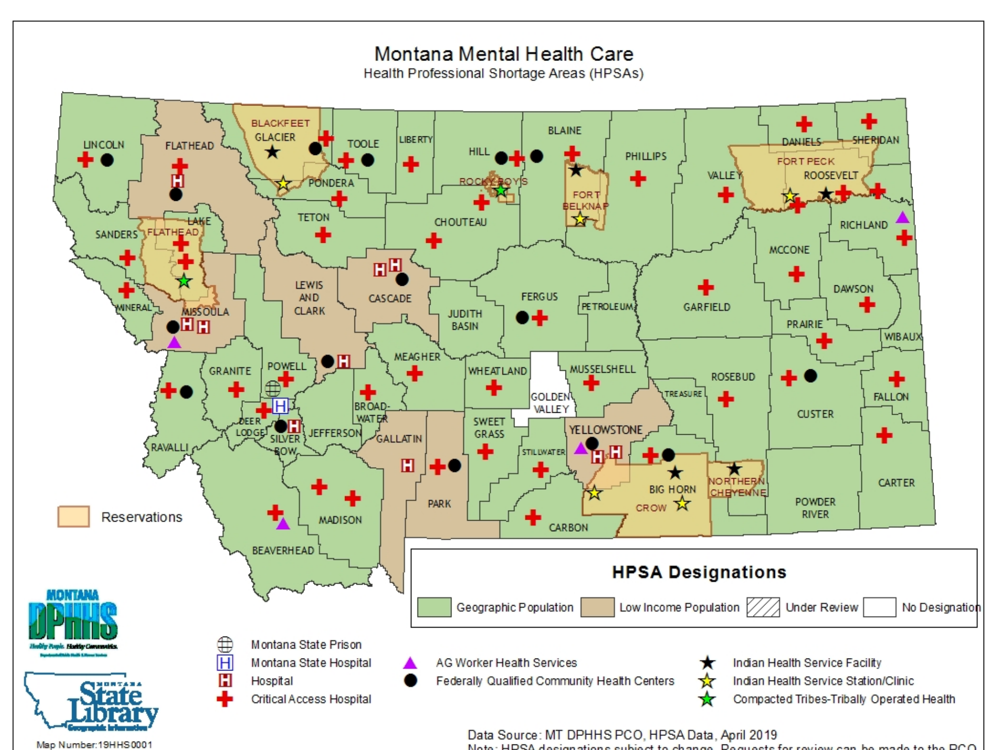
Apx 2_Figure 6. Montana Primary Care Health Professional Shortage Areas



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



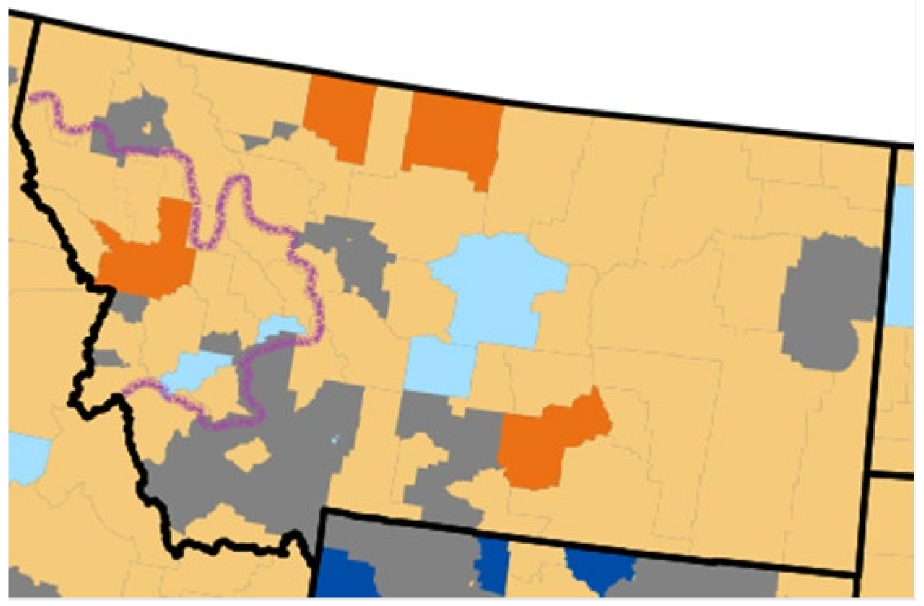
Apx 2_Figure 8. Montana Mental Health Care Health Professional Shortage Areas

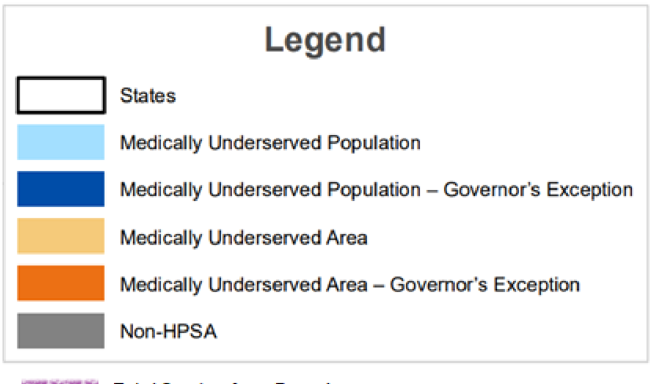


MEDICALLY UNDERSERVED AREA/ MEDICAL PROFESSIONAL SHORTAGE AREA

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

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





Total Service Area Boundary

Appendix 3: Community Input

STAKEHOLDER INTERVIEWS

Introduction

Providence St. Patrick Hospital—Missoula conducted stakeholder interviews, recognizing the importance of including the voices of community leaders who help make Missoula County healthier. Listening to and engaging with the people who live and work in the community is a crucial component of the CHNA, as these individuals have firsthand knowledge of the needs and strengths of the community. The stakeholder interviews are particularly important this CHNA cycle as the COVID-19 pandemic has prevented us from facilitating listening sessions with community members. We relied on community stakeholders to represent the broad needs of the communities they serve.

Providence St. Patrick Hospital—Missoula included the insight of 12 stakeholders, people who are invested in the well-being of the community and have first-hand knowledge of community needs and strengths. The goal of the interviews was to identify what needs are currently not being met in the community and what assets could be leveraged to address these needs.

Methodology

Selection

A total of 10 stakeholder interviews with 12 participants were completed by representatives from Providence St. Patrick Hospital—Missoula. Stakeholders were selected based on their knowledge of the community and engagement in work that directly serves people who have low incomes, have chronic conditions, and/or are medically underserved. Providence St. Patrick Hospital—Missoula aimed to engage stakeholders from social service agencies, health care, education, housing, and government, among others, to ensure a wide range of perspectives. Included in the interviews was a representative from the Missoula City-County Health Department.

Apx 3_Table 1. Community Stakeholder Interview Participants

Organization	Name	Title	Sector
All Nations Health Center	D'Shane Barnett	Executive Director	Mental health, access to care
City of Missoula, Housing and Community Development	Theresa Williams	Reaching Home Program Manager	Homelessness
Human Resource Council	Kate Ybarra	Executive Director	Community resources, aging and vulnerable populations
Missoula Aging Services	Shelli Fortune	In-Home Services Director	Aging services, aging and vulnerable populations
	Gabriel Goeres	Care Management Supervisor	

Missoula City-County Health Department	Nancy Hobbins	Suicide Prevention Coordinator	Mental health
Missoula Food Bank	Aaron Brock	Executive Director	Food insecurity, aging and vulnerable populations
Montana Food Bank Network	Gayle Carlson	Chief Executive Officer	Food insecurity, aging and vulnerable populations
Open Aid Alliance	Christa Weathers	Executive Director	Homelessness, substance use
Partnership Health Center	Rebecca Goe	Director of Innovation	Mental health, access to care
Project Tomorrow Montana	Rosie Ayers	Suicide Prevention Coordinator	Mental health
University of Montana, College of Health Professions and Biomedical Sciences **Missoula County Public Schools**	Wilena Old Person	Program Coordinator, Health Careers Opportunity Program Board of Trustees Member	Education

Facilitation Guide

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

- The role of the stakeholder's organization and community served
- Prioritization of unmet health related needs in the community, including social determinants of health
- Populations disproportionately affected by the unmet health-related needs
- Gaps in services that contribute to unmet health-related needs
- Barriers that contribute to unmet health-related needs
- Community assets that address these health-related needs
- Opportunities for collaboration between organizations

Training

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

Data Collection

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

Analysis

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

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

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

The analyst determined the frequency each code was applied to the dataset, highlighting which codes were mentioned most frequently. The analyst used the query tool and the co-occurrence table to better understand which codes were used frequently together. For example, the code "mental health" can occur often with the code "stigma." Codes for unmet health-related needs were cross-referenced with the domains to better understand the populations most affected by a certain unmet health-related need and the barriers to addressing those needs. The analyst documented patterns from the dataset related to the frequency of codes and codes that were typically used together.

Findings from Stakeholder Interviews

Stakeholders were asked to identify their top five health-related needs in the community. Two needs were mentioned in most interviews and were categorized as high priority. Four additional needs were also frequently prioritized and categorized as medium priority. The effects of the COVID-19 pandemic will be woven throughout the following sections on health-related needs but will also be summarized in its own section.

High Priority Unmet Health-Related Needs

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

1. Homelessness/ lack of safe, affordable housing

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

Homelessness/ lack of safe, affordable housing

Stakeholders shared a lack of living wage jobs combined with the high cost of housing contribute to **poor living conditions**, **overcrowding**, and **unstable housing**. Families are receiving wages that do not enable them to meet their basic needs, such as good-quality housing and healthy food. To compensate for the high-cost of housing, families utilize food banks and other assistance programs.

"We are serving the working poor is what I would say where the high cost of housing in Missoula is what our customers indicate is the number one reason for them having to use the food bank. The families who are making wages that simply do not enable them to have a sustainable living scenario here without some sort of supplemental assistance, like what the food bank provides." – Community Stakeholder

They noted housing as being foundational to well-being; people who are stably housed are better able to care for their **physical and mental health**. Stakeholders shared poor-quality housing and overcrowding contributes to health problems, especially if mold is present or people do not have the space to take care of themselves.

"Those are the pressures that cause a family to live in housing that's not adequate or safe and might have black mold or might have other things that contribute negatively to health impacts." – Community Stakeholder

They emphasized the importance of taking a Housing First approach, noting that people who are experiencing homelessness or housing instability may not have the capacity to address their health needs.

"Another barrier is people just in subsistence living and being too overwhelmed to really even think about their health. That means that we have to wrap services around people before they can really think about health issues and have a Housing First model only with health. In Housing First, you would wrap services around people in order to get them served. Here you would wrap services around people in order to get them to access medical care, because that's what we're talking about, is people who really just don't do that because they're so overwhelmed with their day to day stuff." – Community Stakeholder

Stakeholders noted that exposure to Adverse Childhood Experiences (ACEs), trauma, and racism contribute to mental health challenges, substance use, and overall instability, which can affect their ability to stay in housing and address their housing needs.

"I think are a focus with our population and the need can be met, but then we see the secondary, which is like untreated mental health, isolation, substance use. Those are kind of where we see the biggest impacts, so those will compromise healthcare and housing significantly, and we see that over and over again. We have money to pay for housing, but keeping people in housing becomes the challenge" – Community Stakeholder

Stakeholders spoke to the need for more **permanent supportive housing** that promotes a positive lifestyle to meet the needs of people with behavioral health challenges or disabilities, noting that these needs can compromise housing stability.

"We don't have enough long-term permanent supportive housing vouchers. Those are vouchers that are given to people who are street homeless, who have a disability and we just don't have adequate vouchers. The coordinated entry system is used to assign people those vouchers now. I can't really say we have a waitlist. It's kind of a misnomer when I said it before, in that they don't keep a list. The list we have is the by-name list of people who are homeless. In permanent supportive housing at the Housing Authority, when they have a voucher they ask for referrals and get them." – Community Stakeholder

"I mean, what we see in our population especially is housing. I would even go further, it's not just housing, it has to be positive lifestyle supportive housing. Putting them in a 10 by 10 room with another person, yes, they might have a roof over their head, but they're not going to have the space that they need to adequately take care of themselves." – Community Stakeholder

They also shared there needs to be more housing options that are not just affordable, but actually **match what people are able to pay**. For many people, "affordable housing" is still too expensive and leads to housing cost burden. They spoke to needing to establish rent based on income to ensure families are not paying more than 30% of their income on rent.

"I think the other unmet need we talked about is affordable housing, and then that term usually means units that are at or below fair market rent, but those are still not rents that people can afford. Fair market rent is still high. If you're working at the wages that most people make in Missoula, or you're getting disability of some kind, or you're getting TANF, it is very difficult to find housing to rent. I think housing that people can pay for would be the terminology that I would use. Because when we talk about affordable housing, it usually refers to housing that is at or below fair market rent and that's still pretty high" – Community Stakeholder

Stakeholders described the following barriers to addressing homelessness and housing instability:

- **Complicated systems to navigate:** They described the systems in place to help people with housing as uninviting and challenging for people in crisis to navigate. The system itself acts as a barrier for people by not meeting them where they are, emphasizing the need for more **case management** and navigation supports.

"One of the barriers is they're in crisis themselves and all of the systems that we have are systems and when people are in crisis, they don't do well in engaging with a system. They do better being met where they're at and visited in an old style case management kind of way where you offer them a cup of coffee and you sit down to visit and then you figure out what they want and combine it with what you perceive they need. I think the barrier is the system itself isn't inviting to people. It's this system. That's a barrier." – Community Stakeholder

- **Housing discrimination** contributes to **Native American** and **Black people**, as well as **people identifying as LGBTQ+** having more difficulty accessing good-quality, affordable housing. Landlords deny their applications, leading to them needing to accept poor-quality housing. They noted that creating more affordable housing is important, but these groups will still experience housing discrimination and will still not have access to affordable, good-quality housing. Addressing housing instability requires also addressing racism and discrimination.

"And then housing, we constantly hear complaints from Native Americans that they're denied housing. It's, 'Oh, yes. Your application is good, but there was somebody that was just a little bit better.' It's not never. In the last 20 years, it really isn't landlords saying, 'Oh, I'm not going to rent to you because you're Native,' but they're still finding reasons not to rent, not to give good quality housing. And then because you still need a home, and so Natives will accept subpar housing because they need housing." – Community Stakeholder

" If we actually go out and were we say, 'We need more affordable housing, we need more affordable housing,' but then we talk to Native and LGBT members of Missoula community where we find out, no, it doesn't matter the housing there because the landlords aren't renting to them because of discrimination. Homelessness, housing is not the issue. Discrimination is the issue. Just by going on data alone, we're not getting the full story if we don't have those voices at the table." – Community Stakeholder

Other groups who may have challenges accessing quality housing are people with **criminal backgrounds**, poor credit, or negative housing histories. They shared there are few housing options for these groups.

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

Young people experiencing homelessness, especially those identifying as **LGBTQ+** may not want to engage with services because they are leaving unsafe, violent, and/or unwelcoming homes. They may be trying to "fly under the radar," to avoid being sent back to their homes.

"Then I also think youth sometimes can be disproportionately affected because they're less likely to ask for help. Most homeless youth are attempting to fly under the radar. They don't really want to engage with systems because they're fleeing sometimes home violence and things like that. They don't want to be identified and reunited with the domestic violence situation that they were in. Sometimes often they are feeling persecuted because they may be transgender and that sort of thing. They're not likely to go out and seek out services because they're afraid that they'll be sent back to the places they ran away from." – Community Stakeholder

Multiple stakeholders emphasized the need to engage **individuals with lived experience** with homelessness and housing discrimination in conversations around housing solutions.

Due to **COVID-19**, stakeholders expect to see homelessness increase in Missoula due to more evictions. They also shared they think there will be increased housing discrimination and people experiencing homelessness for longer periods of time.

"I think we're going to see more housing discrimination in trying to get people into housing, so we're going to see people on the streets longer. I also see more people coming into homelessness with evictions." – Community Stakeholder

They noted that overcrowded housing and homelessness may contribute to easier spread of the virus and make physical distancing more difficult.

"Then a group of people who are homeless or low-- are housing insecure, it's a hard place to be. If you can't safely social distance, or if you need to get tested, where do you isolate? As we move into winter, where are people going to stay?" – Community stakeholder

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

Stakeholders identified a history of **inter-generational trauma, child abuse/neglect,** and **poverty** as contributors to both mental health challenges and substance use disorders (SUD).

"I think one of the needs that we saw recently is mental health, especially when it comes to suicide issues. I've seen the impacts of suicide in communities, especially some close to Missoula like the ones up on Flathead, how it impacted the young people there. I think mental health is always a need. There's students who, due to inter-generational trauma and different things like that, the fact of talking about feelings is tough. I think that impacts our students today." – Community Stakeholder

Behavioral health challenges can also be a barrier to accessing needed **health care** services. Stakeholders shared that people with behavioral health challenges may be shamed or turned away from services for their behavior. Health care has created a barrier by developing strict expectations that do not meet people where they are. This can lead to distrust of health care and people avoiding services.

"I think it has to do with access. If you don't have access to health care for whatever reason, because it's insurance, lack of the car, you live in a rural area, or you can't go because you're trying to keep employment and so you can't get in work. Or if you have a substance use problem and/or maybe your behavior, you have a mental health condition and your behavior is not tolerated in that setting. I think all of those things contribute to compounds." – Community Stakeholder

Stakeholders emphasized a need for more mental health services including the following:

- **Peer mental health case managers**, specifically for individuals who do not qualify for Medicaid and those experiencing social isolation.
- Improved **integration of behavioral health** into primary care with **easier access points:** They spoke to needing to make therapy more accessible for people with mild to moderate mental health needs.

"The third one would be more mental health access, because I feel like stuff that's available now is mental health, but it's for severe cases. There's no entry or midway. It feels like it's just a severe form of mental health where we need to get them in to see someone, but it's not regular therapy sessions that some people actually need in different areas." – Community Stakeholder

- Better mental health **assessment tools** to accurately assess psychosocial needs and connect patients to appropriate services
- Improved **gun safety** to reduce suicides, including more free gun locks: Stakeholders suggested handing out gun locks at pediatricians' officers

"Right now what we do in terms of firearm suicide prevention is really just education. We hand out gun locks from my office for free. I spend a good deal of my budget on gun locks for the community. I'm thrilled to pass them out and they fly off the shelves whenever I stock them. When we talk about it in our QPR classes about why means matter and why it's so important because guns are by far the most lethal method of suicide. Suicide is very often a very impulsive act. The combination of having an impulsive act and a very lethal weapon is one of the biggest problems that we have." – Community Stakeholder

- **Crisis services** for people needing immediate, but short-term support, besides the Emergency Department: Stakeholder spoke to wanting to prevent people from ending up in jails or the ED for mental health needs. This might be for people who simply need a safe place to be for a night or two if they are having suicidal ideation or detoxing.

"One of the things that we're trying to work on right now is having a 24/7 urgent mental health care center. Western Montana Mental Health has been working on that. We want to keep people who are in a mental health crisis out of the emergency rooms and out of jail. It's not a small task." – Community Stakeholder

Stakeholders spoke to challenges accessing appropriate SUD treatment services, noting a need for the following:

- **Wraparound, low-barrier, transitional SUD treatment facility** that meets people where they are in their process. Stakeholders shared people often cannot be admitted to the hospital because they do not meet detox criteria, but they also do not meet the criteria for a sober house. They suggested a low-barrier SUD treatment facility with minimal paperwork.

"I think that the barrier that I've experienced the most is, again, there's kind of a juggernaut between people needing detox or needing treatment and so then capturing people. I've had this experience where you have someone who wants treatment but then they can't get it the places they go because they don't fit in the appropriate box at the place that they go to. I feel like we have a lot of barriers to people getting alcohol and drug treatment. I don't think they're intentional, but I just think that it's a theory and practice thing." – Community Stakeholder

- More **harm reduction services**.

They shared **stigma** and a lack of **education** and comfort talking about behavioral health are barriers to people receiving support. Stakeholders shared people may not always have the vocabulary or language to discuss their mental health challenges. They specifically noted older white men have a challenging time expressing these needs.

"I think that access is the primary although maybe hovering around that issue is also the stigma of mental health. The ability to talk about it. That's almost like an education piece that our wider community doesn't have oftentimes the vocabulary or the social safety to be able to talk about it… Making sure that as a whole community, we are helping to combat the stigma or change the dialogue about what it means to talk about your own mental health or to seek help openly." – Community Stakeholder

Providing education to help people better understand what mental health is and offering resilience and self-care training can help normalize conversations about mental health.

"There's so much that people can learn about signs of suicide and proper self-care and resilience training and all those kinds of things that are maybe considered luxury. Red Willow gives some amazing trainings on resilience and serves the veteran population for free, which is amazing. They do all kinds of classes and self-care resiliency training. They're really a great center. Anyway, I don't think a lot of people know about that or use it or feel like they have access to it." – Community Stakeholder

Additionally, lack of **insurance** and the **criminalization** of substance use are barriers to addressing these needs. Fear of prosecution, losing their children, or legal repercussions prevent people from being honest about their mental health or substance use needs.

Stakeholders were concerned about the following populations needing additional support accessing affordable and responsive behavioral health services:

- **People with co-occurring behavioral health and medical needs** who require complex care
- **Native American people**, particularly because of an underreporting and misreporting of mental health data and data related to suicides
- **Young people**, specifically Transitional Age Youth who may have little support
- **People identifying as LGBTQ+**
- **Veterans** because this group is considered higher risk for suicide and Montana has the highest rate of veterans per capita in the county

Stakeholders shared they are seeing more behavioral health needs during **COVID-19**, particularly more hopelessness, anxiety, and depression. They shared the pandemic has exacerbated social isolation and loneliness in older adults, especially those in nursing homes and assisted living facilities who cannot have visitors. People lacking technology may also be more isolated.

"Access to technology. That's how now we're supposed to be connecting with each through social connection. If you don't have that, you might not have a way to connect with people

at all, presuming that you are physically distancing from people. Then I think just social isolation for older adults is something that we have not fully addressed" – Community Stakeholder

Stakeholders described the pandemic as triggering for **Native communities**. Historical trauma and the fact that they are overrepresented in positive diagnoses has created a lot of fear and anxiety in the Native community.

"Same with us, our community, our population, mental health challenges are also disproportionate, especially depression and anxiety. The situation that we're in right now with COVID, I mean, I've had to walk two employees through pretty serious mental breakdowns because they're scared. It's two of my Native employees who this pandemic, literally, is triggering for them. They're employees with training and education. I can't imagine what this would be like for somebody with a different socio-economic background that is trying to struggle and make it through this on their own without an employer like me who is literally holding hands and walking them through. I know, I mean, COVID-19 honestly, has been extremely detrimental for [the Native] community." – Community Stakeholder

While many behavioral health services are being offered virtually, not everyone has the technology, comfort, or privacy to engage with these services successfully.

Medium Priority Unmet Health-Related Needs

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

3. Access to health care services
4. Unemployment and lack of living wage jobs
5. Domestic violence and child abuse/neglect
6. Racism and discrimination

Access to health care services

Stakeholders shared the following barriers to accessing needed care:

- **The complexity of the health care system:** Stakeholders shared people, especially refugee families, people with disabilities, people with behavioral health needs, people experiencing homelessness, and older adults, may need coaching and assistance navigating the health care system. They shared even making appointments, applying for insurance, or knowing where to seek care can be challenging for people, particularly if they are in crisis.

"When people are in subsistence living because they're either really low income or they're homeless, they're really not thinking about their health issues specifically. They're not really thinking about all the things that we might be thinking about. They're really in survival. They're thinking about things like, 'I went to the food bank, and they gave me a can of beans and I don't have a can opener.' Or they're thinking about, 'Oh, I have my dog in the

car. It's really cold out tonight and I can't go in the shelter. What am I going to do with my dog?' It's really hard for them to be thinking about all the things that we're saying to them. I think you do have to just get down to the really simplistic stuff and make phone calls for people and set appointments. Just do that grassroots old style case management." – Community Stakeholder

- **Cost of care**: Especially for people who are uninsured or underinsured, or who have low incomes, concerns about medical debt or co-payments can deter them from seeking care. This can be especially challenging for people who do not qualify for Medicaid, but do not have enough income to cover their basic needs.

"We've done some surveys and some focus groups, and very clearly, many of the people that we are seeing forego needed medical care because of either real or perceived lack of access, which basically means really to pay for it. Is medical debt going to hurt folks who choose to just be sick or to let their bone heal improperly instead? I guess I would say that in this kind of work, there's a temptation to talk about how systems are failing people. I want to just argue vehemently against that and say that I think the systems are actually working exactly the way that they were designed to work. They were designed to work inequitably. They were designed to lift up some people and oppress others. It's not just about race but racism is at the core of systemic marginalization and systemic systems that have resulted in disproportionate poverty. Again, those systems are not completely about race but when you look at race and class, I think that we have to resist this urge to say that the systems that are in place are great ones we just have to use them better." – Community Stakeholder

- **Transportation**: This can be especially challenging for older adults and individuals living in rural areas.
- **Appointment times** during work hours: People may not be able to take time off work or afford losing wages.

People with **behavioral health needs** may be deterred from seeking services because of negative experiences being shamed and turned away for their behavior (see "Behavioral Health Challenges and Access to Behavioral Health Care" above).

Stakeholders shared there is a lack of **culturally responsive care** for Native American communities who may not trust non-Native health systems due to **racism** and **historical trauma**. Stakeholders shared that one reason Native populations want to receive services at IHS is because the services are culturally responsive and from someone who understands them. Additionally, Native people have experienced and seen poor treatment in non-Native health care settings. That trauma of abuse, racism, and discrimination is a barrier.

"I would say that in our discussion on one of the earlier questions, we talked about the impact of racism, but that we also need to understand the impact of historical trauma… The Native patient, they are not going to trust or listen to the work that [a non-Native health care provider] is doing because of that historical trauma. What we see is that even when services are made available, they can go to the county or they can go to other places, one of

the barriers to why they're not doing that is their own internalized trauma in that 20 years ago, 40 years ago at a place like that, they probably saw their mother or their grandmother treated poorly berated, abused. Even though that was 20 years ago, 40 years ago, they're holding on to that trauma, and they're not accessing the services that they need to… their trauma is valid and it is a barrier." – Community Stakeholder

Native American people may experience additional barriers to care if they need to leave their community to access tribal facilities. Stakeholders spoke to Native students waiting until they go home for school breaks to access needed care. Racist policies contribute to the **under-funding** of Native health centers, contributing to limited space and capacity of Native health centers to serve the community. Stakeholders spoke to Native people being overrepresented in the ICU, emphasizing the urgency to better understand the needs of Native communities and engage in conversations with those communities to find solutions.

"That's an access issue with our community that we serve, the target population of Native Americans, but even the safety net population. Especially our Natives' disproportionately high rates of lifestyle related diseases, so obesity, heart disease, stroke, and these are conditions, chronic conditions often co-occurring, and they take a lot of time and resources to address, but I don't have resources and I don't have providers to spend time with them. I'm trying to address the most difficult illnesses with very limited resources. Not only are those conditions co-occurring, but they are also largely linked to when you talked about the social determinants of health." – Community Stakeholder

Native veterans experience additional barriers to care compared to non-Native veterans. For major health care needs, veterans have to travel outside of Missoula, which can be challenging if in pain or lacking transportation. Stakeholders shared that in their experience Native veterans do not feel as welcome accessing VA services.

"The VA might say that that gap has narrowed, but for our service population, that's not their experience. Their experience is that the gap is still there. Major healthcare needs have to go to Helena. That's difficult. Even for anyone who just doesn't feel well, you don't want to drive all the way to Helena. Then add on that, you know, if you're on disability and you can't afford gas, or if you're working and can't take two or three days off to go up to Helena. Even though there is access to some primary services here, the Native veterans don't feel as welcome, and they don't access those services as much as non-Native veterans do. Even though the services physically technically are here, that's not access." – Community Stakeholder

The **COVID-19 pandemic** has created additional barriers to care. People are skipping or delaying needed care because they are afraid to access services, especially if they have underlying conditions that make them more vulnerable to COVID-19. Technology is also a barrier for people accessing telehealth appointments. Stakeholders were concerned that people are not getting their usual HIV and STI tests.

Because of All Nations Health Center's small space, they have been forced to provide services in the parking lot to allow for social distancing. This is not sustainable, particularly as the weather gets colder,

highlighting the **inequitable funding of Native health care,** leading to inequitable access to care for Native people.

Unemployment and lack of living wage jobs

Stakeholders were particularly concerned about a **lack of living wage jobs** in Missoula County, contributing to families being unstably housed and food insecure. Lack of a living wage is a complex, "system issue," at the root of many other problems. People not receiving a living wage may only be able to afford poor-quality housing or need to live in overcrowded housing.

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

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

They noted that a lack of a living wage can put people in the challenging position of making too much money for public benefits, but not enough to meet their basic needs. They also shared a need to increase the **fixed income** amount.

"Largely, I think that the people that are just above the Medicaid limits for income, they fall into that place where they don't qualify for assistance, but they don't make enough money to meet their needs. They fall into the issues with the housing, with the transportation, with medical costs." – Community Stakeholder

Stakeholders noted particular concern for how **racism** contributes to Native American people being disproportionately unemployed or underemployed, and more likely to work in the service industry which are typically lower-wage jobs with fewer benefits. They shared they see Black, Brown, Indigenous, and People of Color, disproportionately affected by food insecurity, which is linked to economic insecurity.

"The same thing goes with employment. There's discrimination that's faced there. What we see is that for our community, they are disproportionately unemployed or underemployed, and they're disproportionately employed in the service industry, which means they're going to be paid less, they're going to have fewer benefits, specifically related to health care. All of those are issues that are directly attributable to race and ethnicity." – Community Stakeholder

Domestic violence and child abuse/neglect

Stakeholders spoke to domestic violence and child abuse/neglect as being upstream predictors of other challenges, such as behavioral health needs and homelessness. They shared that many of the people their organizations' support have histories of trauma. They described **Adverse Childhood Experiences** (ACEs), such as child abuse and neglect, as major contributors to negative adult physical and mental health outcomes, as well as substance use.

They shared particular concern for **young people experiencing homelessness** who may choose not to engage with systems for fear of being returned to abusive and unsafe homes. They may have fled their homes due to violence and abuse, which can be especially true for young people identifying as LGBTQ+ who may not be accepted by their families.

Racism and discrimination

Stakeholders spoke to how embedded racism is in all our systems and the many ways these systems of oppression harm Native American communities in Missoula County. They shared that racism, historical trauma, and abuse prevent Native American communities from receiving high-quality, respectful, and responsive **health care services**. They emphasized that health care services are more effective and better meet community needs when they are delivered in a culturally responsive way. The historical trauma that non-Native health care has caused to Native communities cannot and should not be ignored.

Discriminatory **housing** practices prevent Native American communities and people identifying as LGBTQ+ from accessing good-quality, affordable housing. Native American communities are not being effectively or inclusively engaged in addressing homelessness in Missoula County. Stakeholders emphasized addressing racism and discrimination is crucial for addressing housing instability and homelessness. Adding more housing alone will not create equitable access.

“If I'm specifically thinking about Indigenous people, we have the sole provider, and we tokenize them. When we need this voice at the table and you're the only voice, and you're so busy and you don't show up so we're going to move forward without you type of thing. I see that as a huge gap. We need to keep people that are impacted to be part of the changes policies. We need to be providing more resources for the populations towards that agency and figure out ways to bring more people to the table.” – Community Stakeholder

“I think yes, it's just going back to my previous question around the gap because we've moved so quickly [in addressing homelessness], we failed to bring people to the table, getting their perspective and removing barriers. I think we've removed perceived barriers from our own lens, lens meaning a predominantly white lens that we just create and contribute to more oppression.” – Community Stakeholder

Racism contributes to Native American communities being disproportionately **unemployed and underemployed**, keeping people in **poverty** and preventing **access to opportunities**. Racist policies and historical trauma prevent Native American communities from accessing opportunities that lead to higher paying jobs, including benefits. Access to living wage jobs is connected to housing stability and food security.

“The same thing goes with employment. There's discrimination that's faced there. What we see is that for our community, they are disproportionately unemployed or underemployed, and they're disproportionately employed in the service industry, which means they're going to be paid less, they're going to have fewer benefits, specifically related to health care. All of those are issues that are directly attributable to race and ethnicity.” – Community Stakeholder

Stakeholders spoke to the many ways that racism contributes to oppression of communities, particularly the ways it is has been "institutionalized," meaning **embedded in our policies and systems**.

"I guess I would say that in this kind of work, there's a temptation to talk about how systems are failing people. I want to just argue vehemently against that and say that I think the systems are actually working exactly the way that they were designed to work. They were designed to work inequitably. They were designed to lift up some people and oppress others. It's not just about race but racism is at the core of systemic marginalization and systemic systems that have resulted in disproportionate poverty. Again, those systems are not completely about race but when you look at race and class, I think that we have to resist this urge to say that the systems that are in place are great ones we just have to use them better. I don't believe that to be true. I believe that systems are set up to protect and benefit people who are in positions of power today, so that they are also in positions of power tomorrow. People who are marginalized today have an incredibly challenging road to navigate in order to move out of tough situations." – Community Stakeholder

Stakeholders spoke to the importance of ensuring all community solutions **center equity** and that groups intentionally consider where inequities exist in the community. One way to better ensure equity is centered is by having more community-led interventions and ensuring those most affected are engaged in the solutions.

"It seems like it's probably by neighborhood as a starting point. I also think this is all where it's really important where it is, just thinking about the racism lens, it's really important that we do a better job of ensuring that this is all led by marginalized populations that are mostly impacted." – Community Stakeholder

Effects of COVID-19

Stakeholders discussed how the COVID-19 pandemic has exacerbated needs, particularly **mental health** needs. They emphasized more people are experiencing isolation, anxiety, depression, and hopelessness. They were particularly concerned about older adults who are isolated at home or in assisted living facilities and Native American communities who are disproportionately testing positive for the virus and may find this pandemic triggering from historical trauma.

They shared some people are choosing to delay accessing **health care services** or are unable to get the care they need due to **technology** and internet barriers. Systemic under-funding of Native health care has resulted in All Nations Health Center providing services in their parking lot due to limited space inside. This is not a sustainable solution and highlights inequities in access to care.

Stakeholders expressed concern for increased **housing instability** and **food insecurity**, with some people accessing food resources for the first time. Reduced public transportation has increased **transportation** barriers, especially for older adults. They were also concerned about children falling behind in **school** and families lacking support and resources for remote learning.

"I think it's also exposed that really people do think of people experiencing homelessness or in poverty, as less than if you will. We had to really advocate for this population and saying that they matter, that their healthcare needs matter. That protecting them throughout this pandemic is really, really important, that they're a vulnerable population, and we need to care. It's just not right that we have people sleeping outside with no access to sanitation. It's not okay." – Community Stakeholder

Community Stakeholder Identified Assets

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

Apx 3_Table 2. Community Stakeholder Identified Assets

Health-related need	Community program, organization, or services (number of times mentioned if more than 1)
Behavioral Health	Alcoholics Anonymous and Narcotics Anonymous Open Aid Alliance Program of Assertive Community Treatment (PACT) at Western Montana Mental Health Center Project Tomorrow Signs of Suicide (SOS) program at schools
Collaboratives	FUSE Initiative (Frequent Users Systems Engagement) (2)
Community Capacity Building	Headwaters Foundation
Education	Missoula County Public Schools (2)
Food Security	Double SNAP Dollars at farmers markets Missoula Food Bank & Community Center (2) SNAP
Health Care	All Nations Health Center (2) Healthcare for the Homeless at Poverello Center Montana Medicaid Waivers Nurse-Family Partnership Partnership Health Center (4)
Housing and Homelessness	Homeless Outreach Team (HOT) at Poverello Center Housing Navigator at Partnership Health Center Missoula Manor Reaching Home: Missoula's 10-Year Plan to End Homelessness
Resources and Social Services	Human Resource Council Social Workers located at Providence St. Patrick Hospital Student Advocacy Resource Center
Services for the Aging Population	Clark Fork Riverside Missoula Manor
Services for Native American Communities	All Nations Health Center (2)

Transportation	Mountain Line (2)

Opportunities to Work Together

Participants were asked, “What suggestions do you have for organizations to work together to provide better services and improve the overall health of your community?” Stakeholders shared they consider Missoula to have a “culture of collaboration.” They named the FUSE Initiative as an example of **cross-sector collaboration** to address community challenges and thought that same approach could be used to address other needs, such as mental health.

“Well, I'm biased, but I do believe in this FUSE model, and I do believe in this idea of multiple service providers coming together, because I think that's what it's going to take. It's too big for any one organization to do alone as far as I can tell. I think a framework, the framework for it, the business of it, like how do we make something like that work? And how can it be available to not just the top 10 people in our community who need it, but how can we make it more available.”—Community Stakeholder

While there were some positives, stakeholders also emphasized there is a lot of room for improved collaboration. Specifically, they noted a need for more **“reciprocal” collaboration**, meaning both groups contribute something. Especially important to note is that Black, Brown, Indigenous, and People of Color are often asked to contribute to research or efforts but receive little in return.

“I think reciprocal collaboration is key… [Another organization has] been really good at saying, ‘Hey, if we collaborate, we can do this for you, but you have to do something for us.’ I really see that how impactful that is because I think, even at the university level, I've seen where people have used, I'd say disadvantaged people for their research, whether it be low income or a minority, and not even contribute back to that. I think that has always created a roughness around the relationships. I think seeing how we can be more reciprocal and make it a true effort between two instead of one way, is really important.”—Community Partnership

They also shared a need to better engage people with lived experiences and communities directly affected in conversations regarding addressing those needs. Specifically, there is a need to build more **diverse networks** of people working together, ensuring that people are **engaged inclusively** and not simply tokenized.

“I think there's some robust community organizing work that is happening here in Missoula and that sense of, how do we lift up the voices of people who are most impacted by challenges by food insecurity, by poverty, by lack of access to all of the things that we're talking about and bring them together in a way with our shared power, so many people are disenfranchised with the way systems work and the politics and what it looks to try to affect change. I think there's real potential to build strong, diverse networks of people who can come together to speak in one voice and to ask for change, that's truly going to impact them and make changes in their lives. I would call that out as a bright spot, certainly here locally.” – Community Stakeholder

They noted Native American communities are often not invited "to the table." By not considering who is missing from conversations or assuming the full story is told through data, groups are missing valuable insight and nuance into community needs.

"One of the things that I mentioned to the board members is that it's easy to think that privilege is being able to throw your weight around at the table, but that's not. Privilege is getting to decide who sits at the table… Are we asking who is here to represent [the largely disenfranchised], who is here to speak and give a voice to their needs and concerns? Not what we think are their needs and concerns, but to actually tell us what are their needs and concerns. We like to say, 'Well, I have data so I know what the issue is. I know that the issue is homelessness,' when actually data does not tell us the whole story."—Community Stakeholder

Stakeholders emphasized the importance of collaborating with the intention of making services more accessible and **client-centered**. One way to do this is to build relationships by bringing together agencies and providers periodically to discuss what they are seeing in the community.

"I think that doing things like that periodically and taking stock and where we're at, and where people with boots on the ground where they're at and what they have to say."—Community Stakeholder

They shared a need to improve **referrals** between organizations to ensure clients are not falling through the cracks. Instead of just telling clients where to go, referrals need to have "a beginning, a middle, and an end," meaning guiding clients through the process of connecting with the agency.

"I don't really find [telling people where to go] to be a referral that has a beginning, a middle and an end… Don't just send people places. I think that that's really ineffective. It makes people angry and they use their last dollar of gas to do it. It's not effective because chances are the person is just going to walk out of your office and not do it because they're overwhelmed. They need help. You've captured them. They're there. You should try to actually get something done for the person then. I think that that-- If I could change one thing in this role, it would be that everyone does that."—Community Stakeholder

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

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

Another idea is to **co-locate services** to reduce the number of places clients need to go to get their needs met.

"I think one thing that really is a barrier for people when they have to drive all around town to just fill out applications and they don't have the transportation; they don't have the ability to do that. It's just exhausting."—Community Stakeholder

Stakeholders shared a barrier to partnering is **lack of bandwidth** from organizations just working to survive and meet immediate needs. They shared needing more capacity and support to be able to think more broadly and engage in meaningful partnerships.

"I also just want to add that organizations like ours that are serving people in poverty, we are drowning right now… We wish we weren't in this growth industry. There is this constant daily struggle to just keep doing what we're doing and stay sustainable in it and not burn out our staff and volunteers… It's daunting to think, how do we get out of this daily survival mode and partner in broad ways that address systems? It's not that we're not doing it, that's happening, but everyday people, [other staff] and I, show up and there are little fires all over that we just have put out first and that just takes up a disproportionate amount of our time. When funders ask why we're not partnering better, there is an infrastructural bandwidth component to that answer." – Community Stakeholder

Limitations

While stakeholders were intentionally recruited from a variety of types of organizations, there may be some selection bias as to who was selected as a stakeholder. All sessions were conducted virtually which has its limitations in fostering group conversation.

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

Stakeholder Interview Questions

1. How would you describe your organization's role within the community?
2. How would you describe the community your organization serves? Please include the geographic area.
3. Please identify and discuss specific unmet health-related needs in your community for the persons you serve. We are interested in hearing about needs related to not only health conditions, but also the social determinants of health, such as housing, transportation, and access to care, just to name a few.
4. Can you prioritize these issues? What are your top concerns?
5. Using the table, please identify the five most important "issues" that need to be addressed to make your community healthy (1 being most important). [see table below]
6. Has the COVID-19 pandemic influenced or changed the unmet health-related needs in your community? If yes, in what ways?
7. Are there specific populations or groups in your community who are disproportionately affected by these unmet health-related needs?
8. Please identify and discuss specific gaps in community services for the persons you serve that contribute to the unmet health-related needs you identified earlier.

9. Please identify and discuss specific barriers for the persons you serve that contribute to the unmet health-related needs you identified earlier.
10. What existing community health initiatives or programs in your community are helpful in addressing the health-related needs of the persons you serve, especially in relation to the health-related needs you identified earlier? Can you rank them in terms of effectiveness?
11. What suggestions do you have for organizations to work together to provide better services and improve the overall health of your community?
12. Is there anything else you would like to share?

Question 5: Using the table below, please identify the five most important "issues" that need to be addressed to make your community healthy (1 being most important).			
	Aging problems (e.g. memory/ hearing/ vision loss)		Access to oral health care
	Air quality (e.g. pollution, smoke)		Access to safe, nearby transportation
	Obesity		Lack of community involvement
	Bullying/ verbal abuse		Affordable daycare and preschools
	Domestic violence, child abuse/ neglect		Job skills training
	Few arts and cultural events		Accessibility for people with disabilities
	Firearm-related injuries		Safe and accessible parks/ recreation
	Gang activity/violence		Behavioral health challenges and access to care (includes both mental health and substance use disorders)
	HIV/ AIDS		Poor quality of schools
	Homelessness/ lack of safe, affordable housing		Racism/discrimination
	Food insecurity		Unemployment/lack of living wage jobs
	Access to health care services		Safe streets for all users (e.g. crosswalks, bike lanes, lighting, speed limits)
			Other:

PRIMARY DATA COLLECTION SURVEY RESULTS

In July 2020, the hospital mailed out postcard invitations with a link and QR codes to an online survey. The postcards were mailed to households with median income of $35k or less in zip codes 59801 and 59802. Survey invitations were also mailed in partnership with All Nations Health Center in September. The survey links were shared by Providence staff and partner organizations in the community. 227 total responses were received.

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

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

		2020	%age*	2017	%age*
	Total Responses	227		97	
Gender identity					
	Female	189	84.0%	61	85.9%
	Male	34	15.1%	10	14.1%
	Other or Transgender	2	0.9%	0	0.0%
What is your current employment status?					
	Employed full time	129	57.6%	46	63.0%
	Employed part time	12	5.4%	11	15.1%
	Self-employed	6	2.7%		0.0%
	Retired	70	31.3%	6	8.2%
	Unable to work due to illness, injury, or disability	2	0.9%	5	6.8%
	Homemaker or stay at home parent	0	0.0%	1	1.4%
	Student	1	0.4%	3	4.1%
	Unemployed	4	1.8%	1	1.4%
Do you have a primary care provider?					
	Yes	202	89.8%	47	70.1%
	No	23	10.2%	20	29.9%
What kind of health coverage or insurance do you have?					
	Medicaid	17	6.5%	13	12.6%
	Medicare	59	22.5%	16	15.5%
	VA, TRICARE or other military health care	4	1.5%	0	0.0%
	Indian Health Service (IHS)	1	0.4%	3	2.9%
	Private coverage through an employer or family member's employer	146	55.7%	46	44.7%
	A private plan I pay for myself	22	8.4%	0	0.0%
	Other	11	4.2%	2	1.9%
	No coverage	2	0.8%	23	22.3%
How would you rate your overall physical and mental health?					
	Excellent	27	12.0%	8	11.8%
	Very good	100	44.4%	24	35.3%
	Good	67	29.8%	25	36.8%
	Fair	23	10.2%	9	13.2%
	Poor	8	3.6%	2	2.9%

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

The 2020 survey included two short form questions:

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

48% of responses called for more or improved mental health services. 21% called for more substance abuse treatment options. 18% discussed homelessness and affordable housing.

Selected quotes:

> *"More mental health and addiction services. We have some but usually full to where patients can't get in and they fall through the cracks. Need more inpatient drug and alcohol treatment. Outpatient just sets them up for failure. More trauma informed care. Get kids the help they need so they have a chance to become a productive adult."*
>
> *"More culturally sensitive services for more varied peoples and genders."*

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

18% of responses specified the need to address homelessness and housing that is not affordable. 15% discussed mental health services. 13% described the need for affordable and health care that is accessible to all. 10% called for more substance abuse treatment options.

Selected quotes:

> *"Prioritizing and addressing the root causes of health inequities such as racial and class injustice in the access and affordability of housing, access to educational supports, cost of childcare in this community, racial injustice and inequities in hiring practices for the county's largest employers, pay employees a basic living wage..."*
>
> *"A customer service overhaul. There is incredible racism, sexism, classism, and all other kinds of discrimination here."*

Apx 3_Table 4. Community Input Type

Community Input Type	City, State	Dates	Notes
Online anonymous survey	Missoula, Montana	July 8 – July 26, 2020	• Survey invitations were mailed to households with median income of $35k or less in zip codes 59801 and 59802 • Survey link shared internally with Providence staff and with partner organizations in the community
Online anonymous survey	Missoula, Montana	September 5 – September 29, 2020	• Survey invitations were mailed in collaboration with All Nations Health Center to households served by ANHC

MONTANA CHNA SURVEY QUESTIONS

Demographics

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

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

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

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

Household Finances

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

   Me, plus ___ other adults and ____ children

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

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

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

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

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

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

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

Access to Health Services

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

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

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

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

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

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

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

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

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

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

Quality of Life Issues

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

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

Adapted from Lake County Community Health Assessment, 2018

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

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

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

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

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

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

Short Answers

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

    ____
    ____

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

    ____
    ____

Appendix 4: Prioritization Protocol and Criteria

Apx 4_Figure 1. Prioritization Process Voting Results

Please select the top 3-5 most important needs to prioritize for the 2020 – 2022 CHNA:

Need	Percent
Access to health care services	4%
Access to mental health care	22%
Access to substance abuse treatment	17%
Addressing homelessness	17%
Domestic violence and child abuse/neglect	0%
Lack of living wage jobs	4%
Racism and discrimination	13%
Safe, affordable housing	22%
Other	0%

Five individuals from the SPH CHNA committee voted for the three to five most important needs to prioritize for the CHNA. The top four needs the committee voted to prioritize included two ties at 22% and 17%. Ranking of the needs was based on the committee poll results, with tiebreakers for ranking determined by stakeholder and community member input from interviews and surveys.

Appendix 5: Community Resources Available to Address Significant Health Needs

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

Apx 5_Table 1. Community Resources Available to Address Significant Health Needs

Organization Type	Organization or Program	Description of services offered	Street Address	Significant Health Need Addressed
Addiction Services	Western Montana Addiction Services / Turning Point	Substance use treatment	1325 Wyoming St Missoula, MT 59801	Substance use
Addiction Treatment	Recovery Center	Inpatient substance use treatment	1201 Wyoming St Missoula, MT 59801	Substance use
Agency on Aging	Missoula Aging Services	Promotes independence, dignity and health of older adults in Missoula and Ravalli Counties	337 Stephens Ave Missoula, MT 59801	Access to Services
Disabilities	Summit Independent Living Center	Services for people living with mental or physical impairments. Free and sliding fee scale services	700 SW Higgins Ave, Suite 101 Missoula, MT 59801	Mental Health
Domestic Violence Shelter	YWCA	Domestic and sexual violence services, including emergency shelter	1130 W Broadway Missoula, MT 59802	Emergency Shelter
Emergency Housing for Families	Family Promise	Shelter, meals and moral support for homeless families with children	2205 34th St Missoula, MT 59801	Homelessness
Emergency Shelter	Poverello Center	Food, shelter, clothing and other essential services; Veteran services	1110 W Broadway Missoula, MT 59802	Homelessness
Federally-Qualified Health Center	Partnership Health Center	Medical, mental health, dental services; satellite clinics include rural clinic, Healthcare for the Homeless clinic in the Poverello Center, and clinic at Lowell Elementary School	401 Railroad Missoula, MT 59802	Access to Care

Federally-Qualified Health Center	All Nations Health Center	Medical and mental health services	830 W Central Ave Missoula, MT 59801	Access to Care
Food Pantry	Missoula Food Bank and Community Center	Emergency food assistance and child nutrition programs	1720 Wyoming St Missoula, MT 59801	Food Security
Health Services	Open Aid Alliance	Testing, harm reduction, peer support	1500 W Broadway Missoula, MT 59808	Access to Care
Homelessness Services	Salvation Army	Resources for people who are homeless, including housing assistance	355 S Russell St Missoula, MT 59801	Homelessness
Hospital	Community Medical Center	Primary medical care services, emergency medical services	2827 Fort Missoula Rd Missoula, MT 59804	Access to Care Medical Care
Housing Assistance	Human Resource Council	Rent and utility subsidies	1801 S Higgins Ave Missoula, MT 59801	Affordable Housing
Housing-Focused Nonprofit	Homeword	Affordable, sustainable housing	1535 Liberty Ln, #116A Missoula, MT 59808	Affordable 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 Center	Western Montana Mental Health Center	Mental health and substance use treatment	1321 Wyoming Missoula, MT 59801	Mental Health, Substance use
Public Housing Agency	Missoula Housing Authority	Affordable housing and subsidized housing	1235 34th St Missoula, MT 59801	Affordable Housing

Appendix 6: Providence Montana Community Mission Board Ad Hoc CHNA Committee

Apx 6_Table 1. Providence Montana Community Mission Board Ad Hoc CHNA Committee

Name	Title	Organization	Sector
Joyce Dombrouski	Chief Executive	Providence Montana	Health
William Bekemeyer, MD	Community Mission Board Chair	Providence Montana	Health
D'Shane Barnett	Executive Director	All Nations Health Center	Health; Urban Indian Health Program
Justin Stovall	Director, Strategic Analytics	Providence Montana	Health
Karen Myers	Chief Mission Officer	Providence Montana	Health
Kimberly Dudik	State Representative	District 94	Government
Kaia Peterson	Executive Director	Neighborworks Montana	Housing Policy; Community-Based Organization