Coulee Medical Center

2025-2027

Community Health Needs Assessment

Adopted by | Douglas, Grant, Lincoln, Okanogan Counties Public Hospital District #6 | January 9, 2025

Table of Contents

Coulee Medical Center acknowledges and honors that the hospital and its service area are located on the traditional territories of the people of the Confederated Tribes of the Colville Reservation.

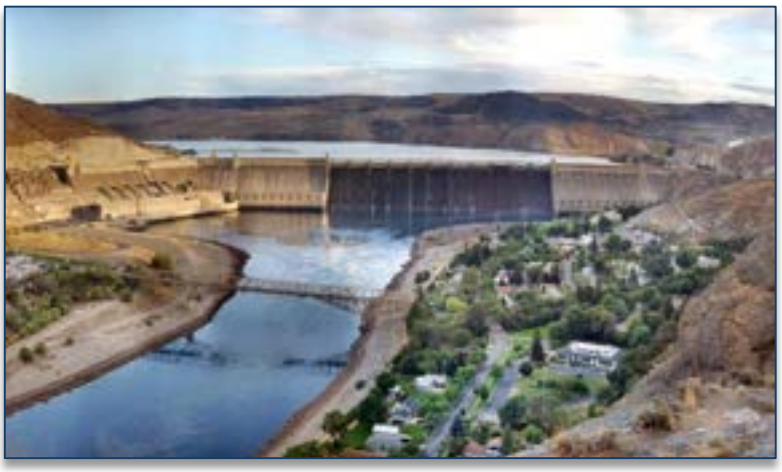
I. Introduction

Coulee Medical Center (CMC) is a 25-bed Critical Access Hospital (CAH) located in Grand Coulee, Washington. The hospital is owned and operated by the Douglas, Grant, Lincoln & Okanogan Counties Public Hospital District #6 (the District).

The service area, the communities from which about 75% of the hospital's patients reside, is fully contained within the District. It is a large, but sparsely populated geography in north central Washington, a portion of which is contained within the lands of the Confederated Tribes of the Colville Reservation. The next closest hospitals to CMC are located in Brewster and Davenport. Both of these CAHs are more than 50 miles from Grand Coulee. The next higher-level service hospitals are in Spokane, a distance of 85 miles, with a travel time, under ideal circumstances of more than 90 minutes.

History

CMC opened in 1934 as Mason City Hospital to care for the workers constructing the Coulee Dam. Construction of the dam was included as part of the Federal Government's Depression Era Public Works Administration program which provided jobs focused on developing the nation's resources.



The Bureau of Reclamation was placed in charge of the Coulee Dam project. On July 16, 1933, the first stake was driven into place, initiating a nine-year construction project to build the largest structure in the world. Construction continued through 1941. Today, Grand Coulee Dam is the largest concrete structure and largest producer of hydropower in the United States.

Within a few years of its opening, the hospital was deemed insufficient for union members' healthcare, and in 1938, when Kaiser Industries won the contract to finish the dam, the facility became the birthplace of the Kaiser Permanente health plan. Kaiser remodeled the hospital and added "modern" amenities, such as air conditioning.

In 1962, Mason City Hospital became the privately owned Coulee Community Hospital and was relocated to a new facility in the city of Grand Coulee. With voter approval, the multi-county tax district—Douglas, Grant, Lincoln & Okanogan Counties Public Hospital District #6—was formed in 1990. The hospital was designated a Critical Access Hospital (CAH) in 2001 by meeting the federal and state designation requirements in the Washington State Rural Health Plan and the Medicare Conditions of Participation.

COULEE MEDICAL CENTER

VISION:

To be an organization where all people are seen as equal and where the complete well-being of those we serve is our ultimate objective.

MISSION:

To inspire excellence as we care for our patients, honor our profession, and serve our community.

VALUES:

Integrity
Compassion
Respect
Competence
Professionalism
Financial Viability

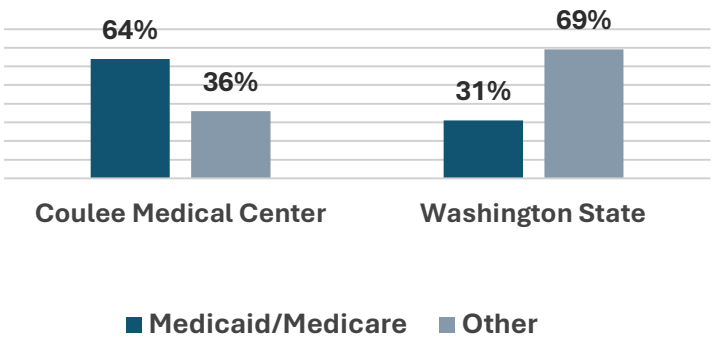
A 66,000-square-foot replacement facility was constructed and opened in 2011. In addition to general inpatient and emergency care, CMC provides surgery, swing beds, women's health and birthing services, laboratory, imaging and other diagnostic services, and family medicine clinics in Coulee City and Grand Coulee that include behavioral health and specialty services.

Today, 50% of all residents in the service area who require hospitalization are hospitalized at CMC, and CMC delivers nearly 60% of all babies born to service area residents. CMC also provides more than 17,000 primary care visits annually and touches more than 100 patients a day through our comprehensive inpatient, outpatient, and clinic programs.

Portions of the District have volunteer-only Emergency Medical Services (EMS). Given the limited access to care available for Colville Tribal members, Coulee is actively exploring partnerships with the Colville Tribe to provide expanded healthcare coverage for Tribal clinics.

As shown in **Exhibit 1**, CMC's percentage of Medicaid patients is two times higher than the average of the other hospitals in Washington State.

Exhibit 1: CMC Patients by Payer



Source: Internal Data

While CMC's focus has historically been on access, staff development, safety, and employee experiences, today, recruiting and retaining primary care providers have been added as an urgent focus, including providing adequate physical space to house additional providers.

II. Our Communities

Exhibit 2: District Boundary

CMC's District boundaries include portions of four counties in north central Washington (Okanogan, Grant, Douglas, and Lincoln) and eight zip codes (**Exhibits 2 and 3**). From a population perspective, about 52% of service area residents reside in Grant County, and another 26% in Okanogan County, 15% Douglas County, and 7% in Lincoln County.

Exhibit 3: Service Area by Zip Code

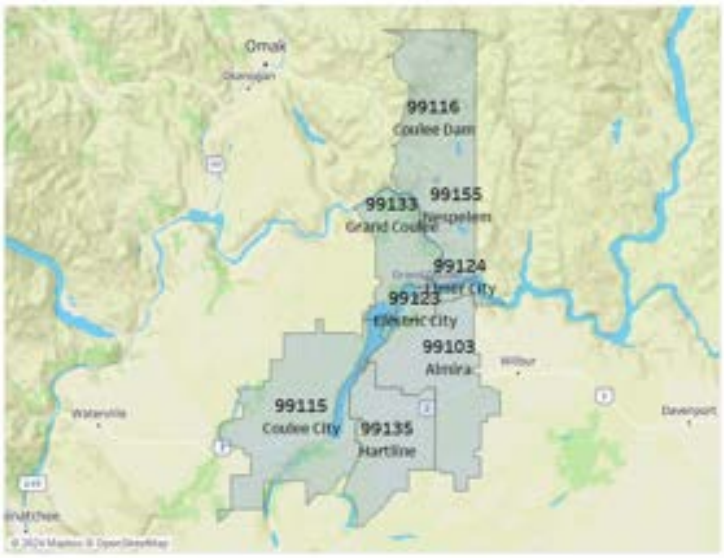


Exhibit 4 shows that the District includes all or part of eight (8) zip codes. Patient origin data indicates that over 75% of CMC's patients come from within these zip codes, making the contiguous geography of these eight (8) zip codes the designated service area for this CHNA.

Exhibit 4: CMC Service Area		
Communities	**Zip Code**	**County**
Almira	99103	Lincoln
Coulee City	99115	Grant
Coulee Dam	99116	Douglas, Grant, Okanogan
Electric City	99123	Grant
Elmer City	99124	Okanogan
Grand Coulee	99133	Grant
Hartline	99135	Grant
Nespelem	99155	Okanogan

Throughout this CHNA, where possible, data was collected specific to the zip codes comprising the District. Where District or service area data was unavailable, county-level data for Grant, Okanogan, Douglas, and Lincoln counties was used.

Land Acknowledgement

CMC acknowledges and honors that CMC and its service area are located on the traditional territories of the people of the Confederated Tribes of the Colville Reservation. Enrollment in the Confederated Tribes of the Colville Tribes is over 9,000 members, and the reservation includes more than 1.4 million acres. The Confederated Tribes of the Colville Reservation's Contract Health Service Delivery Area (CHSDA) includes a larger geography than the District and is comprised of Chelan, Douglas, Ferry, Grant, Lincoln, Okanogan, and Stevens counties. The Tribe offers medical and limited dental services to residents via two Tribally owned and operated primary health clinics in Inchelium and in the San Poil Valley. Additionally, the Tribe has two Indian Health Service clinics in Nespelem and Omak. The Tribe also provides mental health and chemical dependency services in Omak and Inchelium.

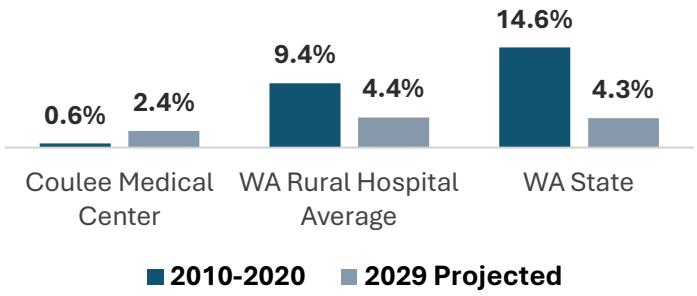
Population

According to 2024 population estimates (**Exhibit 5**), the population of the District is about 7,900. Between 2010 and 2024, the District experienced relatively flat growth of around 1%. The District service area is expected to grow 2.4% by 2029, a level of growth still significantly less than other rural hospitals and Washington State as a whole (**Exhibit 6**).

Exhibit 5: Service Area Key Demographics											
	2010	Pct. of Tot. Pop.	2020	Pct. of Tot. Pop.	Pct. Chg., 2010-2020	2024, Est.	Pct. of Tot. Pop.	Pct. Chg., 2020-2024	2029, Proj.	Pct. of Tot. Pop.	Pct. Chg., 2024-2029
Tot. Pop.	**7,800**	**100.0%**	**7,849**	**100.0%**	**0.6%**	**7,924**	**100.0%**	**1.0%**	**8,112**	**100.0%**	**2.4%**
Pop. by Age											
Tot. 0-64	6,296	80.7%	5,913	75.3%	-6.1%	5,772	72.8%	-2.4%	5,758	71.0%	-0.2%
Tot. 65+	1,504	19.3%	1,936	24.7%	28.7%	2,152	27.2%	11.2%	2,354	29.0%	9.4%
Hispanic	422	5.4%	393	5.0%	-6.9%	423	5.3%	7.6%	483	6.0%	14.2%
AI/AN	2,165	27.8%	2,445	31.2%	12.9%	2,479	31.3%	1.4%	2,513	31.0%	1.4%
Source: Nielsen Claritas, 2024											

As also shown in **Exhibit 6**, all growth since 2010, and projected future growth through 2029, is concentrated in the 65+ cohort. Between the 2010 and 2020 census, while the under 65 population declined by 6%, the 65+ population grew 29%, and is expected to comprise almost one-third of the population by 2029.

Exhibit 6: Population Growth



The District is diverse, with about one-third of residents identifying as American Indian. While the percentage of District residents identifying as Hispanic or Latino(a) is just over 5% in 2024 (lower than the state average of 13.7%), this population is growing at a faster rate overall. By 2029, the Hispanic population is expected to comprise 6% of the population.

Our Community Takeaways

- *CMC's District boundaries include portions of Okanogan, Grant, Douglas, and Lincoln counties in north central Washington.*
- *The District has experienced relatively flat growth since 2010 but is expected to grow 2.4% by 2029.*
- *Both past and projected District population growth is significantly less than other rural hospitals, or Washington State as a whole.*
- *The District is uniquely diverse, with one-third of the population identifying as American Indian and 5% identifying as Hispanic/Latino(a).*

III. 2021-2024 CHNA Accomplishments

CMC's 2021-2024 CHNA identified and prioritized two specific needs related to both health outcomes and health factors in the District. The 2021-2024 priorities were:

- **Access to Care**
- **Behavioral Health**

After consideration of the data, robust community input, and a comprehensive review of all CHNA-related themes and elements, CMC's CHNA Implementation Plan identified two levels of implementation related to the 2021-2024 priorities:

1. Initiatives that CMC should lead based on our skills, expertise, and unique position.
2. Initiatives that CMC should support and advocate for with other partners given their expertise and resources.

CMC's 2021 CHNA Implementation Plan is included as **Appendix 1** to this report. **Exhibit 7** (below) identifies the implementation strategies connected to each of the 2021 CHNA priorities and the accomplishments achieved to date related to each priority and strategy.

Exhibit 7: Prior CHNA Accomplishments, 2021-2024

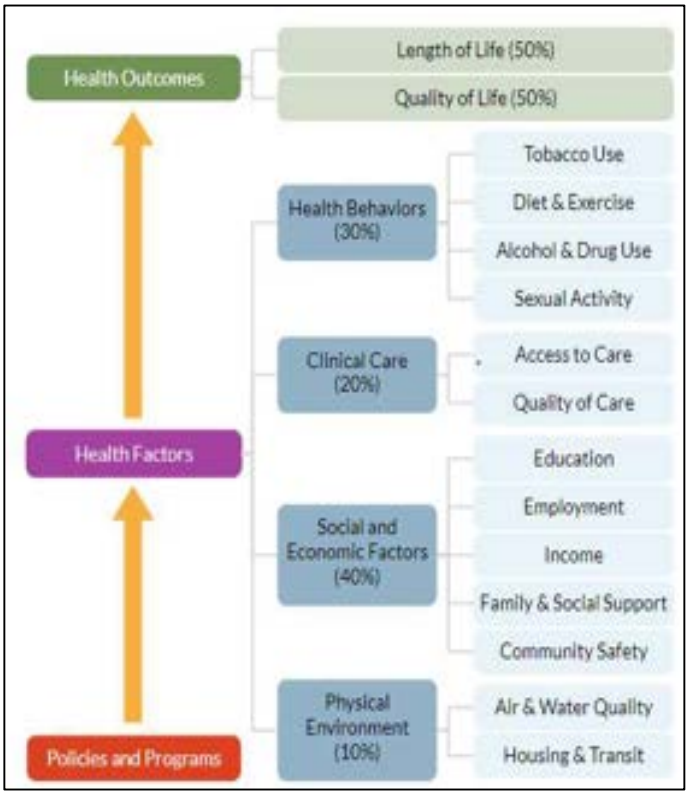
PRIORITY: ACCESS TO CARE	
Implementation Strategies	**Accomplishments**
Recruit providers, with a specific focus on primary care, behavioral health (including SUD/OUD), and specialty care. Explore telehealth options.	Between 2021 and 2024, CMC: • Hired three (3) new providers. • Temporarily moved two (2) providers to cover walk-in and family practice. • Increased one (1) provider's telehealth days to 2/week. • Contracted with Scribe EMR for increased efficiency. • Increased service days in Coulee City Clinic from 2 days to 3 days per week.
Evaluate opportunities to improve throughput of providers to increase provider availability.	CMC's clinic patient panel for family practice has grown: • 4,519 in Sep. 2023 • 4,999 in Sep. 2024 CMC's total clinic visits have grown: • 16,854 clinic visits in 2022 • 17,732 clinic visits in 2023 Average Next Available Appt. Times (Sep. 2023): • Family Practice – 37.27 Days • Behavioral Health – 9.5 Days

Exhibit 7: Prior CHNA Accomplishments, 2021-2024	
PRIORITY: ACCESS TO CARE	
Implementation Strategies	**Accomplishments**
	Average Next Available Appt. Times (Sep. 2024): • Family Practice – 38.6 Days • Behavioral Health – 43 Days While Family Practice wait times are up slightly between 2023 and 2024, the Sep. 2024 wait time is down from a high of 52.19 days out in Aug. 2024 and continues to go down each week. Significant increase in Behavioral Health wait times is due to staffing leave and will be mitigated upon staff return and with the addition of a new BH provider.
Provide ongoing cultural competency training.	Offered Indigenous Healing Perspectives Certificate program through WSU.
Increase community partnerships, potentially creating a formal community task force for trust-building and to increase warm hand-offs.	Attend/host community events to strengthen relationships, e.g., Gathering of Wellness Powwow, National Night Out, Run the Dam, First Fridays, School Career Fairs, WIC Program, the annual employee Food Drive to support local food banks.
Identify, partner with, and distribute to the community information on available community resources.	Partnered with Rural Resources to offer community outreach events every other month.
Expand CCM and TCM programs, including adding additional care coordinators and community health workers into clinics.	Hired two (2) Care Manager Positions to expand our CCM & TCM programs.
PRIORITY: BEHAVIORAL HEALTH	
Reduction in ED visits associated with mental health conditions.	Between 2021 and 2024, CMC: • Hired one (1) licensed Behavioral Health Manager. • Psychiatric nurse practitioner transitioned from family practice. Telehealth pain support group is starting this fall. Starting psychological testing, this Fall. Currently recruiting for additional BH provider to increase access.

Exhibit 7: Prior CHNA Accomplishments, 2021-2024	
PRIORITY: ACCESS TO CARE	
Implementation Strategies	**Accomplishments**
Increase number of individuals assessed for behavioral health needs, including SUD/OUD.	CMC's patient panel for Behavioral Health has grown: • 670 in Sep. 2023 • 975 in Sep. 2024
Earlier identification of ACEs and early intervention.	CMC's Patient Safety and Advocacy RN completed Mental Health First Aid course to become a trainer for staff.
Increase in the number of school education and outreach events.	Implementation pending.

IV. Methodology

Exhibit 8: County Health Rankings



Robert Wood Johnson Foundation's (RWJ) Health Rankings Model, shown in **Exhibit 8**, was used to organize the work of this CHNA. This model emphasizes the factors in population health that, if improved, can help make communities healthier places to live, learn, work, and play.

In the Health Rankings Model, the current health of a community is referred to as **health outcomes** and is calculated by rates of mortality (premature death) and morbidity (chronic diseases). In turn, these health outcomes are influenced by **health factors** in a community, ranked by the calculation of various health behaviors, clinical care measures, social and economic factors, and measures of the physical environment.

Prior to 2024, the RWJ County Health Rankings compared and ranked each county within a given state on more than thirty factors relative to the health of other counties in that state.

Beginning in 2024, RWJ County Health Rankings have shifted away from numerical rankings to a scaled approach. Counties in a state are now represented by a dot, shaded a certain color, and placed on a decile scale from least healthy to most healthy in the nation. The new visual tool shows where a county falls on a continuum of health compared to the least healthy and most healthy counties at the national and state level. In the maps below, darker colored areas indicate populations with healthier rankings.

Health factors represent what will influence the future health of a community, while health outcomes represent how healthy a community is today.

Exhibit 9: Heath Outcomes, Washington State by County

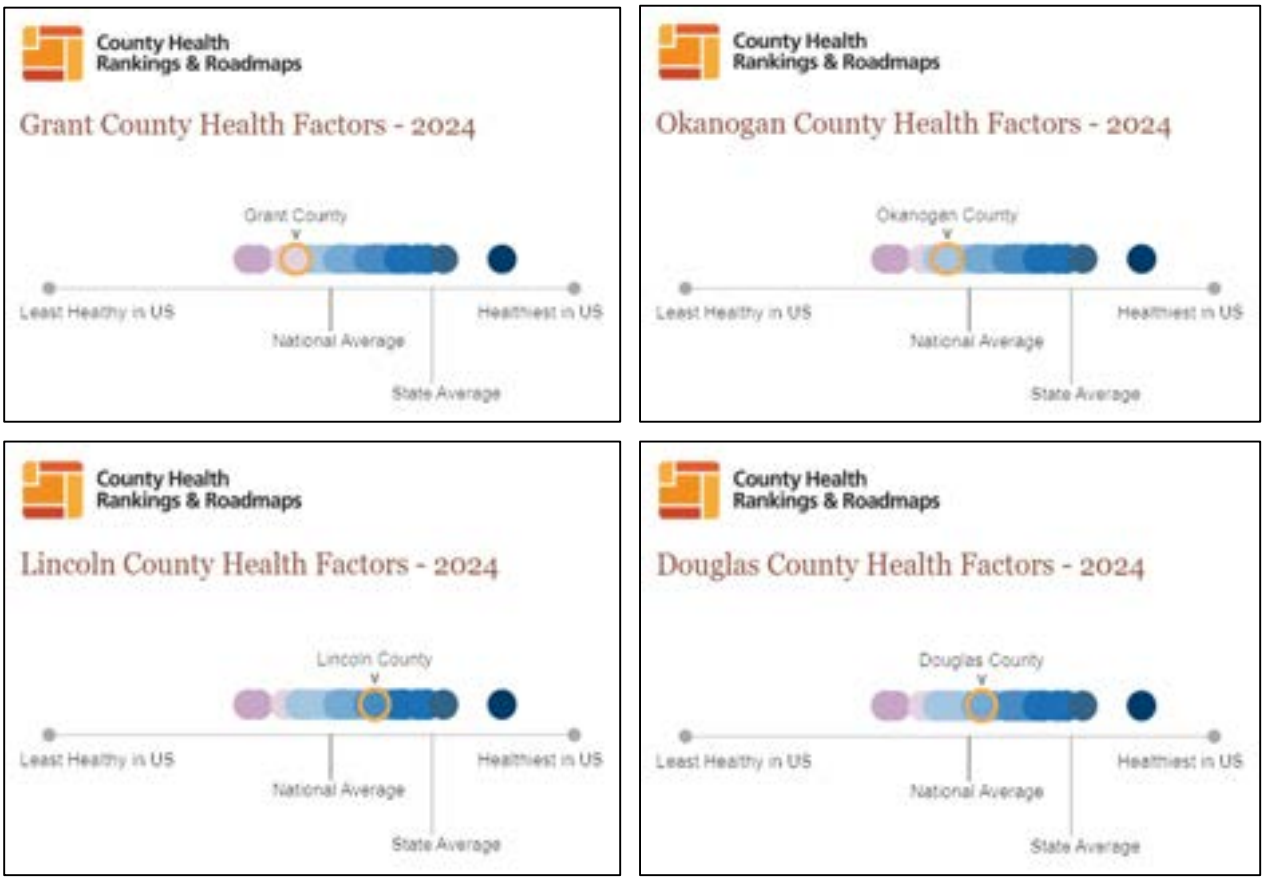
Source: RWJ Foundation. 2024

Exhibit 9 shows where the four counties of the CMC service area fall in terms o**f health outcomes**, from least healthy in the U.S. to healthiest in the U.S., relative to other Washington counties:

- **Grant County** fares significantly worse than the average county in Washington and better than the average county in the nation for health outcomes.
- **Okanogan County** fares significantly worse than the average county in Washington and slightly better than the average county in the nation for health outcomes.

- **Lincoln County** fares worse than the average county in Washington and significantly better than the average county in the nation for health outcomes.
- **Douglas County** is faring about the same as the average county in Washington and significantly better than the average county in the nation for health outcomes.

Exhibit 10: Heath Factors, Washington State by County



Source: RWJ Foundation, 2024

Exhibit 10 shows where the four counties of the CMC service area fall in terms o**f health factors**, from least healthy in the U.S. to healthiest in the U.S., relative to other Washington counties:

- **Grant County** fares significantly worse than both the average county in Washington and the average county in the nation for health factors**.**
- **Okanogan County** fares significantly worse than the average county in Washington and worse than the average county in the nation for health factors.
- **Lincoln County** fares worse than the average county in Washington and significantly better than the average county in the nation for health factors.
- **Douglas County** fares significantly worse than the average county in Washington and is faring about the same as the average county in the nation for health factors.

The remaining sections of this CHNA provide a comprehensive review of data from multiple data sources. In addition to RWJ, data from several federal and state-level sources were used to better understand the demographics, health behaviors, social and economic factors, physical environment, and clinical care characteristics of the region. Specific data sources included:

- Robert Wood Johnson County Health Rankings
- American Community Survey (ACS)
- U.S. Census Bureau
- UDS Mapper HRSA Data Warehouse
- Claritas Population Data
- Washington State Department of Health, Center for Vital Statistics
- University of Washington, Addictions, Drug & Alcohol Institute
- DHHS, Office of the Assistant Secretary for Planning and Evaluation
- United for ALICE
- Centers for Disease Control
- Convening Survey Data

CMC's 2024 CHNA data collection also included a robust, collaborative, and community-centered convening process to review community needs and discuss priorities. This process included a community engagement survey in which over three hundred community members, community organizations, and CMC staff participated to prioritize service gaps and identify unmet needs. CMC also collected community input at the Gathering of the Wellness Powwow in September 2024 (see **Section X. Community Convening**).

V. Health Outcomes

Health Outcomes represent how healthy a community is right now. They reflect the physical and mental well-being of residents within a community through measures representing both length and quality of life. Health outcomes are influenced by many factors, from the quality of medical care received to the availability of good jobs, clean water, and affordable housing. There are significant differences in health outcomes according to where people live, how much money they make, and their race and ethnicity, among other characteristics.

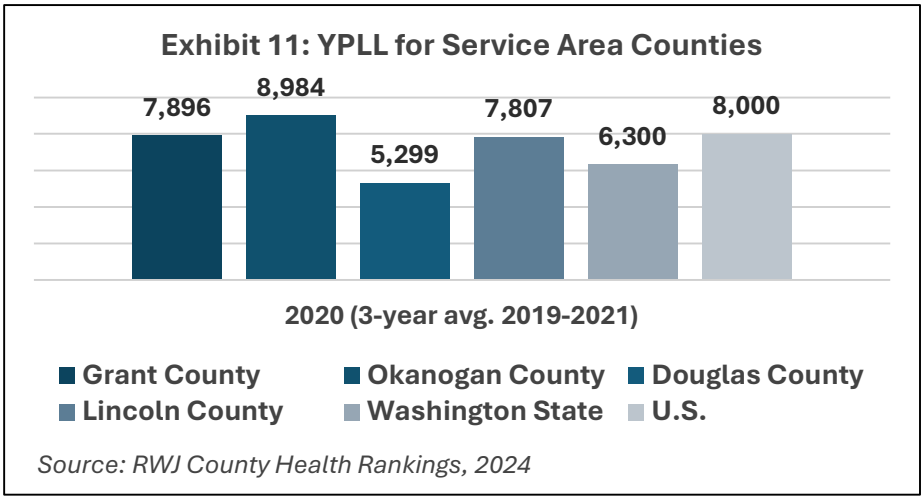
Length of Life

Measuring how long people in a community live demonstrates whether people are dying prematurely and prompts an evaluation of what is driving those premature deaths. By

exploring a county's data related to length of life, important indicators about a community's health can be highlighted.

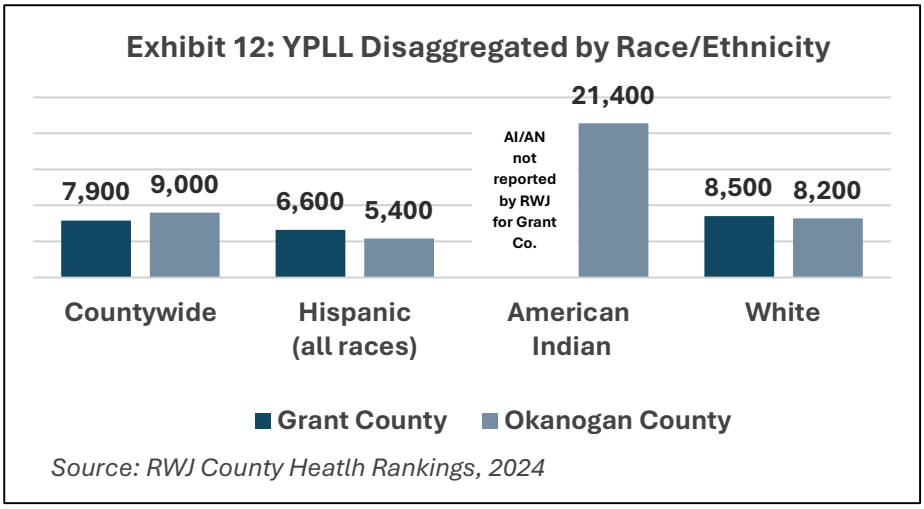
Years of Potential Life Lost (YPLL)

YPLL is a widely used measure of the rate and distribution of premature mortality in a given area. Measuring premature mortality, rather than overall mortality, focuses attention on deaths that might have been prevented. This measure calculates the years of potential life lost for residents under age 75 per 100,000 people. As identified in **Exhibit 11**, of the four service area counties, only Douglas County (5,299 per 100,000 people) fares better than the state and national averages for YPLL. Okanogan County, in particular (8,984 per 100,000 people), fares significantly worse than state and national averages, with Grant and Lincoln counties faring significantly worse than the state, but on par with national averages.



Source: RWJ County Health Rankings, 2024

Importantly, and as shown in **Exhibit 12**, both Grant and Okanogan County data demonstrate significant disparities, with the premature death rate of the American Indian population in Okanogan County almost 2.5 times the county rate.



Source: RWJ County Heatlh Rankings, 2024

In contrast, the Hispanic/Latino premature death rate in both counties is significantly better than each county's total rate, and better than each county's White population.

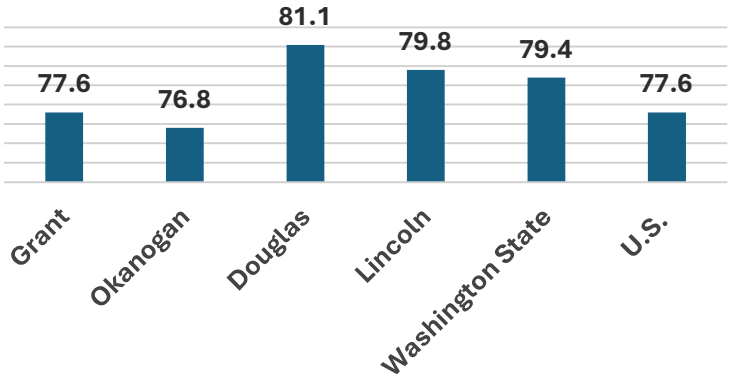
Life Expectancy

Life Expectancy measures the average number of years from birth a person can expect to live, according to the current mortality experience (age-specific death rates) of the population. Life expectancy calculations are based on the number of deaths in a given period and the average number of people at risk of dying during that period, allowing comparison across counties with different population sizes.

As seen in **Exhibit 13**, life expectancy varies across counties, with Douglas and Lincoln outperforming Washington State and the U.S. on measures of length of life, while Grant and Okanogan counties are underperforming when compared to the State.

As with premature death data, the American Indian population in Okanogan County fares far worse on this measure than other races/ethnicities, with an average life expectancy of only 66.8 years. The Hispanic/Latino population again fares better than the county average in both Grant and Okanogan counties, with a life expectancy of 80.5 and 90.1 years, respectively.

Exhibit 13: Life Expectancy for Service Area Counties



RWJ County Health Rankings, 2024

Quality of Life

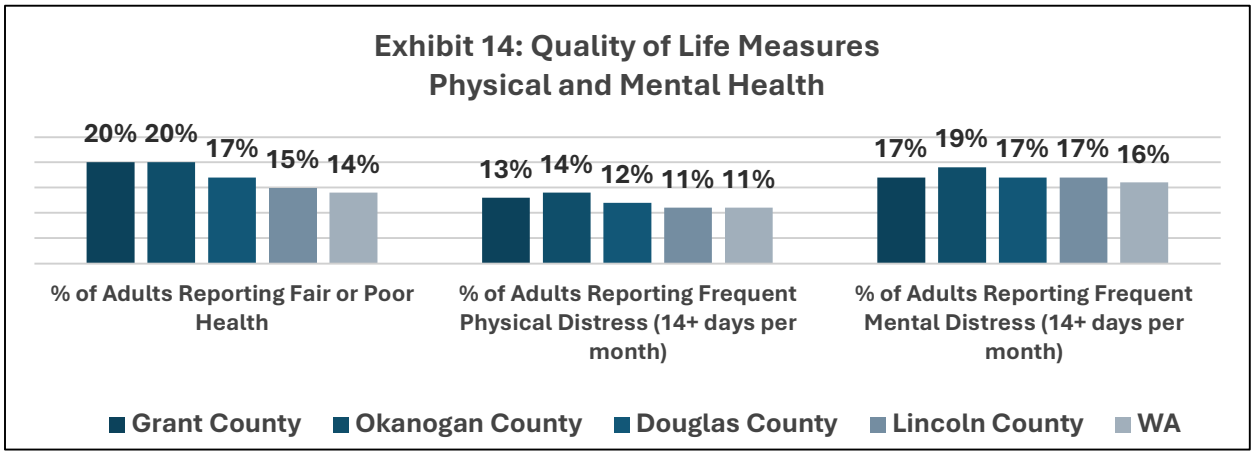
In addition to measuring how long people live, it is important to also include measures that consider how *well* people live. Quality of life refers to how healthy people feel while alive. It represents the well-being of a community and underscores the importance of physical, mental, social, and emotional health from birth to adulthood.

RWJ's Quality of Life measures include adults self-reporting fair or poor health (age-adjusted), frequent physical or mental distress (age-adjusted), and the average number of physically unhealthy and poor mental health days reported in the last 30 days (age-adjusted).

Mental distress happens when a person feels stressed, sad, depressed, or has trouble regulating their emotions. Frequent mental distress is defined as feeling emotionally unhealthy, or very sad, anxious, or troubled, for at least 14 out of the last 30 days. Adults with frequent mental distress are more likely than adults without frequent mental distress

to engage in unhealthy behaviors such as smoking or not sleeping enough; have chronic (long-lasting) health conditions like heart disease or diabetes; and visit the doctor more.

As seen in **Exhibit 14,** two of the four service area counties consistently fare worse than the state in terms of reporting fair or poor health, frequent physical distress, and frequent mental distress: with Lincoln and Douglas at, or close to the State rate.



RWJ's Quality of Life measures also include low birthweight as a percentage of live births.

Low birthweight is used to assess maternal health, nutrition, healthcare delivery, and poverty. Infants born with low birthweight have approximately 20 times greater chance of dying than those with normal birthweight, and those infants who survive may face adverse health outcomes such as impaired language development and chronic conditions (e.g., obesity, diabetes, cardiovascular disease) during adulthood. While the service area counties' percentage of low birthweight babies is in-line with the state overall, as identified in **Exhibit 15**, disaggregated data demonstrates that disparities do exist, with higher percentages of low-birthweight babies among the American Indian population and those reporting Two or More Races than the Non-Hispanic White population in Grant and Okanogan counties.

Exhibit 15: Percentage of Live Births with Low Birthweight by Race/Ethnicity

	Grant County	Okanogan County
Low Birthweight	**7%**	**7%**
Hispanic (all races)	**6%**	**6%**
American Indian	n/a	**9%**
Non-Hispanic, Two or More Races	**11%**	n/a
Non-Hispanic, White	**7%**	**7%**

Source: RWJ County Health Rankings, 2024

Causes of Death

Leading causes of death are widely used as an indicator of a population's overall health status or quality of life. Ranking causes of death in a community is a useful tool for illustrating the relative burden of cause-specific mortality. Analysis of mortality by cause is essential for the development of prevention strategies.

Exhibit 16 identifies the leading causes of death in 2022 for those under the age of 75 by service area county. Cancer-related deaths were 22% higher in Okanogan and Lincoln counties than in Washington State. Okanogan and Grant counties were disproportionately impacted by COVID-19 deaths in 2022 (31% and 65% higher than the state, respectively). Overall, Okanogan County fared worse than Washington State on three of the top five leading causes of death (Cancer, COVID-19, Liver Disease). Lower Respiratory Disease and Chronic Liver Disease were not in the top six leading causes of death across all counties. Risks for each of these diseases can be reduced through controlling key risk factors (including smoking, obesity, and lack of exercise).

Exhibit 16: Leading Causes of Death for Population Under Age 75 in Service Area Counties, Age-Adjusted Rate per 100,000 (2022)

Cause	Grant County	Okanogan County	Douglas County	Lincoln County	WA State
Cancer	**97.2**	**172.2**	**99.3**	**171.6**	**140.9**
Heart Disease	**69.4**	**87.4**	**57.1**	**117.8**	**142.7**
Accidents	**46.3**	**65.1**	**30.6**	*unreliable*	**66.2**
COVID-19	**42.4**	**53.1**	**25.6**	*unreliable*	**31.6**
Lower Respiratory Disease	**19.2**	*n/a*	**17.4**	*unreliable*	**30.7**
Chronic Liver Disease	*n/a*	**39.4**	*n/a*	*unreliable*	**15.1**
Source: RWJ County Health Rankings, 2024					
County Compared to WA State	**Worse**			**Better**	

Health Outcomes Takeaways

- *Significant disparities in health outcomes exist across all four District counties when disaggregating by race/ethnicity.*
- *Significant disparities in health outcomes exist between the four counties as well, with Okanogan and Grant counties generally faring worse on measures of health outcomes.*
- *The Hispanic population generally fared better across the four counties on measures of life expectancy/potential and low birthrate.*

VI. Health Behaviors

There is no single factor that dictates the overall health of an individual or community. A combination of multiple modifiable factors, from clean air and water to stable and affordable housing, needs to be considered to ensure community health for all.

Health behaviors are actions individuals take that affect their health. These include actions that lead to improved health, such as eating well and being physically active, and actions that increase one's risk of disease, such as smoking or excessive alcohol intake. **Exhibit 17** shows that all four service area counties fare significantly worse than the state across health risk factors of obesity and physical activity.

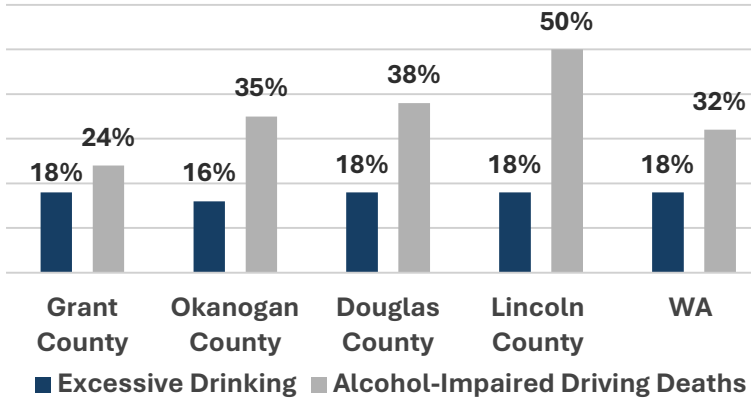
Exhibit 17: Health Risk Factors

Metric	Grant County	Okanogan County	Lincoln County	Douglas County	WA State
Adult Obesity: % of pop. 18+ who report a BMI ≥ 30kg/m2 (age-adjusted)	37%	32%	32%	33%	29%
Physical Inactivity: % of pop. 18+ reporting no leisure-time physical activity (age-adjusted)	25%	22%	20%	22%	18%
Source: RWJ County Health Rankings, 2024					
County compared to WA State	Better		Worse		

Substance Use

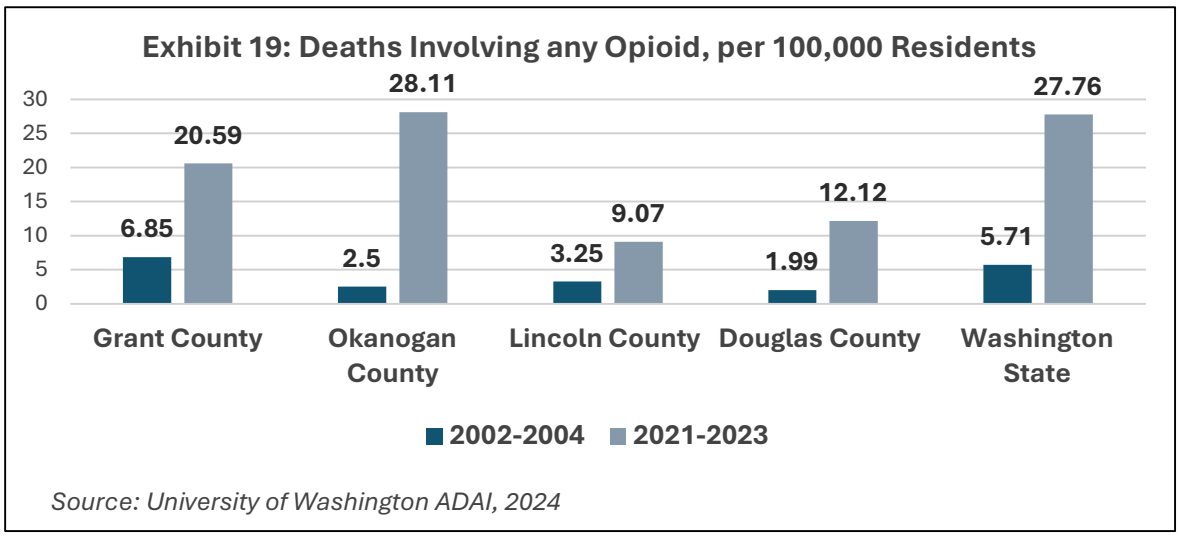
While all four counties fare the same or better on the percentage of adults who report heavy or binge drinking, **Exhibit 18** shows that Grant County (24%) fares better than the state (32%) on alcohol-impaired driving deaths, the other three counties fare worse. Data suggests that 50% of driving deaths in Douglas County are alcohol related.

Exhibit 18: Alcohol-Related Health Factors



Source: RWJ County Health Rankings, 2024

Drug overdoses and opioid misuse mark a serious public health crisis in the United States. This epidemic includes the use of heroin, prescription opioids, and synthetic opioids such as fentanyl. Drug overdose deaths from prescription and illicit opioids across the service area counties have increased sharply since 2002. Washington State has experienced a similar trend. As shown in **Exhibit 19**, the University of Washington's Addictions, Drug & Alcohol Institute research compared all opioid-related death rates between 2002-2004 and 2021-2023. Washington experienced a staggering 386% increase in opioid-related deaths per 100,000 residents (from 5.71 to 27.76) between the two points in time. The data shows that while opioid-related deaths are lower in three of the four service area counties than in the state overall, all four counties have also experienced significant growth in opioid-related deaths. While Grant County (20.59) is approaching the state average (27.76) for number of deaths per 100,000 residents, Okanogan County fared significantly worse, with an astonishing 1,026% increase in opioid-related deaths per 100,000 (from 2.5 to 28.11) in the same period. The Douglas County opioid-related death rate grew over 500%.



Source: University of Washington ADAI, 2024

Teen Pregnancy and Childbearing

According to the CDC, the U.S. teen birth rate has been on the decline since 1991. However, U.S. teen birth rates are still higher than those of other high-income countries and vary greatly among racial, ethnic, geographic, and socioeconomic groups within and across states. Recent research recognizes that pregnancy and childbirth have significant impacts on the educational outcomes of parents.

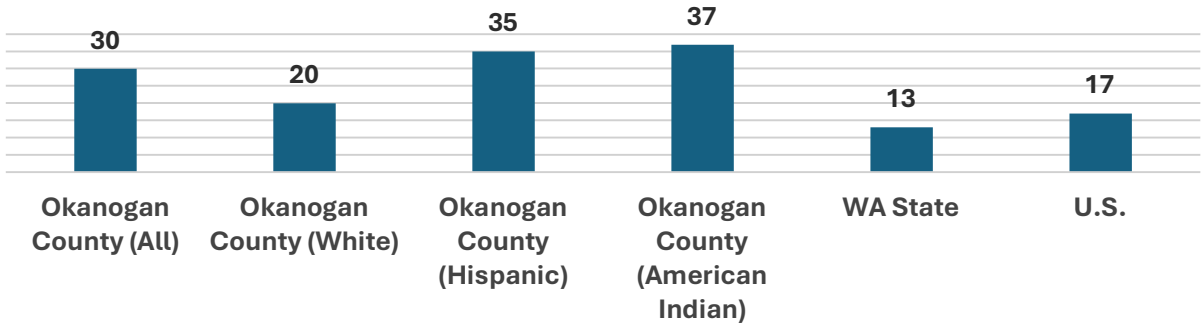
The CDC reports that children born to teen mothers are more likely to:

- Have a higher risk for low birthweight and infant mortality.
- Have lower levels of emotional support and cognitive stimulation.
- Have fewer skills and be less prepared to learn in kindergarten.

- Have behavioral problems and chronic medical conditions.
- Rely more heavily on publicly funded healthcare.
- Have higher rates of foster care placement.
- Be incarcerated sometime time during adolescence.
- Give birth as a teen.
- Be unemployed or underemployed as a young adult.

The number of teen births per population of 15- to 19-year-olds is higher in all four service area counties than in Washington State (130% higher in Okanogan County), with disaggregated rates for Hispanic and American Indian populations higher still (**Exhibit 20**).

Exhibit 20: Number of Births per 1,000 Female Population, Ages 15-19



Source: *RWJF County Health Rankings, 2024*

Health Behaviors Takeaways

- *CMC's service area counties generally fare significantly worse than the state across multiple risk factors of obesity, physical inactivity, and alcohol-related driving deaths.*
- *While opioid-related deaths are lower than the state in three of the four service area counties, all four counties experienced significant (200% to 1,000%-plus) growth in opioid-related deaths.*
- *Teen birth rates are higher in all four service area counties than the state.*

VII. Clinical Care

Access to affordable, quality, and timely healthcare can prevent disease by detecting and addressing health concerns early. Understanding clinical care in a community helps in understanding how the community can improve the health of its members.

Advances in clinical care over the last century, including breakthroughs in vaccinations, surgical procedures like transplants and chemotherapy, and preventive screenings, have led to significant increases in life expectancy. Clinical care and practice continue to evolve, with advances in telehealth and care coordination leading to improved quality and availability of care.

Uninsured

The availability and affordability of health insurance are considered key drivers of health status. Health insurance coverage helps patients get into the healthcare system; lack of insurance is a primary barrier to healthcare access, including regular primary care, specialty care, and other health services. Those without regular access to quality providers and care are often diagnosed at later, less treatable stages of a disease, and, overall, have worse health outcomes, lower quality of life, and higher mortality rates.

Uninsured people are:

- Less likely to receive medical care,
- More likely to die early, and
- More likely to have poor health status.

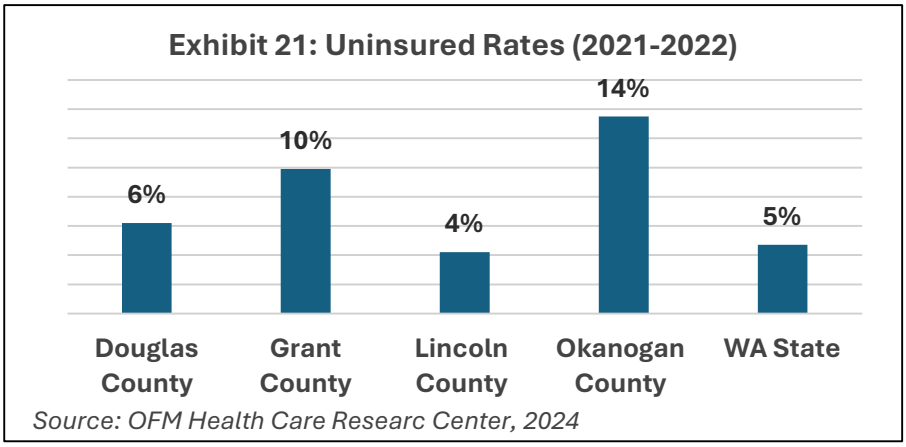
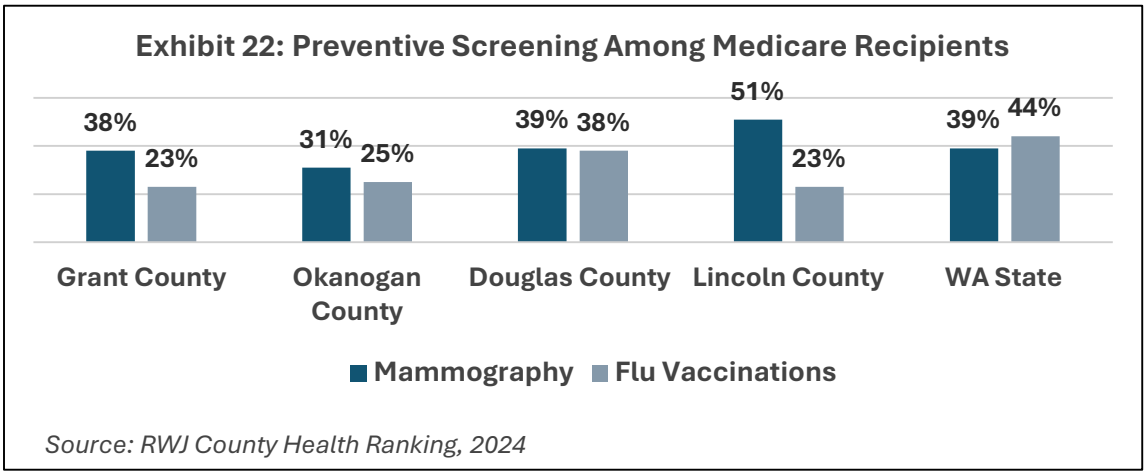


Exhibit 21 demonstrates that, as of 2022, 8% of service area adults were without insurance, versus 6% of adult state residents. While Lincoln County fares better than the state, the other three counties all fare worse.

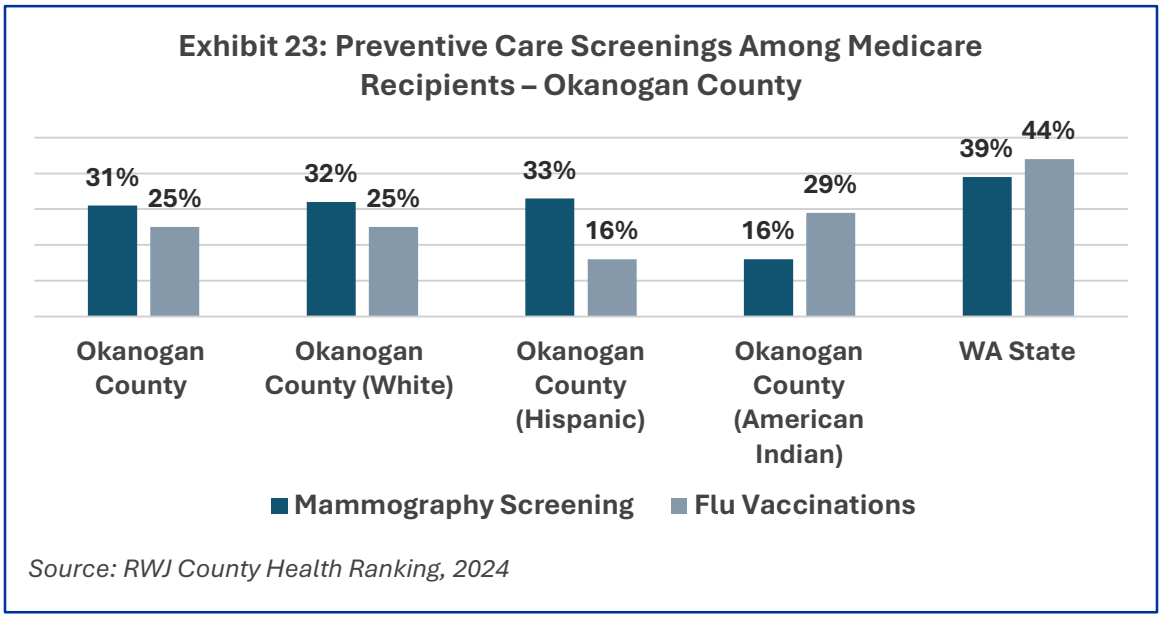
Preventive Care

Key markers of access to healthcare in a community are the rates of vaccines and preventive screenings. Vaccinations prevent many life-threatening illnesses from ever occurring, and preventive screenings catch disease processes early so that treatments are more effective. Yearly influenza outbreaks can prove deadly to seniors, children, pregnant women, and people with asthma or who are immunocompromised; vaccines prevent people from getting severe flu.

As indicated in **Exhibit 22**, the rate of Medicare recipients in the service area counties who receive annual flu vaccines compared to the state is significantly lower, while the rate of mammography screening is on par with, or exceeding, state numbers.



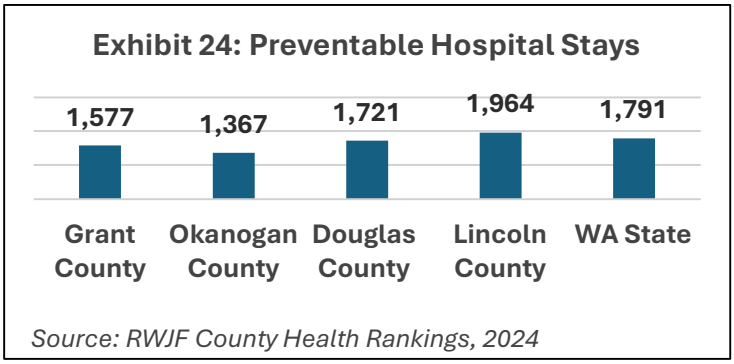
Additional disparities in these rates exist by race and ethnicity. Per **Exhibit 23**, the flu vaccine rate for Hispanic residents who are Medicare recipients residing in Okanogan County is 16%, compared to 25% for the overall county population. Only 16% of American Indian residents in Okanogan County received recommended mammography screenings in 2021, compared to 31% of the county population.



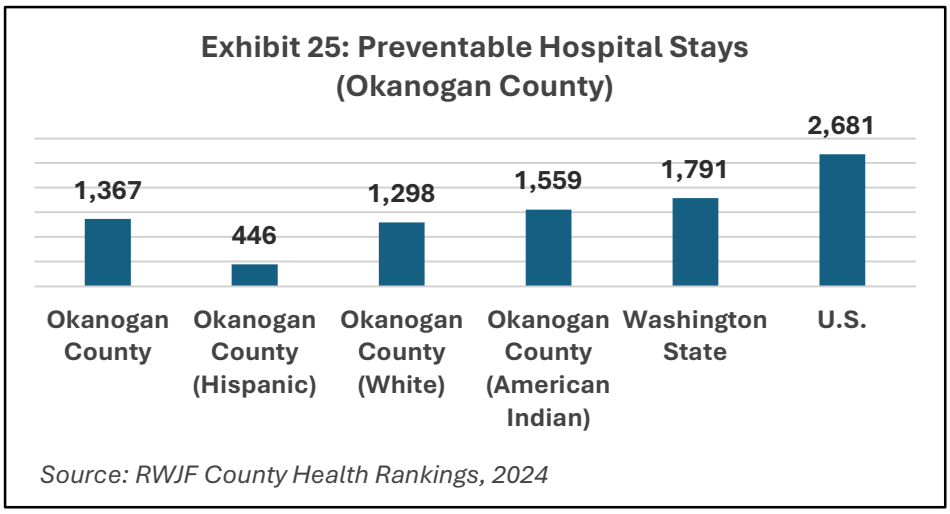
Preventable Hospital Stays

Preventable hospital stays are hospitalizations for ambulatory care sensitive conditions. These are conditions that, if diagnosed and treated in an outpatient setting, could have prevented a hospitalization. Preventable hospital stays can be classified as both a quality and access measure, as some literature describes hospitalization rates for ambulatory care sensitive conditions primarily as a proxy for access to primary healthcare. This measure may also represent a tendency to overuse hospitals as a main source of care.

Grant, Okanogan, and Douglas counties all fare better than Washington State, while Lincoln County had almost 10% more preventable hospital stays per 100,000 Medicare enrollees than the state.



As shown in **Exhibit 24**, and despite an overall shortage of primary care throughout the service area (see also **Exhibits 27** and **30**; as well as survey responses from community convening in **Section X**), the four County region is doing better than Washington State and U.S. top performers in terms of the rate of preventable hospital stays, with overall rates 1,298 to 1,559 per 100,000, compared to 1,791 for the state and 2,681 for U.S. top performers. Discrepancies in the data appear when disaggregating by race and ethnicity (**Exhibit 25**).



Health Professional Shortages

The Federal Health Resources & Services Administration (HRSA) deems geographies and populations as Medically Underserved Areas (MUAs), Medically Underserved Populations (MUPs), and/or Health Professional Shortage Areas (HPSAs). Similarly, an HPSA designation identifies a critical shortage of providers in one or more clinical areas.

There are several types of HPSAs, depending on whether shortages are widespread or limited to specific groups of people or facilities, including a geographic HPSA wherein the entire population in a certain area has difficulty accessing healthcare providers and the available resources are considered overused, or a population HPSA wherein some groups of people in a certain area have difficulty accessing healthcare providers (e.g., low-income, migrant farmworkers, Native Americans).

Once designated, the HRSA scores HPSAs on a scale of 0-26, with higher scores indicating greater need (see **Exhibit 26**). HPSA designations are available for three different areas of healthcare: primary medical care, primary dental care, and mental health care.

These designations are important as more than thirty federal programs depend on the shortage designation to determine eligibility or funding preference to increase the number of physicians and other health professionals who practice in those designated areas.

Exhibit 26: HSPA Scoring Criteria

Three scoring criteria are common across all disciplines of HPSA:

- *The population-to-provider ratio,*
- *The percentage of the population below 100% of the Federal Poverty Level (FPL), and*
- *The travel time to the nearest source of care (NSC) outside the HPSA designation.*

The following figure provides a broad overview of the four components used in Primary Care HPSA scoring:

Source: Health Resources and Services Administration (HRSA)

Exhibit 27 reflects the service area's HPSA designations. As shown, all four service area counties are designated shortage areas for primary, dental, and mental health.

County	Updated	Exhibit 27: HPSA, Score, Designation		
		Primary Care	Dental Health	Mental Health
Okanogan	2021	18 (LI)	18 (LI/H/M)	18 (Geo)
Douglas	2021	13 (LI/H/M)	16 (LI/H/M)	17 (Geo)
Grant	2021	16 (Geo)	14 (LI/H/M)	16 (Geo)
Lincoln	2022	15 (Geo)	16 (LI)	15 (Geo)

Key: LI – Low Income Populations, H – Homeless Populations, M – Migrant Farmworker Populations, Geo – Geographic Population

Source: HRSA Data Warehouse, HPSA Find

As shown in **Exhibit 28**, the population-to-provider ratios across all four counties corroborate the HPSA designations. All four counties have significantly higher (worse) population-to-provider ratios than Washington State.

Exhibit 28: Population to Provide Ratios					
Provider Type	**Okanogan County**	**Douglas County**	**Grant County**	**Lincoln County**	**WA State**
Primary Care Physicians	**1,220:1**	**3,640:1**	**2,510:1**	**3,740:1**	1,200:1
Dentists	**1,310:1**	**2,010:1**	**1,810:1**	**2,320:1**	1,150:1
Mental Health Providers	**270:1**	**1,580:1**	**390:1**	**770:1**	200:1
Source: RWH County Health Rankings, 2024					
Region compared to WA State	**Better**		**Worse**		

Clinical Care Takeaways

- *Except for Lincoln County, which fares better, the service area counties have higher rates of uninsured residents than Washington State.*
- *All four service area counties are designated by HRSA as shortage areas for primary, dental, and mental health.*
- *All four counties have significantly higher (worse) population-to-provider ratios than Washington State.*

VIII. The Social Determinants: Social and Economic Factors

Our basic social and economic supports—good schools, stable jobs, and strong social networks—are foundational to achieving long and healthy lives. For example, family-wage employment provides income that shapes opportunities around housing, education, childcare, food, medical care, and more. In contrast, unemployment and underemployment limit these choices and the ability to accumulate savings and assets that can help cushion in times of economic distress.

Social and economic factors are not commonly considered when it comes to health, yet strategies to improve these factors can have an even greater impact on health than many strategies traditionally associated with health improvement.

Educational attainment is tied to lifetime earnings. As seen in **Exhibit 29**, three out of four service area counties (and the service area itself) all fare worse than the state on measures of students receiving a high school diploma. The differences in the data between the aggregate service area and its disaggregated counties is attributable to the fact the service area represents a portion of each County's much larger population. Said another way, the service area is doing better than three of its four disaggregate counties in measures of high school graduation rates.

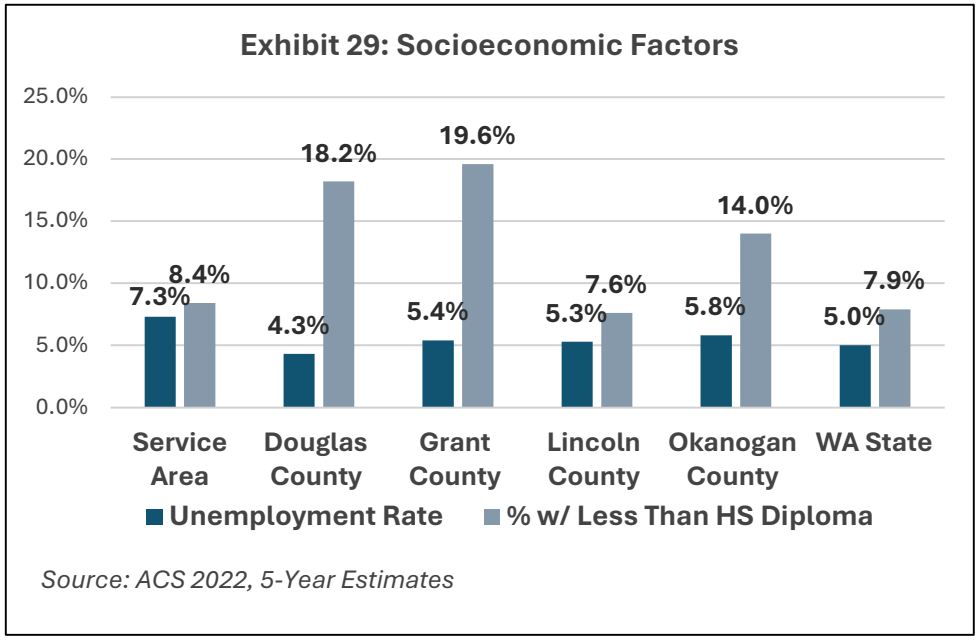
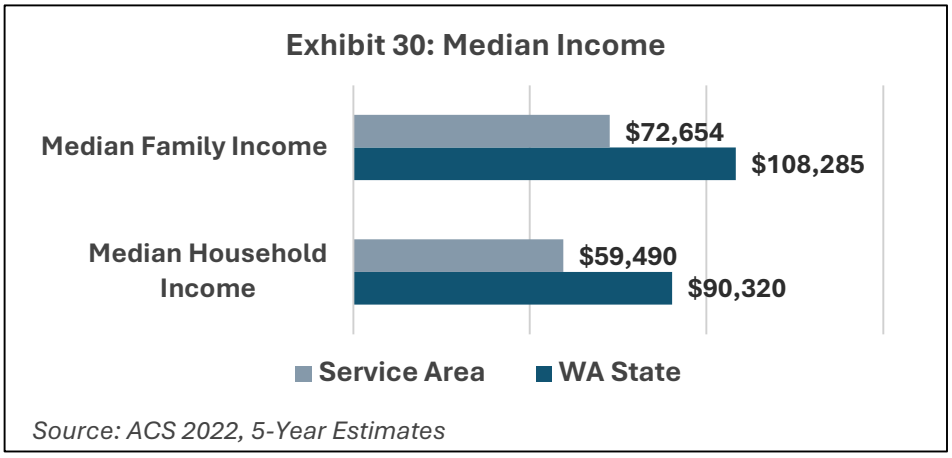
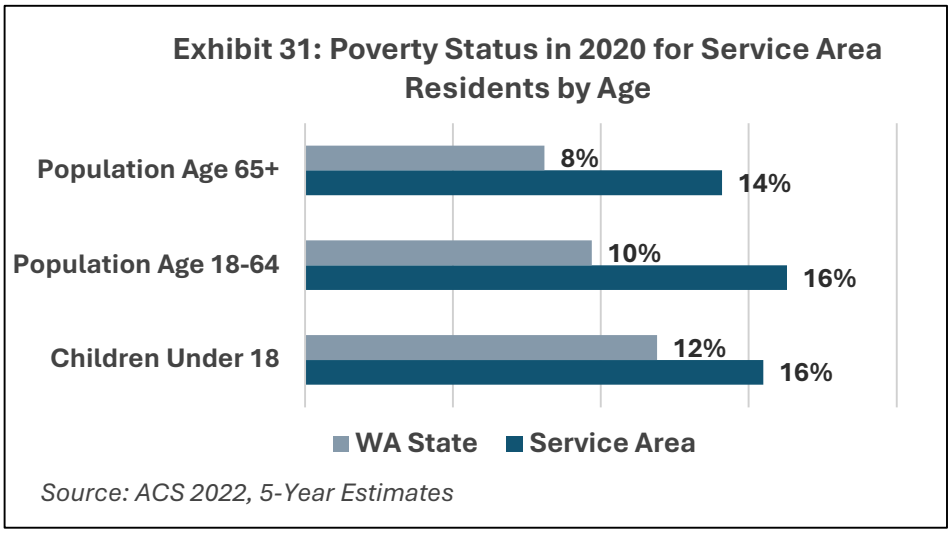


Exhibit 30 shows that the median income for households and families is significantly lower than the state.



According to the U.S. Census Bureau, the child poverty rate fell to its lowest recorded level in 2021, driven by the impact of anti-poverty programs during the COVID-19 pandemic. However, **Exhibit 31** shows that the poverty rates in the service area across all age groups are significantly greater than in Washington State.



United for ALICE

Poverty is defined in the Census by family size and income and is a primary measure of financial stability. However, many families living above the federal poverty level (FPL) still cannot make ends meet. The United Ways' ALICE measure (Asset Limited, Income Constrained, Employed) looks at those making above 100% of FPL. By factoring in a "household survival budget" and "threshold of financial survival" into the equation, the ALICE measure targets those above the FPL, but who fall below a "basic cost of living." Therefore, ALICE-qualifying households can be combined with households earning 100% or below FPL to create a more accurate number of those struggling in a given community.

Exploring ALICE at the service area level uncovers deep disparities in economic outcomes between communities within the service area. **Exhibit 32** shows that four of the eight service area zip codes have 50% or more of households struggling financially. Nespelem, on the Colville Indian Reservation, has 63% of households that do not earn enough to cover basic cost of living expenses and needs.

Exhibit 32: ALICE Data by Service Area Zip Code

City/Zip Code	Combined Poverty + ALICE Households
Almira - 99103	39%
Coulee City - 99115	50%
Coulee Dam - 99116	29%
Electric City - 99123	33%
Elmer City - 99124	50%
Grand Coulee - 99133	50%
Hartline - 99135	36%
Nespelem - 99155	63%

Social Determinants of Health Takeaways

- *Median income for service area households and families is significantly lower than the State.*
- *Poverty rates in the service area across all age groups is significantly greater than the State.*
- *Certain communities within the service area are disproportionately burdened by poverty, with more than 50% of households struggling to make ends meet in Grand Coulee, Coulee City, Nespelem, and Elmer City.*

IX. Physical Environment

Clean air and safe water are necessary for good health. Air pollution is associated with increased asthma rates and lung disorders, and an increase in the risk of premature death from heart or lung disease. Water contaminated with chemicals, pesticides, or other pollutants can lead to illness, infection, and increased risks of cancer.

Stable, affordable housing can provide a safe environment for families to live, learn, and grow. Housing is often the single largest expense for a family, and when a disproportionate amount of a paycheck goes to paying the rent or mortgage, the cost burden can force people to choose between paying for essentials such as utilities, food, transportation, or medical care.

Housing

RWJ County Health Rankings data provides estimates of individuals who have "severe housing problems," meaning individuals who live with at least one of four of the following conditions: overcrowding, high housing costs relative to income, lack of a kitchen, or lack of plumbing. Similarly, RWJ defines a "cost-burdened" household as a household that spends 30% or more of their household's income on housing.

Exhibit 33 identifies that the service area's renters and homeowners fare better than their state peers on cost-burdened households. Also evident in **Exhibit 33**, more than one-in-four renters and almost one-in-five homeowners in the service area are spending more than 30% of their household income on rent. Households experiencing these cost burdens face difficult trade-offs in meeting other basic needs. When most of a paycheck goes toward the rent or mortgage, it makes it hard to afford health insurance, healthcare and medication, healthy foods, utility bills, or reliable transportation to work or school. This, in turn, can lead to increased stress levels, emotional strain, and disease.

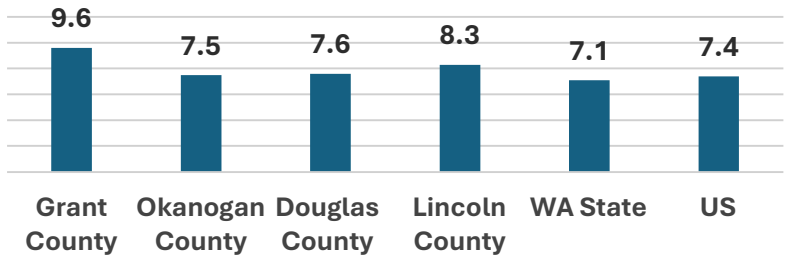
Exhibit 33: Housing Metrics	SA	WA
Renting		
Cost-Burdened *% of Renters Spending 30%-49% of Household Income on Rent*	**14.3%**	**24.6%**
Severe Cost-Burdened *% of Renters Spending 50% or More of Household Income on Rent*	**12.2%**	**21.7%**
Total of Cost-Burdened Renters	**26.5%**	**46.3%**
Home Ownership		
Cost-Burdened *% of Homeowners Spending 30%-49% of Household Income on Home Ownership Costs*	**12.5%**	**23.6%**
Severe Cost-Burdened *% of Homeowners Spending 50% or More of Household Income on Home Ownership Costs*	**5.1%**	**8.9%**
Total of Cost-Burdened Homeowners	**17.6%**	**32.5%**
Source: ACS 2022, 5-Year Estimates		

Air and Water Quality

RWJ's County Health Rankings measures air pollution by the particulate matter in the air. It reports the average daily density of fine particulate matter in micrograms per cubic meter. Fine particulate matter is defined as particles of air pollutants with an aerodynamic diameter less than 2.5 micrometers ($PM_{2.5}$). A number of adverse health effects are associated with exposure to particulate matter, including premature mortality, increased hospitalization, acute and chronic bronchitis, asthma, ER visits, and restricted daily activities. Research points to older adults with chronic heart and lung disease, children, and asthmatics as the groups most likely to experience adverse effects with exposure to particulate matter.[1]

As seen in **Exhibit 34**, all four service area counties fare worse than Washington State and U.S. top performers on this measure of air quality. Lincoln and Grant counties have significantly higher particulate matter than the other service area counties.

Exhibit 34: Average Daily Density of Fine Particulate Matter



In addition to clean air, ensuring the safety of drinking water is important to prevent illness, birth defects, and death. One method for measuring the safety of water in a community is to evaluate drinking water violations (defined as at least one community water system in the area receiving at least one health-based violation in the last year). Of the four service area counties, only Grant County received drinking water violations in 2022, the year of most recent data.

Physical Environment Takeaways

- *While service area renters and homeowners generally fare better than their state peers on cost-burdened households relative to the state, one-in-four renters and almost one-in-five homeowners in the service area are spending more than 30% of their household income on rent or homeownership.*

[1] California Air Resources Board

X. Community Convening

CMC undertook a four-month process of community engagement to solicit community voice in the CHNA process. CMC distributed an online survey with the support of community partners, social and print media, and CMC staff and providers. Survey design focused on accessibility, convenience, and community input on past and future priorities. Surveys were distributed from November 2023 through January 2024. Community engagement included CMC staff hosting tables at the Confederated Tribes of Colville offices, and hard copies of the survey were distributed at various locations throughout the community.

In addition, in September of 2024, CMC along with the Colville Tribal Health Program hosted the annual Gathering of Wellness Powwow & Health Fair. The Powwow & Health Fair grew out of CMC's Board of Commissioners and staff recognition of the need to not just be aware of, but to embrace the cultural needs of, the entire community. CMC used this opportunity to gather additional input on access to care and improving behavioral health in the community.

Community Partners

Confederated Tribes of the Colville

Okanogan County Transportation & Nutrition

Grand Coulee Dam Bureau of Reclamation

Grand Coulee Dam Area Chamber of Commerce

Grand Coulee Dam School District

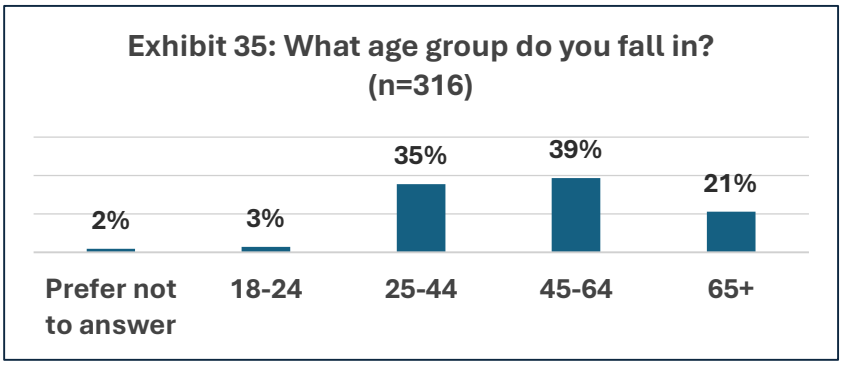
Grand Coulee Dam Rotary

Grand Coulee Eagles (F.O.E. #2577)

Loyal Order of the Moose Lodge (#504)

Survey Demographics

CMC received 316 completed responses to the survey. Twenty-one percent of respondents were aged 65 and above, relative to the 65+ cohort of the total District population which is 27% (**Exhibit 35**).



As shown in **Exhibit 36**, 28% of survey respondents identified as American Indian or Alaska Native, a rate proportional to the over 30% of District residents who identify as such. While the percentage of District residents identifying as Hispanic or Latino(a) is just over 5%, only 2% of survey respondents identified as such.

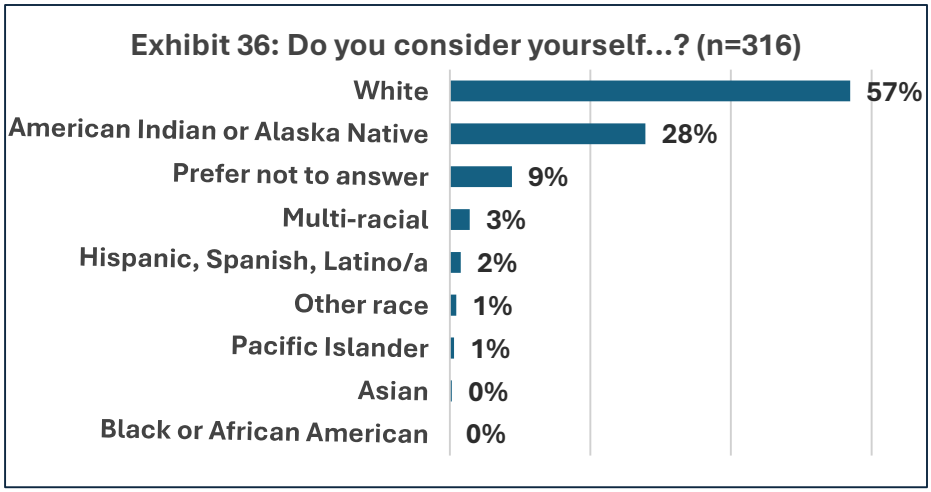


Exhibit 37 shows that 69% of survey respondents who live in the District reside in the communities of Coulee Dam, Grand Coulee, or Electric City.

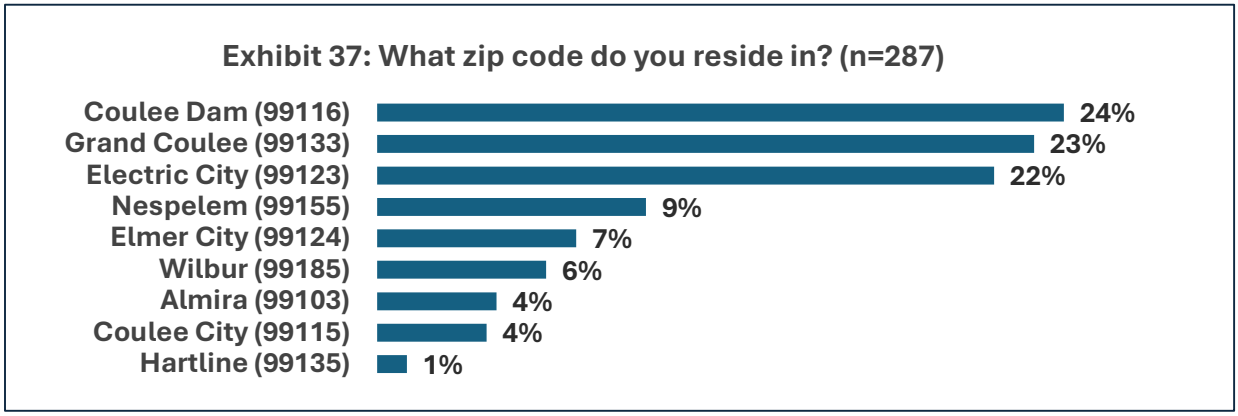
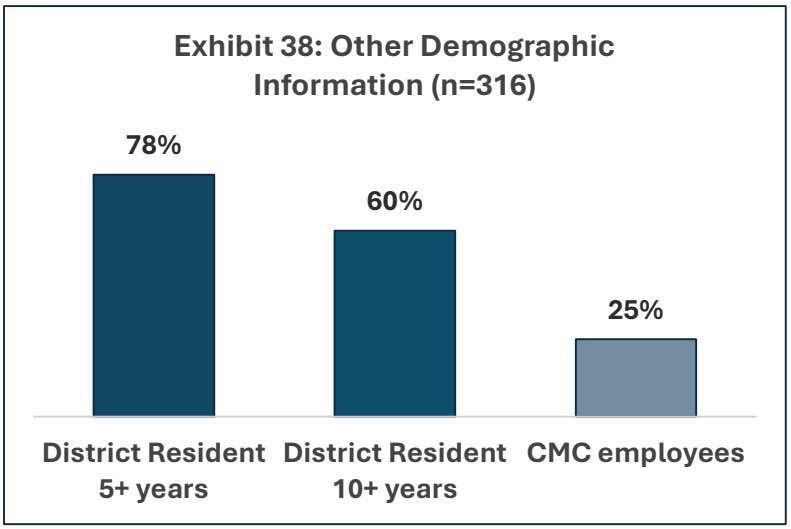
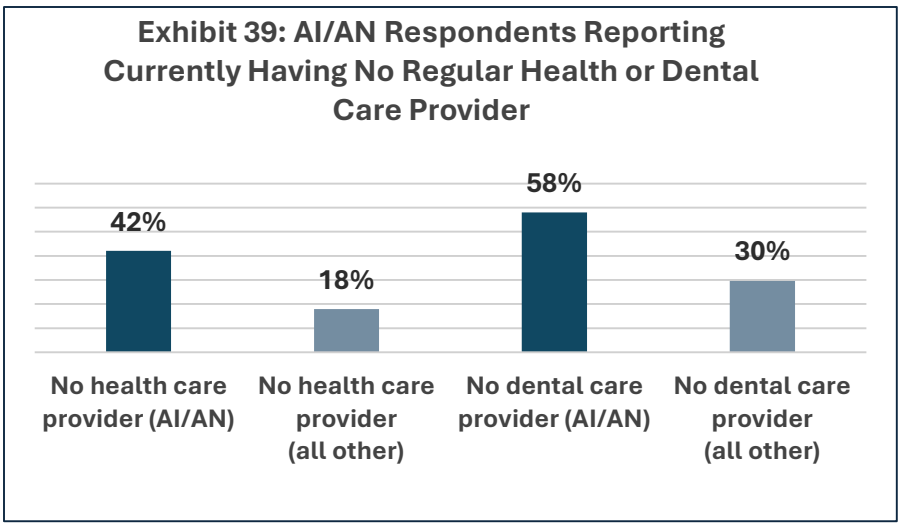


Exhibit 38 demonstrates that survey respondents were overwhelmingly local and long-standing. Seventy-eight percent of respondents have lived in the community for more than five years, and 60% of respondents have lived in the community for more than ten years. Additionally, more than 25% (n=83) of respondents are employed by the CMC.



Access to Care

As seen in **Exhibit 39**,18% of total respondents indicated they do not have a regular, or primary, healthcare provider. Demographic and geographic disparities are evidenced when disaggregating responses by race. The number of American Indian/Alaska Native (AI/AN) respondents reporting that they do not have a primary healthcare provider (42%) is more than twice that of all other respondents (18%). That gap is greater for dental care. As indicated earlier in the report, CMC identified that the Tribal Clinic is currently experiencing staffing shortages and has reached out around collaboration with CMC to support better access.



Community perceptions of access to healthcare (**Exhibit 40**) were measured through questions about wait times for routine, non-urgent care:

Exhibit 40: Perceptions of Access to Care in the District	
HEALTHCARE (n=236)	**DENTAL CARE (n=194)**
• **Almost 60% of respondents reported a wait time of more than a month to access non-urgent healthcare.** • **Fifteen percent of respondents said it takes more than three months to be seen for routine, non-urgent visits.** • **When asked whether the wait times were reasonable, 60% of respondents said "no."** • **While 30% of respondents said these wait times were "about the same in the past few years," almost 60% said wait times had "gotten longer/worse."**	• **Twenty percent of respondents reported a wait time of more than a month to access non-urgent dental care.** • **Eight percent of respondents said it takes more than three months to be seen for routine, non-urgent visits.** • **When asked whether wait times were reasonable, 16% of respondents said "no."**

Community Health Factors and Quality of Life Issues

Respondents were asked to identify the **greatest health problems in the community**. **Exhibit 41** shows the leading responses. While there was general consistency across all respondents, there are several noteworthy differences:

- **Unintentional Injuries** is the greatest priority for American Indian respondents, followed closely by Chronic Health Conditions and Alcohol Use. Unintentional Injuries did not make the top seven for other respondents or respondents age 65+.
- **Impacts of Loneliness** is a top five concern for American Indian respondents but is not in the top seven list for other respondents.

Exhibit 41: Greatest Health Problems (aggregate responses)

- ❑ **Alcohol Use**
- ❑ **Chronic Health Conditions**
- ❑ **Low Vaccination Rate**
- ❑ **Mental Health Conditions**
- ❑ **Opioids and Other Drug Use**

- **Health Inequalities** is a top seven concern for American Indian respondents but is not in the top seven for other respondents.
- **Alzheimer's** was named by 65+ respondents as a top five concern.

Respondents were also asked to identify the **most important factors to improve health and quality of life in the community**. The leading responses are captured in **Exhibit 42**.

There is alignment across all demographic groups that **recruiting and retaining the workforce** is by far the most selected factor.

Exhibit 42: Most Important Factors to Improve Health and Quality of Life (aggregate responses)

- ❑ **Ability to recruit and retain quality healthcare workforce**
- ❑ **Access to healthy and nutritious food**
- ❑ **Better access to behavioral health services**
- ❑ **Services to support seniors to age in place**
- ❑ **Infrastructure to support a healthy future**

Although not a leading selection for all respondents, **Affordable Housing** was the second-most popular response for American Indian respondents, and third overall for 65+ respondents (i.e., Affordable Housing was selected most often as a first, second, or third priority by respondents in these cohorts).

Gathering of Wellness Powwow & Health Fair

iʔ syʕaʔ x̌l sxʷt̓xʷalt̓ət

(We gather for our wellness: Nsəlxcin- Okanogan/Colville)

In September of 2024, CMC and the Colville Tribal Health Program hosted the annual Gathering of Wellness Powwow & Health Fair. The Powwow & Health Fair grew out of recognition by the CMC's Board of Commissioners and staff of the need to not just be aware of, but to embrace the cultural needs of, the entire community.

In its fifth year, but held for the first time since 2019, the Powwow & Health Fair is part of CMC's efforts to bridge cultural gaps in the healthcare field and in the community.

CMC's leadership committed to holding space at the Powwow & Health Fair to gather input on select strategic priorities around improving access to care and improving behavioral health in the community.

Asked about perceptions of access to care over the last several years (**Exhibit 43**), 75% of respondents said it had "gotten better."

Asked about perceptions of the communities' mental health and access to behavioral health services over the last several years (**Exhibit 44**), 74% of respondents said it had "gotten better."

Exhibit 43: How do you feel access to care has changed over the last 2-3 years? (n=32)

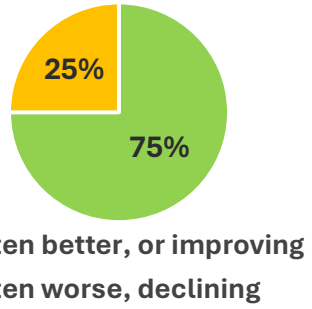


Exhibit 44: Do you feel the community's mental health or access to behavioral health services has changed over the last 2- 3 years? (n=27)

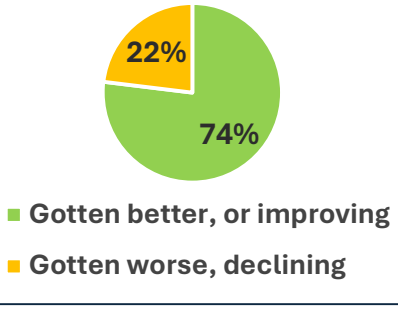
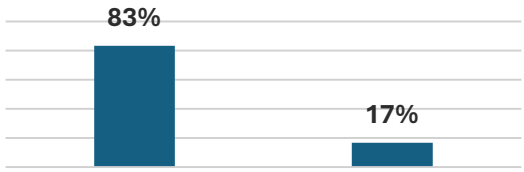


Exhibit 45 shows that 67% of respondents I 2024 said that CMC should "continue with current priorities."

Based on data and community input, CMC identified the following priorities for its 2021 CHNA:

- **Access to Care**
- **Behavioral Health**

Exhibit 45: Should CMC continue to focus on these priorities in the coming years? (n=24)



XI. Implementation Strategy

Consistent with 26 CFR § 1.501(r)-3, the District will adopt an Implementation Strategy on or before the 15th day of the fifth month after the end of the taxable year in which the CHNA is adopted, or, by May 15, 2025. Prior to this date, the Implementation Plan will be presented to the District Board for review and consideration. Once approved, the Implementation Plan will be appended to this CHNA and widely disseminated. It will serve as guidance for the next three years in prioritization and decision-making regarding resources and will guide the development of a plan that operationalizes the adopted priorities.

The data presented within this CHNA, in conjunction with findings from both Community Convenings, suggests that CMC continue to build on its accomplishment from the last CHNA and maintain, at least, the priorities established in the 2021-2024 CHNA:

- **Access to Care**
- **Behavioral Health**

There is strong support within the data and community input suggesting that CMC accelerate its focus on larger social determinants of health in the community, such as housing affordability, which interact directly with the identified priorities. Data and community-identified themes include:

Access to Care (prior priority)

- Continuing to focus on workforce development and provider recruitment and retention to reduce patent wait times.
- Apply patient education and community outreach strategies (youth and adult) towards addressing prevention of chronic health conditions (e.g., obesity) and health behaviors (e.g. teen births, drug/alcohol use).

Access to Behavioral Health (prior priority)

- Continuing to focus on workforce development, complete additional provider hiring.
- Re-focus on increasing the number of school education and outreach events.

Addressing Social Determinants of Health (new priority)

- Build on strengths of CMC's robust community outreach and engagement to develop trust, encourage collaboration, and advocate for policies that improve the health and wellbeing of the District as a whole.
- Maintain community partnerships and leadership role in collaborative work to address housing affordability and availability in the service area.
- Focus community outreach and education across both behavioral health and chronic health conditions issues.

Appendix 1: CMC 2021 Implementation Plan

CMC 2021 Implementation Plan

Identified Priority	Issues	Implementation Strategies	Evaluation Metrics How will we measure our impact?
Access to Care	▪ Cost and time burden of travel out of area ▪ Wait times for primary care/shortage of primary care ▪ Need for intra- and interagency warm handoffs ▪ Higher percentage of residents with poor physical health ▪ Significant aging population ▪ Social, cultural, and financial disparities	Recruit providers, with a specific focus on primary care, behavioral health (including SUD/OUD), and specialty care. Explore telehealth options. Evaluate opportunities to improve throughput of providers to increase provider availability. Provide ongoing cultural competency training. Increase community partnerships, potentially creating a formal community task force for trust-building and to increase warm hand-offs. Identify, partner with, and distribute to the community information on available community resources. Expand CCM and TCM programs, including adding additional care coordinators and community health workers into clinics.	Reduction in wait time for primary care. Increased provider productivity. Increased provider-to-resident ratios. Reduction in ED visits. Reduction in hospitalization and re-hospitalization rates. Increase in number of providers and staff completing cultural competency training. Number of elderly/vulnerable residents having home checks/using remote monitoring. Increase in number of persons enrolled in CCM and TCM programs.

Identified Priority	Issues	Implementation Strategies	Evaluation Metrics How will we measure our impact?
		Determine constraints and remove obstacles to providing home checks, home-based education and screening, and remote monitoring of elderly and other vulnerable populations.	
Behavioral Health	▪ Severe shortage of behavioral health providers ▪ Shortage of local SUD/OUD treatment options ▪ Higher prevalence rate for behavioral health conditions, including depression and anxiety ▪ Higher rates of suicide ▪ Increase in substance abuse ▪ Higher rates and higher burden of ACEs	Expand behavioral health integration in primary care. Explore opportunities for SUD/OUD inclusion. May require both in-person and telepsych/telehealth. Explore standardization of behavioral health and SUD assessments in primary care. Partner with schools to provide outreach, education, stigma reduction, and coordinated treatment. Work with Tribe and identify additional partners to pursue more behavioral health and substance abuse programming in the community.	Reduction in ED visits associated with mental health conditions. Increase in number of individuals assessed for behavioral health needs, including SUD/OUD. Increase in the number of school education and outreach events. Reduction in suicide rates and rates of substance abuse. Earlier identification of ACEs and early intervention.