2024

COMMUNITY HEALTH NEEDS ASSESSMENT

North Puget Sound

Providence Regional Medical Center Everett

Swedish Edmonds

Snohomish County, Washington

Providence SWEDISH

To provide feedback about this CHNA or obtain a printed copy free of charge, please email Jessica Burt at jessica.burt@providence.org or CHI@providence.org

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MESSAGE TO THE COMMUNITY

To our community:

Providence Swedish North Puget Sound is proud to be Snohomish County's health partner. Together, Providence Regional Medical Center Everett and Swedish Edmonds embrace a shared responsibility to provide for the needs of the communities we serve.

Our vision of *Health for a Better World* starts with a clear understanding of and response to the needs of our neighbors -- especially those who are poor and vulnerable. In 2023, Providence Swedish North Puget Sound invested $173 million in community benefit. Along with our partners, we are building communities that promote and transform health and wellbeing.

This important work is extended through our Community Health Needs Assessment (CHNA). Every three years the CHNA is conducted with input from community partners, such as the Providence Community Mission Board and the Providence Institute for Healthier Communities (PIHC), to identify and respond to the greatest unmet needs, and to develop and implement a Community Health Improvement Plan (CHIP).

This year we will focus our efforts on programs addressing behavioral health, including substance use, and access to health care.

Our goal is to identify solutions to transform the health of our communities and collectively work with our partners to help realize *Health for a Better World*.

A special thank you to the PIHC Strategic Oversight Committee for serving as the CHNA Advisory Committee. Their contributions to this important work were invaluable.

You are welcome to learn more about how Providence Swedish is meeting the needs of our community and ensuring our neighbors lead their healthiest lives.

Sincerely,

Kristy Carrington, RN

Chief Executive North Puget Sound

Providence Swedish

ACKNOWLEDGEMENTS

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- John Vandree, MD, Physician (retired), Community Member
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Community Organizations

- City Of Everett
- City Of Lynnwood

- Compass Health
- Community Health Center of Snohomish County
- Edmonds School District/Foundation for Edmonds School District
- Everett School District
- Glacier Peak Institute
- GLOBE (Gay/Lesbian or Bisexual Youth Empowerment)
- Homage Senior and Disabled Services
- House of Wisdom
- Housing Hope
- Korean Women's Association
- Latino Education Training Institute
- LETI (Latino Education Training Institute)
- Mukilteo City Council
- NASHI Immigrant Health Board for Washington State
- Project Girl Mentoring Program
- Snohomish County Sheriff
- Snohomish Health District
- South County Fire
- Tulalip Tribes
- WAGRO Foundation & Lynnwood City Council
- Well Being Youth & Family Resource Center
- Workforce Snohomish
- YMCA of Snohomish County

Land Acknowledgement

Providence Swedish North Puget Sound acknowledges that we occupy the ancestral lands of the Coast Salish Peoples, in particular the Tulalip, Snohomish, Stillaguamish, and Sauk-Suiattle Tribes. Since time immemorial, they have hunted, fished, gathered, and taken care of these lands. We respect their sovereignty, their right to self-determination, and honor their sacred spiritual connection with land and water. We will strive to be honest about our past mistakes and bring about a future that includes their people, stories, and voices to form a more just and equitable society.

EXECUTIVE SUMMARY

Understanding and Responding to Community Needs

The Community Health Needs Assessment (CHNA) is an opportunity for Providence Regional Medical Center, Everett (PRMCE) and Swedish Edmonds, together comprising Providence Swedish North Puget Sound (NPS), to engage the community every three years with the goal of better understanding community strengths and needs. At Providence Swedish, this process informs our partnerships, programs, and investments. Improving the health of our communities is fundamental to our Mission and deeply rooted in our heritage and purpose.

This report is a joint CHNA and reflects the hospitals' collaborative efforts to identify the significant health-related needs in the community and the community strengths. The hospitals participating in this joint CHNA share a service area and community served. The 2024 CHNA was approved by the Providence Regional Medical Center Community Mission Board on October 17th, 2024, and Swedish Health System Board of Trustees on November 12th, 2024 and made publicly available by December 28, 2024.

Gathering Community Health Data and Community Input

Through a mixed-methods approach, using quantitative and qualitative data, we collected information from the following sources: American Community Survey, Behavioral Risk Factor Surveillance System, local public health data, Washington State Department of Health, PRMCE and Swedish Edmonds emergency department utilization data, and the PIHC Health and Well-Being Monitor. To actively engage the community, we conducted five listening sessions with people who have chronic conditions, are from diverse communities, have low-incomes, and/or are medically underserved. We also conducted 20 key informant interviews with representatives from organizations that serve these populations, specifically seeking to gain deeper understanding of community strengths and opportunities. Some key findings include the following:

- A need for supportive relationships that provide opportunities for inclusion and connection.
- A need for access to behavioral health and substance use treatment and prevention resources that serve all, especially young people, families, culturally and racially diverse communities and those formerly incarcerated.
- A need for access and resources across a variety of cultures and subpopulations to meet basic needs that promote economic security including affordable housing, healthy food, transportation, childcare, education and reliable and appropriate healthcare services and delivery across a variety of needs, cultures and populations.
- A need for safe spaces and an environment that ensures personal safety, low crime rates, access to nature, recreational opportunities, and a clean, sustainable environment.
- Community strengths that potentially could provide support are strong community resource networks, collaborative relationships and a growing community with opportunities for engagement and connections to natural resources.

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

Identifying Top Health Priorities

Through a collaborative process engaging our many partners and community members, including the Providence Institute for Healthier Community (PIHC) Strategic Oversight Council, which represents the broad interest and demographics of the community, the PIHC Strategic Oversight Council served as the CHNA Advisory Committee leading the effort to review data and identify the significant health needs of the community.

Providence Swedish NPS utilized a multi-step approach to identify the significant health needs of the community and those that NPS will address in this CHNA cycle. The process started with listening to the voices of the community through key informant interviews, group listening sessions, and a community survey. These findings were used to frame the discussion of the top health needs. A review of the quantitative data was then conducted to validate and enrich the outcomes of the qualitative information provided by the community. The data was compiled and compared to local, state and national data to identify trends, and evaluate the size and seriousness of the need. The next phase included scoring the significant needs based on the size, seriousness, trend, and disproportionate impact on sub-populations. The final phase included an evaluation based on the linkage to the strategic plan, the number of resources required relative to community need, and confidence in our ability to have a positive impact.

Through this evaluation process the following priority areas were identified (listed in order of priority):

BEHAVIORAL HEALTH, INCLUDING SUBSTANCE USE*

Behavioral health, including substance use have key areas of improvement and include access to care services including education, and better care delivery. Access to care encompasses various levels of treatment and other crisis support while being mindful of trauma-informed approaches, particularly on-site school-based care and substance use education. Better delivery of services highlight coordination of care along with culturally matched and linguistically appropriate services. Some populations of greatest need include young people and new parents, the Latino/a community, Indigenous Peoples of the U.S., and individuals who were formerly incarcerated.

ACCESS TO HEALTH CARE SERVICES*

Access to health care services encompasses several areas of need. They include the high cost of care, even with insurance, particularly Medicaid, in addition to the availability of care and the delivery of care. Availability issues call out a need for more care (especially primary care, low-cost/free immunizations, and OB/GYN care), barriers related to long wait times, limited appointment hours, and transportation issues. The delivery of care centers on needs for culturally matched and linguistically appropriate health care delivery, the availability of care navigation (to access available resources, simplify process, provide education), and ensuring health literacy/health information including accessibility in community such as health fairs. Some communities with the greatest needs include refugees and immigrants, people

experiencing homelessness, Indigenous Peoples of the U.S., older adults, and individuals with behavioral health challenges

**Each need area will integrate health equity measures that recognize racism and discrimination as underlying drivers of need. In addition to delivery of care needs named above, these may include improving health equity education, training and hiring practices as well as building trust, reducing stigma and improving community belonging.*

Providence Swedish North Puget Sound (PRMCE and Swedish Edmonds) in collaboration with community partners, and considering resources, community strengths, and capacity will develop a joint three-year Community Health Improvement Plan (CHIP) to respond to these prioritized needs. The 2025-2027 CHIP will be approved and made publicly available no later than May 15, 2025.

Results from the Previous CHNAs and CHIPs

North Puget Sound (PRMCE and Swedish Edmonds) responded to community needs by making investments of direct funding, time, and resources to internal and external programs dedicated to addressing the previously prioritized needs using evidence-based and leading practices. In addition, we invited written comments on the Swedish Edmonds 2021 CHNA and PRMCE 2022 CHNA as well as the resulting Swedish Edmonds 2022-2024 CHIP and PRMCE 2023-2025 CHIP, both made widely available to the public through posting on our website and distribution to community partners. No written comments were received. The Swedish Edmonds CHNA/CHIP and the PRMCE CHNA/CHIP priorities were similar and included the following: behavioral health (including substance use), access to healthcare, housing insecurity, and health equity.

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

Providence Regional Medical Center Everett

- Behavioral health urgent care services expanded to include patients 16 years and over in fall 2023—previously had been adult only and now also offers the option of virtual behavioral health services.
- Supported outpatient cultural health navigators in clinic or in outreach to improve health literacy, remove barriers to care, and improve access to health care for BIPOC communities.
- Collaborated with community partners, Mercy Watch and Washington State University to deliver 600 volunteer hours of street medicine and hygiene kits to people living unhoused.
- Funded Everett Gospel Mission respite program for people experiencing homelessness who need a safe place to recover from short-term, minor medical issues

Swedish Edmonds

- Expanded the available inpatient behavioral health beds.
- Behavioral health professionals were embedded into primary care clinics.

- In partnership with the Snohomish Health Department, administered the Overdose Data to Action (OD2A) program for prevention and tracking.
- Engaged in a medical legal partnership with Northwest Justice Project to offer housing supports such as food, transportation, and financial stability.

INTRODUCTION

Who We Are

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

Providence Regional Medical Center Everett (PRMCE] is an acute care tertiary hospital founded in 1905 and located in Snohomish County, Washington. The hospital has 595 licensed beds, a caregiver staff of more than 4000, serves as a teaching institute for many health professions and has professional relationships with many medical groups in the community and includes over 1300 medical staff. PRMCE is split into two campuses. Colby Campus, including the Cymbaluk Medical Tower, is the only adult level II trauma center in Snohomish County and a primary referral center for strokes and heart issues. The campus offers both medical and surgical intensive care units, acute care, telemetry, emergency and inpatient behavioral health care, and a full-service emergency department for adult and pediatric emergency care. Pacific Campus offers maternity care including a level III NICU, inpatient substance use treatment, acute rehabilitation, transitional care and Providence General Foundation.

Providence 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.

The Swedish Edmonds campus offers the full scope of medical and surgical service, including level IV Trauma emergency medicine, diagnostic, treatment and support services. The Swedish Edmonds campus, formerly known as Stevens Hospital, was operating in the community for 46 years before joining Swedish in 2010, who then formed an affiliation with Providence in 2012. The hospital is in Snohomish County, Washington, and has 217 licensed beds, more than 1,400 staff including clinical and non-clinical personnel and has professional relationship with more than 450 of the most qualified physicians and specialists on medical staff.

Swedish Mission: Improve the health and well-being of each person we serve.

Our Commitment to Community

Providence Swedish North Puget Sound dedicates resources to improve the health and quality of life for the communities we serve. To learn more, see our 2023 NPS Community Benefit Snapshot.

CHNA Framework and Process

How is the data gathered?

SECTION I: CHNA FRAMEWORK AND PROCESS

Equity Framework

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

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

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

Approach

Explicitly name our commitment to equity

Take an asset-based approach, highlighting community strengths

Use people first and non-stigmatizing language

Community Engagement

Actively seek input from the communities we serve using multiple methods

Implement equitable practices for community participation

Report findings back to communities

Quantitative Data

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

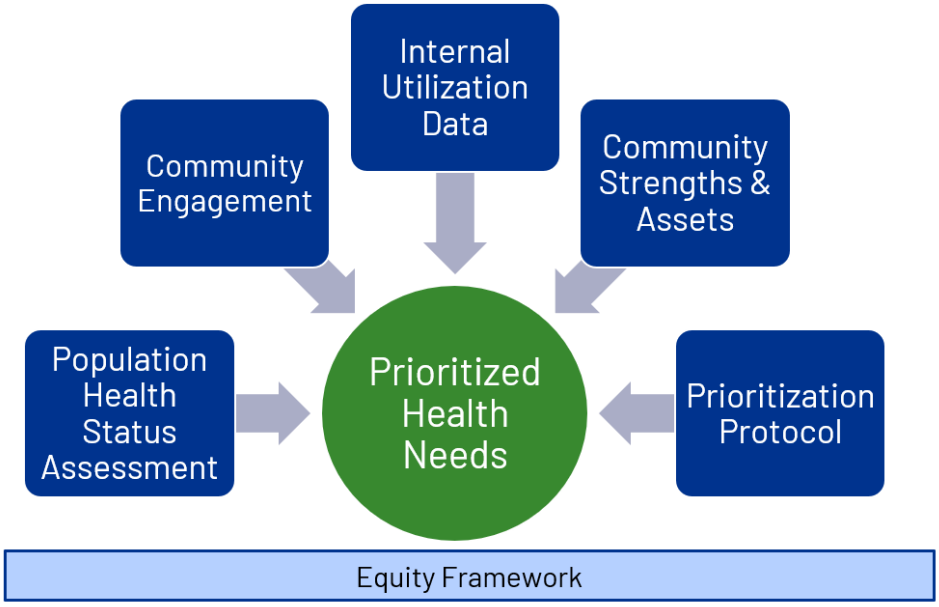
Disaggregate data when responsible and appropriate

Acknowledge inherent bias in data and screening tools

Local efforts to center equity and to engage specific populations included offering the PIHC Health and Well-being Monitor in Spanish and English and providing outreach to those without technology (telephones). We engaged trusted community leaders in leading listening sessions, inclusive of multiple languages and located in preferred community spaces. Participants of key informant interviews and listening sessions included a diversity of race, age, gender identity, sexual orientation, neurodiversity and abilities. The data review also included community members from similar segments.

CHNA Framework

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



*modified MAPP Framework

Data Sources

In gathering information on the communities served by the North Puget Sound (PRMCE and Swedish Edmonds) we looked not only at the health conditions of the population, but also at socioeconomic factors, the physical environment, and health behaviors. In addition, we recognize that the conditions for supporting health in some geographic areas are inadequate relative to nearby areas. Whenever possible and reliable, data are reported at census tract level. These smaller geographic areas allow us to better understand the neighborhood level needs of our communities and better address inequities within and across communities.

We reviewed data from the following sources:

Primary Data Sources	
• Key informant interviews • Community listening sessions	• PIHC Health and Well-being Monitor • Internal hospital utilization data’

Secondary Data Sources	
• American Community Survey from the U.S. Census Bureau • Behavioral Risk Factor Surveillance System (BRFSS) • CDC PLACES • CDC WONDER Online Database • Child Care Aware of America • County Health Rankings and Roadmaps • Environmental Justice Index • Healthy People 2030	• Snohomish County Annual Point-In-Time Count • Snohomish County Health Department • Social Vulnerability Index • Trust for Public Lands, ParkServe® • U.S. Centers for Disease Control • Washington State Cancer Registry • Washington State Department of Health • Washington State Employment Security Department Labor Summaries • Washington State Healthy Youth Survey

Data Limitations and Information Gaps

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

- Not all desired data were readily available, so sometimes we had to rely on tangential or proxy measures or not have any data at all. For example, there is little community-level data on the incidence of mental health or substance use.
- While most indicators are relatively consistent from year to year, other indicators are changing quickly (such as percentage of people uninsured) and the most recent data available may not be an accurate reflection of the current state.
- Reporting data at the county level can mask inequities within communities. This can also be true when reporting data by race, which can mask what is happening within racial and ethnic subgroups. Therefore, when appropriate and available, we disaggregated the data by geography and race.
- Data that are gathered through interviews and surveys may be biased depending on who is willing to respond to the questions and whether they are representative of the population.
- The accuracy of data gathered through interviews and surveys depends on how consistently the questions are interpreted across all respondents and how honest people are in providing their answers.

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

Written comments were solicited on the both the Swedish Edmonds 2021 CHNA and 2022-2024 CHIP reports, and the PRMCE 2022 CHNA and 2023-2025 CHIP which were made widely available to the public via posting on the internet in December 2021 and 2022 (CHNAs) and May 2022 and 2023 (CHIPs) respectively, as well as through various channels with our community-based organization partners. No comments were received.

Description of Community

What are the common characteristics of Individuals that reside in our community?

SECTION II: DESCRIPTION OF COMMUNITY

CHNA Service Area

Based on the availability of data, geographic access to the facility, and other hospitals in neighboring counties, Snohomish County serves as the boundary for the joint CHNA hospital service area. Snohomish County is located in northwest Washington State with boundaries extending from Skagit County in the north, King County in the south, the Cascade Mountains in the east, and the Puget Sound in the west.

Social Vulnerability Index

Providence uses CDC's Social Vulnerability Index (SVI) to identify communities of higher need within our service areas. Census tracts that score higher than the median SVI score are classified as "high need" and are depicted in green. All other census tracts are labeled "broader need" and are shown in blue. For Snohomish County, the median 2020 SVI score for census tracts overall is 0.37.

Community Demographics

Where applicable, graphs provide demographic and socioeconomic information about the service area and how the high need area compares to the broader service area. We have developed a data hub that maps each CHNA indicator at the census tract level: North Puget Sound Dashboard (arcgis.com)

Figure 1. High Need and Broader Need Census Tracts in Snohomish County

Source: North Puget Sound Dashboard (arcgis.com)

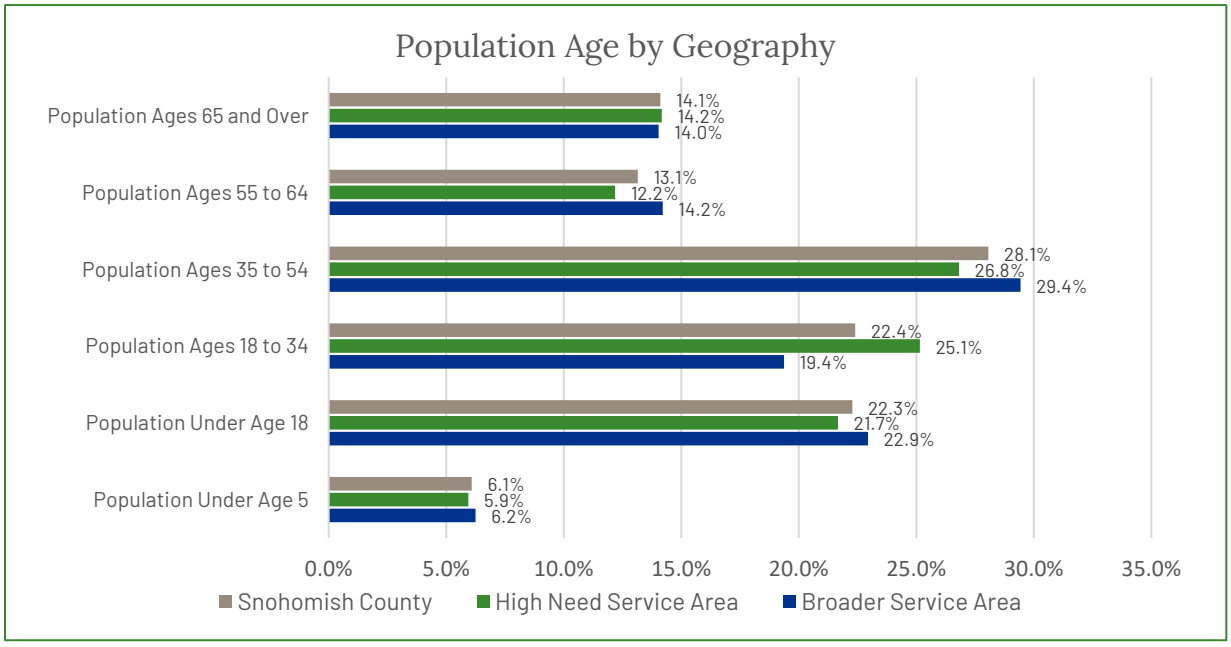
POPULATION

A growing and more diverse population. In 2022, the total population of Snohomish County was 828,337, with 394,207 residents in the broader service area and 434,130 in the high need area, an increase of about 4% for total population (798,808) from the 2019 American Community Survey 5-year estimates. There is an even distribution of reported male and female residents, and the largest percent of residents are in the 35-54 age group (28.1%) compared to other age groups.

- Those younger (18-34) have a disproportionately higher representation in high-need areas.
- Those oldest (age 55 or older) or youngest (age 18 or under) are similarly represented across need areas.
- The largest racial groups include White (68.9%), Asian (12.3%), Hispanic (11.1%) and Black/African American (3.5%), with 9.7% of residents reporting two or more races. Since the last CHNA, the only decrease has been among those reporting as White (75.4% in 2019).

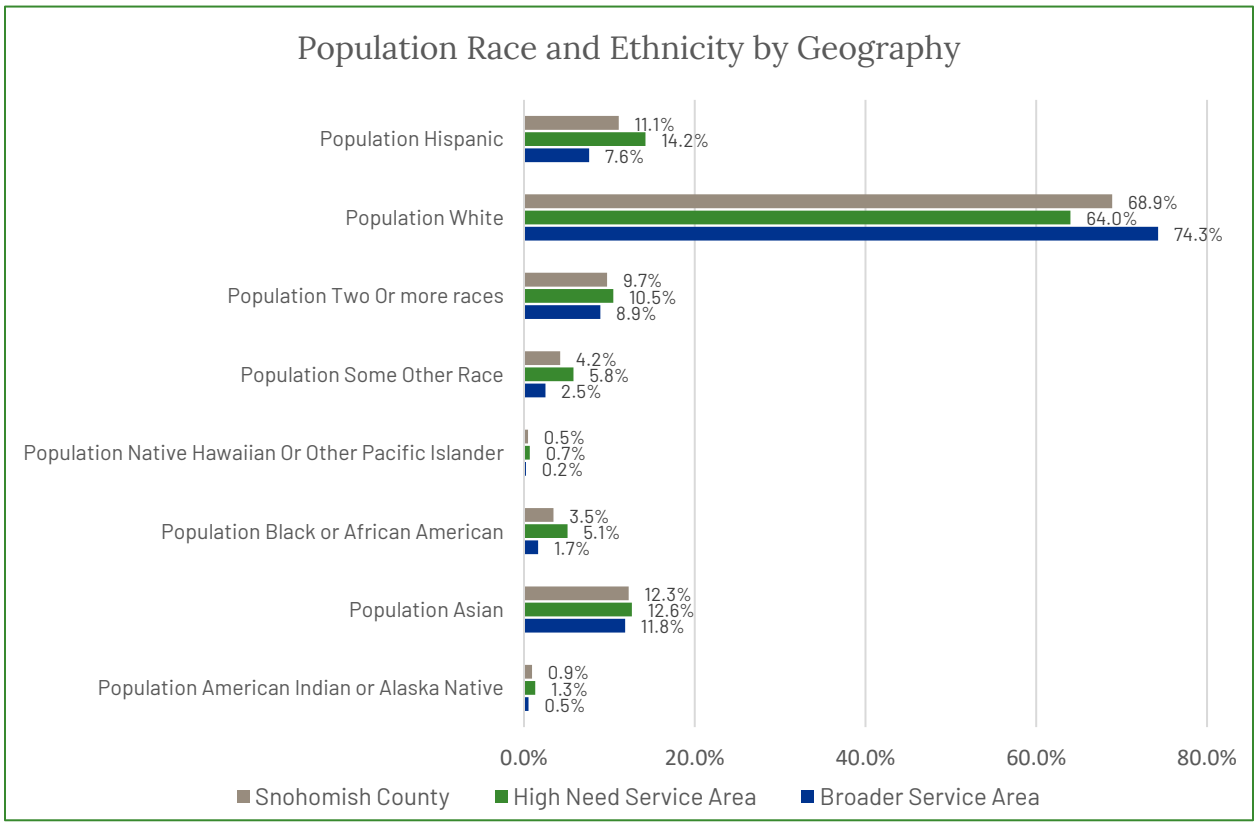
People identifying as Hispanic, two or more races, "some other race," Native Hawaiian or Other Pacific Islander, Black or African American, Asian, and American Indian or Alaska Native are disproportionately represented in the high need service area compared to the broader service area and Snohomish County overall.

Figure 2. Population Age Groups by Geography



Source: U.S Census Bureau, American Community Survey 5-Year Estimates, 2018 – 2022, Table B0100

Figure 3. Percent of Population by Race and Ethnicity



Source: U.S Census Bureau, American Community Survey 5-Year Estimates, 2018 – 2022, Table B030

LANGUAGE

More Limited English Language Households than Washington State A limited English-speaking household is one in which no member 14 years and older speaks only English at home or speaks a language other than English at home. Having limited English can be a barrier to accessing health care and other social services and understanding health information. According to the 2022 American Community Survey 5-Year Estimates, the most prevalent language groups spoken at home in Snohomish County are Asian and Pacific Islander languages (8.2%), Spanish (7.0%), and other Indo-European languages (5.5%).

- In the high need service area, 5.9% of the population lives in a limited English household, compared to 4.4% in Snohomish County overall.

Table 1. Limited English Households

Indicator	High-need Service Area	Broader Service Area	Snohomish County	Washington State
Population in limited English Households	5.9%	2.0%	4.4%	3.8%

Source: US Census Bureau, American Community Survey 5-Year Estimates, 2018 - 2022

Socioeconomic

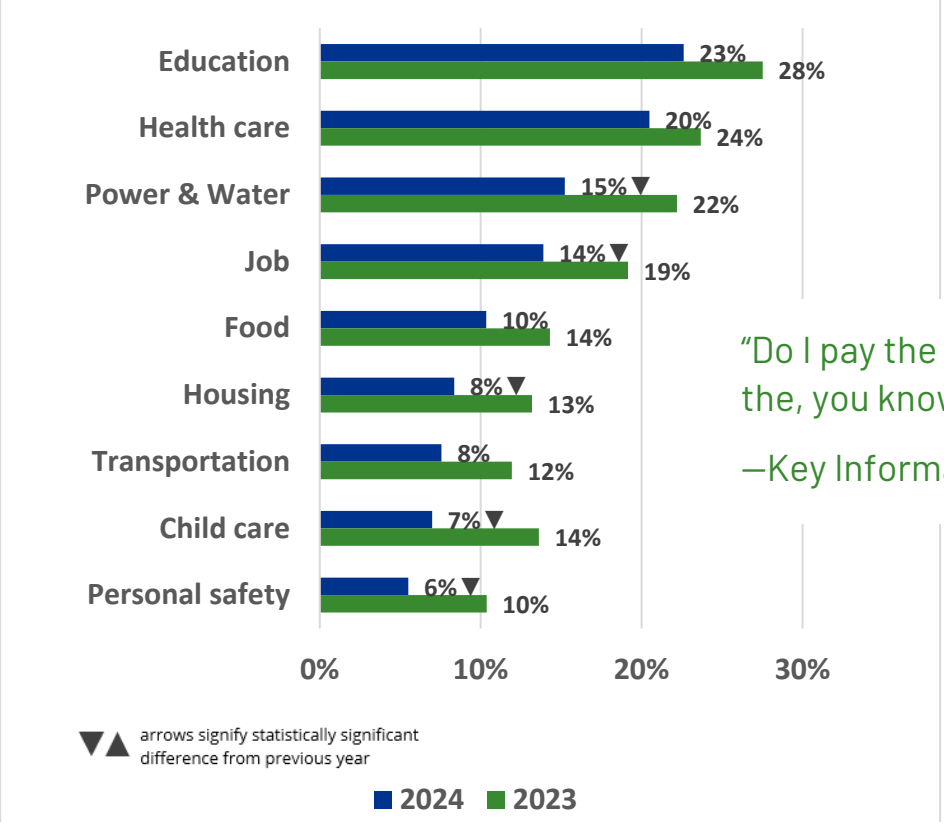
According to the Robert Wood Johnson Foundation: "Good health begins where we live, learn, work and play. Stable housing, quality schools, access to good jobs, and neighborhood safety are all important influences, as is culturally competent healthcare." Lack of access to basic needs and personal safety are linked at all stages of life to physical and mental illness, post-traumatic stress, shorter lifespans and poorer quality of life.

SNOHOMISH COUNTY SOCIAL DETERMINANT OF HEALTH (SDOH) NEEDS DATA

As part of the Providence Institute for a Healthier Community (PIHC) Snohomish County 2024 Health and Well-being Monitor, residents are asked about nine SDOH need areas. In 2024, 39% reported worries around basic needs, overall, down slightly from an all-time high of 49% reporting needs in 2023. However, those who are struggling (12% of respondents), are the most likely to face challenges with basic needs; 73% reported at least one need.

In 2024, the top five needs identified were the same as 2023 and include education, healthcare, power and water, job, and food.

Figure 4. Percent of HWBM Participants Reporting Needs Across 9 SDOH Domains, 2023 and 2024 surveys



"Do I pay the electric bill, or do I go to the, you know, go to the doctor?"

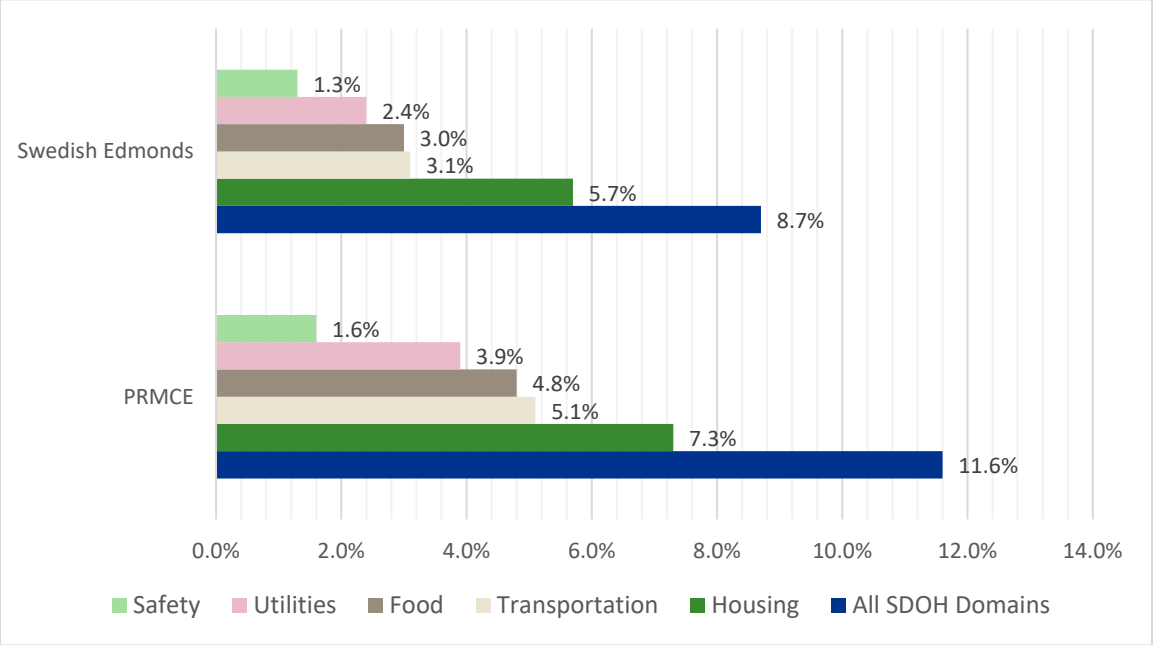
—Key Informant

Source: Providence Institute for a Healthier Community (PIHC) Snohomish County 2024 Health and Well-being Monitor

HOSPITAL SOCIAL DETERMINANT OF HEALTH (SDOH) SCREENING DATA

To better understand and respond to patients' SDOH needs, *each inpatient over the age of 18* is asked about support needs related to housing, transportation, food, utilities, and safety. From October 1, 2023- June 30, 2024, 8.7% of patients screened positive for at least one need at Swedish Edmonds, and 11.6% screened positive at PRMCE. Housing was the greatest need reported across both PRMCE and Swedish Edmonds, with 7.3% and 5.7% of respondents screening positive, respectively. At PRMCE, a greater percentage of patients identifying as Alaska Native/Indigenous America reported at least one SDOH need (19.7%), compared to patients identifying as Black/African American (17.0%), Latino/a/e (12.4%), and white (11.6%).

Figure 5. Percent of Swedish Edmonds and PMCE Inpatients Screening Positive for SDOH Needs



Source: CPH Population Trends, inpatients, 18+years, discharged between 10/1/23-6/30/24

INCOME

Level of income impacts health across the entire lifespan because it affects an individual's ability to obtain basic needs and their access to health care services. According to the 2022 American Community Survey, 5-Year Estimates:

- Snohomish County has a higher median household income ($104,083) than Washington State ($90,325).
- The high need service area has a median household income of $89,141, while the broader service area has a median income of $133,379.
- When surveyed by the PIHC 2024 Snohomish County Health and Well-Being Monitor, 44% of respondents do not feel financially secure, improved slightly from 2023 and 2022.

The following factors help better understand the impact of economic conditions of high need areas: (1) poverty levels, (2) food assistance eligibility, (3) housing costs, and (4) homelessness.

Poverty In Snohomish County, almost 1 in 5 (17.9%) of the population lives below 200% of the Federal Poverty Level.

- In the high-need service area, that increases to almost one quarter (24.2%) of the population.

Food Assistance/Insecurity The Supplemental Nutrition Assistance Program (SNAP) provides food benefits to low-income families to supplement their grocery budgets and improve food security.

- In the high-need service area, 12.0% of households are receiving SNAP benefits compared to 8.7% of households in Snohomish County overall. Food insecurity remains one of the top five needs for those surveyed in the Snohomish County 2024 PIHC Health and Well-being Monitor.

Housing Cost Severe housing cost burden is defined as households spending 50% or more of their income on housing costs.

- The median household income in the high need service area and Washington State are both around $90,000, although the percent of households with severe housing cost burden in the high need service area is higher than Washington State.
- The average percent of households with severe housing cost burden in the high-need service area is 15.7%, which is higher than the county value (13.0%) and the broader service area (9.4%)

Table 2. Snohomish County Social Determinants of Health (SDOH)

Indicator	High Need Area	Broader Area	Snohomish County	Washington
Median Household Income	$89,141	$133,379	$104,083	$90,325
Population Below 200% Federal Poverty Level (FPL)	24.2%	11.4%	17.9%	23.0%
Households Receiving SNAP Benefits	12.0%	4.9%	8.7%	11.1%
Households with Severe Housing Cost Burden	15.7%	9.4%	13.0%	13.1%

Source: US Census Bureau, American Community Survey 5-Year Estimates, 2018 – 2022

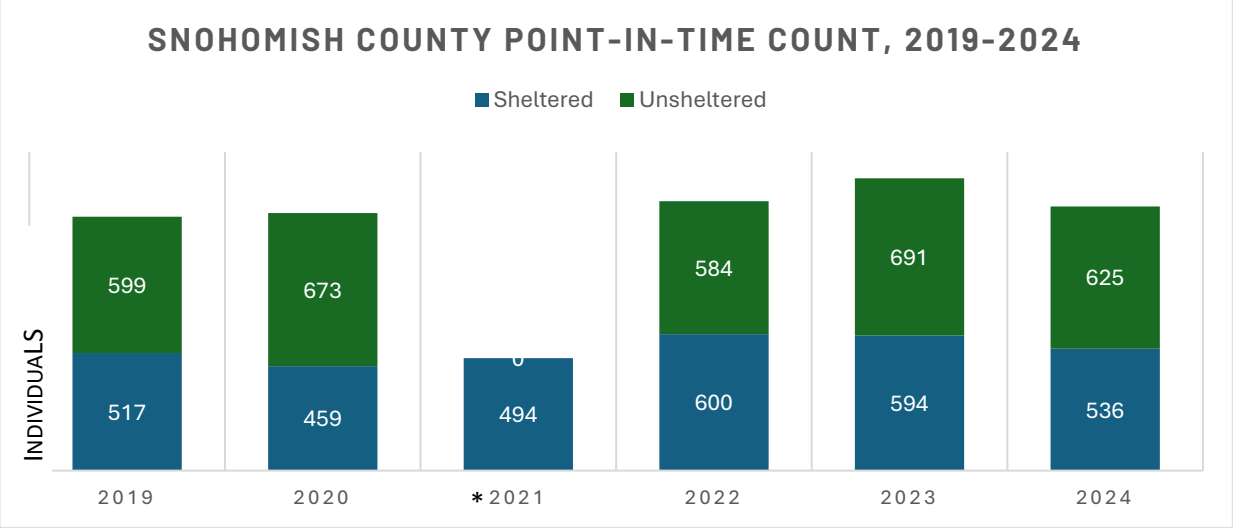
Homelessness and Housing Insecurity According to the Public Health Services Act, a person experiencing homelessness is defined as "an individual without permanent housing who may live on the streets; stay in a shelter, mission, single room occupancy facilities, abandoned building or vehicle; or in any other unstable or non-permanent situation."

Snohomish County Human Services released the Annual Point-In-Time (PIT) count, designed to identify the number of people experiencing homelessness on a single night. In January 2024, there were 1,161 people identified as experiencing homelessness in Snohomish County, including those living sheltered and unsheltered. This represents a slight decrease from 2023 and 2022 (Fig.6.).

When the 2024 PIHC Health and Well-Being Monitor survey asked respondents if they were living without stable housing, currently homeless or worried about losing housing, 8% said yes, which is similar to inpatient hospital SDOH screening data.

> "A client recently said she is one flat tire away from homelessness, and she is doing all the right things."—Key Informant

Figure 6. Point in Time Count (due to Covid-19 pandemic 2021 unsheltered PIT count not conducted)



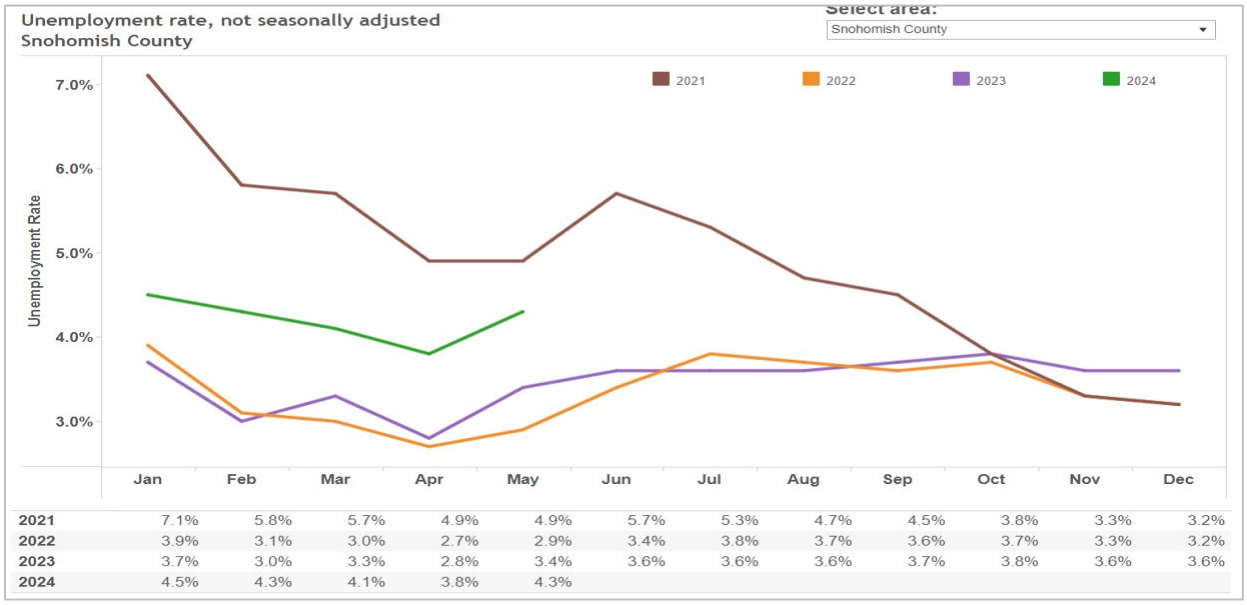
Source: Point in Time (PIT) | Snohomish County, WA - Official Website (snohomishcountywa.gov)
*In 2021, the county was granted an exception from conducting the unsheltered count due to COVID-19 safety concerns.

UNEMPLOYMENT

Health People 2030 acknowledges the effects of employment and unemployment on health and well-being, including job security, work environment, pay, and job demands. In May of 2024, the Washington State Employment Security Department shows the unemployment rate in Snohomish County to be 4.3% (not seasonally adjusted) for those 16 years old and over.

Job training/education remains the top reported need in Snohomish County. The PIHC Snohomish County 2024 Health and Well-Being Monitor survey asked respondents if they need additional education or training to get the job and the income they need. With 23% of respondents answering "yes," education and job training remains the top reported SDOH area of needs (Fig. 4), trending upward since 2018. Similarly, 14% responded yes to the question "Are you without a stable job, or do you need help getting a better job." This is down from 2023, but has trended up overall from 2019, with a few post-COVID surges.

Figure 7. Unemployment Rate, Snohomish County



2021	7.1%	5.8%	5.7%	4.9%	4.9%	5.7%	5.3%	4.7%	4.5%	3.8%	3.3%	3.2%
2022	3.9%	3.1%	3.0%	2.7%	2.9%	3.4%	3.8%	3.7%	3.6%	3.7%	3.3%	3.2%
2023	3.7%	3.0%	3.3%	2.8%	3.4%	3.6%	3.6%	3.6%	3.7%	3.8%	3.6%	3.6%
2024	4.5%	4.3%	4.1%	3.8%	4.3%							

Source: ESDWAGOV - Labor area summaries, May 2024

HIGH SCHOOL EDUCATION

According to research that guides the Healthy People 2030 initiative, a high school education is connected to better employment opportunities and higher wages. In Snohomish County, 92.8% of the adult population ages 25 and older has a high school diploma compared to 90.5% of the population in the high need service area. 2022 American Community Survey, 5-Year Estimates

INTERNET ACCESS

Access to reliable internet improves access to education, employment, and health care opportunities. There are more households without internet access in the high-need service area (5.8%) compared to Snohomish County as a whole (4.6%). 2022 American Community Survey, 5-Year Estimates

CHILDCARE ACCESS

> "I love the idea of quality childcare.... Why? Because it matters, it matters."—Key Informant

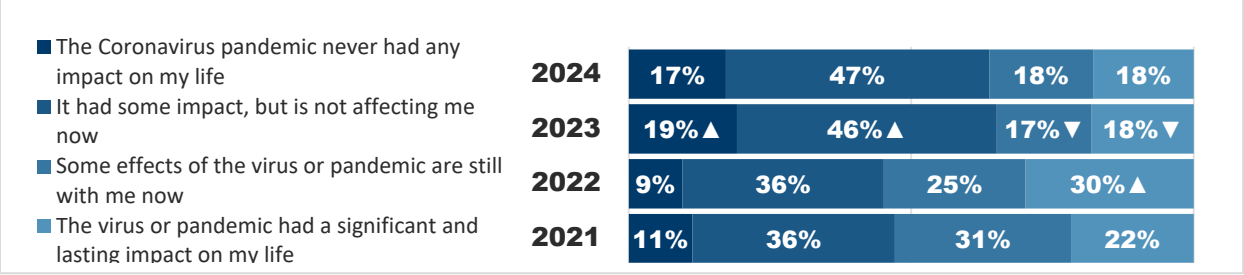
High quality childcare not only keeps children safe but also prepares them for school and beyond. However, childcare can be very costly to families. County Health Ranking and Roadmaps shares that U.S. Department of Health and Human Services recently proposed that childcare is not affordable if it comprises more than 7% of household income. According to 2024 County Health Rankings and Roadmaps, the average household in Snohomish County spends 30% of income on childcare for two children (2023 & 2022 data, The Living Wage Institute; Small Area Income and Poverty Estimates, accessed through County Health Rankings & Roadmaps). For single-parent households with infants, the

cost is even higher. According to Child Care Aware, "Washington's childcare cost to have an infant in a childcare center is a daunting 51.5% of median income for a single mother. Although median household incomes have increased 5% since 2010, median childcare rates have increased between 13-20% for center-based care and 11-31% for family childcare." And, according to a July 18, 2023 White House posted brief on improving childcare access and affordability, "lower income households are more likely to receive childcare for which they do not pay, and childcare expenses increase with family income." In addition, Child Care Aware shares that there is not enough childcare available to meet the demand. As of 2020, there are 62 slots of childcare in the county for every 100 infants, toddlers, or preschoolers whose parents work, far below the state average of 79 slots per 100 children. Washington CCDC - Child Care Aware® of America

COVID IMPACT

The economic and social disruption of COVID-19 was unprecedented and historic. The longer term social and health impacts are yet to be fully understood. When surveyed by the PIHC 2024 Snohomish County Health and Well-Being Monitor, 83% of respondents acknowledged personal impacts of COVID and 36% of residents say the effects of COVID are still impacting their lives, similar to last year with some fading impacts since 2022 and 2021.

Figure 8. Pandemic Impact, Snohomish County



Source: Providence Institute for a Healthier Community (PIHC) Snohomish County 2024 Health and Well-being Monitor

"Four years of being impacted by a global pandemic, we can't just forget about it. Our kids are affected and the isolation that's (been) created..."

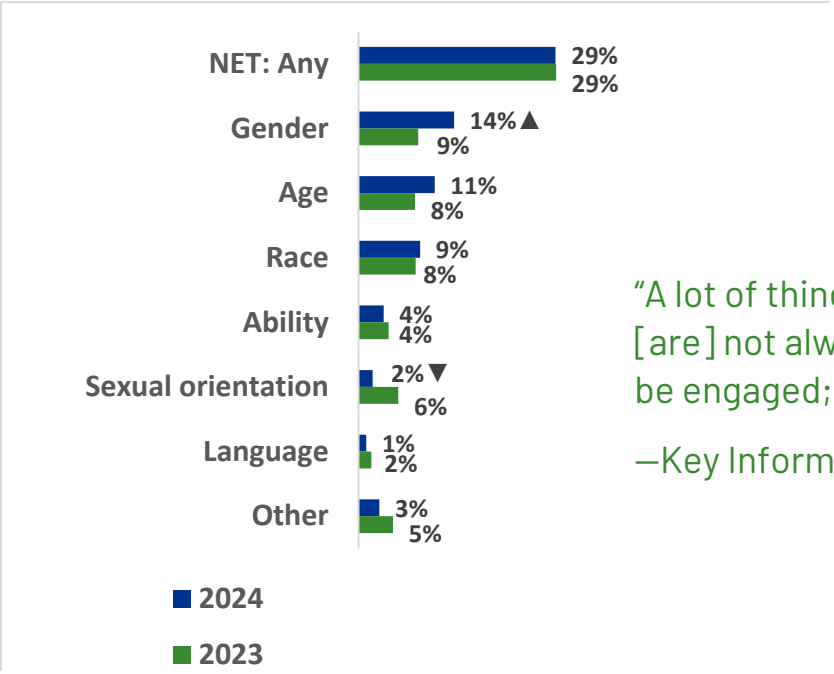
– Key Informant

HEALTH EQUITY, RACISM, AND DISCRIMINATION

According to the Center for Disease Control-Minority Health, racial and ethnic minority groups in the United States have been consistently shown to have higher rates of illness and death across a wide range of health outcomes when compared to their white counterparts. Healthy People 2030-Health Equity, highlights that structural inequities, bias and discrimination affect health. Taking steps to address these factors, by improving health literacy and addressing disparities within critical social determinants of health are key focus areas to combat some of these race-based inequities.

The results of the 2024 PIHC Health and Well-Being Monitor, show a steady level of reported discrimination: 29% of respondents reported some form of discrimination in both 2023 and 2024. Gender, age, and racial discrimination are the most common forms, with a significant increase in gender bias reported in 2024. For those with lower overall well-being scores, the number of respondents who reported any form of discrimination increases to 41% and 37% respectively.

Figure 9. Discrimination, Snohomish County, Self-Reported



"A lot of things out there to fix people, [are] not always helpful. People need to be engaged; not made to feel less than."

—Key Informant

Source: Providence Institute for a Healthier Community Snohomish County 2024 Health and Well-being Monitor

NEIGHBOORHOOD QUALITY AND ENVIRONMENT

The Centers for Disease Control recognizes that green environments offer many health benefits. "They provide a place where people can be physically active to reduce stress, which can improve their mental health. They also provide a place where neighbors can meet, which improves community connections." In addition, according to a special 2022 report by the Trust for Public Lands "Park acres, it turns out, are very good at buffering the effects of climate change. Green space has the power to lower air temperature and absorb floodwater and can be designed in such a way as to significantly enhance those climate benefits."

According to the Trust for Public Lands, 2024 ParkServe® data set, access to green spaces, living within a 10-minute walk of a park, for most cities in Snohomish County is well above the U.S. median city score of 55%. When surveyed through the PIHC 2024 Snohomish County Health and Well-Being Monitor, respondents' ratings of neighborhood quality increased for the first time since 2021. However, there was a downward trend in the number of respondents who indicated "my community is a good place to raise children or grow old"; the trend was more pronounced with the "community as good place to grow old."

Access to Healthcare and Healthcare Quality

"A lot of folks that we care for do not have a primary care provider. We see a high incidence of diabetes, of high and unchecked blood pressure. [It] comes along with having lived in homelessness, having to try to secure energy dense foods that are not good for you, all of those sorts of things." —Key Informant

Key informants discussed the many barriers that prevent people from accessing timely, affordable, and responsive care. The Centers for Disease Control Healthy People 2030 goal emphasizes that "interventions to increase access to health care professionals and improve communication — in person or remotely — can help more people get the care they need."

ANNUAL CHECKUP

Accessing preventive health care services, such as getting routine physical checkups, receiving recommended vaccinations, and having blood pressure and cholesterol checks can reduce morbidity and mortality from chronic diseases. According to 2021 PLACES, Centers for Disease Control, in Snohomish County, 64.5% of adults report having been to the doctor for a checkup in the previous year compared to 66.7% in Washington State. This is a decline from 2019 rates of 68.3% for Snohomish County residents.

DENTAL CARE

Most oral diseases are preventable in part with annual visits to the dentist. In Snohomish County in (year), the rate of dental visits by those over age of 18 was lower (67.0%) than that of Washington State (69.3%). Access to oral health care is associated with various socio-demographic characteristics and geographic location. 2020 PLACES Centers for Disease Control

PHYSICIAN RATIO

Snohomish County has fewer primary care, mental health, and dental providers available for every one resident compared to that of Washington State. Snohomish, Washington | 2024 County Health Rankings & Roadmaps

Primary Care: There is one primary care provider (defined general family medicine, general practice, general internal medicine, and general pediatrics) for every 1,870 residents in Snohomish County compared to one for every 1,200 residents in the state (2021, Area Health Resource File/ American Medical Association, accessed through County Health Rankings & Roadmaps).

Mental Health: Similarly, the ratio of mental health providers to residents in Snohomish County is 1:240, a lower ratio than at the state level (1:200). (2023, CMS, National Provider Identification, accessed through County Health Rankings & Roadmaps).

Dental Care: Similar comparisons between the county and state can be made for the availability of dentists in Snohomish County. There is one provider per 1,300 residents in the county compared to one for every 1,150 residents for the state (2022, Area Health Resource File/ National Provider Identifier Downloadable File, accessed through County Health Rankings & Roadmaps).

HEALTH PROFESSIONAL SHORTAGE AREA

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

Geographic HPSA: a shortage of providers for an entire group of people within a defined geographic area

Population HPSA: a shortage of providers for a specific group of people within a defined geographic area

Facility HPSA: These include correctional facilities, state/county mental hospitals, Federally Qualified Health Centers, Indian Health Facilities, Tribal Hospitals, and others

Snohomish County has several geographic areas, population segments, and facilities that are designated as shortage areas. This information can be used to understand access issues, guide state and local health care planning, determine placement of providers, and influence allocation of limited health care resources

Table 3. Health Professional Shortage Areas, Snohomish County

Indicator	Primary Care	Dental Care	Mental Health
Geographic Shortage Area	Darrington Monroe/Sultan Tulalip	Darrington Monroe/Sultan	Monroe/Sultan Northwest Snohomish
Population Shortage Area	Lynnwood Low Income Marysville Low Income Everett Low Income	None	None
Facility Shortage Area	Monroe CC Community Health CSC Sea-Mar CHC Stillaguamish HC Tulalip HC	Monroe CC Community Health CSC Sea-Mar CHC Stillaguamish HC Tulalip HC	Monroe CC Community Health CSC Sea-Mar CHC Stillaguamish HC Tulalip HC

Source: HPSA Find (hrsa.gov)

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

FACTORS IMPACTING UTILIZATION

Key informants discussed the many barriers that prevent people from accessing timely, affordable, culturally responsive, and linguistically appropriate care: language, health literacy, lack of care navigation and trust in health care, high cost of care and insurance, appointment hours, long wait times,

and transportation. They also highlighted that certain populations and groups may experience more challenges and barriers to accessing needed care. People experiencing homelessness may experience more barriers to getting to care and maintaining an appointment. Indigenous Peoples of the U.S. experience higher rates of health disparities due to systemic factors, including historical trauma. Accessing care can also be more difficult for older adults, people with Medicaid, and people with behavioral health challenges.

Health Insurance According to the U.S Department of Health and Human Services, Office of Disease Prevention and Health Promotion Healthy People 2030 Access to Health Services summary: "Inadequate health insurance coverage is one of the largest barriers to health care access, and the unequal distribution of coverage contributes to disparities in health."

In Snohomish County, 7.8% of the population in the high need service area is uninsured compared to 6.2% in Snohomish County overall, which is also slightly less than the state average of 6.4%. 2022 American Community Survey, 5-Year Estimates

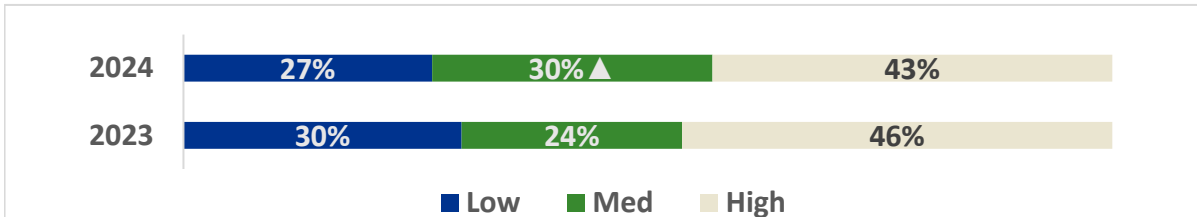
Healthy People 2030 explains that "Uninsured adults are less likely to receive preventive services for chronic conditions such as diabetes, cancer, and cardiovascular disease. Similarly, children without health insurance coverage are less likely to receive appropriate treatment for conditions like asthma or critical preventive services such as dental care, immunizations, and well-child visits that track developmental milestones."

Cost of Care Access to Health Services, Healthy People 2030 emphasizes that "out-of-pocket medical care costs may lead individuals to delay or forgo needed care (such as doctor visits, dental care, and medications), and medical debt is common among both insured and uninsured individuals. … Uninsured adults are less likely to receive preventive services for chronic conditions." Key informants also shared that high copays, deductibles, and monthly premiums may discourage people from seeking needed and preventive care, leading to undiagnosed issues. Paying for medical care and costly medications may lead to spending tradeoffs.

Health Literacy According to the U.S. Centers for Disease Control and Prevention (CDC), personal health literacy is "the degree to which individuals have the ability to find, understand, and use information and services to inform health-related decisions and actions for themselves and others." Key informants identified language as a major barrier for people navigating the health care system due to a lack of linguistically appropriate care. Improving language access is a serious need, particularly for immigrant and refugee populations. Health literacy is also influenced by the proportion of individuals with Limited English Proficiency (LEP). In high need services areas of Snohomish County, 5.9% of the population as LEP, compared to just 2.0% in the broader service area. 2022 American Community Survey, 5-Year Estimates

Ability to Get Health Care/Information The Snohomish County 2024 PIHC Health and Well-being Monitor found that despite the number of people that have health coverage (almost 94%), just 43% of respondents rated their ability to get health care/information "high," similar to 2023, with an overall downward trend in ability since 2017. This is important, as these numbers suggest that access to health insurance does not necessarily correspond with the ability to get care.

Figure 10. Access to Health Care Information, Snohomish County



Source: Providence Institute for a Healthier Community (PIHC) Snohomish County 2024 Health and Well-being Monitor

Fear, Mistrust, and Poor Treatment Key informants discussed racism and discrimination as it relates to many other needs, including access to health care services and behavioral health resources. They shared that racism and discrimination in health care can affect the quality-of-care people receive and lead to health disparities.

Key informants spoke to a lack of trust in health care, particularly around vaccines, as a result of the COVID-19 pandemic. However, the use of peer educators and community navigators can help improve trust.

"Responsiveness is not always what we would hope in our community to treat each person with dignity and respect."—Key Informant

Transportation and Technology Transportation impacts access to care by placing a significant strain on patients' time and resources. For some individuals, the lack of available transportation makes it impossible to seek the care they need. The Snohomish County 2024 PIHC Health and Well-being Monitor reported that 8% of Snohomish County residents were worried about getting to work, school, grocery shopping, or appointments because they don't have a way to get there. SDOH assessments of hospital inpatients revealed 5.1% of patients at PRMCE and 3.1% of patients at Swedish Edmonds identified transportation as a basic need they are lacking (CPH Population Trends, inpatients, 18+years, discharged between 10/1/23-6/30/24). One potential solution to some transportation challenges is telemedicine. Telemedicine can increase access to essential health services, and open opportunities for health care services that residents would otherwise not have access to. According to a Centers for Disease Control, Telemedicine Data Brief publish October 2022, the demonstrated benefits of telemedicine include improved access to care, convenience, and slowing spread of infection.

Health Related Indicators

What are some key physical and mental health issues and risk factors?

SECTION III: HEALTH-RELATED INDICATORS

Please refer to the North Puget Sound Data Hub 2024 to review each of the following health indicators mapped at the census tract level: North Puget Sound Dashboard (arcgis.com). The hub provides data on each indicator in the Snohomish County high need and broader need service areas, and Washington State as well as information about the importance of each indicator.

Mortality and Death Rates

TOP FIVE LEADING CAUSES OF DEATH

1. Cancer-attributed deaths
2. Heart Disease
3. Unintentional Accidents
4. Alzheimer's Disease
5. Chronic Lower Respiratory Disease

Malignant neoplasms (cancer) and heart disease are the top causes of death in both Snohomish County and Washington State, with slightly higher crude rates statewide. Accidental deaths are consistent across both regions, while Alzheimer's, respiratory diseases, and COVID-19 show higher crude death rates at the state level. See Appendix 1 for the top 15 causes of death and crude rates for Snohomish County and Washington. (Centers for Disease Control and Prevention, National Center for Health Statistics. National Vital Statistics System, Mortality 2018-2022 on CDC WONDER Online Database, released in 2024. Data re from the Multiple Case of Death Files, 2018-2022).

RACE/ETHNICITY DISPARITIES

Malignant neoplasms, or cancer, is the leading cause of death across all race groups. The American Indian/Alaska Native population has a notably high crude rate for "accidents," the second-highest cause of death for this group. The White population has the highest crude rate of cancer and diseases of the heart.

Table 4. Leading Causes of Death by Race in Snohomish County, 2018-2022 (Crude Rates per 100,000 population)

Cause of Death	Snohomish County	American Indian/ Alaska Native	Asian	Black/ African American	Native Hawaiian/ Other Pacific Islander	White	More than one Race
Malignant neoplasms	160.1	128.8	74.7	70.6	95.6	188.1	45.1
Diseases of heart	135.8	78.8	56.9	66.9	106.3	161.1	32.9
Accidents	57.1	119.7	17.2	34.1	*	65.1	38.1
Chronic liver disease and cirrhosis	34.2	30.3	*	*	*	16.8	*
Cerebrovascular diseases	40.5	*	21.6	20.1	*	36.4	*
COVID-19	23.5	31.8	14.6	15.2	*	26.4	*

Source: Centers for Disease Control and Prevention, National Center for Health Statistics. National Vital Statistics System, Mortality 2018-2022 on CDC WONDER Online Database, released in 2024. Data are from the Multiple Cause of Death Files, 2018-2022 *Rates are marked as "unreliable" when the death count is less than 20

Mental Health

Mental health, which includes emotional, psychological, and social well-being, is integral to overall well-being and is important for the functionality and safety of individuals, families, and communities The Centers for Disease Control highlights that "mental health conditions (like depression) increase the risk of chronic conditions, which in turn can increase the risk of mental health conditions." Almost 1 in 4 U.S adults was diagnosed with a mental illness in the past year. The National Institutes of Health reported that in 2010, depression was estimated to have cost $210.5 billion in direct costs, suicide-related costs, and workplace costs. The American Psychiatric Association reported that in 2018 the estimated cost of mental health care was $236 billion, an increase of more than 35% since 2010.

> "Mental health needs in the community have never been higher and options for resources have never been lower."—Key Informant

POOR MENTAL HEALTH DAYS

Frequent mental distress is defined as experiencing 14 or more days of feeling mentally unwell during the past 30 days. In Snohomish County, 15.7% of individuals over the age of 18 experienced frequent mental distress, similar to statewide levels of frequent mental distress (15.4%). 2021 PLACES Center for Disease Control and Prevention

According to the 2017-2021 Centers for Disease Control Behavioral Risk Factor Surveillance Survey (BRFSS) trends, in Snohomish County the percentage of adults reporting poor mental health for 1 to 13 days has increased by 4.5% and those reporting 14 or more days by 5.1%. The 2021 BRFSS reports that women and non-Hispanic White adults are about twice as likely to report 14 or more poor mental health days compared to male and BBIPOC individuals, respectively.

POST PANDEMIC STRAINS

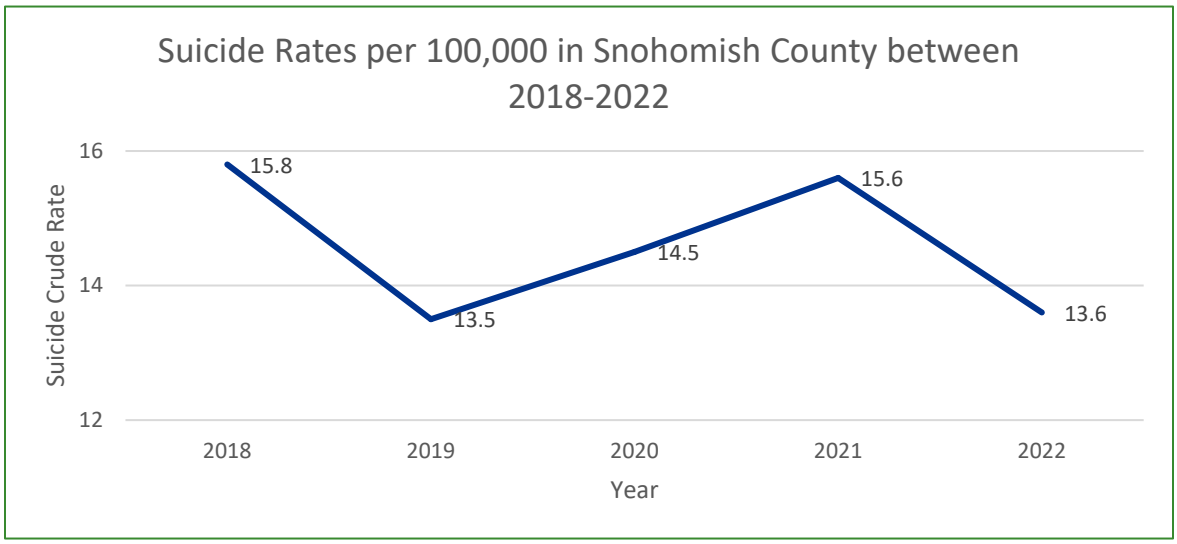
When surveyed through the Snohomish County 2024 PIHC Health and Well-Being Monitor, 32% of respondents said that they were not very satisfied with the state of their mental or emotional well-being, similar to levels reported in 2023. When asked to rate the state of their current mental health, 29% of respondents rated it low. Averages for current state of mental/emotional health and sense of purpose and meaning have been flat since 2022 and have yet to regain higher levels reported in 2019, before COVID-19. Mental health indicators are among the top impacts on overall well-being.

Related survey measures include relationship satisfaction, community belonging, community efficacy and a recent addition measuring feelings of isolation. All of the above measures continue to be strained post-pandemic. Averages remain well below those measured pre-pandemic levels.

SUICIDE

The Healthy People 2030 objective seeks to reduce suicides to 12.8 per 100,000 population from the current national level of 14.2 per 100,000 (age adjusted). Suicide rates in Snohomish County, Washington State, and the U.S. more broadly, have stayed generally steady in recent years. Crude rates of death by suicide in Snohomish County are highest among white, American Indian/Alaska Native and Native Hawaiian/Other Pacific Islander populations (Fig. 11 and Table 5).

Figure 11. Trends Suicide Rates in Snohomish County between 2018-2022 (Crude Rates per 100,000 population)



Source: Centers for Disease Control and Prevention, National Center for Health Statistics. National Vital Statistics System, Mortality 2018-2022 on CDC WONDER Online Database, released in 2024. Data are from the Multiple Cause of Death Files, 2018-2022

Table 5. Suicide Rates by Race and Ethnicity in Snohomish County, 2018-2022 (Crude Rates per 100,000 population)

Race	Crude Rate
American Indian or Alaska Native	15.1
Asian	6.9
Black or African American	7.9
Native Hawaiian or Other Pacific Islander	10.9
White	16.6
More than one race	7.1

Source: Centers for Disease Control and Prevention, National Center for Health Statistics. National Vital Statistics System, Mortality 2018-2022 on CDC WONDER Online Database, released in 2024. Data are from the Multiple Cause of Death Files, 2018-2022

ADVERSE CHILDHOOD EXPERIENCES (ACES)

Adverse Childhood Experiences (ACEs) are potentially traumatic events that may occur in life before the age of 18 years old. These experiences can include neglect, witnessing violence, exposure to substance

misuse, mental health challenges, instability due parental separation or household members being in jail or prison, and other traumatic events. A higher number of ACEs experienced – or ACEs score – corresponds to a higher risk of experiencing poor health outcomes later in life. The Washington HYS ACEs Score (WAH-ACEs) assesses 11 adverse experiences. 2021 was the first implementation of the Healthy Youth Survey (HYS) where students were asked about ACEs.

The 2023 HYS revealed for Snohomish County students in 8th and 10th grades, that a WAH-ACEs score of four or more increased substantially from 2021 to 2023. A change from 11.7% to 16.9% for 8th graders and 13.4% to 17% for 10th graders. For these two grade levels higher WAH-ACEs scores were seen in those who identify as transgender, questioning or female; LGBTQIA+; and Pacific Islander, American Indian/Alaska Native and Black. Data Dashboard - Healthy Youth Survey (askhys.net)

"Reality is that when we intervene early with kids in all kinds of different ways...We know, and research shows us, that those kids are different than when we don't intervene early with kids. So, we can actually change kids' lives, which is changing that next generation."—Key Informant

SUBSTANCE USE

The American Public Health Association declares substance misuse a serious public health challenge. "It includes the use of illegal drugs and the inappropriate use of legal substances, such as alcohol and tobacco. Whether through overindulgence in alcohol, misuse of prescription medication, or use of illegal drugs, such misuse is harmful to our health. More than 15,000 people died from overdoses of prescription opioids in 2015 alone. And 88,000 people die each year from alcohol-related injuries, the third most common preventable cause of death in the United States. Substance misuse also harms our economy. The National Institute on Drug Abuse estimates it costs the United States $232 billion in health care costs and $740 billion overall."

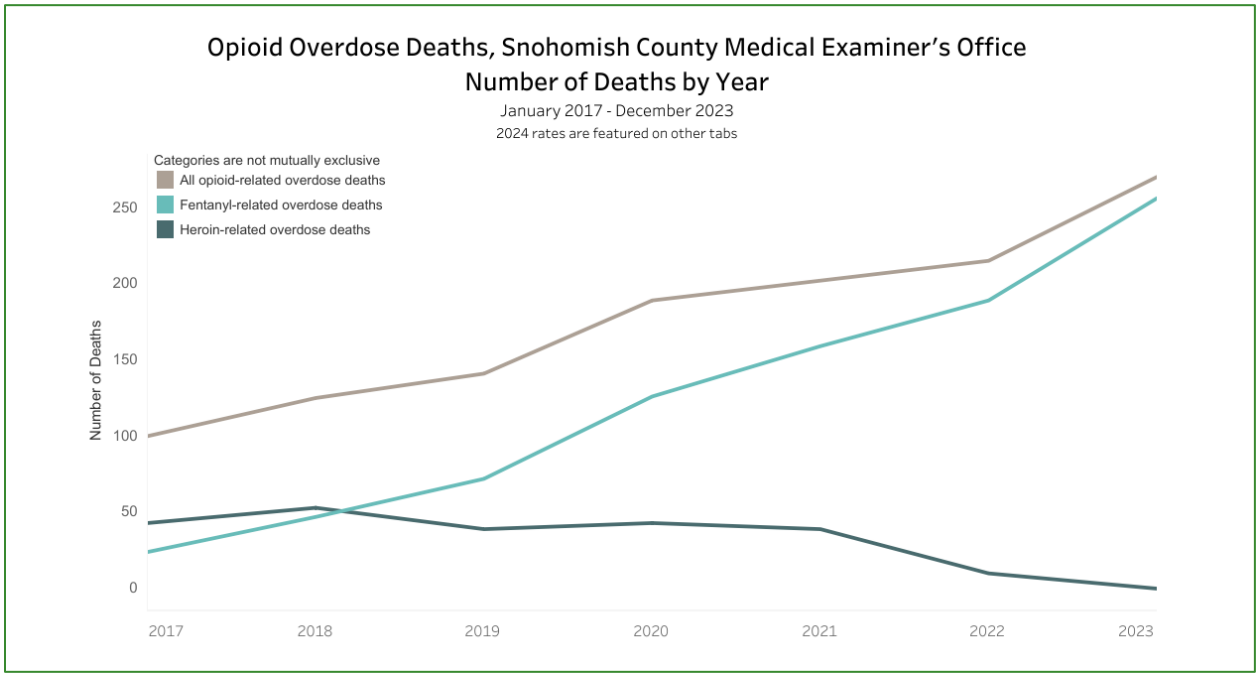
ALCOHOL CONSUMPTION Binge drinking is defined as consuming a certain amount of alcohol within a set period. For males this is five or more drinks per occasion and for females it is four or more drinks per occasion in the last 30 days. The rate of binge drinking for adults over the age of 18 in Snohomish County was 14.9%. 2021, PLACES, Centers for Disease Control, Binge Drinking.

According to the U.S. Centers for Disease Control and Prevention, binge drinking is a risk factor for many health and social problems, including motor-vehicle accidents, violence, suicide, hypertension, acute myocardial infarction, sexually transmitted diseases, unintended pregnancy, fetal alcohol spectrum disorders, and sudden infant death syndrome.

OPIOID USE Opioid use disorders can be linked to various health problems, emergency department visits, and even death. In recent years, overall opioid overdose deaths in Snohomish County have been

increasing from 100 deaths in 2017 to 270 in 2023. The number of heroin-related overdose deaths have been decreasing; however, fentanyl- related overdose deaths have been increasing since 2017.

Figure 12. Snohomish County Opioid Overdose Deaths



Source: Data - Snohomish Overdose Prevention

"So, there's mixed messages about drugs and safety of drugs, and I don't think that people have the delineation in their mind between what is an opioid versus what is marijuana. What does it do to your body? What does it do to your brain? And it's that age old challenge of how do we do good drug education?"—Key Informant

SMOKING Tobacco use, including smoking, remains the leading cause of preventable death in the United States causing more than 480,000 deaths per year. Smoking increases the risk for heart disease, stroke, and lung cancer (Health Effects of Cigarette Smoking | CDC). The U.S. Centers for Disease Control also reports that Chronic Obstructive Pulmonary Disorder (COPD) is usually caused by cigarette smoking (accounting for as many as 8 out of 10 COPD-related deaths), though long-term exposure to other lung irritants, like secondhand smoke, can also contribute to COPD. However, quitting smoking is beneficial to health at any age; quitting earlier in life is better and increases the health benefits of quitting. Benefits of Quitting Smoking | Smoking and Tobacco Use | CDC

In Snohomish County, 11.8% of people report currently smoking compared to 10.8% in Washington state (defined as respondents aged ≥18 years who report having smoked ≥100 cigarettes in their lifetime and currently smoke every day or some days). 2021, PLACES Center for Disease Control, Smoking

Unintentional Injury

Unintentional injuries (accidents) were the 3rd leading cause of death in Snohomish County and in the United States overall: Injury Deaths | County Health Rankings & Roadmaps 2017-2021. Healthy People 2030 states that many unintentional injuries are caused by motor vehicle crashes and falls, and many intentional injuries involve gun violence and physical assaults.

However, drug overdoses are now the leading cause of injury deaths in the United States (and Snohomish County), and most overdoses involve opioids. Overall, in 2022, there were 547 deaths from unintentional injuries in Snohomish County, or an age-adjusted rate of 61.3 per 100,000, which is over the Healthy People 2030 target of 43.2 per 100,000 unintentional injury deaths. Injury Deaths - County and State Dashboards | Washington State Department of Health

Chronic Diseases

According to the Centers for Disease Control "Chronic diseases are the leading cause of illness, disability, and death in America. Most chronic diseases are caused by a short list of risk factors: smoking, poor nutrition, physical inactivity, and excessive alcohol use. Some groups are more affected than others because of factors that limit their ability to make healthy choices."

CANCER

Cancer is the first leading cause of death in Snohomish County and Washinton State. Healthy People 2030 objective seeks to reduce the overall cancer-related deaths to 122.7 per 100,000 population age adjusted rate. Regular cancer screenings are important to detect and treat cancer in its early stages. The top four cancers according to the Washington State Cancer Registry in Snohomish County (age adjusted rates per 100,000 people) are female breast cancer (164.1), prostate cancer (96.7), melanoma (54.3), lung cancer (46.8), which are all higher rates than the state. Washington State Cancer Registry

MAMMOGRAPHY SCREENING Mammograms are the best way to detect breast cancer early. The percentage of female Medicare enrollees between the ages of 65-74 who have received an annual mammogram is slightly lower (30%), than that of the state (34%) and U.S. (37%). In Snohomish County only about 1 in 5 (20%) of BIPOC female Medicare enrollees are receiving annual mammography screening. 2020, Mapping Medicare Disparities Tool, access through County Health Rankings

HEART DISEASE

Heart disease is the 2nd leading cause of death Snohomish County and is also the leading cause of death for people of most races in the United States, including Black/ African American, Native Hawaiian/ Other Pacific Islander, and white people, second only to cancer. Healthy People 2030 focus is on preventing and treating heart disease and stroke and improving overall cardiovascular health.

Centers for Disease Control reports that in 2022, 702,880 died from heart disease in the United States, or 1 in every 5 deaths, and from 2019-2020 heart disease is estimated to cost about 252.2 billion dollars. In Snohomish County, according to the 2021 PLACES Center for Disease Control, the crude prevalence of

coronary heart disease among adults aged 18 years or older is 4.7%people which is higher than the state of 3.0%.

STROKE

A stroke, also known as a brain attack, occurs when blood flow to the brain is blocked or a blood vessel inside or on the surface of the brain bursts. A stroke is a serious medical emergency and requires immediate medical attention, just like a heart attack. It is the most common cause of adult disability in the United States. Stroke Overview | National Institute of Neurological Disorders and Stroke (nih.gov)

Stroke is one of the top 10 leading causes of death in Snohomish County and Washinton State. and a major cause of serious disability in adults. Making sure people who experience a cardiovascular emergency — like stroke, heart attack, or cardiac arrest — get timely recommended treatment can reduce their risk for long-term disability and death. Teaching people to recognize symptoms is key to helping more people get the treatment they need, is an important Healthy People 2030 outcome.

In Snohomish County, according to the 2021 BRFSS, the crude prevalence of stroke among adults aged 18 years or older is 2.6 per 100,000 people.

Hypertension (High Blood Pressure) High Blood pressure is the amount of pressure the body's blood pushes against the arteries. Hypertension, or high blood pressure, is blood pressure that is higher than normal. High blood pressure is very common, usually has no symptoms

Hypertension is a known risk factor for strokes and heart disease. Healthy People 2030 objective seeks to reduce the proportion of adults with high blood pressure to 27.7% which was almost achieved by Snohomish County with 28.1% of adults who are estimated to be hypertensive, according the 2021 BRFSS.

In 2017, the guidelines for diagnosing hypertension were updated by the American College of Cardiology and American Heart Association. These new guidelines lowered the threshold for identifying someone with hypertension. A person is considered to have high blood pressure once the readings are consistently 130/80 mmHg or higher.

RESPIRATORY DISEASES

According to the Centers for Disease Control, chronic respiratory diseases are chronic diseases of the airways and other structures of the lung. The 2021 crude prevalence for COPD in Snohomish County is 5.2% per 1000,000 population, the same as the state - PLACES, Centers for Disease Control, COPD. COPD is the 5th leading cause of death in Snohomish County overall. (*See smoking as risk factor under Substance Use*).

ASTHMA Estimates of asthma prevalence indicate the number and percentage of the population with asthma at a given point in time. National estimates indicate that both adult and child current asthma prevalence estimates have been increasing from 20.3 million persons in 2001 to 25.7 million persons in 2010, of which 7.0 million were children.

In 2021 according to the CDC 10.2% answered "yes" both to both of the following questions: "Have you ever been told by a doctor, nurse, or other health professional that you have asthma?" and the question

"Do you still have asthma?" This is similar to Washington State at 10.5%. PLACES, Centers for Disease Control, Asthma

DIABETES AND OBESITY

The National Institutes of Diabetes and Digestive and Kidney Diseases summarized diabetes as a disease that occurs when your blood glucose, also called blood sugar, is too high. Glucose is your body's main source of energy. Your body can make glucose, but glucose also comes from the food you eat.

Diabetes is the seventh leading cause of death Snohomish County and eighth in Washington State. In 2021, diabetes crude estimate prevalence for Snohomish Conty is similar to Washington State. In Snohomish County those aged ≥18 years who report ever been told by a doctor, nurse, or other health professional that they have diabetes other than diabetes during pregnancy was 8.8%, similar to Washinton state at 8.7%. PLACES, Center for Disease Control, Diabetes

OBESITY Obesity for those aged ≥18 years is measured by those who have a body mass index (BMI) ≥30.0 kg/m² calculated from self-reported weight and height.

Healthy People 2030 objective seeks to reduce the proportion of adults considered obese to 36% or less. As of 2021, 32.9% of people in Snohomish County were considered obese and 28.8% in Washington. 2021, PLACES, Center for Disease Control, Obesity

Infant and Maternal Health

BIRTH RATES

In 2021, 9,855 births occurred in Snohomish County. Snohomish County with a fertility rate of 60.13 per 1,000 women aged 15-44 is greater compared to Washinton State at 53.5. The data indicates that births among women 30-39 from 2018-2022 had a slight upward trajectory. All Births Dashboard - County | Washington State Department of Health

INFANT DEATHS

Healthy People 2030 objective seeks to reduce the rate of all infant deaths within one year of birth to five deaths per 1,000 live births. In 2022, Washington State Department of Health reports the infant death rate at 5.2 deaths per 1,000 live births in Washington and Snohomish County had an infant death rate 3.8 deaths per 1,000 live births, less than Washington's. It is important to understand the factors that contribute to fetal and infant deaths. Factors that can influence fetal and infant mortality rates include many of the same factors related to social determinants of health and access to care, in addition to safe sleep, and breastfeeding factors, according to the Washington State Department of Health.

PRENATAL CARE

Healthy People 2030 objective seeks to increase the proportion of pregnant women receiving prenatal care beginning in the first trimester to 80.5%. The proportion of women that received early prenatal care in 2022 did not meet the Healthy People 2030 objective in Washington (72.00%) or Snohomish County

(72.35%) and show slightly downward trends. In addition, further variances of early prenatal care were found among younger mothers in Snohomish County among those aged 15-19, (52.33%) and 20-24 years old (62.95%). Percent of women giving birth who received prenatal care starting in the first trimester of pregnancy (NCHS measure) | Washington Tracking Network (WTN).

Cognitive

With almost a quarter of the U.S. population estimated to be age 65 or older by 2060, Healthy People 2030 includes several measures to reduce health problems and improve quality of life for older adults. One of those areas is related to improving the health and quality of life for people with Alzheimer's Disease and related dementias.

Alzheimer's disease is a leading cause of death in Washington State. Many feel the impact across Washington—on individuals and families who bear the greatest emotional and financial responsibility and on businesses through lost productivity of family caregivers. Alzheimer's Association reveals 2023 data showing Alzheimer's dementia prevalence estimates for those over 65 in Washington State at 10.2% and Snohomish County at 9.8%. Washington Map and Spreadsheet - Alzheimer's Prevalence.

See Appendix 1 for additional Population Health Data

Hospital Utilization Data

In addition to public health surveillance data, our hospitals can provide timely information regarding access to care and disease burden across the service area. Avoidable Emergency Department (AED) use is reported as a percentage of all Emergency Department visits over a given period, which are identified based on an algorithm developed by Providence's Population Health Care Management team based on NYU and Medi-Cal definitions. AED use serves as a proxy for inadequate access to or engagement in primary care. We review and stratify utilization data by a several factors including self-reported race and ethnicity, patient origin ZIP Code, age, and sex. This detail helps us identify disparities to better improve our outreach and partnerships. In 2023, our data showed the following key insights:

For Providence Regional Medical Center Everett:

- In 2023, 28.0% of ED cases were flagged as potentially avoidable, which is higher than in 2021 (25.8%) and 2022 (26.5%).
- The population of North Everett (98201) accounts for almost 1 in 5 (19.9%) AED cases followed by Marysville (98270) at 11.2%. Out of all of the AED visits, 39.6% are from patients with Medicaid (incl. HMO), higher than any other payor, followed by commercial and then Medicare. Medicaid makes up the highest percentage of the patient payor population, followed by commercial and then Medicare.
- Patients identifying as American Indian or Alaska Native had higher percentages of ED visits that were potentially avoidable (32.1%) compared to other races and ethnicities.
- Patients ages 40 to 64 years had the highest percentage of visits considered potentially avoidable at 29.9% compared to other age groups.

- The top three primary diagnosis groupings for AED visits were substance use disorders, skin infection and urinary tract infection.
- The number of behavioral health cases in the emergency department over the last three years has remained relatively stable, around 9%.
- In 2023, 9.1% of ED visits were for behavioral health needs and 54.4% of those visits were by patients with Medicaid (incl. HMO); 15.1% of ED visits for patients with Medicaid were behavioral health-related, higher than any other payor group.
- Everett (98201) makes up more than one quarter of behavioral health ED visits. About 50% of behavioral health ED cases have been among patients 18-39 years of age.
- 12.3% of ED visits for patients identifying as American Indian or Alaska Native and 12.9% for patients identifying as Black or African American were behavioral health-related, higher than other race and ethnicity groups and the patient population overall at 9.1%.
- The most common diagnosis groupings were related to substance use disorders, mood disorders, and psychosis.

For Swedish Edmonds:

- Lynnwood (98036 and 98037) accounts for almost 30% of AED cases followed by Edmonds (98026). Out of all of the AED visits, 37.2% are from patients with Medicaid (incl. HMO), higher than any other payor, followed by commercial and then Medicare.
- Avoidable Emergency Department (AED) cases have increased slightly over the past 3 years (2021-2023). The top three reasons for avoidable emergency department visits include primary diagnosis groupings of skin infections, urinary tract infections, and bronchitis and other upper respiratory diseases.
- Patients under 18 years had the highest percentage of visits considered potentially avoidable at 29.9% compared to other age groups.
- In 2023, 5.8% of ED visits were for behavioral health needs and 47.4% of those visits were by patients with Medicaid (incl. HMO); 9.0% of ED visits for patients with Medicaid were behavioral health-related, higher than any other payor group. Edmonds and Lynwood combined makes up about one quarter of behavioral health ED visits and almost 50% of cases have been among those younger, 18-39 years of age.
- The most common diagnosis groupings were related to substance use disorders, mood disorders, and anxiety and personality disorders.

For additional information regarding these findings, please contact Jessica.Burt@providence.org.

Community Input

How does our community view health and well-being needs, strengths and opportunities?

SECTION IV: COMMUNITY INPUT

Summary of Community Input

To better understand the unique perspectives, opinions, experiences, and knowledge of community members, representatives from North Puget Sound (PRMCE and Swedish Edmonds) conducted 20 key informant interviews with representatives from community-based organizations and 5 listening sessions with community members. All community input was collected in April and May 2024.

Key informants are defined as people with knowledge of community needs and strengths because of their experience as community leaders, professionals, and/or residents of Snohomish County. Key informants have a wide range of knowledge related to community health and well-being and work within organizations or agencies serving residents, including diverse communities, people with low incomes, and people experiencing barriers to care. During these interviews and listening sessions, community members and nonprofit and government key informants, including Snohomish County Health Department, discussed the issues and opportunities of the people, neighborhoods, and cities of the service area. Below is a high-level summary of the findings of these sessions. Full details on the methodology, organizations and participants are available in Appendix 2.

VISION FOR A HEALTHIER COMMUNITY

Listening session participants were asked to describe their vision of a healthy community. This question is important for understanding what matters to community members and how they define health and wellness for themselves, their families, and their communities. The following is a list of the themes that emerged as necessary for a healthy community:

- Supportive healthy relationships, with good communication, respect, and a community that cares for each other
- Inclusion, openness, and connection
- Safe and clean community that encourages recreation and green spaces
- Mental and emotional needs met and no substance use/misuse
- Access to health care services and physical health
- Basic needs are met, including housing, food, and financial assistance available

COMMUNITY STRENGTHS

While a CHNA is primarily used to identify gaps in services and challenges in the community, we want to ensure that we highlight and leverage the community strengths that already exist, including the following strengths identified by key informants:

- Strong network of community-based resources and services
- Collaborative relationships between local organizations and agencies
- Engaged, compassionate community dedicated to common good
- Growing community with opportunity and natural resources

COMMUNITY NEEDS

Key Informant and listening session participants were asked to identify the top health-related needs in the community.

Homelessness and housing stability	Almost all key informants identified addressing homelessness and housing stability as a priority of high importance, with many noting this is the primary community need and the biggest issue. Addressing housing needs is connected to physical and behavioral health, as well as economic security. Key informants have seen the number of people experiencing homelessness increase and there are fewer resources to meet the growing need, particularly due to the end of COVID-19 emergency funding for housing. Additionally, the cost of housing has increased, leading to overcrowding as multiple families share a small space. Key informants were concerned about refugee/immigrants or other newcomers that are unfamiliar with housing system/policies may not seek support until they are far in debt and being evicted. More education and awareness are needed to understand rental policies, consequences, and how to seek support before reaching this crisis. To address the housing challenges, key informants and community members identified more affordable housing, transition, housing, and family shelters as needs. Besides families and people with low incomes, key informants also noted that they are seeing more older adults experiencing homelessness. People experiencing homelessness are also more likely to be victims of crimes and may have more involvement with the criminal legal system than people living sheltered, highlighting the importance of safe shelter.
Behavioral health challenges and access (mental health and substance use/misuse)	Most key informants identified behavioral health challenges and access to behavioral health care as a priority need. They are seeing very high needs related to mental health and substance use/misuse, with limited resources available. Key informants shared that behavioral health challenges are connected to a history of trauma (specifically Native American Boarding Schools), Adverse Childhood Experiences (ACEs), a lack of community and belonging, and economic insecurity. Several key informants underscored the continued effects of COVID-19 on mental health and isolation. Four years of being impacted by a global pandemic, really affected people, especially kids and their development, families, education, the economy, and the workforce. Key informants identified specific community needs related to behavioral health: increased substance use disorder (SUD) treatment and psychiatric care, behavioral health care for young people, culturally matched and linguistically appropriate mental health services, improved coordination of behavioral health services, more behavioral health urgent cares and crisis support, and more substance use education. Stigma, transportation, insurance, and technology can all prevent people from accessing needed behavioral health services. Key informants discussed barriers to accessing care and increased needs for young people, new parents, the Latino/a community, Indigenous Peoples of the U.S., and individuals that were formerly incarcerated. Community members also noted a particular need for more mental health services for young people and trauma-informed approaches in schools.

The following needs were also discussed by key informants and listening session participants as medium-priority health-related needs, based on community input:

Racism and discrimination	Key informants discussed racism and discrimination as a key community priority because they are drivers of other needs. Racism and discrimination contribute to stressors that impact mental and physical health and can affect access to economic, social and health care and well-being resources. Racism and discrimination in health care can affect the quality-of-care people receive and contribute to health disparities, particularly for Black, Brown, Indigenous, and People of Color (BBIPOC) communities. For patients that are experiencing homelessness, or who are immigrants and refugees, providers may make harmful assumptions about their life circumstances, diminishing the dignity and respect they deserve as patients. Racism and discrimination may also contribute to certain populations not accessing services due to distrust in systems, particularly governmental resources, including housing resources. There is hard work happening to heal generational trauma, to make it better for current and future generations, while recognizing the legacy of deep unresolved issues. Community members discussed the need for culturally connected care, activities that support community belonging, awareness of history, and celebration of cultures, and opportunities to center community strengths and voices. Many called out the importance of visibility of allies, support groups, and inclusive community activities/events, especially for LGTBQIA+ and older adults.
Economic security	Key informants shared economic security is related to many other needs, including mental and physical health, housing stability, food security, and more. They described “no safety net” in emergencies for people with low incomes, contributing to stress and anxiety. During the COVID-19 pandemic, there was more support for basic needs, like diapers and food, but emergency funding ended. Community members said there is a need for more financial education, social services, and better-quality education to address economic insecurity. Some areas of the county may have fewer job opportunities and local investment, particularly smaller communities where businesses may be owned by people living elsewhere. In some areas, like Lynwood, light rail, is providing more opportunities for business and better commutes, but also is creating an increased cost of living and congestion. More BBIPOC small businesses got displaced, with an intention to help relocate. People in more suburban or rural areas of Snohomish County may have to travel to urban hubs for employment, increasing the need for transportation. To improve economic security, language learning services and culturally responsive workforce development is needed. Refugees and immigrants, people that have been formerly incarcerated, and young families may especially need support in accessing employment opportunities and improving their economic security.
Access to childcare and preschools	Key informants described affordable childcare and preschools as very challenging to access, with many inequities. Community members agreed there is a need for more affordable childcare. Particularly as economic insecurity increases and people are working longer, parents may not have the option of relying on grandparents or other family members to provide caregiving. More affordable, accessible childcare and

	early childhood education are needed in the community to meet the needs. Investing in childcare and preschools is critical to support family economic security well-being, as well as children's healthy futures.
Access to health care services	Key informants discussed the many barriers that prevent people from accessing timely, affordable, culturally responsive, and linguistically appropriate care: language, health literacy, lack of care navigation and trust in health care, high cost of care and insurance, appointment hours, long wait times, and transportation. To address these barriers, there is a need for more culturally matched and linguistically appropriate services, a focus on treating all patients with dignity and respect, more pharmacy services, and improved workforce recruitment and retention. Specific health care services and specialties needed in the community are more robust free immunization programs, accessible primary care providers, free or low-cost Obstetrics and Gynecology services and prenatal care, STI services, pediatric inpatient care, and more resources for people with Traumatic Brain Injuries and dementia. Community members noted needing language services, financial support, gender affirming care, health fairs with information, and more preventive care. Certain populations and groups may experience more challenges and barriers to accessing needed care. Many key informants discussed barriers to care refugees and immigrants experience, particularly related to language, health literacy, and insurance. People experiencing homelessness may experience more barriers to getting to care and maintaining an appointment. Indigenous Peoples of the U.S. experience higher rates of health disparities due to systemic factors, including historical trauma. Accessing care can also be more difficult for older adults, people with Medicaid, and people with behavioral health challenges.

Listening session participants primarily spoke to the following needs: *Safety* with reduced violence, shootings, and gang activity in the community and safter schools with no concerns about firearms and substances on school campuses; *Recreation and social activities* with a need for more free recreation opportunities for all and social events and safe spaces for young people*. Civic engagement and community involvement*, particularly opportunities to use their voice to promote change and give back to the community in positive ways, as well as being informed and empowered to vote. The following six needs were frequently prioritized and discussed by key informants and listening session participants.

See Appendix 2 for methodology and participant details

Community Survey

PIHC 2024 SNOHOMISH COUNTY HEALTH AND WELL-BEING MONITOR

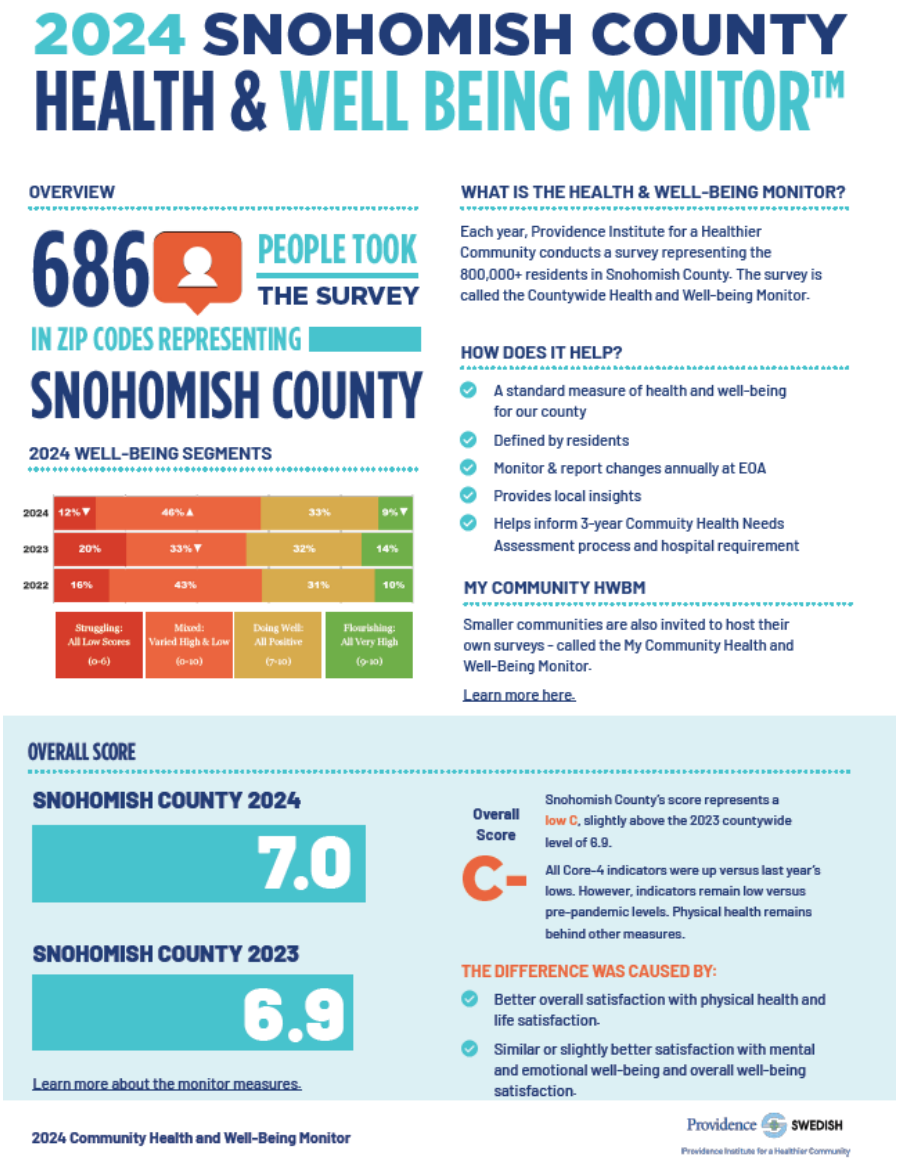
In addition to the listening sessions and key informant interviews, due to the limited data available through local, state, and national sources, the Providence Institute for a Healthier Community (PIHC) conducts an annual survey to obtain additional feedback directly from Snohomish County residents on the community strengths and indicators of health and well-being. The 2024 PIHC Health and Well-being Monitor survey was conducted in May 2024. A total of 686 adults over the age of 18 took the survey through phone and online surveys. The three largest racial groups among survey respondents self-identified as White/Caucasian (79%), Asian/Pacific Islander (9%) and Black/African American (5%). The survey was available in English and Spanish. Every effort was made to ensure the survey responses represented the diversity of the community and captured input from those with low incomes and those otherwise underserved in the community.

The 2024 results utilized the outcomes from 2023 surveys as benchmarks, in addition to trend data beginning in 2017. The central questions of the monitor include how residents define their health and well-being, factors that residents find important to health and well-being, and how satisfied residents are with their own health and well-being. The report groups findings into six dimensions: connections and relationships; physical health; mental/emotional and spiritual health; security and basic needs; neighborhood and environment; and work, learning, and growth. To look at health from the point of view of the residents, respondents also self-reported their current state of overall health, physical health, mental/emotional health, and life satisfaction/well-being. The results of the survey form the basis for the Snohomish County Health and Well-Being Index.

Key highlights include:

- In 2024, the index score was a 7.0 or a C- rating. After several years trending down due to pandemic-related fatigue, the Snohomish County Core4 Index score trended up for this first time since 2021.
- Current state of physical health continues to have the highest impact for overall well-being yet continues to need the most improvement; followed by two mental health indicators, state of mental/emotional health, and for the first time, sense of purpose and meaning.
- Overall, the Snohomish County 2024 PIHC Health and Well-being Monitor shows that some indicators with historic lows last year have mellowed, but there are new impacts on well-being, especially financial security and economic concerns and many other well-being indicators are significantly lower for those younger (ages 18 to 34 years old).
- Most (75%) Snohomish residents report "a little" or "a lot" more capacity to change their health habits for the better. This is up directionally from the 73% who said the same in 2023.
- Relationship satisfaction continues to suffer post pandemic.
- Work & economic strains continue with most reporting low levels. And, although those reporting needing help to meet basic needs have dropped after last year's historic high, the top five needs remain the same.

In addition to the countywide Health and Well-Being Monitor, in 2017 PIHC began working with diverse communities to build upon the infrastructure of the Health and Well-Being Monitor to create a tailored community version to assist organizations and community networks with measuring well-being, informing action steps, and tracking progress. This method allows individual communities to become more active well-being partners based on what matters to them.



See Appendix 1 Primary Data Survey Results PIHC 2024 Snohomish County Health and Well-Being Monitor, for the full methodology and findings from the survey.

Challenges in Obtaining Community Input

While care was taken to ensure a robust and diverse representation of community input, there are limited resources and infrastructure to reach all in our community. In addition, some community members or organizations may be asked by multiple entities to participate in community assessment which leads to survey fatigue and disinterest.

Our community input process involved a variety of solutions such as involving other departments and partnership to extend our reach as much as possible and as time allowed, in addition to offering incentives to show appreciation of time and commitment.

Significant Health Needs

What are the priority health needs?

Which priorities will North Puget Sound address?

SECTION V: SIGNIFICANT HEALTH NEEDS

Review of Primary and Secondary Data

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

A CHNA Advisory Committee was established to inform and guide the CHNA process and to identify the top health priorities for the community based on community input and community health data. The committee comprised local community leaders who represent the broad interest and demographics of the community. The CHNA Advisory Committee met monthly from February through September 2024.

The PIHC Strategic Oversight Council, serving as the CHNA Advisory Committee, reviewed the quantitative and qualitative data collected for each of the following community health-related needs related to security and basic needs, mental/emotional health, physical health, neighborhood and natural environment, and relationships and social connections:

- Access to: Childcare & Preschools, Dental Care, Health Care Services, Transportation
- Behavioral Health: Including Substance Use
- Environmental Concerns
- Education: Job Skills and Training, Opportunity Gap in Education
- Health Issues: Adult Aging and Well-being, Maternal and Child Health, Chronic Conditions, Disability Inclusion
- Relationships: Racism & Discrimination, Community Belonging & Community Efficacy/Civic Engagement
- Security: Economic Security, Food Security, Housing Security and Homelessness
- Safety: Domestic Violence, Child Abuse Safe Streets for All Users, Crimes and Public Safety

Identification and Prioritization of Significant Health Needs

The evaluation portion of the process started with a review of the qualitative findings from the key informant interviews and group listening sessions. These findings were used to frame the discussion of the significant health needs. A review of the quantitative data and the county-wide 2024 PIHC Health and Well-Being Monitor results was then used to validate and enrich discussion of the qualitative findings. Throughout the process we evaluated health and community need using a holistic framework that included social determinants of health, health behaviors, and clinical care.

Through a facilitated discussion and an online ranking tool, the CHNA Advisory Group utilized a methodology which compares local data to state and national data, identifying worsening trends and evaluating the size and seriousness of the problem, the North Puget Sound service area/high need

service area rates worse than state average and/or national benchmarks as well as the disproportionate impact on low-income and/or BBIPOC communities to rank order 20 metrics.

2024 Significant Needs

The list below summarizes the significant health needs identified through the 2024 Community Health Needs Assessment process, listed in order of priority.

1. AFFORDABLE HOUSING AND HOMELESSNESS

Housing needs were identified as the most significant issue related to economic insecurity and are foundational to physical and mental well-being. The major gaps include fewer resources to meet the growing demand and the increased cost of housing. To address these challenges, there is a pressing need for more affordable housing, transitional housing, and family shelters. In addition to families and low-income individuals, there is growing concern for older adults experiencing homelessness and refugees or immigrants who are unfamiliar with housing systems and policies.

2. ACCESS TO HEALTH CARE SERVICES

Access to health care services encompasses several specific needs. The high cost of care, even with insurance, particularly Medicaid, is a significant economic barrier. Other logistical challenges include the availability of care (especially primary care, low-cost/free immunizations, and OB/GYN care), long wait times, limited appointment hours, and transportation issues. There is also a need for culturally matched and linguistically appropriate health care delivery that treats all patients with dignity and respect. Care navigation to access available resources, simplifies the healthcare process, and provides essential education. Similar needs include health literacy/health information and access in community such as health fairs. Highlighted populations include refugees and immigrants, people experiencing homelessness, Indigenous Peoples of the U.S., older adults, and individuals with behavioral health challenges

3. BEHAVIORAL HEALTH INCLUDIND SUBSTANCE USE

Behavioral health, including substance use, was identified as a top need. Key areas for improvement include increased access to services, education, and better delivery. Access to care should encompass treatment for substance use disorders, including detox and psychiatric care, urgent care, and other crisis support. There is also a need for trauma-informed approaches, particularly on-site school-based care and substance use education. Operational improvements for better coordination of care, along with culturally matched and linguistically appropriate mental health services, were also identified. Populations with increased barriers or needs include young people and new parents, the Latino/a community, Indigenous Peoples of the U.S., and individuals who were formerly incarcerated.

4. ACCESS TO CHILDCARE AND PRESCHOOLS

Affordable childcare and preschools have been identified as very challenging to access, with many inequities. As economic insecurity increases and people work longer hours, there are fewer options, including family members, to provide caregiving. The community needs more affordable and accessible

childcare and early childhood education. Investing in these areas is critical to support family economic security and well-being, as well as to ensure healthy futures for children.

5. ECONOMIC SECRUITY WITH FOCUS ON FOOD SECURITY

Food security was identified as a critical need related to economic security, alongside physical and mental health, housing stability, and more. There is concern about the lack of a safety net in emergencies for low-income individuals, which contributes to stress and anxiety. During the COVID-19 pandemic, there was increased support for basic needs like diapers and food, but this emergency funding has ended. Additionally, there is a need for more foundational supports, such as financial education, social services, and better-quality education, to address economic insecurity overall.

6. RACISM AND DISCRIMINATION

Racism and discrimination have been identified as key community priorities because they drive other needs. These issues contribute to stressors that impact mental and physical health and can affect access to economic, social, and healthcare resources. Specific needs include culturally connected care, activities that support community belonging, awareness of history, and celebration of cultures. It's also important to highlight the visibility of allies, support groups, and inclusive community activities/events, especially for LGBTQIA+ individuals and older adults.

Alignment with Other Community Health Needs Assessments

To ensure alignment with local public health improvement processes and identified needs, we reviewed the needs of other publicly available sources that engaged the community in setting priorities, including Snohomish County Health Department, 2022 and Snohomish County 2023 Low-Income Community Needs Assessment, 2023 and Verdant Health Commission Community Needs Assessment, 2022. The CHNA Advisory Committee reviewed these CHNA reports to confirm alignment with government and non-profit organizations serving Snohomish County. The following table provides an overview of the priorities identified by the organizations. Similar themes are seen across assessments and are interrelated: economic insecurity, housing insecurity, and access to basic needs, like food, transportation, and health care. In addition, needs around behavioral health, including substance use, as well as issues of trauma (adverse childhood trauma, and racial/generation trauma) and systemic barriers that undermine access to basic needs, with focus on youth, families and seniors.

*Table **5**. Alignment with Other Community Health Needs Assessments*

2024 NPS Identified Significant Needs of the Community	2022 Snohomish County Health Department 2022	2023 Snohomish County Low-Income Community Needs Assessment	2022 Verdant Health Commission Community Needs Assessment
• Housing Instability and Homelessness • Access to health care services • Behavioral health, including substance use • Access to Childcare/Preschools • Economic Security (with focus on food security) • Racism, and discrimination	• Persons experiencing homelessness • Mental health access and provider ratios • Opioid overdose • Adverse Childhood Experiences (ACEs) • Inadequate prenatal care • Food security	• Access to health and dental services • Adult and youth mental health services • Adult and youth substance services and prevention programs • Affordable childcare • Education and job training for a livable wage • Generational Trauma • Housing, basic needs, and community safety • Regulatory and policy barriers • Services for seniors • Systemic racism and infrastructure barriers • Youth sports	• Healthcare access and quality • Mental health • Economic stability • Housing • Food security • A safe and connected community

2024 Priority Needs to Be Addressed

There are several significant health needs in our community, however, due to lack of effective interventions, resource constraints, or absence of expertise, PRMCE and Swedish Edmonds cannot directly address all needs identified in a CHNA. Based on the outcome of the evaluation from the CHNA Advisory Committee to review and identify the significant health needs of the community, the North Puget Sound Executive Leadership Team considered those ranked priorities and scored the significant needs of the community using the following criteria:

- Alignment with the strategic plan and existing Providence priorities
- Availability of resources and/or partnerships
- Confidence in Providence's ability to have a positive impact.

The results of the ranking and prioritization of significant needs revealed the following priority areas that North Puget Sound will address as part of a joint PRMCE and Swedish Edmonds 2025-2027 Community Health Improvement Plan:

1. Behavioral health – mental health and substance use*
2. Access to health care*

*Each need area will integrate health equity measures that recognize racism and discrimination as underlying drivers of need.

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 Snohomish County Health Department, Community Health Centers of Snohomish County, Sea Mar Community Health Centers and Cascade Valley Hospital. In addition, there are numerous social service non-profit agencies, faith-based organizations, and private and public-school systems that contribute resources to address these identified needs. For a list of potentially available resources available to address significant health needs see Appendix 3.

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

Evaluation of Current CHIP

What progress was made since the previous CHNA?

SECTION VI: EVALUATION OF 2022-2024 & 2023-2025 CHIPS

The Swedish Edmonds 2021 and PRMCE 2022 CHNA's and respective 2022-2024 and 2023-2025 Community Health Improvement Plan (CHIP) priorities were the following for both PRMCE and Swedish Edmonds: Behavioral Health including Substance Use, Housing Insecurity and Homelessness, Access to Healthcare, and Health Equity. Each hospital, PRMCE and Swedish Edmonds, 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.

This report evaluates the impact of the Swedish Edmonds 2022-2024 CHIP and PRMCE 2023-2025 CHIP. The hospitals' CHIPs are associated with their 2021 and 2022 CHNAs, respectively, where each identified similar community needs and responded 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.

Behavioral Health (Mental Health and Substance Use)

The programs and services implemented to improve this community need and the resulting outcomes are described in the table below.

Table 7. Mental Health Programs and Services

Description	Results/Outcomes
Providence Regional Medical Center Everett	
Access to mental health and crisis services for adults and adolescents through timely services in the Behavioral Health Urgent Care	• Expanded services for those ages 16 and up fall 2023-- previously had been adult only. • Offering virtual behavioral health services: 2280 Total Visits, 172 virtual visits in 2023.
Improve rate of mental health screening (depression and suicide) in the emergency department, primary care, and urgent care settings	• In 2023, provided 147,464 depression screenings and 4,861 suicide screenings in primary care; provided 4,312 suicide screenings in the emergency department and 2280 depression/suicide screenings in Behavioral Health Urgent Care.
Access to substance use treatment options such as Medication Assisted Treatment and Naloxone	• Conducted a study for methamphetamine use disorder treatment in the Emergency Department • Provided certified peer counselor support to 65 individuals with a substance use disorder. An overdose prevention training was conducted for outpatient clinic caregivers.
Collaborate with and support community partners	• Participated in a community behavioral health committee with focus on identifying barriers, raising level of care, and improving access. • Aligned grants and donations with community organizations that support mental health, such as Camp Fire, grief support groups for youth and YWCA Pathways support programs for women.

Description	Results/Outcomes
Providence Regional Medical Center Everett	
	• Coordinated annual community conference (Edge of Amazing) with break-out groups discussing community barriers and solutions to behavioral health. • Participated in the Snohomish County Collaborative to expand trauma informed care.
Swedish Edmonds	
Intensive outpatient behavioral health program through the partial hospitalization program	• Expanded the available inpatient behavioral health beds to 25 and expanded the behavioral health partial hospitalization program from 1-2 patients to 8-10 patients. • Behavioral health professionals were embedded into primary care clinics.
Depression screening and suicide risk assessment screenings for patients in primary care clinics and the ED	• 89% of patients screened for depression/suicide.
Offer medication assisted treatment (suboxone) in the ED to assist in the treatment of opioid use disorder	• Provided medication opioid use disorder treatment and Narcan in the emergency department.
Collaborate with and support community partners	• Aligned grants and donations with community organizations that support behavioral health, including substance use, such as the Washington Poison Center. • Participated in the Bridge-to-Treatment Opioid Network Program, partnering with care navigators for patients presenting with opioid use disorder.

Housing Instability and Homelessness

Tabel 8. Housing Instability and Homeless Programs and Services

Description	Results/Outcomes
Providence Regional Medical Center Everett	
Identify solutions to the health care needs of the homeless population post discharge	• Partnered with the Everett Gospel Mission to provide medical respite beds for men experiencing homelessness who need a safe place to recover and heal following hospital discharge. • Provided clothing for individuals experiencing homelessness being discharged from the Emergency Department in need of clean clothing. • Provided funding to Northwest Justice Project to provide legal aid for people experiencing housing instability to help address poor-quality housing conditions.
Collaborate with and support community partners	• Aligned grants and donations with community organizations that support housing insecurity and homelessness, such as Everett Gospel Mission and Cocoon House.

Description	Results/Outcomes
Providence Regional Medical Center Everett	
	• Coordinated annual community conference (Edge of Amazing) with resources discussing community barriers and solutions to housing access, homelessness. • Participated in the Improving School Attendance for Families Experiencing Homelessness Collaborative (ISA), serving students from the Everett School District. Unstable housing decreased from 49% to 16%, satisfaction with school attendance increased by 32%, and overall well-being increased 12%. Reported in 2022-2023 School Year – *My Community* PIHC Health and Well-being Monitor, for ISA. • Collaborated with community partners, Mercy Watch and Washington State University to provide 600 volunteer hours of street medicine and hygiene kits to people living unhoused. • Collaborated with American Cancer Society to provide lodging vouchers for temporary respite and for those that don't have safe, stable housing during cancer treatment
Swedish Edmonds	
Collaborate with community agencies to address the housing and homelessness	• Engaged in a medical legal partnership with Northwest Justice Project to provide housing supports such as food, transportation and financial stability • Funded Everett Gospel Mission respite program for people experiencing homelessness in need of safe, short-term medical recovery
Sponsorships, grant funding and in-kind support	• Aligned grants and donations with community organizations that support housing insecurity and homelessness, such as Everett Gospel Mission and Foundation for Edmonds School District.

Health Equity (Racism & Discrimination)

Table 9. Health Equity Programs and Services

Description	Results/Outcomes
Providence Regional Medical Center Everett	
Create better connections to health care resources and health information, reaching diverse communities where they live, work and play	• Supported outpatient cultural health navigators in PMG outpatient clinics or in community outreach events to improve health literacy and remove barriers to care. • Provided health information at a variety of community events, reaching over 5,000 community members, and hosted 12 community Equity Partnership meetings that focused on access to immunizations, preventative screenings, education and job training. • Host and coordinate www.livewelllocal.org , community resources health and well-being hub, highlighting services that support social determinants of health.

Description	Results/Outcomes
Providence Regional Medical Center Everett	
Implement tools and benchmarks to help people/organizations measure improvement in well-being and feeling of belonging in their community	• Conducted and provided data analytics, reports and education for three comprehensive health and well-being surveys to communities, reaching over 1,300 participants.
Collaborate with and support community partners	• Aligned grants and donations with community organizations that support health equity, such as Latino Education and Training Center. • Coordinated annual community conference (Edge of Amazing) with break-out groups discussing health equity and community collaborations, reaching over 300 participants in 2023.
Leverage best practices to enhance the care environment (workforce and physical setting) to improve cultural inclusivity	• Supported Caregiver Health Equity Fellowship • Provided training to caregivers on topics including implicit bias, health inequities, and trans+ health. • Made updates to signage and infographics to be more diverse, welcoming, and inclusive. • Piloted Trauma Informed Environment of Care Survey
Swedish Edmonds	
Reduce the education and income gap for diverse communities	• Supported the Multi-Employer Training Fund to help healthcare workers who are seeking further training, education, and career development, including people who are learning English as a second language, with low incomes, from diverse communities, and that are underrepresented in healthcare.
Collaborate with and support community partners	• Aligned grants and donations with community organizations that support health equity, such as access to basic needs through the Nourish Network.

Access to healthcare

Table 10. Access to HealthCare Programs and Services

Description	Results/Outcomes
Providence Regional Medical Center Everett	
Access Access center to ease the way of patients needing care	• Funded cultural health navigators and community health worker program to help improve access to health care and for BBIPOC communities. • Expanded behavioral health services from adults only to include young people ages 16 years and older. Added virtual visits. • Began pilot to develop an access hub for outpatient clinic and promoted and engaged patients in a care app to streamline scheduling, appointment management, access to health records and virtual appointments.

Description	Results/Outcomes
Providence Regional Medical Center Everett	
Health care workforce Recruited additional care providers to increase the available workforce and interest in the health care field	• Supported 72 medical, 8 pharmacy residents, and 32 pharmacy students. • Developed college and high school collaborations to host 72 summer interns, providing exposure to healthcare environment/careers, directly supporting 3 school districts. • Participated in community health/job fairs to draw interest to health care careers and promote openings at Providence.
Community partnerships Collaborate with and support community partners	• Provided community education at more than 25 outreach events and/or classes, including Heart Health, Stop the Bleed® Interactive Course, fall prevention training, Aging Gracefully, and breast cancer screenings. • Aligned grants and donations with community organizations that support access to healthcare • Coordinated annual community conference (Edge of Amazing) that brought together over 90 community partners facilitating collaboration and shared resources that support access to care among more than 300 care professionals.
Swedish Edmonds	
Health education, health fairs, community outreach and support groups	• Provided health education and participated in health fairs to provide information on strokes, cancer, and bereavement. • Taught community nutrition classes at summer meal programs • Facilitated food drives
Collaborate with and support community partners.	• Aligned grants and donations with community organizations that support access to care.

Addressing Identified Needs

The Community Health Improvement Plan developed for the North Puget Sound service area will consider the prioritized health needs identified in this CHNA and develop strategies to address needs considering resources, community capacity, and core competencies. Those strategies will be documented in the CHIP, describing how PRMC and Swedish Edmonds 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 PRMCE and Swedish Edmonds 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 either or both PRMCE and Swedish Edmonds and community-based organizations in addressing the health need. The CHIP will be approved and made publicly available no later than May 15, 2025.

2024 CHNA GOVERNANCE APPROVAL

This joint Community Health Needs Assessment[1] was adopted by the Community Mission Board of the Providence Regional Medical Center on October 17th, 2024, and by the Swedish Health System Board of Trustees of the Swedish Edmonds Campus on November 12th, 2024. The final report was made widely available by December 28, 2024.

10/21/24

Kristy Carrington, RN — Date
North Puget Sound Chief Executive
Providence Swedish

DocuSigned by:
10/24/2024
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Ed Petkus — Date
Chair, Providence Regional Medical Center Community Mission Board

11/19/2024

Elizabeth Wako, M.D., MBA — Date
President and Chief Executive Officer
Swedish Health Services

11/20/24

R. Omar Riojas, JD — Date
Chair, Swedish Health System Board of Trustees

DocuSigned by:
Kevin Brooks
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11/21/2024

Kevin Brooks, MHA, FACHE — Date
North Division Chief Executive
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To request a printed copy free of charge, provide comments, or view electronic copies of current and previous Community Health Needs Assessments, please email CHI@providence.org.

[1] **See Appendix 4: North Puget Sound Community Health Needs Assessment Advisory Committee**

Appendices

Appendix 1: Qualitative Data

Appendix 2: Community Input

Appendix 3: Community Resources to Address Significant Health Needs

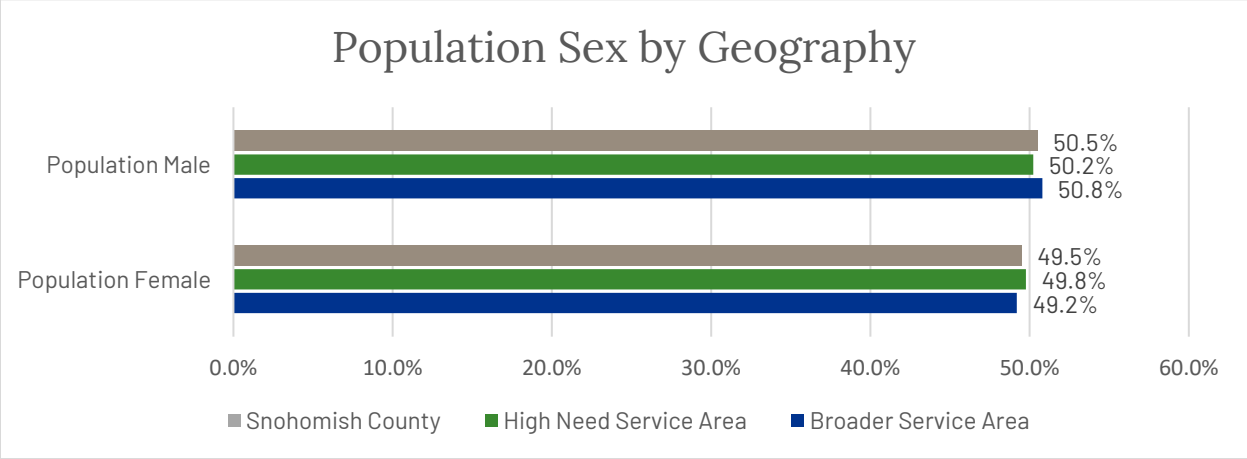
Appendix 4: North Puget Sound CHNA Advisory Committee

APPENDICES

Appendix 1: Quantitative Data

POPULATION LEVEL DATA

Figure 1 Appendix 1. Population Sex by Geography



Source: U.S Census Bureau, American Community Survey 5-Year Estimates, 2018 – 2022, Table B01001

Table1 Appendix 1. Population Demographics

Indicator	Snohomish County	Broader Service Area	High Need Service Area
Population by Age Groups			
Total Population	828,337	394,207	434,130
Population Under Age 5	6.1% (50,413)	6.2% (24,627)	5.9% (25,786)
Population Under Age 18	22.3% (184,523)	22.9% (90,455)	21.7% (94,068)
Population Ages 18 to 34	22.4% (185,558)	19.4% (76,375)	25.1% (109,183)
Population Ages 35 to 54	28.1% (232,466)	29.4% (116,023)	26.8% (116,443)
Population Ages 55 to 64	13.1% (108,926)	14.2% (56,024)	12.2% (52,902)
Population Ages 65 and Over	14.1% (116,864)	14.0% (55,330)	14.2% (61,534)
Population by Sex			
Female	49.5% (409,995)	49.2% (193,936)	49.8% (216,059)
Male	50.5% (418,342)	50.8% (200,271)	50.2% (218,071)
Population by Race			

American Indian and Alaska Native	0.9% (7,819)	0.5% (2,085)	1.3% (5,734)
Asian Population	12.3% (101,576)	11.8% (46,708)	12.6% (54,868)
Black or African American Population	3.5% (28,662)	1.7% (6,526)	5.1% (22,136)
Native Hawaiian and Other Pacific Islander Population	0.5% (3,906)	0.2% (928)	0.7% (2,978)
Other Race Population	4.2% (35,079)	2.5% (9,910)	5.8% (25,169)
Two or more Races Population	9.7% (80,634)	8.9% (35,257)	10.5% (45,377)
White Population	68.9% (570,661)	74.3% (292,793)	64.0% (277,868)
Population by Ethnicity			
Hispanic Population	11.1% (91,866)	7.6% (30,093)	14.2% (61,773)

Source: U.S Census Bureau, 2018 – 2022 American Community Survey 5-Year Estimates, Tables

SOCIAL DETERMINANTS OF HEALTH

Table 2 Appendix 1. Social Determinates of Health (SDOH)

Indicator	High Need Area	Broader Area	Snohomish County	Washington
Median Household Income	$89,141	$133,379	$104,083	$90,325
Households Receiving SNAP Benefits	12.0%	4.9%	8.7%	11.1%
Population Below 200% Federal Poverty Level (FPL)	24.2%	11.4%	17.9%	23.0%
Households with Severe Housing Cost Burden	15.7%	9.4%	13.0%	13.1%
Limited English Households	5.9%	2.0%	4.4%	3.8%
Population Unemployed	4.9%	3.8%	4.4%)	5.0%
Population with at Least a High School Diploma	90.5%	95.3%	92.8%	92.1%
Population Uninsured	7.8%	4.3%	6.2%	6.4%
Households without Internet	5.8%	3.3%	4.6%	5.6%

Source: US Census Bureau, American Community Survey 5-Year Estimates, 2018 - 2022

PHYSCIAL HEALTH/DISEASE INDICATORS

Table 3 Appendix 1. Leading Causes of Death in Snohomish County and Washington State, 2018-2022 (Crude Rates per 100,000 population)

#	Cause of Death	Crude Rate (Snohomish)	Crude Rate (Washington)
1	Malignant neoplasms	160.1	170.8
2	Diseases of heart	135.8	160.6
3	Accidents (unintentional injuries)	57.1	56.9
4	Alzheimer disease	41.8	47.9
5	Chronic lower respiratory diseases	34.2	37.4
6	Cerebrovascular diseases	32	40.5
7	Diabetes mellitus	28	26.4
8	COVID-19	23.5	30.4
9	Intentional self-harm (suicide)	14.6	16.2
10	Chronic liver disease and cirrhosis	14.2	15.9

Data Source: Source: Centers for Disease Control and Prevention, National Center for Health Statistics. National Vital Statistics System, Mortality 2018-2022 on CDC WONDER Online Database, released in 2024. Data are from the Multiple Cause of Death Files, 2018-2022

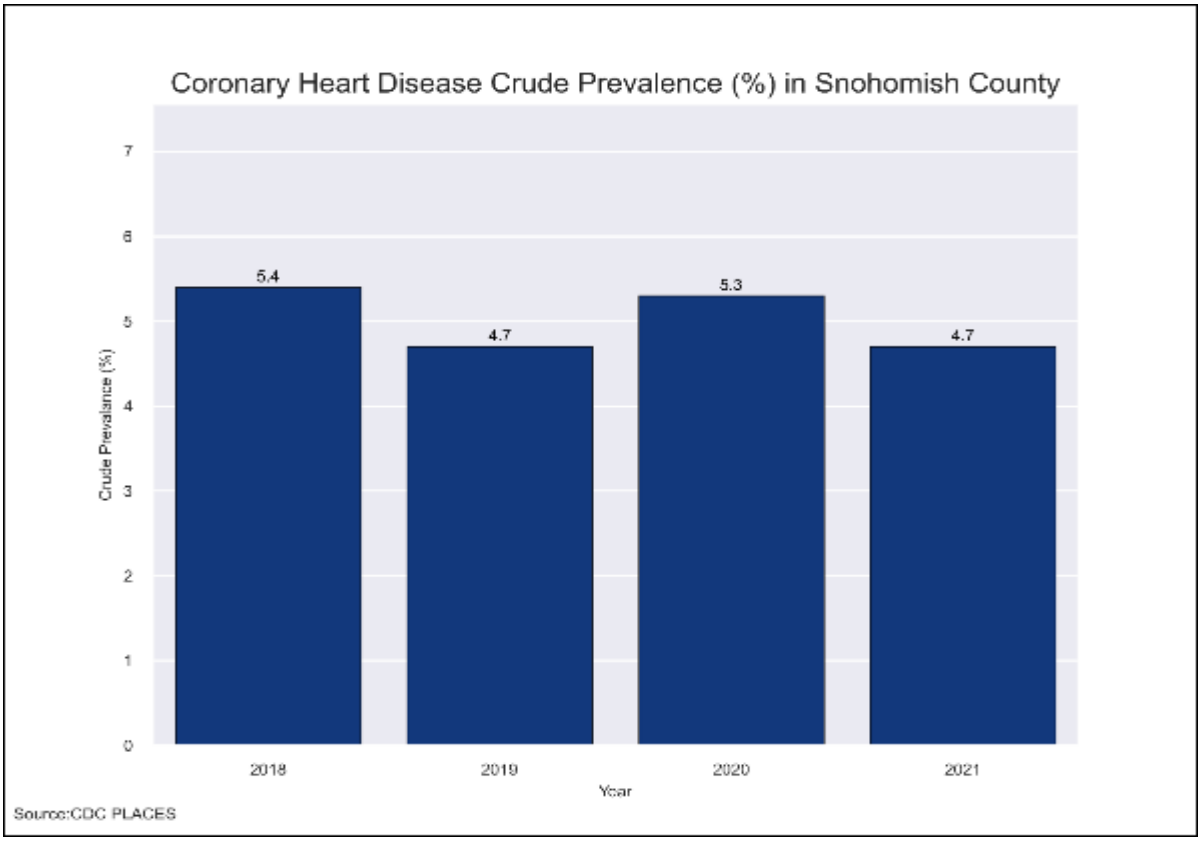
CORONARY HEART DISEASE

Table 4 Appendix 1. Coronary Heart Disease Prevalence

Indicator	Snohomish County	Washington State
Coronary Heart Disease prevalence	4.7%	3.0%

Data Source: PLACES. Center for Disease Control and Prevention, 2021

Figure 2 Appendix 1. Coronary Heart Disease % crude prevalence in Snohomish County, 2018 - 2021 yearly trend



Data Source: PLACES. Center for Disease Control and Prevention, 2021

HEALTH BEHAVIORS

OBESITY AND PHYSICAL ACTIVITY

Table 5 Appendix 1. Obesity and Physical Inactivity

Indicator	Snohomish County	Washington State
Obesity Crude Prevalence	32.9%	28.8%
Physical Inactivity Crude Prevalence	18.4%	17.8%

Data Source: PLACES. Center for Disease Control and Prevention, 2021

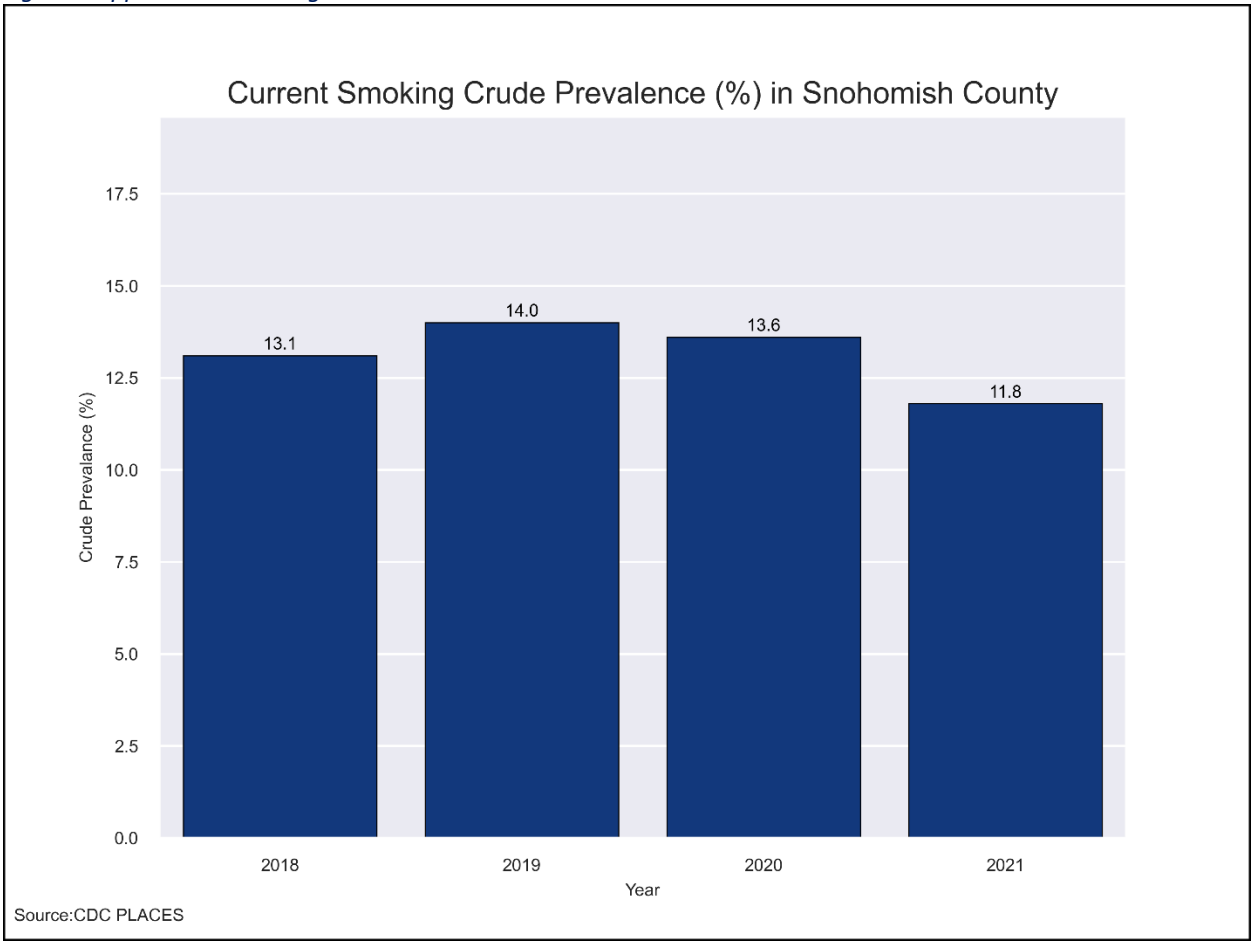
SMOKING

Table 6 Appendix 1. Smoking

Indicator	Snohomish County	Washington State
Smoking Crude Prevalence	14%	12.7%

Data Source: PLACES. Center for Disease Control and Prevention, 2021

Figure 3 Appendix 1. Smoking

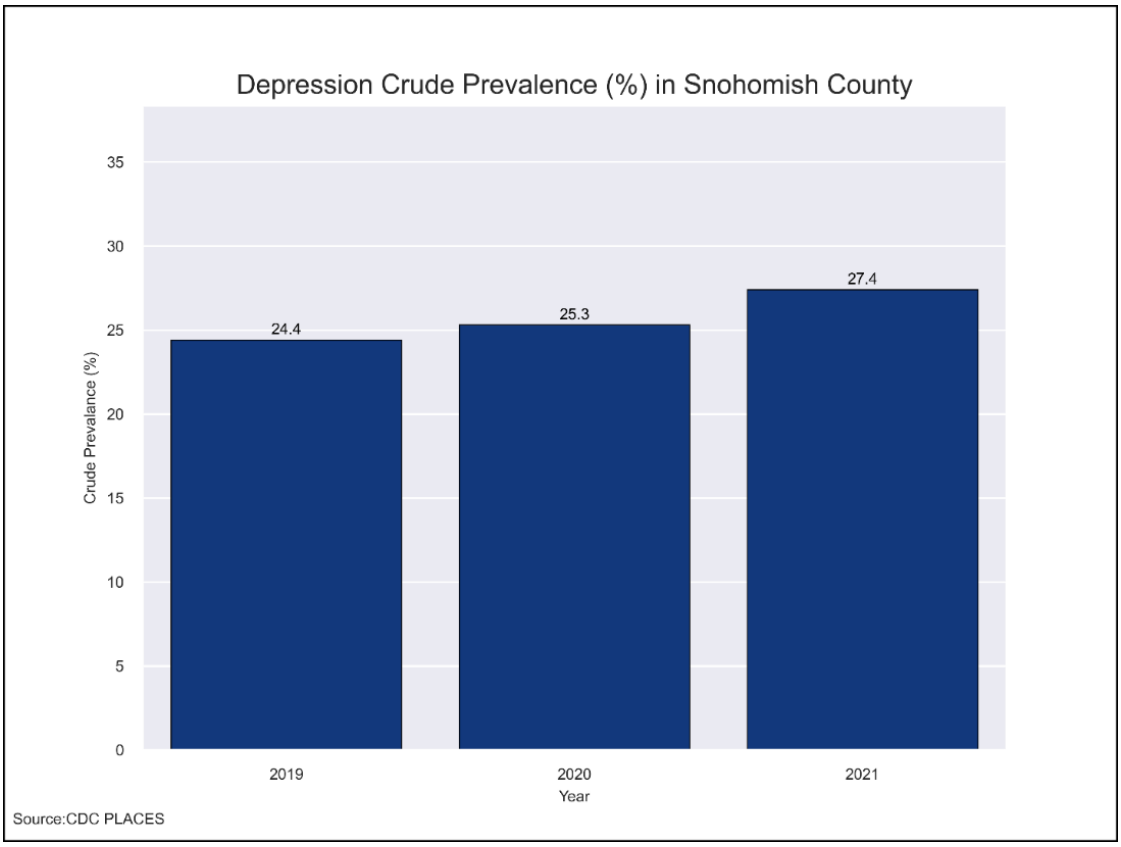


Data Source: PLACES. Center for Disease Control and Prevention, 2021

BEHAVIORAL/MENTAL HEALTH INDICATORS

DEPRESSION

Figure 4 Appendix 1. Smoking

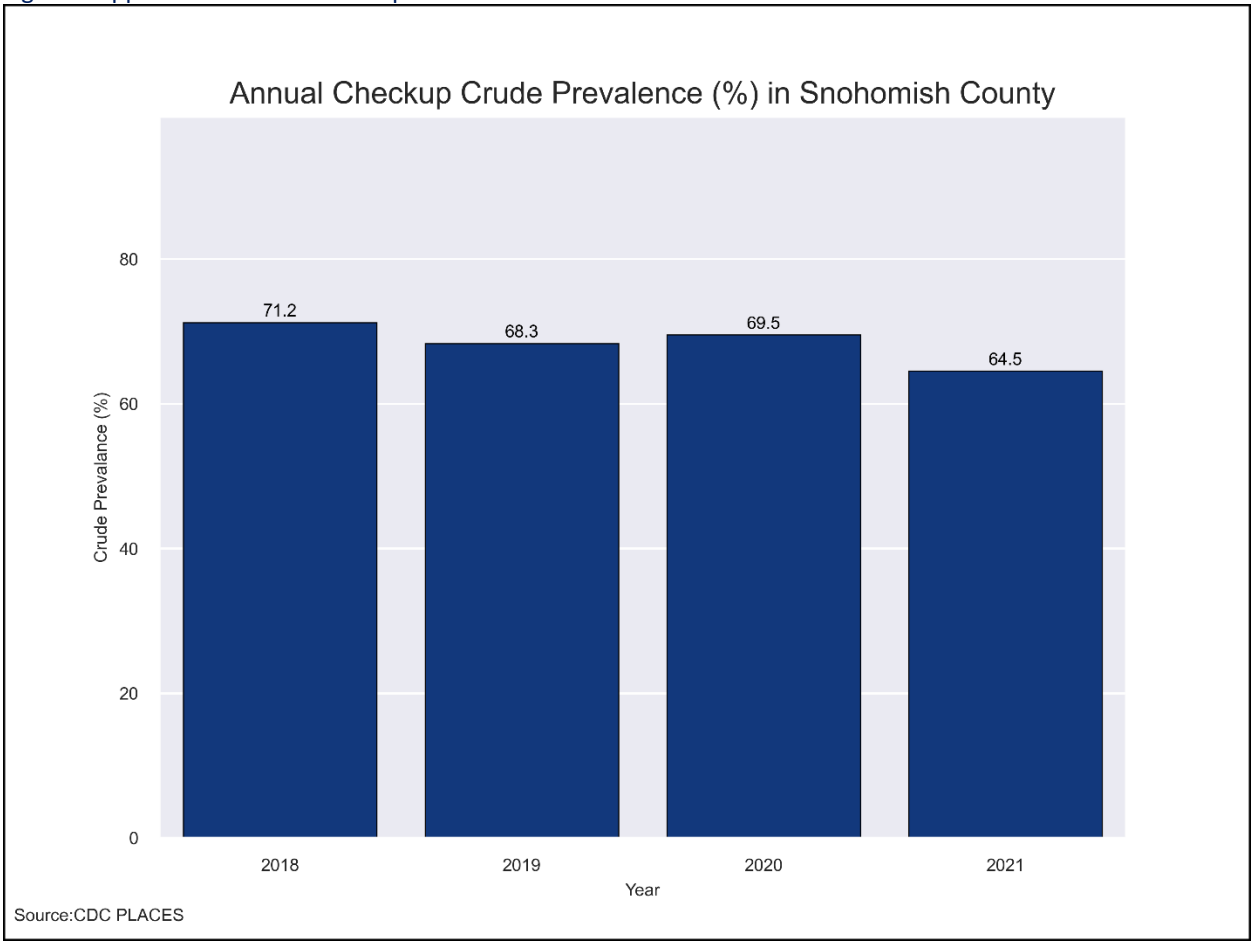


Data Source: PLACES. Center for Disease Control and Prevention, 2021

CLINICAL CARE

ANNUAL CHECK-UP

Figure 5 Appendix 1. Annual Checkup



Data Source: PLACES. Center for Disease Control and Prevention, 2021

DENTAL CARE

Table 7 Appendix 1. Dental Visit

Indicator	Snohomish County	Washington State
Dental Visit Crude Prevalence	67.0%	69.3%

Source: PLACES. Center for Disease Control and Prevention, 2020

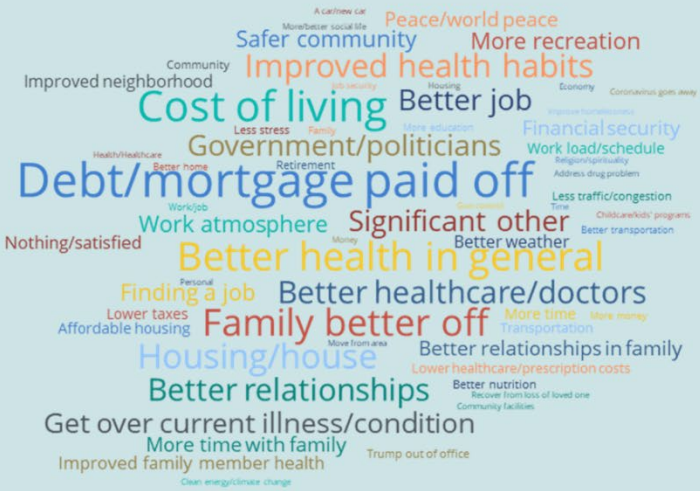
Health & Well-being Monitor 2024 Results Report Snohomish County

With SnoCo Benchmark Trend Results

Prepared for:

Providence Swedish, NPS – PRMCE Everett

August 2024



2024 Word Cloud

Prepared by:

Providence SWEDISH

Providence Institute for a Healthier Community

Table of Contents

Providence SWEDISH

Providence Institute for a Healthier Community

Welcome

Each year, PIHC conducts this survey representing the 800,000+ residents in Snohomish County. Our hope is that communities can benefit and act along common well-being metrics identified and affirmed by the community, to help guide priorities and programming to improve well-being in the ways that matter to you. The results are a blueprint for action.

Supporting Our Community

- Annual standard measure of health and well-being for our county, providing local insights
- Defined by residents and organized around six dimensions of health and well-being, based on early foundational work
- Informs 3-year CHNA process and hospital requirement
- Smaller communities are also invited to host their own surveys - called the My Community Health and Well-Being Monitor.

Engaging Our Values

- *Listening to the Community:* understanding the communities we serve is the key to success.
- *Advocating for Big-Picture Health*: humans are complex, and health and wellbeing are multi-dimensional.
- *Educating and Empowering our Partners*: sharing collective resources with our partners, making it easier for them to do their jobs well

Health is More than Healthcare

Being healthy is about so much more than physical health—it's about mental and emotional health, strong relationships, safe places to live, healthy food, connected communities and good jobs. It's also about our perceptions and beliefs not just health and economic outcomes.

The Original Research: How do you define health and well-being?

The original research began in 2015 with that question – looking at health from the point of view of residents what they think is important to their health and how they measure up to their own standards. The HWBM core index is based upon people's satisfaction with their health rather than their assessment of their health – a significant difference between from other health survey's.

The initial research drew on insights from 130 community members from organizations as diverse as Familias Unidas, Native peoples, the NAACP, Minority Achievers Program alums, low-income housing residents, university students, YMCA members, faith leaders; street interviews; conventional focus groups of different ages, income and geography and more.

Based on foundational work of the Institute in community-based participatory research in 2015, listening to and learning how communities define health and well-being, 24 common attributes emerged. In January 2016, our first survey was fielded by Elway Research and through factor analysis of those 24 attributes, revealed natural groupings into Six Dimensions of Health™ . Because that is how communities define wellbeing, so do we.

Since 2016, more than 12,000 people have participated in the Institute's regional and Community Health & Well-being Monitor studies, yielding a growing body of research data including under-represented populations unlikely to be included in conventional research.

This 2024 Health & Well-being Monitor relies on 9 years of robust sampling of residents of Snohomish County. This is the most comprehensive, community-based study of well-being of its kind for Providence. A starting point our work, the monitor continues to be a key initiative. Our entire Institute team thanks you for your commitment to community well-being.

In good health,

Jessica Burt, MPH
Director, Providence Institute for a Healthier Community
Providence Regional Medical Center - Everett

Blueprint for Action

Using the Data

- **Share results and deepen trust and mutual understanding** with your community
- **Use results to go deeper.** What resonates, what doesn't? Are there additional, deeper conversations that can help guide action steps. Discover what energizes and resonates most with your community.
- **Set priorities together** that resonate most with your community and that you can influence the most.

Remember

- **It All Matters.** look at the data, but remember a start anywhere is a step towards better overall health &well-being. **Tune In to Heart & Soul.** what are your communities' interests, priorities, values? They matter.
- **Start Small.** Is there an easy 'win'? Build confidence and self-efficacy - 'We Can Do This.'
- **Assess Resources.** Have enough people, time, money or other supports? Supports ensure success.

A spirit of learning and growing in each of these dimensions is important if we are to feel fulfilled and whole as individuals and communities, both in the absence and presence of disease!

Six Dimensions of Health and Well-being

This report, along with all the work of the Providence Institute for a Healthier Community, is organized around Six Dimensions of Health™ based on foundational work of the Institute in community based participatory research in 2015, listening to and learning how communities define health and well-being. Each Dimension of your community's health influences, impacts, & contributes to other Dimensions and overall well-being. Well-being is dynamic.

Demographics

Gender Identity	%
Male	48%
Female	50%
Self-describe	1%
Refused	0%

Age	%
NET: 18-34	*28%*
18-24	9%
25-34	18%
NET: 35-54	*34%*
35-44	18%
45-54	16%
NET: 55+	*35%*
55-64	17%
65-74	11%
75 or older	7%
Refused	3%

Ethnicity	%
American Indian or Alaska Native	5%
Asian or Pacific Islander	9%
Black or African American	5%
White or Caucasian	79%
Hispanic or Latino	4%
Other	2%
Refused	3%

Household	%
Single, living alone or with other adults	25%
Couple with no children at home	28%
Single with children at home	4%
Couple with children at home	33%
Three generations in household	3%
Other	6%
Refused	1%

Employment	%
NET: Employed	*63%*
Employed full time	56%
Employed part time	7%
NET: Not employed	*35%*
Not currently employed	11%
Student	5%
Retired	19%
Refused	2%

Income	%
NET: Less than $50k	*20%*
Less than $25,000	8%
$25,000-$49,999	12%
NET: $50k-$99.9k	26%
$50,000-$74,999	13%
$75,000-$99,999	13%
NET: $100k+	*49%*
$100,000-$124,999	10%
$125,000-$149,999	10%
$150,000-$199,999	12%
$200,000 or more	16%
Refused	5%

Education	%
Did not finish high school	7%
High school diploma / GED	23%
Vocational / Technical school	11%
Some College	24%
NET: College Grad+	*35%*
Bachelor's Degree	23%
Graduate School	12%
Refused	0%

Sample Size	n=
2024	686

Defining the Measures: Glossary of Terms

1. **CORE4™ Measures**

   CORE4™ Well-being Index (grade average): 1 metric, linked to Core4™ satisfaction indicators

   CORE4™ Well-being Measure Scores (averages for each): 4 key satisfaction Indicators, that together inform the Index The four key satisfaction question are: satisfaction with life, overall-wellbeing, physical health and mental/emotional health.

   CORE4™ Well-being Segments: The distribution of our community's well-being, based on how each person answered each of the Core4

2. **CAN-DO™ Scores:** Capacity & Motivation to improve
3. **Six Dimensions of Health:** Indicators across six dimensions of health
4. **What It Takes for Communities to Flourish:** Indicators across the six dimension that most impact overall well-being (CORE4 Well-being Index)
5. **Topical Question(s):** Additional questions that that dive deeper into a current issue or need
6. **One Thing Make Your Life Better Word Cloud:** A visual compilation of text answers to 'one thing that would make your life better'.

Snohomish County Core4 ™ Well-being Index and Individual Core4 ™ Measures Trend up for the first time since 2021

After several years trending down due to pandemic-related fatigue, the Snohomish County Core4 Index score trended up for this first time since 2021.

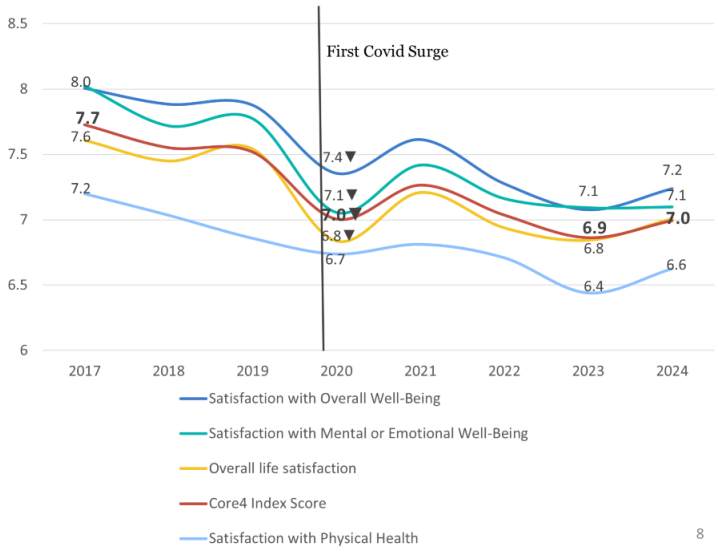
The Core4 score inched back up after falling to a post-pandemic low last year.

As has been the case most years, Snohomish County residents expressed the most satisfaction with their Overall Well-Being this year and the least with their Physical Health.

All four measures, trended back up after hitting all-time lows last year.

The Core4™ Index Score *is an average of satisfaction across four well-being areas: Life, Mental and Emotional Well-Being, Physical Health, and Overall Well-Being.*

▲▼ arrows signify statistically significant difference from previous year



Fewer are "Struggling" this year, but fewer are also "Flourishing"

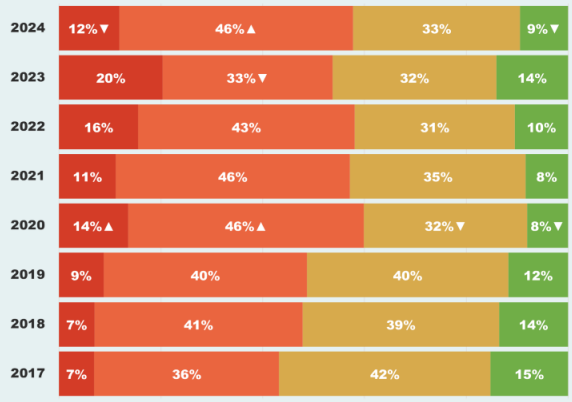
The number in the community who are Struggling and Flourishing slowed this year, halting the trend towards the post-pandemic "shrinking middle."

There was a significant increase in the mixed category, with levels almost identical to 2021, the most hopeful year, post-pandemic.

Segments are derived from ratings of the Core4 measures: Life, Mental and Emotional Well-Being, Physical Health, and Overall Well-Being.

Well-Being Segments Trends

Averages on 0-10 scale, where 10=completely satisfied



▲▼ arrows signify statistically significant difference from previous year

Financial security and a sense of purpose and meaning impact well-being across *all segments*. Most look for improvements in community as place to raise children or grown old. Struggling are most likely to face barriers to basic needs (healthcare, money for bills) and physical health. Mixed are most likely to face challenges with affordable housing. Doing Well are concerned with healthcare access. Flourishing crave more recreation time and better family relationships.

Who is Struggling in our Community?

- *12% of community*; East County (28%).
- About a 1/3 in each lower, middle and older categories, within averages.
- Most are single/living alone or with other adults, or couples with kids.
- Most have high school or bachelor's, w/higher unemployment 45% employed FT, more part-time employment (12%), lower incomes.
- Racial demographics at average.

Who is Mixed in our Community?

- *46% of community*; Central (26%) or South County (25%).
- About a 1/3 each lower, middle and older, significantly more 18-24.
- Similar household make-up as struggling.
- Average high school, some college or bachelors' w/ slightly higher unemployment, 54% employed FT, slightly more students (7%), average income, (significantly more 200K+).
- Racial demographics at average.

Who is Doing Well in our Community?

- *33% of community*; Central /Central Coast (31%).
- More than average age 55+.
- Most couples without kids at home (significantly more) or couple with kids.
- Most have some college or bachelor's education, fewer unemployed, 61% employed FT, slightly more retired, average income, (significantly more 100k -124K).
- Racial demographics at average.

Who is Flourishing in our Community?

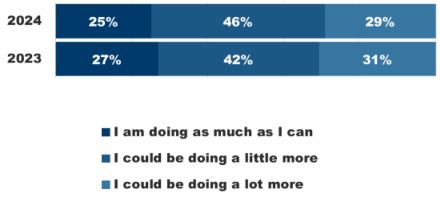
- *9% of the community*; East (28%), significantly more in Central/S. East (23%).
- Most ages 35-54, significantly more between 35-44.
- Most (50%) couples with kids.
- Higher than average college 4+, most have bachelor's, least unemployed, 67% employed FT, slightly more retired, higher incomes (significantly more 150K-199K).
- Racial demographics at average.

Motivation to change has also increased slightly

Most (75%) Snohomish residents report "a little" or "a lot" more capacity to change their health habits for the better. This is up directionally from the 73% who said the same in 2023.

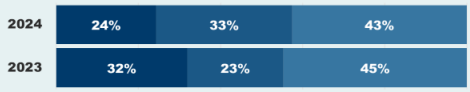
Individual Can-Do

When it comes to maintaining or improving your health, which of these statements best describes you. (16)



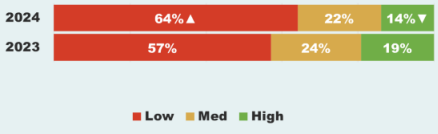
Can-Do Among Those Struggling

Among those who are Struggling, openness to change has increased from 2023, with 76% open to making changes, vs. 68% in 2023.



Community Efficacy

However, community efficacy trended down, with only a third (36%) feeling they can make a significant impact on the community (vs. 43% in 2023).



▼▲ arrows signify statistically significant difference from previous year

Overall, physical health, emotional health, and sense of purpose and meaning are key to well-being

Three areas rise to the top as having the most potential positive impact on community well-being. These include improvements to:

•Physical Health

Physical health remains a key driver of well-being, and an area where residents continue to struggle - only 1 in 5 rates their physical health highly;

•Mental / Emotional Health

The proportion who rate their mental and emotional health highly remains well below pre-pandemic levels;

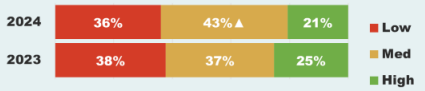
•Sense of Purpose and Meaning

A second measure of mental health, having a sense of purpose and meaning also remains well below pre-pandemic levels.

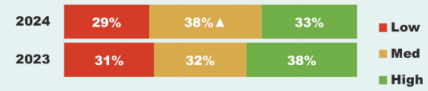
Note: This was the first year that Relationships and Social connections was not part of the top three indicators. Replaced by Purpose & Meaning (3), Financial Security (4), and then Relationships (5).

The top three indicators that are the most likely to influence your overall Core4 Index Score span across the 6 dimensions of health. See page 15 (How Your Community Can Flourish) for how additional indicators stack up and interplay across the six-dimensions of health

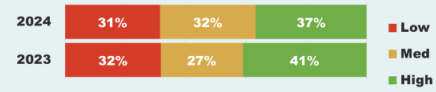
State of Physical Health



State of Mental/Emotional Well-being



Sense of Purpose and Meaning

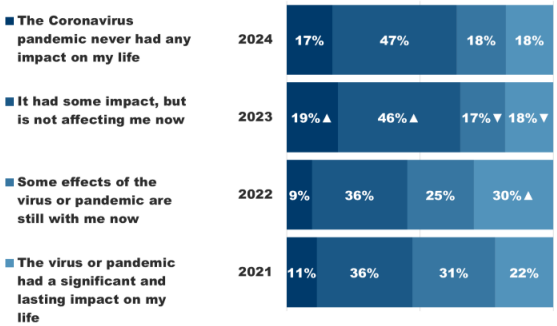


▼▲ arrows signify statistically significant difference from previous year

Tailored Questions

Perceived impact and severity of Coronavirus very similar to last year

- 83% report the Coronavirus has had or still has some impact.
- About half (46%) say the Coronavirus has had an impact, but not now.
- 18% say that the Coronavirus is still impacting their lives.

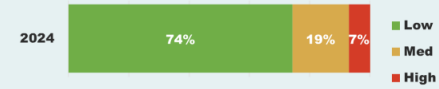


Social media are not widely used to stay in touch with others

- Social media contact: Fewer than 1 in 5 (18%) regularly uses social media to stay in touch with family and friends; more than half (58%) say their use of social media to stay in touch is low.

Feelings of isolation from others touches some

- Feeling of isolation: A quarter (25%) of residents reports a medium or high sense of isolation from others.



▼▲ arrows signify statistically significant difference from previous year

Summary Six Dimension of Health
What Your Community is Telling You

Providence SWEDISH
Providence Institute for a Healthier Community

Relationships & Social Connections

- Relationships continue to suffer post-pandemic: those reporting *strong personal relationships* reached an all-time low (37% vs. 43% in 2023).
- Community connections are also in decline, despite some positive movement last year. Ratings for *feeling like part of a community/belonging* are at all time low and *community efficacy* is also near its lowest point.
- Close to a third continued to experience some type of discrimination (29%), and gender discrimination trended up significantly this year (14%, vs. 9% in 2023).

Mental & Emotional Health

- State of *high emotional health* dipped this year, with more rating themselves in the middle. Levels remain below pre-pandemic ratings.
- Importance of *religion and spirituality* is down slightly this year, continuing a downward trend.
- *Purpose and meaning* showed slight positive movement, although overall trend remains down.

Neighborhood and Environment

- Community satisfaction with *neighborhoods* is similar to last year. While the proportion rating their neighborhood highly dipped a little, most still rate moderate or high, however.
- Ratings of community as a *good place to raise kids* continues to improve, maintaining last year's gains (38% rate high, vs. 36% in 2023, and 28% in 2022).
- Ratings of community as a *good place to grow old* trended down, with fewer in the middle and more reporting low: 24% rate moderate (vs. 29% in 2023), 44% low (vs. 40% in 2023).

Physical Health

- *Physical health* continues to need improvement: those rating their physical health highly reached an all time low (21%). Most rate moderate (43%).
- Like last year nearly 61% of residents ate *fruits and veggies* fewer than 5x/week, however there was some positive movement for those consuming healthy foods 3-4 x/week (27% vs. 24% in 2023).
- *Exercise habits* continued to slightly improve, with 71% reporting at least 3 days of exercise per week, matching an all time high, and there was another significant drop for those reporting no exercise.

Work, Learning & Growth

- After a drop last year, *work satisfaction* is stable. About a third each rate their work satisfaction low, moderate, and highly.
- Perceived *opportunities for learning and growth* are also stable after a drop last year. As with work satisfaction, about a third each rate low, moderate, and highly on this measure. Education remains the top overall stated need (23%).
- Positive movement: *Job insecurity* dropped to 14%, down from 19% in 2023.

Security & Basic Needs

- *Financial security* moved towards more moderate ratings, although many (44%) still report low levels.
- The *ability to meet basic needs* improved slightly; more rated moderate this year, and fewer low (23% vs. 27% in 2023).
- Fewer (39%, vs. 49% in 2023) reported worries about at least one *basic need*. However, the top five stated needs remain the same: education, healthcare, power & water, job, food.
- *Ability to get medial care/health information* also shifted to the middle. The shift draws from both low and high measures: 27% rate low, 43% high.

Six Dimension of Health
How Your Community Can Flourish

The good news: Your community is telling you that improvements in multiple Dimensions of Health can exert a powerful influence on your community's well-being.

Better news: These are inter-related. Improvement in any Dimension contributes to overall wellbeing *and* is likely to positively influence other areas as well.

Physical Health

- **1st most impactful indicator** of overall well-being: current state of physical health
- Most influenced by state of mental/emotional health.
- Also strongly related to more exercise.
- Additionally, supported by a sense of financial security and opportunities to access medical care information.
- Plus relationship satisfaction has a positive impact.

Mental & Emotional Health

- **2nd most impactful indicator** of overall well-being: Current state of mental/emotional health (*each impacts the other*)
- Most influenced by state of physical health and strongly related to growing relationship with others.
- Also related, ability to get medical care/information and opportunities for learning/growth.
- **3rd most impactful indicator**: Sense of purpose and meaning (*each impacts the other*)
- Highly impacted by work/job satisfaction.
- Strongly related to relationship satisfaction and community belonging.
- Also, religion/spiritualty plays a role.

Security & Basic Needs

- **4th most impactful indicator** of overall well-being: Financial security (*each impacts the other*)
- Strongly related to job satisfaction and opportunities for learning and growth.
- Additionally, better neighborhood quality and improved state of physical health are impactful.
- **7th most impactful indicator** of overall well-being: Ability to meet basic needs (*each impacts the other*)
- Strongly influenced by access to medical care/health information and opportunities for learning & growth.
- Additionally, supported by good neighborhood quality and improve emotional well-being.

Relationships & Social Connections

- **5th most impactful indicator** of overall well-being: Relationships with other people
- Most influenced by community belonging and a strong sense of purpose and meaning.
- Additionally, impacted by less isolation from others and emotional well-being.
- Plus, ability to access medical care/health information has positive impact.

Work, Learning & Growth

- **6th most impactful indicator** of overall well-being: Work or job satisfaction
- Most influenced by opportunities for learning and growth (8th impact on overall well-being).
- Strongly related to a sense of financial security and purpose and meaning.
- Additionally, supported by relationship satisfaction and community efficacy.

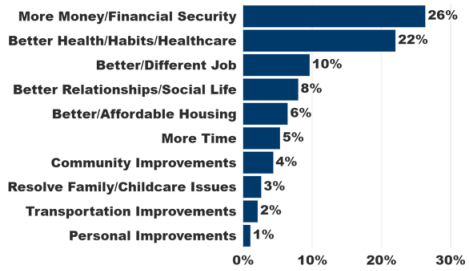
Neighborhood and Environment

- Important in overall well-being, especially impacted by relationships with other people, ability to meet basic needs, and financial security.
- Also, supported by neighborhood quality.
- And, good community environments for children and seniors have a positive impact.

"One Thing..."

Before asking specifics about respondent's health and well-being, we asked them to tell us, in their own words, the "one thing" that would make their lives better. We coded the responses into categories:

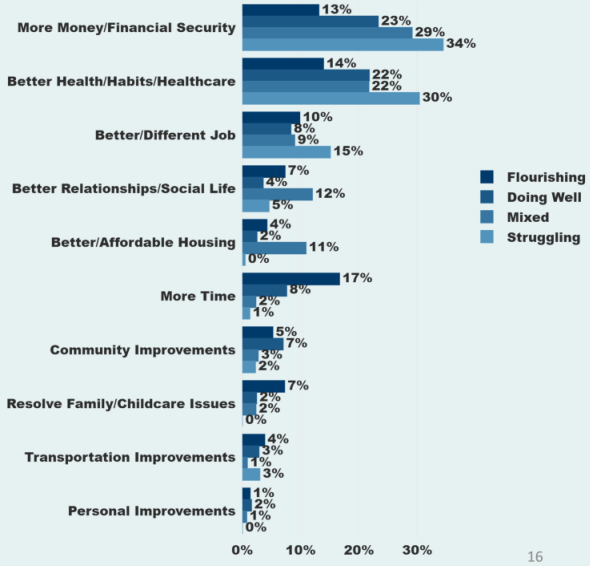
If you were to name one thing that would make your life better, what would that be?



Key Findings

- A quarter of respondents cite More Money/Financial Security and Better Health/Habits/Healthcare as the top areas that would make the most difference to their lives.
- However, issues related to money and health are more relevant to those Struggling/Mixed/Doing Well than to those Flourishing. Respondents who are Flourishing are most likely to cite More Time as their "one thing."

"One Thing..." by Well-being Level



"One Thing..." Detailed Responses

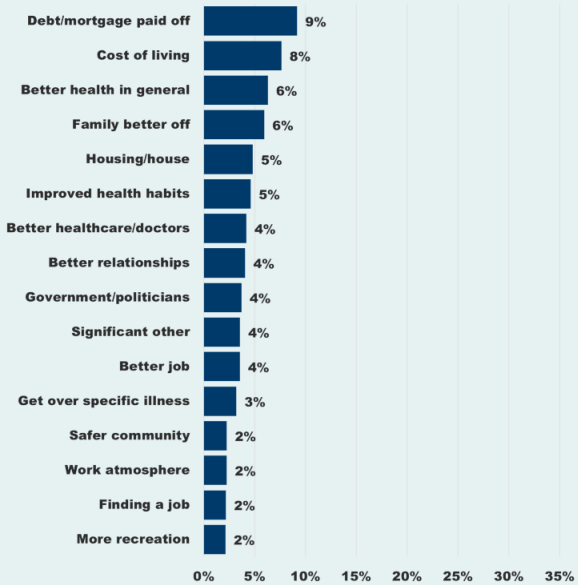
If you were to name one thing that would make your life better, what would that be?

Key Findings

The top specific items that residents cite as having the most direct impact on improving their lives are:

- Debt/mortgage paid off;
- Changes to the cost of living;
- Better health in general;
- Family better off;
- Better or different housing; and
- Improved health habits.

"One Thing..." Detailed Answers



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Core4 ™ Scores, Well-being Segments, and Can-Do Charts

Core4 ™ Scores
Well-being Segments Overview
Can-Do – Individual and Community Efficacy
Well-being Segments Full Summaries

Core4 Well-being Index Score

The Core4™ are measures of satisfaction across four well-being areas.

Scores are averaged across these four measures to create the composite score below.

Core4 Index Score: C-

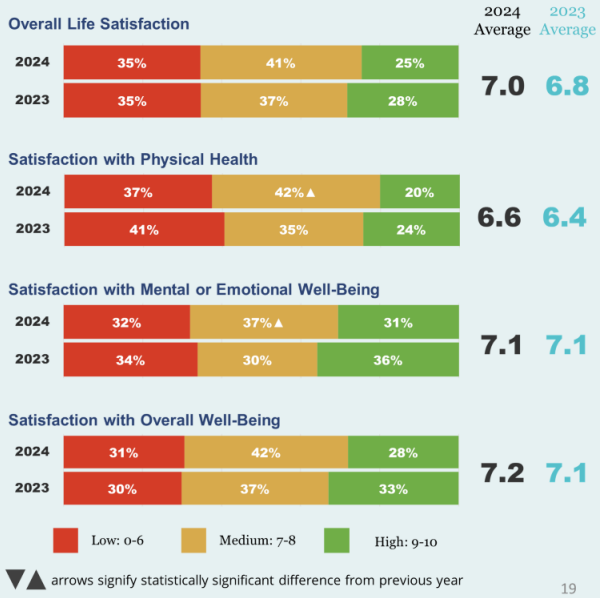
Key Influences

These measures are the most likely to impact your overall Core4 Index Score. They span across the 6 dimensions of health and well-being and are in rank order:

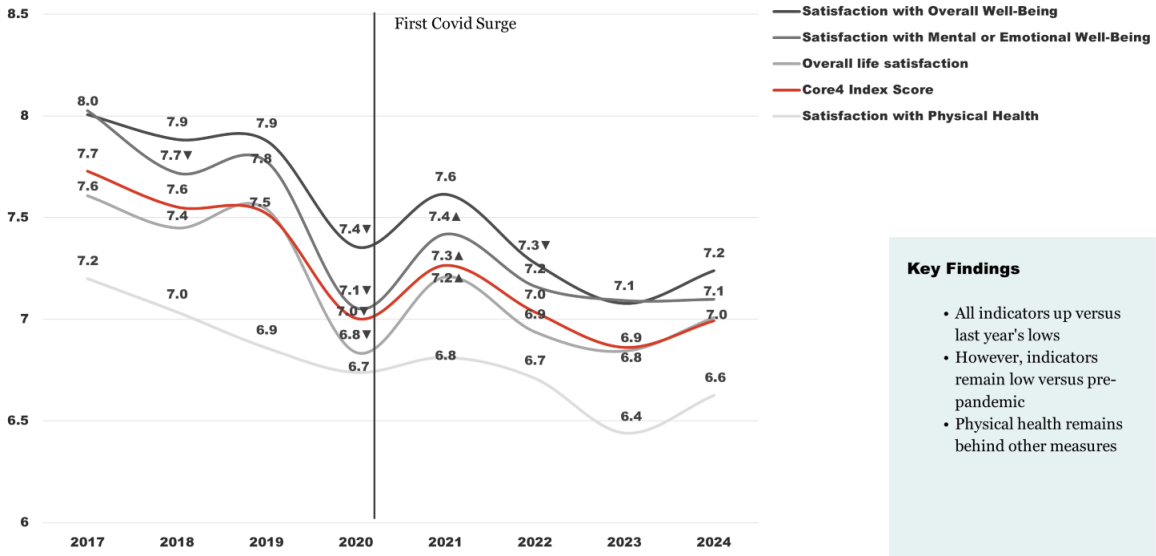
- Current State of Physical Health (PH)
- Current State of Mental/Emotional Health (MES)
- Sense of Purpose and Meaning (MES)
- Financial Security (SBN)
- Relationship Satisfaction (RSC)
- Work or Job Satisfaction (WLG)
- Ability to Meet Basic Needs (SBN)
- Opportunities for Learning and Growth (WLG)

Core4 Well-being Score:

Averages on 0-10 scale, where 10=completely satisfied



Core4 Trends



Key Findings

- All indicators up versus last year's lows
- However, indicators remain low versus pre-pandemic
- Physical health remains behind other measures

Well-being Segments

The HWBM Well-being segments give a picture of how each member of your community is doing across all four Core4 measures.

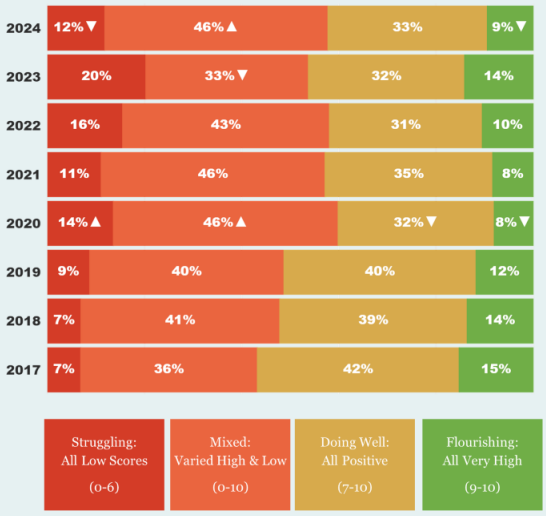
- People who score highest (9-10) on all four are FLOURISHING.
- Those whose scores are all positive (7-10) are DOING WELL.
- People with a mix of lower and higher scores (0-10) are MIXED.
- People whose scores are all low (0-6) are STRUGGLING.

Key Findings

- Middle has rebounded. Movement is again at both ends, but this year we see fewer Struggling and Flourishing;
- The proportion who are Mixed (46%) remains the largest segment and rebounded after dropping off last year (33%);
- As we have seen since 2020, more in the community are Struggling or Mixed (58%) rather than Doing Well or Flourishing (41%).

Well-Being Segments Trends

Averages on 0-10 scale, where 10=completely satisfied



▼▲ arrows signify statistically significant difference from previous year

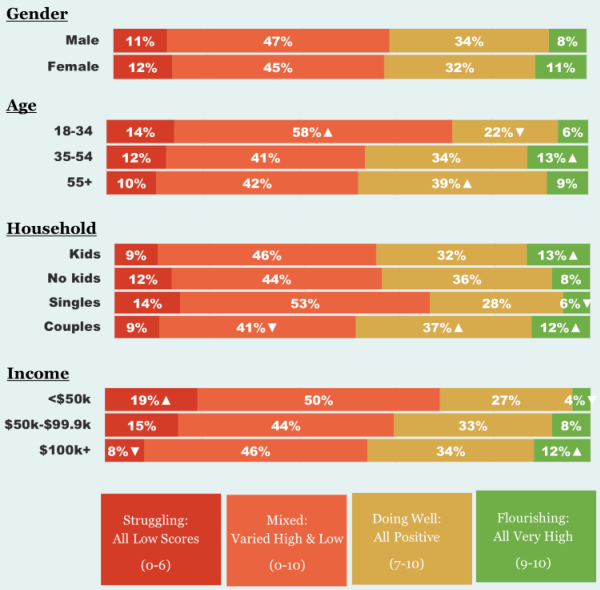
Well-being Segment Demographics

The HWBM Well-being segments differ across demographic characteristics in the Snohomish County community. Understanding these demographic characteristics can help you to better target groups most in need of help or additional resources.

While we can identify trends across demographics and well-being segments, it is important to note that some portion of each demographic falls into each segment. However, these profiles provide a good overview of who is most likely to be Flourishing, Doing Well, Mixed, and Struggling.

Key Findings

- **FLOURISHING.** Most likely to be Flourishing in Snohomish County include those age 35-54, couples, those with kids, and higher income residents ($100k+).
- **DOING WELL.** Those most likely to be Doing Well include age 55+, couples, and those earning $50k+ per year.
- **MIXED.** Among those most likely to Mixed are residents ages 18-34, singles, and lower income earners (<$50k).
- **STRUGGLING.** Similarly, those Struggling are most likely younger (18-34), singles, and lower income earners.

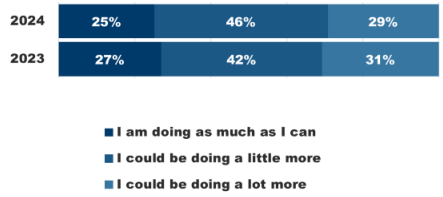


▼▲ arrows signify statistically significant difference from others not in group

Individual Can-Do

Your Can-Do™ score gives insights into your community's current CAPACITY to improve well-being and MOTIVATION to change. Capacity is the % of respondents who say they can be doing more to improve their health. Motivation is indexed by the percentage who say they can do "a little more" or "a lot more."

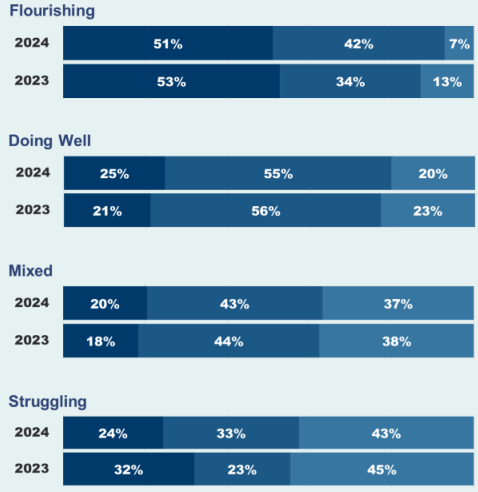
When it comes to maintaining or improving your health, which of these statements best describes you. (16)



Key Findings

- The capacity to change remains strong in Snohomish County: 75% of residents say they could be doing more to maintain or improve health.
- At least half in each segment report at least some capacity to change, and motivation remains highest among those Struggling and Mixed.

Can-do by Well-being Level



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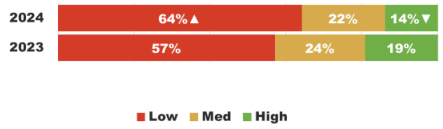
Community Efficacy

Community Efficacy is an individual's belief that they can influence well-being on a community-level.

While, Can-Do provides insights into respondents' capacities to improve their individual well-being.

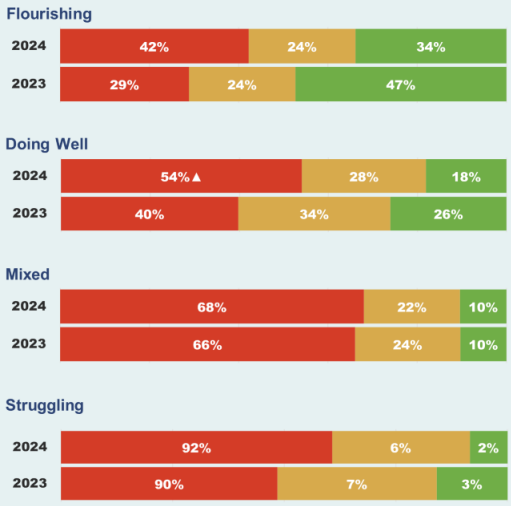
Community Efficacy



Key Findings

- Community efficacy trended back down this year after recovering in 2023 from an all-time low in 2022.
- Community efficacy was down in all segments but decreased the most versus last year among those Doing Well and Flourishing.

Community Efficacy by Well-being Level



▼▲ arrows signify statistically significant difference from previous year

Who is Struggling in our Community?

Core4 Well-Being Score
3.8▼ (F)

Proportion of Community
12%

Demographics

- This year, many Struggling demographics are close to average. Age shifted to include more older residents, more residents with advanced degrees, and more Caucasians than last year. However, this segment continues to suffer more unemployment, and lower incomes than average.

Well-Being & Capacity for Change

- Struggling score low across all indicators of well-being. Their Core4 score remains the lowest of all groups: 3.8 – an F. Although, they are the most likely to indicate they can do "a lot more" to maintain or improve health. This segment reports the least amount of social media use to connect with others.

How to Improve Well-Being

- Along with **higher unemployment** and **lower income**, this group is the most likely to face challenges with basic needs like health care (50%), power and water (43%), job (32%), or food (25%). Those Struggling also report **greater discrimination**, especially about age or ability.
- Areas with the greatest opportunities for improvement on well-being among the Struggling population are:
  - **Improved ability to meet basic needs like health care, money for bills, job support and training, food access, and personal safety.**
  - **Sense of belonging and community efficacy.**
  - **Improvements in state of physical health, including nutrition and exercise.**

Struggling

All Low Core 4 Scores (0-6)

Capacity for Change (Can-Do)
43%▲ - I Can Do A lot More
33% - I Can Do A Little More
24% - Doing All That I Can

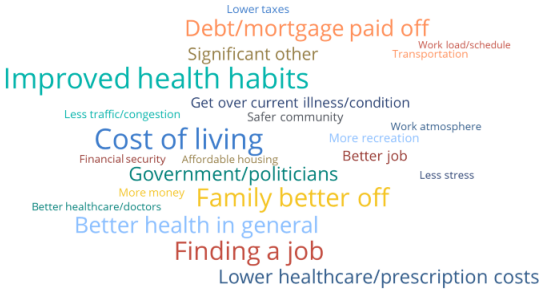
Gender		Age		Employment		Yearly Income	
Men	46%	18-34	33%	Employed	57%	<$50k	32%▲
Women	53%	35-44	36%	Not employed	21%▲	$50k-$99.9k	33%
Self-Describe	<1%	55+	31%	Student	2%	$100k+	33%▼
				Retired	18%		

Race		Region		Household		Education	
Caucasian	79%	North Coast/N. East	17%	Single no kids	33%	No high school	8%
Black	3%	Central/Central Coast	21%	Couple no kids	21%	High school	31%
Asian/PI	9%	South/South Coast	19%	Single w/ kids	1%▼	Vocational	10%
Native Am.	3%	Central/S. East	15%	Couple w/kids	27%	Some college	19%
Hispanic	1%	East	28%	Multi-gen	2%	College+	32%

Coronavirus Impact – Strong: 40%▲ report Coronavirus is having a lasting impact on their lives (vs. 18% on avg.), and another 22% say some effects are still with them

"One Thing..." among those Struggling

If you were to name one thing that would make your life better, what would that be?



Key Findings

- Those Struggling cite changes to the "cost of living, "improved health habits," "family better off," and "finding a job" as the top specific areas that could improve their lives.

"One Thing..." Detailed Answers among Struggling

Who is Mixed in our Community?

Core4 Well-Being Score
6.4 ▼ (D)

Proportion of Community
46%

Demographics

- Those Mixed in our community are largely Caucasian and younger than average. Unemployment is also higher than average. Education levels and income are at average, for those that do report higher income, significantly more report 200k+.

Well-Being & Capacity for Change

- Mixed score below average on the Core4 Well-Being Index (6.4, a D). There is much capacity for change within this group: Most can do a lot (37%) or a little (43%) more to improve their health and well-being. This segment reports significantly **more feelings of isolation** and have **higher rates of gender discrimination** than average.

How to Improve Well-Being

- Improvements in meeting basic needs are significant: 42% report at lease one need, especially in **education to improve job/income**.
- In addition, areas most with greatest opportunities for improvement on well-being among the Mixed population include:
  - **Support meeting specific needs, especially, education, healthcare, paying bills and affordable housing.**
  - **Sense of belonging and community efficacy.**
  - **Improvements in community supports for both kids and older adults.**

Mixed

Varied Low & High Core4 Index Scores (0-10)

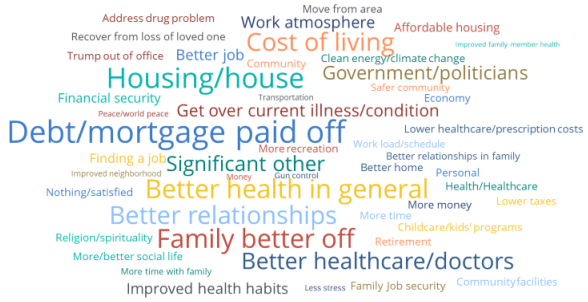
Capacity for Change (Can-Do)
37%▲ - I Can Do A lot More
43% - I Can Do A Little More
20%▼ - Doing All That I Can

Gender		Age		Employment		Yearly Income	
Men	50%	18-34	35%▲	Employed	59%	<$50k	22%
Women	49%	35-44	31%	Not employed	15%▲	$50k-$99.9k	25%
Self-Describe	1%	55+	32%	Student	7%	$100k+	49%
				Retired	16%		
Race		**Region**		**Household**		**Education**	
Caucasian	81%	North Coast/N. East	17%	Single no kids	30%	No high school	8%
Black	4%	Central/Central Coast	26%	Couple no kids	22%▼	High school	26%
Asian/PI	9%	South/South Coast	25%	Single w/ kids	4%	Vocational	10%
Native Am.	7%	Central/S. East	12%	Couple w/kids	33%	Some college	24%
Hispanic	3%	East	21%	Multi-gen	3%	College+	32%

Coronavirus Impact – Broad, but Waning: Nearly all (87%▲) say the pandemic has had an impact (vs. 83% on avg.), but nearly half (44%) report it is no longer having an impact

"One Thing..." among those Mixed

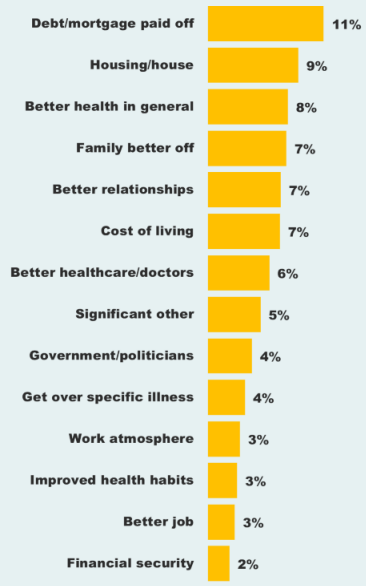
If you were to name one thing that would make your life better, what would that be?



Key Findings

- The top items those Mixed give as having the potential to improve their lives are "debt/mortgage paid off," better or different "housing," and "better health in general."

"One Thing..." Detailed Answers among Doing Well



Who is Doing Well in our Community?

Core4 Well-Being Score 8.3▲ (B)

Proportion of Community 33%

Demographics

- Residents who are Doing Well in our community are older than average and are more likely to reside as part of a couple with no kids. Like the average, most have some college or a college degree, but unemployment is lower than average. Those Doing Well are also at average across racial categories.

Well-Being & Capacity for Change

- Those Doing Well score higher than average across indicators of well-being and have an average Core4 score of 8.3 (B). There remains room for improvement, and some capacity for change: More than half say they can do a little more (55%).

How to Improve Well-Being

- Those Doing Well are more financially stable but have significantly more moderate incomes (more 100K-125K) than mixed or flourishing. **Helping to maintain and improve financial security** is important. A third (32%) still reported specific needs, most notably **support for education for a better job and healthcare access.**
- In addition, areas most with greatest opportunities for improvement on well-being among the Doing Well population are:
  - **Relationships with other people.**
  - **Access to physical activity opportunities.**
  - **Sense of community belonging and efficacy.**

Doing Well

Varied Positive Core 4 Scores (7-10)

Capacity for Change (Can-Do)

20%▼ - I Can Do A lot More
55%▲ - I Can Do A Little More
25% - Doing All That I Can

Gender		Age		Employment		Yearly Income	
Men	50%	18-34	18%▼	Employed	68%	<$50k	17%
Women	49%	35-44	35%	Not employed	3%▼	$50k-$99.9k	26%
Self-Describe	1%	55+	42%▲	Student	5%	$100k+	51%
				Retired	23%		
Race		**Region**		**Household**		**Education**	
Caucasian	76%	North Coast/N. East	16%	Single no kids	19%▼	No high school	6%
Black	8%	Central/Central Coast	31%	Couple no kids	39%▲	High school	18%
Asian/PI	8%	South/South Coast	18%	Single w/ kids	6%▲	Vocational	12%
Native Am.	4%	Central/S. East	17%	Couple w/kids	29%	Some college	28%
Hispanic	4%	East	18%	Multi-gen	4%	College+	36%

Coronavirus Impact – Moving On: More than half (55%▲) report Coronavirus is no longer impacting them (vs. 47% on avg.) and only 22%▼ report lingering effects (vs. 36% on avg.)

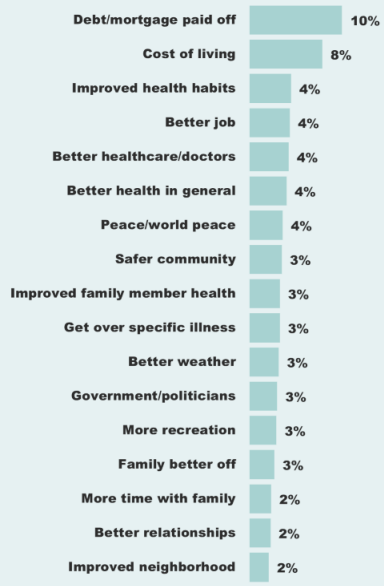
"One Thing..." among those Doing Well

If you were to name one thing that would make your life better, what would that be?

Key Findings

- The top items those Doing Well cite as having the potential to improve their lives are "debt/mortgage paid off" and changes to the "cost of living."

"One Thing..." Detailed Answers among Doing Well



Who is Flourishing in our Community?

Core4 Well-Being Score 9.7▲ (A+)

Proportion of Community 9%

Demographics

- Those Flourishing in our community are primarily aged 35+, have higher incomes, are more likely to be college educated, and more likely to live together as a couple. Some 23% live in the Central/South East district (vs. 15% on average).

Well-Being & Capacity for Change

- Flourishing residents report high levels of satisfaction across all areas of well-being. All indicators of well-being are above average as well, and as such the group reports less capacity for change than do others: Half (51%) says they are doing all they can. Flourishing report the most social media use for connection and significantly less feelings of isolation.

How to Improve Well-Being

- Although those who are Flourishing report the highest levels of well-being in our community, there are areas that for improvement that may help ensure longer-term well-being. Many (10%) cite the need for **education support for a better job**. Many say they could use **more recreation time and better family relationships.**
- In addition, areas most with greatest opportunities for improvement on well-being include among the Flourishing population are:
  - **Sense of community efficacy and belonging.**
  - **Improvements in community supports, especially for growing old, but also raising kids.**
  - **Security about financial future.**

Flourishing

All High Core 4 Scores (9-10)

Capacity for Change (Can-Do)

7%▼ - I Can Do A lot More

42% - I Can Do A Little More

51%▲ - Doing All That I Can

Gender		Age		Employment		Yearly Income	
Men	41%	18-34	18%	Employed	73%	<$50k	8%▼
Women	58%	35-54	46%▲	Not employed	1%▼	$50k-$99.9k	22%
Self-Describe	1%	55+	32%	Student	2%	$100k+	61%▲
				Retired	23%		
Race		**Region**		**Household**		**Education**	
Caucasian	80%	North Coast/N. East	15%	Single no kids	16%▼	No high school	0%
Black	6%	Central/Central Coast	22%	Couple no kids	29%	High school	17%
Asian/PI	9%	South/South Coast	12%	Single w/ kids	1%	Vocational	12%
Native Am.	3%	Central/S. East	23%▲	Couple w/kids	50%▲	Some college	21%
Hispanic	7%	East	28%	Multi-gen	2%	College+	51%▲

Coronavirus Impact – Sprinting Past: Most (83%▲) report Coronavirus never had impact or is no longer affecting their lives (vs. 64% on avg.)

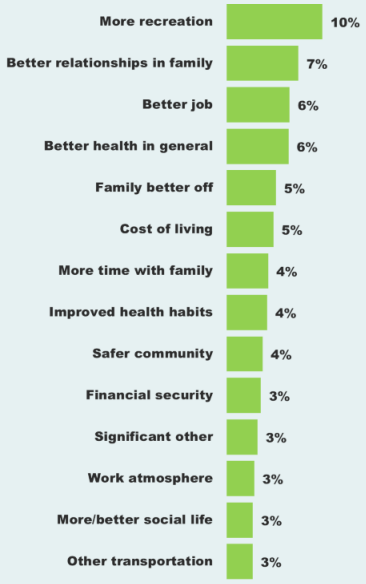
"One Thing..." among those Flourishing

If you were to name one thing that would make your life better, what would that be?

Key Findings

- "More recreation time," "better relationships within the family," a "better job," and "better health in general" are given most often as the areas that could most improve the lives of those Flourishing.

"One Thing..." Detailed Answers among Flourishing



Providence SWEDISH

Providence Institute for a Healthier Community

Six Dimension & Tailored Questions

Current year benchmarks and trend averages

- Relationship rating (q6g)
- Sense of community belonging (q7e)
- Community efficacy (q7c)

Relationships & Social Connections

Healthy relationships are vital to health. Strong family ties, friendships, and partnerships can increase our sense of security, self-esteem, and belonging and provide a buffer against stress, anxiety, and depression. Low social connection is linked to declines in physical health, healing and mental health.

How Your Community Can Flourish

In 2024, relationships with other people continue to have a **strong impact on overall well-being, ranking 5th across all indicators.** Relationships also have a strong impact on both Physical and Mental health, the top indicators of well-being.

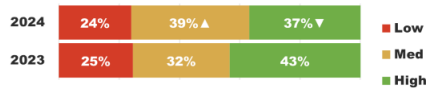
Key indicators with the strong impact on Relationships/Social Connections: sense of purpose and meaning, ability to get medical care, current emotional state, feeling like part of a community, and lack of isolation from others.

Well-being Segment Impacts: Struggling report the most disparity from other well-being segments in feeling like part of a community, followed by relationships with other people. The same is true for those mixed, when compared to those doing better. Mixed, doing well, and flourishing have the lowest overall ratings in this category for community efficacy, struggling for community belonging.

Key Findings

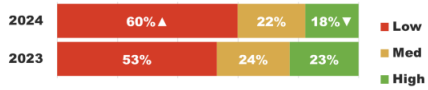
High relationships satisfaction with other people are in decline.

- Personal relationships: Relationships continue to suffer post-pandemic: the proportion reporting strong personal relationships trended down this year to reach an all-time low (37%).



Community connections are also in decline despite some positive gains last year.

- Part of a community/sense of belonging: Fewer than 1 in 5 (18%) report a robust sense of community connections, a low for this measure. More than half rate low (60%).



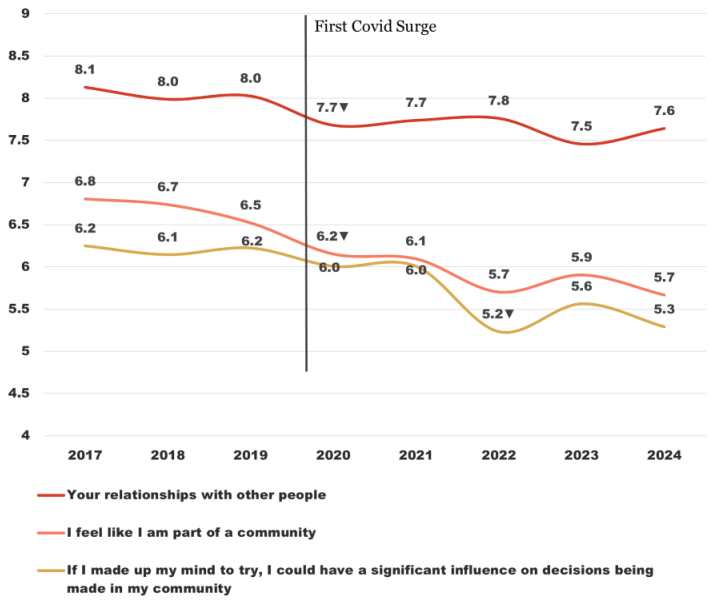
- Community efficacy: Resident's rating of their ability to make a difference in their communities also remained well below pre-pandemic levels, with two-thirds rating low this year (64%).

▼▲ arrows signify statistically significant difference from previous year

Relationships and Social Connections Trends

Personal relationships, community connections, and community efficacy continue to be strained post-pandemic

- Averages remain well below those measured pre-pandemic, and even after the first full COVID year (2021).



- Discrimination (10)
- Frequency of discrimination(10.1)

Discrimination

The impact of discrimination on well-being can be significant and detrimental on our health. Mental health, relationships, and physical health impacts include stress, anxiety, depression and chronic diseases. It can also erode confidence and a sense of belonging. Security and basic needs impacts include limiting opportunities to education, housing, employment and healthcare. It is crucial to address and combat discrimination in order to promote equality, inclusivity and overall well-being.

How Your Community Can Flourish

Promote relationships and interactions with other people. Offer opportunities for learning and growth.

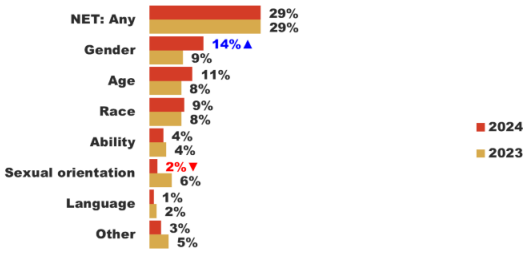
Those most impacted by discrimination are those struggling and mixed. Struggling report higher than average rates of discrimination in age and ability; those mixed report higher than average rates in gender. Age, gender and race are the top 3 reported areas of perceived discrimination for those struggling; for mixed it is gender, age and race.

For those 18-35, overall reported discrimination (45%) is higher than for nearly all other demographic groups. Middle income report a significant increase in age discrimination (16%, vs. 9% in 2023); Caucasians show a significant increase in gender discrimination (15% vs. 8% in 2023). BBIPOC report racial discrimination as the top type they experience (24%).

Key Findings

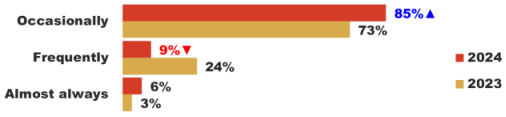
Reported discrimination similar to last year

- As in 2023, 3 in 10 residents (29%) experienced some form of discrimination. However, this year saw an increase in gender-related discrimination, and a decrease in discrimination related to sexual orientation.
- Top 3: Gender (14%); Age (11%); Race (9%)



Discrimination on a "Frequent/Almost Always" basis trended down.

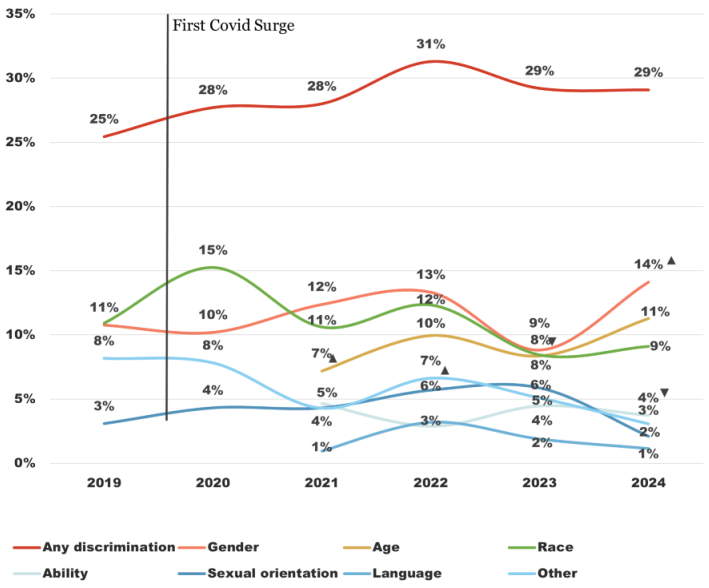
- The proportion reporting discrimination occurring frequently or almost always was down (15% vs. 27% in 2023). Most continued to say discrimination had occurred "occasionally" (85%).



Discrimination Trends

The proportion of residents who experienced some form of discrimination has been relatively steady over time.

Some forms bounced higher this year after all-time lows last year. Especially gender and age. Ability, sexual orientation, language and other all showed declines.



- Emotional Well-being current state rating (q6h)
- Religion/Spirituality importance (q7a)
- Sense of Purpose & Meaning (q7b)

Mental, Emotional & Spiritual Health

Recognizing your own and others' emotions and responding appropriately makes a difference. It is the ability to cultivate positive thoughts, practice self-compassion, express emotions, and consciously choose your responses, including engaging in support systems to help cope. A strong sense of spirituality provides important benefits to health. It is linked with a sense of meaning and purpose which offers a sense of direction, shapes goals, influences behavior, and provides comfort during life's challenges.

How Your Community Can Flourish

Emotional/mental well-being has the **2nd strongest impact on overall well-being;** Purpose and Meaning ranks **3rd.**

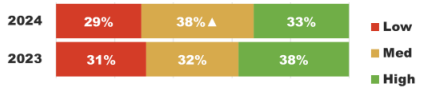
Key indicators with most impact on Emotional/Mental Health**:** Physical health, sense of purpose and meaning, relationships with others, opportunities for learning and growth, and ability to get medical care. **Key indicators** for Purpose and Meaning: mental health, work/job and relationship satisfaction, community belonging, and religion/spiritualty plays a role.

Well-being Segment Impacts: Compared to all other segments, the largest area of disparity for struggling is in current state of mental health. *This is largest gap between those struggling and other segments across all indicators in all dimensions.* Sense of purpose and meaning is also lower for struggling, compared to other segments, and is the top indicator in this category for those mixed, when compared to those doing better. All segments have the lowest overall rating for importance of religion/spirituality.

Key Findings

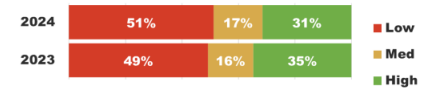
Emotional Health trends back down slightly.

- State of high emotional health dipped this wave, after trending up in 2023.
- More rate themselves in the middle (38%) than last did year (32%).



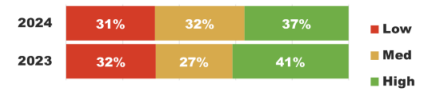
Religion and Spirituality slightly lower than in 2023 and continues overall downward trend.

- Half continue to rate themselves low on religion and spirituality.
- Fewer than a third rate themselves highly.



Purpose and Meaning trend remains down.

- A third continue to rate themselves low on having a sense of purpose and meaning. Only 37% rate high.

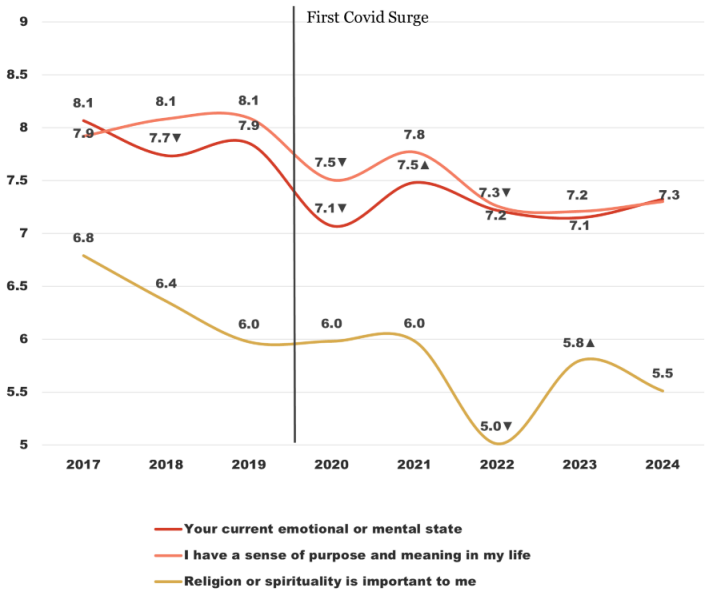


▼▲ arrows signify statistically significant difference from previous year

Mental, Emotional & Spiritual Health Trends

Mental, Emotional, and Spiritual health remains down

- These measures have yet to regain levels measured before 2020 and the first Covid surge.
- Mental/emotional health and sense of purpose and meaning have been flat since 2022.
- Religion/spirituality is trending down overall.



- Neighborhood Quality Rating (6a)
- Cmty Good Place to Raise Kids (8a)
- Cmty Good Place to Grow Old (8b)

Neighborhood & Environment

In important ways, your location defines your health. Safe, connected, walkable neighborhoods with access to nutritional food, good education for children, and human services make it easier to enjoy well-being. Being in nature not only makes you feel better emotionally, it contributes to your physical well-being. It soothes, restores and connects. People who live near parks and natural areas are more physically active, live longer, and these open spaces draw people together, enhancing social connections.

How Your Community Can Flourish

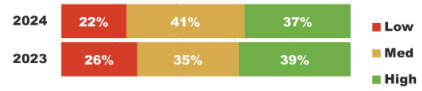
Neighborhood & Environment is less directly impactful on overall well-being than other dimensions. However, **the neighborhood one lives in is strongly predictive of other key well-being measures**, including relationships with other people, the ability to meet basic needs, and financial security.

Well-being Segment Impacts: Compared to all other segments, the most disparity for struggling is in ratings of neighborhood quality for growing old. For mixed, the lowest indicators when compared to doing well/flourishing are neighborhood quality in general and neighborhood quality as a place to raise children. All segments have the lowest overall ratings in this category for community is a good place to grow old.

Key Findings

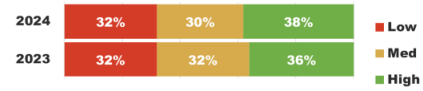
Community satisfaction with neighborhoods similar to last year.

- Most residents continue to rate their neighborhoods high or moderate, although 22% rate low.



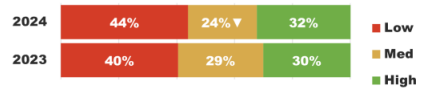
Snohomish County communities continue to improve in being good places to raise children.

- Some 38% rate their communities highly on this measure, maintaining last year's gains from 2022.



Snohomish County communities trend down slightly in being good places to grow old

- Medium ratings were displaced more by low ratings rather than high ones.



▼▲ arrows signify statistically significant difference from previous year

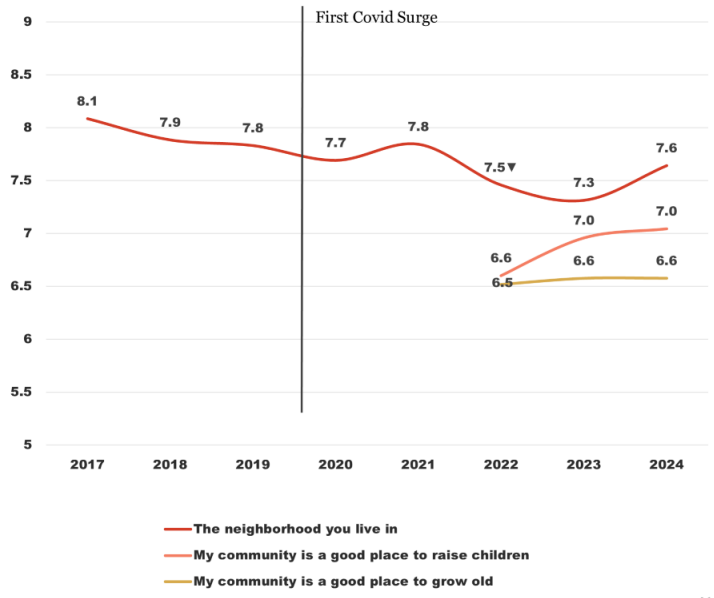
Neighborhood and Environment Trends

Neighborhood quality increased

- Ratings of neighborhood quality increased for the first time since 2021.

Trends for raising children and growing old are stable.

- However, community as a place to grow old is trending towards the end, meaning residents are increasingly likely to have either a "low" or "highly" rated experience, rather than a moderate one.



- Work or Job rating (q6d)
- Opportunities for Learning and Growth (q6g)
- Sense of Purpose and Meaning - *see Mental & Emotional Health* (q7b)
- Job Insecurity/unemployment (q9e)

Work, Learning & Growth

Employment, education and opportunities for personal growth are bedrocks of well-being. Using available resources to develop and create opportunities that resonate with your unique gifts, skills, and talents contributes to meaning and purpose, and helps you remain active and involved throughout life.

Opportunities for ongoing growth brings a sense of purpose and meaning. A work life or career consistent with your personal values, interests, beliefs and balances both work and can contributes greatly to all six dimensions of well-being.

How Your Community Can Flourish

Satisfaction with one's work or job has the **6th highest impact on overall well-being**; opportunities for learning and growth ranks **8th**.

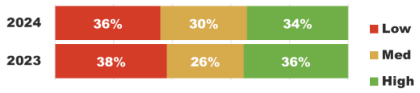
Key indicators with the most impact on job satisfaction**:** opportunities for learning and growth, financial security, relationships with others, sense of purpose and meaning, and community efficacy.

Well-being Segment Impacts: Compared to all other segments the most disparity for struggling is in opportunities for learning and growth. Satisfaction with work/job is the biggest gap in this category among mixed, when compared to those doing better.

Key Findings

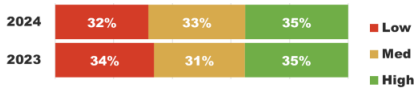
Work satisfaction is similar to last year

- About a third each rate low, moderate, and high job satisfaction.



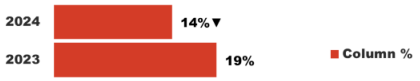
Perceived opportunities for learning and growth also stable

- As with job satisfaction, and third each rate low, medium, and high.
- Education remains top need across *TotalHealth* measures (*see TotalHealth 9*).



Job insecurity down this year.

- Job insecurity trended down significantly to 14%, versus 18% in 2023.



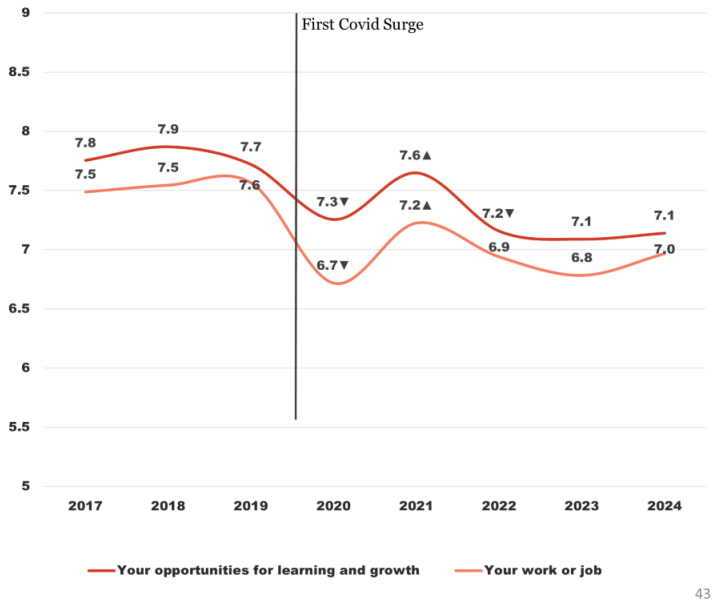
▼▲ arrows signify statistically significant difference from previous year

Work, Learning and Growth Trends

Work/job satisfaction & opportunities for learning and growth trends are flat

- Both measures have been steady, and well below pre-pandemic levels, since 2022.

Additional Work, Learning and Growth Trends Shown in *TotalHealth 9* Trends



- Future financial security (7d)
- Ability to Meet Basic Needs (6e)
- Access to Health Care and Information (6c)

Security & Basic Needs

Having enough, and freedom from worry. We need enough money for food, rent or mortgage, health care, medical bills and basic expenses of daily living. Lack of access to basic needs and personal safety are linked at all stages of life to physical and mental illness, post-traumatic stress, shorter lifespans and poorer quality of life. The experience of others affects you. 2019 Monitor™ research found that overall community well-being was measurably lower for ALL where rates of homelessness are higher. Research shows that 'extras' don't really contribute to our well-being-unless it is for fun activities and friends, or expenses that match our values.

How Your Community Can Flourish

Financial security has the **4th highest impact on overall well-being**; ability to meet basic needs ranks **7th.**

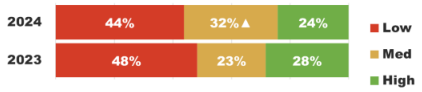
Key indicators with the most impact on financial security**:** Ability to meet basic needs, work or job satisfaction, opportunities for learning and growth, neighborhood quality, and physical health. **Key indicators** with impact on ability to meet basic needs: financial security, access to medical care/health information, opportunities for learning & growth. Also neighborhood quality and mental health.

Well-Being Segment Impacts: Compared to all other segments, the most disparity for struggling is in ability to meet basic needs and financial security. These are among the biggest gaps for struggling across all indicators across all dimensions. The biggest gap between mixed and those doing well/flourishing is in financial security, followed by ability to get medical care and health information. All segments have the lowest overall ratings in this category for financial security.

Key Findings

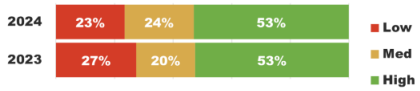
Financially security trends toward the middle.

- A third now report medium levels of financial security (32%), versus a quarter in 2023 (23%).
- The shift towards the middle pulls equally from the proportion rating both low and high in this measure.



The ability to meet basic needs improved slightly, with more moderate ratings reported this year.

- Like last year, half (53%) rate the ability to meet basic needs highly.
- However, more rate moderate this year (24%, vs. 20%) than low (23%, vs. 27%).



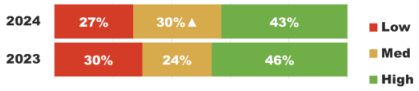
▼▲ arrows signify statistically significant difference from previous year

- Future financial security (7d)
- Ability to Meet Basic Needs (6e)
- Access to Health Care and Information (6c)

Security & Basic Needs

Ability to get medical care and information shifts to the middle.

- Nearly a third (30%) in 2024 report a moderate ability to find medical care and information, up from 24% in 2023.
- The shift towards the middle draws equally from the proportion rating themselves as low and high on this measure.



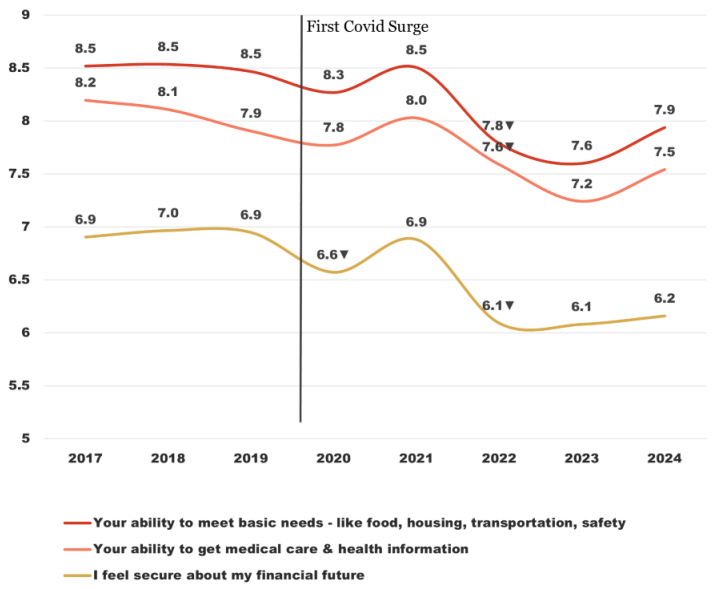
▼▲ arrows signify statistically significant difference from previous year

Security and Basic Needs Trends

Security and basic needs remain well below pre-pandemic levels.

- However, the ability to meet basic needs and the ability get medical care and information regained ground lost in 2023.

Additional Security and Basic Needs Trends Shown in *TotalHealth 9* Trends



Total Health 9

39% reported worries around basic needs, down significantly from 2023, when 49% reported worries about basic needs.

The proportion reporting needs in many areas also decreased.

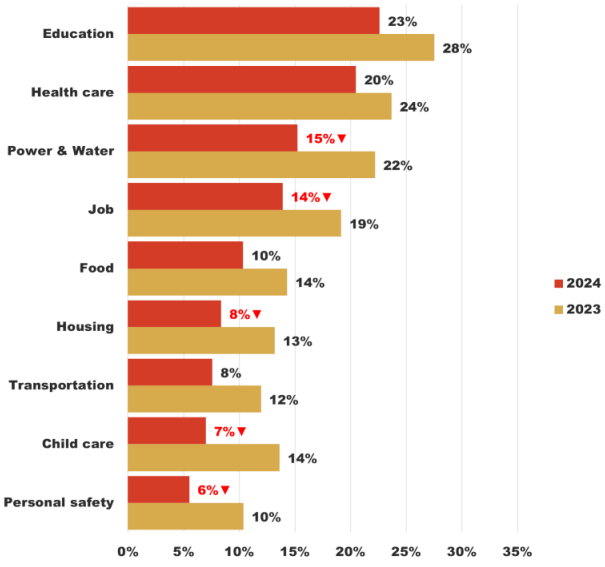
Top Five Needs this year are the same as last year and include:

1. Education; 23%
2. Healthcare; 20%
3. Power & Water; 15%
4. Job; 14%
5. Food; 10%

Most Significant Decrease:

1. Child care; -50%
2. Personal safety; -40%
3. Housing; -38%

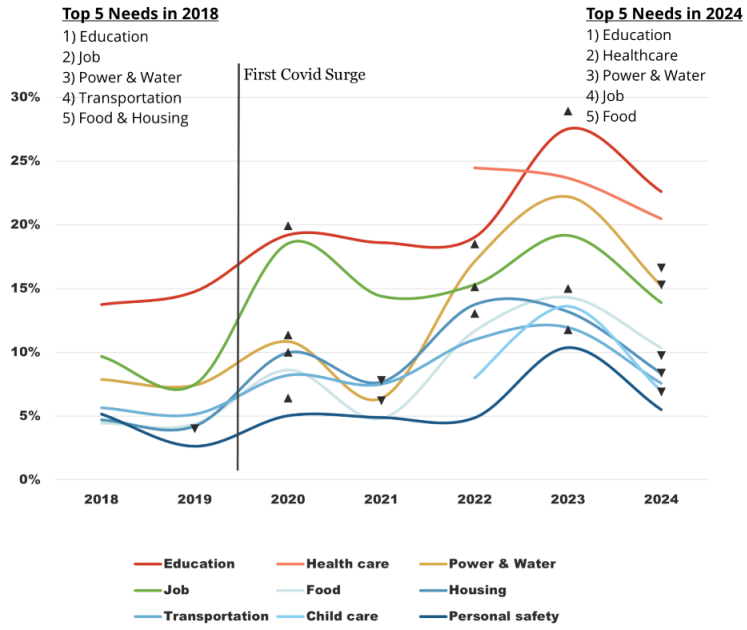
Key Findings



Total Health 9 Trends

39% reported needs this year, vs. 49% in 2023 and 46% in 2022.

The proportion with needs in each area trended down, after all bumped up in 2022/2023.



- Physical Health Current State Rating(6b)
- Behavior: Days fruit & veggies (9a)
- Behavior: Days exercise > 30 minutes (9b)

Physical Health

Physical health is both a state of being and a practice. Behaviors such as diet, exercise, sleep and stress have a profound effect on disease conditions and well-being. Physical health is also directly linked to hygiene routines, use of tobacco, alcohol and other drugs, the use of personal protective equipment, workplace safety and following safety guidelines, not taking unnecessary risks and the wise use of healthcare resources, including regular checkups and recommended screenings.

How Your Community Can Flourish

As in 2023, the state of one's **physical health has the #1 impact on overall well-being**.

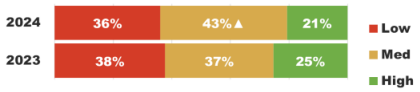
Key indicators with the most impact on physical health**:** mental/emotional well-being, regular exercise, financial security, ability to get medical care and information, and relationships with other people.

Well-Being Segment Impacts: Compared to all other segments, the most disparity for struggling is state of physical health, which is also true for mixed, when compared to those doing better. However, all segments fall below the FDA rated amount of fresh fruit and vegetable consumption.

Key Findings

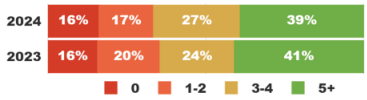
Physical health continues shifts down.

- More rate themselves moderate in 2024 (43%) than did last year (37%).
- However, the proportion who rates highly reached an all-time low (21%).

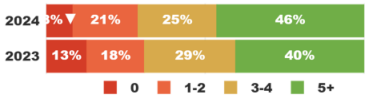


Consumption of fruits and vegetables similar to last year; exercise improves.

- Most (61%) residents ate fresh fruits and vegetables fewer than 5 times per week (CDC guideline: 7 times/wk).
- Some 16% ate no fresh fruits and vegetables.



The proportion with zero exercise days continued to trend down (8% in 2024 vs. 13% in 2023).



▼▲ arrows signify statistically significant difference from previous year

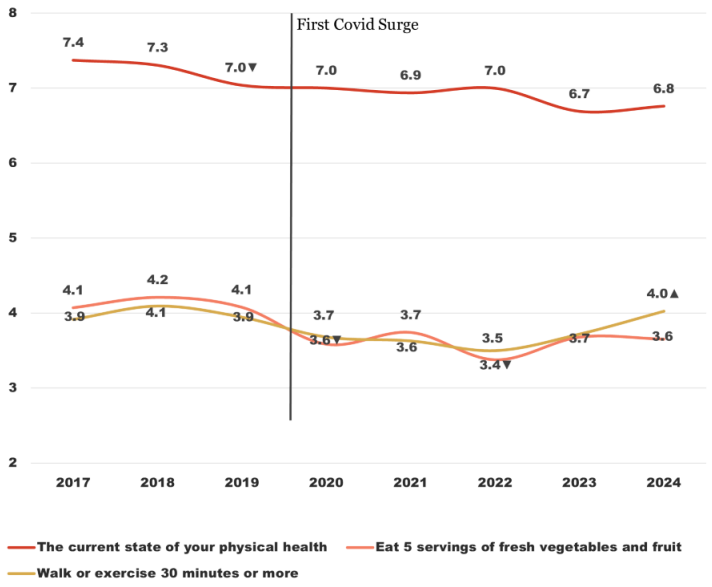
Physical Health Trends

Physical health has leveled off.

- After a significant decline in 2019, physical health average has held relatively steady.

Diet and exercise health behaviors diverge.

- Fruit & Veggie Intake; Relatively steady since 2020.
- Exercise 30 Minutes or More; Improvement in 2024 versus past several years.



• Covid-19 Impact

Tailored Questions

Coronavirus Pandemic Impacts Vary by Well-being Levels

Struggling report most impact and severity: The most of any segment, a majority of struggling report either significant and lasting impact (40%) or that the effects of the pandemic are still with them (22%).

Mixed report moderate impact: Most report some impact, but not now (44%). More than average report some effects are still with me now (24%).

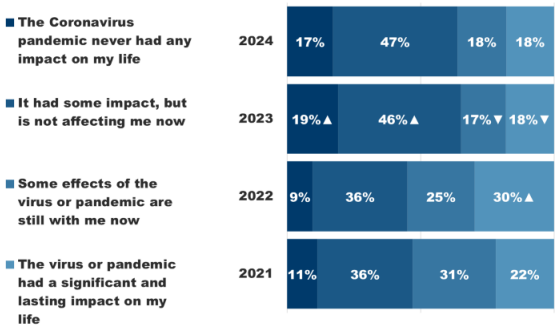
Doing Well report less impact now: Most report some impact, but not now (55%), and quarter say the pandemic never had any impact (23%).

Flourishing report least impact: Most report some impact, but not now (55%) and more than a quarter say the pandemic never had any impact (28%).

Key Findings

Perceived impact and severity of Coronavirus very similar to last year.

- 83% report the Coronavirus has had or still has some impact.
- About half (46%) say the Coronavirus has had an impact, but not now.
- 18% say that the Coronavirus is still impacting their lives.



▼▲ arrows signify statistically significant difference from previous year

• Covid-19 Impact

Tailored Questions

Social Media Impacts Vary by Well-being Levels

Struggling report lowest social media use and low levels of isolation: Most report low use of social media to stay in touch with others, which is significantly lower than other segments (75% vs. 58% average). There is no disparity in isolation compared to those overall.

Mixed report most close to average social media use, but more feelings of isolation: Most report low use of social media to stay in touch with others, like average (60%). However, significantly more report moderate to high rates of isolation (32%).

Doing Well report closer to averages for both social media use and similarly low rates of isolation: Most report low use of social media to stay in touch with others (53%) and low rates of isolation (79%).

Flourishing report highest rates of social media use and lowest levels of isolation: Most report moderate or high use of social media to stay in touch with others (53%) and the lowest rates of isolation (86%).

Key Findings

Social media are not widely used to stay in touch with others.

- Social media contact: Fewer than 1 in 5 (18%) regularly uses social media to stay in touch with family and friends; more than half (58%) say their use of social media to stay in touch is low.

Feelings of isolation from others touches some

- Feeling of isolation: A quarter (25%) of residents reports a medium or high sense of isolation from others.

▼▲ arrows signify statistically significant difference from previous year

Providence SWEDISH

Providence Institute for a Healthier Community

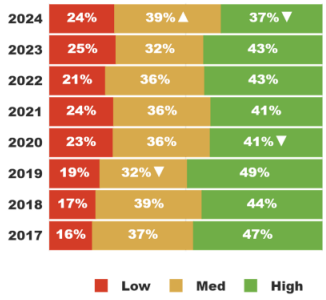
Appendix

Six Dimension Trend Net Promotor Bar Charts

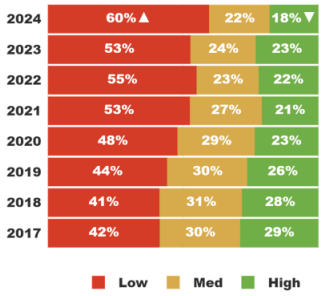
APPENDIX

Relationships & Social Connections

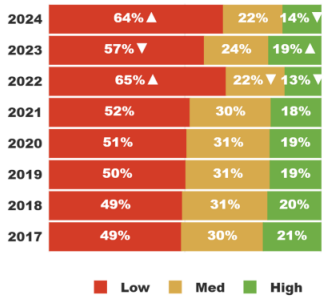
Q6g How satisfied are you with your relationships with other people?



Q7e I feel like I am part of a community/ sense of belonging. (7e)



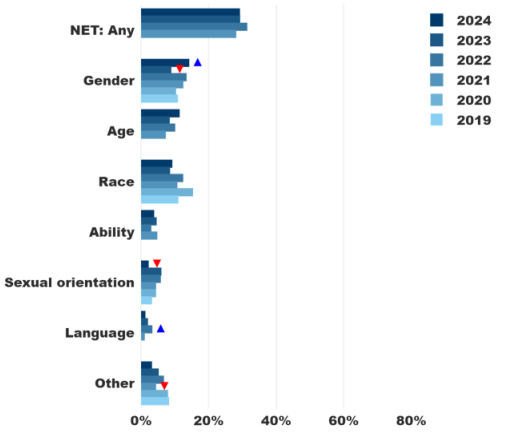
Q7c If I made up my mind to try, I could have a significant influence on decisions being made in my community. (7c)



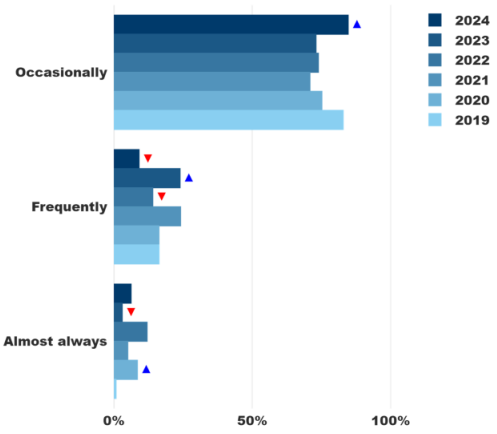
APPENDIX

Discrimination

Q9 During the past 12 months, have you personally experienced discrimination or been treated unfairly for any reason?



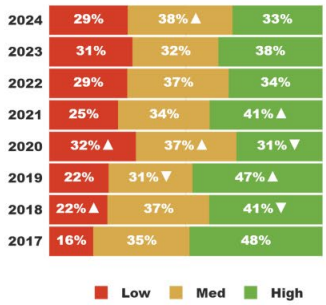
Q81 IF YES: Do you feel like you are discriminated against...?



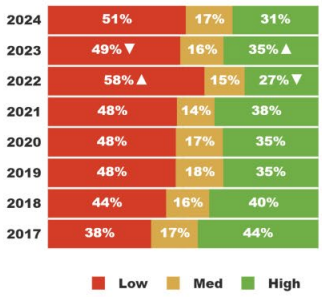
APPENDIX

Mental, Emotional & Spiritual Health

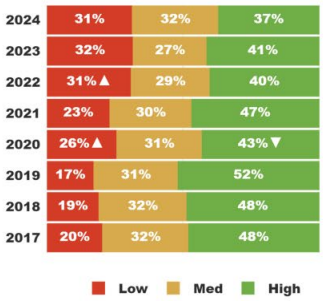
Q6h Rate your emotional well-being.



Q7a Religion or spirituality is important to me.



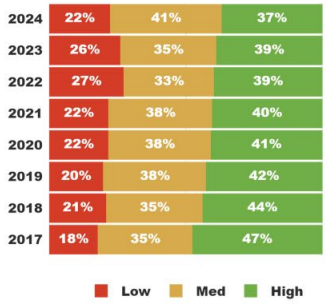
Q7b I have a sense of purpose and meaning in my life.



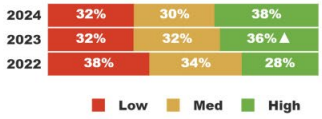
APPENDIX

Neighborhood and Environment

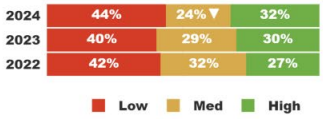
Q6h Rate the neighborhood you live in.



Q7a My community is a good place to raise children.



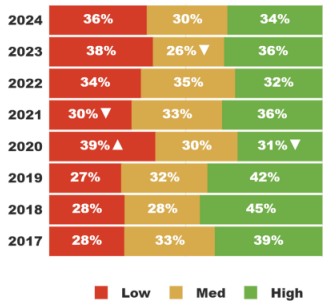
Q7b My community is a good place to grow old.



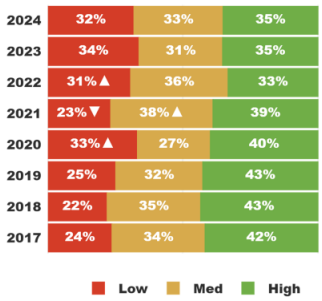
APPENDIX

Work, Learning and Growth

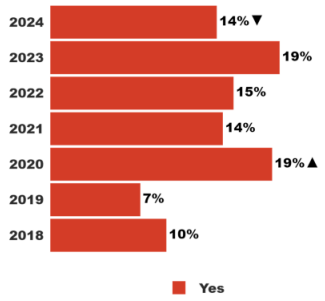
Q6d Rate your work or job (poor-excellent).



Q6g Rate your opportunities for learning and growth (poor-excellent).



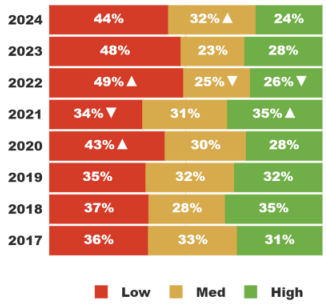
Q8e Do you need additional education or training to get the job and income you need?



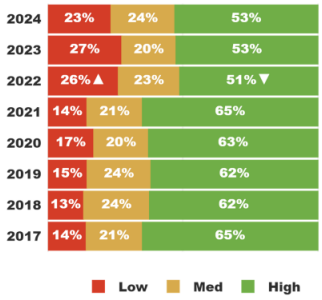
APPENDIX

Security and Basic Needs

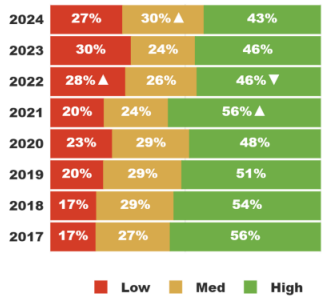
Q7d I feel secure about my financial future.



Q6e Your ability to meet your basic needs - like food, housing, transportation, safety.

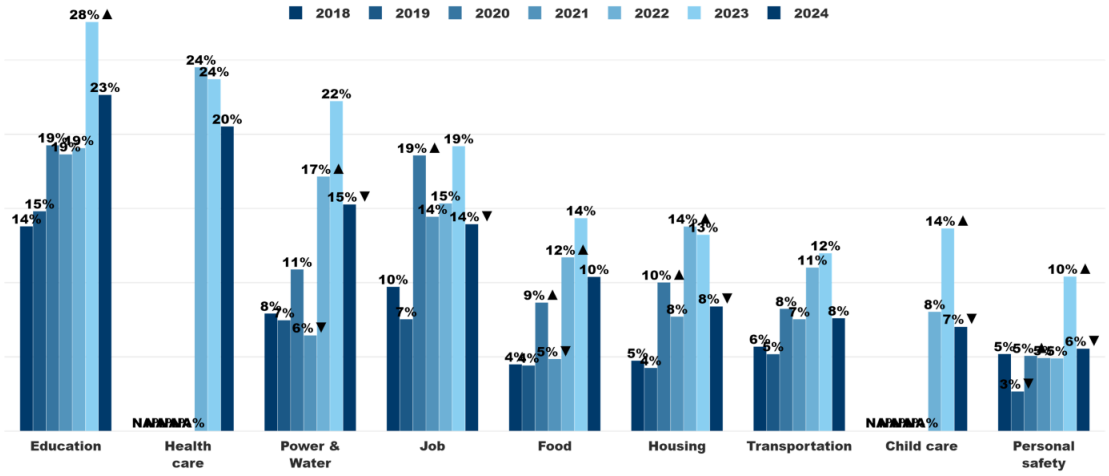


Q6c Rate your ability to get medical care & health info.



APPENDIX

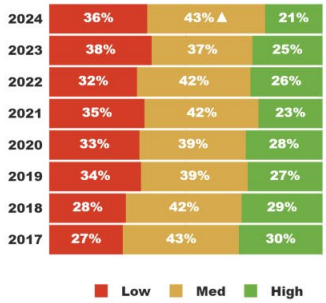
Total Health 9



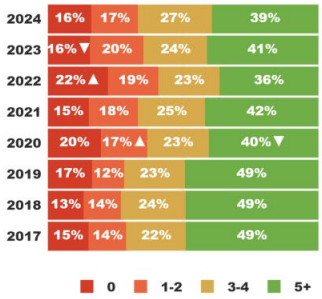
APPENDIX

Physical Health

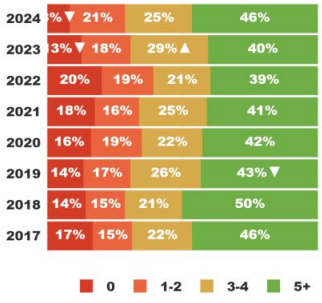
Q6b Rate the current state of your physical health.

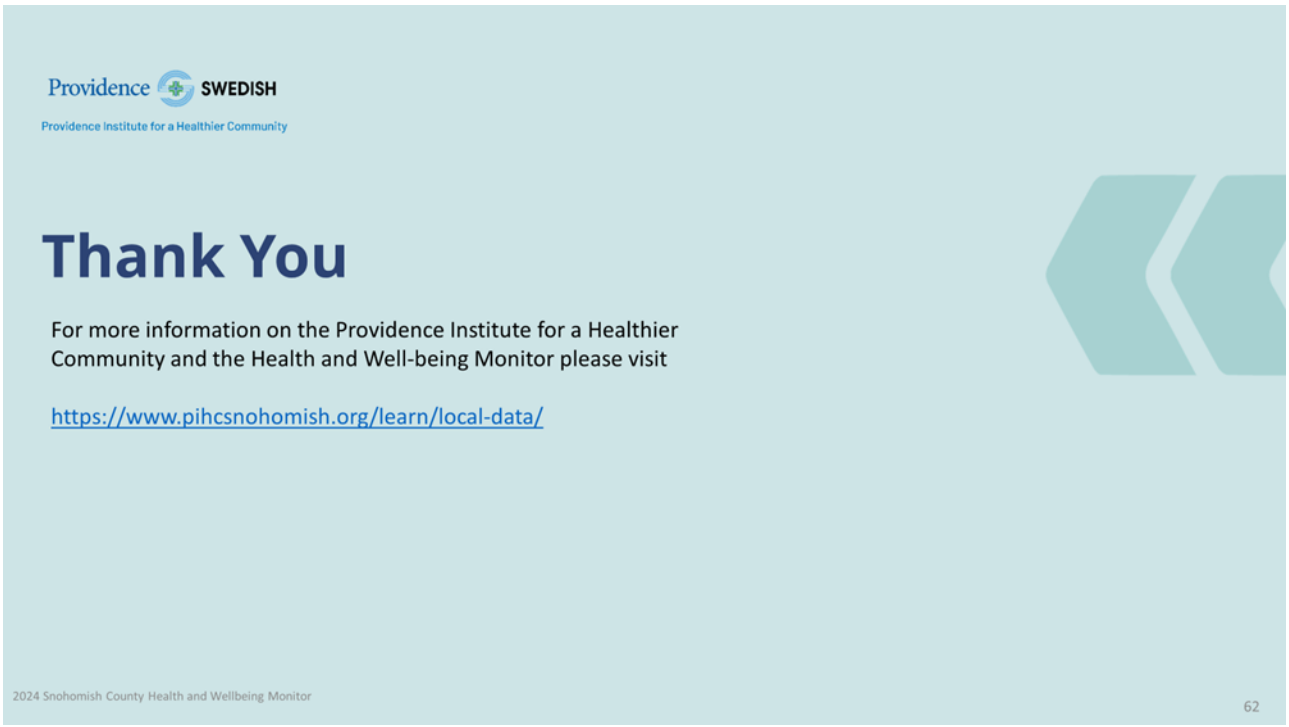


Q9a In the last week, how many days did you eat 5 servings of fresh vegetables & fruit?



Q9b How many days in the past week did you walk or exercise 30 minutes or more?





HEALTH PROFESSIONAL SHORTAGE AREA

Table 8 Appendix 1. Physician Ratio

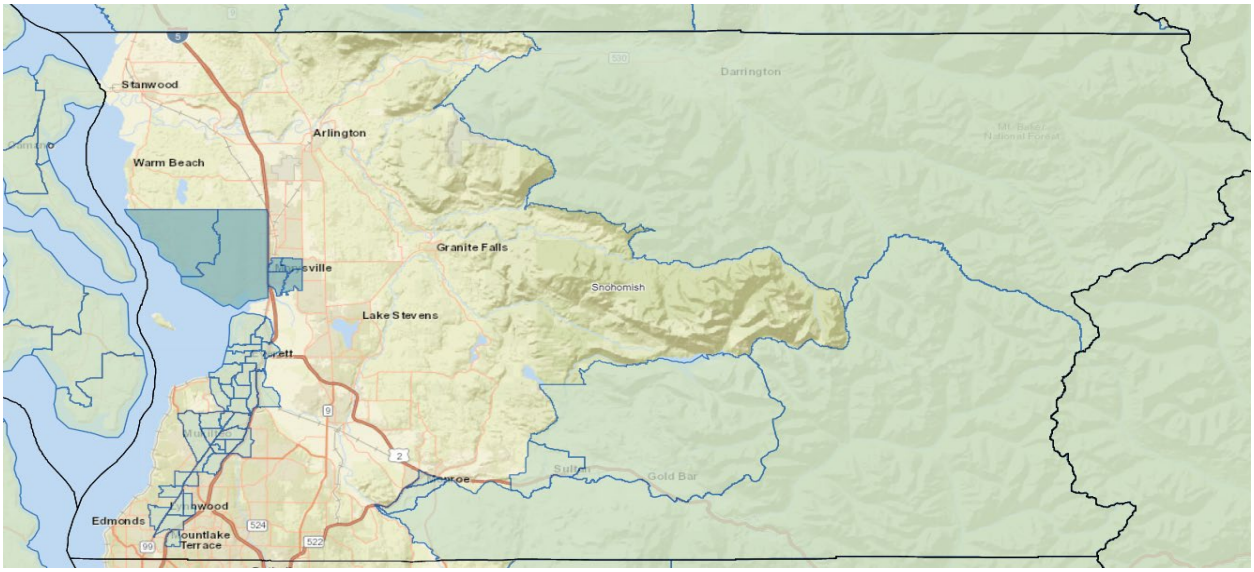
Indicator	Snohomish County	Washington State	Top U.S. Performers
Ratio of population to primary care physician	1870:1	1200:1	1330:1
Ratio of population to mental health provider	240:1	200:1	320:1
Ratio of population to dentist	1300:1	1150:1	1360:1

Source: County Health Rankings and Roadmap Snohomish, Washington | County Health Rankings & Roadmaps

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).

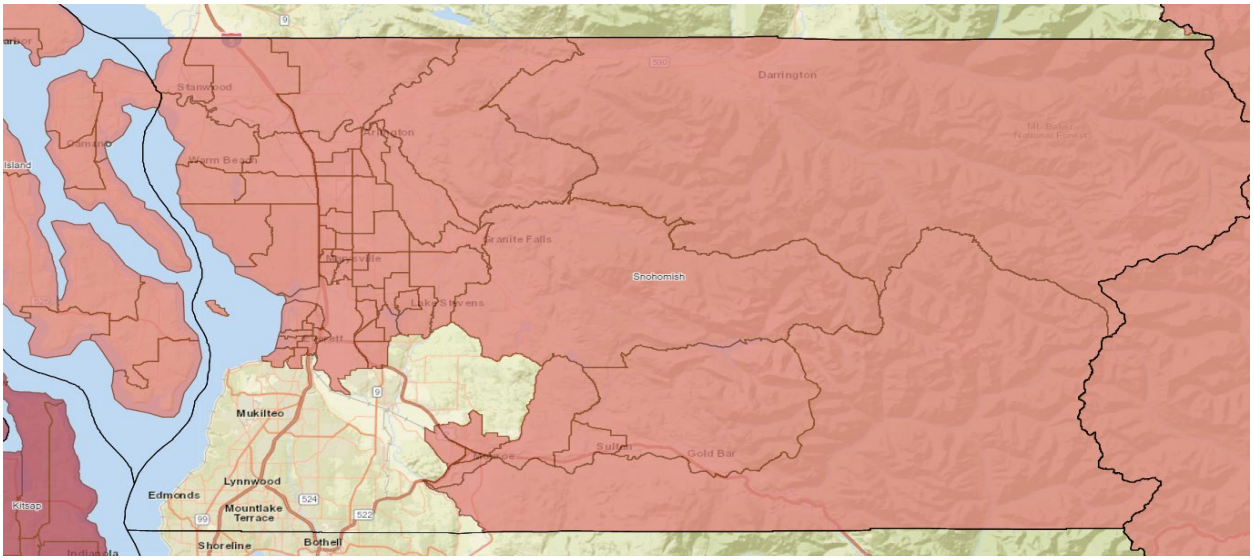
Snohomish County has locations that are designated as shortage areas. This information can be used to understand access issues, state and local health care planning, placement of providers, and allocation of limited health care resources. The maps below depict these shortage areas. An interactive map can also be found on the HRSA website: HPSA (arcgis.com).

Figure 6. Appendix 1. Primary Care HPSA



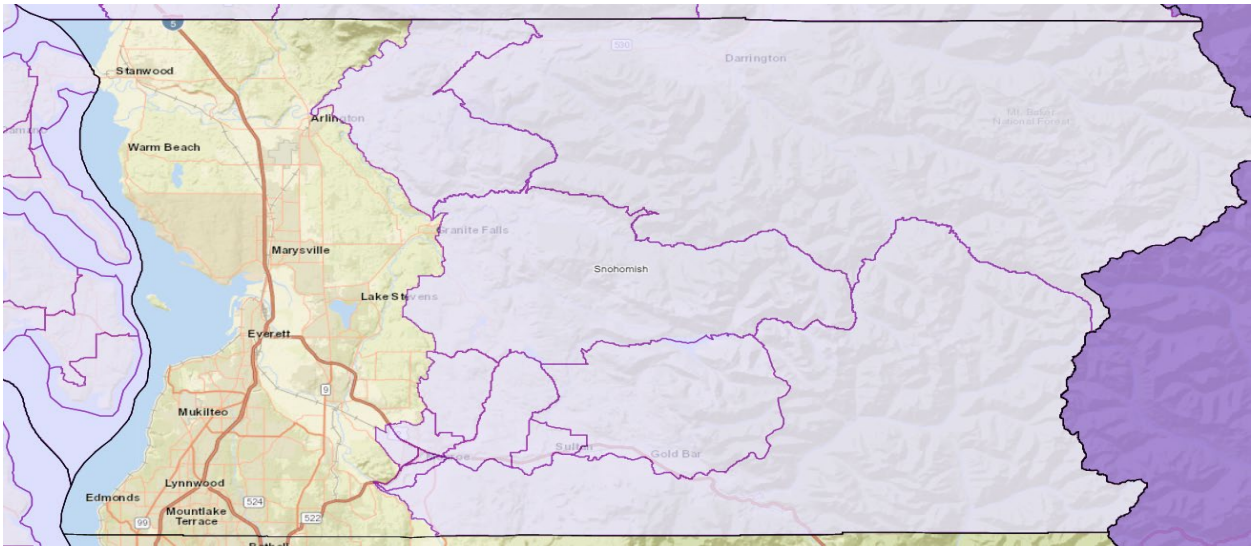
Source: County Health Rankings and Roadmap

Figure 7. Appendix 1. Mental Health HPSA



Source: County Health Rankings and Roadmap

Figure 8. Appendix 1. Dental Care HPSA



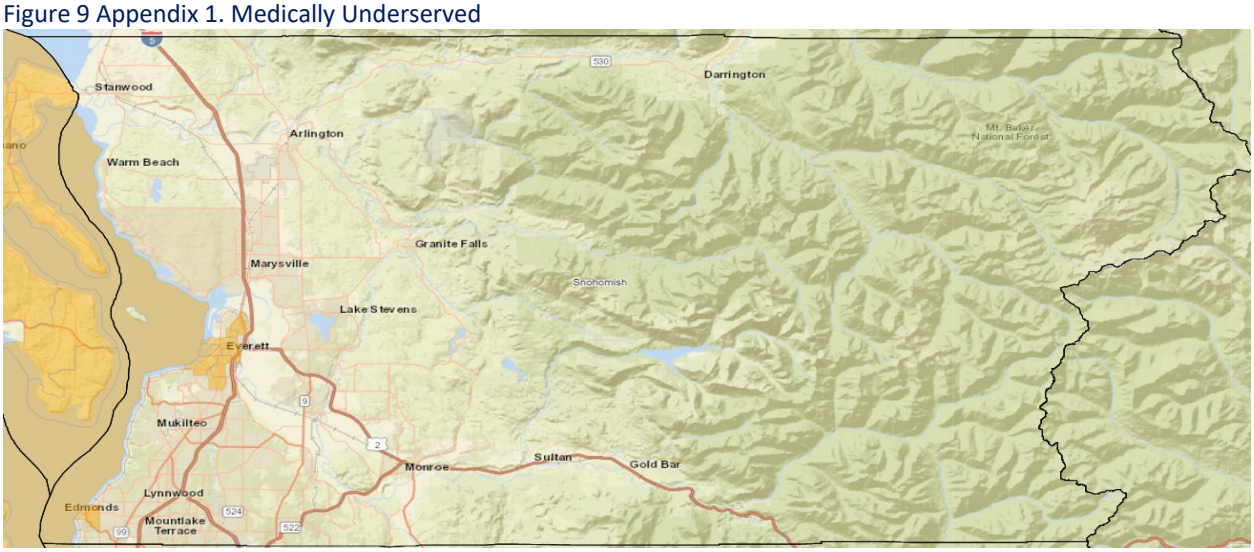
Source: County Health Rankings and Roadmap

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 primary health care services. MUAs are identified by calculating a composite index of need indicators compiled 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.

Snohomish County has two areas that are designated as medically underserved: Central Everett and West Edmonds. The following map depicts the MUAs within Snohomish County.

Figure 9 Appendix 1. Medically Underserved



Source: MUA Find (hrsa.gov)

Appendix 2: Community Input

METHODOLOGY

Participants

The hospital completed 5 listening sessions that included a total of 50 participants. The sessions took place April and May 2024.

Table 1 Appendix 2. Community Input

Community Input Type and Population	Location of Session	Date	Language
Hispanic community members	LETI (Latino Education Training Institute) Lynnwood, WA	4/27/2024	Spanish
Gay, Lesbian, Bisexual, Transgender, or Questioning young people.	GLOBE (Gay/Lesbian or Bisexual Empowerment) Everett, WA	4/17/2024	English
Senior and disabled community members and volunteers	Homage Senior and Disabled Services Lynnwood, WA	4/23/2024	English
Parents with neurodiverse family members from diverse backgrounds	Well Being Center / Leading With Love Silver Creek Family Church Lynnwood, WA	5/07/2024	Spanish
Diverse range of young people of color, many of the participants speak 2 languages and are in transitional housing.	Project Girl Mentoring Program Lynnwood, WA	4/25/2024 & 5/09/2024	Spanish & English

The hospital completed 20 key informant interviews that included a total of 30 participants. The interviews took place between April and May 2024.

The goal was to engage representatives from social service agencies, health care, education, housing, and government, among others, to ensure a wide range of perspectives. The hospital included the Health Officer and the Director from Snohomish County Health Department as a key informant to ensure the input from a state, local, tribal, or regional governmental public health department.

Table 2 Appendix 1. Key Community Key Informant Participants

Organization	Name	Title	Sector
Childstrive	Mary Cline-Stively	Chief Executive Officer	Children-early childhood
City Of Everett	Julie Willie	Director of Community Development	Government/City
City Of Lynnwood	Douglas Raiford	Race and Social Justice Advisor	Government/City DEI
Compass Health	Dr. Kathryn Gilligan	Chief Medical Officer	Behavioral Health
Community Health Center of Snohomish County	Jim Geracci, MD	Interim Chief Medical Officer	Healthcare
Community Health Center of Snohomish County	Tové Skaftun, RN	Chief Nursing Officer	Healthcare

Organization	Name	Title	Sector
Edmonds School District/Foundation for Edmonds School District	Dr. Sally Guzmán MNPL, Ed.D	Family Community Engagement Coordinator	Education/K-12
Everett School District	Dave S. Peters	Director Student Support Services	Education/K-12
Glacier Peak Institute	Oak Rankin	Executive Director	Rural Community
House of Wisdom	Ahmad Hilal Abid	Founder/President	Education - Refugee/Immigrant
Housing Hope	Donna Moulton	Chief Executive Officer	Housing
Korean Women's Association	Mi-Young (Cheryl) Lee, J.D	Executive Director, Social Services Director	BIPOC: Asian / Pacific Islander
Korean Women's Association	Dina Prigodich	Social Service Division Manager	BIPOC: Asian / Pacific Islander
Korean Women's Association	Christine Hwang	Korean Women's Association	BIPOC: Asian / Pacific Islander
Latino Education Training Institute	Rosario Reyes	Founder and Chief Executive Officer	BIPOC: Latino
Latino Education Training Institute	Marisol Bejarano	Director of Health and Wellness Programs	BIPOC: Latino
Mukilteo City Council	Louis Harris	City Council President	Government
NASHI Immigrant Health Board for Washington State	Tamara Cyhan Cunitz, MN	affiliate Professor UW School of Nursing, NASHI Executive Director	Immigrant
Snohomish County Sheriff	Susanna Johnson	Sheriff	Law Enforcement
Snohomish Health District	James Lewis, MD, MPH	Health Officer Snohomish County Health Department	Public Health
Snohomish Health District	Dennis Worsham	Director Snohomish County Health Department	Public Health
South County Fire	Shawneri Guzman	Community Outreach Manager	Healthcare/Public Safety
South County Fire	Nicole Picknell	Community Resource Paramedic Captain	Healthcare/Public Safety
Tulalip Tribes	Karen Foster-Schubert MD	Medical Director	Tribal/Healthcare
Tulalip Tribes	Verna Hill	Community Health Director	Tribal/Healthcare
Tulalip Tribes	Jeremy Howell, DHA, FACHE	Health System Administrator	Tribal/Healthcare
Tulalip Tribes	Ashley Schmidt, MSN RN	Lead Community Health Nurse	Tribal/Healthcare
WAGRO Foundation & Lynnwood City Council	Altamirano-Crosby, Julieta	Vice President and Co-Founder	Government & BIPOC Community
Workforce Snohomish	Joy Emory	Chief Executive Officer	Workforce/Job Access, Training and Development
YMCA of Snohomish County	Patsy Cudaback	Senior Vice President Chief Operating Officer of YMCA of Snohomish County	Community Center (youth, seniors, childcare, etc.)

Organization	Name	Title	Sector
YMCA of Snohomish County	Jennifer Willows	Senior Vice President Chief Development Officer of YMCA of Snohomish County	Community Center (youth, seniors, childcare, etc.)

Facilitation Guides

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

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

For the key informant interviews, Providence developed a facilitation guide that was used across all hospitals completing their 2024 CHNAs:

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

Training

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

Data Collection

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

Analysis

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

If applicable, the recorded interviews were sent to a third party for transcription, or the notes were typed and reviewed. The key informant names were removed from the files and assigned a number to reduce the potential for coding bias. The files were imported into Atlas.ti. The analyst used a standard list of codes, or common topics that are mentioned multiple times. These codes represent themes from

the dataset and help organize the notes into smaller pieces of information that can be rearranged to tell a story. The analyst developed a definition for each code which explained what information would be included in that code. The analyst coded eight domains relating to the topics of the questions: 1) name, title, and organization of key informant, 2) population served by organization, 3) greatest community strength and opportunities to leverage these strengths 4) unmet health-related needs, 5) disproportionately affected population, 6) effects of COVID-19, 7) successful programs and initiatives, and 8) opportunities to work together.

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

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

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

Limitations

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

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

FINDINGS FROM COMMUNITY LISTENING SESSIONS

Vision of a Healthy Community

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

- **Everyone has supportive, healthy relationships and the community cares for one another:** In a healthy community, people have support systems they can ask for help. People take care of their neighbors through volunteerism and reaching out. There is kindness, trust, and loyalty. There are also strong family relationships and young people have trusted adults they can reach out to. People are not isolated, which supports their mental health.

- **People can easily access health care services to care for their physical health:** In a healthy community, there is easy and safe access to health care services. People know how to access the needed resources and there is health education and promotion to keep people, especially children, in good health.
- **Basic needs, like housing and food, are met and there is financial assistance available:** Everyone has a home and access to healthy food. In a healthy community, people's basic needs are met, and no one is living unsheltered. People can eat healthfully and grow food in community gardens. Additionally, there is financial assistance available to pay for bills to afford necessities. There is easy access to educational and employment opportunities for people to meet their basic needs.
- **People communicate with and respect one another:** In a healthy community there is honest and direct conversation that helps people understand one another. There is emotional safety—people have respectful dialogue and can communicate with their neighbors and others in their community.
- **The community is safe and clean so that people can be active outside:** In a healthy community, people have access to safe and clean neighborhoods where they can be physically active. There are parks and green spaces where they can focus on being physically healthy. The community is free from trash, violence, and gangs.
- **People's mental and emotional needs are met and there is no substance use/misuse:** In a healthy community people are emotionally well and there is no substance use/misuse. People have access to support groups and mental health services, and people know where to go for help and to express their emotions.
- **Inclusion and openness are foundational:** There is an openness of mind and heart, where all people are included. Specifically, there is racial equity and inclusion of older adults.

Community Needs

Listening session participants were asked to discuss community health-related needs. The following themes emerged:

High priority unmet health-related needs

- **Inclusion and connection**: All listening sessions discussed the importance of people feeling accepted, included, and connected in their community. They shared the need for more education about diversity to promote respect and empathy for others. They discussed the need for more inclusion of the LGBTQIA+ community and older adults through visibility of allies, support groups, and community activities. There is also the need for more cultural awareness and understanding of the history of Indigenous Peoples of the U.S. They would like to see people getting to know their neighbors, caring for one another, and having more healthy conversations.
- **Safety**: All listening sessions spoke to the need for improved community safety. They would like to see physical safety from crime and violence, spaces where people feel safe walking, and

reduced violence, shootings, and gang activity. They were specifically concerned about firearms and substances on school campuses and would like to see schools as a safe place for young people to learn.

- **Behavioral health:** Community members shared their need for better access to affordable mental health services to address community mental health needs, particularly for young people. They shared a lot of young people have a lot of stress and there should be trauma-informed approaches in schools to better meet students' needs. Addressing substances in schools is also needed. Additionally, to improve community well-being, there needs to be more acknowledgement and healing of generational trauma.

Medium priority unmet health-related needs

- **Basic needs, including housing, food, and transportation**: Community members shared there is a need for more affordable housing and shelters, buses that run later, and community gardens to access fresh foods. They would also like free or affordable access to basics like toiletries, clothes, school supplies, and phones, as well as improved food in schools.
- **Access to health care services**: Improving access to health care services is important. Community members noted needing language services, financial support, gender affirming care, health fairs with information, and more preventive care.
- **Recreation and social activities:** There is a need for free recreation and social activities, including safe places for people to walk, free social events for young people, and recreation facilities. Participants noted wanting more pools, water parks, and malls.
- **Economic security, including education and childcare:** Community members said they would like to see less poverty in the community. To do this, there is a need for more financial education, childcare for parents, and social services. There is also a need for better quality education, including more supportive teachers, free tutoring, and free and good-quality school supplies.
- **Civic engagement and community involvement:** Opportunities to use one's voice to promote change and to give back to the community in positive ways are needed. Young people would like to be informed and encouraged to be empowered when voting and to use their voice in spaces where decisions are being made about them

FINDINGS FROM KEY INFORMANT INTERVIEWS

Community Strengths

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

A strong network of community-based resources and services

Across Snohomish County there are many services and resources available to support the needs of the community, with many organizations providing services and support. For example, there are well-connected schools that serve families in culturally responsive ways to meet their basic needs. There are also free transportation programs, public libraries with laptops and online tutoring, churches and faith communities that provide meals and resources, and organizations like the YMCA that provide youth programming. Related to health care, there are school-based health clinics with mental health services, mobile medical units providing direct services to families, Federally Qualified Health Centers providing affordable care, and community navigators helping people understand the services available. All of these services work to meet pressing community needs and outreach serves to build trust and increase access.

Key informants spoke to the dedication and collaboration of the people within organizations doing the work to serve the community. Many staff members in local organizations are from the community and/or have their own lived experience, which they use to provide culturally responsive services.

> *"This is our strength. We have wonderful people from diverse communities coming and helping at the [organization]. Communities are our strength and people who invest their time and their energy."—Key Informant*

To leverage this strength of a strong network of community-based resources and services, key informants suggested the following:

- Empower community members to better understand what is available in the community and how systems work. As a result of COVID-19, some resources have changed, and people may not be aware. Provide more education and outreach about how to seek help and be proactive in using resources.
- Prioritize partnering with community members on education and outreach.
- Build on trusted community resources to provide new services, using what is already working well.
- Fund community-based services and programs that already have strong trust with specific communities.
- Continue to bring services to people, meeting them where they are in their homes and communities.
- Ensure service providers engage in their own development and training to provide culturally responsive care to communities and understand the history and culture of the people they work with.

Collaborative relationships between local organizations and agencies

There are strong partnerships and relationships between local organizations. Key informants described Snohomish County as a very collaborative area where the expertise of each organization is valued. This benefits clients and patients, with more wraparound services where community-based organizations are collaborating to best meet people's needs by linking services.

Health care and public health have developed partnerships to work together to service the community, particularly in response to behavioral health challenges. As a result of the COVID-19 pandemic, these relationships have been strengthened.

> *"Those relations [between public health and health care] are very strong and allow us to tackle the problems together, more efficiently certainly than we would be able to otherwise."—Key Informant*

To leverage this strength of strong collaborative relationships between local organizations and agencies, key informants discussed continuing to focus on meaningful systems collaboration between organizations and service providers. They emphasized avoiding siloed work and the benefit of addressing needs in partnership. They suggested the following strategies:

- Develop consortiums/collaboratives of organizations doing similar work: Bring together organizations that address similar needs to look at needs more broadly across the county and have a bigger impact on addressing the issues.
- Share data to understand health disparities and social inequities: Some populations may not be well represented in data. Organizations can collaborate to share their data and gain a more complete picture of needs to focus interventions, particularly for Black, Brown, Indigenous, and People of Color (BBIPOC) communities.
- Leveraging funding more efficiently and effectively: Use funding resources in collaboratives to be more efficient. Funders can think more holistically about how funding can be used to support staff training and development, rather than focusing only on number of people served with dollar amounts.
- Collaborate on CHNAs: Many organizations produce CHNAs and more collaboration and sharing of data could be beneficial.
- Focus on whole person care: Continue to build up wraparound services and address the factors that contribute to needs.

An engaged, compassionate community dedicated to the common good

Community members are engaged, compassionate, and collaborative. People have a desire to help and, even with few resources, they want to make a difference in their community. Key informants described the community as welcoming and caring, with robust volunteerism and desire for change. Events are generally well attended as people show up to provide insight and participate. Many community organizations draw on this engagement by creating feedback loops with the community, seeking to ask the community what they need rather than making assumptions.

To leverage this strength of an engaged, compassionate community dedicated to the common good, key informants suggested focusing on "true engagement" by continuing to engage people in solutions. Getting feedback on policy change is also important. They emphasized the importance of listening to what the community wants and learning from people with lived experience.

"A lot of things out there to fix people, [are] not always helpful. People need to be engaged, not made to feel less than."—Key Informant

"Getting feedback from the community helps inform what sort of policy changes we need to better serve those community members."—Key Informant

Developing more engagement opportunities in the community can help address isolation and create a sense of belonging by building relationships. To ensure inclusion, translate information and have interpreters available at events. Staff members engaging with the community should also be from the community or culturally responsive.

Engage volunteers in formal and informal capacities. Community members excel at word-of-mouth connection and networking with their neighbors, family, and friends. Therefore, they can help share important information and resources. Health care can also partner with the community to introduce youth, particularly BBIPOC youth, to the health care field. This is a way to develop pathways for career development so they can come back and serve their communities.

Connection with culture and family

Connection with culture and family are protective factors. Leveraging those resources provides strength, grounding, better health and more connected care. Key informants shared parents are motivated to make healthy changes for their families. Additionally, parents show a lot of perseverance when it comes to caring for their children. Many community members are motivated by their families and grounded in their cultures. There is a lot of diversity of cultures in Snohomish County and people bring that cultural wealth to the community and want to share it with their children. Many people, particularly immigrants and refugees, are resourceful and community-minded, desiring a better life for themselves and their children, dedicated to succeeding in a new community.

To leverage this strength of family relationships and culture, key informants suggested focusing on early intervention with youth, appealing to parents to create healthier families.

"Reality is that when we intervene early with kids in all kinds of different ways...We know, and research shows us, that those kids are different than when we don't intervene early with kids. So, we can actually change kids' lives, which is changing that next generation."—Key Informant

They also discussed the importance of focusing on healing generational trauma and healing family wounds as part of addressing behavioral health.

Celebrating cultures and ensuring there are arts and music festivals that are inclusive of the community is important. To build on the cultures and diversity in the community, strengthen Promotores programs, valuing community members for their connection to the community and shared culture.

A growing community with opportunity and natural resources

Key informants emphasized that there is a lot of natural beauty in Snohomish County, and it is growing, particularly as a result of the light rail extending to the area. With this growth, more people will be coming to the area and there are more opportunities for businesses (it should be noted, the growth

could also make the area less affordable for some businesses and families). There has been some diversification of employers, moving beyond the manufacturing core, presenting more retail and tourism. Additionally, Snohomish County has robust suburban hiking trails and proximity to many areas in the region. Key informants suggested leveraging outdoor activities to prevent and support mental health challenges. Additionally, fostering a connection to the land and nature can improve health.

High Priority Unmet Health-Related Needs

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

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

Homelessness and housing stability

Almost all key informants identified addressing homelessness and housing stability as a priority of high importance, with many noting this is the primary community need and the biggest issue.

> *"Once folks are housed, and you know everything else has the ability to finally, you know, sort of fall into place."—Key informant*

Housing was identified as a key need because key informants have seen more people living unsheltered and experiencing homelessness. Specifically, they are seeing more families living in their cars and the number of McKinney-Vento students growing. The emergency funding to keep people housed during the COVID-19 pandemic has ended, making it even more difficult to address housing stability. Additionally, the cost of housing has increased, leading to overcrowding as multiple families share a small space.

Key informants were concerned that people do not seek support or housing resources until they are far in debt and being evicted. More education and work to prevent people from being in these crises is needed.

Addressing housing needs is connected to physical and behavioral health, as well as economic security. People with low incomes and experiencing economic insecurity may be one emergency away from losing their housing. Additionally, people with a behavioral health challenge may need more support accessing housing.

To address the housing challenges, key informants identified the following community needs:

- More affordable housing: Adequate housing for people with low incomes is needed. There are extremely long wait times for affordable housing and not enough resources to meet the volume of needs.
- More transitional housing: There is a need for more transitional housing, particularly on-demand spots available to meet people when they are ready for help.

- Family shelters: Key informants are seeing more families experiencing homelessness and living in their cars. Particularly families that are not experiencing a substance use disorder may have a longer wait list for housing.

Besides families and people with low incomes, key informants also noted that they are seeing more older adults experiencing homelessness and living in their cars. People experiencing homelessness are also more likely to be victims of crimes, noting the importance of supporting people in accessing safe living situations.

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

Most key informants identified behavioral health challenges and access to behavioral health care as a priority need. Addressing one's physical health, housing needs, and more is difficult to do with an untreated behavioral health challenge. Therefore, addressing behavioral health needs can be foundational to meeting other needs.

Addressing behavioral health is also critical because key informants are seeing very high needs related to mental health and substance use/misuse, with limited resources available. Key informants described a substance use crisis and were particularly concerned about fentanyl being highly accessible and pervasive in the community and in homes. Mental health needs are also reported to be very high.

> *"Mental health needs in the community have never been higher and options for resources have never been lower."—Key Informant*

Key informants shared that behavioral health challenges are connected to a history of trauma and Adverse Childhood Experiences (ACEs), a lack of community and belonging, and economic insecurity. Unaddressed trauma is a driver of behavioral health needs. Historical trauma, such as Native American Boarding Schools, negatively affect people's mental and physical health and well-being. With increased social isolation, particularly because of the COVID-19 pandemic, some people may feel less connected to their community and lack a sense of belonging. This may be especially relevant for immigrants and refugees. Celebrating people's cultures and creating community connections is one way to address this. Additionally, economic insecurity can contribute to stress and substance use/misuse as people seek to cope in challenging times.

Key informants identified specific community needs related to behavioral health:

- Increased substance use disorder (SUD) treatment and psychiatric care: More SUD treatment services, including detox services, are needed, particularly in south Snohomish County. More psychiatric care and stabilization for people coming out of mental health treatment are needed. Currently, people have to wait for services and may be lost to care or no longer ready when a service does become available. Timely access and responsiveness to people seeking care is critical.
- Behavioral health care for young people: On-site school-based behavioral health programs, increased SUD treatment services, and therapy for children, teens, and their families are needed. Additionally,, discharge support after psychiatric care is needed to help sustain next

steps of care. To support families, more classes and information on Social Emotional Learning could help.

- Culturally matched and linguistically appropriate mental health services: There are a lack of Black, Brown, Indigenous, and People of Color (BBIPOC) providers. Language can be a major barrier for people accessing mental health services. There is a particular need for more bicultural providers to serve Latino/a community members and support groups that can help create community and connections for BBIPOC individuals.
- Improved coordination of behavioral health services: Many of the behavioral health services are siloed. More warm hand-offs increased coordinated care, and follow-up by social workers after discharge would help prevent crises and avoidable Emergency Department encounters.
- More behavioral health urgent cares and crisis support: There are limited resources for people in mental health crisis. More capacity and hours for behavioral health urgent care are needed.
- More substance use education: Key informants were concerned about seeing substance use/misuse in young children and easy access in homes and the community. They would like to see improved messaging about the effects and dangers of opioids and other substances.

> *"So, there's mixed messages about drugs and safety of drugs, and I don't think that people have the delineation in their mind between what is an opioid versus what is marijuana. What does it do to your body? What does it do to your brain? And it's that age old challenge of how do we do good drug education?"—Key Informant*

A variety of barriers prevent community members from accessing needed behavioral health services:

- Stigma: Key informants shared some individuals from the Latino/a community and immigrant and refugee communities may not access services due to stigma.
- Transportation
- Insurance: Changing providers, lack of insurance, or being underinsured can prevent people from seeking services.
- Technology: Telehealth services can be underutilized if people do not have access to or comfort with technology.

Certain populations and groups may experience more behavioral health challenges and/or barriers to accessing needed care:

- Young people: There is a need for more quickly accessible mental health support and therapy for children, teenagers, and families. Psychiatric care, particularly related to suicide, and discharge support and coordination is needed. More SUD treatment for young people and mental health care is needed. Key informants spoke to seeing suicidal ideation, loneliness, lack of community and connection as common issues.
- New parents: Particularly as a result of COVID-19, key informants are seeing more parents isolated and without support, leaving them in "survival mode."

- Latino/a community: There is a need for more bicultural providers to serve the Latino/a community. Stigma may also prevent people from accessing mental health care.
- Indigenous Peoples of the U.S.: This population is disproportionately affected by the opioid epidemic. Historical trauma can also contribute to behavioral health needs.
- Formerly incarcerated individuals: This population may be at higher risk for behavioral health issues and need support accessing employment.

Medium Priority Unmet Health-Related Needs

Four additional needs were often prioritized by key informants:

3. Racism and discrimination
4. Economic security
5. Access to childcare and preschools
6. Access to health care services

Racism and discrimination

Key informants discussed racism and discrimination as related to many other needs, including access to health care services and behavioral health. They identified it as a community priority because white supremacy activity and racism are significant issues in the county that need to be discussed openly and addressed as a community. For some people in the community, they may have a lack of awareness of the effects of racism and discrimination, contributing to a need for more education, trainings, and conversation.

Key informants shared that racism and discrimination in health care can affect the quality-of-care people receive and lead to health disparities. Indigenous Peoples of the U.S. experience health disparities related to births and chronic disease due to racism and historical trauma which has contributed to less trust in the medical system. The effects of unhealed and unaddressed trauma from the Native American Boarding Schools also continues to affect people's physical and emotional well-being, contributing to behavioral health challenges. This trauma and racism also diminish trust in health care.

Discrimination and a lack of dignity within some health care encounters can also affect patients' care and well-being. For patients that are experiencing homelessness, or who are immigrants and refugees, providers may make harmful assumptions about their life circumstances. For examples, providers may assume refugees do not understand their care and do not want to participate in it, but most want to be healthy and want to participate in their care.

> *"Responsiveness is not always what we would hope in our community to treat each person with dignity and respect."—Key Informant*

Racism and discrimination may also contribute to certain populations not accessing services due to distrust in systems, particularly governmental resources, including housing resources. Some organizations reported that those seeking services are not reflective of the demographics in the community, with BBIPOC populations accessing services at lower rates.

Economic security

Key informants shared economic security is related to many other needs, including mental and physical health, housing stability, food security, and more. A lack of economic security contributes to anxiety and behavioral health issues, particularly as people worry about not being able to afford a crisis, like a flat tire, which could lead to homelessness. They described "no safety net" in emergencies for people with low incomes.

> *"A client recently said she is one flat tire away from homelessness, and she is doing all the right things."—Key Informant*

During the COVID-19 pandemic, there was more support for basic needs, like diapers and food, but emergency funding has ended. Additionally, frequent job changes and financial concerns affect people's ability to make connections with others, affecting social connections.

Some areas of the county may have fewer job opportunities and local investments. For example, in Darrington, many businesses are owned by people who live in different cities, funneling wealth outside of the community. Key informants shared wanting to see more local investments and economic opportunities that support people. People in more suburban or rural areas may have to travel to other communities for employment, increasing the need for transportation.

> *"[Economic] priorities are profit based, not people based."—Key Informant*

Key informants identified the following needs to improve economic security:

- Language learning services: Language can be a major barrier to people finding employment.
- Culturally responsive workforce development: Empowering the community in a culturally responsive way and focusing on building trust is important. Organizations need to support people in addressing their employment needs.

> *"The question is, how do you support [workforce development] in a way that is culturally responsive and acknowledges where one organization really has trusted relationships?... It really has to be synthesized and coordinated and empowering to those community versus saying 'just send them over to us.'"—Key Informant*

Certain populations may experience more economic insecurity:

- Refugees and immigrants: Focusing on building resumes and developing language skills is needed. Navigating employment can be difficult for immigrants and refugees.
- People that have been formerly incarcerated: A criminal history can be a barrier to employment, which disproportionately affects BBIPOC communities.
- Young families: Young families may have lower incomes and difficulty meeting basic needs, like purchasing car seats.

Access to childcare and preschools

Key informants described affordable childcare and preschools as very challenging to access, with many inequities. Finding childcare has only gotten more challenging over the past few years. Particularly as economic insecurity increases and people are working longer, parents may not have the option of relying on grandparents or other family members to provide caregiving.

There is a need for more affordable, accessible childcare in the community. Some is present, but not nearly enough to meet the needs. More early childhood education is also needed because there are some areas within Snohomish County that lack any early childhood education.

Investing in childcare and preschools is important because it is an opportunity to prevent family challenges and support children in having healthy futures. It is also important for a family's economic security and overall well-being; parents need to know that while they are working their children are taken care of, learning, and growing in a way that has positive impacts for a lifetime.

> *"Reality is that when we intervene early with kids in all kinds of different ways... we know, and research shows us, that those kids are different than when we don't intervene early with kids. So, we can actually change kids' lives, which is changing that next generation."—Key Informant*

> *"I love the idea of quality childcare.... Why? Because it matters, it matters."—Key Informant*

Access to health care services

Key informants discussed the many barriers that prevent people from accessing timely, affordable, and responsive care. Key informants emphasized the importance of support navigating care for people who may be unfamiliar with the healthcare system and experience the following barriers:

- Language: Key informants identified language as a major barrier for people navigating the health care system due to a lack of linguistically appropriate care. Improving language access is a serious need, particularly for immigrant and refugee populations. A lack of language services and linguistic access can lead to expecting children and advocates to carry the burden.
- Health literacy: Improving health literacy to support people in navigating health care is important. For some populations, particularly people that are unfamiliar with the health care system in the U.S., providing support is needed. This may be particularly true for immigrants, refugees, Indigenous Peoples of the U.S., and people with low incomes.
- Care navigation: Education and care navigation are important for supporting people in navigating the resources available, including managing appointments, organizing transportation, explaining insurance and payment options, and more. This may be particularly relevant for populations with lower health literacy.
- Lack of trust in health care: Key informants spoke to a lack of trust in health care, particularly around vaccines, because of the COVID-19 pandemic. Using peer educators and community navigators can help improve trust.

Additional logistical barriers related to cost of care and navigating appointments include the following:

- High cost of care and insurance: People that are underinsured or uninsured may not be able to afford care or to purchase insurance. High copays, deductibles, and monthly premiums may discourage people from seeking needed and preventive care, leading to undiagnosed issues. Paying for medical care and costly medications may lead to spending tradeoffs.

  "Do I pay the electric bill, or do I go to the, you know, go to the doctor?"—Key Informant

- Appointment hours: Many people cannot afford to take time off work to seek medical care.
- Long wait times: Wait times for appointments may also discourage people from seeking care or lead to delayed diagnoses.
- Transportation: Getting to appointments is difficult for many people, particularly people experiencing homelessness, with low incomes, and refugees. Snohomish County is spread out with central areas, such as Lynwood or Everett, with a lot of resources. For people that cannot afford to live in these areas, they may live further away with limited transportation. There is a need for improved public transportation that is low cost.

To address these barriers and improve community access to health care services, key informants identified the following community needs:

- Culturally matched and linguistically appropriate services: Particularly to serve immigrant and refugee populations, key informants noted a need for more bicultural, culturally matched providers. They shared seeing refugee community members wait to see care until there is a provider that shares their culture and is recommended by their community.
- Improve dignity and respect for all patients: To better serve community members, having a better understanding of their experiences and avoiding any judgment or discrimination is important. Particularly for patients that may be experiencing homelessness, have low incomes, or who are immigrants and refugees, providers may make harmful assumptions about their life circumstances. For example, providers may assume refugees do not understand their care and do not want to participate in it, but most want to be healthy and want to participate in their care.

  "Responsiveness is not always what we would hope in our community to treat each person with dignity and respect."—Key Informant

- Timely and affordable access to primary care providers: Improving access for wellness checks and chronic disease management is needed.
- More pharmacy services: In some areas of the county people drive over an hour to access pharmacy services.
- Workforce recruitment, retention, and burnout prevention: For providers that work with patients with highly complex social needs, there is an increased risk of burnout. Addressing burnout and retention of providers is needed.
- Specific health care services and specialties:

- More robust free immunization programs
- Free or low-cost Obstetrics and Gynecology (OB/GYN) services and prenatal care
- Sexually Transmitted Infections (STI) services
- Pediatric inpatient care
- More resources for people with Traumatic Brain Injuries (TBIs)
- More resources for patients with dementia and needing memory care

Certain populations and groups may experience more challenges and barriers to accessing needed care:

- Refugees and immigrants: Key informants shared there are many immigrants and refugees in Snohomish County, with a particularly large new Ukrainian refugee population. Language barriers and a new health care system can make accessing care and insurance difficult. Immigration status can also prevent access to Medicaid (people with undocumented status in particular) and there are disparities in accessing Medicaid for Ukrainian refugees due to changes in eligibility. Accessing primary care providers can be difficult, with refugees needing free vaccines, tuberculosis clinics, and more. The Ukrainian refugee population has a low immunization uptake.
- People experiencing homelessness: People living unsheltered may be underserved because they may not routinely seek medical care if they are focused on meeting their immediate needs. A history of trauma can also create a reluctance to reach out for assistance. The traditional appointment system may also not be accommodating to people experiencing homelessness who may experience more barriers to getting to care and maintaining an appointment.

"A lot of folks that we care for do not have a primary care provider. We see a high incidence of diabetes, of high and unchecked blood pressure. [It] comes along with having lived in homelessness, having to try to secure energy dense foods that are not good for you, all of those sorts of things."—Key Informant

- Indigenous Peoples of the U.S.: This population experiences health disparities related to births and chronic disease due to racism and historical trauma which has contributed to less trust in the medical system. A lack of health literacy and disconnection from traditional ways may also contribute to health disparities.
- Older adults: Older adults, particularly those living alone, may have difficult navigating care and technology involved. They may need in-home medical care if transportation is an issue.
- People with Medicaid: There are a lack of providers who accept Medicaid, making it more difficult for people to access an appointment and primary care provider.
- People with behavioral health challenges: Accessing care can be more difficult with an untreated behavioral health challenge.

Appendix 3: Community Resources Available to Address Significant Health Needs

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

Table 1 Appendix 4. Community Resources Available to Address Significant Health Needs

Organization Type	Organization or Program Name	Description of Services Offered	Address	Website	Health Need(s) Addressed					
					Access to Healthcare	Behavioral health, incl.	Housing	Economic (Food) Security	Childcare (Preschools)	Racism and Discrimination
Healthcare	Cascade Valley Hospital, Skagit Regional Health	Inpatient and outpatient medical services	330 S. Stillaguamish Ave Arlington, WA 98223	https://www.skagitregionalhealth.org/location-details/cascade-valley-hospital	X	X				
Healthcare	Optum (previously The Everett Clinic)	Primary and specialty medical care	Various Locations	https://optumwa.com/	X	X				
Healthcare	Safe Harbor Free Clinic	Free medical care to individuals and families without insurance or underinsured	7209 265th St NW Stanwood, WA 98292	https://www.safeharborfreeclinic.org/	X					
Healthcare	Snohomish County Health Department	Provides public health services for Snohomish County	3020 Rucker Ave Everett, WA 98201	https://www.snohd.org/	X					
Healthcare	Western Washington Medical Group	Primary and specialty medical care	Various Locations	https://www.wwmedgroup.com/	X					
Healthcare (including BH & Dental)	Community Health Center of Snohomish County	Comm. medical, dental, & behavioral health provider	Various Locations	https://www.chcsno.org/	X	X				

Healthcare (including BH)	Evergreen Health Monroe	Inpatient and outpatient medical services	14701 179th Ave SE Monroe, WA 98272	https://www.evergreenhealth.com/locations/locations-profile/evergreenhealth-monroe/	X	X				
Healthcare (including BH)	Lahai Health	Providing hope and health for underserved peoples, medical, dental, and counseling	Various Locations	https://lahai.org/	X	X				X
Healthcare (including BH)	Mercy Watch	Serve those on the streets with addiction, mental health crisis, social needs, etc.	PO Box 1550 Mukilteo, WA 98275	https://mercywatch.org/	X	X				X
Healthcare (including BH)	Sea Mar	In-office and school-based services for mental health, chemical dependency, primary care, educating health care providers	Various Locations	https://www.seamar.org/	X	X				X
Behavioral Health	Bridgeways	Services that promote quality of life for individuals living with mental illness	5801 23rd Drive W. Everett, WA 98203	https://bridgeways.org/		X				X
Behavioral Health	Fairfax	Inpatient facility in Everett, Monroe, and Kirkland	916 Pacific Ave Everett, WA 98201	https://fairfaxhospital.com/		X				
Behavioral Health	Smokey Point Behavioral Hospital	Inpatient and outpatient psychiatric care	3955 156th St NE Marysville, WA 98271	https://www.smokeypointbehavioralhospital.com/		X				
Behavioral Health	Volunteers of America - 988	Food, shelter, housing, outreach, counseling, dispute resolution, referrals for mental health professionals, community resource centers	2802 Broadway Everett, WA 98201	https://www.voaww.org/behavioralhealth		X	X	X		
Behavioral Health and Housing for Youth	Cocoon House	Provides short- and long-term housing to young people experiencing homelessness and their children.	3530 Colby Ave Everett, WA 98201	https://www.cocoonhouse.org/		X	X			X

Behavioral Health & Substance Use	Advocates Recovery Services	Offers a range of services designed to support both mental health and substance use recovery for our community	16404 Highway 99 Lynnwood, WA 98037	https://www.advocatesrecovery.org/	X	X				
Behavioral Health & Substance Use	Catholic Community Services	Chronically homeless housing, child, youth and family services, addiction recovery, mental health, services for seniors and people with disabilities	1918 Everett Ave Everett, WA 98201	https://ccsww.org/	X	X	X			X
Behavioral Health & Substance Use	Compass Health	Provides mental and chemical dependency services to all ages, income levels and ethnic cultures	Various Locations	https://www.compasshealth.org/		X				X
Behavioral Health & Substance Use	Conquer Clinics	Outpatient mental health and addiction treatment	809 W Main St Unit C Monroe, WA 98272	https://conquerclinics.com/		X				
Behavioral Health & Substance Use	Snohomish County Diversion Center	Offers short-term placement and shelter to homeless adults with a substance use disorder and other behavioral health issues, diverting them away from incarceration and toward treatment.	1918 Wall St. Everett, WA 98201	https://snohomishcountywa.gov/4006/Diversion-Center		X	X			
Behavioral Health & Substance Use	Sound Pathways	Sound Pathways serves as a beacon of hope and healing for at-risk individuals and families facing challenges related to alcohol, substance use, and mental health in Snohomish County	1721 Hewitt Ave STE 200 Everett, WA 98201	Https://soundpathways.org/		X				
Substance Use	Alcoholics Anonymous	Alcoholism treatment program and support group	1625 Marine View Dr	http://www.snocoaa.org/		X				

			Everett, WA 98201							
Substance Use	Alpine Recovery Services	Addiction treatment services inpatient and outpatient	16404 Smokey Point Blvd #109 Arlington, WA 98223	https://ALPINERECOVERY.COM/		X				
Substance Use	EMOTE	Emergency Mobile Opioid Treatment Everett	Mobile Services	https://www.everettwa.gov/AgendaCenter/ViewFile/Item/16836?fileID=94294		X				
Substance Use	Everett Area Narcotics Anonymous	Support group	3606 Rockefeller Ave. Everett, WA 98201	https://everettna.org/		X				
Substance Use	Everett Recovery Cafe	Safe place for individuals to pursue their healing and recovery	1212 California St Everett, WA 98201 (located in Sno-Isle Food Co-op)	https://www.everettrecovERYcafe.org/		X				
Substance Use	Ideal Option	Outpatient addiction treatment center	4301 Hoyt Ave Everett, WA 98203	https://www.idealopTion.com/		X				
Housing	Housing Hope, Hope Works Social Enterprise	Promotes and provides affordable housing and tailored services to reduce homelessness and poverty	3331 Broadway, Everett, WA 98201	Housing Hope | Nonprofit | Everett			X		X	X
Housing	Interfaith Family Shelter	Services for families experiencing poverty and homelessness	2520 Cedar Street, Everett	Interfaith Family Shelter | Sheltering families. Strengthening communities.			X			
Housing	Millennia Ministries	Crisis, transition, and permanent housing and food to help end homelessness	3426 Broadway, Everett	www.millenniaministries.org			X			X
Equity	NAACP Snohomish County	Ensure the political, educational, social, and economic equality of rights for all persons	info@naacp-snoco.org	Home - NAACP Snohomish County						X

Equity	Snohomish County, Office of Social Justice	Seeks to dismantle the individual, institutional, and structural racism that exists in the County.	3000 Rockefeller Avenue Everett, WA 98201	Office of Social Justice | Snohomish County, WA - Official Website						X
Equity and Social/ Health Services	Refugee and Immigrant Services Northwest	Assistance to newly arrived refugees and immigrants to rebuild lives and become self-sufficient	2000 Tower Street Everett, WA 98201	HOME | Refugee & Immigrant Services Northwest | RISNW						X
Childcare/Early Childhood Education and Health and Well-being	YWCA Snohomish County	School-Age Care, Early Childhood Education and Pre-Schol	Various locations in Snohomish County	Child Care – YMCA of Snohomish County					X	X
Childcare and Pre-schools	Early Childhood Education & Assistance Program - ECEAP	ECEAP is a Washington State funded free pre-school program with 29 locations throughout the County.	3000 Rockefeller Avenue Everett, WA 98201	Early Childhood Education & Assistance Program - ECEAP | Snohomish County, WA - Official Website					X	X
Food Security	Snohomish County Food Bank Coalition	Food Bank Coalition is comprised of over 18 members serving clients from Darrington and Stanwood-Camano south to Mountlake Terrace, east to Sultan and all points in between.	Various Location in Snohomish County	Snohomish County Food Bank Coalition				X		

Appendix 4: North Puget Sound Community Health Needs Assessment Advisory Committee

Table 1 Appendix 5. Community Health Needs Assessment Committee Members

Name	Title	Organization	Sector
Altamirano-Crosby, Julieta	Executive Director Council Member	WAGRO Foundation and Lynnwood City Council	Social services focusing on BBIPOC community. Government
Bai, Amelia	Co-Director	Oceania Northwest	Social services focusing on AAPI community
Tanya Baniak	Program Planner	Snohomish County	County Government
Clay, Kevin MD	Physician (retired)	Community member	Health care
Dinh-Kuno, Van	Executive Director	Refugee & Immigrant Services Northwest	Social services focusing on refugee and immigrant community
Drewel, Bob	Executive (retired)	Community Member	Government and education
Leach, Bob	Financial advisor (retired)	Community member	Banking
Leach, Dan	Senior Vice President, Financial Advisor, Branch Manager	D.A. Davidson	Banking
Vandree, John MD	Physician (retired)	Community member	Health care
Whitehead, Carol	Public school superintendent (retired)	Community member	Education