A Region-wide Community Needs and Opportunity Assessment

Community Data Indicators and Strategic Philanthropic Plan for the Lewis-Clark Valley Healthcare Foundation

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Author Note

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Executive Summary

Needs assessment is a commonly understood term, defined by Wikipedia as "a systematic process for determining and addressing needs, or 'gaps' between current conditions and desired conditions or 'wants'." While the definition may sound straightforward, designing, implementing and reporting on a needs assessment can be challenging. How are current conditions measured? Whose perspective is included or excluded when deciding what needs to address? This report summarizes a needs assessment conducted for the Lewis Clark Valley Healthcare (LCVH) Foundation – a hospital conversion foundation established in 2017. The LCVH Foundation serves nine counties across Southeast Washington, Northeast Oregon, and North Central Idaho. To fairly evaluate community needs for over 200,000 persons living throughout this region, this project took a three-pronged approach:

- A **community survey** sent to a random sample of over 8,400 households in this area. The random sample was designed to reduce bias and ensure that diverse viewpoints were represented. Nearly one third (32%) of invited household completed a survey.
- An analysis of **secondary data indicators** was completed to assess community outcomes and conditions using publicly available data from the U.S. Census Bureau and other sources. The project 'data hub' includes a community assessment tool: www.inlandnorthwestinsights.org/community-assessment-tool/.
- A **series of community forums** were held to share results from data collection and hear from residents about community strengths, opportunities, and experiences. The forums included a 'data walk' where people could hold small-group discussions at stations focused on an important community topic.

Every needs assessment process will have some shortcomings and this year-long project may include limitations that are noted throughout this report. However, the underlying principle for each phase was grounded in a desire for inclusiveness and broad community participation. Listening to the 'voice' of community organizations and residents was imperative for this needs assessment. Based on a synthesis of survey/data analysis and resident feedback, we identified four themes where community needs were evident.

1. **Economic security and empowerment** – Unexpected household hardships and rising costs of living impact the health and well-being of persons, particularly financial insecure households, in this region. Addressing food insecurity/hunger, transportation obstacles and support for struggling households (such as fixed income seniors and low-income working families) were key themes reflected in the assessment.

2. **Educational opportunity and youth development** – Empowering residents to improve health and expand personal opportunity starts with access to education. The assessment revealed that school-based supports (such as mental health counseling), activities for teenagers, and training/education pathways that improve job prospects represent current gaps in many communities.

3. **Access to quality health and dental services** – Based on analysis of collected data and feedback from community forums, access to quality medical and dental care stood out as a key need highlighted in this assessment. There are numerous challenges to health service delivery throughout this region – distance, cost, and a changing policy environment among them. But these challenges create an opportunity for innovative delivery models (e.g. telehealth), patient

engagement (e.g. mobile care) and philanthropic support (e.g. rural residents). The healthy community rests on proactive and preventative care models. This assessment underlines the strong desire to have predictable, accessible and affordable health care available to all community members.

4. **Community development and social connection** – The strength and pride and witnessed in the towns and rural communities throughout this region stood out as a memorable takeaway from this assessment process. Participants expressed a strong desire to work together to improve health by supporting community gathering and recreation places and inclusive civic participation models. Social isolation is perpetuated when residents do not feel like they are a part of the community. This disconnection hinders effort to promote wellness and prevent disease. Bringing people together and building on community pride – through housing options, community centers, public spaces and community-led initiatives – are all avenues for bolstering health and wellness.

All of these themes surfaced as ‘gaps’ in the community. The four themes based on data indicators and survey responses are not ranked by importance. Rather, these issues stand as guideposts, marking community concerns and essential needs (also called social determinants of health). These guideposts, and the findings laid out in this report, provide a means to navigate available opportunities, define community priorities and move forward on the road to improving health and wellness in the region.

Purpose

The Lewis-Clark Valley Healthcare (LCVH) Foundation was established in 2017 with the sale St. Joseph's Hospital in Lewiston, Idaho. The foundation manages the initial $26 million endowment that resulted from the conversion of the hospital from a nonprofit to a for-profit entity. The LCVH Foundation is charged with:

> Making grants, contributions, or program-related investments to qualified (nonprofit) organizations that promote the health, wellness, or disease prevention within the St. Joseph Regional Medical Center's service area.[1]

The hospital's service area includes Clearwater, Idaho, Latah, Lewis and Nez Perce counties (Idaho), Wallowa county (Oregon), and Asotin, Garfield and Whitman counties (Washington) – **Exhibit 1**. The endowment will generate an estimated $1 million in annual grants made available to serve the estimated 200,000 persons that reside in the 20,000 square mile service area.

Exhibit 1: Lewis-Clark Valley Healthcare Foundation Service Region

Idaho Trust Bank serves as the trustee for the LCVH Foundation and grant decisions are made by a volunteer Board of Community Advisors (BCA). In the first grant round administered by the LCVH Foundation, the BCA elected to award Innovia Foundation a research grant to conduct a comprehensive needs assessment that will guide grantmaking strategies in the coming years.

Lewis~Clark Valley
Healthcare Foundation

The BCA recognized the tremendous potential to improve the health and wellness of area residents through the stewardship of foundation assets. In this sense, the **strategic philanthropic plan** outlined in this report provides *both* a needs and opportunity assessment. While this report is directed to the BCA, the work outlined here can benefit numerous organizations and entities concerned with improving community health and wellness in the region, including:

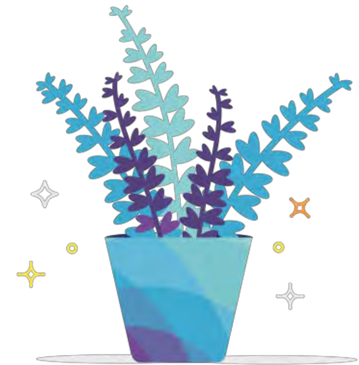
- Community organizations and nonprofits
- Local governments, boards and committees
- Public agencies
- Grantmaking foundations and community investment groups

The purpose of this project is twofold. First, through the process outlined below, we aimed to identify the most pressing health and wellness needs facing the region's population. Second, and of equal importance, this assessment provided a forum to engage in community conversation around opportunities to support locally driven solutions.

The intention behind this effort is to utilize multiple sources of data, assemble up-to-date, reliable information and solicit feedback from diverse voices. In doing so, the assessment cannot only provide a report that serves as a useful reference, but outline a framework for examining, analyzing and sharing community needs.

Scope

For grantmaking foundations and community funders, requests for support invariably outpace available grant dollars. To achieve maximum impact with community funding, it is necessary to define both the scope of the issue and the intended response to address identified community needs. As noted by Wright, Williams and Wilkerson:



> Importantly, health needs assessment also provides a method of monitoring and promoting equity in the provision and use of health services and addressing inequalities in health. The importance of assessing health needs rather than reacting to health demands is widely recognized, and there are many examples of needs assessment in primary and secondary care. There is no easy, quick-fix recipe for health needs assessment. Different topics will require different approaches. These may involve a combination of qualitative and quantitative research methods to collect original information or adapting and transferring what is already known or available.[2]

While the mission of the LCVH Foundation is broad – promoting health, wellness and disease prevention – the mandate for this assessment reflects an intentional plan meant to extend the reach of this work and achieve long-term results. This assessment plan emphasized the following priorities:

- Collaboration – input and ‘buy-in’ from community partners
- Proactive response – prevention focus
- Generalizable data – reflect population
- Replicable findings – shared openly

Collaboration between partners

From the outset of this project, the BCA expressed a desire to involve community partners to create a comprehensive and inclusive understanding of community needs and opportunities. Fortunately, additional regional funders and foundations recognized the value of collecting reliable data and developing a common 'playbook' for assessing community needs. Organizations providing financial support to this project included:

- Lewis-Clark Valley Healthcare Foundation (primary sponsor)
- Innovia Foundation (primary sponsor)
- Idaho Community Foundation (supporting partner - ID)
- Avista Foundation (supporting partner – WA and ID)
- Premera Social Impact (supporting partner – WA)
- Federal Reserve Bank of San Francisco Community Development (community forums)

In addition, the commitment to collaboration involved numerous community partners that contributed to the design and implementation of this needs assessment. This included, but was not limited to, revisions to survey questions, distribution of paper surveys, selection of community indicators, and outreach for community forums and events.

The project was guided by both a Technical Advisory Committee and Oversight Committee. The Technical Advisory Committee provided regional representation and the content expertise necessary to ensure assessment produced valid and usable information. The Oversight Committee ensured that the project made consistent progress in meeting shared objectives of partners. Both groups met regularly to review the needs assessment methodology (described next) and suggest changes, where necessary.

Members of each committee are listed in **Appendix A** and included representatives from project funders and members of the following organizations:

- North Central Idaho Public Health
- Community Action Center
- COAST Transportation
- Twin County United Way
- Nimiipuu Health
- Lewis-Clark State College
- Syringa Hospital
- University of Idaho

It is important to note that dozens of additional community organizations and hundreds of area residents participated in the community forum phase of the project. The direct involvement from key organizations in planning the assessment demonstrates the broad commitment to share results of data analysis and work together to improve regional health indicators. These partnerships and pooled resources are particularly valuable in responding to health issues in rural areas. As Allen Smart, writing for Exponent Philanthropy notes,

> Successful small foundations in rural areas leverage a number of non-financial assets to improve the lives of those they serve. They focus on meeting each community's own vision of success by exploring the strategic possibilities that are well beyond the realm of check-writing.[3]

According to Smart, this type of engagement can improve health and wellness by 1) highlighting important issues, 2) educating the community, 3) building local infrastructure, 4) leveraging fundraising capacity, and 5) growing local voices. The coalition assembled for this project represents trusted community voices and content experts who can evaluate complex health problems and contribute to thoughtful solutions that are appropriate to the unique aspects of each community. These community contributions will prove the true value of this assessment, beyond any information presented in this report.

Proactive planning – prevention strategies

In considering grantmaking priorities, LCVH Foundation adopted a preference for looking ‘upstream,’ beyond the walls of the healthcare facility to focus on *social determinants of health (SDOH)*. Definitions of social determinants vary. However, a practical description involves, “complex circumstances in which individuals are born and live that impact their health. They include intangible factors such as political, socioeconomic and cultural constructs, as well as place-based conditions including accessible healthcare and education systems, safe environmental conditions, well-designed neighborhoods, and availability of healthful food.”[4] While not exhaustive, the social determinants listed in **Exhibit 2** shows the wide range of factors that influence population health outcomes.

Exhibit 2: Social Determinants

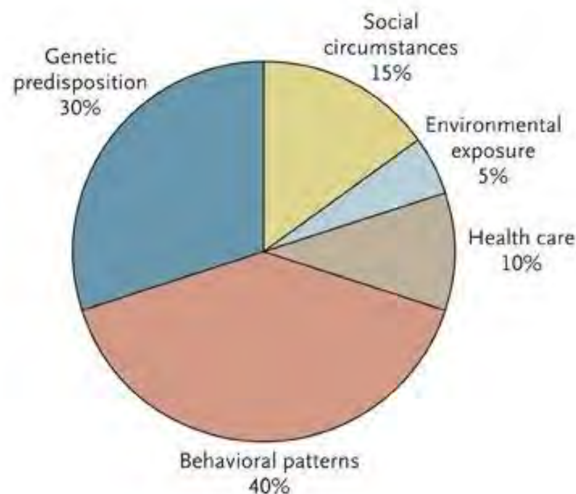
Economic Stability	Neighborhood and Physical Environment	Education	Food	Community and Social Context	Health Care System
Employment	Housing	Literacy	Hunger	Social integration	Health coverage
Income	Transportation	Language	Access to healthy options	Support systems	Provider availability
Expenses	Safety	Early childhood education		Community engagement	Provider linguistic and cultural competency
Debt	Parks	Vocational training		Discrimination	Quality of care
Medical bills	Playgrounds	Higher education		Stress	
Support	Walkability				
	Zip code / geography				

Health Outcomes
Mortality, Morbidity, Life Expectancy, Health Care Expenditures, Health Status, Functional Limitations

Source: Orgera, K. & Artiga, S. (2018, August 8). Disparities in Health and Health Care: Five Key Questions and Answers. Retrieved from https://www.kff.org/disparities-policy/issue-brief/disparities-in-health-and-health-care-five-key-questions-and-answers/.

Monitoring SDOH-related data as part of an ongoing assessment process makes logical sense, given the accumulation of research on domains that influence health outcomes. Only 10% of premature deaths, for example, are related to clinical or health-care related causes. The majority of early deaths (55%) can be attributed to behavioral or social factors (**Exhibit 3**).

Exhibit 3: Proportional Contribution to Premature Death



Source: Schroeder, S. A. (2007 September 20). We Can Do Better — Improving the Health of the American People. *New England Journal of Medicine, 357,* 12, 1221-1228. Retrieved from https://www.nejm.org/doi/full/10.1056/NEJMsa073350

Full lists and categories of potential social determinants are available from a number of sources. The technical advisory committee for this project reviewed many of these sources including Robert Wood Johnson Foundation's County Health Rankings, Institute of Medicine's Committee on Recommended Social and Behavioral Domains, United Health Foundation's Health Rankings and the World Health Organization's Health in All Policies initiative. The details of the selected indicators are listed in the methodology section (p. 6). Rather than debate the acceptability of each item on the list, however, it is important to emphasize the importance of thinking of health improvement in a new way. Meeting the goal of this effort – promotion of health, wellness, and disease prevention – cannot take place solely in a hospital or doctor's office; it must start in homes, schools, parks, community gathering places and neighborhoods where we all live, work and recreate.

Generalizable data - reflecting population

The nine-county area served by LCVH Foundation is a diverse and changing region. For example, nearly one in five residents lives below the poverty line (19%), but the county poverty rates vary between 14% and 26% of the population. Region-wide, 17% of the population is age 65 or older, but the age 65+ population in each county ranges between 10% and 27%. With over 8,500 square miles, Idaho County represents the 18th largest county in the United States, by land area. Most of the census tracts and counties within this region have fewer than 20 persons per mile. However, in the quad-cities (Pullman, Moscow, Lewiston, Clarkston), population density exceeds 2,000 persons per square mile.

The stated priority of this effort, however, is to ensure that results reflect all members of the population. Partners cannot be responsive to population health needs if certain subgroups are not included in the assessment findings. The data collection methods outlined below were designed to collect a representative sample of the region's population, including hard to reach and underserved groups, as well as those persons who may be more likely to respond to survey and self-report questions. Findings can be summarized to reflect the entire region or disaggregated to compare and highlight the county and local-area differences discussed above. By adhering to rigorous sampling procedures and proven

data collection methods, project partners were able to ensure the accuracy and credibility of assessment findings.

Replicable – able to update and verify information

Finally, project partners wanted to ensure that this was a "living assessment," with information and analysis that could be accessed beyond the pages contained in this report. The importance of this commitment is twofold. First, the conclusions and summaries provided here could only be considered trustworthy if source material were open to further investigation and validation. Second, the needs and interests of community partners and funders varied. If data were open and accessible, additional learning about particular groups or locations could take place as part of this effort. With these goals in mind, community survey data collected for this assessment will be made available to requesting organizations and agencies. Additionally, access to a rich source of secondary data and locally relevant research has been compiled at the online project data hub: www.inlandnorthwestinsights.org. Both of these resources are discussed in the project methodology section.

Methods

Effective needs assessment requires a factual and wide-ranging understanding of important issues experienced by a community. Different data collection approaches each come with inherent strengths and limitations. To account for these trade-offs, the project team decided to adopt a three-phase approach: 1) primary data collection through a representative community survey, 2) secondary data collection and synthesis of available public data, and 3) a series of community forums and listening sessions to share findings and hear directly from community residents.

Community Survey

Administration and Scope

The objective of this survey was to obtain a comprehensive and illustrative profile of population health and social service needs facing households in Southeast Washington (Asotin, Columbia and Garfield counties), Latah County, Nez Perce County and North Central Idaho (Clearwater, Idaho and Lewis counties). The Social and Economic Sciences Research Center (SESRC) at Washington State University implemented the survey in collaboration with the Lewis-Clark Valley Healthcare Foundation, Innovia Foundation and other community partners.

It is important to note that two additional counties are part of the needs assessment project, but were not included in the community survey. These two counties are:

- **Wallowa County, OR –** At the time of the survey planning, project staff at the Northeast Oregon Health Network (www.neoregon.org) were preparing to launch a random-sample survey in Wallowa County, Oregon. The survey was designed to support the Oregon Health Authority (OHA) Coordinated Care Organization Care Integration Assessment. The prospect of two surveys in the field was likely to confuse residents and lower response rates. Therefore, for the 2019 cycle, a second survey in Wallowa County was postponed, and the Northeast Oregon Health Network agreed to share survey responses and reports for use in this assessment.

- **Whitman County, WA –** The Whitman Health Network utilized local and national funding sources to conduct a county-wide survey in both 2015 and late 2018. SESRC also administered the Whitman County survey using the same methodology for this survey study (described below). While the questionnaire for the Whitman County survey served as the basis for this effort, several questions were added or modified during the technical review process described previously. Partners from Whitman Health Network agreed to share responses from their 2018 survey, and it was determined that re-surveying the county in 2019 would not be necessary.

Population and Sample Segments

The surveyed population across this region includes nearly 140,000 persons. As discussed previously, it was important from a project standpoint to compare and explore differences for locations within this region. Therefore, we designed a survey frame that included a representative sample from four sub-regions (**Exhibit 4**). A random sample of 8,419 residential households was obtained from Marketing Systems Group for use with this study. The sample was drawn from an Address-Based Sampling (ABS) frame with the United States Postal Services Delivery Sequence File (USPSDSF) as its primary source.

Based on previous experience, survey managers at SESRC expected a 20-25% response rate. It was necessary to mail at least 2,000 invitations within each sub-region to ensure that survey estimates approximated population values with low sampling error. The survey administration and steps taken to increase response rate are detailed in the next section. Following these steps, the final response rate for the survey exceeded expectations, with 32% of available households completing an online or paper (mail) version of the survey. The calculated sample error was +/-1% - indicating low uncertainty between drawing a sample versus surveying the entire population. This high response rate provides an additional level of confidence in survey findings and improves the ability to draw conclusions about particular sub-populations and demographic groups.

Exhibit 4 – Community Survey Sample Frame and Response Rate

Region	Households	Invitations	Eligible	Completions	Response Rate
Southeast Washington Asotin*, Columbia, Garfield	28,879	2,419	2,283	679	30%
Latah County	40,134	2,000	1,858	638	34%
Nez Perce County	40,408	2,000	1,896	557	29%
North Central Idaho Clearwater, Idaho, Lewis	29,132	2,000	1,839	613	33%
Region Total	**138,553**	**8,419**	**7,876**	**2,487**	**32%**

The response rate is the ratio of completed and partially completed surveys to the total eligible within the sample. This formula is considered the industry standard for calculating response rates and complies with the American Association for Public Opinion Research (AAPOR) standard definition of response rate. The formula is: (completed interviews + partially completed interviews)/ [(completed interviews + partially completed interviews) + refusals + unable to interview + unable to reach]. Asotin County was oversampled so a representative sample could be obtained for both Southeast Washington and Asotin County.

Survey Implementation/Design

Using questions developed by project partners, in consultation with SESRC staff, a final questionnaire was created, with both an online and paper version. A survey protocol, based on the **Total Design Method**, was instituted. The total design method was pioneered by Don Dillman (Washington State University) and includes several prescribed steps designed to connect with potential respondents and encourage survey completion:

- For the random sample, a $1 cash pre-incentive was enclosed with the mailing of the introductory letter. The cash pre-incentive is a token of appreciation, which helps draw attention to the mailing and helps to motivate respondents to participate. The cash pre-incentive was used to help improve survey response rates. The initial letter (**Appendix B**) introduced project partners and outlined the purpose of the study. Each letter included a unique code that allowed a member of the household to access the online survey site. The adult with the most recent date of birth was asked to complete the survey.
- The following week, residents who had yet to participate in the survey received a postcard reminder.
- Two weeks later, non-respondents received a paper questionnaire (**Appendix C**), and two weeks after that they received a final reminder letter.

The survey reminder period occurred between April and May 2019. During this period, each returned mail survey was coded into a database by SESRC data collection staff. The surveys were double-coded (entered a second time) to ensure accurate recording of all responses.

With assistance from COAST Transportation and other project partners, paper survey versions with pre-paid envelopes were distributed to libraries, senior centers, health offices and public gathering spaces throughout the region. The online version of the survey was also opened to the public with announcements airing on Northwest Public Broadcasting during two weeks in June. Despite extensive outreach with nearly 2,000 paper versions distributed, only 291 paper and online surveys were completed. While the results reported here do not include responses from this convenience sample, this extended dataset is available on request.

Public Data Indicators

Overview and Criteria

While the community survey data collected for this project are incredibly valuable, self-reported responses cannot provide a complete profile of issues facing a community. Important questions were omitted from the survey questionnaire where responses were likely to be subject to bias. Sensitive topics (e.g. sexual health, death by suicide), topics with social stigma (e.g. mental health, substance use), topics concerning vulnerable populations (e.g. incapacitated persons) or topics covered by populations not included in the survey (e.g. children) potentially fall in this category.

A robust collection and analysis of secondary data indicators was planned to both verify and augment information collected by the community survey. Secondary data indicators include those publicly available data sources that provide aggregated information for geographic regions of interest (i.e. counties, zip codes, school districts, census tracts). Of course, there are an innumerable set of public data sources that could potentially be examined as part of this effort. To narrow the list, we adopted the following criteria:

- Nationally available (not state-specific)
- Current (recent data in last 5 years)
- Consistent (published on a regular basis – not one time)
- Ongoing (data updates, permit trend analysis)
- Valid (data collected and published according to accepted research standards)
- Relevant (consistent with survey topics, health and wellness)
- Rural focus (possible to reliably examine rural profile and trends)

Data Hub

Ideally, data elements utilized for the assessment could be readily updated and made available to project partners in a cost-effective manner. Funding partners reviewed costs and features from several organizations that offered online data clearinghouses. After consideration, we contracted with the Center for Applied Research and Engagement Systems (CARES), located at the University of Missouri. The CARES Engagement Network (www.engagementnetwork.org/) provides an analysis and reporting platform that "connects communities to data." The center develops customizable 'data hubs' that have been adopted by community networks across the United States.

A data hub for this assessment was developed with input and assistance from project funders and the technical advisory committee. The resulting online data hub – www.inlandnorthwestinsights.org – offers powerful mapping, reporting and data management tools. The hub also serves as a resource for grant writing, program development, and data-driven decision-making that can be accessed by community organizations and residents. Community research and results from the survey (www.inwinsights.org/community-survey/) discussed previously are also hosted on the data hub. Two recorded webinars were provided by the CARES team to explain features and functionality available on this site.

Community Assessment Reporting

The online mapping tool on the data hub makes over 15,000 indicators from hundreds of data sources available for rapid access, queries and export. The data cover topics ranging from civic/social, economic, education, environment and health (www.inlandnorthwestinsights.org/map-room/). While the mapping tool includes a vast repository of data, the geographic analysis of information cannot capture all aspects about the relative importance of a single data indicator. To rank indicators against relevant benchmarks and report on local trends, the data hub provides a community assessment tool (www.inlandnorthwestinsights.org/community-assessment-tool/).

The community assessment tool provides detailed reporting at the specified geography comparing rates to state and national benchmarks, showing annual trends, highlighting regional differences and demonstrating results by gender and racial/ethnic categories, when available. In total, the community assessment tool makes 100 indicators available for detailed analysis and reporting. The indicators are classified into the following categories, based on social determinants of health literature discussed earlier (Exhibit 5):

Exhibit 5 – Data Hub Community Indicators, by Category

1. Social and Economic Factors
- Poverty
- Early Childhood Education
- Reading Proficiency
- High School Graduation
- High School Transitions
- Social Support

2. Neighborhoods and Communities
- Housing Affordability
- Child Care Availability
- Transportation
- Parks and Recreation

3. Clinical Care
- Health Care Access
- Provider Availability
- Screening and Prevention
- Insurance Coverage
- Primary Care Utilization

4. Health Behaviors
- Alcohol Consumption
- Smoking and Tobacco Use
- Food Insecurity and Hunger
- Substance Use
- Physical Activity and Obesity

5. Health Outcomes
- Chronic Health Conditions
- Mortality and Premature Death
- Infant Health
- Oral Health
- Sexual Health
- Mental Health

6. Demographic Profile
- Sex
- Age Groups
- Ethnicity
- Household Composition
- Veteran Populations

Detailed definitions and sources for the selected indicators are provided in **Appendix D**. The inventory of data indicators was selected by project partners based on several considerations. First, the selected indicators should show potential to be improved through philanthropic investment (and not the primary role of public financing). Second, the indicators should be comparative, so that results could be benchmarked to state or national levels. Third, indicators should be of high interest to local community groups. The local interest and focus on certain topics were also gauged against the list of community groups that submitted applications to the LCVH Foundation's 2018 funding announcement. Finally, the BCA and project partners sought to 'look upstream' and prioritize prevention-related projects with a potential for early intervention and long-term impact. While one category covers health outcomes, the remaining provide leading measures of health, wellness, or disease prevention goals specified in the LCVH Foundation mission.

Rankings Calculation

The primary challenge with assessing and ranking a collection of measures, like those discussed here, comes from comparing figures with different baseline numerators and denominators. Diverging information should be evaluated on an 'apples-to-apples' basis whenever possible. Similar health ranking initiatives[1] have utilized a 'z-score' to standardize and compare each measure. The z-score transforms percentages and rates to a common metric based on the distribution of total scores.

For each indicator, raw data (percentages or rates) are obtained for each county in the LCVH Foundation service area. The z-score for each county is calculated as:

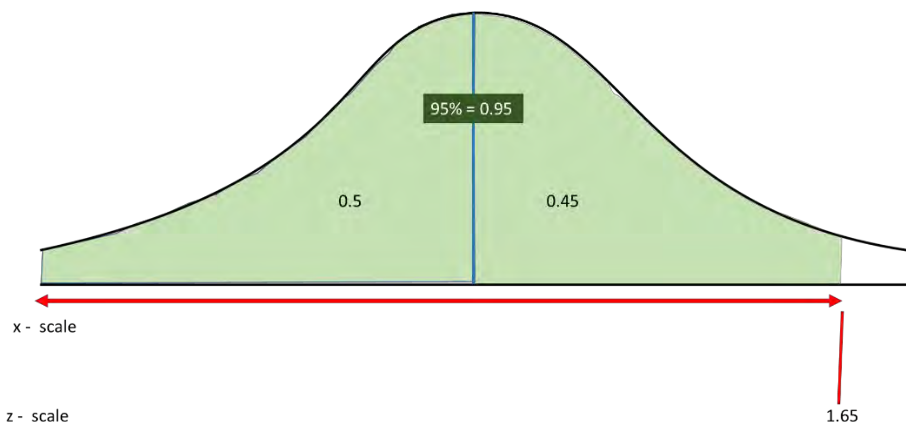
$$Z_{\boldsymbol{region}} = \frac{(county\ value) - (\boldsymbol{regional\ value})}{(standard\ deviation\ of\ all\ counties\ in\ \boldsymbol{region})}$$

In this case, each z-score represents the number of standard deviations above or below the regional value. A z-score of 0.0, for example, indicates that the county has the same value as the entire region. To examine the relative position for each indicator at a national level, we also calculated a z-score based on results from all counties in the nation.

$$Z_{\boldsymbol{nation}} = \frac{(county\ value) - (\boldsymbol{national\ value})}{(standard\ deviation\ of\ all\ counties\ in\ \boldsymbol{nation})}$$

The normalization of results into a z-score provides a common means to compare indicators on a regional or national basis. The z-score gives a consistent metric (standard deviation units) that show whether a county is above or below a regional/national norm. The z-score ranges between -3 and +3, but the meaning of this number can be difficult to communicate.

Fortunately, the z-score describes population values on a normal distribution (bell-curve) and shows the position a particular value (county) relative to all others. A county with a z-score of 1.65, for example, is higher than an estimated 95% of all other counties.



[1] RWJF County Health Rankings (https://www.countyhealthrankings.org/explore-health-rankings/our-methods/calculating-ranks) and United Health America's Health Rankings (https://assets.americashealthrankings.org/app/uploads/2018ahrannual_020419.pdf)

The indicator results presented in the results section correspond to the relative position of the county – the percentage of county scores that are above/below the selected county. There are no firm rules about how to categorize this continuous number. For the purpose of evaluating values of concern, this report adopts the following format:

- **much worse** – county value is in the lowest 10% of all counties regionwide/nationwide
- **worse** – county value is in the bottom 10%-30% of all counties regionwide/nationwide
- **better** – county value is higher than 30-60% all counties regionwide/nationwide
- **much better** – county value is higher than 60% of all counties regionwide/nationwide

Results provided in the next section include the indicator name and ranking (regional/national) according to the above format.

Community Forums and Feedback

Format

The final phase of the needs assessment involved direct conversations with area residents in a series of community forums. Innovia staff and members of the LCVH Foundation joined project partners in hosting nine forums held throughout the region. The forums included a daytime and evening event with the following formats:

- **Community leader forums –** a morning session was held with persons identified by project partners to be community leaders or local influencers. The purpose of the morning session was threefold. First, we aimed to encourage partnerships and facilitate coalition-building aimed at improving health and wellness of residents. Second, the sessions were also intended to introduce community organizations to project data and tools (survey and data hub). As mentioned, these tools are open and available to nonprofit organizations, civic groups, health systems, local governments, educational institutions and others interested in community improvement. Finally, the morning sessions provided a preview of the evening 'data walk' events with the opportunity to discuss preliminary data analysis results. Discussions at these morning forums were facilitated by the Regional Manager for Community Development with the Federal Reserve Bank of San Francisco (www.frbsf.org/community-development/).

- **Evening 'data walk' and community conversation –** to encourage public participation and feedback from a diverse cross-section of the community, we also hosted a series of evening forums. The events included a free meal and childcare to show appreciation for participation and encourage attendance from all types of families. The events were held in a 'data walk' format. Data walks are "an interactive way for community stakeholders, including residents, researchers, program administrators, local government officials, and service providers, to engage in dialogue around research findings about their community."[5]

  The data walk invited participants to visit 4-5 different stations where a poster displayed early research findings from the community needs assessment. The stations focused on the following topics: economic security, food security, healthcare access, housing affordability, health limitations and behavioral health. Of course, community needs are not limited to the topics introduced at this session. However, based on the results from the community survey and feedback from the

technical advisory group, these were the topics chosen for a deeper dialogue with different stakeholders in the community.

At each station, participants were asked to address some of the following questions:

- What surprises you?
- What questions do these data raise for you?
- What further information would be helpful?
- What solutions can you think of to address these issues?
- What's the story behind the data?
- What are the gaps in the community?
- What is role for… public/private sector? …nonprofits and philanthropy?

The discussion provided an opportunity to 'ground-truth' the preliminary results and determine if data summaries aligned with residents' views and experiences. At the conclusion of the data walk, participants recapped their conversations, shared local resources and discussed previous local initiatives. At the conclusion, the moderator asked a final open question – if you had a magic wand, what would you change in your community? This question invited attendees to 'dream big' and think about important areas where groups could come together to address challenges and opportunities. The responses to these questions are synthesized in the results section.

Schedule

The event locations, dates and attendance counts are displayed in **Exhibit 6**. Selected invitations, photos and references to news articles about these forums are included in **Appendix E**.

Exhibit 6 – Community Forum Schedule and Attendance

<table>
<tr><th>Event Location</th><th>Date</th><th>Community Partner</th><th>Attendees</th></tr>
<tr><td>Moscow Community Forum</td><td>23-Sep</td><td rowspan="3">Whitman County Health Network</td><td>19</td></tr>
<tr><td>Pullman Community Forum</td><td>23-Sep</td><td>17</td></tr>
<tr><td>Palouse Data Walk</td><td>23-Sep</td><td>50</td></tr>
<tr><td>Lewiston/Clarkston Community Forum</td><td>30-Sep</td><td rowspan="2">Twin County United Way</td><td>18</td></tr>
<tr><td>Lewiston/Clarkston Data Walk</td><td>30-Sep</td><td>94</td></tr>
<tr><td>Grangeville Community Forum</td><td>2-Oct</td><td>Syringa Hospital</td><td>22</td></tr>
<tr><td>Grangeville Data Walk</td><td>2-Oct</td><td>University of Idaho Extension</td><td>46</td></tr>
<tr><td>Orofino Community Forum</td><td>3-Oct</td><td rowspan="2">Clearwater Economic Development</td><td>11</td></tr>
<tr><td>Orofino Data Walk</td><td>3-Oct</td><td>64</td></tr>
<tr><td>Total</td><td></td><td></td><td>341</td></tr>
</table>

The events were not recorded, and verbatim participant feedback was not collected at the forums. Rather, a scribe wrote down comments on an easel visible to all attendees. The questions and conversation followed a consistent, but not identical, structure. Overall, however, the forums achieved the intended goal of engaging community residents, service providers and other stakeholders in a data-centered discussion about community change. The forums introduced a diverse group of stakeholders to the foundation's work and will also provide a candidate pool for foundation board and leadership committees. Active community engagement represents a vital piece of the needs assessment process and reminds us that this work should be an ongoing part of responding to community needs.

Results

A considerable amount of data was collected for this assessment and, as a result, information from the survey, data hub and community forums can be utilized to address countless questions concerning the status and concerns of adults, children, families, senior citizens and other residents across the region. Given the limited space for this report, we focused on main findings and themes with the goal of prioritizing philanthropic funds for community benefit. Results are presented for each component of the assessment (survey, data indicators, forums) in this section. A synthesis of all three assessment phases is outlined in the final section – strategic direction for foundation grantmaking.

Community Survey

The 12-page community survey administered for this assessment included 48 questions spanning a number of topics such as household composition, employment/economic status, health/well-being, need for services, housing and food access. Results from each question are available on the project data hub: www.inwinsights.org/community-survey. Community organizations and groups wishing to query survey responses can also request access to raw data or the online analysis tool (Qualtrics) by contacting Innovia Foundation.

"Thank you for your work with this survey to support our community!"

-Survey participant

The results presented here cover six multi-part questions that ask respondents about household needs, health conditions, hardship situations and community involvement – factors directly related to grant funding priorities. It is important to note that results reflect population estimates – across all (adult) age groups, household sizes and income levels.[2]

Access to affordable healthcare services is critical to disease prevention, detection and treatment of illnesses, and improving quality of life. Rural residents, in particular, may face additional barriers to receiving necessary health care services, such as lack of health or dental insurance accepted by local providers, transportation distances or lack of convenient appointment times, among others. In addition, unexpected or rising medical costs pose difficulties for all area households. In this survey, 36-40% of respondents expressed a need for affordable medical or dental care (**Exhibit 7**). This need surpassed other household issues and was also consistent across surveyed regions (**Exhibit 8**).

"Even though we have a decent income, the cost of medical insurance and doctor dental care is a huge strain on our budget."

-Survey participant

[2] Survey results for Whitman County, Washington and Wallowa County, Oregon were conducted by external organizations. Responses from these surveys were shared and a summary is provided in a separate supplementary report. As noted, the survey questionnaires differ from results presented here, but the supplementary report provides information on similar topics covered in this section.

Approximately 1 in 10 respondents reported being unable to see a doctor in the past 12 months due to inability to pay and 1 in 8 reported that lack of convenient appointment times prevented access. These rates are consistent with nationally reported numbers and demonstrate the importance of continued focus on care delivery.[6] Additionally, the need for affordable dental and medical care is particularly pronounced for low-income households (under 200% poverty level) – where out-of-pocket health costs may be 2-3 times higher than moderate to high income families (as a percentage of family budget).[7] Patients without consistent primary care often seek needed care in more intensive (and expensive) settings. Among all survey respondents, 15% reported accessing non-emergency care in the emergency room because they were unable to see a primary care provider. Effective solutions to address disparities in healthcare delivery may be a worthwhile investment that result in downstream savings for hospitals, health systems and public taxpayers.

"It is very difficult to find local dentists that accept Medicaid for my children. We have to drive over 70 miles for appointments with our dentist because they are the only providers that accept Medicaid within 200 miles"

-Survey participant

Exhibit 7: What is your household's level of need for the following health and social services? (Q28)

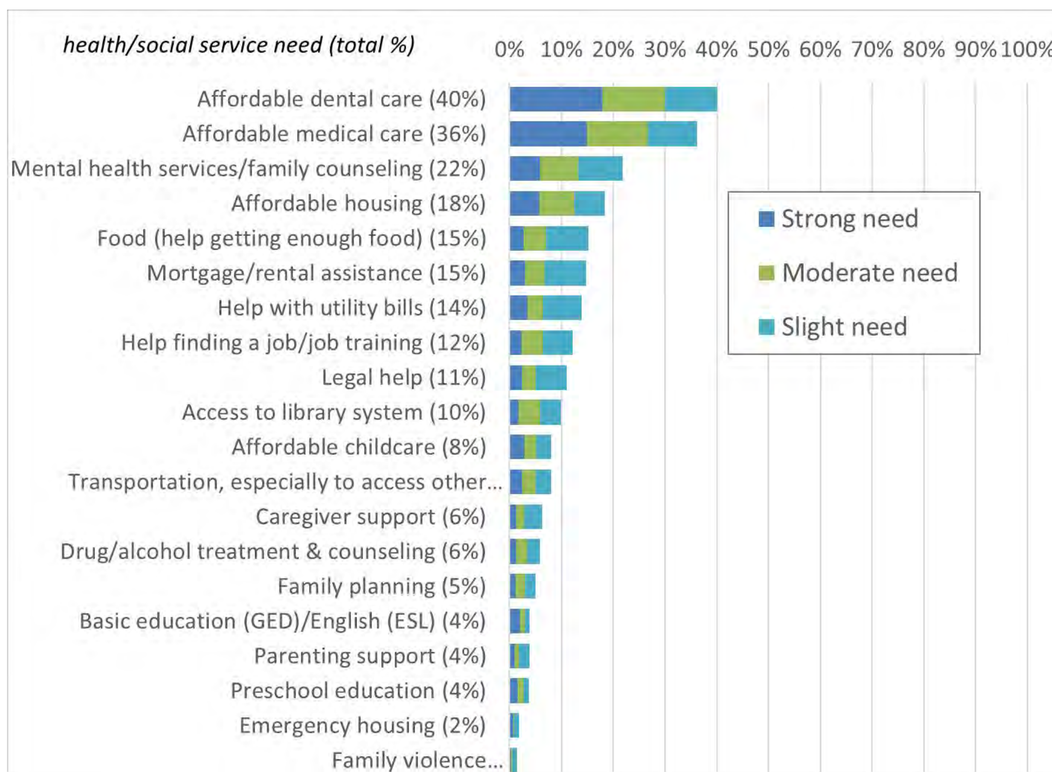


Exhibit 8: Need for social and health services by region (Q28)

Health/Social service need	*percent reporting need (rank)*				
	Latah	N Central Idaho	Nez Perce	SE Washington	Region
Affordable dental care	**44% (1)**	**38% (1)**	**36% (1)**	**42% (1)**	**40% (1)**
Affordable medical care	**40% (2)**	**34% (2)**	**33% (2)**	**37% (2)**	**36% (2)**
Mental health services/family counseling	**30% (3)**	12% (5)	**21% (3)**	**21% (3)**	**22% (3)**
Affordable housing	29% (4)	11% (8)	13% (7)	18% (4)	18% (4)
Food (help getting enough food)	17% (6)	14% (4)	14% (6)	14% (6)	15% (5)
Mortgage/rental assistance	17% (5)	11% (7)	15% (4)	14% (5)	15% (6)
Help with utility bills	12% (9)	**16% (3)**	15% (5)	14% (7)	14% (7)
Help finding a job/job training	15% (7)	9% (9)	11% (9)	12% (8)	12% (8)
Legal help	10% (10)	11% (6)	11% (10)	12% (9)	11% (9)
Access to library system	13% (8)	9% (10)	6% (14)	11% (10)	10% (10)
Affordable childcare	6% (14)	7% (11)	12% (8)	6% (14)	8% (11)

Reported health conditions for persons responding to the survey are listed in **Exhibit 9**. As shown, hypertension (high blood pressure) was reported by one-quarter (26%) of respondents, twice as high as other prevalent conditions (obesity, mental health issues, asthma).

Exhibit 9: Do any of the following conditions apply to you? (Q27)

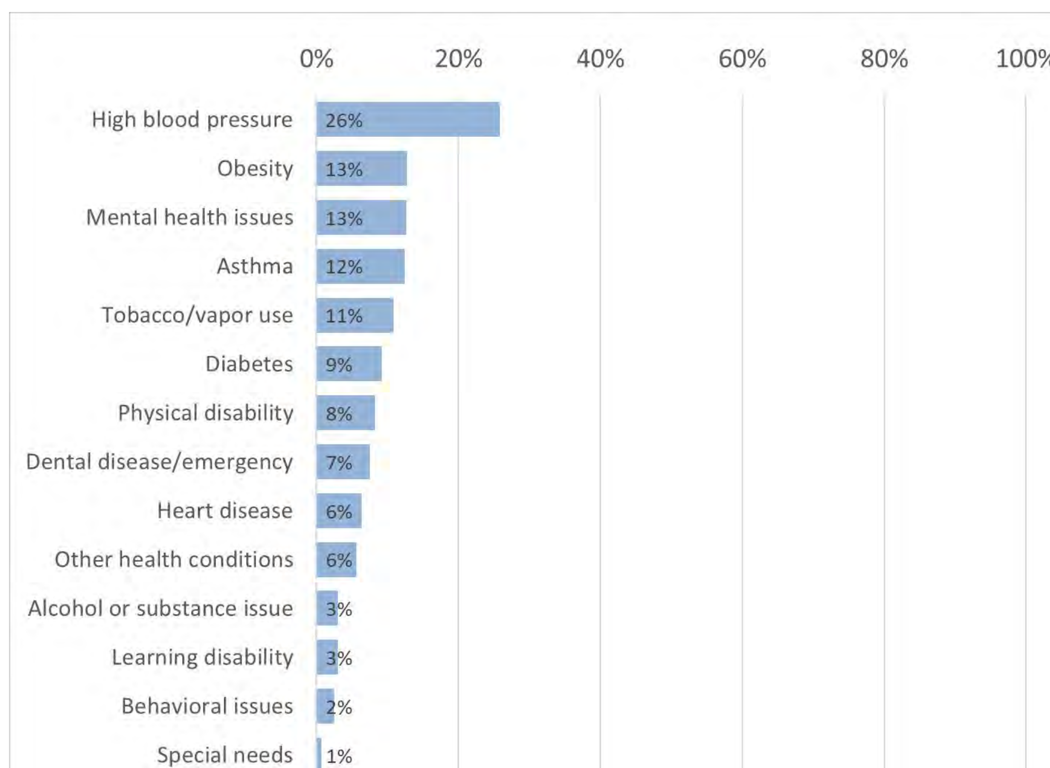


Exhibit 10: Reported Health Conditions (Q27)

Health condition	*percent reporting health condition (rank)*				
	Latah	N Central Idaho	Nez Perce	SE Washington	Region
High blood pressure	**17% (1)**	**28% (1)**	**27% (1)**	**35% (1)**	**26% (1)**
Obesity	9% (4)	**12% (2)**	**15% (2)**	**15% (2)**	**13% (2)**
Mental health issues	**16% (2)**	6% (8)	**14% (3)**	12% (6)	**13% (3)**
Asthma	**12% (3)**	11% (4)	13% (5)	**15% (2)**	12% (4)
Tobacco/vapor use	8% (5)	9% (6)	13% (4)	14% (4)	11% (5)
Diabetes	6% (7)	9% (5)	10% (6)	13% (5)	9% (6)
Physical disability	4% (9)	**12% (3)**	8% (8)	11% (7)	8% (7)
Dental disease/emergency	6% (6)	6% (9)	8% (7)	10% (8)	7% (8)
Heart disease	4% (10)	9% (7)	6% (9)	8% (9)	6% (9)
Alcohol or substance issue	3% (11)	1% (11)	5% (10)	1% (12)	3% (10)

"Cost of medical insurance, copays and deductibles are the largest expense and concern for this household. We save what we can to cover these expenses but cannot afford it if we both have an issue, which leads to skipping medications and Doctor visits."

-Survey participant

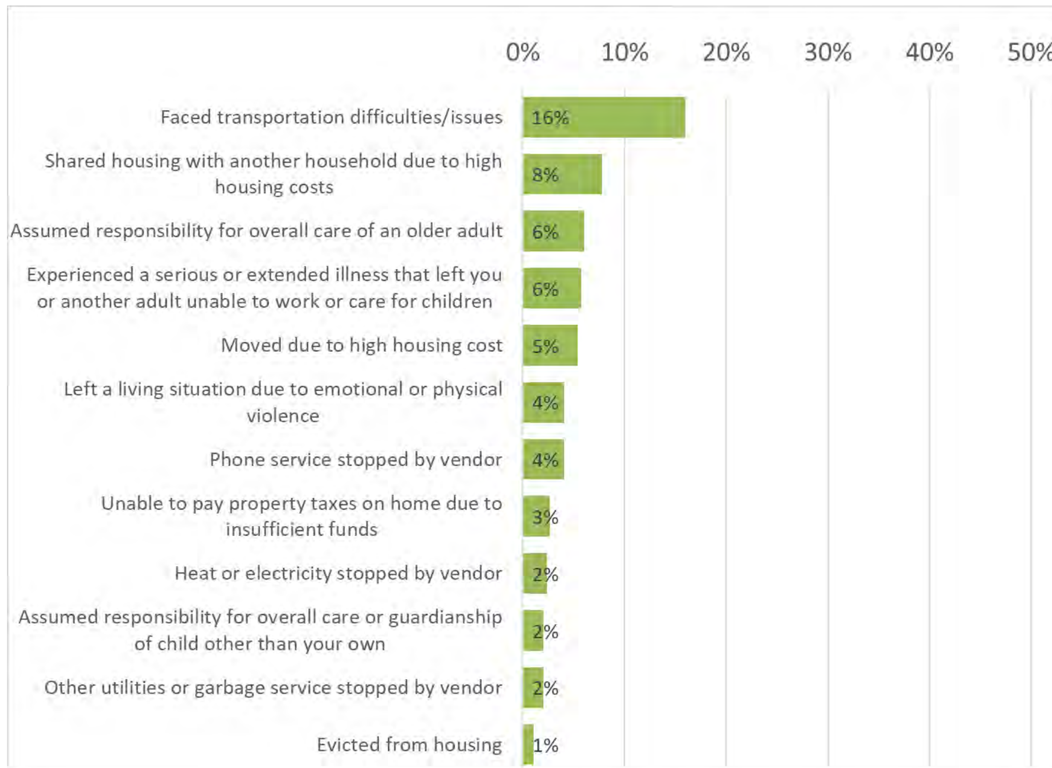
Of course, respondents may under-report personal health issues due to social stigma or misconceptions about clinical categories that define a condition. In the next section, the prevalence of these conditions is also explored using secondary data indicators from public sources. While the specific occurrence of each condition can only be estimated, the rankings also indicate similar concerns across counties (**Exhibit 10**).

Another way to assess health needs involves taking a closer look at hardship situations faced by households in the community. Hardship situations may be a one-time or repeated event for a household. Additionally, a household may experience multiple difficulties that impact financial stability, quality of life and health outcomes. **Exhibit 11** shows the hardship situations for survey respondents, with transportation difficulties reported most frequently (16%). Given that rural residents rely on vehicles more than urban residents and make longer trips, on average, it is not surprising that transportation issues top the list of hardships in all surveyed regions.

"I find it very difficult to get quality health care. My deductible is around 7,000 dollars, so I will be unable to pay for any type of medical services. If something catastrophic were to happen, we could literally lose everything we have in order to pay for the medical bills. It is extremely stressful."

-Survey participant

Exhibit 11: In the past 12 months, did any of the following hardship situations happen to you or any member of your household? (Q30)



As shown in **Exhibit 12** (next page), the occurrence of other hardship situations varied across counties in the survey. Many of the situations, however, result in unexpected changes to lifestyle or family budgets. Car repairs, rent increases, extended illnesses, new caregiving responsibilities and family violence can create a level of financial and personal stress that impacts health and well-being. Navigating these challenges in rural areas can result in additional difficulties such as accessing healthcare services, commuting to employment or education settings, and utilizing social services or available local resources. While single questions are reported from this survey, underlying issues are often interconnected and require comprehensive strategies to address immediate needs and improve health and well-being.

"The most difficult thing for us, in this community, is finding decent housing. Over the years, we have rented houses, but were asked to leave because the owners wanted to live in their houses again or sell them. We were only given 20 days to leave our last house. Rentals are hard to find..."

-Survey participant

"There are very few jobs in this town. My husband is unemployed because he cannot find a job here. He could work 40 minutes away in a bigger city, but the transportation is very limited."

-Survey participant

Exhibit 12: Reported hardship situations (Q30)

Hardship	*percent reporting hardship (rank)*				
	Latah	N Central Idaho	Nez Perce	SE Washington	Region
Faced transportation difficulties/issues	**18% (1)**	**12% (1)**	**19% (1)**	**13% (1)**	**16% (1)**
Shared housing with another household due to high housing costs	**11% (2)**	3% (7)	**9% (2)**	5% (5)	**8% (2)**
Assumed responsibility for overall care of an older adult	5% (5)	**6% (3)**	**7% (3)**	5% (4)	**6% (3)**
Experienced a serious or extended illness that left you or another adult unable to work or care for children	6% (4)	**6% (2)**	5% (6)	**5% (3)**	6% (4)
Moved due to high housing cost	**9% (3)**	2% (8)	7% (4)	2% (10)	5% (5)
Left a living situation due to emotional or physical violence	3% (6)	2% (10)	5% (7)	**6% (2)**	4% (6)
Phone service stopped by vendor	3% (7)	4% (5)	6% (5)	4% (6)	4% (7)
Unable to pay property taxes on home due to insufficient funds	2% (9)	4% (4)	3% (8)	2% (9)	3% (8)
Heat or electricity stopped by vendor	2% (10)	4% (6)	2% (10)	2% (8)	2% (9)
Assumed responsibility for overall care or guardianship of child other than your own	1% (11)	2% (9)	2% (9)	3% (7)	2% (10)
Other utilities or garbage service stopped by vendor	3% (8)	2% (11)	2% (11)	1% (11)	2% (11)
Evicted from housing	0% (12)	1% (12)	2% (12)	1% (12)	1% (12)

"In my work, I interact with people who are in great economic need. There is food insecurity on the Palouse, and with that comes a range of mental health problems. I hope community leaders find solutions for helping people in poverty. Many are working and not making enough to live on."

-Survey participant

The need for food assistance and the extent of hunger in a region should be considered from multiple perspectives. Regionwide, six percent of persons replied 'yes' to the question: "In the past 12 months, have you or anyone in your home gone hungry because you were not able to get enough food?" Reported hunger varied across survey regions, with 3% to 9% of households facing hunger in the last year (**Exhibit 13**). This definition, however, accounts for the most serious food-related issues facing households. When asked about food assistance, 15% of respondents reported "needing help getting enough food" (**Exhibit 14**). This is more consistent with national figures that show one in eight individuals (13%) are food insecure.[8] Food security is present when "access to adequate food is limited by lack of money or other resources."[9] As shown in Exhibit 13, individuals typically rely on friends and family for food assistance (15%), but these rates also vary across survey regions, with food banks, SNAP benefits and church support also playing a role.

Examining food insecurity and response systems on a local level is a critical step in meeting population health needs. A review of county-level data from the Centers for Disease Control (CDC) and American Community Survey (ACS) found that counties with higher than average rates of food insecurity also had a higher share of people with a disability, diabetes or obesity.[10] This relationship works both ways. Households with chronic health conditions may face choices between paying for medical expenses and food. Conversely, households struggling with hunger and access to nutritious food may face stress and rely on less expensive foods with poor dietary quality. These strategies are likely to increase risk of chronic conditions, such as depression, diabetes, heart disease and others. Food insecurity rates vary by household composition, age, race/ethnicity and income levels.[11] A collaborative, comprehensive response is necessary, particularly among populations more likely to struggle with hunger and food insecurity.

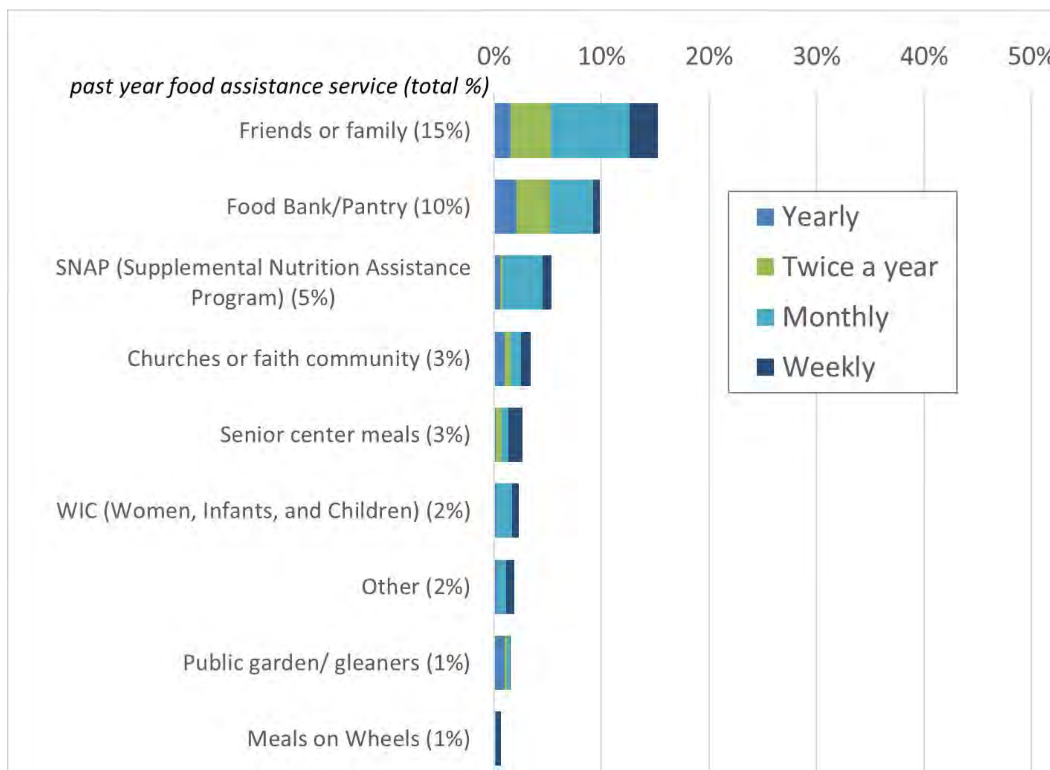
"In the past 12 months our family has been secure, but in the past we have struggled with food shortage and inability to pay for childcare. We found it cheaper for one adult to stay home to care for the toddler rather than have two working adults and pay daycare."

-Survey participant

Exhibit 13: Past Year Food Assistance Services (Q36 & Q37)

	percent reporting food assistance (rank)				
	Latah	N Central Idaho	Nez Perce	SE Washington	Region
Faced hunger in last 12 months	9%	3%	6%	9%	6%
Used Food Assistance in Last Year					
Friends or family	**20% (1)**	**10% (2)**	**17% (1)**	**11% (1)**	**15% (1)**
Food Bank/Pantry	**7% (2)**	**12% (1)**	**12% (2)**	**9% (2)**	**10% (2)**
SNAP (Supplemental Nutrition Assistance Program)	3% (4)	**6% (3)**	**6% (3)**	**7% (3)**	**5% (3)**
Churches or faith community	**6% (3)**	2% (6)	3% (5)	3% (5)	3% (4)
Senior center meals	2% (5)	4% (4)	2% (7)	3% (4)	3% (5)
WIC (Women, Infants and Children)	2% (6)	3% (5)	3% (4)	2% (6)	2% (6)
Public garden/ gleaners	1% (7)	1% (7)	2% (6)	1% (8)	1% (7)
Meals on Wheels	0% (8)	1% (8)	1% (8)	1% (7)	1% (8)

Exhibit 14: In the past 12 months, how often have you or your household used each of the following types of food assistance services? (Q37)



The World Health Organization defines social determinants as "the conditions in which people are born, grow, live, work and age."[12] While the survey results presented thus far focused on impediments or gaps in health and well-being, it is also important to consider community assets and strengths when assessing these conditions. The Well Being Alliance (https://winnetwork.org/well-being-alliance/) represents a consortium of organizations and cities across the country with leaders committed to "improving the vital conditions for inter-generational well-being for all in the US." The Alliance has developed a series of 'Vital Conditions Primers' that provide a framework and common metrics for conditions of well-being. The primer on 'Belonging and Civic Muscle' describes this condition as:

> an indispensable vital condition that we all depend on for our health and well-being. Social support through friends, family, and other networks contributes to our practical and emotional needs, enhances mental well-being, helps us navigate the challenges of life and reinforces healthy behaviors. People with a stronger sense of efficacy, belonging and social connectedness tend to live healthier, happier lives.[13]

Exhibits 15 and 16 (next page) shows a high level of community engagement in this region. At least once a month, survey respondents reported following local news (77%), visiting public parks and trails (46%), attending religious services (35%), participating in community events (29%) and going to a library (25%). These activities were even more common on a yearly basis (**Exhibit 17**) with 85% or more of respondents reporting visiting public parks and trails and at least 75% either going to a movie, sporting event, concert or museum, or participating in community events.

Exhibit 15: In the past 12 months, how often did you do the following? (Q46)

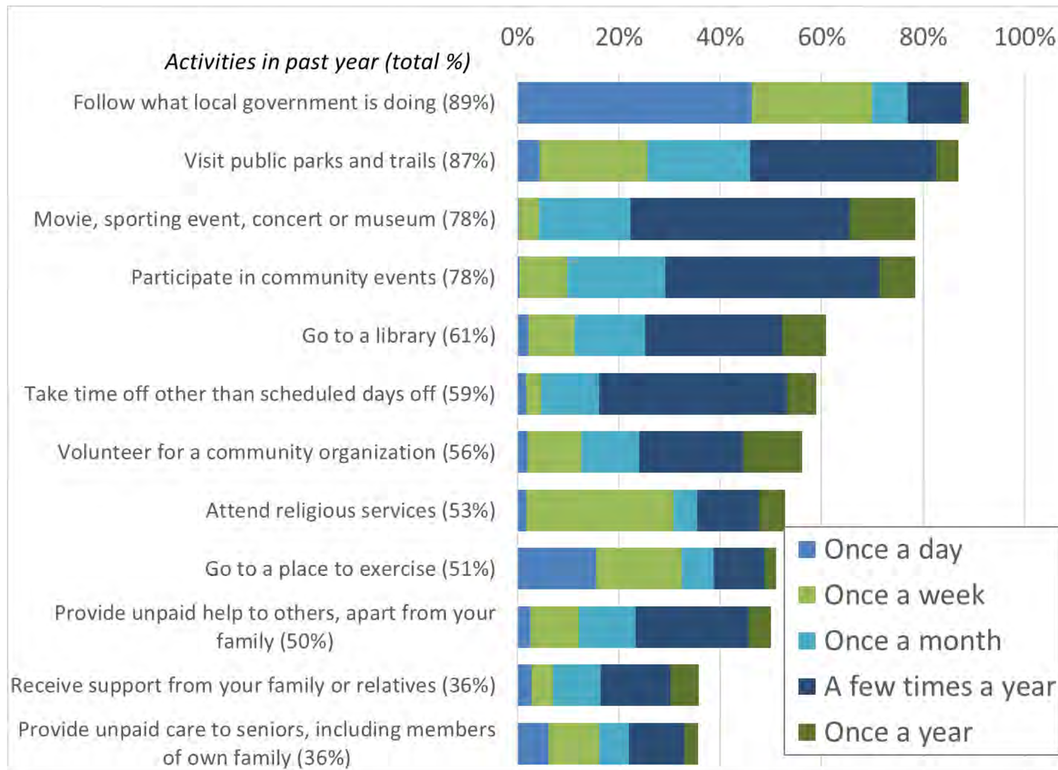


Exhibit 16: Participate in Activity At Least Monthly (Q46)

Participate in activity at least monthly	*percent reporting monthly activity (rank)*				
	Latah	N Central Idaho	Nez Perce	SE Washington	Region
Follow what local government is doing	**67% (1)**	**84% (1)**	**78% (1)**	**81% (1)**	**77% (1)**
Visit public parks and trails	**56% (2)**	**36% (3)**	**44% (2)**	**44% (2)**	**46% (2)**
Go to a place to exercise	**55% (3)**	22% (8)	34% (4)	**39% (3)**	**39% (3)**
Attend religious services	30% (6)	**39% (2)**	**37% (3)**	37% (4)	35% (4)
Participate in community events	38% (4)	24% (6)	25% (7)	28% (5)	29% (5)
Go to a library	34% (5)	23% (7)	18% (10)	26% (6)	25% (6)
Volunteer for a community organization	28% (9)	25% (5)	19% (9)	24% (7)	24% (7)
Provide unpaid help to others, apart from your family	29% (7)	20% (9)	26% (6)	16% (10)	23% (8)
Go to a movie, sporting event, concert or museum	28% (8)	15% (10)	22% (8)	21% (8)	22% (9)
Provide unpaid care to seniors, including members of own family	19% (12)	25% (4)	26% (5)	18% (9)	22% (10)
Receive support from your family	27% (10)	9% (12)	13% (12)	13% (11)	16% (11)
Take time off other than your scheduled days off	20% (11)	13% (11)	17% (11)	13% (12)	16% (12)

Exhibit 17: Participate in Activity At Least Yearly (Q46)

Participate in activity at least yearly	*percent reporting monthly activity (rank)*				
	Latah	N Central Idaho	Nez Perce	SE Washington	Region
Follow what local government is doing	**87% (3)**	**91% (1)**	**91% (1)**	**88% (1)**	**89% (1)**
Visit public parks and trails	**93% (1)**	**85% (2)**	**84% (2)**	**85% (2)**	**87% (2)**
Go to a movie, sporting event, concert or museum	**88% (2)**	67% (4)	77% (4)	**79% (3)**	**78% (3)**
Participate in community events	84% (4)	**75% (3)**	**77% (3)**	76% (4)	78% (4)
Go to a library	71% (5)	51% (7)	57% (6)	61% (5)	61% (5)
Take time off other than your scheduled days off	67% (6)	51% (8)	61% (5)	53% (8)	59% (6)
Volunteer for a community organization	67% (7)	52% (6)	50% (9)	53% (7)	56% (7)
Attend religious services	47% (11)	55% (5)	54% (7)	57% (6)	53% (8)
Go to a place to exercise	66% (8)	36% (11)	47% (10)	50% (9)	51% (9)
Provide unpaid help to others, apart from your family	57% (9)	45% (9)	53% (8)	41% (10)	50% (10)
Receive support from your family	48% (10)	32% (12)	33% (12)	25% (12)	36% (11)
Provide unpaid care to seniors, including members of own family	32% (12)	37% (10)	41% (11)	32% (11)	36% (12)

"There needs to be more activities for people of all ages in the town area. For example, what do kids of young adults do in the evenings or after dark?"

-Survey participant

The primary focus of the community survey included questions about individual experiences or circumstances. Several questions, however, did ask about personal *viewpoints* regarding needs in the community. Across all surveyed regions, over 40% of respondents said that wage levels and local cost of living were "most in need of improving" in their community (**Exhibit 18**). Job prospects, affordable decent housing and activities for teenagers were also consistently listed (38%-41%) as community concerns and needed areas of improvement (**Exhibit 19**).

The Vital Condition Primer of Meaningful Work and Wealth covers:

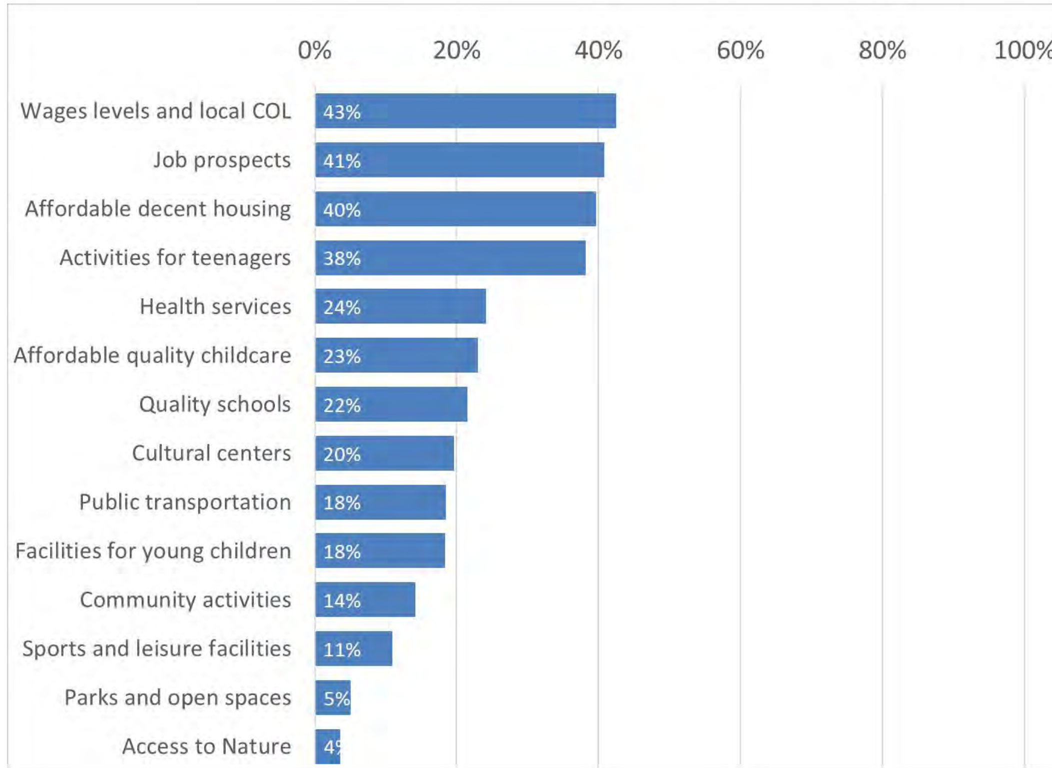
> personal, family, and community wealth that provides the means for healthy, secure lives. It is about good paying, fulfilling jobs and careers, and financial security that extends across the lifespan.[14]

As discussed earlier, social and economic factors will be examined as part of the analysis of secondary (public) data sources covered in the next section. The indicators provide additional evidence about relative need as reflected by a variety of factors available from county summary data. In addition to testing the consistency of public indicators to survey responses (for measures like food security), we also examined new indicators for issues not covered by the survey (for sensitive measures like suicide mortality or substance use).

"I go to places to exercise, but not places I have to pay for. Walking around reservoirs, biking down roads, kayaking down rivers, etc."

-Survey participant

Exhibit 18: Thinking about this community, which of the things below, if any, do you think most need improving? (Q4)



"My wife and I are retired, and we don't need much assistance or services. This area is good for retired people such as us. But nearly all of my kids have moved away because of lack of job prospects that will cover their basic needs. Housing costs for family's with kids are not affordable, nor is childcare or insurance. They can't earn enough due to lack of good paying jobs to cover their living expenses. They have had to move to places where there are more help for families. States that have expanded Medicaid so they could have affordable healthcare, and help with childcare, and housing costs. None of these things are affordable for young families here. They cannot earn enough to cover these costs. They had to leave the area to get help. Sad but true!"

-Survey participant

Exhibit 19: Aspects of Community Most in Need of Improvement (Q4)

Improvement Area	percent reporting (rank)				
	Latah	N Central Idaho	Nez Perce	SE Washington	Region
Wages levels and local COL	**41% (1)**	**42% (1)**	**44% (1)**	**43% (1)**	**43% (1)**
Job prospects	**40% (2)**	**41% (2)**	**40% (3)**	**43% (2)**	**41% (2)**
Affordable decent housing	**39% (3)**	39% (4)	**40% (2)**	**42% (3)**	**40% (3)**
Activities for teenagers	36% (4)	**39% (3)**	40% (4)	39% (4)	38% (4)
Health services	26% (5)	23% (5)	21% (6)	27% (5)	24% (5)
Affordable quality childcare	24% (6)	22% (6)	24% (5)	22% (8)	23% (6)
Quality schools	23% (7)	20% (8)	20% (7)	23% (7)	22% (7)
Cultural centers	18% (9)	20% (7)	17% (10)	24% (6)	20% (8)
Public transportation	17% (10)	18% (9)	18% (9)	22% (9)	18% (9)
Facilities for young children	19% (8)	16% (10)	19% (8)	19% (10)	18% (10)
Community activities	15% (11)	13% (11)	14% (11)	15% (11)	14% (11)
Sports and leisure facilities	10% (12)	12% (12)	13% (12)	9% (12)	11% (12)

Community Indicators

Utilizing selected indicators from the project data hub, we rated the relative position of each health-related factor on several different dimensions (see **Appendix D** for indicator definitions and sources). Overall ratings appear in **Exhibit 20**, where we compare regional values for all nine counties combined (Clearwater, Idaho, Latah, Lewis, Nez Perce, Wallowa, Asotin, Garfield and Whitman counties) against national figures for each indicator. We then examine the variability of results for all states to gauge the degree to which this region is behind (or ahead) of the national average (see methods section).

All nine counties in the LCVH Foundation are rated according to where the region sits in relation to other states for the given indicator. As a reminder, the ratings are classified as follows:

- ↓ **much worse** – region value is in the lowest 10% of all states
- ↘ **worse** – region value is in the bottom 10%-30% of all states
- ↗ **better** – region value is higher than 30-60% all states
- ↑ **much better** – region value is higher than 60% of all states

Based on the distribution of all states nationwide, we found that the following values for the multi-state LCVH Foundation would be considered in the lowest 10% of all states:

- Opioid Drug Claims, Percentage of Total Claims
- Population Health Professional Shortage (Underserved)
- Cohort Graduation Rate
- Estimated Number with Regular Pap Test
- Mortality – Suicide
- Percent Population with Income at or Below 200% FPL

Many of these indicators identified as 'much worse' than national rates are also reflected as concerns in survey responses (health professional shortage, household wage levels). Other indicators were not included in the survey (opioid drug use, suicide mortality), but should be considered in health promotion efforts. In similar fashion, the region shows a higher rate of residents with social/emotional supports, mirroring the higher degrees of civic involvement in the survey.

While these results show *overall* rankings of health-related indicators, each county has a distinct demographic, social and economic profile. There are also nine community hospitals and four public health districts that serve this region. It is vital to understand the status of health indicators in each county, as well. The county-level results and ratings are presented in **Exhibit 21** (page 26).

"We moved here to be closer to ailing parents and due to a good opportunity to stay active while maintaining our own place. My wife has always wanted to live where she could walk out her door w/doggie and go for a run/walk. We do that here."

- Survey participant

Exhibit 20: Health and Wellness Data Indicator Ratings, LCVH Foundation Region

Rating		Indicator	Region	United States
↓	**0.01**	Opioid Drug Claims, Percentage of Total Claims	7%	5%
↓	**0.04**	Population Health Professional Shortage (Underserved)	27%	13%
↓	**0.07**	Cohort Graduation Rate	81%	87%
↓	**0.07**	Estimated Number with Regular Pap Test	73%	79%
↓	**0.08**	Mortality – Suicide	19.3	13.3
↓	**0.10**	Percent Population with Income at or Below 200% FPL	40%	33%
↘	**0.11**	Median Household Income	$45,998	$57,652
↘	**0.13**	Percent Population in Poverty	17%	14%
↘	**0.15**	Dentists, Rate per 100,000 Population	46.6	65.6
↘	**0.17**	Food Access - Grocery Stores - Establishments, Rate per 100,000 Population	8.3	11.0
↘	**0.18**	Food Insecurity Rate	15%	13%
↘	**0.20**	Median Family Income	$61,634	$70,850
↘	**0.24**	Population with Diagnosed Diabetes, Age-Adjusted Rate	8%	9%
↘	**0.25**	Estimated Adults Drinking Excessively (Age-Adjusted Percentage)	19%	17%
↘	**0.25**	Percent Population with no Leisure Time Physical Activity	20%	23%
↘	**0.29**	Percent Population Under Age 18 at or Below 200% FPL	46%	42%
↘	**0.30**	Percent Population with Low Food Access	25%	22%
↗	**0.31**	Percent Female Medicare Enrollees with Mammogram in Past 2 Years	61%	63%
↗	**0.31**	Percent Renter-Occupied Housing Units	38%	38%
↗	**0.32**	Percent Free/Reduced Price Lunch Eligible	42%	49%
↗	**0.34**	Percentage of Cost Burdened Households (Over 30% of Income)	30%	32%
↗	**0.34**	Cancer Incidence Rate – Lung	54.7	60.2
↗	**0.35**	Cancer Incidence Rate - All Sites	132.5	124.7
↗	**0.37**	Percent Adults with Asthma	14%	13%

Rating	Indicator	Region	United States
↗ **0.37**	Percent Within 1/2 Mile of a Park	33%	38%
↗ **0.41**	Mental Health Care Provider Rate (Per 100,000 Population)	178.0	202.8
↗ **0.47**	Estimated Population with Annual Pneumonia Vaccination	67%	68%
↗ **0.50**	Percentage of Cost Burdened Households (Over 50% of Income)	15%	15%
↗ **0.50**	Primary Care Physicians, Rate per 100,000 Population	74.3	75.6
↗ **0.50**	Percent Adults with Heart Disease	4%	4%
↗ **0.51**	Percent Adults with High Blood Pressure	28%	28%
↗ **0.52**	Estimated Population Ever Screened for Colon Cancer - Percent Adults Overweight	62%	61%
↗ **0.53**	Percent Population Age 25+ with Bachelor's Degree or Higher	31%	31%
↗ **0.53**	Percent Adults with BMI > 30.0 (Obese)	29%	29%
↗ **0.57**	Chlamydia Infections, Rate (Per 100,000 Population)	479.8	497.3
↗ **0.57**	Rate of Federally Qualified Health Centers per 100,000 Population	3.3	2.8
↗ **0.60**	Percent Population Age 25+ with Associate's Degree or Higher	41%	39%
↑ **0.61**	Percent Population Smoking Cigarettes (Age-Adjusted)	17%	18%
↑ **0.62**	Percent Adults with Inadequate Fruit / Vegetable Consumption	77%	76%
↑ **0.63**	Percent Adults with No Dental Exam	29%	30%
↑ **0.63**	Percent Adults Without Any Regular Doctor	20%	22%
↑ **0.65**	Establishment Rate per 10,000 Population	11.4	10.4
↑ **0.68**	Percent Population Under Age 18 in Poverty	18%	20%
↑ **0.69**	Estimated Population with Poor or Fair Health	14%	16%
↑ **0.73**	Mortality - Premature Death - Years of Potential Life Lost	6,076	6,947
↑ **0.76**	Ambulatory Care Sensitive Condition Discharge Rate	41.8	49.4
↑ **0.77**	Percent Adults with Poor Dental Health	13%	16%
↑ **0.79**	Percentage of Households with No Motor Vehicle	6%	9%
↑ **0.86**	Percentage Commuting to Work Alone in a Car	71%	76%
↑ **0.87**	Food Access - Grocery Stores - Establishments, Rate per 100,000 Population	28.7	21.2
↑ **0.89**	Percent Adults Overweight	35%	36%
↑ **0.90**	Head Start Programs, Rate (Per 10,000 Children)	13.6	7.2
↑ **0.92**	Percent with Depression	15%	18%
↑ **0.93**	Percentage Commuting More than 60 Minutes	4%	9%
↑ **0.93**	Teen Births, Rate per 1,000 Population	13.1	24.7
↑ **0.93**	Infant Mortality Rate (Per 1,000 Births)	4.7	6.5
↑ **0.96**	Gonorrhea Infections, Rate (Per 100,000 Population)	53.6	145.8
↑ **0.97**	Percent Population Age 25+ with No High School Diploma	7%	13%
↑ **0.97**	Lack of Social or Emotional Support	16%	21%
↑ **0.98**	Percentage of Population Age 16-19 Not in School and Not Employed	4%	7%
↑ **0.98**	Low Weight Births, Percent of Total	5%	8%

County-level ratings in **Exhibit 21** include only those indicators where results are much worse (bottom 10%) than either other counties in the LCVH Foundation region or much worse than other counties in the United States. Complete information (percentage or rates) for each listed indicator is included in **Appendix F**. Based on these criteria, several counties (Nez Perce, Latah, Wallowa counties) only have 3-4 identified indicators. Other counties (such as Clearwater, Idaho, Lewis) had a longer list of indicators with a low rating. This analysis speaks to geographic disparities in social determinants of health and emphasizes the need for county-specific prioritization.

The final phase of this assessment involved a series of community forums held throughout the region. The forums provided an opportunity to explore local challenges, opportunities and community priorities. The next section outlines key findings from these forums and provides potential pathways for health improvement efforts offered through the experiences and perspectives of area residents.

Exhibit 21: Health and Wellness Data Indicator Ratings, by County

Nez Perce County, ID		
Indicator	***Rating Relative to Counties in Region***	***Rating Relative to Counties in U.S.***
Population Driving Alone to Work	↓ 0.04	
Heart Disease (Adult)	↓ 0.06	
Mortality - Suicide		↓ 0.08
Depression (Medicare Population)	↓ 0.09	

Asotin County, WA		
Indicator	***Rating Relative to Counties in Region***	***Rating Relative to Counties in U.S.***
Asthma Prevalence	↓ 0.04	
Teen Births	↓ 0.05	
Mortality - Suicide		↓ 0.05
Diabetes (Adult)	↓ 0.05	
Population Driving Alone to Work	↓ 0.06	
Current Smokers	↓ 0.07	
Dental Care Utilization	↓ 0.08	
Children Eligible for Free/Reduced Price Lunch	↓ 0.09	
Opioid Drug Claims		↓ 0.09
Poor General Health	↓ 0.09	
STI - Gonorrhea Incidence	↓ 0.10	

Garfield County, WA		
Indicator	***Rating Relative to Counties in Region***	***Rating Relative to Counties in U.S.***
Food Access - Low Food Access	↓ 0.00	
Health Professional Shortage Areas	↓ 0.00	↓ 0.01
Physical Inactivity	↓ 0.05	
Access to Mental Health Providers	↓ 0.05	
Recreation and Fitness Facility Access	↓ 0.06	↓ 0.08
Weight - Obesity	↓ 0.07	
Poverty - Population Below 200% FPL	↓ 0.07	↓ 0.09

Whitman County, WA		
Indicator	*Rating Relative to Counties in Region*	*Rating Relative to Counties in U.S.*
Poverty Rate (< 100% FPL) (SAIPE)	↓ 0.01	↓ 0.03
Cost Burdened Households (50%)	↓ 0.04	
STI - Chlamydia Incidence	↓ 0.04	
Food Insecurity Rate	↓ 0.05	↓ 0.08
Renter-Occupied Housing	↓ 0.05	↓ 0.01
Cost Burdened Households (30%)	↓ 0.06	↓ 0.02
Households with No Motor Vehicle	↓ 0.08	

Latah County, ID		
Indicator	*Rating Relative to Counties in Region*	*Rating Relative to Counties in U.S.*
Cancer Incidence - All Sites		↓ 0.05
Cancer Screening - Pap Test	↓ 0.08	↓ 0.06
Renter-Occupied Housing		↓ 0.10

Wallowa County, OR		
Indicator	*Rating Relative to Counties in Region*	*Rating Relative to Counties in U.S.*
Low Birth Weight	↓ 0.00	
Park Access	↓ 0.05	
Poverty - Children Below 100% FPL	↓ 0.00	
Preventable Hospital Events	↓ 0.08	

Clearwater County, ID		
Indicator	*Rating Relative to Counties in Region*	*Rating Relative to Counties in U.S.*
Population Commuting to Work Over 60 Minutes	↓ 0.00	↓ 0.02
Mortality - Premature Death	↓ 0.00	↓ 0.07
Education - High School Graduation Rate	↓ 0.00	↓ 0.00
High Blood Pressure (Adult)	↓ 0.01	↓ 0.04
Mortality - Suicide	↓ 0.02	
Teen Births	↓ 0.03	
Park Access	↓ 0.03	
Current Smokers	↓ 0.04	
Preventable Hospital Events	↓ 0.04	
Children Eligible for Free/Reduced Price Lunch	↓ 0.05	
Education - Bachelor's Degree or Higher		↓ 0.07
Poor General Health	↓ 0.08	

Idaho County, ID		
Indicator	***Rating Relative to Counties in Region***	***Rating Relative to Counties in U.S.***
Dental Care Utilization	↓ 0.01	
Poverty - Children Below 200% FPL	↓ 0.01	↓ 0.07
Cancer Screening - Sigmoidoscopy or Colonoscopy	↓ 0.02	↓ 0.02
Mortality - Suicide	↓ 0.04	↓ 0.01
Poor General Health	↓ 0.04	
Weight - Overweight	↓ 0.06	
Physical Inactivity	↓ 0.06	
Social Associations	↓ 0.06	
Lack of a Consistent Source of Primary Care	↓ 0.06	
Cancer Screening - Pap Test		↓ 0.08
Income - Median Household Income	↓ 0.09	↓ 0.09
Weight - Obesity	↓ 0.10	

Lewis County, ID		
Indicator	***Rating Relative to Counties in Region***	***Rating Relative to Counties in U.S.***
Young People Not in School and Not Working	↓ 0.00	↓ 0.01
Fruit/Vegetable Consumption	↓ 0.01	↓ 0.08
Alcohol Consumption		↓ 0.02
Children Eligible for Free/Reduced Price Lunch	↓ 0.02	
High Blood Pressure (Adult)	↓ 0.03	↓ 0.09
Lack of Social or Emotional Support	↓ 0.03	
Cancer Screening - Mammogram	↓ 0.04	↓ 0.07
Physical Inactivity	↓ 0.04	
Infant Mortality	↓ 0.05	
Opioid Drug Claims	↓ 0.05	↓ 0.02
STI - Gonorrhea Incidence	↓ 0.06	
Recreation and Fitness Facility Access	↓ 0.06	↓ 0.08
Access to Mental Health Providers	↓ 0.06	
Education - High School Graduation Rate		↓ 0.07
Poverty - Children Below 200% FPL	↓ 0.07	
Access to Primary Care	↓ 0.08	↓ 0.08
Teen Births	↓ 0.08	
Population Commuting to Work Over 60 Minutes	↓ 0.09	
Income - Median Household Income	↓ 0.09	↓ 0.09
Education - Bachelor's Degree or Higher	↓ 0.09	↓ 0.06
Education - Associate's Level Degree or Higher	↓ 0.09	↓ 0.08

Community Forums

The listening sessions and public forums held for this assessment served an important purpose. As noted, a morning session involved invited community leaders from different sectors, including education, banking, social services, health systems/hospitals, churches, local/tribal governments, philanthropy and others. In the evening, a public 'data walk' was held. A free catered meal and childcare was provided in order to draw a wide range of participants. The attendees heard a short opening presentation and then were invited to join small groups to walk around the room and discuss posters with data exhibits. The data exhibits shared findings from both the community survey and data indicator analysis with key topics reflected in the results, including behavioral health, economic security, food security, health access/affordability and housing affordability.

Each of these forums provided an opportunity to learn additional detail and gather needed context to inform the assessment and guide subsequent activity. The conversation provided understanding about the community makeup and strengths, illuminated the issues that people in the community care about, and helped outline community priorities - based on local resources, experiences and values. In every forum, both during morning and evening sessions, we asked a similar set of starter questions:

- What is missing in the data?
- What has the community tried in the past?
- What are your big ideas for community change?

Over 300 people in total attended one or more of the nine forums hosted by Innovia and LCVH Foundation (see **Appendix G** for list of organizations represented). Staff at each event recorded notes and participant input and this material is available on request. The following synopsis highlights notable issues raised during the visit to each area. While the summary is necessarily subjective and not comprehensive, the topics outlined also appear as important issues based on analysis of survey and public data.

Palouse Forum Summary - Moscow, Idaho/Pullman, Washington (September 23, 2019)

- Federal poverty statistics for the Palouse are difficult to interpret due to higher percentage of college students with temporary low-income levels. While publicly reported figures are often considered over-inflated, there is considerable **poverty and economic hardship**, particularly in rural Whitman and Latah counties.

- **Food insecurity** remains a concern in this region for both students and resident populations. There is an interest in connecting to all residents through mobile food delivery, connections between food banks and health clinics, and distribution at existing community sites (such as libraries). Some of these efforts are in planning or early implementation stages but require additional marketing/communications support and resource commitments.
- A lack of **affordable public transportation** options makes it difficult to connect services and supports across counties. A bus between Pullman and Moscow no longer operates but was a valuable service.
- The high percentage of rental **housing** and low stock of affordable single-family homes in this area can cause difficulty for low- and moderate-income households. Increasing housing stock

and adopting solutions that involve homeowners/landlords/renters is necessary. While in two different states, Moscow and Pullman share a housing market, so approaches adopted in one county (e.g. Moscow Housing Trust) should be considered for expansion, when possible.

- A need for increased access to **mental health** providers/services was emphasized. Telehealth options for both mental and physical health delivery should continue to be evaluated.

"An important thing we're missing is public transportation, especially regionally in rural communities."

-Pullman forum participant

LC Valley Forum Summary - Clarkston, Washington/Lewiston, Idaho (September 30, 2019)

- A lack of **economic opportunity** was a central theme that encompassed many comments. Differences in minimum wage (between Idaho and Washington), lack of high-wage jobs, inability to participate in education/training and generational cycles of poverty create impediments to prosperity. A desire was expressed for cross-sector and community led solutions driven by participation by diverse stakeholders (i.e. **community visioning process**). The development of two new technology training centers are one example of a way to provide opportunity and grow the economy, but diversification of industry is necessary to retain students and residents.
- **Mental health services and suicide prevention** for youth and young adults emerged as a strong need expressed by forum participants. Suggested responses included adding providers in high schools and expanding preventative services by investing in **early childhood education and quality childcare**. The importance of addressing hopelessness and promoting resiliency through public messaging and the adoption of trauma-informed practices was also emphasized.

"If I could wave a magic wand, we would pull teams together to come up with a plan around these issues and take action on it with community, legislators and funders."

-Lewiston forum participant

- While there are low-cost and community dental providers in the LC Valley, a need to grow capacity for **affordable dental care** was noted by many participants. This may include additional clinics, practitioners, clinic space or expansion of appointments for Medicaid patients.

- **Health services and access** were identified as a real need. While community clinics are available in the region, a desire for availability of after-hours appointments was expressed. Specialized services, such as reproductive and sexual health care for young people, health literacy, and transportation/mobile services for senior and rural residents were frequently mentioned.

Idaho/Lewis County Forum Summary - Grangeville, Idaho (October 2, 2019)

- Job growth in this region has exceeded other areas in state, with opportunities in forestry, agriculture, industry and manufacturing. There was an interest in developing **regional education** models to meet this demand, with a focus on satellite vocational training, local internships, business outreach and closer ties with state colleges and universities.
- Retaining younger workers and families will require a commitment to new **housing development**. There has been a lack of multi-family units and entry-level homes built in recent decades. Consequently, there are fewer rental units or affordable options for home buyers. A coordinated effort is needed to engage local leaders and identify regulatory, capital and other options to change this dynamic. This may be an area where impact investing and involvement of community re-investment programs can create incentives favorable for investment.
- Multiple participants talked about the lack of a **community center** in Grangeville. A lack of year-round recreational opportunities for youth and teenagers was underscored. A community center could also provide a gathering space to enhance social connections, serve as a clearinghouse for community resources and act as a performance space.
- The distance between towns in Idaho and Lewis counties also presents a real challenge to the provision of quality health care services. **Health care access** could be improved by increasing provider reimbursement rates (noted for mental health), recruiting new providers (noted for EMT) and developing substance use treatment options appropriate for rural residents. Continued work with local, state and federal partners, such as University of Idaho's WWAMI Rural Underserved Opportunities Program, will be necessary to support efforts to expand care.
- There was also an interest in restarting a community visioning process similar to the Horizons initiative that was carried out in Grangeville over ten years ago.

Clearwater County Forum Summary - Orofino, Idaho (October 3, 2019)

- Participants stressed the need for greater **access to dental care** – particularly increasing the number of providers that accept Medicaid patients or provide services at a sliding-scale fee. The existing low-cost dental clinic is only open Monday-Wednesday and has a long waiting list.
- Clearwater County has a number of towns that are separated by distance and geographical features. It is often difficult for some residents to access services available in different areas (such as senior meals). **Transportation options** to connect communities was listed as a recognized need. While the Nez Perce Tribe used to operate a cross-county bus, this service was discontinued.
- Attendees said that a distinct lack of **affordable rental housing** causes difficulties with household budgets. The mountains in and around Orofino place limitations on the availability of buildable lots and elevate development costs. Regional housing coalitions may be able to find options for gap financing or develop a strategy to leverage federal tax incentives, such as Opportunity Zones.
- There have been many community conversations about developing a **walking/biking trail** to promote recreation, connect different parts of the city and provide a safe way to navigate the state highway.

Note: *orange highlighted items received most selections in dot-voting exercise*

The topics brought forth at these forums are notable, because many of the expressed needs do not directly link to health treatment or delivery. This underscores the fact that disease prevention and health promotion occur during the time spent *outside* of the doctor's office. Supporting healthy living involves reducing financial stress, facilitating social connections and encouraging healthy behaviors. These social and economic determinants of health are complex, inter-related and often engrained in societal norms in ways that make transformative change difficult. This project, however, reveals the tremendous civic commitment and emerging networks that present real opportunities for making meaningful, measurable change. The next section presents a strategic direction for philanthropic grantmaking based on the learning acquired through this assessment.

"We each have a piece of information that adds to the whole, and it took this gathering to bring them together to provide a better picture of ourselves; what we offer and what still we need to accomplish."

-Idaho County Free Press Editorial

Strategic Direction

Focus Areas

The findings laid out in this report are intended to serve as a reference for questions about regional needs. In addition, the tools and data available through this assessment establish an open resource for investigating and responding to regional concerns. The report does not, however, lay out specific recommendations about which identified needs are most important and should emerge as the highest priority for regional grantmaking. The assessment creates a foundation and starting point for strategic philanthropic grantmaking. Strategic philanthropy represents a dynamic process, not a static plan, as noted by Douglas Easterling and Laura McDuffee in a recent issue of *The Foundation Review*.

> Becoming strategic requires time, commitment, in-depth analysis, hard choices, focused action, a host of complex skills, the ability to learn, and the willingness to let go of approaches that aren't working…Conversion foundations throughout the United States have similarly taken intentional steps to set a strategic direction that takes into account their resources, position, and values, ***as well as*** the needs and interests of the community that the foundation is serving. (*emphasis added*)[15]

The LCVH Foundation has made an early decision to consider its mandate to "promote health, wellness, or disease prevention" in a holistic fashion, by addressing those social and economic determinants of health in a way that improves not just health care, but community health. This is a tall order, as Easterling and McDuffee note, "Health foundations should not enter into SDOH work expecting to find some sort of 'low hanging fruit' that has been previously overlooked. Just as with improving health care, improving social and economic conditions is complex, long-term, politicized work."[16] A strategic decision toward community impact rests on identifying a selected number of determinants where the influence of the foundation (and partners) intersects with community needs. A number of themes related to community needs arose from this assessment process and could be used as a guidepost for strategic decision-making:

1. **Economic security and empowerment** – This assessment revealed a high level of civic engagement and participation from residents throughout this region. This type of community pride and involvement is not uncommon in rural America.[17] However, both data results and community conversations also reflected struggles by many to meet rising housing costs, pay unexpected medical bills or respond to other financial emergencies. When household budgets are strained, stress levels rise, and proactive care is often postponed.

   Health promotion and prevention means investing in people and empowering them with the support and tools needed to build a healthy future. There are a number of strategies that bolster economic security and individual health – such as helping seniors age in place, providing nutritious food and education to families in need, and improving transportation options to connect people, services and opportunity.

2. **Educational opportunity and youth development –** After concerns related to household finances, the desire for educational opportunities and support was a key community need repeated in the assessment. Educational goals vary according to an individual's stage of life, of course. However, not all residents grow up with the same educational aspirations and opportunities. Supporting education narrows this 'opportunity gap,' reduces health disparities

and encourages a lifetime of healthy choices.[18] Quality early childhood education, social and school-based supports (such as mental health counseling), and post-secondary opportunities are just a few ways that foundations can foster a healthy community. When considering the relationship with life-expectancy, disease prevention and other health outcomes, education may be the ‘single most important modifiable social determinant of health,’ according to a recent review from the American Public Health Association.[19]

3. **Access to quality health and dental services –** At the individual level, access to affordable dental and medical care was a predominant need conveyed by assessment participants. The LCVH Foundation serves an area that encompasses three states, nine hospital service areas and multiple payers/insurers with overlapping or discontinuous coverage areas. The low population density and changing policy environment makes health service delivery challenging. Fortunately, there are two research universities that operate medical schools committed to providing rural health care. Both universities and regional foundations are committed to rural medical education and service delivery.[20] The provision of preventive and primary care services is a critical step to ensuring a healthy community. In a diverse region such as this, foundation partners can play a key role in filling gaps in acute care services, supporting new and innovative delivery models, and bringing together community organizations to meet emerging needs.

4. **Community development and social connection –** While hospitals are often a crucial part of a community’s health delivery system, the health of a region depends in large part on social connections, physical conditions and economic opportunities cultivated throughout the entire community. City officials, economic development directors, business leaders, civic organizations and other community leaders play a key role in creating opportunities for health.[21] Indeed, many from these sectors attended community conversations and heard community members express desire for community and recreation centers, parks and public spaces, safe and functional municipal infrastructure, and inclusive local economies. Research is clear that social isolation results in lasting harm to both mental and physical health.[22] The connected community creates an environment that encourages health and supports personal wellness.

Research detailing the impact of social determinants of health on population health outcomes are available from a number of different sources.[23] Foundation granting may support work across all of these areas. Together with competitive grants, a concentrated strategy can leverage foundation assets and create momentum for measurable, lasting change. For example, Empire Health Foundation (Spokane, Washington), developed a strategy centered around healthy youth development (through childhood obesity prevention programs) and health equity, and patient empowerment (family resilience and health coaching for seniors). A stated commitment helps demonstrate progress toward community impact and attract new funding.[24]

Based on the regional needs assessment, sufficient evidence exists for a philanthropic focus on any of the above issue areas. By identifying one or two of these determinants, the LCVH Foundation can set a strategic focus (establish a ‘why’ for work), convey the improvement desired (what work hopes to achieve) and develop a strong network of partners committed to these outcomes (how the work gets executed). The challenge involves leveraging local and outside resources, identifying new opportunities, and aligning partner interests and objectives to effectively respond to these needs and make a lasting impact. **Exhibit 22** shows a few examples of technical assistance resources that may inform strategy development. Additional considerations for strategic planning are included in the final section.

Exhibit 22: Example Resources for SDOH Strategy Development

Economic security and empowerment		
	Grantmakers in aging	www.giaging.org/initiatives/rural-aging
	The Futures Project	https://caporegon.org/what-we-do/the-future/ www.cap4action.org/program/future-story-initiative-2/ www.wapartnership.org/what-we/futures
	Housing Assistance Council	www.ruralhome.org/hac-services/technical-assistance
	Rural Community Assistance Corporation (RCAC)	www.rcac.org
Educational opportunity and youth development		
	National Child Traumatic Stress Network	www.nctsn.org
	Mental Health First Aid Training	www.mentalhealthfirstaid.org/population-focused-modules/teens
	Community childcare (example school partnership)	www.nebcommfound.org/news/shickley-big-little-town-good-reasons
	Search Institute Developmental Assets	www.search-institute.org/our-research/youth-development-research/developmental-assets/
Access to quality health and dental services		
	Area Health Education Coordinators (AHEC)	www.uidaho.edu/academics/wwami/ahec https://inside.ewu.edu/ewahec
	National Rural Health Resource Center	www.ruralcenter.org
	Federal Office of Rural Health Policy	www.hrsa.gov/rural-health
	University of Idaho Project ECHO (Extension for Community Healthcare Outcomes)	www.uidaho.edu/academics/wwami/echo
	State Offices of Rural Health and Primary Care	http://healthandwelfare.idaho.gov/Health/RuralHealthandPrimaryCare/tabid/104 www.doh.wa.gov/forpublichealthandhealthcareproviders/ruralhealth
Community development and social connection		
	Federal Reserve Bank – Community Development	www.federalreserve.gov/consumerscommunities/comm-dev-system-map.htm
	Build Healthy Places Network	www.buildhealthyplaces.org
	Enterprise Community Loan Fund	www.enterprisecommunity.org/financing-and-development/community-loan-fund
	WealthWorks	www.wealthworks.org

As the LCVH Foundation reviews grant proposals and develops a strategic direction for work in this region, it is worthwhile to consider approaches that emphasize intervention and prevention. This assessment project identified many immediate needs and short-term requirements, such as the shortage of Emergency Medical Technicians and equipment in remote, rural areas, need for sexual health treatment, crisis mental health services, and others. Responding to these direct needs may not further sustainable, long-term health improvement. These care interventions, however, can save lives and establish the credibility of the foundation as a trusted partner able to meet critical community needs.

A recent article in Health Affairs titled, "Meeting Individual Social Needs Falls Short of Addressing Social Determinants of Health" suggests addressing the determinants of health at the community level and individual level, where both social and clinical needs are met. While long-term approaches and preventative efforts focus on the 'up-stream,' there is also a role for interventions that meet individual social needs. This 'midstream' impact (displayed in **Exhibit 23**) covers many of the social determinants that are associated with creating a healthy environment and providing social supports to all residents. A comprehensive 'whole stream' strategy is necessary to build healthy communities and ensure that the commitment to health and wellness extends beyond hospitals and health systems.[25]

Exhibit 23: Social Determinants and Social Needs – A 'Whole Stream' Approach

Source: Castrucci, B. & Auerbach, J. (2019 January 16). Meeting Individual Social Needs Falls Short of Addressing Social Determinants of Health. Health Affairs Blog. Retrieved from https://www.healthaffairs.org/do/10.1377/hblog20190115.234942/full/

Strategic Planning Practices and Principles

The following recommendations are intended to assist the LCVH Foundation in developing a strategic response to the issues identified in this regional assessment. Of course, there is no uniform formula for creating community change. A clear set of practices and principles, however, helps all stakeholders move from vision to action – and advance change in the same direction.

While there are an overabundance of frameworks, models and theories about strategic philanthropic giving, any approach worth adopting will consider the complexity and changing nature of community needs and opportunities. The emerging practice of *Impact-Driven Philanthropy* provides a worthwhile starting place for establishing a strategic action plan. The core practices of the Impact Driven Philanthropy are listed below:

Start with a "beginner's mind"

- Even if we've accomplished big things in other arenas, we challenge ourselves to approach philanthropy with openness, curiosity and humility. We listen more than we talk and seek to understand the wisdom, beliefs, needs, aspirations and life experiences of the people we hope to serve.
- We look for causes connected to our life experiences and values. A heartfelt connection drives passion for improving—and often increases the meaning, purpose and joy of giving.
- We focus our resources for impact. Focusing on a small set of issues, rather than taking a scattershot approach, gives us more opportunities to build meaningful relationships and knowledge in our chosen fields.
- We let form follow function. We develop our strategies and goals before selecting the best giving vehicle(s) to help achieve them.

Do our homework

- We invest the resources and time to unpack the complex issues we care about and understand the social and historical context in which these issues exist.
- We identify the outstanding needs and current actors in the space, including who has the power to make decisions that will affect change and who does not.
- We acknowledge our own beliefs about how systems work and change happens and consider all the resources we can contribute beyond money—including our professional skills, networks and influence.
- We develop goals based not only on the best evidence available but also the lived experience of those we hope to serve.
- We develop good indicators to help us determine where we're headed and course-correct, as needed.

Work with others

- We seek out people who have intimate knowledge of the problems we're trying to solve and join with them to co-create solutions. We avoid top-down "solutions" informed by experts but not the communities we hope to serve.
- Whenever possible, we engage other funders and build a network of peers with similar goals.

- If we have limited time to commit to our causes, we identify others who can leverage our resources for maximum impact, such as funding intermediaries or other donors.
- Whenever possible, we give flexible, multi-year grants—the types of support that organizations need to invest deeply in learning, innovation and talent.
- We help our partners strengthen their organizations' performance, not just their programs.
- We stick with strong grantees for a time period consistent with expectations and the difficulty of achieving social change. We communicate openly and often, and exit relationships with care.

Never stop learning

- We lean into ongoing learning to understand what's working and what's not—and help our nonprofit partners do the same. We use every resource available to inform our work, from peers and consultants to online platforms and in-person learning opportunities.
- We use qualitative and quantitative means to understand the impact of our efforts—positive and negative, intentional and unintentional—on the people and communities we serve.
- We seek unbiased, regular feedback from all of our stakeholders—including intended beneficiaries, grantees and other funders.

Source: The Giving Compass. (2017 October 24). *What Is Impact-Driven Philanthropy?* Retrieved from www.givingcompass.org/pdf/understanding-impact-driven-philanthropy/.

Building Connections

With these guidelines in mind, we encourage the LCVH Foundation to explore options to connect to local efforts and experience in order to enhance community health improvement efforts. The following options represent examples, but not necessarily endorsements, of potential connection opportunities.

✓ **Create and foster venues for local problem solving (build collective capacity)**

At several of the community forums, there was shared interest in launching a community prioritization process. Over 10 years ago, such a process was initiated in Spokane, Washington. Today, Priority Spokane (www.priorityspokane.org) brings together local government, businesses, nonprofit organizations and funding organizations to review community indicators and set a plan to prioritize community action. The priorities are re-evaluated every 2-3 years. Prior initiatives resulting from this process have included high school graduation rates, student and family homelessness, and child trauma and violence. The Priority Spokane effort continues to provide a common ground for community members to come together and respond to the most pressing local issues. Innovia Foundation was an early funder of this effort and continues to play a role on the oversight committee.

✓ **Support existing momentum**

At the time of this assessment, a number of community coalitions were already working to address health, economic and social service needs in the community. The Partnership for Economic Prosperity (www.pepedo.org) sponsored a regional housing needs report for the Palouse and the Palouse Tables Project (www.cacwhitman.org/palousetablesproject) and continues to develop collection plans to respond to food insecurity in the region. The ability of foundations to drive change rests on being part of the community conversations and collective action. Leading and joining community partnerships should be a key component of foundation efforts to catalyze and sustain health improvement. If current partnerships are effective and have ongoing 'momentum,' there is a particularly compelling case to explore foundation involvement.

- ✓ **Create relationships with partners region-wide**

  While the political, economic, demographic and geographic diversity in this area poses distinct challenges for philanthropic initiatives, there are also inherent benefits to operating in such a region. There are a number of quality organizations and agencies with a reach that extends across multiple counties. Community health systems, public health offices, community action agencies, libraries and more operate throughout this area and can work side-by-side with grantmaking foundations on initiatives that have a regional reach. **Appendix G** includes a list of organizations that attended the data walk forums and have shown interest in community collaboration.

  This assessment project – with multiple collaborators, funders and contributors – serves as just one example of the power of leveraging time, talent and resources from committed partners. In addition, the expertise at two land grant research universities and one regional college provides an unsurpassed knowledge base that the foundation can utilize to continue learning and responding to the most pressing needs in the region.

- ✓ **Stay connected to experts in field**

  The field of philanthropy draws talented individuals with deep experience across a variety of sectors in business, government and industry. New, innovative ideas and well-tested viewpoints are shared through philanthropic publications and member organizations. While LCVH Foundation BCA members are already accessing and utilizing many of these knowledge stores, an initial list is provided here for the sake of completeness. As the strategy and direction of the LCVH Foundation continues to grow and evolve, these resources will serve as a useful reference to ensure the foundation can meet challenges and take advantage of new opportunities.

  - Grantmakers in Health (www.gih.org)
  - Peak Grantmaking (www.peakgrantmaking.org)
  - Grantmakers for Effective Organizations (www.geofunders.org)
  - Stanford Social Innovation Review (https://ssir.org)
  - Center for Effective Philanthropy (https://cep.org)
  - Exponent Philanthropy (www.exponentphilanthropy.org)
  - Philanthropy Northwest (https://philanthropynw.org)

The opportunity to steward philanthropic dollars for the benefit of the community is a tremendous privilege. The clear communication of the foundation's strategy and direction is integral to building support in the community. However, the strategy must also evolve and adapt to changing circumstances and conditions in the community. As John Cawley, Director of Programs and Operations at McConnell Foundation notes, "The difference is between having a compass and a map. A map assumes that you're going over terrain that somebody has been over before."[26] The final assessment report does not map out a fixed direction for foundation activity. Rather, we survey the landscape and provide markers of the complex challenges and issues facing this region today. With humility and a commitment to service and learning, foundations can utilize data, build partnerships, leverage resources and generate a community impact that leaves a legacy for generations.

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