TriState Health

Community Health

NEEDS ASSESSMENT

2026-2028

Adopted by the TriState Health Board of Directors, May 4, 2026

Table of Contents

Who We Are

TSH Memorial Hospital, now TriState Health (TSH), was established in 1955 as the only community owned, not-for-profit hospital in the Lewis-Clark Valley at the confluence of the Snake and Clearwater rivers and the Idaho-Washington border. The area is widely known as a hub for outdoor recreation, including being the gateway to Hells Canyon. Today, TSH serves a wide geography, including Asotin County and parts of adjacent Garfield County in Washington and Nez Perce County in Idaho.

TSH is a 25-bed critical access hospital offering inpatient care, 24-hour emergency services, three primary care clinics, and over a dozen specialty care clinics, laboratory, imaging, pharmacy, surgery, and physical therapy. In 2025, TSH expanded new service lines in outpatient OB/Gynecology, Orthopedics, and Dermatology.

TSH has recently undertaken several construction projects to expand outpatient and clinic-based services. The hospital operates several unique services, including outpatient dialysis and hyperbarics for wound care. As the largest employer in Asotin County, TSH is committed to its mission of caring for community and ensuring, “your health is our first priority.”

TSH was designated as a Critical Access Hospital (CAH) by meeting the federal and state designation requirements in the Washington State Rural Health Plan and the Medicare Conditions of Participation.

TriState Health

Our Mission: Your Health Is Our First Priority!

Our Vision: We place the healthcare needs of our community first by partnering to bring care beyond our walls through innovative technology and collaboration. We are a regional healthcare leader and employer of choice, delivering the highest quality of care to facilitate health, healing, and wellbeing throughout our community and those we touch.

Our Values:

☑ **Quality**

Through teamwork, we strive to continuously improve our quality of care and service.

♥ **Compassion**

We are the caretakers of our community, and we treat each patient, partner, and team member with a tender touch and an unparalleled level of care.

Respect

We create a culture of respect by engaging professional staff who demonstrates respect for each other, our patients, and their families.

Collaboration

We seek healthy partnerships—both within and outside our walls—to build teams that deliver the highest quality of care.

Innovation

We embrace and integrate new ideas and technology to improve our community’s health and wellness.

In 2025, TSH received a prestigious 5-Star Rating in Patient Experience from the Centers for Medicare & Medicaid Services’ Hospital Consumer Assessment of Healthcare survey.

Our promise at TSH goes beyond medicine. It is a pledge to care for our community, strengthen local connections, and support the people who make health care possible. For 70 years, TSH has served families across Washington, Idaho, and beyond, providing care close to home, no matter

which side of the river a person lives on. What began as a small community hospital has grown into a system of clinical and surgical care underpinned by a commitment to partnership, collaboration, and service in support of the communities' needs. In 2025, TSH put its values to work, partnering with:

- **Clarkston School District** – TSH has been selected as the partner for the school-based health center (SBHC) which is scheduled to open after construction is completed in the Fall/Winter 2026. The SBHC will serve district students' health and wellness needs, support an Athletic Training position, and create a Certified Nursing Assistant job training pathway.
- **Lili Gynecological Foundation** – Serving as a Food Pantry sponsor in the creation of dedicated food pantry space and helping cover operational costs in support of wrap around services for women and families affected by gynecological cancers.
- **Snake River Community Clinic** – Working to provide ongoing pharmaceutical support and sponsor the renovation of a new medication dispensary area.
- **Elson S. Floyd College of Medicine at Washington State University** – TSH is in the planning stages to launch a family medicine residency program designed to train and retain physicians who want to serve in rural, community-based settings.

At the close of 2024 TSH had subsidized $2,369,480 in uncompensated financial medical assistance. In 2025 TSH provided:

Introduction: Process & Methodology

Community Health Needs Assessment Process

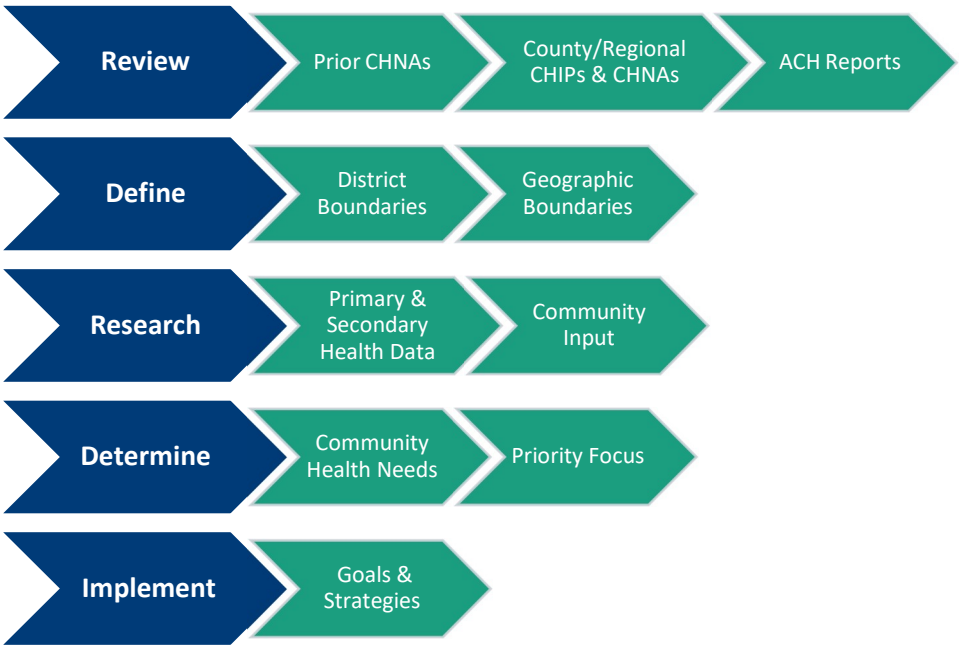
Every three years, non-profit hospitals are federally required to complete a Community Health Needs Assessment (CHNA) to identify, understand, and respond to the health needs of the communities they serve. A CHNA must:

- **Define the community** it serves.
- **Assess the health** of that community.
- **Gather community input** representing both the broad interests of the community and those with special knowledge of or expertise in public health.
- **Identify and prioritize significant health needs** of the community.
- **Adopt and document the CHNA in a written report** widely available to the public.
- **Develop and adopt a written Implementation Plan** addressing the community's priority health needs.

This 2026–2028 Community Health Needs Assessment (CHNA) presents key health indicators, trends, and community characteristics across the TSH Service Area, based on comprehensive analysis of local health data and a service area-wide survey of community health leaders. As a public document, a CHNA serves to identify the service area's most pressing health needs and inform strategic planning. The CHNA is used by local government, hospitals, and community organizations to align priorities, address barriers, and guide initiatives aimed at improving the health and well-being of TSH Service Area residents.

Methodology

TSH engaged Health Facilities Planning & Development, Seattle, to conduct its 2026-2028 CHNA using the following framework:



Data Collection

Primary and secondary data were collected to assess the overall health status of the TSH Service Area. This data informed the identification and analysis of unmet health needs, as well as the development of key themes and priorities related to community well-being.

Because every hospital's service area serves a distinct geographic area, data was analyzed at the service area level when available. Where sub-county data was not available, county-level data was used, and relevant findings are presented throughout the report. A detailed description of data sources, collection methods, analytic approach, and supporting data tables is provided in **Appendix 1**.

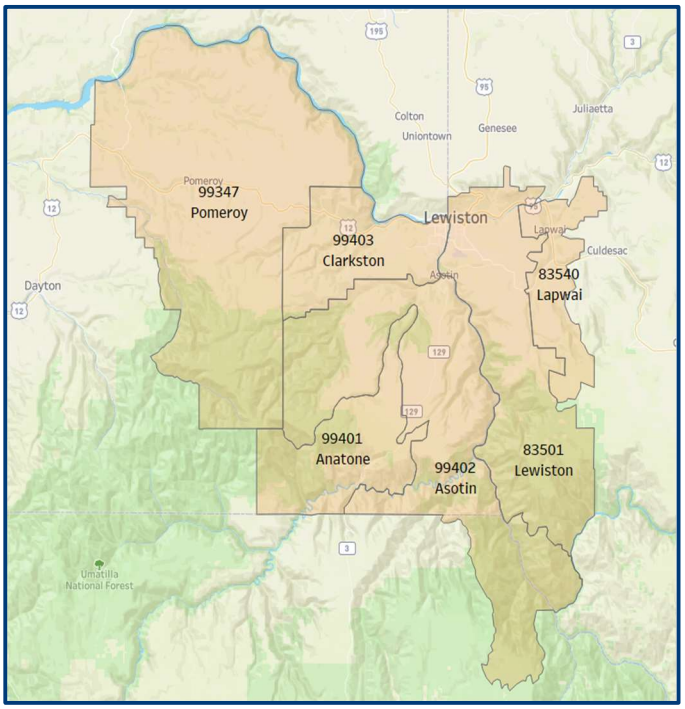
Service Area

The TSH Service Area, accounting for close to 90% of TSH's patients, includes the Lewis-Clark Valley (the Valley) located at the confluence of the Snake and Clearwater rivers, and encompasses the entirety of Asotin County and portions of Garfield County in Washington, and portions of Nez Perce County across the border in Idaho. Most of the Valley is located on the ancestral lands of the Nez Perce tribe.

TSH Service Area communities include:

TSH Service Area			
Community	**Zip Code**	**County**	**State**
Pomeroy	99347	Garfield	WA
Anatone	99401	Asotin	WA
Asotin	99402	Asotin	WA
Clarkston	99403	Asotin	WA
Lewiston	83501	Nez Perce	ID
Lapwai	83540	Nez Perce	ID

TSH Service Area Map



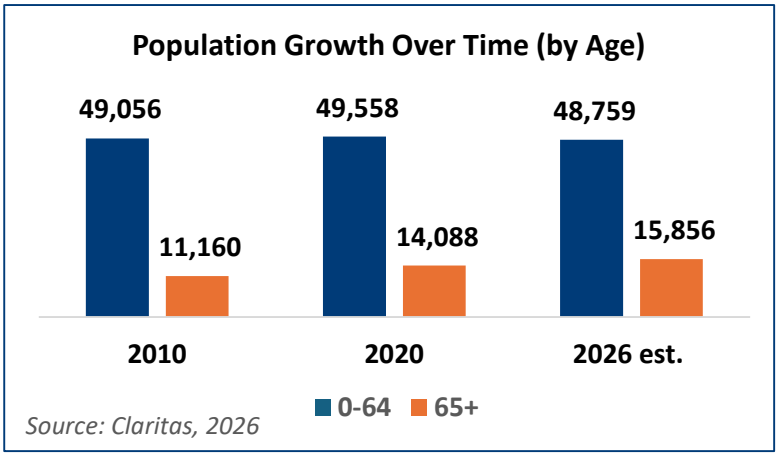
Community at-a-Glance: Population

- The Service Area population is estimated at 64,615 in 2026.
- The Service area experienced 7% growth between 2010 and 2026.
- A one percent (1%) growth in the Service Area is expected by 2031, with the population projected to be just over 65,000.

Service Area Population:
64,615 (*2026 est.*)

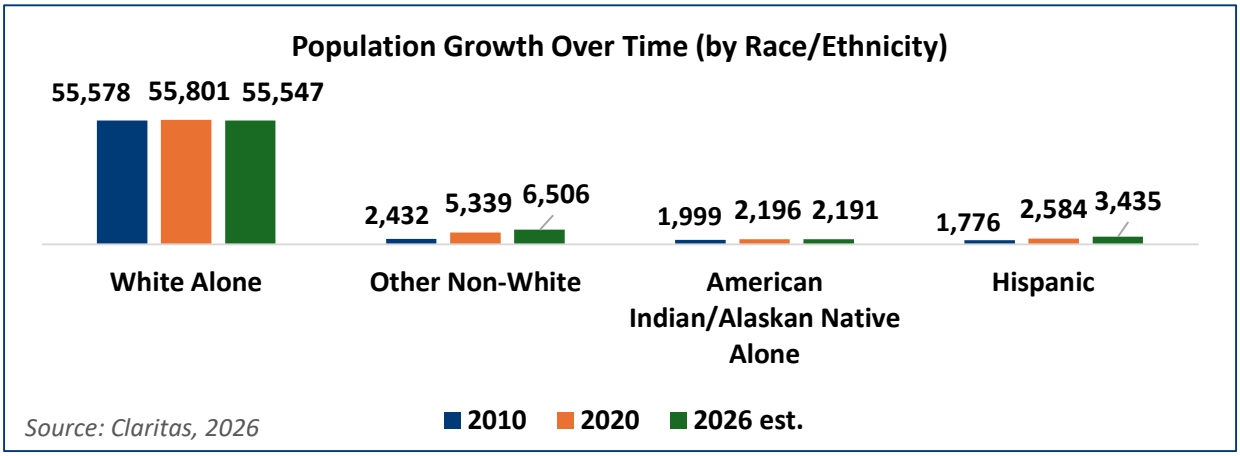
5-Year Growth:
+1,136 (*Percent Growth: 1%*)

- One quarter (24.5%) of the Service Area's population is 65+ relative to 17.3% for Washington State.
- The 65+ population is growing faster than the Service Area overall, and is projected to grow 10% by 2031 to account for almost 27% of the Service Area population.



- While the Valley has diversified since 2010 with double-digit growth in the Hispanic community and strong minority growth, the Service Area is less diverse overall than Washington State with 5.3% of the Service Area identifying as Hispanic relative to almost 15% statewide. An exception is the American Indian population, which is 3.4% of the Service Area relative to 2% statewide, with the Nez Perce Tribal Reservation overlapping the Service Area.

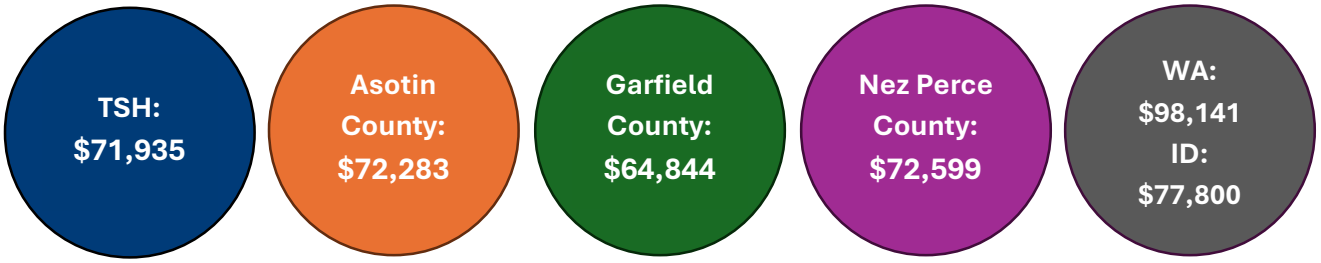
A detailed Service Area population table is included in **Appendix 1**.



Community at-a-Glance: Service Area Socioeconomic Characteristics

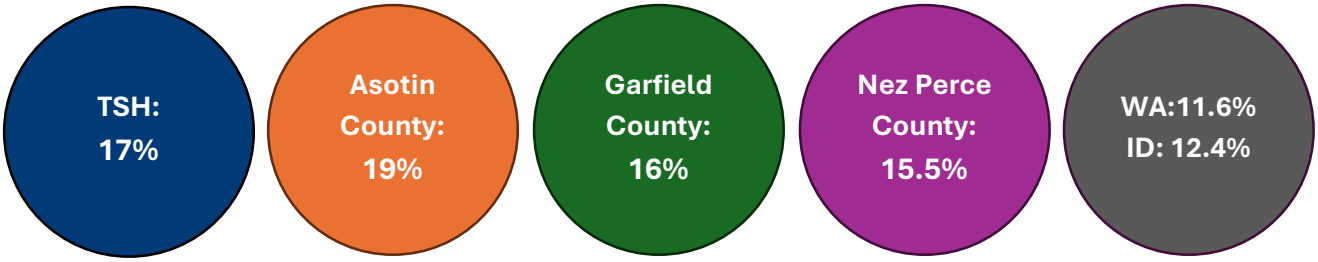
Median Household Income

Source: ACS, 2020-2024 5-Year Estimates



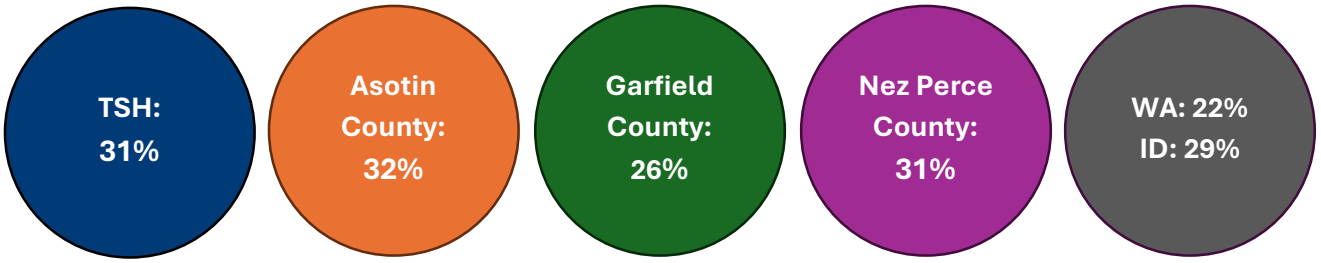
Children (<18) Living in Poverty

Source: ACS, 2020-2024 5-Year Estimates



Population Earning Less than 200% of Federal Poverty Level

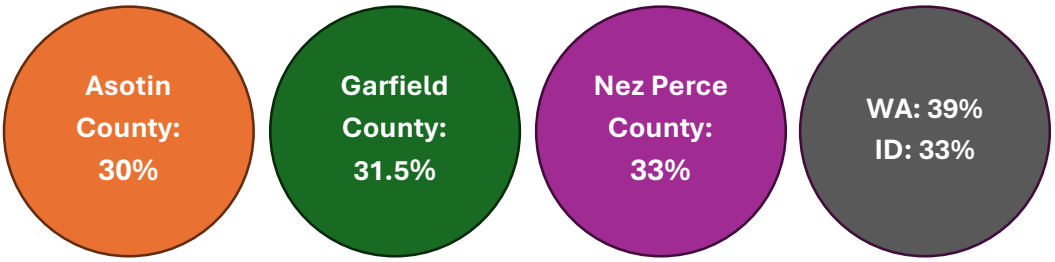
Source: ACS, 2020-2024 5-Year Estimates



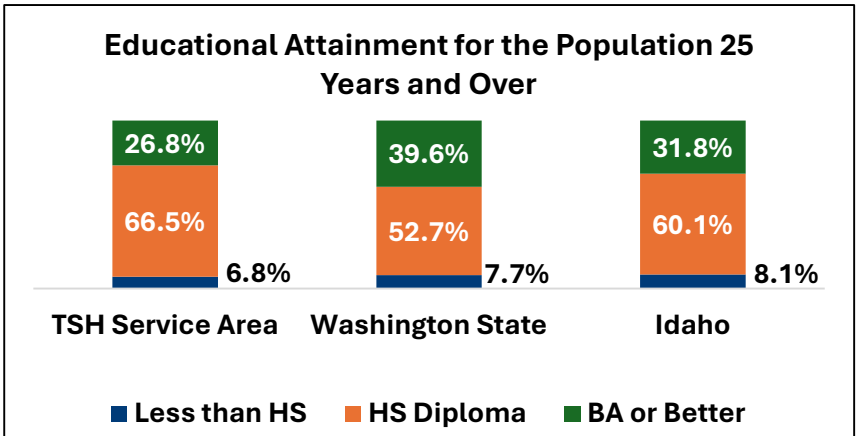
Severe Housing Problems

(% of Households with at least 1 of 4 issues: overcrowding, high costs, lack of kitchen facilities, lack of plumbing facilities)

Source: RWJ County Health Rankings, 2017-2021 5-Year Estimates

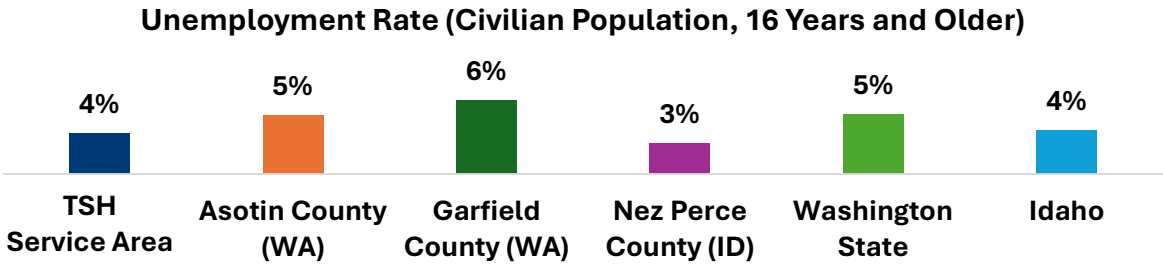


- Socioeconomic data in the Service Area is in line with the three counties that constitute it. Asotin (WA) and Nez Perce (ID) counties share almost identical socioeconomic data profiles, while Garfield County, as the most rural and least populous, differs only slightly.
- Median income in the Service Area, as a measure of material resources available to a community, is almost 8% lower relative to Idaho and almost 27% lower relative to Washington State.
- Childhood poverty rates in the Service Area (17%) are approximately 40% higher (worse) compared to Idaho (12.4%) and Washington State (11.6%).
- Approximately one-third of the Service Area population (31%) is struggling to make ends meet (earning less than 200% of FPL), a rate 7% higher relative to Idaho (29%) and 40% higher relative to Washington State (22%).
- Severe Housing Problem rates (households with at least 1 of 4 issues: overcrowding, high costs, lack of kitchen facilities, lack of plumbing facilitates) are a key indicator of economic stress. The Service Area (32%) fares better compared to Idaho (33%) and Washington (39%).
- Educational attainment is a strong predictor of long-term income, employment, and health literacy. Those with less than a high school diploma in the Service Area is slightly lower (better) relative to either Idaho or Washington State, however, those with advanced degrees (BA or better) are also lower (worse) than state averages.



Source: ACS, 2020-2024 5-Year Estimates

- Unemployment is a direct measure of economic stability and opportunity. The Service Area is in line with the three counties and two states comprising its boundaries.



Source: ACS, 2020-2024 5-Year Estimates

Health and Well-Being

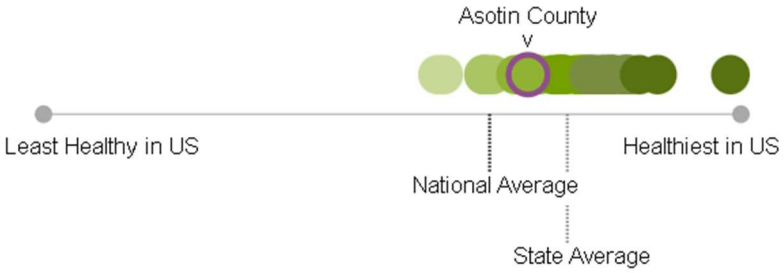
Prior to 2024, the RWJ County Health Rankings compared and ranked counties on more than 30 factors relative to the health of other counties.

Beginning in 2024, RWJ County Health Rankings shifted away from numerical rankings to a scaled approach. Counties in a state are now represented by a dot, shaded a certain color, and placed on a decile scale from least healthy to most healthy in the state and nation. The darker colored areas indicate populations with healthier rankings. The RWJ County Health Rankings does not provide data below the county level.

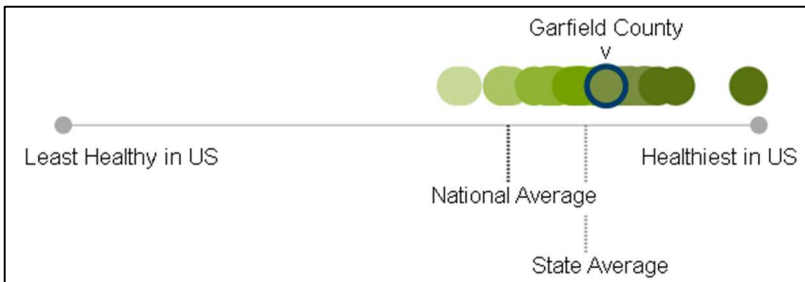
Health and Well-Being data tells us how long people live, on average, within a community, and how much physical and mental health people experience in a community while they are alive.

All three TSH Service Area counties fare better than the national average on RWJ's County Health Rankings for health and well-being, though relative to their home state, Asotin fares slightly worse, Garfield slighlty better, and Nez Perce about the same.

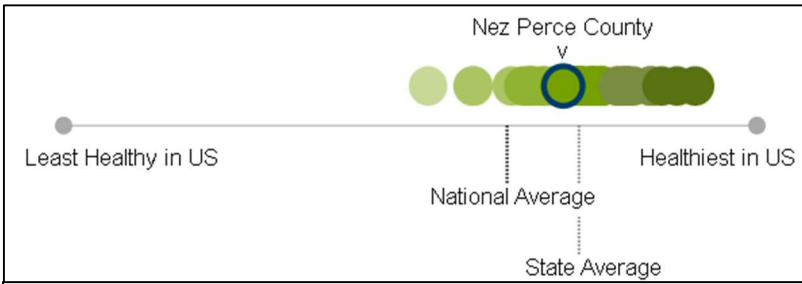
County Health Rankings & Roadmaps



Asotin County is faring slightly worse than the average county in Washington for Population Health and Well-being, but slightly better than the average county in the nation.



Garfield County is faring slightly better than the average county in Washington for Population Health and Well-being, and better than the average county in the nation.

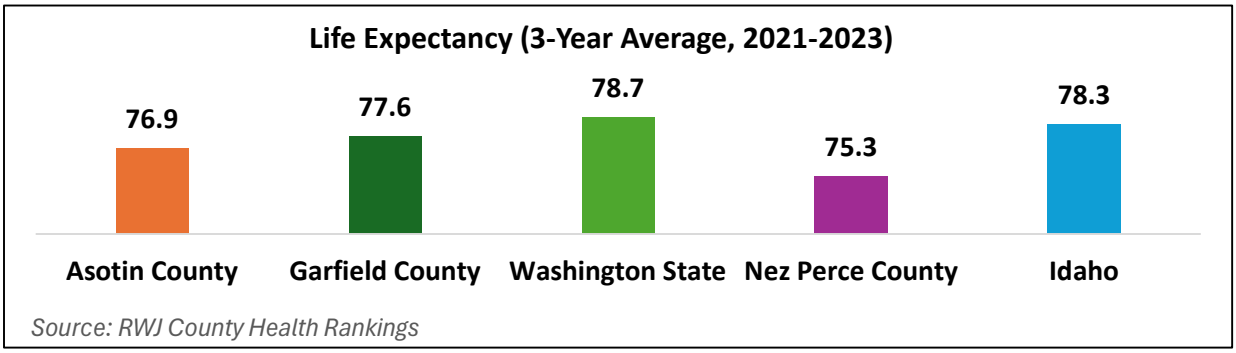


Nez Perce County is faring about the same as the average county in Idaho for Population Health and Well-being, and better than the average county in the nation.

Length of Life

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

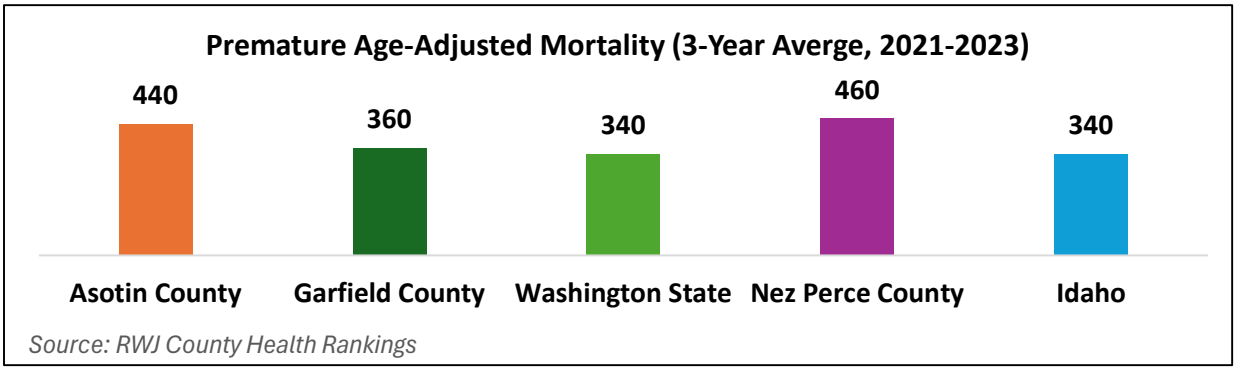
Life expectancy measures the average number of years from birth a person can expect to live, according to the current mortality experience (age-specific death rates) of the population. Life expectancy calculations are based on the number of deaths in a given period and the average number of people at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



Source: RWJ County Health Rankings

All three TSH Service Area counties have lower (worse) life expectancies compared to both Washington State and Idaho as a whole, with Nez Perce County, in particular, experiencing significantly lower outcomes.

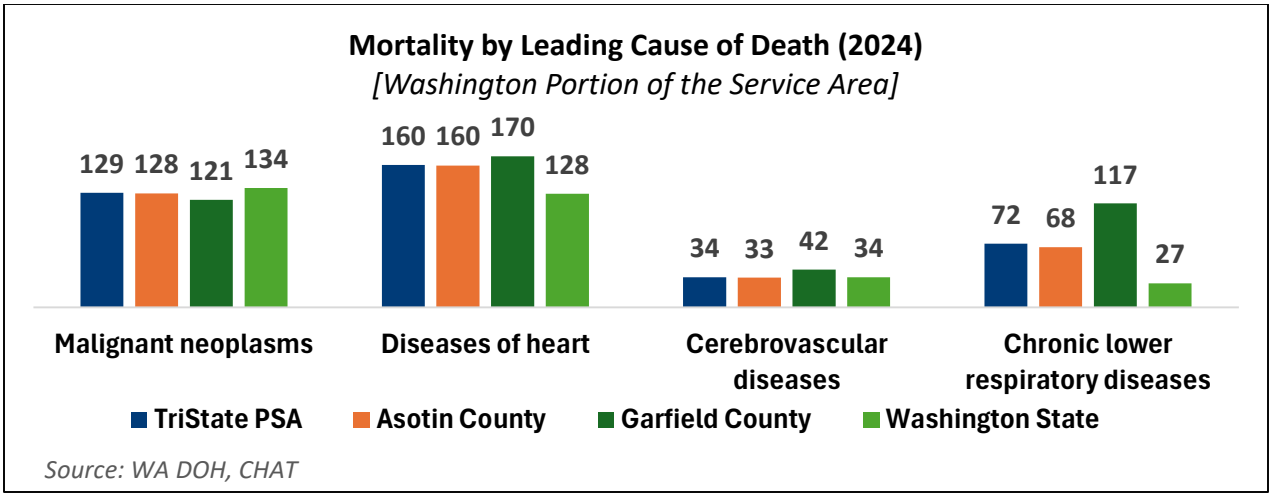
Premature mortality measures the number of age-adjusted deaths among residents under age 75 per 100,000 population.



Source: RWJ County Health Rankings

All three TSH Service Area counties have higher (worse) rates of premature mortality than either Washington State or Idaho (which are in line with each other). Asotin and Nez Perce counties, in particular, experience rates of premature death 29% – 35% higher than their respective state averages.

Using the Washington State Department of Health's Community Health Assessment Tool (CHAT) allows a deeper dive into mortality by leading cause of death data on the Washington side of the Service Area. Idaho does not have a comparable data set.



The TSH Service Area and its two Washington counties have about 25% higher (worse) rates of mortality from diseases of the heart relative to Washington State. They also have significantly higher (worse) rates of mortality by chronic lower respiratory disease, such as COPD.

The Service Area and Asotin County rates of mortality from chronic lower respiratory disease relative to Washington State are more that 150% higher, while the Garfield County rate is more than 300% higher. Some caution should be exercised with the Garfield County data as its much smaller population makes its average mortality rate susceptible to larger variances based slight changes in death rates.

Other Health Outcomes

The Behavioral Risk Factor Surveillance System (BRFSS) is a state-based, nationwide survey conducted by the CDC that collects self-reported health outcomes data among U.S. adults. It is one of the largest ongoing health surveys in the world and is widely used to identify population health trends, disparities, and risk factors at state and local level. BRFSS data is not available in a single, centralized dataset; instead, it is accessed through multiple CDC tools and/or state-level sources, with availability and geographic detail varying by year and indicator.

Selected measures of health outcomes data are available at the zip code level through the Health Resources and Services Administration (HRSA). As detailed below and on the following page, while often in line or faring better on measures of health relative to its three constituent counties, the TSH Service Area fares worse compared to both Washington State and Idaho on selected BRFSS health outcome measures:

- **Service Area rates of obesity are slightly higher (worse) than WA or ID.**
- **Service Area rates of high blood pressure are in line with or lower than its constituent counties, but substantially higher (worse) than WA or ID.**
- **Service Area rates of diabetes are in line with or lower than its constituent counties, but are higher (worse) than WA or ID.**

Percentage of Obesity in Adults (2022)

35% TSH Service Area	35% Asotin Co.	35% Garfield Co.	31% WA	35% Nez Perce Co.	33% Idaho

Percentage of Adults with High Blood Pressure (2021)

36% TSH Service Area	37% Asotin Co.	37% Garfield Co.	29% WA	36% Nez Perce Co.	32% Idaho

Percentage of Adults with Diabetes (2022)

12% TSH Service Area	12% Asotin Co.	13% Garfield Co.	10% WA	12% Nez Perce Co.	10% Idaho

Source: HRSA GeoCare Navigator

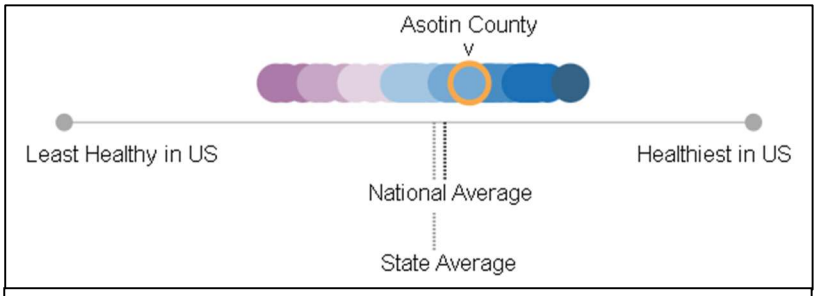
Community Conditions

As with Health and Well-being data, the RWJ County Health Rankings uses a scaled approach to rank counties on a decile scale from least healthy to most healthy in the state and nation on select health factors. The darker colored areas indicate populations with healthier rankings.

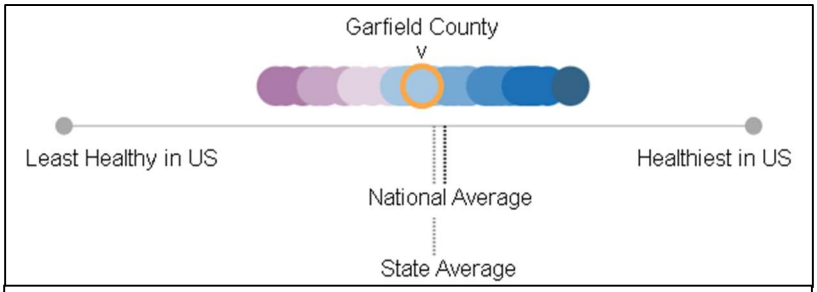
Community Conditions represent things we can improve to live longer and healthier lives and are indicators of the future health of our communities. Examples include reducing tobacco, drug, or alcohol use, increasing physical activity, improving diet, etc.

Asotin County fares slightly better than the national avearge and about the same relative to Wasington State on RWJ's County Health Rankings for community conditions. Garfiield County fares about the same relative to Washington State, but slightly worse than the national average, while Nez Perce County fares about the same relative to Idaho and slightly better than the national average.

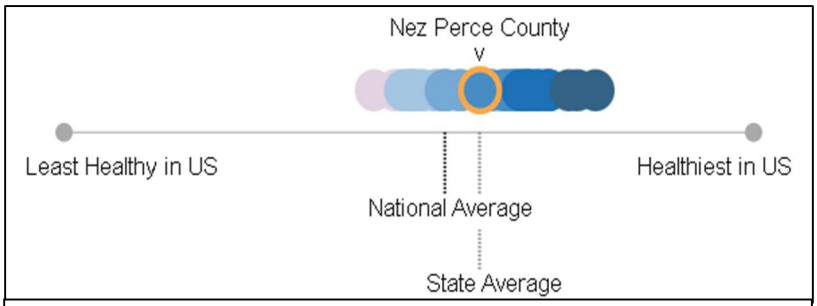
County Health Rankings & Roadmaps



Asotin County is faring slightly better than the average county in Washington for Community Conditions, and about the same as the average county in the nation.



Garfield County is faring about the same as the average county in Washington for Community Conditions, and slightly worse than the average county in the nation.

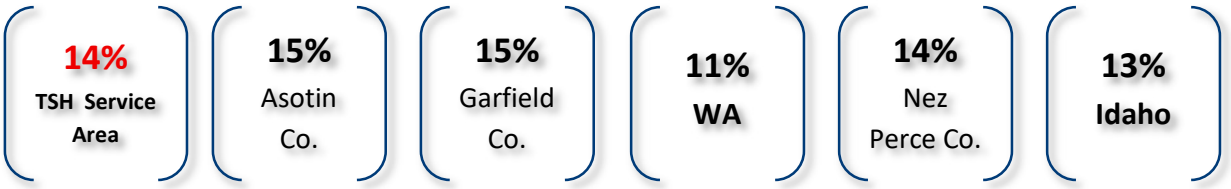


Nez Perce County is faring about the same as the average county in Idaho for Community Conditions, and slightly better than the average county in the nation.

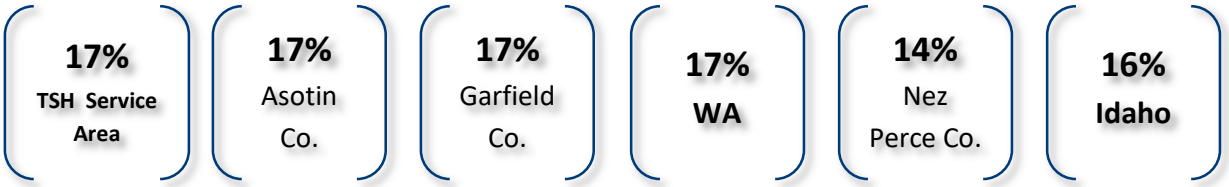
As with Health Outcomes, BRFSS also collects self-reported data on health behaviors and preventive services use among U.S. adults. Looking at selected measures of health behavior:

- **TSH Service Area rates of smoking are slightly higher (worse) than WA or ID.**
- **Service Area rates of binge drinking (5 or more drinks on one occasion for males and 4 per occasion for females) is in line with WA and ID.**

Percentage of Adults Who Smoke (2022)



Percentage of Adults Who Are Binge Drinkers (2022)



Source: HRSA GeoCare Navigator

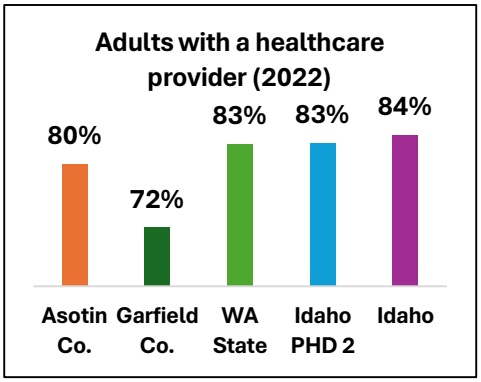
Clinical Care

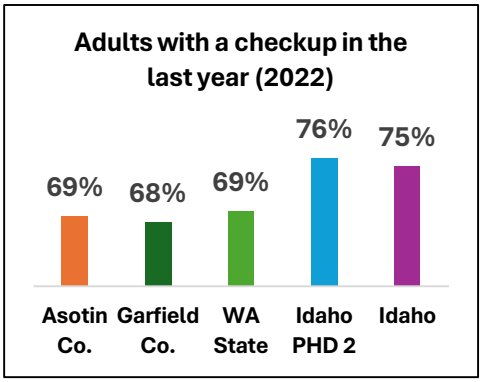
Access to affordable, high-quality, and timely healthcare is a primary driver of reduced morbidity and mortality, enabling earlier detection and more effective management of disease. Expanded coverage and improved access are consistently associated with increased use of preventive services and measurable reductions in avoidable illness. Conversely, individuals without regular access to quality providers are more likely to be diagnosed at later, less treatable stages of disease and, consequently, experience poorer outcomes, lower quality of life, and higher mortality, along with greater financial burden.

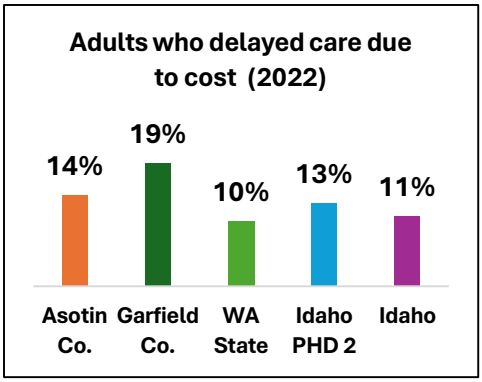
Selected measures of BRFSS clinical care and preventive services data are only available at the county level in Washington State via the Department of Health Community Health Assessment Tool, and at the public health district (PHD) level in Idaho through the Idaho Department of Health & Welfare. Some caution is needed in comparison, as Idaho PHD 2 comprises five counties and TSH's service area overlaps just one of those counties, Nez Perce, which about 60% of Idaho PHD 2's total population.

While in line across the Service Area, looking at selected measures of clinical care shows:

- **Garfield County in Washington has lower (worse) rates of the adult population with access to a usual source of primary care and higher (worse) rates of adults who delayed care due to cost.**
- **Idaho PHD 2 (and statewide) has higher (better) rates of adults who received an annual medical checkup.**





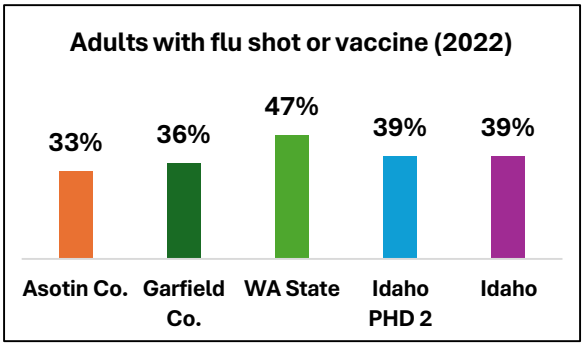


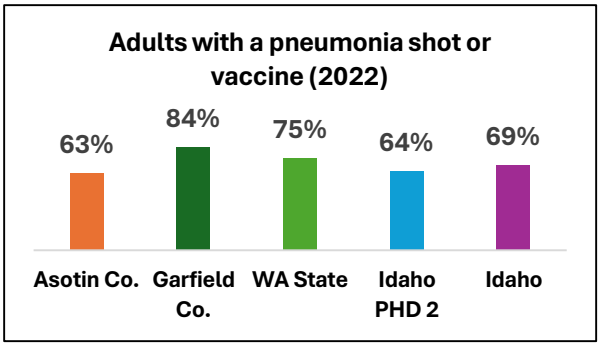
Source: DOH CHAT (WA); Division of Public Health (ID)

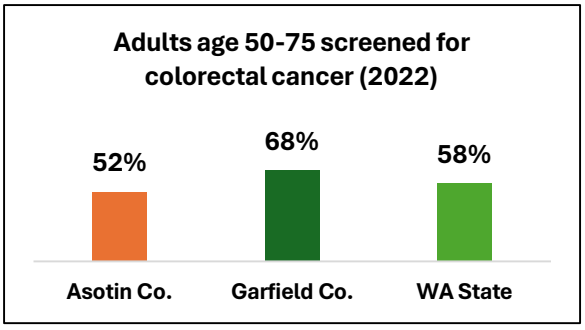
Preventive Care

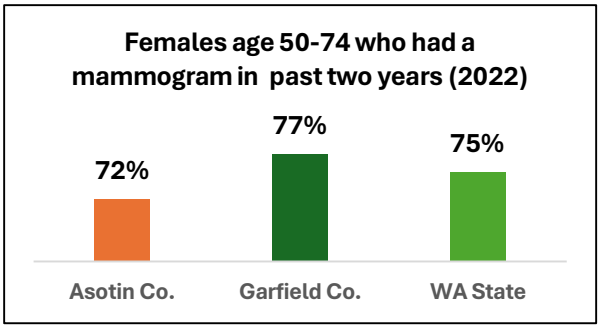
Looking at selected measures of clinical care shows:

- **The rate of flu vaccination in the Service Area's constituent geographies is well below the Washington State average but in line with Idaho.**
- **Garfield County is a positive outlier for pneumonia vaccination at 84%, significantly above Washington, Idaho, or other Service Area counties' averages, while Asotin County is well below other service area geographies at 63%.**
- **Likewise, Garfield County outperforms Asotin County and the Washington State average for colorectal screening and is in line on mammogram utilization.** Both colorectal screening and mammogram utilization data from Idaho are suppressed due to low sample size, which may cause unreliable estimates.









Source: DOH CHAT (WA); Division of Public Health (ID)

Youth in the Valley

The **Healthy Youth Survey** (HYS) is a statewide, school-based survey administered every two years to students in grades 6, 8, 10, and 12 to measure health behaviors, risk factors, and protective factors among youth. It provides data used by schools, communities, and policymakers to guide youth prevention programs. Washington State HYS data is publicly available at the county level, while Idaho HYS data is only available at the state level.

The **2023 Washington HYS** data shows 10th graders on the Washington side of the Valley are experiencing higher (worse) rates in several measures:

Measure	Asotin County	Garfield County	Washington State
Depression: Percentage of 10th grade youth who report feeling sad or hopeless almost every day for two weeks or more in the last year	**34%**	**32%**	**30%**
Hope Scale: Percentage of 10th grade youth who report no or very low hope on the Children's Hope Scale	**8%**	**14%**	**8%**
Suicide: Percentage of 10th grade youth who report attempting suicide in the past year	**10%**	**9%**	**7%**
Annual Physical Exam: Percentage of 10th grade youth reporting an annual check-up or physical exam in the past 24 months	**71%**	**55%**	**67%**
Binge Drinking: Percentage of 10th grade youth who report drinking five or more drinks in a row in the past two weeks	**3%**	**10%**	**4%**
Source: 2023 Washington Healthy Youth Survey			

In June 2025, Clarkston School District conducted a **Guiding Voices Survey** of students, families/guardians, and educators to assess student health and wellness needs and inform the design of a proposed school-based health center (SBHC) in collaboration with TSH.

The proposed SBHC is intended to support academic success and student well-being by increasing access to timely medical and mental health care, reducing barriers such as transportation and insurance challenges, and providing a safe, confidential, on-campus space for whole-child care. Additional goals include expanding access through telehealth to support family involvement and improving coordination between physical and behavioral health services.

TSH has a long-standing partnership with Clarkston School District, including programs such as Athletic Training, Certified Nursing Assistant training, and Scrubs Camp, which introduces students to healthcare careers through hands-on experiences.

Survey findings (detailed in the **Community Convening** section) indicate strong support for a school-based health center and highlight a clear need for integrated physical and behavioral health services delivered in a convenient, trusted, school-based setting. Across all respondent groups, there is consistent evidence that reducing access barriers and expanding mental health supports are critical priorities for improving both student well-being and academic outcomes.

Health Professional Shortages & Medically Underserved Areas

The Federal Health Resources and Services Administration (HRSA) designates certain geographies and populations as Medically Underserved Areas (MUAs), Medically Underserved Populations (MUPs), and Health Professional Shortage Areas (HPSA). Service Area designations indicate critical shortages of healthcare providers and may apply broadly to a geographic area or specifically to certain populations or facilities. Geographic shortage areas reflect provider shortages affecting the entire population within a defined area, while population shortage areas identify access challenges among specific groups.

HPSA Scoring Criteria

Three scoring criteria are common across all disciplines of HPSA:

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

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

Asotin County WA, HPSA Designations – 2025 Update		
Professional Area	**Designation Type**	**Score**
Primary Care	Low Income	15
Dental Health	Low Income	16
Mental Health	Geographic	16
Source: HRSA Data Warehouse, HPSA Find		

Garfield County WA, HPSA Designations – 2025 Update		
Professional Area	**Designation Type**	**Score**
Primary Care	Geographic	13
Dental Health	Low Income	16
Mental Health	High Needs Geographic	10
Source: HRSA Data Warehouse, HPSA Find		

Nez Perce County ID, HPSA Designations – 2025 Update		
Professional Area	**Designation Type**	**Score**
Primary Care	Low Income	15
Dental Health	Low Income	15
Mental Health	Geographic	16
Source: HRSA Data Warehouse, Hservice area Find		

Once an area is designated as HPSA, HRSA assigns a score ranging from 0 to 26, with higher scores reflecting greater shortages and need. Scores are calculated separately for three areas of care: primary medical, dental, and mental health services. These designations and scores are significant because they influence eligibility for more than 30 federal programs that support funding, loan repayment, and other incentives to attract and retain healthcare professionals in underserved communities.

The TSH Service Area sits at the center of three counties, all with significant professional shortages. All three Service Area counties are designated primary care, dental health, and mental health professional shortage areas.

HRSA's MUAs and MUPs identify geographic areas and populations with a lack of access to primary care services. The MUA/P score is dependent on the Index of Medical Underservice (IMU) calculated for the area or population proposed for designation. Under the established criteria, an area or population with an IMU of 62.0 or below qualifies for MUA/P designation.

MUA/P Scoring Criteria

MUA/P Indicators

- *Provider per 1,000 population ratios*
- *% Population at 100% of the Federal Poverty Level (FPL)*
- *% Population age 65 and over*
- *Infant Mortality Rate*

TSH Service Area, Medically Underserved Areas		
Service Area	**Discipline**	**Score**
Asotin County (WA)	Primary Care	53.1
Garfield County (WA)	Primary Care	60.9
Nez Perce County (ID)	Primary Care	56.3
Source: HRSA Data Warehouse, HPSA Find		

As with HPSA designations, all three TSH Service Area counties have also been designated as medically underserved areas for Primary Care.

As depicted below, and given the above designations, it is not surprising that the **TSH Service Area counties generally face worse provider-to-population ratios compared to state averages.**

- **Asotin and Garfield counties have fewer primary care providers per population than Washington State; Nez Perce County has fewer primary care providers per population than the state of Idaho.**

- **Both Asotin and Nez Perce counties fare slightly worse than Washington State in access to dental providers; Nez Perce County fares slightly better than Idaho in access to dental providers.**

- **Garfield County is an outlier in mental health access, with significantly higher (worse) population-to-provider ratios for mental health practitioners.**

Population-to-Provider Ratios					
Provider Type	**Asotin County**	**Garfield County**	**Washington State**	**Nez Perce County**	**Idaho**
Primary Care Physicians	**1,610:1**	**2,360:1**	**1.170:1**	**1,480:1**	**1,610:1**
Other Primary Care Providers (NP, PA)	**1,320:1**	**480:1**	**800:1**	**450:1**	**650:1**
Mental Health Providers	**170:1**	**2,400:1**	**180:1**	**300:1**	**350:1**
Dentists	**1,250:1**	**1,180:1**	**1,130:1**	**1,190:1**	**1,510:1**
Source: County Health Rankings 2026					

Prior CHNA Accomplishments

Based on the data, key informant surveys, and the Board's consideration of TSH's resources and expertise, TSH elected to carry forward the 2020-2022 priorities as continued areas of focus for the 2023-2025 CHNA. While measurable progress was made in several 2020-2022 Implementation Plan focus areas, TSH's 2023-2025 Community Health Needs Assessment (CHNA) acknowledged that continued unmet health needs and gaps in the community remained.

Of particular concern were gaps related to community mental health and substance use (including opioids). The 2023-2025 CHNA also identified the need to continue focusing on access to primary care and screenings, as well as education regarding preventable diseases and increasing services and support of at-risk youth.

The specific strategies selected in the 2023-2025 CHNA and Implementation Plan were:

1. Recruit and develop services and support to improve retention of primary care providers.
2. Optimization of workflows, processes, people, and technology to support efficient and effective care delivery (thereby improving access).
3. Continue to grow behavioral health services, with a special focus on youth in the community and integrating behavioral health services within primary care.
4. Continue to grow telemedicine and tele-behavioral health services.
5. Partner with community organizations to educate, inform, and support youth and adults in healthy living.
6. Support healthy aging and mitigate impacts of chronic health and behavioral health concerns in the Valley's elderly population.

Despite ongoing high demand for primary care services, TSH's prior accomplishments include:

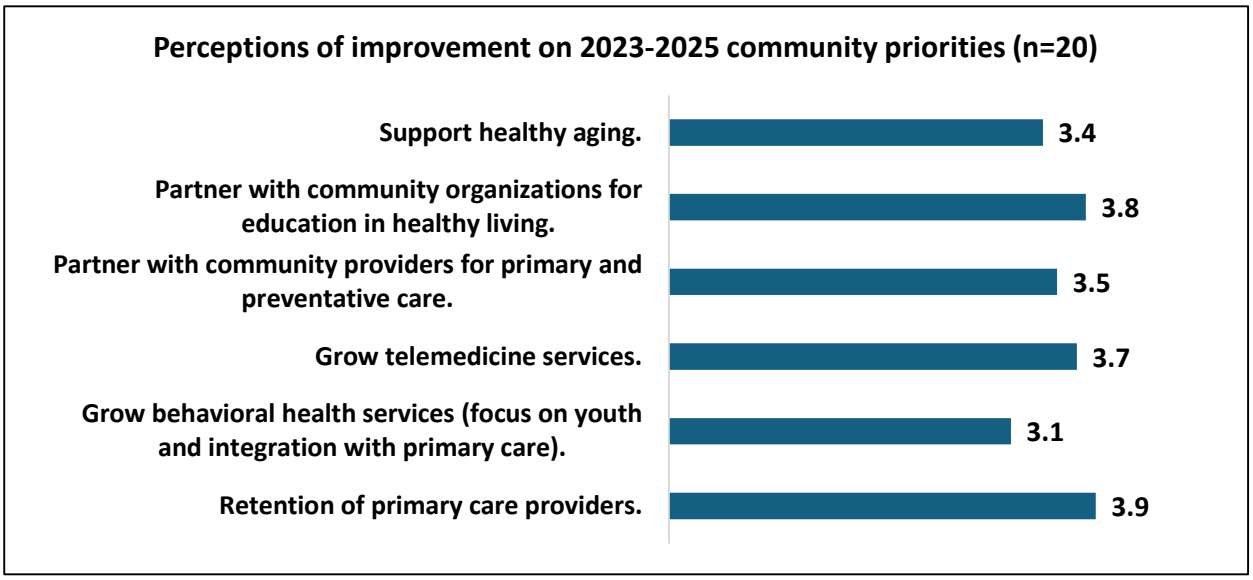
- Increased primary care provider retention and higher customer satisfaction.
- Ninety percent (90%) of primary care providers exceeded production expectations.
- The addition of two primary care-integrated behavioral health providers and additional behavioral health treatment options.
- Increased telehealth services and expanded urgent care access, resulting in increased numbers of patients served and decreased no-show rates.
- Dozens of robust community partnerships dedicated to community education and supporting preventive medicine and healthy living.

Tables detailing the 2023-2025 priority strategies, resources required, identified collaborators, anticipated outcomes, and accomplishments made to date are included as **Appendix 2** to this report.

Community Convening

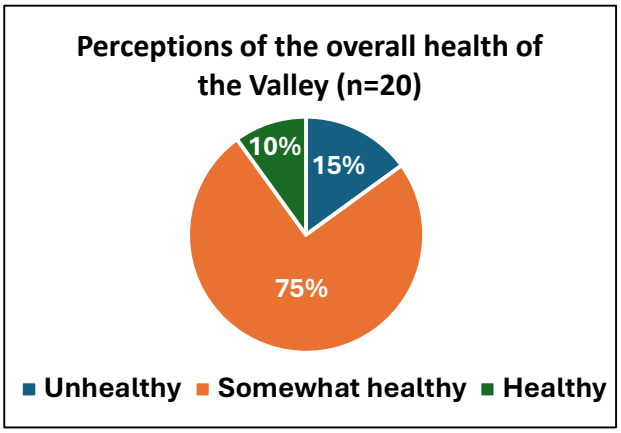
The process for the 2026-2028 TSH CHNA included a service area-wide survey of key cross-sector community leaders to gain insight and perspective on progress made and gaps remaining related to the prior 2023-2025 CHNA priorities. The survey was developed for local community leaders from healthcare, education, law enforcement, social services, faith-based, and non-profit sector organizations with direct experience and knowledge of the TSH Service Area communities' strengths, needs, and gaps. Twenty community leaders from multiple community organizations responded to the TSH Community Health Needs Survey. Out of 20 community leader responses, 50% are from the Asotin County/Clarkston, WA, side of the service area and 50% are from the Nez Perce County/Lewiston, ID, side of the services area, while one respondent was a TSH provider or staff member.

Leaders were asked to rank the progress or changes in the community related to the 2023 community priorities on a scale of 1 (no improvements) to 5 (much progress). The weighted average for each and all community priorities was ranked above moderate progress (a 3 or higher), with efforts to retain primary care, partnering with community organizations on health education, and growing telemedicine receiving the highest weighted averages.



When asked if these previous priorities should continue as a priority for the next three years, **all six priorities were overwhelmingly supported as continuing priorities for 2026-2028**.

Asked to rate the overall health of the Valley, no respondent ranked the Service Area's health as "very unhealthy" or "very healthy," with the majority assessing it as "somewhat healthy."



Community leaders were also asked to identify populations in the community experiencing greater disparities, key health problems in the community, and the most important factors in addressing those disparities and health problems.

Fifty percent of respondents (n=10) identified the following special populations as experiencing greater health disparities:

- "Women veterans need more outreach and involvement… not all seniors are getting the help they need."
- "Rural communities and not having rides to healthcare appointments."
- "Children with obesity issues."
- "Unaccompanied minors."
- "Those with chronic mental health and/or substance abuse issues."
- "Women."
- "The homeless population, including adults and children, as well as the low-income population."
- "Elderly."
- "Children in low-income households."
- "Families and individuals with socioeconomic struggles."

When asked to identify and rank the greatest health problems in the community, ***Mental Health Conditions*** and rising ***Health Care Costs*** were the top identified health problems in the Service Area communities.

Perceptions of the Greatest Community Health Problems. (n=20)

Health Problem	Ranking
Mental health conditions (e.g., anxiety, depression, and suicide)	**#1**
Health care costs	**#2**
Behavioral health conditions (alcohol, opioids and drugs, substance use, etc.)	**#3 (tied)**
Chronic health conditions	**#3 (tied)**
Health inequalities (systematic differences in health and access between different groups of people).	**#3 (tied)**
Unhealthy behaviors in youth and adolescents (e.g., bullying, vaping, smoking, alcohol, and drug use)	**#3 (tied)**
Unhealthy behaviors in adults (e.g., lack of exercise, poor nutrition, smoking, alcohol, and drug use)	**#3 (tied)**
Lack of local access to hospital and specialty care services	**#3 (tied)**
Lack of services to support aging in place	**#3 (tied)**
Unintentional injuries (e.g., motor vehicle crash injuries, falls, burns)	**#4**

When asked to identify the three most important factors that will improve the health and quality of life in the community, respondents overwhelmingly selected Improved ***Access to Behavioral Health*** and the ***Ability to Recruit and Retain a Quality Healthcare Workforce*** as the most important.

Perceptions of the Most Important Health Factor for Improvement. (n=20)

Health Factor	Ranking
Improved access to behavioral and mental health professionals (including substance abuse)	**#1**
Ability to recruit and retain a quality healthcare workforce	**#2**
Improved access to primary care	**#3 (tie)**
Improved local access to specialty care and hospital services	**#3 (tie)**
Opportunities for youth/adult connection (addressing loneliness, lack of community/school connection)	**#3 (tie)**
Annual provider visit to screen for and discuss risk factors and to develop a prevention plan	**#4 (tied)**
Affordable housing	**#4 (tied)**

As noted in the Youth in the Valley section (p. 17), Clarkston School District conducted a June 2025 **Guiding Voices Survey** of students (n=26), families/guardians (n=156), and educators (n=68) to assess health and wellness needs and inform the development of a proposed school-based health center (SBHC) in partnership with TSH. Percentages reflect the share of respondents selecting each option (multiple responses were allowed).

Access and Utilization Drivers

- Convenience is a key factor: 65% of students and 75% of families reported they would be more likely to use services if those services were available at school.
- Transportation remains a barrier, with ~30% of students and 25% of families indicating that reduced transportation needs would improve access.

Demand for Physical and Preventive Services

- Students showed highest interest in sports physicals (68%), annual check-ups (56%), and nutrition services (44%).
- Families similarly prioritized sports physicals (55%), nutrition (45%), and acute care (35%).

Mental and Behavioral Health Needs

- Families ranked mental health services as a top priority, with 61% selecting support for depression/anxiety.
- Educators reported high student need related to anxiety (77.6%), social-emotional challenges (65.7%), and environmental stressors (59.7%).

Impact on Academic Outcomes

- Educators identified significant effects on learning and engagement, including missed school (91%), low classroom engagement (79%), behavioral issues (70%), and emotional dysregulation (67%).

These findings underscore the connection between student health and academic success, supporting integrating health services within the school setting to expand timely access to medical and mental health care; reduce barriers such as transportation, insurance, and provider shortages; and provide a safe, confidential, on-campus setting for whole-child care.

2026-2028 Community Priorities

TSH's 2023-2025 CHNA priorities (see **Appendix 2**) were :

- Recruit and develop services and supports to retain primary care providers.
- Optimize workflows, processes, people, and technology to support efficient and effective delivery of primary care and to support retention of providers.
- Continue growth of behavioral health services, with a special focus on youth in the community and integrating behavioral health services with primary care.
- Continue to grow telemedicine and tele-behavioral health services.
- Partner with community organizations to educate, inform, and support youth and adults around healthy living.
- Support healthy aging and mitigate impacts of chronic and behavioral health concerns in the Valley's elderly.

TSH's recent 2025 strategic plan also included the expansion of primary and specialty care and reduction of outmigration as priority initiatives.

The data presented in this report, including the identified community priorities, suggest a continued focus on these previously identified priorities, which are restated below with current supporting data from this report.

1. Continue Efforts to Expand Access to Behavioral and Mental Health Services

- Community leaders ranked Mental Health as the #1 health problem and improving access to behavioral health as the top solution.
- Youth data shows elevated need: 34% of 10th graders report depression, and 10% report suicide attempts (higher than state averages).
- Educators report high prevalence of anxiety (77.6%) and social-emotional challenges (65.7%).

2. Increase Access to Primary and Specialty Care and Reduce Unnecessary Outmigration for Services

- All Service Area counties are designated Health Professional Shortage Areas for primary care.
- In support of local access*, Strengthen Provider and Workforce Recruitment and Retention* was identified as the #2 most important factor for improving community health by stakeholders.
- Community leaders identified *Recruit and Retain a Quality Healthcare Workforce* and *Improved Access to Behavioral and Mental Health Professionals* as key priorities for improving overall community health.

3. Improve Youth Health and Access to Care

- Educators report major academic impacts related to youth health: 91% report increased absences, 79% report high levels of disengagement.
- Youth data shows gaps in annual physical exams (as low as 55% in some areas).

- Youth mental health indicators exceed state averages (depression, suicide attempts).
- Approximately 30% of students and 25% of families surveyed identified transportation barriers as a key factor limiting access to care.
- Sixty-five percent (65%) of students and 75% of families reported they would be more likely to access care if it was available at school and more convenient.
- Strong support for school-based health center: 65% of students and 75% of families reported they would be more likely to access care if it was available at school and more convenient.
- There is strong demand for core primary care services among students, including:
    - Sports physicals (68%)
    - Annual check-ups (56%)
- Families also identified need for acute care visits (35%) and preventive services such as nutrition support (45%).

4. Engage to Support Chronic Disease and Prevention

- The Service Area has higher rates of obesity (35%), hypertension (36%), and diabetes (12%) than Washington State and Idaho.
- Mortality from heart disease in the Service Area is ~25% higher than Washington State, and chronic respiratory disease is significantly elevated.
- All Service Area counties have lower life expectancy than state averages.
- Premature mortality is 29–35% higher than state benchmarks in some counties.
- Screening rates (e.g., colorectal, mammography) show variation and gaps, especially in certain counties.

Implementation Plan

Consistent with 26 CFR § 1.501(r)-3, TriState Health will adopt an Implementation Plan on or before the 15th day of the fifth month after the end of the taxable year in which the CHNA is adopted, or, by May 15, 2027. Prior to this date, the Implementation Plan will be presented to the Board of Directors of TriState Health for review and consideration. Once approved, the Implementation Plan will be appended to this CHNA and widely disseminated. It will serve as guidance for the next three years in prioritization and decision-making regarding resources and will guide the development of a plan that operationalizes the adopted priorities adopted.

APPENDIX 1 – Data Collection Methodology, Primary Service Area Population Table, and Source Data Tables

Methodology

TSH engaged Health Facilities Planning & Development, Seattle, to conduct its 2026-2028 CHNA using the following framework:

Data Collection

Primary and secondary data were collected to assess the overall health status of the counties and the Service Area. This data informed the identification and analysis of unmet health needs, as well as the development of key themes and priorities related to community well-being.

Because each hospital serves a distinct geographic region, data was analyzed at the Service Area level when available. Where sub-county data was not available, county-level data was used, and key findings are presented throughout the report.

Primary Data

TSH conducted a service area-wide survey of key cross-sector community leaders to gain insight and perspective on progress made and gaps remaining related to the prior 2023-2025 CHNA priorities.

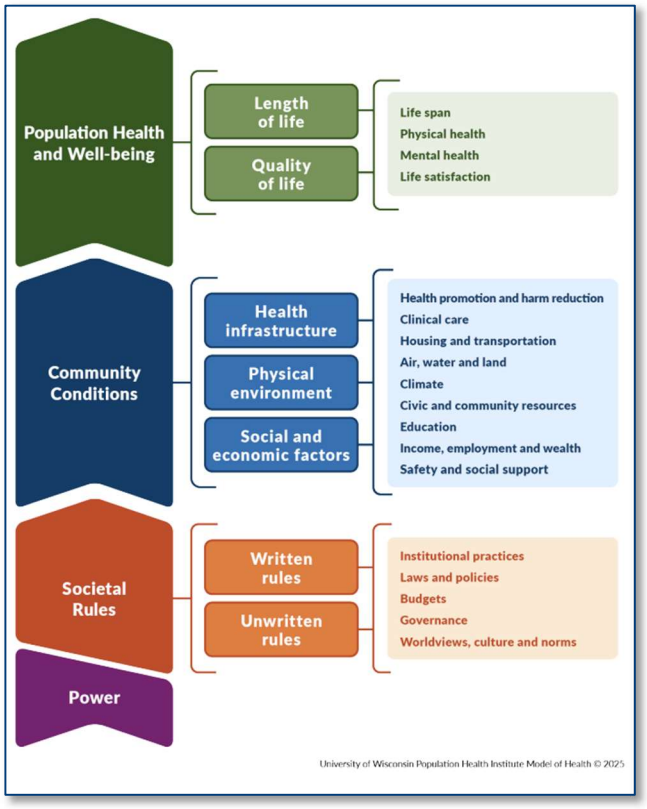
Additionally, TSH and the Clarkston School District conducted a Guiding Voices Survey of students (n=26), families/guardians (n=156), and educators (n=68) to assess student health and wellness needs and inform the design of a proposed school-based health center (SBHC) in collaboration with TSH.

Secondary Data

Secondary data was sourced from national, state, and regional/local databases to provide insight into demographics, health behaviors, socioeconomic factors, environmental conditions, and clinical care across the Service Area. Specific data sources include, but were not limited to:

- Claritas Population Data
- Community Health Assessment Tool (CHAT), Washington State Department of Health
- Washington Tracking Network (WTN), Washington State Department of Health
- Idaho Department of Public Health, Vital Statistics
- National Institute of Health, National Vital Statistics System
- Health Resources & Services Administration (GeoCare Navigator)
- American Community Survey (ACS)
- Robert Wood Johnson (RWJ) County Health Rankings
- Centers for Disease Control (Places)
- Washington State Healthy Youth Survey
- Rural Health Information Hub
- Washington State Office of Financial Management, Small Area Estimates
- Behavioral Risk Factor Surveillance System
- U.S. Census Bureau

After gathering and analyzing primary and secondary source data and information, several frameworks were applied to identify themes and determine priorities from the data—foremost, the Robert Wood Johnson Foundation's (RWJ) County Health Rankings Model.



In the County Health Rankings Model, **Population Health and Well-being** represents how well and how long we live, including our physical, mental, and social well-being. **Community Conditions** encompass where we live, learn, work, and play, including affordable housing, clean water, and socioeconomic factors. **Societal rules** are set and held by people who wield power, shape the conditions that affect our health, and are formalized in policies and laws. **Power** is the ability to create change. People and groups who hold power influence societal rules and determine how they are applied.[1]

[1] 2025 County Health Rankings & Roadmaps Report

Service Area Population									
	2020	Pct. of Tot. Pop.	Pct. Chg. 2010-2020	2026 Est.	Pct. of Tot. Pop.	Pct. Chg. 2020-2026	2031 Proj.	Pct. of Tot. Pop.	Pct. Chg. 2026-2031
Tot. Pop.	**63,646**	**100.0%**	**5.7%**	**64,615**	**100.0%**	**1.5%**	**65,149**	**100.0%**	**0.8%**
Pop. by Age									
0-17	13,522	21.2%	3.0%	12,843	19.9%	-5.0%	12,413	19.1%	-3.3%
18-44	20,094	31.6%	3.9%	20,604	31.9%	2.5%	20,592	31.6%	-0.1%
45-64	15,942	25.0%	-3.8%	15,312	23.7%	-4.0%	14,707	22.6%	-4.0%
65-74	7,718	12.1%	36.6%	8,671	13.4%	12.3%	8,982	13.8%	3.6%
75-84	4,496	7.1%	20.1%	5,299	8.2%	17.9%	6,404	9.8%	20.9%
85+	1,874	2.9%	6.0%	1,886	2.9%	0.6%	2,051	3.1%	8.7%
Tot. 0-64	49,558	77.9%	1.0%	48,759	75.5%	-1.6%	47,712	73.2%	-2.1%
Tot. 65 +	14,088	22.1%	26.2%	15,856	24.5%	12.5%	17,437	26.8%	10.0%
Fem. 15-44	11,244	17.7%	3.7%	11,365	17.6%	1.1%	11,357	17.4%	-0.1%
Hispanic	2,584	4.1%	45.5%	3,435	5.3%	32.9%	4,170	6.4%	21.4%
African American	310	0.5%	49.8%	471	0.7%	51.9%	608	0.9%	29.1%
Asian	536	0.8%	25.5%	592	0.9%	10.4%	643	1.0%	8.6%
Native American	2,196	3.5%	9.9%	2,191	3.4%	-0.2%	2,166	3.3%	-1.1%
Other - Non-White	4,803	7.5%	139.6%	5,814	9.0%	21.0%	6,685	10.3%	15.0%

Health & Wellbeing (Health Outcomes)

Indicator	Definition / Source	TriState Health ("The Valley")	Asotin County	Garfield County	Washington State	Nez Perce County	Idaho
Health Conditions							
Obesity	Percentage of adults (18+) with a BMI of 30 kg/m2 or greater, 2022; HRSA GeoCare Navigator	35.3	34.8	35.0	31.4	35.5	33.2
High Blood Pressure	Percentage of adults (18+) with high blood pressure, 2021; HRSA GeoCare Navigator	36.3	37.1	37.4	29.2	35.6	31.5
Diabetes	Percentage of adults (18+) with Diabetes, 2022; HRSA GeoCare Navigator	12.0	12.4	12.5	9.6	11.7	10.2
Premature Mortality	Number of deaths among residents under age 75 (age-adjusted), 2021-2023; RWJ County Health Ranking		440	360	340	460	340
Cancer	Rate of deaths due to malignant neoplasms per 100,000, age-adjusted; 2024, DOH CHAT (WA); 2019-2023, National Vital Statistics System (ID)	129.1	128.4	121.0	134.4	126.4	138.6
Heart Disease	Rate of deaths due to diseases of the heart per 100,000, age-adjusted; 2024, DOH CHAT (WA); 2019-2023, National Vital Statistics System (ID)	160.3	159.7	170.2	127.7	148.8	156.8
Stroke	Rate of deaths due to cerebrovascular disease per 100,000, age-adjusted; 2024, DOH CHAT (WA); 2019-2023, National Vital Statistics System (ID)	33.9	33.4	42.4	33.8	42.0	36.5
Chronic Respiratory Disease	Rate of deaths due to cerebrovasculare disease per 100,000, age-adjuste; 2024, DOH CHAT (WA); 2019-2023, National Vital Statistics System (ID)	71.8	67.7	117.0	27.0	55.2	42.0
Accident Deaths	Rate of deaths due to accident per 100,000, age-adjusted; 2024, DOH CHAT (WA); 2019-2023, National Vital Statistics System (ID)	79.5	87.1	data suppressed	66.9	75	56.6
Life Expectancy	Average number of years people are expected to live, 2021-2023; RWJ County Health Ranking (National average = 77.6)		76.9	77.6	78.7	75.3	78.3
Pregnancy & Childbirth							
Prenatal Care	Percentage of women who received pre-natal care in the first trimester, 2024; DOH CHAT (WA) and Department of Health & Welfare (ID)	85.3	83.9	97.7	79.3	80.0	79.4
School-requried Immunizations	Percentage of Kindergarteners out of compliance with required immunizations (excludes exemptions), 2024-2025; DOH Washington Tracking Network		85.0	100	87.2	unavailable	74.8
Mental Health							
Suicide	Age-adjusted rate of deaths by suicide (self-injury) per 100,000; 2024, DOH CHAT; 2019-2023, National Vital Statistics System (ID)	39.7	43.5	data suppressed	14.4	21.1	21.9
Suicide (Youth)	Percentage of 10th grade youth who report attempting suicide in the past year; 2023 Heathy Youth Survey		10.0	9.1	7.1	unavailable	unavailable
Depression (Youth)	Percentage of 10th grade youth who report feeling sad or hopeless almost every day for 2 weeks or more in the last year; 2023 Heathy Youth Survey		33.8	31.8	29.9	unavailable	unavailable
Hope Scale (Youth)	Percentage of 10th grade youth who report no or very low hope on the Children's Hope Scale; 2023 Heathy Youth Survey		8.4	14.3	7.8	unavailable	unavailable
Physical Environment							
Regular Source of Primary Care	Percentage of adults (18+) with a healthcare provider, 2022; BRFSS via Washington DOH CHAT and Idaho DPH		80.0	72.0	83.0	83*	84.0
Physical Exam (Adult)	Percentage of adults (18+) reporting a routine check-up within the past year, 2022; BRFSS via Washington DOH CHAT and Idaho DPH		69.0	68.0	69.0	76*	75.0
Delayed Care	Percentage of Adults Who Delayed/ Not Sought Care Due to High Cost; 2022; BRFSS via Washington DOH CHAT and Idaho DPH		14.0	19.0	10.0	13*	11.0
Physical Exam (Youth)	Percentage of 10th grade youth reporting an annual check-up or physical exam in the past 24 months; 2023 Heathy Youth Survey		71.3	54.5	66.7	unavailable	unavailable
Flu Vaccine	Percentage of adults (18+) reporting receing a flu shot or vaccine, 2022; BRFSS via Washington DOH CHAT and Idaho DPH		33.0	36.0	47.0	39*	39.0
Pneumonia Vaccine	Percentage of adults (18+) reporting receiving a pneumonia short or vaccine, 2022; BRFSS via Washington DOH CHAT and Idaho DPH		63.0	84.0	75.0	64*	69.0
Breast Cancer Screening	Percentage of female residents, ages 50-74, who report receiving a mammogram in the past two years, 2022; BRFSS via Washington DOH CHAT and Idaho DPH		72.0	77.0	75.0	data suppressed	data suppressed
Colorectal Screening	Percentage of adult residents, ages 50-75, who had appropriate screening for colorectal cancer in the past year, 22022; BRFSS via Washington DOH CHAT and Idaho DPH		52.0	68.0	58.0	data suppressed	data suppressed

** Idaho Public Health District 2 (Nez Perce County is approximately 60% of PDH 2 population*

Health Factors (Community Conditions)

Indicator	Definition / Source	TriState Health ("The Valley")	Asotin County	Garfield County	Washington State	Nez Perce County	Idaho
Health Behaviors							
Tobacco Use	Percentage of adults who are current smokers lage-adjusted) 2022; HRSA GeoCare Navigator	14.0	15.0	15.0	11.0	14.0	13.0
Tobacco Use (Youth)	Percentage of youth (10th grade) who report using smoking in the last 30 days; 2023 Heathy Youth Survey		2.9	5.0	2.2	unavailable	unavailable
Binge Drinking	Percentage of adults (18+) who report binge drinking (5 drinks for men, 4 drinks for women) in the past 30 days, 2022; HRSA GeoCare Navigator	17.0	17.0	17.0	17.0	14.0	16.0
Binge Drinking (Youth)	Percentage of 10th grade youth who report drinking 5 or more drinks in a row in the past 2 weeks; 2023 Heathy Youth Survey		3.4	9.5	4.2	unavailable	unavailable
Drug Overdose Deaths	Number of drug poisoning deaths per 100,000 population, 2021-2023; RWJ County Health Rankings		37.0	data suppressed	36.0	35.0	19.0
Health Infrastructure and Access							
Health Insurance	Uninsured rate, 2020-2024 5-Year Estimate; ACS	7.0	6	4.3	6.3	7.7	9.1
Primary Care Physician	Ratio of one primary care physician per people, 2021; RWJ County Health Rankings		1,610:1	2,360:1	1.170:1	1,480:1	1,610:1
Other Primary Care Providers	Ratio of one primary care provider (NP, PA, etc.) per people, 2021; RWJ County Health Rankings		1,320:1	480:1	800:1	450:1	650:1
Mental Health Provider	Ratio of one mental health provider per people, 2024; RWJ County Health Rankings		170:1	2,400:1	180:1	300:1	350:1
Dentists	Ratio of one dentist per people, 2022; RWJ County Health Rankings		1,250:1	1,180:1	1,130:1	1,190:1	1,510:1
Socioeconomic Factors							
High School Graduation	Percentage of adults (25+) with a high school degree or equivalent, 2020-2024 5-Year Estimate; ACS	93.2	92.1	94.4	92.3	93.8	91.9
Income	Median household income (2023 inflation adudsted dollars), 2020-2024 5-Year Estimate; ACS	$71,935	$72,283	$64,844	$98,141	$72,599	$77,800
Unemployment	Unemployment rate for civilian workforce 16 years and over, 2020-2024 5-Year Estimate; ACS	3.5	5.0	6.3	5.1	2.6	3.7
Poverty	Children in poverty (<18) , 2020-2024 5-Year Estimate; ACS	16.8	19.1	15.9	11.6	15.5	12.4
Poverty	Adults in poverty (18-64) , 2020-2024 5-Year Estimate; ACS	13.0	14.6	11.3	9.6	12.4	10.3
Poverty	Senior in poverty (65+), 2020-2024 5-Year Estimate; ACS	8.8	9.2	10.7	8.9	8.4	8.9
Poverty	Population earning less than 200% of FPL, 2020-2024 5-Year Estimate; ACS	30.8	31.9	25.6	22.4	30.7	28.9
Poverty	Families earning less than 200% of FPL, 2020-2024 5-Year Estimate; ACS	23.9	23.0	18.1	16.3	24.9	22.2
Physical Environment							
Childcare Cost Burden	Childcare costs for a 2-child household as a percent of median income, 2023-2024; RWF County Health Rankings (National average = 28%)		38.0	39.0	37.0	24.0	21.0
Food Insecurity	Percentage of people who did not have a reliable source of good, nutritous good / Average meal cost, 2023; Map the Meal Gap, feedingamerica.org		15.0	16.0	13.0	14.0	13.0
Severe Housing Problems	Percentage of households with at least 1 of 4 issues: overcrowding, high costs, lack of kitchen facilities, lack of plumbing facilities), 2017-2021, RWJ County Health Rankings		11.0	9.0	17.0	18.0	13.0
Acess to Parks	Percentage of population living within a half mile of apark, 2020 & 2024, RWJ County Health Rankings (National average = 51%)		35.0	43.0	57.0	12.0	30.0
Air Pollution	Particulate matter (micrograms/cubic meter) relative to EPA 12mg standard, 2020; RWJ County Health Rankings (National average = 7.3)		10.7	9.8	10.3	10.8	7.2
Broadband Access	Percentage of households with broadband internet connection, 2019- 2023; RWJ County Health Rankings; DOH CHAT (National average = 90%)		87.0	84.0	94.0	89.0	92.0

Health Centers & Shortage Areas

Indicator	Definition / Source	TriState Health ("The Valley")	Asotin County, WA	Garfield County, WA	Nez Perce County, ID
Federally Qualified Health Centers					
Dominant FQHCs	2023; HRSA GeoCare Navigator	**Community Health of Spokane, Yakima Valley Farm Workers Clinic**			**Community Health of Spokane; Indian Health Services**
Utilization (all)	FQHC Percentage Penetration of Total Population, 2023; HRSA GeoCare Navigator	**11.8**			
Utilization (low-income)	FQHC Percentage Penetration of Low-Income, 2023; HRSA GeoCare Navigator	**36.7**			
Health Professional Shortage Areas					
Primary Care	Designation: Low Income or Geographic; Rural Health Information Hub, 2026	**Yes**	**Yes**	**Yes**	**Yes**
Dental Health	Designation: Low Income; Rural Health Information Hub, 2026	**Yes**	**Yes**	**Yes**	**Yes**
Mental Health	Designation: Geographic; Rural Health Information Hub, 2026	**Yes**	**Yes**	**Yes**	**Yes**
Medically Underserved	Medically underserved area for primary care; Rural Health Information Hub, 2026	**Yes**	**Yes**	**Yes**	**Yes**

APPENDIX 2 – TSH 2023-2025 CHNA Implementation Plan and Prior Accomplishments

2023-2025 Implementation Plan & Prior Accomplishments

After measurable progress was made in several 2020-2022 Implementation Plan focus areas, Tri-State Health's (TSH) 2023-2025 Community Health Needs Assessment (CHNA) acknowledged that continued unmet health needs and gaps in the community remained. Of particular concern were gaps related to community mental health and substance use (including opioids). The 2023-2025 CHNA also identified the need to continue focusing on access to primary care and screenings, as well as education regarding preventable diseases and increasing services and support of at-risk youth.

Based on the data, key informant surveys, and the Board's consideration of TSH's resources and expertise, TSH elected to carry forward the 2020-2022 priorities as continued areas of focus, while revising the adopted priority list to include behavioral health:

Support individuals and families through comprehensive and patient-centered primary care, behavioral health, and wellness programming.

The specific strategies selected in the 2023-2025 CHNA and Implementation Plan were:

1. Recruit and develop services and support to improve retention of primary care providers.
2. Optimization of workflows, processes, people, and technology to support efficient and effective care delivery.
3. Continue to grow behavioral health services, with a special focus on youth in the community and integrating behavioral health services within primary care.
4. Continue to grow telemedicine and tele-behavioral health services.
5. Partner with community organizations to educate, inform, and support youth and adults in healthy living.
6. Support healthy aging and mitigate impacts of chronic health and behavioral health concerns in the Valley's elderly population.

During the development of the 2023-2025 Implementation Plan, some of the above strategies were expanded, combined, or aligned to reflect common goals and action items. The following tables outline the 2023-3025 priority strategies, resources required, identified collaborators, anticipated outcomes, and accomplishments made to date.

CHNA Board Adopted Priority: *Support individuals and families through comprehensive and patient-centered primary care, behavioral health, and wellness programming.*

Strategy #1: Recruit and develop services and support to improve retention of primary care providers.

Resource Plan *Resources committed to the success of the health improvement strategy*	Anticipated Impact *How the success of the strategy will improve the health of the community*	Evaluation *What will be measured to determine level of success.*	Planned Collaboration *Community or internal partners*
▪ Recruit high priority primary care providers including Internal Medicine, Family Practice, and Advanced Nurse Practitioners (ARNP). ▪ Create a Provider Engagement Team to provide orientation, education, and support to new providers. ▪ Create a formal onboarding process for new providers (IT, Quality, ACO, Referrals, Resources, etc.) ▪ Establish a "mentor" provider process to ensure new providers (and families) are "wrapped" with support both professionally and personally. ▪ Optimize workflows, processes, people, and technology to support efficient and effective care delivery, including optimizing current EMR and evaluating the feasibility of EMR transition.	▪ ARNP and IM providers recruited and hired in 2023. ▪ Additional high priority primary care providers recruited based on market assessment. ▪ Reduce wait times for new patients. ▪ Providers employed by TSMH are engaged and supported. ▪ Long-term provider/patient relationships are maintained, resulting in increased trust and patient satisfaction. ▪ Barriers to physician productivity and patient access are minimized. ▪ Decreased turnover leading to increased patient satisfaction and reduced recruitment and onboarding costs.	▪ Number of net additional providers ▪ Rate of provider turnover ▪ Percentage of patients "lost to follow up." ▪ Wait times for new patient appointments. ▪ Patient satisfaction ▪ Provider satisfaction ▪ Provider productivity	***Internal:*** Primary Care Providers; Provider Engagement Team; Provider Mentors; TSMH Administration TSMH IT

Accomplishments:

Primary Care at TriState: Number of primary care providers has been stable at 19. Demand for primary care continues to be remarkably high – in 2025 – 4088 patients requested TriState PCPs, 2024 - 7037, and 2023 – 4270. 90% of the 19 PCPs exceed their production expectations. Turnover is exceptionally low. Wait times for new patient appointments is variable by provider – ranging from same day to several weeks. Patient satisfaction tracking is ongoing and is remarkably high (4.93 on average out of a possible 5). No-show rates in the primary care clinics have improved. In 2022 no show rates were as high as 6% and in 2025 we saw a decrease to less than 4%.

Strategy # 2: Continue to grow behavioral health services, with a special focus on youth in the community and integrating behavioral health services within primary care.			
Resource Plan *Resources committed to the success of the health improvement strategy*	Anticipated Impact *How the success of the strategy will improve the health of the community*	Evaluation *What will be measured to determine level of success.*	Planned Collaboration *Community or internal partners*
▪ Continue integration and support related to BH providers integration into primary care, including recruiting additional psychiatric mental health nurse practitioners (PMHNP). ▪ Standardized processes and evidence-based tools in primary care and ED for screening for and treating depression, anxiety, and other conditions that can be effectively managed in the primary care settings. ▪ Consider state and federal grants that support development of prevention, treatment, and recovery programs for BH conditions, SUD, and OUD. ▪ Provide naloxone kits to community agencies that serve people who are using opioids or people who **are likely to** witness an opioid overdose**.** ▪ Engage/survey current TSMH BH and PC providers and community partners to determine behavioral health provider/resource needs. ▪ Expand access to tele-behavioral health services, with a particular focus on adolescent mental health.	▪ Reduced readmission rates and ED use for those with underlying behavioral health conditions ▪ Improvement in behavioral health outcomes ▪ Increase in number of patients being identified with and treated for depression, anxiety, suicidal ideation, and other mental health conditions. ▪ Identification, reduction and prevention of SUD and OUD. ▪ Reduction in opioid deaths and overdoses. ▪ Additional behavioral health providers are integrated into primary care clinics.	▪ Patients receiving BH screening, including SUD and OUD ▪ Patients discharged with a BH referral. ▪ Admission rates, ED use ▪ Naloxone administration ▪ Rates of overdose resulting in hospitalization and overdose death rates. ▪ Depression, anxiety, and suicide rates ▪ Provider and community survey results. ▪ Percentage of residents reporting poor mental health ▪ Number of PMHNP's in primary care clinics.	***Internal:*** Primary Care and Behavioral Health Providers; Clinic and ED Providers, Care Coordinators, and Staff. ***Community Partners:*** Greater Columbia Behavioral Health Organization; Quality Behavioral Health – Clarkston; Greater Columbia Accountable Community of Health; Federal granting agencies (HRSA); Boys and Girls Club; Asotin/Anatone, Lewiston and Clarkston School Districts; NW Children's Home

Accomplishments:

Behavioral Health: Behavioral health added Spravato as a treatment option in 2025. We continue Suboxone/MAT therapy options in several clinics. Received some grant funding which has allowed funding for a pilot for IM behavioral health medications – this use has proven to reduce improve medication compliance – which has reduced ED admissions and resulted in improved patient success (employment, etc.). Telemedicine is offered by our BH clinic – over 5500 visits per year are virtual.

BH Expansion: Added two additional BH providers in 2024-2025 – each integrated into a primary care practice setting.

Strategy #3: Continue to grow telemedicine services to offer lower cost and high ease of access means for accessing care.			
Resource Plan *Resources committed to the success of the health improvement strategy*	Anticipated Impact *How the success of the strategy will improve the health of the community*	Evaluation *What will be measured to determine level of success.*	Planned Collaboration *Community or internal partners*
▪ Expand existing telemedicine opportunities for outpatient, primary care, and behavioral health services. ▪ Expand specialty telemedicine opportunities for infectious disease, and cardiology services. ▪ Evaluate need for additional telemedicine specialty services to reduce barriers, enhance access, and increase coordination with primary care, ED, and inpatient services. ▪ Identify and implement best practices for engaging the community in telehealth, including accessible sites of care.	▪ Overcome barriers to health services caused by distance between patient and providers, access to reliable transportation, fragmentation of care due to gaps in time between appointments, and lack of available providers. ▪ Increase access to primary/urgent/behavioral health services. ▪ Enhance access to specialty consultation and services.	▪ Wait times for urgent and new patient appointments and specialty referrals. ▪ Provider satisfaction and provider productivity ▪ Increase show rate for specialty care appointments. ▪ Number of virtual consultations and visits	***Internal:*** Primary, Specialty, ED and inpatient Providers and Staff. ***Community Partners:*** Greater Health Now; Quality Behavioral Health – Clarkston; Boys and Girls Club; Asotin/Anatone, Lewiston and Clarkston School Districts; NW Children's Home

Accomplishments:

Virtual Care / Telemedicine: Telemedicine is an option in many of our clinics. Adding this service has secured access to specialists such as rheumatology, pulmonology, infectious disease, behavioral health, etc. that otherwise patients would have to leave the community to access. Volume of tele visits in 2025 included over 2250 Pulmonology visits, 1800 visits in rheumatology, over 400 visits for infectious disease, and over 5500 behavioral health visits. In behavioral health – no show rates have decreased to 4.4% or lower in 2025. This compares to no show rates as high as 9.5% in 2022. In 2022 – it often took more than 30 days to receive a new patient appointment in behavioral health – in 2025 that had decreased to 14-15 days. Acute care (inpatient and ED) also has virtual access to needed specialty consults such as cardiology, neurology, pulmonology, infectious disease, and behavioral health. Utilizing these specialty consults allows for admission (rather than transfer) of more inpatients with the added availability of specialty consult and follow up.

Urgent Care: TriState continues to offer a walk in urgent care clinic and expanded availability in 2025 to 7 days a week. This is an attempt to improve access to care and ensure availability of at the appropriate level of service (Urgent Care vs. ED) for patients in need. TriState's walk-in urgent care volume has increased significantly over the years from 15,581 in 2022 to 17,724 in 2025. Emergency department volume has remained stable, but acuity of presenting patients has increased. Since the addition of Sunday Urgent Care hours – TriState ED has reported a decrease in volume on Sundays specifically related to non-emergent conditions. Walk in Urgent Care is seeing an average of 33 patients each Sunday.

Strategy #4: Partner with community providers that provide primary and preventative care in the community to high priority populations.			
Resource Plan *Resources committed to the success of the health improvement strategy*	Anticipated Impact *How the success of the strategy will improve the health of the community*	Evaluation *What will be measured to determine level of success.*	Planned Collaboration *Community or internal partners*
▪ Provide staffing to support the school nurse program in the schools. ▪ Provide support to the Snake River Community Free Clinic	▪ School age students receive urgent and preventative care services in the schools. ▪ Underserved and underinsured/non-insured populations receive needed primary and preventative services.	▪ Number of student encounters ▪ Number of primary care and preventative visits provided without cost. ▪ Cost of medication support to Snake River Community Clinic	***Internal:*** Primary Care, Human Resources, Patient Financial Counselors ***Community Partners:*** Asotin/Anatone School District; Lewiston School District; Clarkston School District; Snake River Community Free Clinic

Accomplishments:

TriState continues to support the Snake River Community Clinic (SRCC). TriState has supported their medication budget annually up to $50,000. They also benefit from access to our preferred pricing for medication and supplies as an affiliate of the hospital. We also have a hospital leader who serves as a Board Member for this free clinic. 2025 medication support for SRCC - $54,342.83 and 2024 - $42,818.23.

TriState continues to fund a part-time school nurse for Asotin School District. TriState funds approximately 20 hrs. each week for the school nurse in the Asotin School District. TriState offers onsite health services (such as immunization clinic / flu shots to staff annually).

TriState continues to offer a walk in urgent care clinic and expanded availability in 2025 to 7 days a week. This is an attempt to improve access to care and ensure availability of an appropriate level of service (Urgent Care vs. ED) for patients in need. Since opening on Sundays, the walk in urgent care setting is seeing an average of 33 patients each Sunday.

Athletic Trainer Partnership with Clarkston School District. TriState has partnered with Clarkston School District to share the salary and benefit costs for their Athletic Trainer. This partnership started in August of 2024 and continues through the present. This demonstrates our ongoing commitment to the education and wellness of the youth in our community. In the Fall 2024 there were 1,203 student athletes and 1,151 in the Spring of 2025. The athletic trainer interacts with each athlete for a total of 2,354 interactions. 103 injury interventions complete in the Fall of 2024 and 130 in the Spring of 2025. There were 163 concussion baseline tests completed in 2024-2025. In 2025-2026 school year, Fall had 1,570 student athletes receiving 1,650 treatment interventions and 232 injury evaluations and 134 baseline concussion baseline tests and 66 WIAA wrestling weight certifications for both the Clarkston and Asotin wrestling teams. The athletic trainer became a certified CPR instructor in 2025 and has completed training of more than 70 individuals (students/staff).

Strategy #5: Partner with community organizations to educate, inform, and support youth and adults in healthy living.			
Resource Plan *Resources committed to the success of the health improvement strategy*	Anticipated Impact *How the success of the strategy will improve the health of the community*	Evaluation *What will be measured to determine level of success.*	Planned Collaboration *Community or internal partners*
Utilize TSMH Community Wellness Team in collaboration with community partners to offer healthy living programming including: ▪ Kids' nutrition and cooking program ▪ Prediabetes classes ▪ Eat Healthy, Be Active Community Workshop ▪ Gestational Diabetes (informative video) ▪ "Where to go for Care?" community education program on use of ED vs. primary care and urgent care. Increase knowledge of where healthy foods can be purchased or picked-up at low to no cost.	▪ Community educated and empowered to manage health and wellness. ▪ Learned behaviors incorporated into day-to-day activities, ▪ Care is received in the most appropriate setting.	▪ Rates of ED visits that could have been managed in a different setting or avoided through more appropriate preventive care. ▪ Pre-and-post programming surveys. ▪ Percentage of residents reporting regular exercise. ▪ Percentage of residents reporting access to healthy foods.	***Internal:*** TSMH Community Wellness Team, Primary Care, Emergency Department, Urgent Care ***Community Partners:*** WSU Extension- Master Gardener; TSMH Foundation; Boys and Girls Club; SE WA Health Alliance; Lewiston Library; Asotin/Anatone, Lewiston, and Clarkston School Districts; Greater Health Now; Twin County United Way

Accomplishments:

TriState periodically provides community education on "where to go for care" that focuses on the most appropriate place to seek care depending on the signs, symptoms a patient has.

The "Where to go for care?" Public Service Announcement is an ongoing campaign that launched 2023. The campaign encompasses streaming and local TV commercials, digital display advertisements, print advertisements, and radio advertisements. The campaign reach is 100 miles of Clarkston, WA on digital and radio, but heavily targeted local families in the Clarkston, WA, Lewiston, ID, and Asotin, WA area through local TV, print advertisements, and digital billboards.

In the fall of 2025, the decision was made to expand the TriState Urgent Care hours of operation to include Sundays. We have seen this location being utilized consistently on Sundays and the Emergency Department has reported a decrease in "non-emergent" care being provided on Sundays.

TriState Health participates with community education and wellness in a variety of ways. Below is a snapshot of some of the programs offered.

Kids Nutrition Program. During the 2022-2023 academic year, 308 students, grades K-5, participated in the program from Asotin-Anatone School District. In the 2023-2024 academic year, we introduced food and nutrition education for students in Kindergarten and first grade at local WA public schools. Activities were conducted with four elementary schools in the Clarkston School District serving a total of 306 Kindergarten and first grade students. 44 Asotin-Anatone District Kindergarten students also received supplies, totaling 350 students served altogether. Students received aprons and cookbooks in May 2024. Teachers were provided with a voluntary survey code, intended to measure success. An additional 120 cookbooks were purchased to be distributed in the fall of 2024 to sustain the program amongst these schools.

Asotin-Anatone Jr. High Nutrition Workshop

The PE/Health teacher in Asotin asked us to supplement her health and nutrition education class. We developed a course to review general healthful nutrition, identifying added sugars, mindful eating, meal planning, sports nutrition and preparing healthy snacks. We performed a cooking demonstration and allowed the students to taste a healthy snack while going over intuitive eating principles. The workshop was implemented during normal health class hours with the school's 8th graders. In 2023, we taught 48 students, in 2024- 33 students & in 2025- 40 students. We intend on expanding this program to the Clarkston School District.

Prediabetes Class

Prediabetes classes are offered quarterly in the TriState Health Conference Rooms. Registration is free and available online via TSH website or QR-code.

Diabetes Seminars

Monthly free classes resurrected in 2024. No registration required. Monthly topics vary each month. In 2024 we had 110 people participate. In 2025 the participation increased to 114. In 2026, there is an annual Wellness calendar with all community events posted on the website and classes are moved to a quarterly basis to hopefully maximize attendance.

Gestational Diabetes

Though nutrition is the first treatment focus area when someone becomes diagnosed with gestational diabetes, insurance does not often cover Medical Nutrition Therapy visits for this diagnosis. Our Wellness program continued to receive referrals from local providers and patients would often decline services due to lack of insurance coverage. We wanted to provide free education to this population in meaningful, yet fiscally responsible manner. We received a grant from our TSH Foundation to develop a professional video and rack card to distribute to local OB-Gyn clinics. The video is 15-minutes in length, and the rack card gives access to the video via QR-code and doubles as a Carb Food List resource for carbohydrate counting. As of 1/2026 there have been 236 views of the video.

Eat Healthy, Be Active

This course was developed in 2022, using the USDA's curriculum Eat Healthy, Be Active and in collaboration with WSU's Master Gardening Program to provide nutrition and gardening education. The goal of the program is to promote health and sustainability. In early 2023, we partnered with LCSC to provide this class to employees for free with 10 participants. The second cohort had 15 finally the program was offered for the last time in the fall of 2023 on TSH campus with 18 registrants. After that, we moved to offer Healthy Bites in 2025.

Healthy Bites

Healthy Bites was developed in 2025 for the purpose of community nutrition education, in replacement of prior Eat Healthy, Be Active classes. This program has three components- monthly articles, monthly recipes cards and quarterly workshops. Articles and recipe cards were made available online with the option for community members to join our Recipe Card Club where they receive mailers each month. Per the analysis that Marketing conducted, there were 220 responses to our program with 123 signed up for email and 97 signed up for the postcard. The first two workshops were done in collaboration with Idaho Foodbank and presented at their demo kitchen. We chose to simplify upcoming classes by only using our own dietitian and cooks. Attendance was maxed out for each venue and participants received ingredients to replicate class recipes at home.

Annual National Nutrition Month Community Education

Every year the outpatient dietitian provides a community nutrition education seminar in honor of National Nutrition Month (March). 2023 and 2024 were offered virtually and in 2025 a new format of a panel was utilized at the TSH conference room, in addition to a Podcast. 11 people attended the panel. Future seminars will be hosted in-person.

Food Pantry Partnership with Lili GC Foundation. TriState Health supported up to $20,000 in 2025 to build a Food Pantry providing cooking classes to the families and children of women impacted by cancers. Classes focused on fresh products, herbs, healthy oils, and reducing refined sugars and processed foods. In 2025 the classes impacted 278 families and 29 children.

Backpack and School Pantry Partnership with Idaho Foodbank. In 2024 and 2024 TriState Health supported up to $3,500 to promote all-day air talking on local radio station to inform the public on child hunger, nutrition, and the effects on kids' abilities to learn without adequate food to fuel their brains. In 2024, two Registered Dietitian Nutritionists were guest speakers on the talk show.

TriState Health Flu Public Service Announcement. In 2025, TriState Health provided educational flyers, tissues, and hand sanitizers to place in Clarkston, WA, Asotin, WA schools, and throughout local businesses promoting preventative care during the flu season.

TriState Health offered Free Sports Physicals in 2023, 2024, and 2025. 80 Sports physicals were completed in 2023, 72 were completed in 2024, and 90 were completed in 2025.

Twin County United Way Kindergarten Boot Camp Partnership in 2024. In 2024, TSH supported TCUW's Kindergarten Bootcamp by offering classes to kids in Asotin and Clarkston. There were five classes, each up to 10 kids. The class was held for one week during July 2024.

Twin County United Way "For Her" Program Partnership in 2023, 2024, and 2025. TSH, in partnership with TCUW and other surrounding healthcare facilities improved access to essential feminine hygiene products, reducing health-related stigma, and promoting health education in the school setting. Since its launch, 14 elementary schools, 7 middle/junior high schools, and 8 high schools have been impacted. Districts served included: Asotin, Clarkston, Culdesac, Lapwai, and Lewiston, including 438 Custom Kits to Middle & High Schools and 270 "We all Start Somewhere" Elementary Kits.

TriState Health Podcast. In October 2024, TriState Health launched a community podcast covering topics such as urogynecology, nutrition, diabetes care, primary care, mental health, where to go for care, and trauma prevention. Since its launch, the podcast has had 481 plays and downloads.

TriState Health Urology Community Education. In October 2025, TSH hosted a community education seminar with Dr. Julius Szigeti II as the speaker. The topic was solutions for incontinence. 35 in attendance requested follow-up calls from the Urogynecology Clinic.

TriState Health Urogynecology Community Education. In June 2025, TSH hosted a community education seminar with Dr. Kenneth Berger as the speaker. The topic was Interstream. 32 in attendance requested follow-up calls from the Urology Clinic.

Strategy #6: Support healthy aging and mitigate impacts of chronic health and behavioral health concerns in the Valley's elderly.			
Resource Plan *Resources committed to the success of the health improvement strategy*	Anticipated Impact *How the success of the strategy will improve the health of the community*	Evaluation *What will be measured to determine level of success.*	Planned Collaboration *Community or internal partners*
▪ Grow and expand TSMH Community Wellness programming specific to elderly and management of chronic conditions. ▪ Employ Care Coordinators to enroll and engage patients in TSMH's provider-directed and patient-centered chronic care management program and to connect them to behavioral health providers and resources. ▪ Continue to offer the American Lung Association's Better Breathers Club support groups for individuals with chronic lung disease and their caregivers. ▪ Continue to support the Meals on Wheels project and donation of food resources to address food insecurity and isolation among the senior population.	▪ Improved disease management and better engagement of patients in their own care. ▪ Improved integration of primary care and behavioral health services for the Valley's elderly. ▪ Improved outcomes and quality of life for COPD, pulmonary fibrosis, and asthma patients. ▪ Meals and social interactions provided to housebound/low-income seniors	▪ Participants rates in community wellness programs ▪ Number of patients enrolled in chronic care management. ▪ Number of TSMH's elderly patients screened and referred to behavioral health services. ▪ Participation rates in the Better Breather Club participants ▪ Number of meals delivered and/or number of meals donated	***Internal:*** TSMH Community Wellness; TSMH Care Coordinators, Primary Care Providers and Health Educators. ***Community Partners:*** American Lung Association; Meals on Wheels

Accomplishments:

Chronic Care Management: TriState currently employs to outpatient care coordinators working across TriState Health. They routinely manage approximately 200 patients, mostly with chronic disease, multiple medications, and complex medical care that benefits from a team that assists with care coordination.

We support an organization called Community On Call (COC) by donating food and meals from our organization. In 2024 we donated food to COC at a value of $12,164.74 and in 2025 we donated food and meals at a value of $12,903.44.

Food Drive: TriState coordinates a food drive around the holidays each year and in 2025 we donated 1,463 food items and in 2024 1,945 items.

Better Breathers Club was put on "pause" during COVID due to group meeting restrictions – after these restrictions were lifted post COVID – the attendance did not return, and this group has been disbanded.