Gritman MEDICAL CENTER

Gritman Medical Center

2026-2028

Community Health Needs Assessment

Approved by the Board of Directors on December 17th, 2025

Dear Community Member:

At Gritman Medical Center, we have spent more than 125 years providing high-quality compassionate healthcare to the Palouse. The 2026-2028 Community Health Needs Assessment identifies local health and medical needs and provides a plan of how Gritman will help respond to such needs. This document illustrates one way we are meeting our commitment to efficiently deliver medical services.

In compliance with the Affordable Care Act, all not-for-profit hospitals are required to develop a report on the medical and health needs of the communities they serve. We welcome you to review this document not just as part of our compliance with federal law, but of our continuing efforts to meet your health and medical needs. Gritman will conduct this effort at least once every three years. The report produced three years ago is also available for your review and comment. As you review this plan, please see if, in your opinion, we have identified the primary needs of the community and if you think our intended response will lead to needed improvements.

We do not have adequate resources to solve all the problems identified. Some issues are beyond the capabilities of the hospital and action is best suited for a response by others. Some improvements will require personal actions by individuals rather than the response of an organization. We view this as a plan for how we, along with other area organizations and agencies, can collaborate to bring the best each has to offer in order to support change and address the most pressing identified needs.

Most importantly, this report is intended to guide our actions and the efforts of others to make needed health and medical improvements in our area. I invite your response to this report. As you read, please think about how to help us improve health and medical services in our area. We all live in, work in, and enjoy this wonderful community, and together, we can make our community healthier for every one of us.

Thank You,

Kara Besst
President & CEO
Gritman Medical Center

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Executive Summary

Gritman Medical Center ("GMC" or the "Hospital") performed a Community Health Needs Assessment (CHNA) together in partnership with Ovation Healthcare ("Ovation") to assist in determining the health needs of the local community and an accompanying implementation plan to address the identified health needs. This CHNA report consists of the following information:

1) a definition of the community served by the Hospital and a description of how the community was determined;

2) a description of the process and methods used to conduct the CHNA;

3) a description of how the Hospital solicited and considered input received from persons who represent the broad interests of the community it serves;

4) commentary on the 2022 CHNA Assessment and Implementation Strategy efforts;

5) a prioritized description of the significant health needs of the community identified through the CHNA along with a description of the process and criteria used in identifying certain health needs as significant and prioritizing those significant health needs; and

6) a description of resources potentially available to address the significant health needs identified through the CHNA.

Data was gathered from multiple well-respected secondary sources to help build an accurate picture of the current community and its health needs. A broad community survey was performed to review and provide feedback on the prior CHNA and to support the determination of the Significant Health Needs of the community in 2025.

The health priorities identified by Gritman Medical Center from this assessment are:

Improve ***patient financial education*** with a focus on price transparency, financial advocacy, and assistance support.

Grow ***access to primary and specialty care services*** through continuous recruitment of providers and optimizing appointment availability and scheduling.

Promote ***mental health and well-being*** by leveraging strong community partnerships and integrating behavioral health services with primary care.

In the Implementation Strategy section of the report, the Hospital addresses these areas through identified programs and resources with intended impacts included for each health need to track progress towards improved community health outcomes.

Community Health Needs Assessment
Overview

CHNA Purpose

A CHNA is part of the required documentation of "Community Benefit" under the Affordable Care Act for 501(c)(3) hospitals and fulfills requirements for accreditation for many health and public health entities. However, regardless of status, a CHNA provides many benefits to an organization. This assessment provides comprehensive information about the community's current health status, needs, and disparities and offers a targeted action plan to address these areas, including programmatic development and partnerships.

Organizational Benefits

- Identify health disparities and social drivers to inform future outreach strategies
- Identify key service delivery gaps
- Develop an understanding of community members' perceptions of healthcare in the region
- Support community organizations for collaborations

CHNA Process

Survey the Community

Develop a CHNA survey to be deployed to the broad community in order to assess significant health priorities.

Data Analysis

Review survey data and relevant data resources to provide qualitative and quantitative feedback on the local community and market.

Determine Top Health & Social Needs

Prioritize community health and social needs based on the community survey, data from secondary sources, and facility input.

Implementation Planning

Build an implementation plan to address identified needs with actions, goals, and intended impacts on significant health needs.

Process & Methods

This assessment takes a comprehensive approach to determining community health needs and includes the following methodology:

- Several independent data analyses based on secondary source data
- Augmentation of data with community opinions through a community-wide survey
- Resolution of any data inconsistency or discrepancies by reviewing the combined opinions formed by local expert advisors and community members

Data Collection and Analysis

This assessment relies on secondary source data, which primarily uses the county as the smallest unit of analysis. Most data used in the analysis is available from public internet sources and proprietary data. Any critical data needed to address specific regulations or developed by the community members cooperating in this study are displayed in the CHNA report appendix.

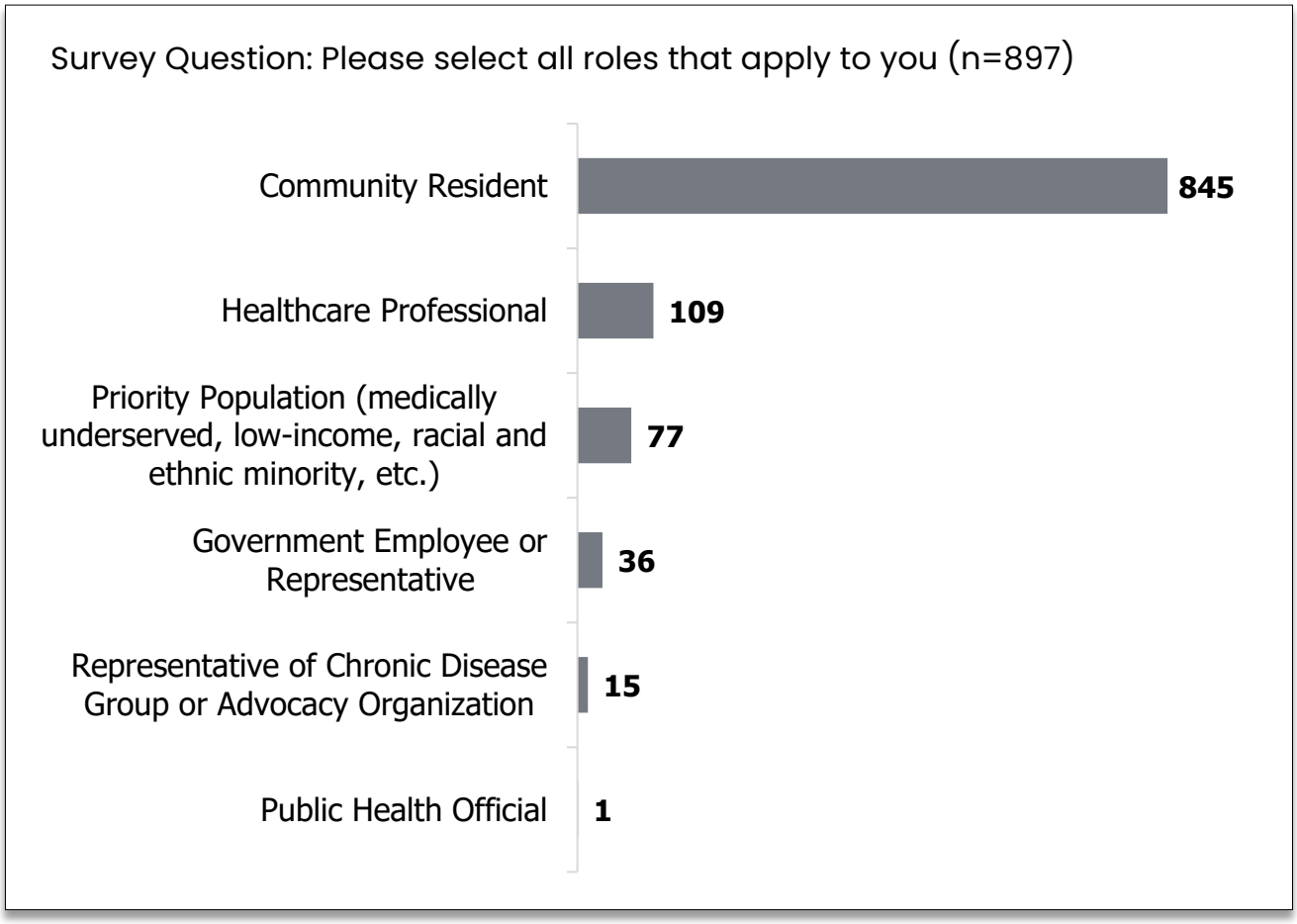
All data sources are detailed in the appendix of this report with the majority of the data used in this assessment coming from:

- County Health Rankings 2025 Report
- Centers for Medicare & Medicaid Services – CMS
- Centers for Disease Control and Prevention – CDC
- Idaho Behavioral Risk Factor Surveillance System – BRFSS

A standard process of gathering community input was utilized. In addition to gathering data from the above sources, a CHNA survey was deployed to local expert advisors and the general public to gain input on local health needs and the needs of priority populations. Local expert advisors were local individuals selected according to criteria required by the Federal guidelines and regulations and the Hospital's desire to represent the region's economic, racial, and geographically diverse population. Nine hundred and one (901) survey responses from community members were gathered in September 2025.

Community Input

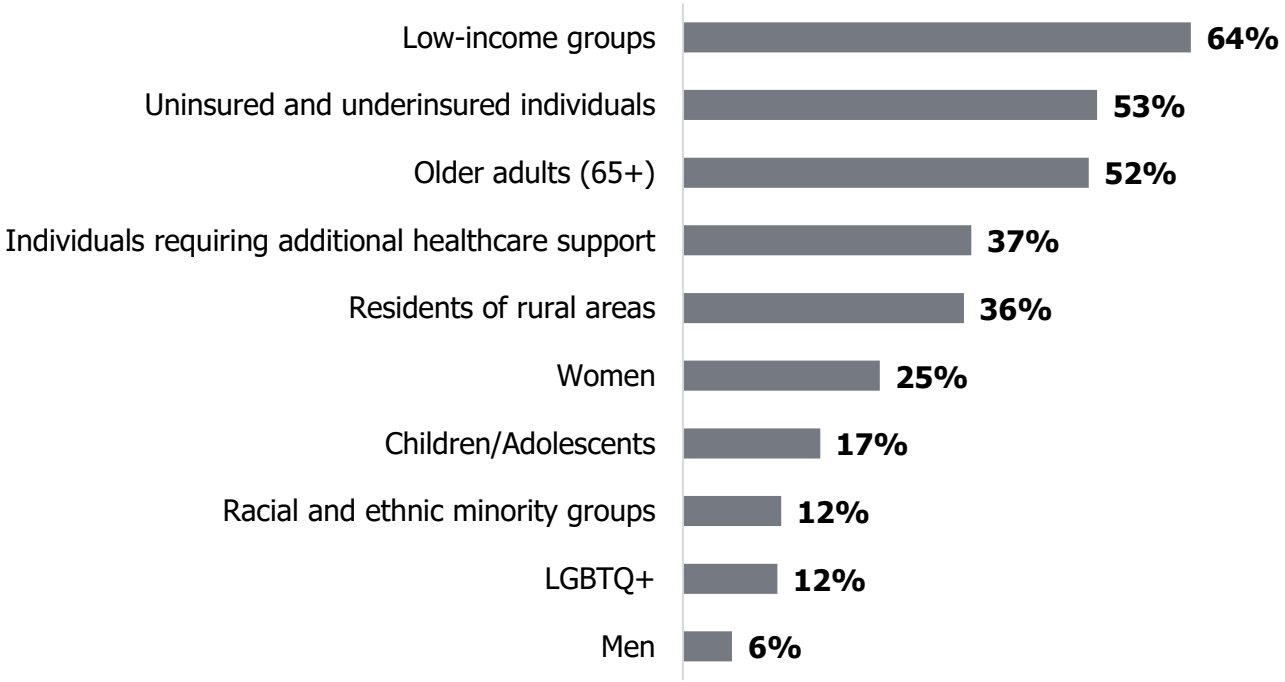
Input was obtained from the required three minimum federally required sources and expanded to include other representative groups. The Hospital asked all those participating in the written comment solicitation process to self-identify into any of the following representative classifications, which are detailed in the appendix to this report. Additionally, survey respondents were asked to identify their age, race/ethnicity, and income level to ensure a diverse range of responses were collected.



Priority Populations

Medically underserved populations are those who experience health disparities or face barriers to receiving adequate medical care because of income, geography, language, etc. The Hospital assessed what population groups in the community ("Priority Populations") would benefit from additional focus and asked survey respondents to elaborate on the key health challenges these groups face.

Survey Question: Which groups would you consider to have the greatest health needs (rates of illness, trouble accessing healthcare, etc.) in your community?



Local opinions of the needs of Priority Populations, while presented in their entirety in the appendix, were abstracted into the following key themes:

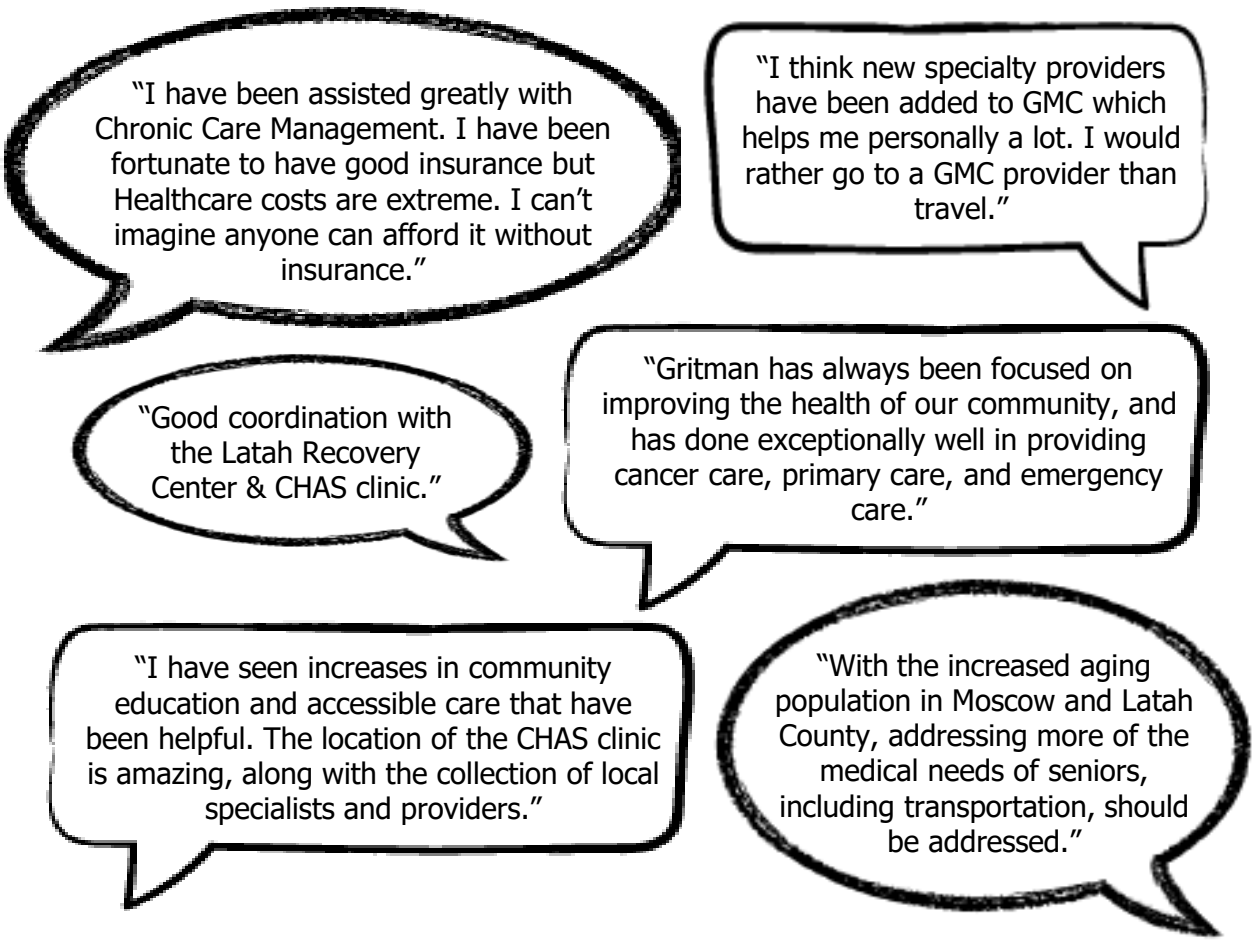
- The top three priority populations identified were low-income groups, un/underinsured individuals, and older adults (65+).
- Summary of unique or pressing needs of the priority groups identified by the respondents:

Limited Financial Resources | Lack of Transportation | Access to Health Services

Input on Actions to Address the 2022 Significant Health Needs

GMC considered written comments received on the prior CHNA and Implementation Strategy as a component of the development of the 2025 CHNA and Implementation Strategy. Comments were solicited from community members to provide feedback on any efforts and actions taken by GMC since the 2022 CHNA and Implementation Plan were conducted. These comments informed the development of the 2025 CHNA and Implementation Plan and are presented in full in the appendix of this report. The health priorities identified in the 2022 CHNA are listed below with a selection of survey responses.

- Behavioral Health
- Access and Affordability
- Prevention
- Chronic Disease Management



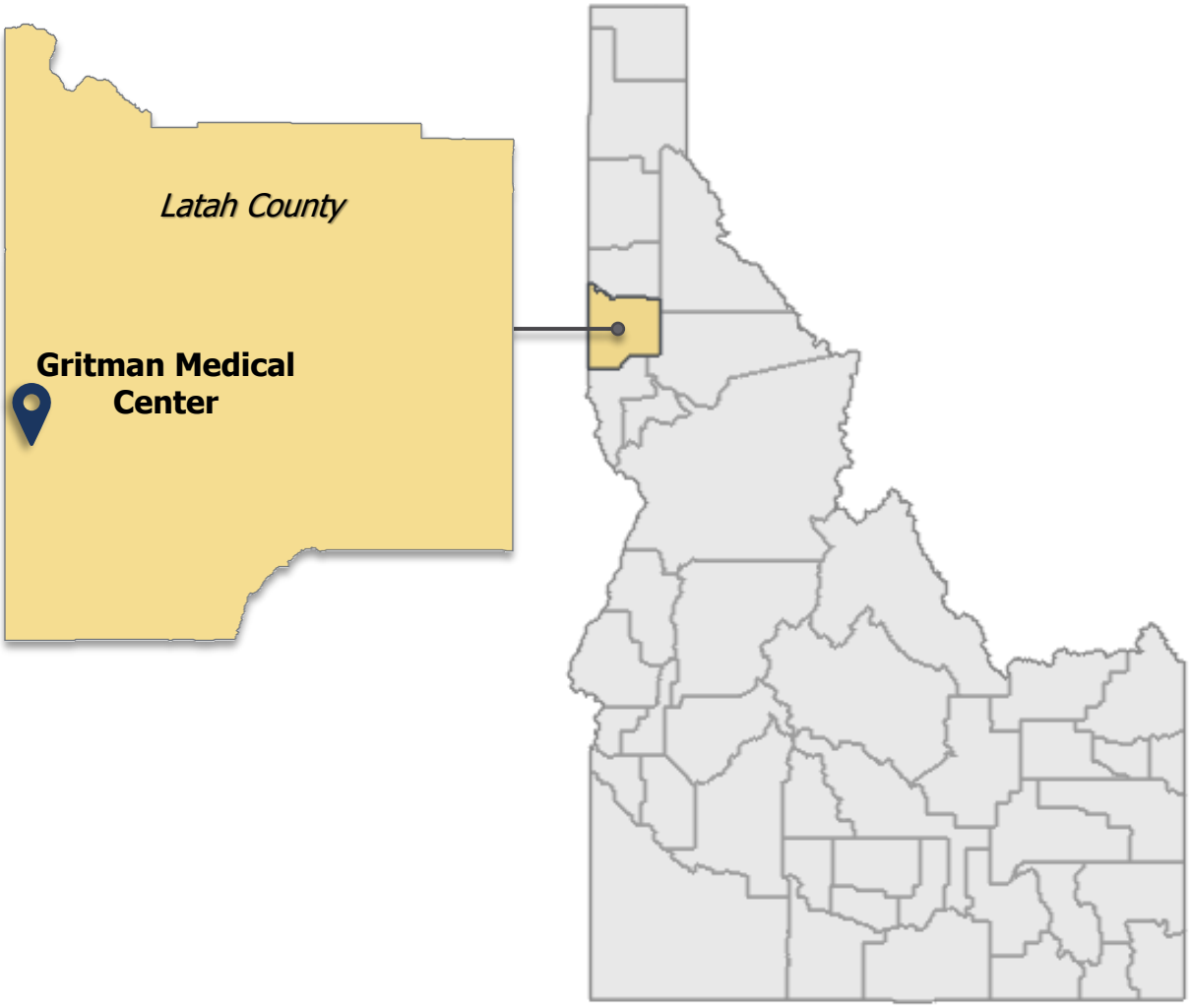
Community Served

For the purpose of this study, the service area is defined as Latah County in Idaho. The data presented in this report is based on this county-level service area and compared to state averages. Geographically, GMC is located in western Latah County. Gritman Medical Center is the only hospital in Latah County.

Service Area

Latah County

Total Population: **41,301**



Source: County Health Rankings 2025 Report, ArcGIS

Service Area Demographics

	Latah	Idaho
Demographics		
Total Population	41,301	1,964,726
Age		
Below 18 Years of Age	19.4%	23.8%
Ages 19 to 64	65.5%	58.9%
65 and Older	15.1%	17.4%
Race & Ethnicity		
Non-Hispanic White	87.9%	80.3%
Non-Hispanic Black	0.8%	0.8%
American Indian or Alaska Native	0.9%	1.7%
Asian	2.4%	1.7%
Native Hawaiian or Other Pacific Islander	0.2%	0.2%
Hispanic	5.1%	13.8%
Gender		
Female	48.8%	49.7%
Male	51.2%	50.3%
Geography		
Rural	34.4%	30.8%
Urban*	65.6%	69.2%
Income		
Median Household Income	$63,916	$74,859

*Notes: *Urban is defined by the US Census Bureau as census blocks that encompass at least 5,000 people or at least 2,000 housing units*
Source: County Health Rankings 2025 Report

Methods of Identifying Health Needs

Collect & Analyze

Analyze existing data and collect new data

737 indicators collected from data sources

901 surveys completed by community members

Evaluate

Evaluate indicators based on the following factors:

- Worse than benchmark
- Identified by the community
- Impact on health disparities
- Feasibility of being addressed

Select

Select priority health needs for implementation plan

Prioritizing Significant Health Needs

The survey respondents participated in a structured communication technique called the "Wisdom of Crowds" method. This approach relies on the assumption that the collective wisdom of participants is superior to the opinion of any one individual, regardless of their professional credentials.

In the Hospital's process, each survey respondent had the opportunity to prioritize community health needs. The survey respondents then ranked the importance of addressing each health need on a scale of 1 (not at all) to 5 (extremely), including the opportunity to list additional needs that were not identified.

The ranked needs were divided into "Significant Needs" and "Other Identified Needs." The determination of the breakpoint — "Significant" as opposed to "Other" — was a qualitative interpretation where a reasonable breakpoint in rank order occurred. The Hospital analyzed the health issues that received the most responses and established a plan for addressing them.

Ranked Health Priorities

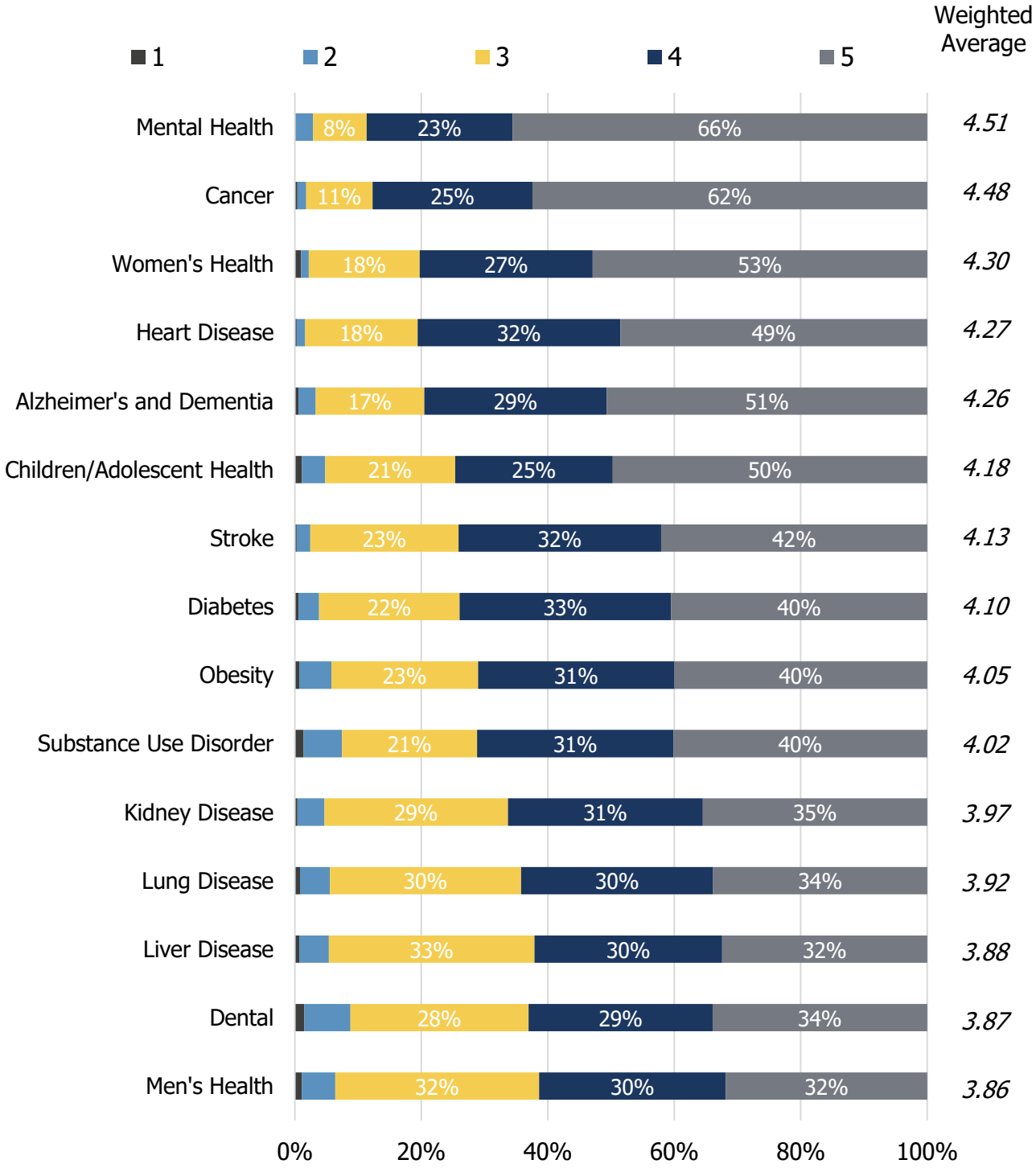
The health priority ranking process included an evaluation of health factors, community factors, and personal factors, given that they each uniquely impact the overall health and health outcomes of a community:

- Health factors include chronic diseases, health conditions, and the physical health of the population.
- Community factors are the social drivers that influence community health and health equity.
- Behavioral factors are the individual actions that affect health outcomes.

In our community survey, each broad factor was broken out into more detailed components, and respondents rated the importance of addressing each component in the community on a scale from 1 to 5. The results of the health priority rankings are outlined below:

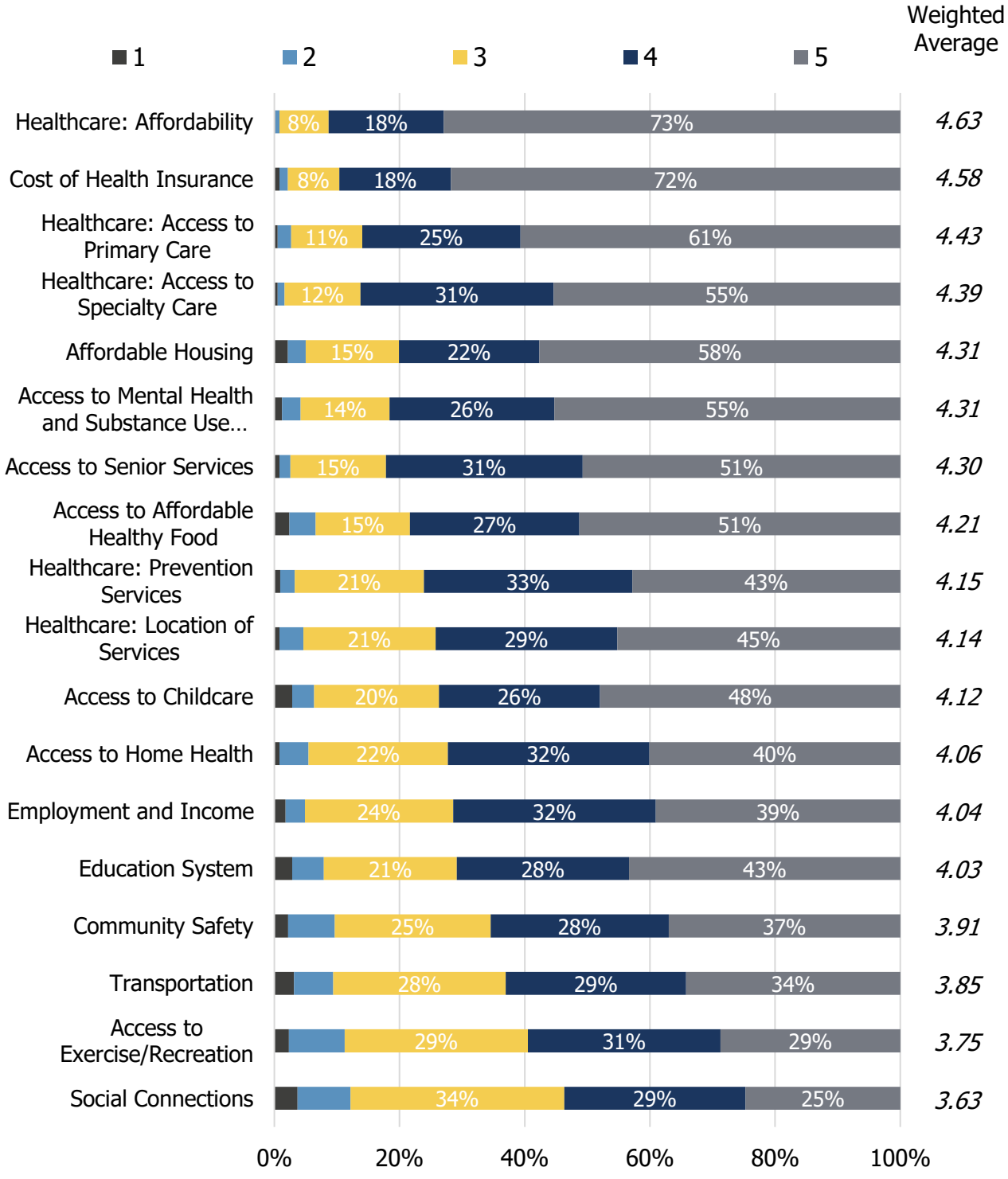
Health Factors

Survey Question: Please rate the importance of addressing each health factor on a scale of 1 (Not at all) to 5 (Extremely).



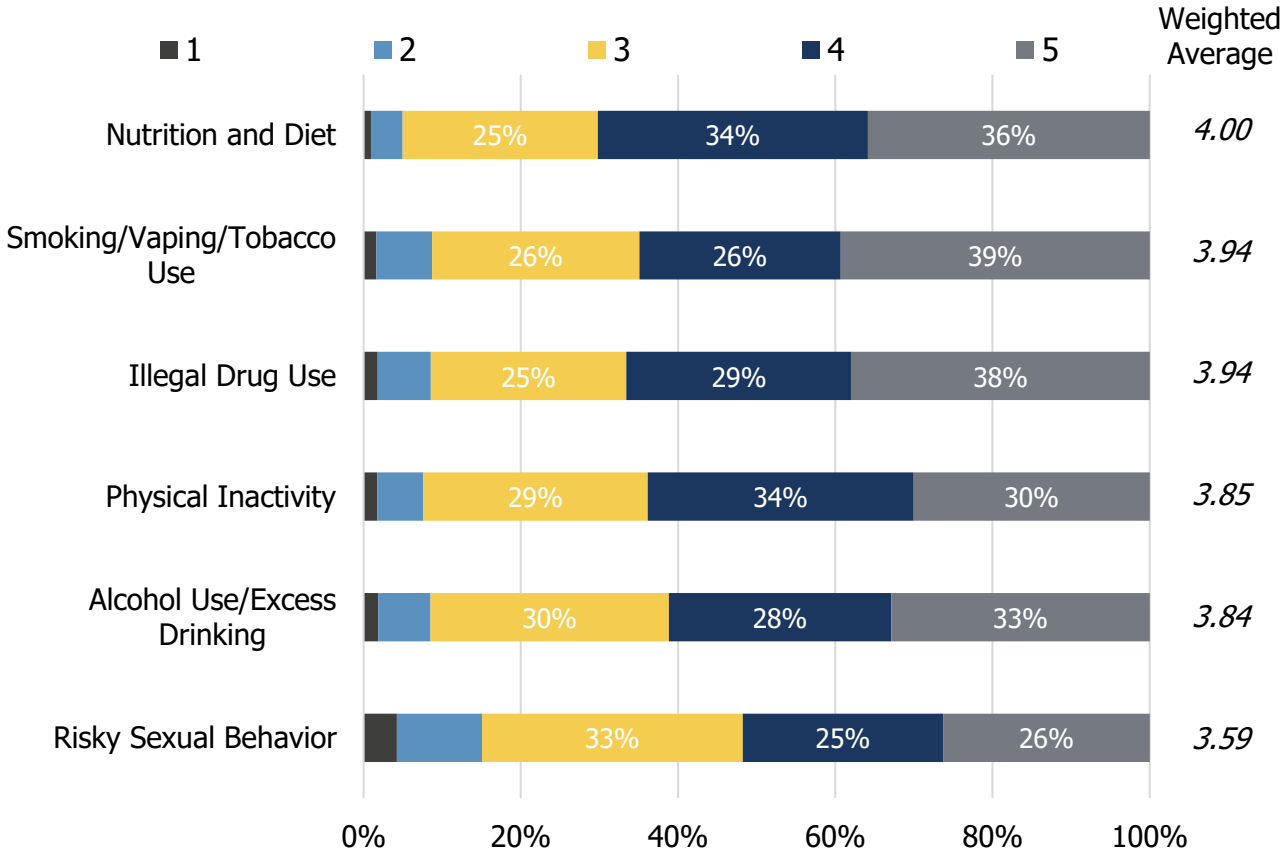
Community Factors

Survey Question: Please rate the importance of addressing each community factor on a scale of 1 (Not at all) to 5 (Extremely).



Behavioral Factors

Survey Question: Please rate the importance of addressing each behavioral factor in your community on a scale of 1 (Not at all) to 5 (Extremely).



Overall Health Priority Ranking (Top 10 Highlighted)

Health Issue	Weighted Average (out of 5)	Combined 4 (Important) and 5 (Extremely Important) Rating
Healthcare: Affordability	4.63	91.3%
Cost of Health Insurance	4.58	89.6%
Mental Health	4.51	88.7%
Cancer	4.48	87.7%
Healthcare: Access to Primary Care	4.43	86.0%
Healthcare: Access to Specialty Care	4.39	86.3%
Access to Mental Health and SUD Services	4.31	81.6%
Affordable Housing	4.31	80.1%
Women's Health	4.30	80.3%
Access to Senior Services	4.30	82.2%
Heart Disease	4.27	80.6%
Alzheimer's and Dementia	4.26	79.5%
Access to Affordable Healthy Food	4.21	78.3%
Children/Adolescent Health	4.18	74.7%
Healthcare: Prevention Services	4.15	76.1%
Healthcare: Location of Services	4.14	74.3%
Stroke	4.13	74.1%
Access to Childcare	4.12	73.7%
Diabetes	4.10	73.9%
Access to Home Health	4.06	72.3%
Obesity	4.05	71.0%
Employment and Income	4.04	71.4%
Education System	4.03	70.8%
Substance Use Disorder	4.02	71.2%
Nutrition and Diet	4.00	70.2%
Kidney Disease	3.97	66.3%
Illegal Drug Use	3.94	66.6%
Smoking/Vaping/Tobacco Use	3.94	64.9%
Lung Disease	3.92	64.2%
Community Safety	3.91	65.5%
Liver Disease	3.88	62.1%
Dental	3.87	63.1%
Men's Health	3.86	61.4%
Transportation	3.85	63.0%
Physical Inactivity	3.85	63.9%
Alcohol Use/Excess Drinking	3.84	61.2%
Access to Exercise/Recreation	3.75	59.5%
Social Connections	3.63	53.7%
Risky Sexual Behavior	3.59	51.8%

Survey Ranking Comparison from 2022 to 2025

The 2025 GMC CHNA survey showed significant progress in community engagement, with nearly 6 times more responses than in 2022. The 2025 survey highlights consistent concern around healthcare affordability and mental health, but with some notable shifts in priority emphasis. In 2025, affordability-related issues led the top responses, including overall healthcare affordability, cost of health insurance, and access to care, suggesting growing financial pressures and perceived barriers to healthcare access. Mental health remains a top concern, reflecting continued community focus on behavioral health needs. Newer or elevated priorities include cancer, women's health, and access to senior services, indicating increased attention to chronic disease management and priority populations.

2025 GMC Survey (n=901)	
Top 10 Health Priorities	Rank
Healthcare: Affordability	*4.63*
Cost of Health Insurance	*4.58*
Mental Health	*4.51*
Cancer	*4.48*
Healthcare: Access to Primary Care	*4.43*
Healthcare: Access to Specialty Care	*4.39*
Access to Mental Health and SUD Services	*4.31*
Affordable Housing	*4.31*
Women's Health	*4.30*
Access to Senior Services	*4.30*

2022 GMC Survey (n=136)	
Top 10 Health Priorities	Rank
Mental Health	*4.62*
Access to Childcare	*4.45*
Healthcare Services: Affordability	*4.44*
Affordable Housing	*4.41*
Healthcare Services: Location, Services, Physicians, etc.	*4.38*
Livable Wage	*4.30*
Healthcare Services: Prevention	*4.27*
Alcohol/Substance Abuse	*4.23*
Diabetes	*4.22*
Cancer	*4.20*

Community Health Characteristics

This section highlights health status indicators, outcomes, and relevant data on the health needs in Latah County. The data at the county level is supplemented with benchmark comparisons to the state data. The most recently available data is used throughout this report with trended data included where available. A scorecard that compares the population health data of the service area county to that of Idaho can be found in the report appendix.

Behavioral Health

Mental Health

Mental health was the #3 community-identified health priority, with 89% of respondents rating it as important to be addressed in the community (important is categorized as a 4 or 5 rating on the community survey). The suicide mortality rate in Latah County is 14.1 per 100,000, which is lower than the Idaho average (21.5 per 100,000) (CDC).

Latah County has less access to mental health providers compared to the state, where there is 1 provider for every 475 county residents. Additionally, the county has higher rates of frequent mental distress and adult depression compared to the state.

	Latah	Idaho
Suicide Mortality Rate per 100,000 (2019-2023)	14.1	21.5
Poor Mental Health Days past 30 days (2022)	5.3	4.9
Population per 1 Mental Health Provider (2024)	475:1	371:1
Adult Depression (2021-2023)	24.5%	22.9%
Frequent Mental Distress (2021-2023)	16.6%	14.8%

Source: NIH: HDPulse, County Health Rankings 2025 Report, PLACES: Local Data for Better Health, Idaho BRFSS

Drug, Substance, and Alcohol Use

While there is not enough data to evaluate the rate of drug-related overdose deaths in Latah County, the Idaho average is 20.5 per 100,000 population, which is less than the U.S. average of 31.3 per 100,000 population. The prevalence of excessive drinking and alcohol-impaired driving deaths is higher in Latah County compared to the state. Alternatively, the rate of adult smoking is slightly lower than the state average.

	Latah	Idaho
Drug-Related Overdose Deaths per 100,000 (2023)	N/A	20.5
Excessive Drinking (2022)	20.2%	17.8%
Alcohol-Impaired Driving Deaths (2018-2022)	38.5%	32.7%
Adult Smoking (2022)	11.2%	12.4%

Source: CDC National Vital Statistics System, County Health Rankings 2025 Report

Chronic Diseases

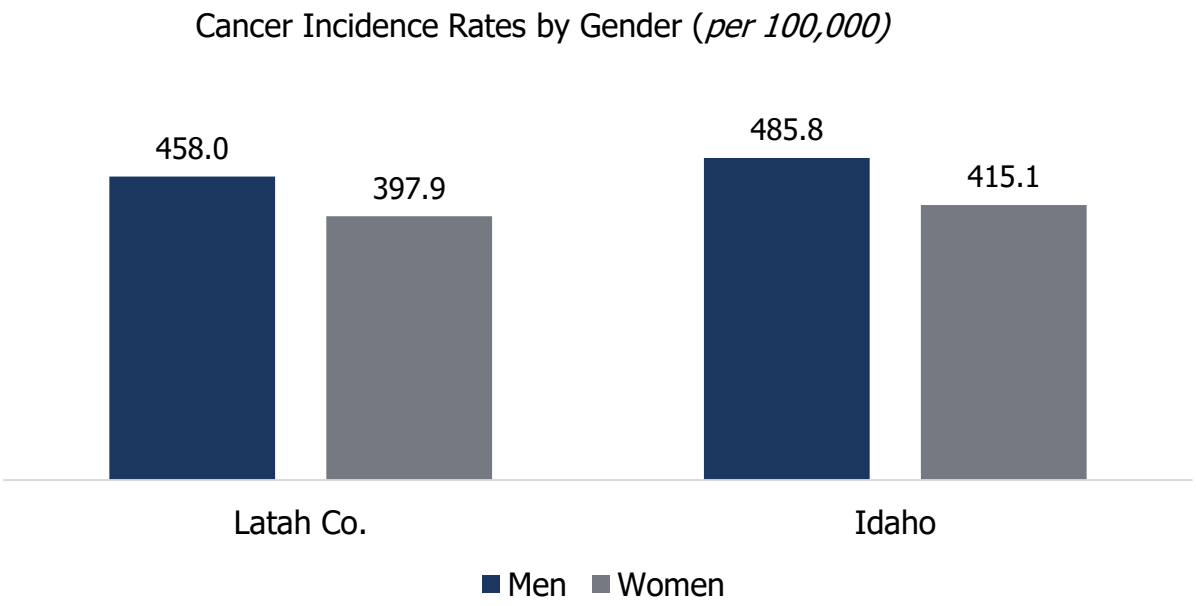
Cancer

Cancer was identified as the #4 community health concern, with 88% of survey respondents rating it as important to address in the community. Cancer is the 2nd leading cause of death in Latah County. Additionally, 29% of survey respondents said they would like to see additional access to cancer care in Latah County. Latah County has both a lower cancer incidence rate and mortality rate compared to Idaho cancer rates.

When evaluating health disparities across gender, men have higher incidence rates of cancer compared to women in the county and the state. This disparity can be due to a multitude of factors, including behavioral factors like tobacco use and diet, as well as healthcare utilization like preventative care and screening (CDC).

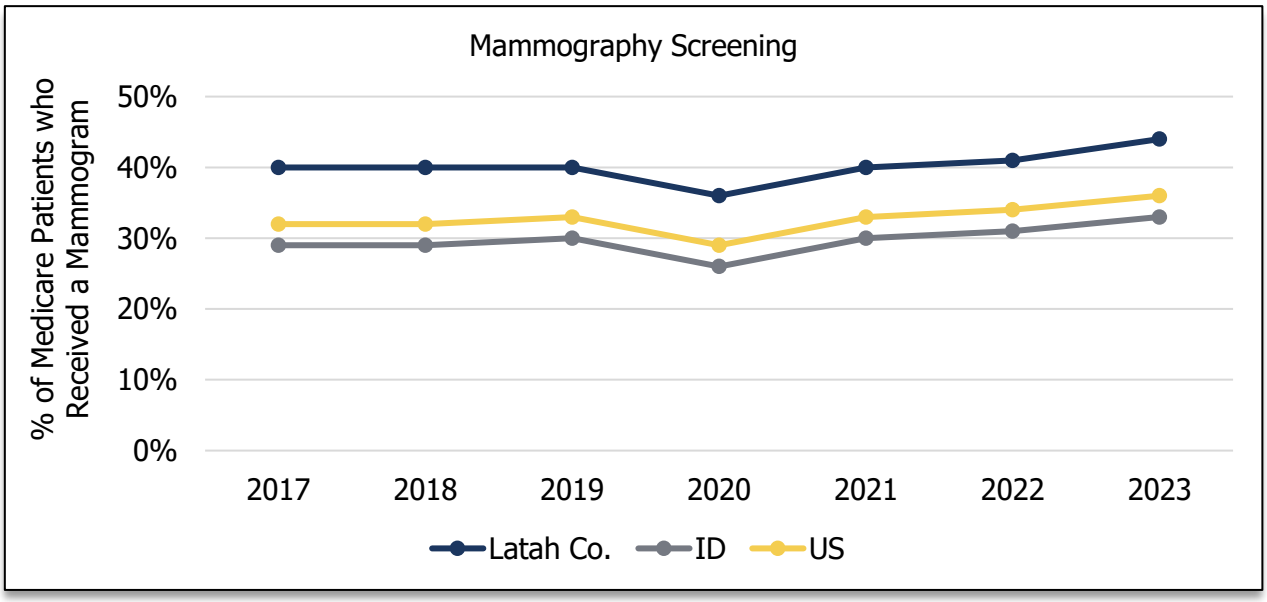
	Latah	Idaho
Cancer Incidence Rate Age-Adjusted per 100,000 (2017-2021)	422.6	445.7
Cancer Mortality Rate per 100,000 (2019-2023)	129.1	138.6

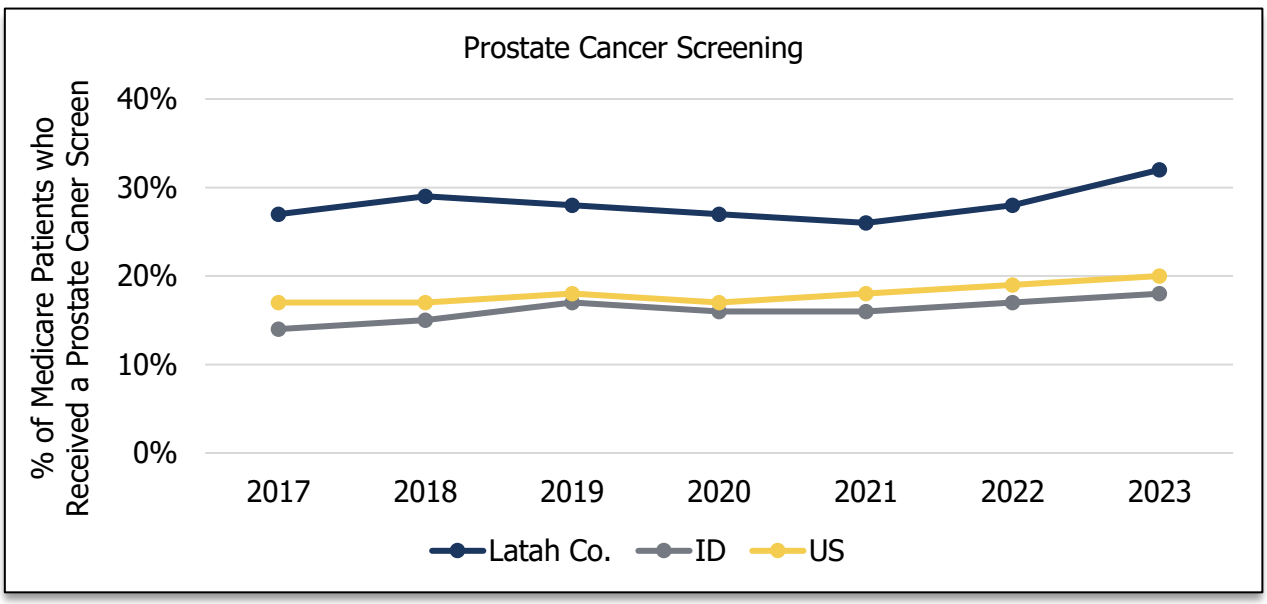
Source: NIH: HDPulse, National Cancer Institute



Source: National Cancer Institute

The rate of Medicare enrollees (women age 65+) who have received a mammogram in the past year is higher in Latah County compared to the state (44% compared to 33% respectively). These rates have increased in recent years after a dip downward in 2020 during the COVID-19 pandemic. Among Medicare enrollees (men age 65+), Latah County also has higher rates of prostate cancer screening compared to the state (32% compared to 18% respectively), with rates increasing in recent years.





Source: Centers for Medicare & Medicaid Services: Mapping Medicare Disparities by Population

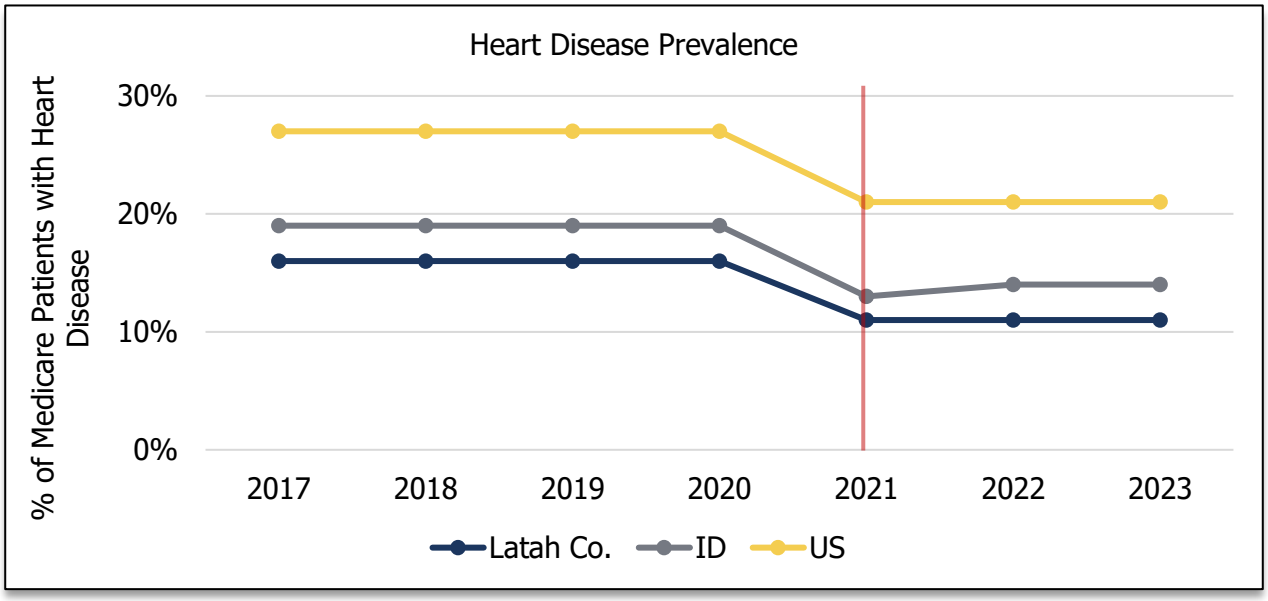
Cardiovascular Health

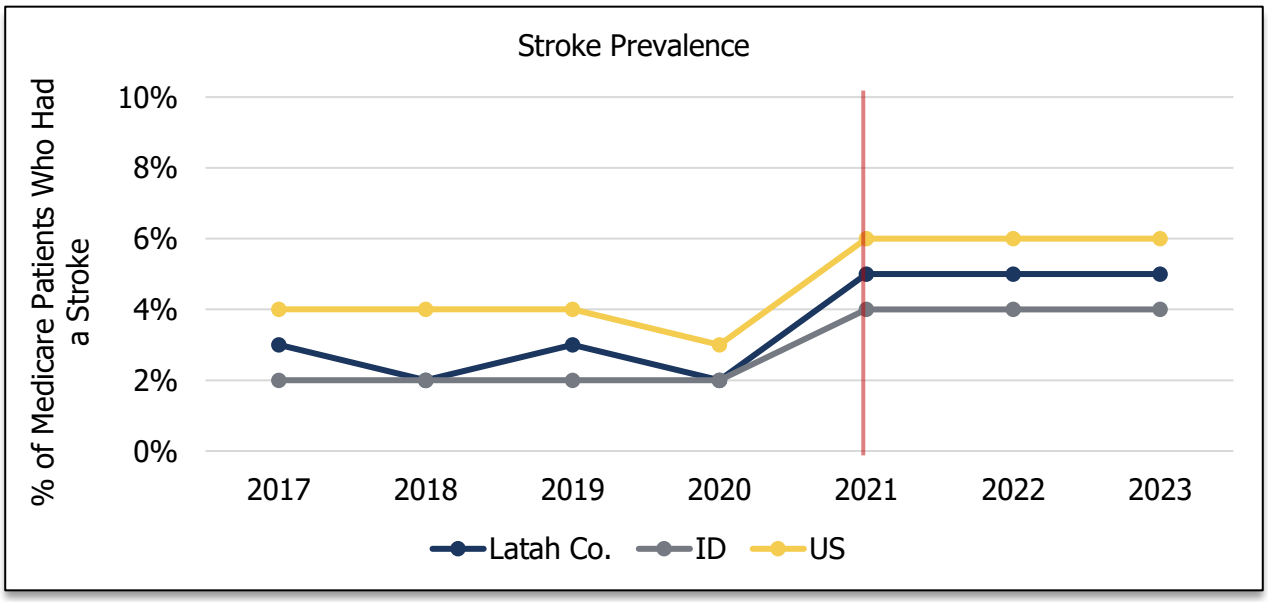
Heart disease is the leading cause of death in Latah County, though the county has a lower mortality rate for both heart disease and stroke compared to state averages. Looking at risk factors for negative cardiovascular health, Latah County has a lower prevalence of high blood pressure and high cholesterol compared to the Idaho averages.

	Latah	Idaho
Heart Disease Mortality Rate per 100,000 (2019-2023)	129.5	156.8
Stroke Mortality Rate per 100,000 (2019-2023)	26.8	36.5
Coronary Heart Disease Prevalence (2021-2023)	5.6%	3.3%
Stroke Prevalence (2021-2023)	2.7%	3.0%
High Blood Pressure (2021-2023)	25.6%	31.2%
High Cholesterol (2021-2023)	28.2%	34.4%

Source: NIH: HDPulse, PLACES: Local Data for Better Health, Idaho BRFSS

In the Medicare population, Latah County has a lower prevalence of heart disease compared to the state (11% compared to 14% respectively), while the prevalence of stroke is slightly higher (5% compared to 4% respectively).





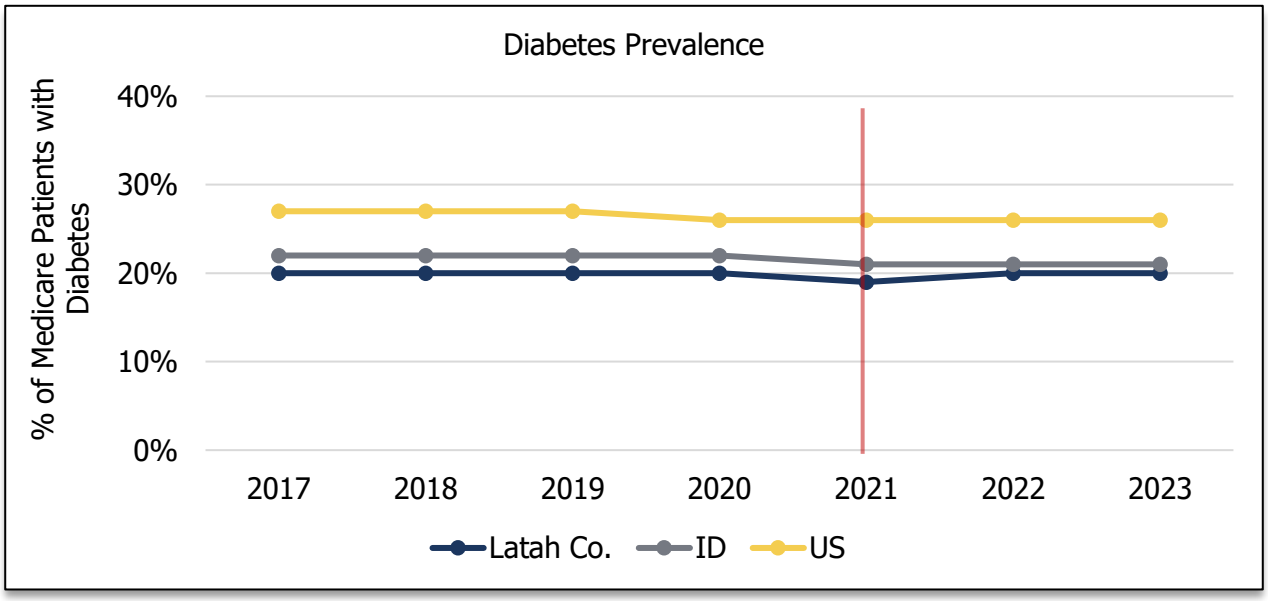
Note: There was a change in the algorithm of reported data in 2021 noted by a red bar
Source: Centers for Medicare & Medicaid Services: Mapping Medicare Disparities by Population

Diabetes

The prevalence of diabetes in Latah County is similar to the Idaho average, and the county sees a diabetes mortality rate lower than the state's. When evaluating the Medicare population, Latah County has a slightly lower prevalence of diabetes compared to the state (20% and 21% respectively), though rates have remained stable over the past decade.

	Latah	Idaho
Diabetes Mortality Rate per 100,000 (2019-2023)	12.0	14.5
Diabetes Prevalence (2022)	8.7%	8.8%

Source: NIH: HDPulse, County Health Rankings 2025 Report



Note: There was a change in the algorithm of reported data in 2021 noted by a red bar
Sources: Centers for Medicare & Medicaid Services: Mapping Medicare Disparities by Population

Obesity and Unhealthy Eating

In Latah County, adults have lower rates of obesity than in Idaho on average. Additionally, the county sees lower rates of physical inactivity than the state, though the county has lower access to exercise opportunities (proximity to a park or recreation facility). Obesity, physical inactivity, and diet are well-established risk factors for type 2 diabetes development (American Diabetes Association).

	Latah	Idaho
Adults Obesity (2022)	29.1%	33.6%
Limited Access to Healthy Foods (2019)	4.6%	7.9%
Physical Inactivity (2022)	16.9%	21.0%
Access to Exercise Opportunities (2020-2024)	69.7%	76.8%
Frequent Physical Distress (2021-2023)	10.9%	13.3%

Source: County Health Rankings 2025 Report, PLACES: Local Data for Better Health, Idaho BRFSS

Healthcare Access

Access & Affordability

Access to affordable and quality healthcare services is a key driver of improved health outcomes, economic stability, and health equity. In the community survey, 46% of respondents said they would like to see additional primary care availability in the county. Latah County has a lower household income than the Idaho average, but sees a lower uninsured population than the state. Latah County has 1 primary care physician (MD, DO) for every 1,390 residents, which indicates greater access compared to the state on average (1 physician for every 1,619 residents). Alternatively, Latah County has less access to dental providers compared to Idaho.

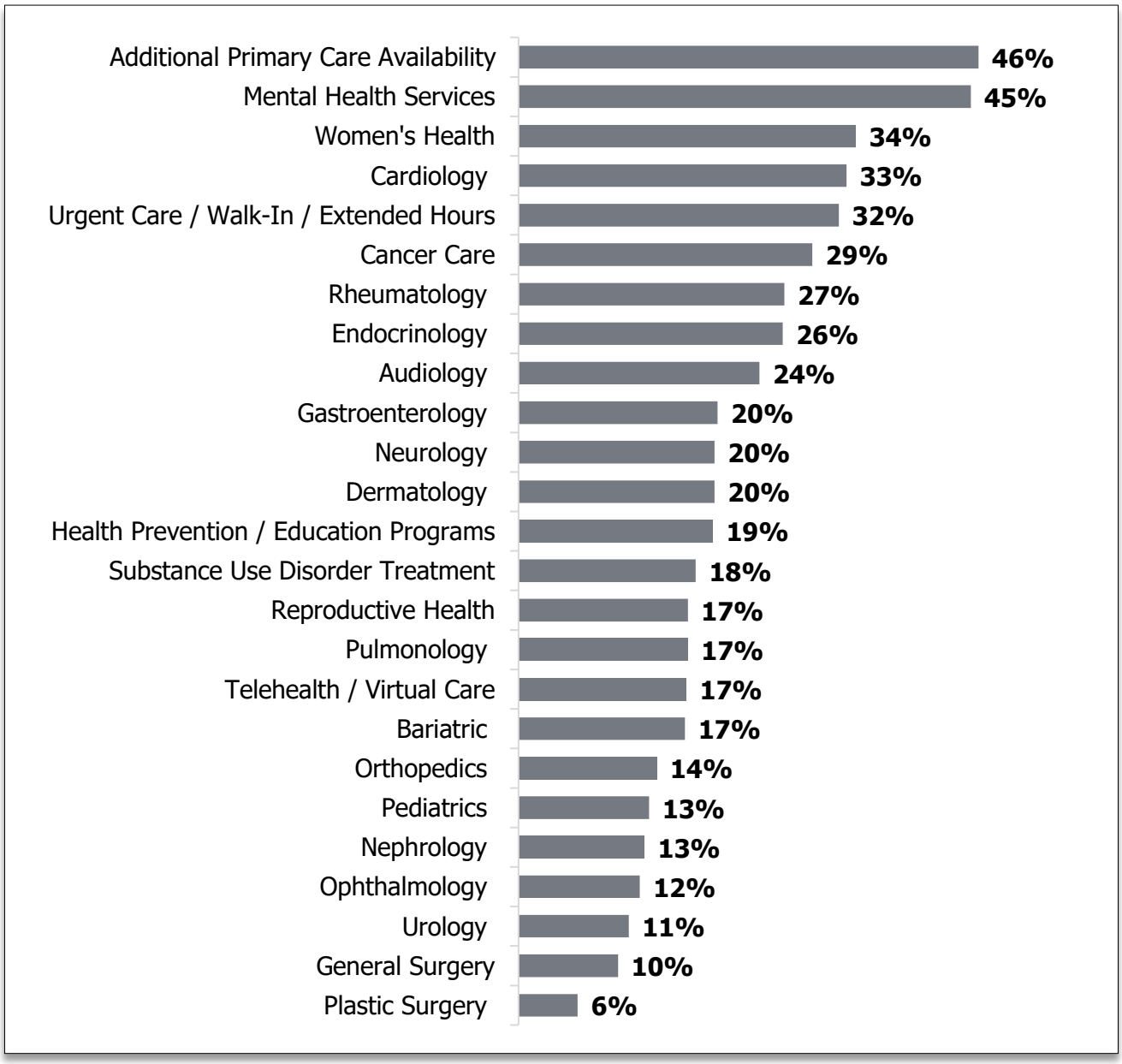
Transportation can be a barrier to accessing health programs, services, and other basic needs. In Latah County, nearly 7% of households do not have a vehicle available, compared to only 4% in the state.

	Latah	Idaho
Uninsured Population (2022)	8.4%	11.5%
Population per 1 Primary Care Physician (2021)	1,390:1	1,619:1
Population per 1 Dentist (2022)	2,157:1	1,534:1
Dental Visit in Past Year (2021-2023)	70.2%	68.7%
Households with No Vehicle Available (2021-2023)	6.7%	3.8%

Source: County Health Rankings 2025 Report, PLACES: Local Data for Better Health, Idaho BRFSS

In the community survey, respondents were asked to identify what healthcare services and programs they would like to see available in their community. Additional primary care availability was the top identified service need, with 46% of respondents saying they would like to see it available in their community, followed by mental health services (45%) and women's health services (34%).

Survey Question: What additional services/offerings would you like to see available locally? (select all that apply)



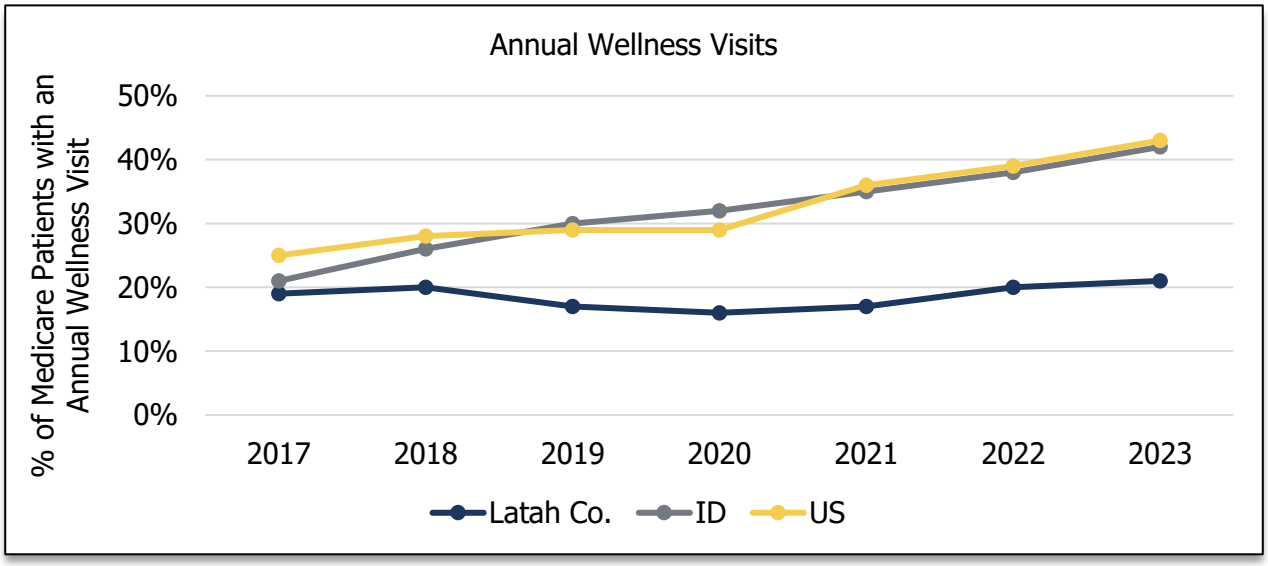
Prevention Services

Prevention services, including routine check-ups, health screenings, and education, can help prevent or detect diseases early when they are easier to treat. Preventive care reduces the burden on healthcare systems by preventing unnecessary hospital stays and costly care. In the community survey, 19% of respondents said they would like to see additional health prevention and education programs available in the community.

Latah County has higher flu vaccine adherence rates than the state and also sees lower rates of preventable hospital stays (hospital stays for ambulatory-care sensitive conditions). This rate represents the effectiveness of preventive care in a community, reflecting how well primary care services manage chronic conditions and prevent avoidable hospital admissions. The rate of annual wellness visits in the Medicare population is lower in Latah County compared to Idaho, and rates have remained relatively stable in recent years, while rates are increasing at the state level.

	Latah	Idaho
Preventable Hospital Stays per 100,000 (2022)	1,151	1,543
Flu Vaccination (2022)	46.0%	40.0%

Source: County Health Rankings 2025 Report



Source: Centers for Medicare & Medicaid Services: Mapping Medicare Disparities by Population

Women's Health

Rural communities face significant barriers to women's health, including provider shortages, long travel distances, and financial constraints, which limit access to preventive care, maternity services, and chronic disease management. This lack of access contributes to poorer health outcomes, such as higher rates of late-stage cancer diagnoses, maternal complications, and untreated chronic conditions. Strengthening women's health services improves maternal and infant health while also supporting the local workforce and promoting long-term community sustainability (RHIhub).

	Latah	Idaho
Female Population (2023)	48.8%	49.7%
Teen Births per 1,000 (Females Ages 15-19) (2017-2023)	4.5	13.7
Mammography Use in the Past Two Years (Females Ages 50-74) (2021-2023)	75.9%	71.7%

Source: County Health Rankings 2025 Report, PLACES: Local Data for Better Health

	Idaho	U.S. Avg.
All-cause Mortality Rate per 100,000 (Women Ages 15-44) (2022)	92.0	110.3
Breast Cancer Deaths per 100,000 (Female Population)	17.9	18.7
Infant Mortality per 1,000 Live Births (2022)	5.3	5.6
Maternal Mortality per 100,000 Live Births (2020-2022)	24.1	26.3
No Early Prenatal Care (2022)	19.1%	23.0%
Self-Pay In-Hospital Births (2022)	4.8%	2.9%

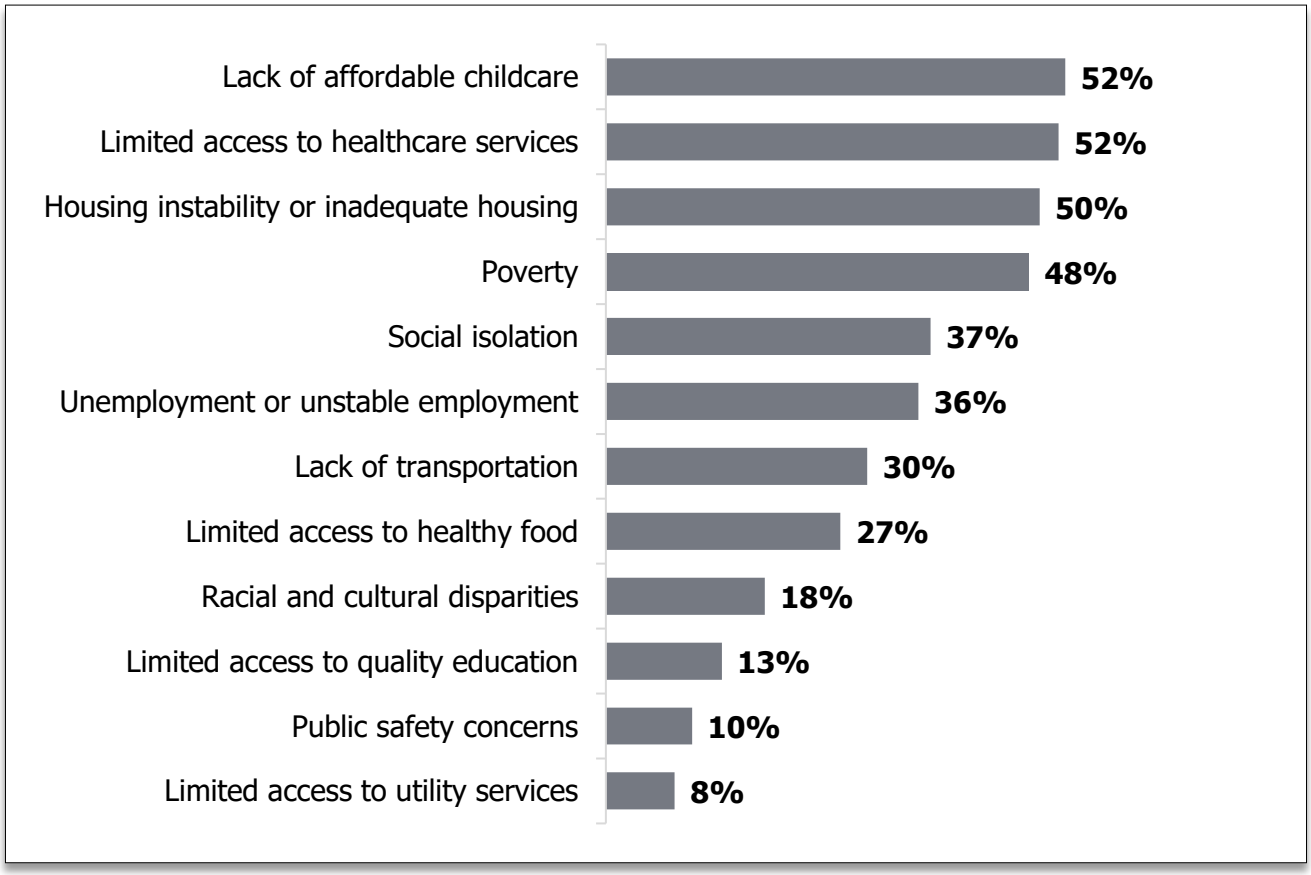
Source: Idaho BRFSS

Social Determinants of Health

Social determinants of health, such as economic stability, education, and access to healthcare, significantly influence health outcomes by shaping individuals' living conditions, behaviors, and access to resources necessary for maintaining good health. These factors can lead to health disparities, with marginalized groups often experiencing worse health outcomes due to these determinants (Healthy People 2030).

Survey respondents were asked to identify the key social conditions that negatively impact the community. The top social condition identified was lack of affordable childcare with 52% of survey respondents reporting it as negatively impacting the community's health, followed by limited access to healthcare services and housing instability.

Survey Question: Please select the key social determinants that negatively impact the health of you or your community (select all that apply):



Housing

Access to affordable and safe housing influences a wide range of factors that contribute to physical and mental well-being. There is evidence that a lack of access to affordable and stable housing can lead to negative health outcomes such as mental illnesses and stress, exposure to environmental hazards, and financial instability (Center for Housing Policy). More Latah County residents experience severe housing problems (overcrowding, high housing costs, lack of plumbing) than the state average. Additionally, 14% of Latah County residents spend 50% or more of their household income on housing.

	Latah	Idaho
Severe Housing Problems (2017-2021)	16.1%	13.2%
Severe Housing Cost Burden (2019-2023)	14.3%	11.1%
Broadband Access (2019-2023)	89.7%	91.0%

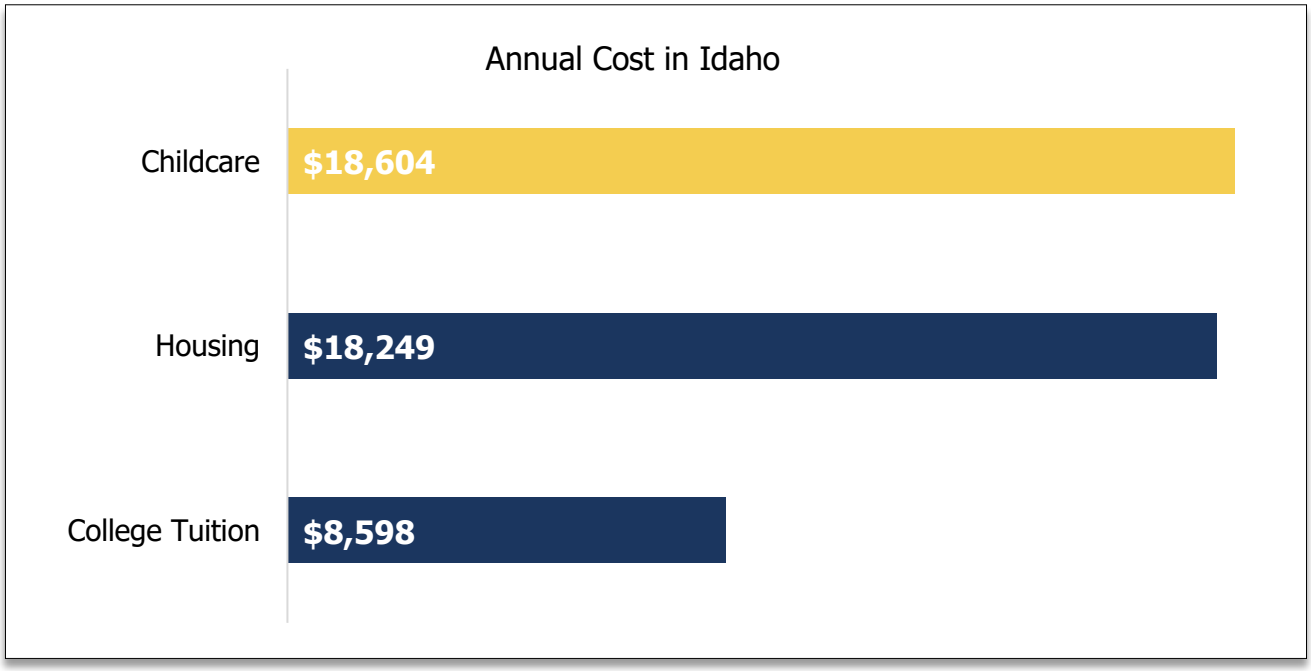
Source: County Health Rankings 2025 Report

Access to Childcare

The average yearly cost of infant care in Idaho is $10,108. The U.S. Department of Health and Human Services defines affordable childcare as being no more than 7% of a family's income (Economic Policy Institute). In Latah County, nearly 36% of household income is required for childcare expenses, and there are 5 childcare centers for every 1,000 children under age 5 in the county, compared to almost 6 in the state.

	Latah	Idaho
Children in Single-Parent Households (2019-2023)	16.6%	17.0%
Child Care Cost Burden - % of HHI Used For Childcare (2023-2024)	35.5%	20.9%
Child Care Centers per 1,000 Under Age 5 (2010-2022)	4.9	5.6

Source: County Health Rankings 2025 Report



Note: Annual childcare price for 2 children (an infant and 4-year-old) in a center
Source: Child Care Aware (2023)

Income, Employment, and Education

Income, employment, and education play a role in the community's ability to afford healthcare and impact health outcomes through health literacy and access to health insurance. Educational attainment and employment impact mental health through poverty and unstable work environments, health behaviors like smoking, diet, and exercise, and access to health insurance (HealthAffairs). Additionally, these factors impact people's ability to afford services to live healthy and happy lives, like safe housing, transportation, childcare, and healthy food.

	Latah	Idaho
Median Household Income (2023)	$63,916	$74,859
High School Completion (2021-2022)	96.9%	91.7%
Some College – Includes Those Who Had and Had Not Attained Degrees (2019-2023)	78.9%	66.6%
Unemployment (2023)	2.7%	3.1%
Children in Poverty (2019-2023)	9.1%	11.3%
Receives SNAP Benefits (2021-2023)	7.0%	6.5%

Source: County Health Rankings 2025 Report, PLACES: Local Data for Better Health

Evaluation Process

Worse than Benchmark Measure

Health needs were deemed "worse than the benchmark" if the supported county data was worse than the state and/or U.S. averages

Identified by the Community

Health needs expressed in the online survey and/or mentioned frequently by community members

Feasibility of Being Addressed

Growing health needs where interventions are feasible, and the Hospital could make an impact

Impact on Health Equity

Health needs that disproportionately affect vulnerable populations and can impact health equity if addressed

Health Need Evaluation	Worse than Benchmark	Identified by the Community	Feasibility	Impact on Health Equity
Healthcare: Affordability	✓	✓	✓	✓
Cost of Health Insurance		✓		✓
Mental Health	✓	✓	✓	✓
Cancer		✓	✓	✓
Healthcare: Access to Primary Care		✓	✓	✓
Healthcare: Access to Specialty Care	✓	✓	✓	✓
Access to Mental Health and SUD Services	✓	✓	✓	✓
Affordable Housing	✓	✓		✓
Women's Health		✓	✓	✓
Access to Senior Services		✓	✓	✓

Implementation Plan

Health Priority Selection Process

To determine the top health priorities for the community, a structured evaluation and selection process was conducted, where Hospital leaders reviewed and discussed both community survey findings and key secondary data indicators, comparing local health outcomes to state benchmarks to identify areas of concern. Each potential priority was assessed based on several criteria: the level of community concern (as reflected in survey responses), whether the issue showed worse-than-average performance compared to the state, the hospital's capacity and resources to meaningfully address the need, and the alignment with the Hospital's strategic goals. This collaborative, data-informed process ensured that the selected priorities were both grounded in evidence and aligned with the hospital's mission and capabilities.

The top 3 health priorities identified by GMC with the development of implementation strategies are:

Goal: Improve ***patient financial education*** with a focus on price transparency, financial advocacy, and assistance support.

Relevant Health Needs: Healthcare Affordability, Cost of Health Insurance

Goal: Grow ***access to primary and specialty care services*** through continuous recruitment of providers and optimizing appointment availability and scheduling.

Relevant Health Needs: Access to Primary Care, Access to Specialty Care

Goal: Promote ***mental health and well-being*** by leveraging strong community partnerships and integrating behavioral health services with primary care.

Relevant Health Needs: Mental Health, Access to Mental Health and Substance Use Disorder Services

Health Needs Not Addressed

GMC acknowledges the significance of all health priorities identified through the community survey and overall assessment. While many of these needs are currently being addressed through existing programs, resources, and strategies led by other community organizations and the Hospital, GMC has chosen to focus its future efforts on three top-priority areas where it can make the most meaningful impact in line with its strategic goals. By concentrating attention and resources on these key issues, the Hospital aims to strengthen outcomes through targeted programming and strategic collaboration with local partners.

Patient Financial Education

GMC Services and Programs Committed to Respond to This Need

- Financial Assistance Program: GMC offers assistance covering medical bills with eligibility based on income relative to federal poverty guidelines; the hospital will not deny medically-necessary care regardless of ability to pay.
- Hospital Price Transparency: Patients have access to clinic and hospital price lists as well as a price estimator tool on the website.
- Patient Financial Services: Financial counselors are available by phone and for walk-in assistance Monday through Friday to help patients navigate their medical bills and identify assistance opportunities and payment options.
- MyChart online portal: Easily view and pay bills for services at all GMC locations.
- Prescription Medicine Support: GMC works with Partnership for Prescription Assistance to help individuals who do not have prescription coverage and cannot afford prescribed medicine.
- Bosom Buddies: Provides free mammograms to Latah County women who are unable to cover the costs of a screening on their own. A physician's referral is required.
- The Light a Candle program: Supports cancer patients to ease pressures and improve their quality of life. A physician's referral is required, and assistance recipients must be Latah or Whitman County residents in active treatment.

Future Goals and Objectives to Address this Significant Health Need

Goal: Improve ***patient financial education*** with a focus on price transparency, financial advocacy, and assistance support.

Objectives:

- Evaluate current price transparency tool for usability and effectiveness for patient access and education.
- Identify opportunities to provide financial advocacy and education during open enrollment to support patients.
- Expand education on MyChart bill pay utilization and explore opportunities to integrate financial education resources in MyChart portal.

Metrics to Track the Impact of Actions and Access to Resources

- Reduce financial barriers to care:
    - Patients enrolled in financial assistance program
    - Total charity care provided
    - Financial resources available in MyChart

Other Local Organizations Available to Respond to This Need

- CHAS Health – Latah Clinic (FQHC)
- Community Action Partnership
- Idaho Department of Health and Welfare
- Latah County Social Services

View more details at: https://www.gritman.org/wp-content/uploads/Community-Resources-FINANCIAL-ASSISTANCE.pdf

Access to Primary and Specialty Care

GMC Services and Programs Committed to Respond to This Need

- Family & Internal Medicine services are provided at multiple convenient locations:
  - Gritman Internal Medicine Clinic
  - Kendrick Family Medicine
  - Moscow Family Medicine
  - Potlatch Family Medicine
  - Troy Family Medicine
  - Warrior Health (Lewis-Clark State College Warrior Health clinic)
- A range of specialty services are provided locally by GMC and partners, including:
  - Cancer care
  - Dialysis
  - ENT & Audiology
  - Cardiac Care
  - Infusion Services
  - Pulmonary Care
  - Neurology
  - Orthopedics
  - General Surgery
  - Urology
  - Wound
  - And more
- QuickCARE: Available at Moscow Family Medicine with a full-service walk-in clinic 7 days a week.
- MyChart online portal: Allows patients to conveniently request appointments online, message with their provider, access test results, and more.

Future Goals and Objectives to Address this Significant Health Need

Goal: Grow ***access to primary and specialty care services*** through continuous recruitment of providers and optimizing appointment availability and scheduling.

Objectives:

- Continuously recruit providers and expand services locally to limit the community's need to travel for care.
- Optimize self-scheduling capabilities through MyChart for better communication and functionality.
- Increase patient education and awareness of online scheduling and appointment availability.
- Improve patient care coordination between primary care and specialty care services.

Metrics to Track the Impact of Actions and Access to Resources

- Improve access to local healthcare services:
    - Provider count/FTE
    - MyChart appointment scheduling utilization
    - Third next available appointment

Other Local Organizations Available to Respond to This Need

- Apple A Day Family Medicine
- Health Motivate Care
- Link Family Medicine
- Moscow Pullman OB/GYN
- Palouse Medical
- Pullman Family Medicine
- Palouse Health Center
- Palouse Pediatrics
- Palouse Surgery Center
- Pullman Ready Care
- Story Family Medicine (Direct Primary Care)
- Vandal Health Clinic – University of Idaho

View more details at: https://www.gritman.org/wp-content/uploads/Community-Resources-CLINICS.pdf

Mental Health and Well-Being

GMC Services and Programs Committed to Respond to This Need

- Individual Counseling: One-on-one therapy with licensed professionals for anxiety, depression, stress, trauma, grief, and other mental health concerns.
- Psychiatric Services: Medication management by a Psychiatric Mental Health Nurse Practitioner for mood disorders, anxiety, and related conditions.
- Integrated Behavioral Health: Collaborative care combining behavioral health and primary care services for comprehensive mental and physical health support.
- Neurodevelopmental Assessment & Testing: Comprehensive evaluations for Autism Spectrum Disorder across all ages to inform treatment planning and support.
- Case Management: Care coordination assistance, including appointment management, connections to community resources, skilled nursing facilities, inpatient rehab, and assisted living to ensure continuous, tailored care.
- Emergency Department Safe Room: Dedicated space in the ED for patients presenting with mental health crises.
- Employee Assistance Program: GMC employees and family members receive four free visits to mental health professionals per topic annually.
- Latah Recovery Community Center Partnership: Collaboration providing resources, classes, and coaching to support recovery and organize community-wide behavioral health solutions.
- Mental Health & Substance Abuse Screening: Intake forms include screening questions; positive screenings prompt provider intervention and resource connection.
- Mental Health Education Resources: In-house materials and education on mental health and substance abuse issues.

Future Goals and Objectives to Address this Significant Health Need

Goal: Promote ***mental health and well-being*** by leveraging strong community partnerships and integrating behavioral health services with primary care.

Objectives:

- Continue to foster strong partnerships with community organizations like Latah Recovery Community Center to provide patients with coordinated behavioral health services.
- Promote integrated behavioral health with primary care services to support coordination of patient care.
- Maintain continuous recruit efforts for a strong, local behavioral health workforce.

Metrics to Track the Impact of Actions and Access to Resources

- Improve community mental health outcomes:
    - Suicide mortality rate
    - Patients screened positive for behavioral health needs who are connected to resources
    - Number of referrals to community behavioral health partners

Other Local Organizations Available to Respond to This Need

- Idaho Crisis & Suicide Hotline
- Latah Recovery Community Center
- Moscow Counseling
- Paradise Creek Counseling
- University of Idaho Counseling and Mental Health Center

View more details at:

Counseling: https://www.gritman.org/wp-content/uploads/Community-Resources-COUNSELING.pdf

Substance Abuse Treatment: https://www.gritman.org/wp-content/uploads/Community-Resources-SUBSTANCE-ABUSE.pdf

Appendix

Community Data Tables

Leading Cause of Death

The Leading Causes of Death are determined by the official Centers for Disease Control and Prevention (CDC) final death total. The Leading Causes of Death are listed in the tables below in U.S. rank order. Latah County's mortality rates are compared to the Idaho state average, and whether the death rate was higher (red), or lower (green) compared to the state average.

	Latah	Idaho	U.S.
Heart Disease	129.5	156.8	168.9
Cancer	129.1	138.6	145.4
Accidents	48.7	56.6	59.7
Alzheimer's	41.2	38.2	30.8
Chronic Lower Respiratory Disease	32.1	42.0	35.9
Cerebrovascular Diseases (Stroke)	26.8	36.5	39.8
Diabetes	20.1	21.5	23.9
Suicide	14.1	21.9	13.9
Liver	12.0	14.5	13.1
Pneumonia	n/a	7.2	10.7
Kidney	n/a	8.0	13.4
Blood Poisoning (Septicemia)	n/a	5.5	10.0
Homicide	n/a	3.0	7.6

Source: NIH: HDPulse, CDC (2019-2023)

County Health Rankings

	Latah	Idaho	US Overall
Length of Life			
Premature Death*	**5,065**	7,099	8,400
Life Expectancy*	**81**	78	77
Quality of Life			
Poor or Fair Health	**14%**	15%	17%
Poor Physical Health Days	**4.1**	4.2	3.9
Poor Mental Health Days	**5.3**	4.9	5.1
Low Birthweight*	**5%**	7%	8%
Health Behaviors			
Adult Smoking	**11%**	12%	13%
Adult Obesity	**29%**	34%	34%
Limited Access to Healthy Foods	**5%**	8%	6%
Physical Inactivity	**17%**	21%	23%
Access to Exercise Opportunities	**70%**	77%	84%
Excessive Drinking	**20%**	18%	19%
Alcohol-Impaired Driving Deaths	**38%**	33%	26%
Drug Overdose Deaths*	**n/a**	18	31
Sexually Transmitted Infections*	**327**	308	495
Teen Births *(per 1,000 females ages 15-19)*	**5**	14	16
Clinical Care			
Uninsured	**8%**	11%	10%
Primary Care Physicians (MDs & DOs)	**1390:1**	1619:1	1,330:1
Other Primary Care Providers (APPs)	**1377:1**	688:1	710:1
Dentists	**2157:1**	1534:1	1,360:1
Mental Health Providers	**475:1**	371:1	300:1
Preventable Hospital Stays*	**1,151**	1,543	2,666
Mammography Screening	**48%**	42%	44%
Flu Vaccinations	**46%**	40%	48%
Social & Economic Factors			
High School Completion	**97%**	92%	89%
Some College	**79%**	67%	68%
Unemployment	**3%**	3%	3.6%
Children in Poverty	**9%**	11%	16%
Children in Single-Parent Households	**17%**	17%	25%
Injury Deaths*	**59.8**	81.9	84
Child Care Cost Burden *(% of HHI used for childcare)*	**36%**	21%	28%
Child Care Centers *(per 1,000 under age 5)*	**5**	6	7
Physical Environment			
Severe Housing Problems	**16%**	13%	17%
Long Commute - Driving Alone *(> 30 min. commute)*	**23%**	25%	37%
Severe Housing Cost Burden *(50% or more of HHI)*	**14%**	11%	15%
Broadband Access	**90%**	91%	90%

***Per 100,000 Population**

Key (Legend)
Better than ID Same as ID Worse than ID

Source: County Health Rankings 2025 Report

Data and Inputs

Data Limitations

Rural communities and those with low population sizes face several data limitations including but not limited to:

- Small sample sizes: small populations reduce the statistical power and do not capture the full diversity of the community
- Data privacy: to ensure the confidentiality of individuals in small communities, data may be aggregated or withheld
- Data gaps: some events may happen less frequently in small populations leading to limited data and gaps in time
- Resource constraints: rural areas often have less funding for data collection and access to data collection technologies
- Underrepresentation in national surveys: many national level data sources focus on urban areas due to the higher population making access to data in small communities more limited

This assessment is meant to capture the health status of the service area at a specific point in time, combining both qualitative data from the local community through survey collection and quantitative data from multiple sources where the county is available as the smallest unit of analysis.

Local Expert Groups

Survey Respondents self-identify themselves into any of the following representative classifications:

1) Public Health Official – Persons with special knowledge of or expertise in public health
2) Government Employee or Representative – Federal, tribal, regional, State, or local health or other departments or agencies, with current data or other information relevant to the health needs of the community served by the Hospital
3) Chronic Disease Groups – Representative of or member of Chronic Disease Group or Organization, including mental and oral health
4) Community Resident – Individuals, volunteers, civic leaders, medical personnel, and others to fulfill the spirit of broad input required by the federal regulations
5) Priority Population – Persons who identify as medically underserved, low-income, racial and ethnic minority, rural resident, or LGBTQ+
6) Healthcare Professional – Individuals who provide healthcare services or work in the healthcare field with an understanding / education on health services and needs.
7) Other (please specify)

Data Sources

Source	Data Element	Date Accessed	Data Date
County Health Rankings 2025 Report	Assessment of health needs of the county compared to all counties in the state; County demographic data	October 2025	2014-2023
NIH: HDPulse – CDC	Leading causes of death, median household income	October 2025	2019-2023
Idaho BRFSS (via the Idaho Department of Health & Welfare)	State level public health data dashboards	October 2025	2021-2023
PLACES: Local Data for Better Health	County level health, socioeconomic, and environmental data	October 2025	2024
CDC National Vital Statistics System	State drug overdose deaths	October 2025	2023
National Alliance on Mental Illness – NAMI	Statistics on mental health rates and services	October 2025	2022
NIH National Cancer Institute	State cancer profiles; incidence rates	October 2025	2017-2021
Centers for Medicare & Medicaid Services: Mapping Medicare Disparities by Population	Health outcome measures and disparities in chronic diseases	October 2025	2022
American Diabetes Association	Type 2 diabetes risk factors	October 2025	2005
Centers for Disease Control and Prevention – CDC	Racial and ethnic disparities in heart disease	October 2025	2019
Rural Health Information Hub – RHIhub	Barriers to Improving Rural Maternal Health	October 2025	2020
Healthy People 2030 – OASH	Social Determinants of Health	October 2025	n.d.
Center for Housing Policy	Impacts of affordable housing on health	October 2025	2015
Child Care Aware	Childcare costs	October 2025	2023
Health Affairs: Leigh, Du	Effects of low wages on health	October 2025	2022

Survey Results

Based on 901 survey responses gathered in September 2025.

Due to a high volume of survey responses, not all comments are provided in this report. All included comments are unedited and are contained in this report in the format they were received.

Q1: Your role in the community (select all that apply)

Answer Choices	Responses	
Community Resident	94.20%	845
Healthcare Professional	12.15%	109
Priority Population (medically underserved, low-income, racial and ethnic minority, rural resident, or LGBTQ+)	8.58%	77
Government Employee or Representative	4.01%	36
Representative of Chronic Disease Group or Advocacy Organization	1.67%	15
Public Health Official	0.11%	1
	Answered	897
	Skipped	4

Q2: Race/ethnicity (select all that apply)

Answer Choices	Responses	
White or Caucasian	95.24%	841
Hispanic or Latino	1.70%	15
American Indian or Alaska Native	1.59%	14
Asian or Asian American	1.47%	13
Black or African American	0.57%	5
Native Hawaiian or other Pacific Islander	0.11%	1
Other	2.04%	18
	Answered	883
	Skipped	18

Q3: Age group

Answer Choices	Responses	
18-24	2.90%	26
25-34	5.58%	50
35-44	12.39%	111
45-54	13.95%	125
55-64	20.54%	184
65+	44.64%	400
	Answered	896
	Skipped	5

Q4: What ZIP code do you primarily live in?

Answer Choices	Responses	
83843	74.3%	657
83855	5.3%	47
83871	5.1%	45
83823	3.8%	34
83872	2.1%	19
83537	1.4%	12
99163	1.4%	12
83857	1.1%	10
83501	1.0%	9
83535	0.8%	7
83806	0.7%	6
83832	0.6%	5
83834	0.5%	4
99161	0.3%	3
83844	0.3%	3
All Others (1 Response Each)	1.2%	11
	Answered	884
	Skipped	17

Q5: Which groups would you consider to have the greatest health needs (rates of illness, trouble accessing healthcare, etc.) in your community? (please select your top 3 responses if possible)

Answer Choices	Responses	
Low-income groups	64.47%	537
Uninsured and underinsured individuals	52.58%	438
Older adults (65+)	51.50%	429
Individuals requiring additional healthcare support	36.61%	305
Residents of rural areas	35.65%	297
Women	24.97%	208
Children/Adolescents	17.41%	145
Racial and ethnic minority groups	12.48%	104
LGBTQ+	12.00%	100
Men	6.24%	52
	Answered	833
	Skipped	68

What do you believe to be some of the specific needs of the groups selected above?

- General wellness and timely attention during episodes of illness.
- Overall access, appointment availability, travel time, ability to have consistent care for chronic illness
- Cost and appropriate health care professionals (including mental health)
- Affordable care
- Lack of health care insurance. Limited knowledge of how to access the healthcare system.
- The ability to pay for their health costs. Low income children have most their needs covered by the government but some women and older adults have less coverage than they need for their preventative health needs.
- Low income groups- Do they know the services available to them? And do they have transportation to the service
- Lack of transportation for those who live outside of the local area of the Hospital and specialty care.
- Professional support to improve diet and exercise for better health
- Women's health care is underserved nationally, however, in our local area, access to specialists for common and often debilitating conditions is dismal.
- Access to high-quality, affordable care

Q6: Please rate the importance of addressing each health factor on a scale of 1 (Not at all) to 5 (Extremely)

	1	2	3	4	5	Total	Weighted Average
Mental Health	1	20	62	169	480	732	4.51
Cancer	3	10	77	185	457	732	4.48
Women's Health	7	9	127	198	383	724	4.30
Heart Disease	2	10	130	235	355	732	4.27
Alzheimer's and Dementia	4	20	126	211	371	732	4.26
Children/Adolescent Health	8	27	149	181	361	726	4.18
Stroke	2	16	171	234	307	730	4.13
Diabetes	4	24	162	244	295	729	4.10
Obesity	5	37	169	226	291	728	4.05
Substance Use Disorder	10	44	155	225	291	725	4.02
Kidney Disease	3	31	211	224	258	727	3.97
Lung Disease	6	34	219	220	245	724	3.92
Liver Disease	5	34	237	216	236	728	3.88
Dental	11	53	205	212	247	728	3.87
Men's Health	8	38	233	213	230	722	3.86
Other (please specify)						52	
						Answered	741
						Skipped	160

Other:

- Autoimmune diseases/rheumatology
- Preventive Medicine and Education
- orthopedics, emergency
- Sexual Education
- Orthopedic care, Urology, Labor & Delivery
- Abortion Right to Choose
- Pain management
- Long Covid and chronic illness in general
- Disease prevention in general
- Individuals with disabilities, child and adult, cognitive and physical

Q7: Please rate the importance of addressing each community factor on a scale of 1 (Not at all) to 5 (Extremely)

	1	2	3	4	5	Total	Weighted Average
Healthcare: Affordability	1	5	58	136	539	739	4.63
Cost of Health Insurance	6	10	61	132	532	741	4.58
Healthcare: Access to Primary Care	4	16	84	187	449	740	4.43
Healthcare: Access to Specialty Care	4	8	90	229	411	742	4.39
Access to Mental Health and SUD Services	9	22	105	195	409	740	4.31
Affordable Housing	16	21	110	166	426	739	4.31
Access to Senior Services	6	13	113	233	376	741	4.30
Access to Affordable Healthy Food	18	31	112	201	381	743	4.21
Healthcare: Prevention Services	7	17	152	245	315	736	4.15
Healthcare: Location of Services	6	28	155	213	332	734	4.14
Access to Childcare	21	26	147	190	354	738	4.12
Access to Home Health	6	34	164	237	295	736	4.06
Employment and Income	13	23	174	238	287	735	4.04
Education System	21	37	156	202	318	734	4.03
Community Safety	16	55	183	209	272	735	3.91
Transportation	23	46	202	211	251	733	3.85
Access to Exercise/ Recreation	17	66	216	227	212	738	3.75
Social Connections	27	62	250	212	181	732	3.63
Other (please specify)						32	
						Answered	747
						Skipped	154

Other:

- Access to vaccines
- Prevention is less expensive that cure.
- There are amazing food banks available in our communities! But people may not realize it or be willing to or able to access them.
- Rural ambulances always available
- Lack of money is the cause of all these issues.
- Political advocacy. Housing insecurity.
- Transportation for homebound elderly

Q8: Please rate the importance of addressing each behavioral factor in your community on a scale of 1 (Not at all) to 5 (Extremely)

	1	2	3	4	5	Total	Weighted Average
Nutrition and Diet	7	30	184	255	266	742	4.00
Illegal Drug Use	13	50	183	211	279	736	3.94
Smoking/Vaping/Tobacco Use	12	52	194	188	289	735	3.94
Physical Inactivity	13	43	211	250	222	739	3.85
Alcohol Use/Excess Drinking	14	49	224	209	243	739	3.84
Risky Sexual Behavior	31	79	242	186	192	730	3.59
Other (please specify)						22	
						Answered	745
						Skipped	156

Other:

- Family Violence and Psychological Abuse. Violence Against Woman. Hate Crimes of all types.
- Racism, Online bullying, Domestic abuse
- Bullying/abuse
- Encourage health-information-addiciton
- My biggest worry on vaping isn't tobacco. It is illegal drugs and chemicals added to the tobacco
- Identifying the causes of these behaviors would go a log ways toward resolving them.
- Domestic violence, vaccination
- Good Sleep Habits

Q9: Please provide feedback on any actions you've seen taken by GMC to address the significant health needs in your community and what additional actions you would like to see.

- Getting into quick care is pretty easy and addresses the difficulty of getting a timely appointment with primary care doctor
- Grateful that our residents no longer have to travel outside community for dialysis and cancer treatment. Grateful we have visiting cardiologist and better skin clinic in community. Outstanding lab and diagnostics units.
- We need more affordable care, CHAS is wonderful but the income guidelines need to change.
- Collaboration and support of Latah Recovery Center and Crisis Center is important and should be continued. Timely access to healthcare continues to be a problem. Sometimes a person waits weeks for appointments.
- Oncology clinic great addition. (I am a cancer patient). Some system put in place to make primary care doctors more accessible.
- Gritman does an amazing job for a small hospital. Welcoming , informative and Community minded.
- Oncology services. Some substance abuse mental health services. Some behavioral health in clinics. Chronic disease: Our community could really use a good rheumatologist.
- I appreciate that GMC set up a financial aid package for me when the inferior insurance I had didn't cover ANYTHING. I am not aware of what classes and programs they may offer for prevention and disease management, perhaps they could advertise with local community pages or newsletters?
- We need more doctors! Actual, licensed physicians, not NPs, PAs, etc. We need more experts who can understand complex health issues and treat them.
- They have added behavioral health services which is great. Overall we need more providers in all areas to support our community. I know that this is a tough ask.
- They seemed to have more classes in Alcohol/Drug abuse, and more diagnosis of diabetes and cancer. I'm not sure on success rate though.
- Gritman has clinics in some of the outlying communities
- Faster emergency care.
- Increased access to specialty care (like a pulmonologist or more specialty physicians). Also more patient parking.
- The addition of social workers & psychologists to MFM clinic; Creating an opioid education program for local schools

Q10: What is your perception of Gritman Medical Center and its services?

Answer Choices	Responses	
Very Negative / Very Poor	5.23%	38
Negative / Poor	8.80%	64
Neutral / Fair	22.15%	161
Positive / Good	43.05%	313
Very Positive / Excellent	20.77%	151
Weighted Average	3.65	
	Answered	727
	Skipped	174

What is the reason for your response?

- Time between scheduling an appointment and the appointment date is far too long at Moscow Family Medicine.
- I've had nothing but good experiences in all of my visits to Gritman!
- Ive had good experiences, seen community outreach.
- Very visible and history of community trust.
- I personally have been treated with good care. My partner had a different experience. And I am sharing what I hear from friends.
- Evaluation would have been higher but there were no rooms available after emergency treatment. Personnel was excellent.
- I've been treated well every time I've been a patient.
- Friendly & helpful
- I have very few negative experiences so far.
- I have been in Gritman Emergency, ICU, and General Surgery and was cared for and treated very well by its employees
- We've had both good and poor care at Gritman over the past 21 years.
- I think billing issues taint a lot of my perception
- Not enough low cost care.
- Some good services but much more needed. No more van transport to appointments
- Community outreach is appreciative

Q11: How do you find out about updates related to Gritman Medical Center's services?

Answer Choices	Responses	
Doctor/Healthcare Provider	49.93%	352
Word of Mouth	46.38%	327
Family or Friends	38.58%	272
Gritman Medical Center Website	22.27%	157
Social Media (Facebook, Twitter, Instagram, etc.)	21.42%	151
Newspaper/Magazine (Print Publications)	18.01%	127
Onsite at Hospital or Clinic (flyers, signs, etc.)	17.45%	123
Newspaper/Magazine (Online Publications)	15.04%	106
Workplace	10.35%	73
Radio	7.38%	52
Television	2.55%	18
School/College	1.13%	8
Other (please specify)	12.06%	85
	Answered	705
	Skipped	196

Comments:

- Billboards
- Don't hear anything.
- I've seen info on new doctors but I can't remember where-maybe the newspaper?
- Announcements in the mail.
- Chamber of commerce.
- My Chart notices
- Since retirement, I hear very little except from friends who are still working.
- I search online
- The print info that GMC mails to my home periodically.
- I really don't hear about updates.
- GH media campaigns
- Gritman newsletters
- MyChart

Q12: Social drivers of health (SDoH) are conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes. Please select the key social drivers that negatively impact the health of you or your community (select all that apply):

Answer Choices	Responses	
Lack of affordable childcare	52.46%	341
Limited access to healthcare services	51.69%	336
Housing instability or inadequate housing	49.54%	322
Poverty	48.31%	314
Social isolation	37.08%	241
Unemployment or unstable employment	35.69%	232
Lack of transportation	29.85%	194
Limited access to healthy food	26.77%	174
Racial and cultural disparities	18.15%	118
Limited access to quality education	13.23%	86
Public safety concerns	9.85%	64
Limited access to utility services	7.85%	51
Other (please specify)	15.23%	99
	Answered	650
	Skipped	251

Comments:

- High housing costs
- Affordable senior housing
- Mental health
- Generational apathy
- No interest in healthy food
- Specialists are hard to get.
- Underemployment
- Limited access to quality psychiatric care
- Food insecurity
- Healthcare is too expensive and getting worse.

Q13: What barriers keep you or anyone in your household from receiving local healthcare services? (select all that apply)

Answer Choices	Responses	
Difficulty getting an appointment (long wait times)	56.70%	347
Limited availability of services or specialties	46.24%	283
High cost of services	41.83%	256
Unhappy with previous experience with providers or staff	25.65%	157
Billing issues or lack of clarity in billing statements	25.16%	154
Poor communication from providers or staff	16.83%	103
Perception of low-quality care	15.85%	97
Limited facility hours (inconvenient for working individuals)	14.22%	87
Underinsured/no insurance	13.24%	81
Out-of-network for insurance plans	12.25%	75
Not aware of the local healthcare services or programs	11.44%	70
Facilities are too far from home	5.56%	34
Language or cultural barriers	1.47%	9
Other (please specify)	11.76%	72
	Answered	612
	Skipped	289

Comments:

- Lack of availability or having to wait months to get in to see providers
- we currently have no issues accessing healthcare. Insurance referrals slow down the process of receiving care when you are ill.
- Inability to do many diagnostic tests
- referrals are not adequate or insurance not taken in town
- transportation availability
- appointment times are months out.. very long a wait
- Hard to make appointments over the phone
- Costs are too high. Many offices do not accept my insurance.
- Lack of options when choosing a provider
- Lack of specialty doctors
- Taking time off work

Q14: What additional services / offerings would you like to see available locally? (select all that apply)

Answer Choices	Responses	
Additional Primary Care Availability	46.03%	296
Mental Health Services	45.26%	291
Women's Health	33.75%	217
Cardiology	32.81%	211
Urgent Care / Walk-In / Extended Hours	32.04%	206
Cancer Care	29.39%	189
Rheumatology	26.59%	171
Endocrinology	26.44%	170
Audiology	24.11%	155
Gastroenterology	19.91%	128
Dermatology	19.60%	126
Neurology	19.60%	126
Health Prevention / Education Programs	19.44%	125
Substance Use Disorder Treatment	17.73%	114
Pulmonology	16.95%	109
Reproductive Health	16.95%	109
Telehealth / Virtual Care	16.80%	108
Bariatric	16.64%	107
Orthopedics	13.84%	89
Pediatrics	13.06%	84
Nephrology	12.60%	81
Ophthalmology	12.13%	78
Urology	11.04%	71
General Surgery	9.95%	64
Plastic Surgery	5.91%	38
Other (please specify)	12.75%	82
	Answered	643
	Skipped	258

Comments

- Radiology
- Orthotics
- Dental health too
- Podiatrist
- More variety of exercise options, need for expanded physical therapy
- Allergist specialty care