Providence Mount Carmel Hospital, Colville, WA and Providence St. Joseph Hospital, Chewelah, WA

2020-2022 Community Health Improvement Plan (CHIP)

To request a paper copy without charge or provide feedback about this Community Health Improvement Plan, email Sara Clements-Sampson, Community Health Investment Manager at Sara.Clements-Sampson@Providence.org

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OUR COMMITMENT TO COMMUNITY

Providence Mount Carmel Hospital and Providence St. Joseph Hospital dedicates resources to improve the health and quality of life for the communities it serves, with special emphasis on the needs of the economically poor and vulnerable. During 2018, our Spokane and Stevens County ministries provided more than $143.8 million in community benefit in response to unmet needs and improve the health and well-being of those we serve in Spokane and Stevens counties.

Our region includes: Providence Health Care is the eastern Washington region of Providence Health & Services. Our network of services includes Providence Sacred Heart Medical Center, Sacred Heart Children's Hospital and Providence Holy Family Hospital, nationally recognized for quality care. We also have two critical access hospitals, Providence Mount Carmel Hospital in Colville and Providence St. Joseph Hospital in Chewelah. A full continuum of services are provided through the Providence Medical Park in Spokane Valley (a comprehensive multi-specialty center), three urgent care centers, home health, assisted living, adult day health and skilled nursing care. Providence Medical Group of Eastern Washington includes more than 800 physicians and advanced practitioners, including primary care providers, surgical subspecialists and medical specialists.

PLANNING FOR THE UNINSURED AND UNDERINSURED

Financial Assistance Program (Free and Discounted Care)

Our aim is to provide quality care to all our patients, regardless of ability to pay. We believe that no one should delay seeking needed medical care because they lack health insurance. That is why Providence Mount Carmel Hospital and Providence St. Joseph Hospital has a **Patient Financial Assistance Program (FAP).** The Financial Assistance Policy can be found here: https://www.providence.org/obp/wa/financial-assistance that provides free or discounted services to eligible patients.

One way Providence Mount Carmel Hospital and Providence St. Joseph Hospital informs the public of FAP is by posting notices. Notices are posted in high volume inpatient and outpatient service areas. Notices are also posted at locations where a patient may pay their bill. Notices include contact information on how a patient can obtain more information on financial assistance as well as where to apply for assistance. These notices are posted in English and Spanish and any other languages that are representative of 5% or greater of patients in the hospital's service area. All patients who demonstrate lack of financial coverage by third party insurers are offered an opportunity to complete the Patient Financial Assistance application and are offered information, assistance, and referral as appropriate to government sponsored programs for which they may be eligible.

Medicaid Program

Providence Mount Carmel Hospital and Providence St. Joseph Hospital extend their commitment to provide critical access to preventive care and other services to the poor and vulnerable of the state of Washington by participating in the Medicaid program. Medicaid is a government health insurance program available to people with very limited income and resources. To learn more on how to apply

for Medicaid go to: https://www.providence.org/obp/wa/financial-assistance or https://www.dshs.wa.gov/altsa/home-and-community-services/medicaid

2019 COMMUNITY HEALTH IMPROVEMENT PLAN PRIORITIES

As a result of the findings of our 2019 Community Health Needs Assessment (CHNA) and through a prioritization process aligned with our Mission, resources and hospital strategic plan, Providence Mount Carmel Hospital and Providence St. Joseph Hospital will focus on the following areas for its 2020-2022 Community Benefit efforts:

- Support for youth and families
- Continuing care for the aging population
- Increase access to care

COMMUNITY NEEDS AND ASSETS ASSESSMENT PROCESS AND RESULTS

Summary of Community Needs, Assets, Assessment Process and Results

Providence Mount Carmel Hospital and Providence St. Joseph Hospital anticipate that implementation strategies may change and therefore, a flexible approach is best suited for the development of its response to the Providence Mount Carmel Hospital and Providence St. Joseph Hospital CHNA. For example, certain community health needs may become more pronounced and require changes to the initiatives identified by Providence Mount Carmel Hospital and Providence St. Joseph Hospital in the enclosed CHIP.

Identification and Selection of Significant Health Needs

The following community health needs were identified in the 2019 Tri County Health District Community Health Needs Assessment:

- ***Immunizations***
- ***Adult Substance Abuse***
- ***Youth Substance Abuse***

Community Health Needs Prioritized

- **Support for youth and families**
    1. Address the cycle of poverty for families with substance abuse and mental health treatment access
    2. Homelessness including habitable dwellings
    3. Proper nutrition for children and families
- **Continuing care of the aging population**
    1. Gap in rural home health care needs and isolation
    2. Homelessness including habitable dwellings
    3. Proper nutrition for the aging population to help with chronic diseases.
- **Access to care**
    1. Immunizations

2. Transportation
3. Health education
    - Medicaid
    - Diabetes
    - Nutrition
    - Substance abuse
    - Technology
    - Palliative care
    - Mental health

Needs Beyond the Hospital's Service Program

No hospital facility can address all of the health needs present in its community. We are committed to continue our Mission through the Community Benefits granting program.

Some of these areas may be out of our scope. However, we see the interconnectedness of health, housing, education, and income and this needs assessment process identified needs that we will be addressing. If we can improve the health of our workforce, they will be better employees. If we can address medical needs in housing situations, they may be able to live in their homes longer.

In addition, Providence Mount Carmel Hospital and Providence St. Joseph Hospital Chewelah will continue to collaborate with local organizations that address aforementioned community needs, to coordinate care and referral and address these unmet needs.

COMMUNITY HEALTH IMPROVEMENT PLAN

Summary of Community Health Improvement Planning Process

On May 16, 2019 a group of Providence employees gathered to review the Tri County Health District Community Health Needs Assessment and identify the key areas Providence should focus over the next three years. After reviewing the data from the community needs assessment, discussion was led to identify how Providence could best address these needs and if there were areas outside of these needs where we should lead the effort. After the discussion, votes were held on prioritization. Each participant was given three votes.

Prioritization was based on the following criteria:

- Input from the community
- Severity (i.e. impact at individual, family and community levels)
- Size/magnitude (i.e. number of people per 1,000, 10,000, 100,000)
- Disparities of subgroups
- Ability to impact

The following questions were used to further identify our role in these needs:

- Is there potential to make meaningful progress on the issue?
- Is there a meaningful role for the hospital on this issue?
- Where do we want to invest our time and resources over the next three years?

The following were the top areas we wanted to focus efforts within the community identified needs:

1. Support for youth and families

2. Continuing care for the aging population
3. Access to care
    a. Immunizations
    b. Transportation
    c. Health education
        - Medicaid
        - Diabetes
        - Nutrition
        - Substance abuse
        - Technology
        - Palliative care
        - Mental health

Addressing the Needs of the Community:
2020-2022 Key Community Benefit Initiatives and Evaluation Plan

1. Initiative/Community Need being Addressed: Support for youth and families
Goal (anticipated impact): Decrease depression in youth and adults
Target Population: General population of Stevens County

Outcome Measure	Baseline	FY20 Target	FY22 Target
Increase childhood immunizations to promote physical health leading to less stress factors	47.8% YTD through May 2019	62.35%	72.18%
Opioid addiction treatment to decrease substance abuse factors on the family	80%	TBD	TBD

Strategy(ies)	Strategy Measure	Baseline	FY20 Target	FY22 Target
1.Northport School District Para-Counselor	Decrease discipline referrals	25% decrease in discipline referrals from previous year.	5% decrease	TBD
2. New Alliance Evaluation & Treatment Center Support to increase restraint and seclusion space	Average daily census	80%	TBD	TBD
3. Train Medical Assistants to provide support/resources	Number of new patients entering into program	333	25 New Inductions per month for 12 months	25 New Inductions per month for 6 months

opioid addiction hub				
4.Childhood immunizations through Colville School District partnership	Colville School District will be holding Immunization Clinics and Clinics will have standing orders for childhood immunizations.	47.8% YTD through May 2019	62.35%	72.18%

Key Community Partners: Rural Resources, Colville School District, New Alliance, Tri County Health District, Ferry County Hospital, Stevens County Prosecutors Office, Lake Roosevelt Health and Services Inchelium and Keller Clinics.

Resource Commitment: Community Benefit donations will utilize an application process with special attention paid to those addressing an identified need.

2. Initiative/Community Need being Addressed: Continuing care for the aging population

Goal (anticipated impact): Increase resources and ability to live safely in home
Target Population: Those sixty-five and older living in poverty in Stevens County

Outcome Measure	Baseline	FY20 Target	FY22 Target
Decrease share of adults reporting poor mental health through nutrition and safe homes.	15%	TBD	TBD

Strategy(ies)	Strategy Measure	Baseline	FY20 Target	FY22 Target
1.Hunger Coalition	Nutritional daily servings delivered to each food pantry and school	15,862 lbs.	TBD	TBD
2.Recognition for home health shortage area to expand home health clinic services through Providence Rural Health Clinics.	Capacity to make timely responses to referrals for service.	3.5% users out of FFS Beneficiaries	TBD	TBD

Evidence Based Sources: Creating Health Care and Community Partnerships to Tackle Food Insecurity Public Health Institute (January 2017) policy brief.
Making Food Systems Part of Your Community Health Needs Assessment (July 2016). CDC Foundation, Public Health Institute and Nutrition and Obesity Network.
Focus on Food Security: Bringing Food Justice to Washington (2018). Northwest Harvest's Focus Group Report.

Key Community Partners: Buena Vista Healthcare, Assisted Living, Prestige Care & rehabilitation – Pinewood Terrace, Parkview Senior Living, Fulcrum Institute DRC, Hunger Coalition and partner food banks, Tri-County Economic Development District.

Resource Commitment: Community Benefit donations will utilize an application process with special attention paid to those addressing an identified need.

3. Initiative/Community Need being Addressed: Access to care

Goal (anticipated impact): Increase access to referral sources with emphasis on health education and transportation for medically fragile.
Target Population: Broader community living in Stevens County

Outcome Measure	Baseline	FY20 Target	FY22 Target
Increase health education options through various mediums	Develop in 2019 based on current offerings.	TBD	TBD

Strategy(ies)	Strategy Measure	Baseline	FY20 Target	FY21 Target
1.Stevens County Sheriffs Ambulance scholarships for EMT education	EMT Test taken and passed	54%	73%	91%

Key Community Partners: Stevens County Sheriff Ambulance, Colville, Kettle Falls, Marcus and Northport and backup EMS for Chewelah Rural Ambulance.

Resource Commitment: Community Benefit donations will utilize an application process with special attention paid to those addressing an identified need.

Other Community Benefit Programs

Initiative/Community Need Being Addressed:	Program Name	Description	Target Population (Low Income or Broader Community)
1. Basic foods/nutrition	Hunger Coalition	Coordination between rural food banks	Low Income
2. Basic foods/nutrition	Tri County Economic Development District (TEDD)	Gleaning program from local farms directly to local food banks	Low income
3. Access to care	Stevens County Sheriff's Ambulance	Ambulance for rural area	Broader community, but useful for low income without access to services
4. Access to care	Stevens County Sheriff's Ambulance	Scholarships for EMT education and testing	Broader community, but useful for low income without access to services
5. Early childhood support	Reach Out and Read	Provide books to children during well child appointments	Broader community, but useful for low income without access to services
6. Early childhood support	Colville Rotary and Stevens County Libraries	Imagination library with books mailed each month.	Broader community, but useful for low income without access to services
7. Behavioral health	New Alliance Evaluation and Treatment	Provide space for the Evaluation and Treatment Center	Broader community, but also outreach to low income without access to behavioral services
8. Behavioral health	Northport School District	Pilot program that focuses on meeting basic needs and mental health needs for children.	Broader community, but useful for low income without access to services

2020 CHIP GOVERNANCE APPROVAL

This community health improvement plan was adopted on September 25, 2019 by the Community Ministry Board of Providence Health Care. The final report was made widely available[1] on December 12, 2019.

9/25/19

Elaine Couture
Executive VP/Region Chief Executive,
Washington/Montana
PHC Chief Executive

Date

9/25/19

Mary Selecky
Chair
Providence Health Care Community Ministry Board

Date

12/09/2019

Joel Gilbertson
Senior Vice President, Community Partnerships
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Request a paper copy without charge, provide comments or view electronic copies of current and previous community health needs assessments and community health improvement plans:

https://www.psjhealth.org/community-benefit/community-health-needs-assessments

[1] Per § 1.501(r)-3 IRS Requirements, the CHNA and CHIP posted on hospital website and is available without cost.

Definition of Terms

Community Benefit: An initiative, program or activity that provides treatment or promotes health and healing as a response to identified community needs and meets at least one of the following community benefit objectives:

a. Improves access to health services;
b. Enhances public health;
c. Advances increased general knowledge; and/or
d. Relieves government burden to improve health.

Community benefit includes both services to the poor and broader community.

To be reported as a community benefit initiative or program, community need must be demonstrated. Community need can be demonstrated through the following:

a. Community health needs assessment developed by the ministry or in partnership with other community organizations;
b. Documentation that demonstrates community need and/or a request from a public agency or community group was the basis for initiating or continuing the activity or program; or
c. The involvement of unrelated, collaborative tax-exempt or government organizations as partners in the community benefit initiative or program.

Health Equity: Healthy People 2020 defines *health equity* as the "attainment of the highest level of health for all people. Achieving health equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and health care disparities."

Social Determinants of Health: Powerful, complex relationships exist between health and biology, genetics, and individual behavior, and between health and health services, socioeconomic status, the physical environment, discrimination, racism, literacy levels, and legislative policies. These factors, which influence an individual's or population's health, are known as *determinants of health*. *Social determinants of health* are conditions in the environment 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 and risks.

Initiative: An initiative is an umbrella category under which a ministry organizes its key priority efforts. Each effort should be entered as a program in CBISA Online (Lyon Software). Please be sure to report on all your Key Community Benefit initiatives. If a ministry reports at the initiative level, the goal (anticipated impact), outcome measure, strategy and strategy measure are reported at the initiative level. Be sure to list all the programs that are under the initiative. Note: All Community Benefit initiatives must submit financial and programmatic data in CBISA Online.

Program: A program is defined as a program or service provided to benefit the community (in alignment with guidelines) and entered in CBISA Online (Lyon Software). Please be sure to report on all community benefit programs. Note: All community benefit programs, defined as "programs", are required to include financial and programmatic data into CBISA Online.

Goal (Anticipated Impact): The goal is the desired ultimate result for the initiative's or program's efforts. This result may take years to achieve and may require other interventions as well as this program. (E.g. increase immunization rates; reduce obesity prevalence.).

Scope (Target Population): Definition of group being addressed in this initiative: specific description of group or population included (or not included, if relevant) for whom outcomes will be measured and work is focused. Identify if this initiative is primarily for persons living in poverty or primarily for the broader community.

Outcome measure: An outcome measure is a quantitative statement of the goal and should answer the following question: "How will you know if you're making progress on goal?" It should be quantitative, objective, meaningful, and not yet a "target" level.