2026-2028

COMMUNITY HEALTH IMPROVEMENT PLAN

Providence Mount Carmel Hospital

Colville, WA

Providence St. Joseph's Hospital

Chewelah, WA

To provide feedback about this CHIP or obtain a free printed copy, please email Christina Kamkosi Chery at christina.kamkosi@providence.org

Providence

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EXECUTIVE SUMMARY

Providence continues its Mission of service in Stevens County through Providence Mount Carmel and Providence St. Joseph's Hospitals. The following Community Health Improvement Plan (CHIP) outlines our strategic response to addressing the prioritized needs from the 2025 Community Health Needs Assessment (CHNA).

This is a joint Community Health Improvement Plan, including Providence Mount Carmel and Providence St. Joseph's Hospitals in response to a joint 2025 CHNA. The strategies included in this plan are representative of efforts taken by [both/all] hospitals to address the identified community needs.

Providence Mount Carmel and Providence St. Joseph's Hospitals dedicate resources to improve the health and quality of life for the communities it serves, with special emphasis on the needs of people experiencing social inequities and health disparities. The Community Health Needs Assessment (CHNA) is an opportunity for Providence Mount Carmel and Providence St. Joseph's Hospitals to engage the community every three years with the goal of better understanding community strengths and needs.

Through a mixed-methods approach, using quantitative and qualitative data, we collected information from the following sources: American Community Survey, Behavioral Risk Factor Surveillance System, Environmental Justice Index, local public health data regarding health behaviors; morbidity and mortality; and hospital-level data. To actively engage the community, we conducted three listening sessions with people who have chronic conditions, are from diverse communities, have low-incomes, and are medically underserved. We also conducted 11 key informant interviews with representatives from organizations that serve these populations, specifically seeking to gain deeper understanding of community strengths and opportunities.

Our commitment to improving the health of our community extends beyond patient care. Through community health improvement and strategic partnerships, health professions education and research, free, discounted and subsidized care, and other means of outreach, we commit to caring for those we serve through high-impact community benefit programs and investments.

Providence Mount Carmel Hospital and Providence St. Joseph's Hospital Community Health Improvement Plan Priorities

As a result of the findings of our 2025 CHNA and through a prioritization process aligned with our Mission, resources, and hospital strategic plan, Providence Mount Carmel and Providence St. Joseph's Hospitals will focus on the following areas for its 2026-2028 Community Benefit efforts:

ACCESS TO HEALTH CARE SERVICES

Challenges in accessing healthcare including dental care and chronic conditions, particularly in rural areas. These challenges include geographic and economic barriers, long travel times to reach providers, limited appointment availability, and significant wait times for services. A common concern was that residents often do not know what services are available to them, even with efforts like health fairs.

BEHAVIORAL HEALTH CHALLENGES

The deep interconnection between homelessness, substance use/misuse, and mental health, identifying them as mutually reinforcing issues that contribute to ongoing instability for many individuals in the community. Fragmented care was seen as a barrier to effective recovery, particularly when people are forced to navigate separate systems for help.

SOCIAL DETERMINANTS OF HEALTH

Needs in this category included homelessness and housing stability, food security and transportation.

Homelessness and housing stability: challenges related to housing affordability and homelessness, which intersect with health and social services.

Food security: a result of interconnected economic, structural, and social challenges.

Transportation: significant barrier affecting access to essential services and resources within the community.

INTRODUCTION

Who We Are

Our Mission	As expressions of God's healing love, witnessed through the ministry of Jesus, we are steadfast in serving all, especially those who are poor and vulnerable.
Our Vision	Health for a Better World.
Our Values	Compassion — Dignity — Justice — Excellence — Integrity

Providence Mount Carmel, a 25-bed Critical Access Hospital, was founded in 1919 to meet the health care needs of the small community of Colville. More than a century later, Providence Mount Carmel serves a three-county area, offering services including 24-hour emergency care, surgery, and labor and delivery.

Providence St. Joseph's Hospital was founded by the Dominican Sisters in 1929 to meet the health care needs of the small community of Chewelah and surrounding communities of Stevens County. Services include 24-hour emergency care, acute care/skilled care services, radiology and imaging, rehabilitation, and outpatient day surgery.

Providence Inland Northwest Washington (INWA) in Stevens County includes Providence Northeastern Washington Medical Group, Providence Mount Carmel and Providence St. Joseph's Hospitals. INWA served the tri-county area of Stevens, Ferry, and Pend Oreille Counties. Clinics include locations in Colville, Chewelah, and Kettle Falls.

Our Commitment to Community

Providence Mount Carmel and Providence St. Joseph's Hospitals dedicate resources to improve the health and quality of life for the communities and people we serve. For more information, refer to the Annual Report to our Communities and Community Health Needs Assessments/Community Health Improvement Plans.

Joint CHIP Report

This is a "joint CHIP report," within the meaning of Treas. Reg. § 1.501(r)-3(b)(6)(v), by and for Providence including Providence Mount Carmel and Providence St. Joseph's Hospitals. These hospitals completed a joint 2025 CHNA report. A joint approach to addressing the needs identified in the joint CHNA will be most effective given that the hospitals share a CHNA service area and community served, staffing, leadership teams, and resources. The strategies included in this plan are representative of efforts taken by both hospitals to address the identified community needs. The hospitals have a shared governance structure and share the Providence INWA Community Mission Board that adopts the CHIP for both hospitals.

Equity Practices in the CHIP

At Providence, we are committed to addressing the underlying and root causes of inequities and health disparities. We work to address not only the clinical factors that determine a person's length and quality of life, but also the social and economic dimensions, physical environment, and other factors that play a role in determining health outcomes. Addressing these factors includes leveraging community strengths and utilizing evidence-based and leading practices.

We recognize that long-standing inequities and systemic injustices exist and that they can lead to health disparities. To promote health equity, we routinely evaluate health disparities in the communities we serve and use qualitative and quantitative data to inform how we enhance access to high-quality, evidence-based and equitable care. The purpose of the CHIP is to respond to the needs we hear from our communities. The CHIP strategies are designed to meet the highest level of need, based on the CHNA data, which is ultimately in service to all our community members.

Financial Assistance Program

Our mission is to improve the health and well-being of each person we serve, regardless of ability to pay. We believe no one should delay seeking needed medical care because they lack health insurance. Providence has a Financial Assistance Program (FAP) that provides free or discounted services to eligible patients.

COMMUNITY HEALTH NEEDS ASSESSMENT PROCESS AND RESULTS

Our Community and the Community Health Needs Assessment Process and Results

Providence Mount Carmel and Providence St. Joseph's Hospitals conducted a 2025 Community Health Needs Assessment (CHNA). The CHNA service area is the entirety of Stevens County.

The CHNA is an opportunity for Providence hospitals to engage the community every three years with the goal of better understanding strengths and needs. Through a mixed-methods approach, using quantitative and qualitative data, the CHNA process relies on several sources of information: state and national public health data, qualitative data from key informant interviews and community listening sessions, hospital utilization data, and more. An oversight committee reviews all the data from the CHNA and identifies priority needs to address in the 2026-2028 Community Health Improvement Plan (CHIP).

More information on the CHNA process and findings can be found in the 2025 Providence Mount Carmel Hospital and Providence St. Joseph's Hospital CHNA.

Significant Community Health Needs Prioritized

Providence Mount Carmel and Providence St. Joseph's Hospitals will focus on the following priority areas identified in the 2025 CHNA to best leverage their capacity, expertise, and resources for greatest impact:

ACCESS TO HEALTH CARE SERVICES

Challenges in accessing healthcare including dental care and chronic conditions, particularly in rural areas. These challenges include geographic and economic barriers, long travel times to reach providers, limited appointment availability, and significant wait times for services. A common concern was that residents often do not know what services are available to them, even with efforts like health fairs.

BEHAVIORAL HEALTH CHALLENGES AND ACCESS (MENTAL HEALTH AND SUBSTANCE USE/MISUSE)

The deep interconnection between homelessness, substance use/misuse, and mental health, identifying them as mutually reinforcing issues that contribute to ongoing instability for many individuals in the community. Fragmented care was seen as a barrier to effective recovery, particularly when people are forced to navigate separate systems for help.

Needs Beyond the Hospital's Service Program

Providence is committed to improving the health of the communities we serve and investing in spaces where we can have the greatest impact. By leveraging our expertise and core competencies as health

care providers, we can meaningfully contribute to high-impact solutions for expanded access to high-quality, equitable health care.

The following community health needs identified in the 2025 CHNA will not be directly addressed by the hospitals and an explanation is provided below:

- Social determinant of health:
    - Homelessness and housing instability: challenges related to housing affordability and homelessness, which intersect with health and social services.
    - Food security: a result of interconnected economic, structural, and social challenges.
    - Transportation: significant barrier affecting access to essential services and resources within the community.
- Care and support for older adults
- Childcare providers and school programs
- Communication and advocacy
- Community gathering and recreational spaces
- Economic security
- Safety

The hospitals will not directly add the needs above due to resource constraints and other facilities or organizations in the community are addressing them.

In addition, Providence Mount Carmel and Providence St. Joseph's Hospitals will collaborate with local organizations that address the aforementioned community needs to coordinate care and referrals to address these unmet needs.

COMMUNITY HEALTH IMPROVEMENT PLAN

Summary of Community Health Improvement Planning Process

The 2025 Stevens County CHNA completed for Providence Mount Carmel and Providence St. Joseph's Hospitals was the basis for the 2026-2028 CHIP. The assessment identified community needs, assets, resources, and strategies to improve health for Stevens County residents.

The Tri County Advisory Committee evaluated the needs and supporting data identified in the 2025 CHNA and selected areas of focus for Providence Mount Carmel and Providence St. Joseph's Hospitals: access to health care services, behavioral health challenges and access (mental health and substance use/misuse) and social determinants of health (homelessness and housing instability, food security and transportation). Prioritizing these needs allows the hospitals to focus on leveraging their strengths, expertise, and resources for greatest impact.

A multi-disciplinary team spanning Mission, Community Health, Business Development, Administrative/Executive leadership, Behavioral Health, Clinical Operations and Physicians was convened in October 2025 as part of the 2026-2028 CHIP Committee to identify strategies, programs, and initiatives that respond to the prioritized needs. Individuals on the committee bring their deep knowledge of the prioritized needs, clinical and community based best practices, and Stevens County communities.

Through a series of dialogue and feedback sessions with members of the committee and other internal subject matter experts, a set of core CHIP strategies were presented to the Tri County Advisory Committee, senior leaders, and the Providence INWA Community Mission Board for additional review, feedback, and alignment.

On October 16, 2025, the Providence INWA Community Mission Board adopted the 2026-2028 CHIP, including the following strategies for addressing the priority community needs.

Addressing the Needs of the Community: 2026- 2028 Key Community Benefit Initiatives and Evaluation Plan

The following strategies for addressing priority needs consider how communities change over time, as well as their existing strengths and capacity. They were intentionally selected with the understanding that some community health needs may evolve during the duration of the CHIP, and that subsequent implementation strategies may require adjustment based on resources and to best meet the needs of our communities. While our response to community need must remain flexible to changing dynamics, our commitment to improving the health of our communities is unwavering.

COMMUNITY NEED ADDRESSED #1: ACCESS TO HEALTH CARE SERVICES

Population Served

People in need of timely, affordable and culturally responsive care, including primary and specialty care; people with limited access to care due to age, disability, or lack of culturally responsive care options.

In line with our mission, we are focused on underserved populations, including those with low incomes, uninsured, and underinsured.

Long-Term Goal(s)/ Vision

To improve access to health care and preventive resources for people with low incomes and those uninsured by deploying programs to assist with navigating the health care system.

To ease the way for people to access the appropriate level of care at the right time.

Table 1. Strategies and Measures for Addressing Access to Health Care Services

Identified need: Access to Health Care Services				
Strategy	**Population Served**	**Strategy Measure (s)**	**Baseline**	**2028 Target**
Streamlining the referral process to specialty care, including dental care, through hiring of a care navigator and use of findhelp.org in the primary care setting	Individuals with barriers to accessing specialty care	Hire care navigator Use findhelp.org for referrals	No care navigator	Care Navigator hired
Access to suitable foods for patients with chronic conditions, including diabetes through clinic-based food pantry and the Fruit & Veggie Program	People with low-incomes with diabetes	# of people served by the clinic-based food pantry # of households served by the Fruit & Veggie Program	24 households for Fruit & Veggie Program	Serve 5 – 10 people through the clinic-based food pantry and maintain baseline
Improving rates of controlled blood pressure for people with hypertension through increased access nurse visits in primary care setting	People with hypertension	# of visits with Nurse Care Manager in primary care setting for regular follow-ups to support blood pressure control	80 visits	100 visits a month

Retain medical students within the Rural Training Track Provider Retention Program	Broader community	# of medical students participating in Retention program	Two medical students	Retain one medical student within the program for a permanent position over three years

Community and Research Informed Resources

Health Care Access and Quality — Evidence-Based Resources - Healthy People 2030 | odphp.health.gov

Federally qualified health centers (FQHCs) | County Health Rankings & Roadmaps

Chronic disease management programs | County Health Rankings & Roadmaps

Cultural competence training for health care professionals | County Health Rankings & Roadmaps

Health insurance enrollment outreach & support | County Health Rankings & Roadmaps

Ensuring Access in Vulnerable Communities - Taskforce Report and Resources | AHA

Telemedicine | County Health Rankings & Roadmaps

Community health workers | County Health Rankings & Roadmaps

Resource Commitment

Providence Mount Carmel and Providence St. Joseph's hospitals will continue to provide critical health services including primary and specialty care services, commit staff time, supplies, equipment, cash and in-kind donations to support these strategies.

Key Community Partners

Providence Mount Carmel and Providence St. Joseph's hospitals works with many community partners across Stevens County to help address needs for those who are underserved. Examples of the partners we work with as part of our commitment to addressing access to health care services include:

NEW Health – NEW Health

David C Wynecoop Memorial Clinic Dhhs Ihs Wellpinit Service Unit in Wellpinit, WA - Medicare Clinic/Center

Sheriff's Ambulance - Stevens County WA

COMMUNITY NEED ADDRESSED #2: BEHAVIORAL HEALTH CHALLENGES AND ACCESS (MENTAL HEALTH AND SUBSTANCE USE/MISUSE)

Population Served

People in need of mental health care, people experiencing behavioral health crisis, people with limited access to behavioral care due to age, disability, or lack of culturally responsive care options.

In line with our mission, we are focused on underserved populations, including those with low incomes, uninsured, and underinsured.

Long-Term Goal(s)/ Vision

To reduce substance use disorders and related health conditions through evidence-based prevention, treatment, and recovery support services.

Table 2. Strategies and Measures for Addressing Behavioral Health Challenges and Access (Mental Health and Substance Use/Misuse)

Identified need: Behavioral Health Challenges and Access (Mental Health and Substance Use/Misuse)				
Strategy	**Population Served**	**Strategy Measure(s)**	**Baseline**	**2028 Target**
Increase access to Medication for Opioid Use Disorder (MOUD) program through Hub and Spoke Model of referrals	People seeking treatment for substance use/misuse disorders	# of referrals per month to the MOUD program	5 referrals a month	Maintain baseline
Partner with NEW Alliance Behavioral Health to perform crisis evaluations to increase utilization of crisis stabilization support	People with severe and persistent mental illness in crisis	Rate of utilization at the Stabilization Facility	Utilization at 2.5 beds	Increase utilization by 10% yearly
Improve community awareness and engagement with available mental health services through educational initiatives and positive media campaigns	Broader community	# of public inquiries received through findhelp.org # of Providence Communications regarding mental health services	N/A	Increase public inquiry through findhelp.org and one written article by Providence communications

Maintain active participation in the Suicide Overdose Fatality Review Board and increasing the utilization of the 988-crisis line	Broader community	# of people from Providence on the Board Utilization rates of the 988-crisis line	Two people on the Board Under 1%	Maintain baseline Increase current rate to 5% yearly
Increase tele psych visits to connect people with severe and persistent mental illness to telepsychiatry services.	People with severe and persistent mental illness	# of telehealth visits	5 visits a week	7 visits a week

Community and Research Informed Resources

Medication-assisted treatment access enhancement initiatives | County Health Rankings & Roadmaps

Behavioral health primary care integration | County Health Rankings & Roadmaps

Telemental health services | County Health Rankings & Roadmaps

Community health workers | County Health Rankings & Roadmaps

Part 2, Chapter 2 - Behavioral Health Services for American Indians and Alaska Natives - NCBI Bookshelf

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Key Community Partners

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About — Bridges of Hope Men's Recovery Center

Behavioral Health – NEW Health

NEWABH - Stevens County WA

David C Wynecoop Memorial Clinic Dhhs Ihs Wellpinit Service Unit in Wellpinit, WA - Medicare Clinic/Center

Other Community Benefit Programs

Table 3. Other Community Benefit Programs in Response to Community Needs

Initiative (Community Need Addressed)	Program Name	Description	Population Served (Low Income, Vulnerable or Broader Community)
1. Access to Health Care Services	Wound Care	Outpatient wound treatment	Low Income, Vulnerable
2. Access to Health Care Services	Family Maternity	Comprehensive pregnancy and birthing services	Low Income, Vulnerable
3. Access to Health Care Services	Physical Therapy	Treatment services to improve mobility and range of motion	Low Income, Vulnerable
4. Behavioral Health Challenges and Access (Mental Health and Substance Use/Misuse)	Medication Assisted Treatment	Recovery housing program in Colville	Low Income, Vulnerable and Broader Community
5. Behavioral Health Challenges and Access (Mental Health and Substance Use/Misuse)	Bridges of Hope Men's Recovery House	Integration of medications with counseling and behavioral therapies to address substance use disorders	Low Income, Vulnerable

2026- 2028 CHIP GOVERNANCE APPROVAL

This Community Health Improvement Plan was adopted by the INWA Community Mission Board of the hospital on October 16, 2025. The final report was made widely available by May 15, 2026.

10/31/25

Susan Stacey **Date**
Chief Executive, Providence Inland ~~Northwest~~ Washington

11/3/25

Mary Koithan **Date**
Chair, Providence INWA Community Mission Board

11/18/25

Scott O'Brien **Date**
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