

2026-  
2028

# COMMUNITY HEALTH IMPROVEMENT PLAN



## Providence Kodiak Island Medical Center

Kodiak, AK



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# EXECUTIVE SUMMARY

Providence continues its Mission of service in Alaska through Providence Kodiak Island Medical Center (PKIMC). The following Community Health Improvement Plan (CHIP) outlines our strategic response to addressing the prioritized needs from the [2025 Community Health Needs Assessment](#) (CHNA).

PKIMC dedicates resources to improve health and increase equitable access to quality care in Kodiak. The CHNA is an opportunity for the hospital to engage the community every three years with the goal of better understanding community strengths and needs.

The results of the CHNA are used to guide and inform efforts to better address the needs of the community. 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 Kodiak Island 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, PKIMC will focus on the following areas for its 2026-2028 Community Benefit efforts:

- Basic needs/economic security
- Mental health
- Substance use/misuse
- Access to healthcare

# INTRODUCTION

## Who We Are

<b>Our Mission</b>	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.
<b>Our Vision</b>	Health for a Better World.
<b>Our Values</b>	Compassion — Dignity — Justice — Excellence — Integrity

Providence took over management of the Kodiak Island Medical Center in 1997, which is now referred to as the Providence Kodiak Island Medical Center. It is a critical access hospital that features 25 acute care beds, including four birthing suites, two psychiatric care beds and two ICU beds. In addition, [Chiniak Bay Elder House](#), PKIMC’s extended care facility, has 22 long-term care beds.

PKIMC provides an extensive array of inpatient and outpatient services, including emergency department, surgery, laboratory services, maternity, general medicine, physical therapy, occupational therapy, respiratory therapy, sleep studies, specialty clinics, diagnostic imaging services, telehealth diabetes education, and pharmacy. The PKIMC Outpatient Specialty Clinic provides additional support services including pediatrics, urology, allergy, dermatology, podiatry, [psychiatry](#), gynecology, audiology and ear, nose and throat specialists. PKIMC is staffed by a mix of primary care physicians, surgeons and specialists who provide family and general practice, internal medicine, obstetric, and radiology services.

## Our Commitment to Community

PKIMC dedicates 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](#).

## Equity Practices in the CHIP

At Providence, we are committed to addressing the underlying and root causes of health disparities and inequities in the communities we serve. 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, leading practices.

Through literature and our community partners, we recognize that long-standing systemic inequities exist and that they can lead to health disparities. 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 care. The purpose of the CHIP is to respond to and address the needs identified by our communities. The CHIP strategies are based on the CHNA data to meet the highest level of need, 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 Kodiak Island Medical Center (PKIMC) conducted a 2025 Community Health Needs Assessment (CHNA) for its service area, which is defined as the entirety of the Island of Kodiak.

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, a community survey, 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 PKIMC CHNA](#).

## Significant Community Health Needs Prioritized

PKIMC will focus on the following priority areas identified in the 2025 CHNA to best leverage their capacity, expertise, and resources for greatest impact:

### BASIC NEEDS / ECONOMIC SECURITY

There is substantial and increasing evidence that socioeconomic factors are just as important to an individual's health as genetics or certain health behaviors. Financial security is chief amongst the factors that impact an individual's health, wellbeing, and longevity. Individuals and families that lack economic security experience an increased risk of food insecurity, homelessness, and inability to meet other basic needs. Approximately 1 in 6 Kodiak residents indicated they are without a stable job or need help getting a better job. 1 in 13 live below the Federal Poverty Level, and 1 in 4 struggle with food insecurity. The lack of availability and high cost of childcare was identified as a barrier for many, affecting both the workforce and the community as a whole. Affordability and availability of housing are top concerns, as roughly 10% of residents indicated they are living without stable housing, are currently homeless, or are worried about losing housing.

### MENTAL HEALTH

Mental health is foundational to quality of life, physical health, and the health of the community, and affects emotional, psychological, and social wellbeing. The community conditions that support resilience and social connection, along with timely access to behavioral health care and services, are fundamental to healthy individuals and a healthy community. The community is experiencing challenges with timely access to needed mental health services. 25% of residents reported needing these services in the last 12 months; lack of affordable housing and childcare availability contribute to mental health workforce

shortages. Suicidal ideation and thoughts of self-harm are concerns in the community, as is social isolation.

## SUBSTANCE USE/MISUSE

Misuse of alcohol and other substances has significant health and social impacts both for individuals and the community. Substance misuse and mental health disorders such as depression and anxiety are closely linked. Alcohol and drugs are often used to self-medicate the symptoms of unaddressed mental health issues. The challenges of substance use disorders (SUD) have compounding physical, mental, and economic impacts on individuals, families, and the greater community. The social and economic environment, along with cultural beliefs and social stigma, are factors influencing the incidence of SUD in the community, as well as issues related to access to treatment. 29% of Kodiak residents reported engaging in binge drinking in the last 30 days, and nearly 67% of avoidable emergency department visits at Providence Kodiak Island Medical Center are attributed to substance use disorders. Recruitment and retention of trained and certified SUD professionals is a significant challenge due to provider shortages as well as other economic issues such as availability of affordable housing and childcare for workers

## ACCESS TO HEALTHCARE

Appropriate access to preventive and acute care has significant impact on individuals' ability to maintain good health. Appropriate healthcare access means receiving the right care at the right time and in the right place or setting – the timely use of personal health services to achieve the best outcomes. 20.1% of Kodiak residents under age 65 lack comprehensive health insurance, affecting their ability to access needed care. Of residents who reported that they needed dental care in the past 12 months, roughly 1 in 6 indicated they were unable to get the dental care they needed, citing inability to pay, lack of insurance/insurance not covering, and lengthy wait times as the primary causes. Of residents who reported they needed health care in the past 12 months, almost 1 in 6 indicated they were unable to get the care they needed, with more than 2 out of 3 citing lack of available appointments and wait time to appointment as the cause. Nearly half who were unable to get necessary care indicated they needed a specialist not available in Kodiak. Just as with mental health and SUD workforce, recruitment and retention of healthcare professionals is a significant challenge for Kodiak healthcare providers due to provider shortages as well as other economic issues such as availability of affordable housing and childcare for workers.

# COMMUNITY HEALTH IMPROVEMENT PLAN

## Summary of Community Health Improvement Planning Process

The 2025 CHNA completed for PKIMC was the basis for the 2026-2028 CHIP. The assessment identified community needs, assets, resources, and strategies to improve health for Kodiak Island residents.

The CHNA Advisory Council evaluated the needs and supporting data identified in the 2025 CHNA and selected areas of focus for PKIMC: basic needs/economic security, mental health, substance use/misuse, and access to healthcare. Prioritizing these needs allows the hospital to focus on leveraging its strengths, expertise, and resources for greatest impact.

A multi-disciplinary team was convened 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 Kodiak Island 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 senior leaders and the PKIMC Community Advisory Council for additional review, feedback, and alignment.

In April 2026, the Providence Alaska Region 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: BASIC NEEDS / ECONOMIC SECURITY

#### *Population Served*

In line with our mission, we are focused on underserved populations, including those with low incomes, uninsured, and underinsured. Within these populations, we aim to serve individuals and families who need assistance in meeting their basic needs.

#### *Long-Term Goal(s)/ Vision*

To ensure all people can be economically secure and meet their basic needs

**Table 1. Strategies and Measures for Addressing Basic Needs / Economic Security**

	<b>Strategy</b>	<b>Population Served</b>	<b>Measure</b>	<b>Baseline</b>	<b>2028 Target</b>
<b>A.</b>	Identify and connect individuals with community-based care and resources that address social drivers of health (SDOH) impacting health and access to care—such as housing, transportation, and other basic needs—in partnership with community-based organizations.	Patients screened positively for SDOH	<p>a. Establish process to identify and document patients with SDOH needs</p> <p>b. % of patients screened for SDOH</p> <p>c. % of patients admitted positive for at least one SDOH need</p>	<p>a. No established process to identify and document patients with SDOH needs</p> <p>b. 95% of patients screened for SDOH</p> <p>c. 37% of patients admitted positive for at least one SDOH need</p>	<p>a. Process to identify and document patients with SDOH needs established and adopted</p> <p>b. 100% of patients screened for SDOH</p> <p>c. 32% of patients admitted positive for at least one SDOH need</p>
<b>B.</b>	Work with YMCA and other community partners to establish a Kodiak Childcare Steering Committee to address childcare needs in Kodiak	Broader Community	Established childcare Steering Committee with community partners to develop plan for improvement in childcare needs in Kodiak	No childcare steering committee	Established childcare Steering Committee with community partners to develop plan for improvement in childcare needs in Kodiak

*Community and Research Informed Resources*

County Health Rankings & Roadmaps. (2022). Social service integration. Retrieved from <https://www.countyhealthrankings.org/strategies-and-solutions/what-works-for-health/strategies/social-service-integration>

*Resource Commitment*

Providence will commit staff time, supplies and equipment, cash and in-kind donations to support these strategies.

*Key Community Partners*

PKIMC works with many community partners across Kodiak Island to help address needs for those who are underserved. Examples of the partners we work with as part of our commitment to addressing basic needs/economic security include the YMCA, Kodiak Area Native Association (KANA), and the Kodiak Island Borough.

## COMMUNITY NEED ADDRESSED #2: MENTAL HEALTH

### Population Served

In line with our mission, we are focused on underserved populations, including those with low incomes, uninsured, and underinsured. Within these populations, we aim to serve youth and adults needing behavioral health services.

### Long-Term Goal(s)/ Vision

- To ensure equitable access to high-quality, culturally appropriate behavioral health services, especially for populations with low incomes

**Table 2. Strategies and Measures for Addressing Mental Health**

	Strategy	Population Served	Measure	Baseline	2028 Target
<b>A</b>	Provide outpatient therapy, school-based services, and telehealth through the Kodiak Counseling Center; provide behavioral health support to medical floor patients in our care by deploying counseling center clinicians for patients with extended stays or pending transfer	Youth and adults needing behavioral health services	<p>a. Number of individuals receiving outpatient services</p> <p>b. Number of students receiving school-based services</p> <p>c. Number of medical floor behavioral health patient-support visits</p>	<p>a. Approximately 564 individuals receive outpatient services annually</p> <p>b. Baseline for this measure to be developed as part of CHIP</p> <p>c. Baseline for this measure to be developed as part of CHIP</p>	<p>a. Increase Number of individuals receiving outpatient services by 5% annually</p> <p>b. Track and establish baseline by 3<sup>rd</sup> quarter 2026 and increase number of students receiving school-based services by 5% annually</p> <p>c. Establish baseline by 3<sup>rd</sup> quarter 2026 and maintain number of medical floor behavioral health patient-support visits by 5% annually</p>
<b>B</b>	Provide crisis assessments through the counseling center and hospital collaboration; implement safeTALK training for staff and community members; expand Crisis Prevention Institute (CPI) de-escalation training for staff; host school counselors at the counseling center	Individuals experiencing suicidal ideation or behavioral health crisis	<p>a. # of crisis assessments completed</p> <p>b. # of individuals trained in safeTALK</p>	Baseline for these measures to be developed as part of CHIP	<p>a. Establish baseline by third quarter 2026 and maintain or increase number of crisis assessments by 5% annually</p> <p>b. Establish formal safeTALK program and increase number of individuals trained by 10% annually</p>

	for training and collaboration		<p>c. % of staff trained Crisis Prevention Institute (CPI) training</p> <p>d. #of school counselors participating in training</p>		<p>c. Establish baseline by third quarter 2026 and increase percentage of staff trained in CPI by 10% annually</p> <p>d. Establish baseline by third quarter 2026 and increase number of school counselors participating in training by 5% annually</p>
C	Provide behavioral health screenings and referrals through school-based services, school counselor collaboration, primary care partnerships, and counseling center intake processes	Individuals with unmet behavioral health needs	<p>a. Number of individuals screened using an evidence-based substance use screening tool, including the Alcohol Safety Action Program (ASAP)</p> <p>b. Number of individuals referred to behavioral health or substance use disorder services</p> <p>c. Number of individuals entering treatment following screening</p>	Baseline for these measures to be developed as part of CHIP	<p>a. Establish baseline by third quarter 2026 and increase number of individuals screened annually by 5%</p> <p>b. Establish baseline by third quarter 2026 and increase number of referrals annually by 5%</p> <p>c. Establish baseline by third quarter 2026 and increase number of individuals entering treatment annually by 5%</p>

*Community and Research Informed Resources*

County Health Rankings & Roadmaps. (2023). Telemedicine. Retrieved from <https://www.countyhealthrankings.org/strategies-and-solutions/what-works-for-health/strategies/telemedicine>

County Health Rankings & Roadmaps. (2024). Telemental health services. Retrieved from <https://www.countyhealthrankings.org/strategies-and-solutions/what-works-for-health/strategies/telemental-health-services>

County Health Rankings & Roadmaps. (2024). School-based health centers. Retrieved from <https://www.countyhealthrankings.org/strategies-and-solutions/what-works-for-health/strategies/school-based-health-centers>

*Resource Commitment*

Providence will commit staff, training resources, and facilities to support behavioral health care and coordination.

*Key Community Partners*

Providence Kodiak Island Medical Center works with many community partners across Kodiak Island to help address needs for those who are underserved. Examples of the partners we work with as part of our commitment to addressing mental health include Kodiak Area Native Association (KANA), Kodiak Community Health Center (KCHC), Kodiak Island Borough School District, Providence Kodiak Island Counseling Center (PKICC), Kodiak Public Health, community organizations, and public safety partners.

**COMMUNITY NEED ADDRESSED #3: SUBSTANCE USE/MISUSE**

*Population Served*

In line with our mission, we are focused on underserved populations, including those with low incomes, uninsured, and underinsured. Within these populations, we aim to serve youth and adults needing behavioral health services.

*Long-Term Goal(s)/ Vision*

To reduce substance use disorders and related health conditions through evidence-based prevention, treatment, and recovery support services, especially for those who are underserved and populations with low incomes.

**Table 3. Strategies and Measures for Addressing Substance Use/Misuse**

	<b>Strategy</b>	<b>Population Served</b>	<b>Measure</b>	<b>Baseline</b>	<b>2028 Target</b>
<b>A</b>	Provide substance use education and early intervention through school-based services; deliver annual training to schoolteachers and counselors by a licensed professional counselor with a master’s degree in addition to support identification and response to substance use concerns	Youth and school personnel in Kodiak	<p>a. Number of training sessions provided to school counselors</p> <p>b. Number of students referred from school-based services to the counseling center for substance use concerns</p>	<p>a. No consistent training program currently provided to school counselors</p> <p>b. Baseline for this measure to be developed as part of CHIP</p>	<p>a. Provide at least 2 annual training sessions for school counselors, including substance use identification and response and safeTALK suicide prevention training</p> <p>b. Establish baseline by third quarter 2026 and increase number of student referrals for substance use concerns by 5% annually</p>

<b>B</b>	Provide outpatient substance use treatment and establish evening SUD group services through the Kodiak Counseling Center; utilize clinician referrals and Number of Alcohol Safety Action Program (ASAP) screening results to identify and enroll individuals in treatment	Adults with substances use disorders	<p>a. Number of individuals receiving outpatient substance use disorder services</p> <p>b. Number of substance use disorder group sessions offered</p>	<p>a. Baseline for these measures to be developed as part of CHIP</p> <p>b. No substance use disorder group sessions currently offered (Start date 4/30/2026)</p>	<p>a. Establish baseline by third quarter 2026 and increase number of individuals receiving outpatient substance use disorder services by 5% annually</p> <p>b. Offer 25 substance use disorder group sessions annually</p>
<b>C</b>	Provide drug and alcohol screenings through Alcohol Safety Action Program (ASAP) and counseling center services and connect individuals to appropriate outpatient treatment and SUD group services	Individuals needing substances use screening or treatment	<p>a. Number of Alcohol Safety Action Program (ASAP) screenings completed</p> <p>b. Number of individuals referred to treatment following screening</p> <p>c. Number of individuals entering treatment following referral</p>	Baseline for these measures to be developed as part of CHIP	<p>a. Establish baseline by third quarter 2026 and increase number of Alcohol Safety Action Program (ASAP) screenings completed by 5% annually</p> <p>b. Establish baseline by third quarter 2026 and increase number of individuals referred to treatment by 5% annually</p> <p>c. Establish baseline by third quarter 2026 and increase number of individuals entering treatment by 5% annually</p>

*Community and Research Informed Resources*

County Health Rankings & Roadmaps. (2024). School-based health centers. Retrieved from <https://www.countyhealthrankings.org/strategies-and-solutions/what-works-for-health/strategies/school-based-health-centers>

*Resource Commitment*

Providence will commit clinical staff, group services, and facilities to support substance use prevention and treatment.

*Key Community Partners*

PKIMC works with many community partners across Kodiak Island to help address needs for those who are underserved. Examples of the partners we work with as part of our commitment to addressing substance use/misuse include Kodiak Area Native Association (KANA), Kodiak Community Health Center (KCHC), Kodiak Island Borough School District, Providence Kodiak Island Counseling Center (PKICC), and Kodiak Public Health.

**COMMUNITY NEED ADDRESSED #4: ACCESS TO HEALTHCARE**

*Population Served*

In line with our mission, we are focused on underserved populations, including those with low incomes, uninsured, and underinsured. Within these populations, we aim to serve individuals who are experiencing barriers to accessing healthcare services.

*Long-Term Goal(s)/ Vision*

Expand access to high-quality and culturally responsive preventive and specialty health care services and care navigation for those who are uninsured, underinsured or otherwise unable to pay for their care.

**Table 4. Strategies and Measures for Addressing Access to Healthcare**

	<b>Strategy</b>	<b>Population Served</b>	<b>Measure</b>	<b>Baseline</b>	<b>2028 Target</b>
<b>A.</b>	Continue to provide transitional workforce housing to address healthcare workforce shortages	Broader Community	Units of transitional workforce housing	16-units of transitional workforce housing	Continue to provide 16-units of transitional workforce housing
<b>B.</b>	Provide immersive job shadow and training opportunities for registered nursing (RN) and certified nursing assistant (CNA) program students to address healthcare workforce shortages	Broader Community	a. # registered nurse training positions available annually  b. # CNA training positions available annually	a. 3-4 registered nurse training positions available annually  b. 9-10 CNA training positions available annually	a. Maintain 3-4 registered nurse training positions annually  b. Maintain 9-10 CNA training positions available annually
<b>C.</b>	Establish a Kodiak Healthcare Collaborative in partnership with community stakeholders to strengthen relationships	Broader Community	Established Kodiak Healthcare Collaborative	There is no existing Healthcare Collaborative	Established Kodiak Healthcare Collaborative with strategic framework

	across the provider community, develop pathways for expanded specialty services, and align goals and resources to address community health needs.				to assess and address community health needs
D.	Provide clinical and surgical space to visiting specialists (e.g. Orthopedics, Urology, Gynecology, ENT, Dental)	Individuals with barriers to accessing specialty care	Availability of two surgical suites and two clinic rooms for visiting specialists	Two surgical suites and two clinic rooms are maintained and made available for visiting specialists	Maintain two surgical suites and two clinic rooms for visiting specialists

*Community and Research Informed Resources*

County Health Rankings & Roadmaps. (2022). Career pathways programs. Retrieved from <https://www.countyhealthrankings.org/strategies-and-solutions/what-works-for-health/strategies/career-pathways-programs>

*Resource Commitment*

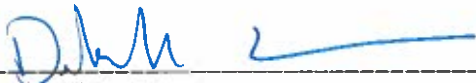
Providence will commit staff time, supplies and equipment, cash and in-kind donations to support these strategies.

*Key Community Partners*

PKIMC works with many community partners across Kodiak Island 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 healthcare include Kodiak Area Native Association (KANA), Kodiak Community Health Center (KCHC), and the State of Alaska Department of Health and Human Services.

## 2026-2028 CHIP GOVERNANCE APPROVAL

This Community Health Improvement Plan was adopted by the Providence Alaska Region Board on April 21, 2026. The final report was made widely available by May 15, 2026.



Deborah Berini  
Chief Executive, Providence Alaska Region

4-21-26

Date



Donna Logan  
Chair, Providence Alaska Region Board

04/21/2026

Date

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