

2021 - 2023

COMMUNITY HEALTH IMPROVEMENT PLAN

**Providence St. Joseph
Medical Center**

Polson, Montana



To provide feedback on this CHIP or obtain a printed copy free of charge, please email Hollie Timmons at Hollie.Timmons@providence.org.

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EXECUTIVE SUMMARY

Providence Health & Services continues its Mission of service in Lake County Providence St. Joseph Medical Center. Providence St. Joseph Medical Center is a critical-access hospital with 22 licensed beds, founded in 1916 and located in Polson, Montana. The hospital's service area is much of Lake County, which includes a majority of the Flathead Indian Reservation and is the ancestral home of the Bitterroot, Salish, Kootenai and Pend d'Oreille tribes, organized as the Confederated Salish and Kootenai Tribes of the Flathead Nation. Lake County's 2019 population is 31,036.

Providence St. Joseph Medical Center, Providence St. Patrick Hospital, and Providence Medical Group together make up Providence Montana. The Providence Montana service area dedicates resources to improve the health and quality of life for the communities it serves, with special emphasis on the needs of marginalized populations. In 2020, Providence Montana provided \$26 million¹ in Community Benefit² in response to unmet needs and to improve the health and well-being of those we serve in western Montana, including \$4.8 million in free and low-cost care for people who are underinsured or uninsured.

The Community Health Needs Assessment (CHNA) is an opportunity for Providence St. Joseph Medical Center to engage the community every three years with the goal of better understanding community strengths and needs. The CHNA allows Providence Montana to target our investments to areas of greatest need, including to addressing health disparities by race, particularly in our American Indian communities. Racism has impacted the health of Montanans for decades, and the COVID-19 pandemic further emphasized this crisis as Providence observed higher infection rates and loss of life among people of color as compared to white Montanans.

The results of the CHNA guide and inform efforts to better address the needs of the community. Through a mixed-methods approach using quantitative and qualitative data, the CHNA process relied on several sources of information: state and national public health data, qualitative data from interviews with community stakeholders, primary data from a community survey, and hospital utilization data. We hope to continue to build relationships and gain insights from those who experience health disparities, particularly our American Indian population. A significant and exciting part of the CHIP is the creation of

¹Data is consolidated based on unaudited financial reporting.

²A community benefit is 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. Note: Community benefit includes both services to the economically 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: 1) community health needs assessment developed by the ministry or in partnership with other community organizations; 2) 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; 3) or the involvement of unrelated, collaborative tax-exempt or government organizations as partners in the community benefit initiative or program.

new and better ways to reach and support this population, designed *by* and *for* communities most impacted by racism and poverty.

Providence St. Joseph Medical Center Community Health Improvement Plan Priorities

As a result of the findings of our [2020 CHNA](#) and through a prioritization process aligned with our Mission, resources, and hospital strategic plan, Providence St. Joseph Medical Center will focus on the following areas for its 2021-2023 Community Benefit efforts:

PRIORITY 1: ACCESS TO MENTAL HEALTH SERVICES

Access to mental health and behavioral health services, including for children and adolescents, regardless of payer source or ability to pay for services, as well as rapid access for people experiencing a mental health crisis.

PRIORITY 2: ACCESS TO SUBSTANCE ABUSE DISORDER TREATMENT SERVICES

Access to both outpatient and inpatient alcohol and drug treatment and detox, regardless of payer source or ability to pay, as well as expanded treatment models, such as medication-assisted treatment and peer support programs.

PRIORITY 3: SAFE AND AFFORDABLE HOUSING

Safe and affordable housing allows households to pay for other nondiscretionary expenses that are integral to good health, like healthy food, health care, and education.

Reducing health disparities requires service providers to learn from the populations impacted by racism and poverty. Conversations, human-centric designs, and innovative interventions will be part of the above focus areas, with an emphasis on American Indian voice and novel interventions.

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 St. Joseph Medical Center is a critical access hospital founded in 1916 and located in Polson, Montana; the Sisters of Providence took responsibility of the hospital in 1990. It is one of eight critical access hospitals in the Montana service area and has 22 licensed beds. Providence St. Joseph Medical Center has a staff of more than 270. Major programs and services offered to the community include acute inpatient care, primary care, specialty clinics, outpatient diagnostics, surgical services, as well as an assisted living facility.

Our Commitment to Community

In 2020, Providence Montana provided \$26 million in Community Benefit in response to unmet needs and to improve the health and well-being of those we serve in western Montana, including \$4.8 million in free and low-cost care for people who are underinsured or uninsured. The Providence Montana service area includes Providence St. Joseph Medical Center, Providence St. Patrick Hospital in Missoula, and Providence Medical Group, including 11 outpatient primary care clinics and 14 specialty clinics throughout western Montana.

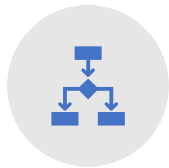
Health Equity

At Providence St. Joseph Health, we acknowledge that all people do not have equal opportunities and access to living their fullest, healthiest lives due to systems of oppression and inequities. We are committed to ensuring health equity for all by addressing the underlying causes of racial and economic inequities and health disparities. Our Vision is “Health for a Better World,” and to achieve that we believe we must address not only the clinical care factors that determine a person’s length and quality of life, but also the social and economic factors, the physical environment, and the health behaviors that all play an active role in determining health outcomes.

Through the literature and our community partners, we know that racism and discrimination have detrimental effects on community health and well-being. We recognize that racism and discrimination prevent equitable access to opportunities and the ability of all communities to thrive. We name racism as contributing to the inequitable access to all the determinants of health that help people live their best lives, such as safe housing, nutritious food, responsive health care, and more. The CHIP is an important process for identifying strategies for addressing these inequities within the communities we serve and building upon the strengths and assets identified in the CHNA.

To ensure that equity is foundational to our CHIP, we have developed an equity framework that outlines the most promising and innovative practices that each of our hospitals will implement when completing a CHIP. Learning from and design with those most affected by racial and economic injustice is central to this framework. These practices include, but are not limited to the following:

Figure 1. Framework for Centering Equity in the CHIP



Address root causes of inequities by utilizing evidence-based and leading practices



Explicitly state goal of reducing health disparities and social inequities



Reflect our values of justice and dignity



Leverage community strengths by learning and designing together

Community Benefit Governance

Providence St. Joseph Medical Center further demonstrates organizational commitment to the community benefit process through the allocation of staff time, financial resources, participation and collaboration to address community identified needs. Providence St. Joseph Medical Center is responsible for ensuring compliance to the Federal 501(r) requirements.

Providence Montana has dedicated staff focused on community benefit throughout the year, as well as during the three-year CHNA and CHIP cycle. Community benefit staff worked with a committee that included members of Providence St. Joseph Medical Center Advisory Council to review the CHNA, prioritize needs to address in the CHIP, and to identify strategies to address those needs. The Advisory Council reviewed and approved the final CHIP document and is committed to regular review of the progress and challenges to the priorities and strategies.

Planning for the Uninsured and Underinsured

Our Mission 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 St. Joseph Medical Center has a Financial Assistance Program (FAP) that provides free or discounted services to eligible patients.

One way Providence St. Joseph Medical Center 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

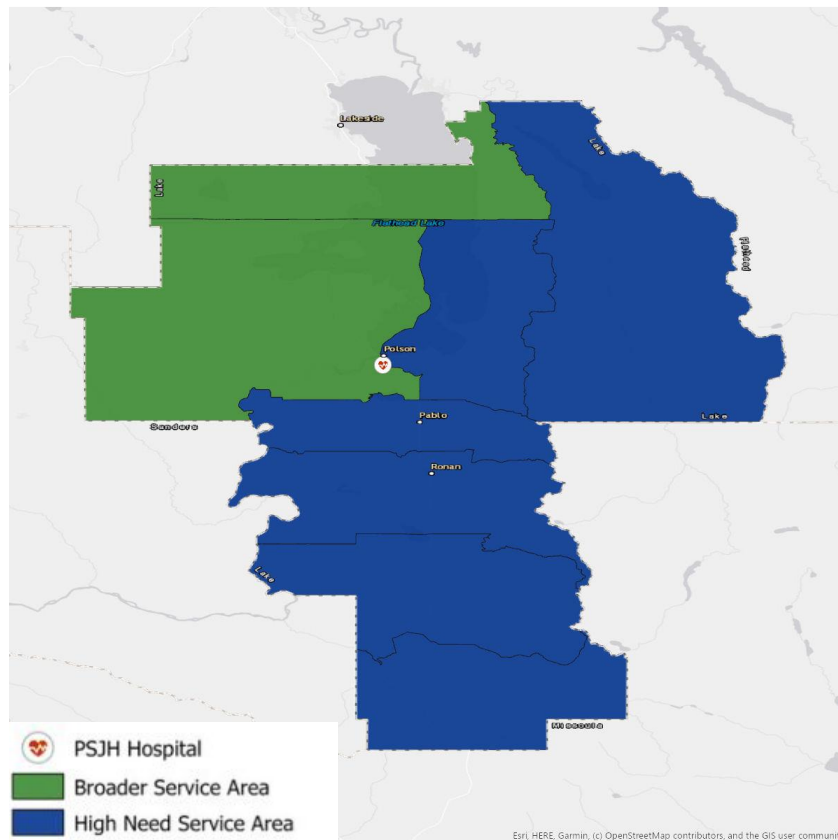
more information on financial assistance as well as where to apply for assistance. These notices are posted in English and Spanish and any other languages that are representative of 5% or greater of patients in the hospital's service area. All patients who demonstrate lack of financial coverage by third-party 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. For information on our Financial Assistance Program click [here](#).

OUR COMMUNITY

Description of Community Served

Providence St. Joseph Medical Center serves as a critical access hospital to Lake County and surrounding communities, including the Flathead Indian Reservation, which is the ancestral home of the Bitterroot, Salish, Kootenai and Pend d'Oreille tribes, organized as the Confederated Salish and Kootenai Tribes of the Flathead Nation. Lake County, as well as the immediate surrounding area, is rural. Flathead County (to the north and northeast) and Missoula County (to the south and southeast) include the cities of Kalispell and Missoula, respectively, which each have larger hospitals. Sanders County, to the west, is rural, and is home to another critical access hospital.

Figure 2. Providence St. Joseph Medical Center Total Service Area



Of the 31,036 permanent residents of Lake County in 2019, roughly 74% live in the “high need” area, defined by lower life expectancy at birth, lower high school graduation rates, and more households at or below 200% FPL compared to census tracts across the county. For reference, in 2020, 200% FPL represents an annual household income of \$52,400 or less for a family of four. These households are more likely to regularly make spending tradeoffs regarding utilities, rent, groceries, medicine, and other basic needs.

Community Demographics

POPULATION AND AGE DEMOGRAPHICS

For the most part, the age distribution is roughly proportional across Lake County geographies, with those aged between under the age of 34 slightly more likely to live in a high need area. Those aged 65-84 are less likely to live in a high need area compared to the broader service area.

The male-to-female ratio is approximately equal across geographies.

POPULATION BY RACE AND ETHNICITY

Of the Lake County area, over 65% of residents are white, with over 25% identifying as American Indian and over 7% identifying as two or more races. The American Indian population is more likely to live in a high need area, as well as people identifying as two or more races. The Hispanic population is also more likely to live in a high need service area. White people are less likely to live in a high need area.

SOCIOECONOMIC INDICATORS

Table 1. Income Indicators for Lake County Service Area

Indicator	Broader Service Area	High Need Service Area	Lake County
Median Income Data Source: American Community Survey Year: 2019	\$51,681	\$45,735	\$47,594
Percent of Renter Households with Severe Housing Cost Burden Data Source: American Community Survey Year: Estimates based on 2013 – 2017 data	9.91%	15.55%	14.20%

The median income in the high need service area is slightly lower than Lake County overall, with the high need service area being almost \$2,000 lower. There difference in median income between the broader service area and the high need service area is slightly greater, with the high need service area being almost \$6,000 lower.

Full demographic and socioeconomic information for the service area can be found in the [2020 CHNA for Providence St. Joseph Medical Center](#).

COMMUNITY NEEDS AND ASSETS ASSESSMENT PROCESS AND RESULTS

Summary of Community Needs Assessment Process and Results

Through a mixed-methods approach using quantitative and qualitative data, the CHNA process used several sources of information to identify community needs. Across Lake County, information collected includes public health data regarding health behaviors, hospital utilization data, input from key community stakeholders, and surveys of target neighborhoods.

QUANTITATIVE DATA

Public Health Data

Quantitative data used to identify community needs included community data from County Health Rankings and Esri data and mapping.

Hospital Utilization Data

Hospital utilization data used to identify community needs included avoidable emergency department visits and avoidable hospitalizations. Hospital utilization data for July 2019 – June 2020 was used for the 2020 CHNA.

A summary of quantitative data can be found starting on page 36 of the [2020 CHNA](#) for Providence St. Joseph Medical Center.

QUALITATIVE DATA

Stakeholder Interviews

Stakeholders were selected based on their knowledge of the community and engagement in work that directly serves people who have low incomes, have chronic conditions, and/or are medically underserved. Providence St. Joseph Medical Center aimed to engage stakeholders from social service agencies, health care, education, housing, and government, among others, to ensure a wide range of perspectives. Included in the interviews was a representative from the Lake County Public Health.

Surveys of Households in Target Neighborhoods

In July 2020, invited targeted households to complete an online survey. The postcards were mailed to households with median income of \$35k or less in zip codes 59821, 59860, 59864, and 59865. The survey link was also shared by Providence staff and partner organizations in the community. The survey was open from July 8 – July 26.

A summary of qualitative data can be found starting on page 50 of the [2020 CHNA](#) for Providence St. Joseph Medical Center.

IMPACTS OF COVID-19

The 2020 Community Health Needs Assessment and 2021 Community Health Improvement Plan processes were disrupted by the SARS-COV-2 virus and COVID-19, which has impacted all of our communities. While our communities have focused on crisis response, it has required concentration of resources and reduced community engagement, which impacted survey fielding and community listening sessions. Additionally, the impacts of COVID-19 are likely to affect community health and well-being beyond what is currently captured in secondary and publicly available data. We have made efforts to engage the community as directly as possible in prioritizing needs and will continue to engage with our partners on an ongoing basis to ensure we are addressing those needs.

Significant Community Health Needs Prioritized

As Providence, we understand there are clear disparities, including racial, across these prioritized areas that we will be diligent in addressing as we seek and implement solutions.

The list below summarizes the rank ordered significant health needs identified through the 2020 Community Health Needs Assessment process:

PRIORITY 1: ACCESS TO MENTAL HEALTH SERVICES

Access to mental health and behavioral health services, including for children and adolescents, regardless of payer source or ability to pay for services, as well as rapid access for people experiencing a mental health crisis.

PRIORITY 2: ACCESS TO SUBSTANCE ABUSE DISORDER TREATMENT SERVICES

Access to both outpatient and inpatient alcohol and drug treatment and detox, regardless of payer source or ability to pay, as well as expanded treatment models, such as medication-assisted treatment and peer support programs.

PRIORITY 3: SAFE AND AFFORDABLE HOUSING

Safe and affordable housing allows households to pay for other nondiscretionary expenses that are integral to good health, like healthy food, health care, and education.

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 collaborating with partner organizations in the community to address the needs identified in our CHNA, with full acknowledgment that these needs are among the most challenging to address in any community, and require long-term focus and investment from all levels of community stakeholders.

COMMUNITY HEALTH IMPROVEMENT PLAN

Summary of Community Health Improvement Planning Process

The Advisory Council for Providence St. Medical Center met in February 2021 to review the final CHNA document and to prioritize needs to address in the CHIP. Following prioritization, the Community Mission Board discussed current strategies to address ongoing community needs and how those strategies can be carried forward in the 2021-2023 CHIP.

In March and April 2021, a work group continued develop the draft of the CHIP, with the full Advisory Council receiving the draft for review in April. April 28, 2021, the full Providence St. Joseph Medical Center Advisory Council met again to review and approve the final CHIP.

The 2021-2023 Community Health Improvement Plan (CHIP) process was impacted by the SARS-CoV-2 virus and COVID-19, which has impacted all of our communities. While we have focused on crisis response, it has required a significant re-direction of resources and reduced community engagement in the CHIP process.

This CHIP is currently designed to address the needs identified and prioritized through the 2020 CHNA, though COVID-19 will have substantial impacts on our community needs. These impacts are likely to exacerbate some of the needs identified, and cause others to rise in level of priority. While this is a dynamic situation, we recognize the greatest needs of our community will change in the coming months, and it is important that we adapt our efforts to respond accordingly. We are committed to supporting, strengthening, and serving our community in ways that align with our Mission, engage our expertise, and leverage our Community Benefit dollars in the most impactful ways. Serving communities, specifically people of color, requires an authentic “doing with” approach.

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

Addressing the Needs of the Community: 2021- 2023 Key Community Benefit Initiatives and Evaluation Plan

COMMUNITY NEED ADDRESSED #1: ACCESS TO MENTAL HEALTH SERVICES

Population Served

People in need of mental health therapy or counseling; people experiencing mental health crisis; people whose mental wellness has been impacted by the COVID-19 pandemic, with an emphasis on those who are marginalized.

Long-Term Goals / Vision

To ensure equitable access to high-quality, culturally responsive, and linguistically appropriate mental health services, especially for populations with low incomes.

An improved workforce of mental health professionals that is representative of the community served and can effectively and compassionately respond to the community’s mental health and substance use needs.

Table 2. Strategies and Strategy Measures for Addressing Access to Mental Health Services

Strategy	Population Served	Strategy Measure	Baseline	2023 Target
1. Integrated mental health care in primary care setting	People in need of mental health services	# of patients served # PMG MT patients with depression treatment response in 12 months	2020: 255 patients	300 patients
2. Increase inpatient treatment access	Adults and youth in need of acute mental health care	# of patients served at Providence St. Patrick Hospital Neurobehavioral Inpatient unit Wait time for placement	2020: 587 adults 89 adolescents* <i>*New unit opened on 8/31/20</i> 2020 decision to admit <4 hours: 95.5% 2020 ED arrival to depart <4 hours: 21.5%	2023: 850 adults 360 adolescents 2023 Decision to admit <4 hours: 97% 2023 ED arrival to depart <4 hours: 30% Establish standardized workflow for placement
3. Trauma-informed care for rural youth	Rural youth	# of patients screened	384 children and teens screened in 2018-2020 CHIP	4% increase in children and teens screened
4. Improve crisis mental health response	Adult and youth experiencing mental health crisis	# MHP evaluations provided in ED Assess with community partners gaps in crisis mental health services	# MHP evaluations in ED 2020: 227	1% reduction in # crisis mental health encounters

5. Increased regional coordination for acute mental health services	Adults and youth in need of acute mental health care	Mental health admissions from Lake County to Providence St. Patrick Hospital Wait time for placement	2020: 18 adults 14 adolescents	2023: 30 adults 30 adolescents
6. Montana Service Area Health Disparity Intervention in support of Native American population	Patients who identify as Native American and who need resources and treatment for mental health and substance use disorder	Implicit Bias training completed by core leaders and providers Decreased Avoidable ED Use (AED) for Mental Health and Substance Use Disorder diagnosis groups	2020: 0% 2019: 212 AED visits for Mental Health and Substance Use Disorder diagnosis groups	Completion rate of at least 50% by core leaders and providers 2% reduction in AED for Mental Health and Substance Use Disorder diagnosis groups

Evidence Based Sources

[Behavioral health primary care integration](#)

[Trauma-informed health care](#)

[Culturally adapted health care](#)

[Behavioral Health Services for American Indians and Alaska Natives: For Behavioral Health Service Providers, Administrators, and Supervisors](#)

Resource Commitment

Providence Montana is committed to investing in serving the mental health needs of our communities. Providence St. Joseph Medical Center is committed to collaborating with community partners to support the mental health needs of residents of Lake County.

Key Community Partners

[Behavioral Health Alliance of Montana](#)

[Confederated Salish and Kootenai Tribes Behavioral Health](#)

[Western Montana Mental Health Center](#)

COMMUNITY NEED ADDRESSED #2: ACCESS TO SUBSTANCE USE DISORDER TREATMENT

Population Served

Patients with a substance use disorder; people seeking substance use disorder treatment.

Long-Term Goal / Vision

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

Table 3. Strategies and Strategy Measures for Addressing Access to Substance Use Disorder Treatment

Strategy	Population Served	Strategy Measure	Baseline	2023 Target
1. IMAT (Integrated Medication-Assisted Treatment)	People with alcohol and/or opioid substance abuse disorders	# of patients served Substance use disorder as percent of population	170 patients served in 2018-2020 CHIP 2020: 10% Lake County (any substance)	Average of 60 patients per year served 9% substance use disorder
2. Bridge to Hope	Drug-affected newborns and their caregivers	# of patients served	Average of 40 infants per year born with neonatal abstinence syndrome; all mothers offered Bridge to Hope support	All mothers with infants born with NAS participate in Bridge to Hope Virtual support available to patients
3. Improved access to chemical dependency evaluations	People with substance use disorder	# of patients receiving chemical dependency evaluations # ED encounters for substance use	PMG MT St. Joseph Medical Clinic chemical dependency evaluations average of 73 per since 2017 2019: 98 avoidable ED encounters for substance use disorders	Average of 80 CD evaluations per year 1% reduction in # ED encounters for substance use

4. Collaborate with community-based organizations to increase access to peer support services	People with substance use disorder	# organizations offering peer support services	Peer support services not available in Lake County as of 2021	Peer support available in Lake County
5. Montana Service Area Health Disparity Intervention in support of Native American population	Patients who identify as Native American and who need resources and treatment for mental health and substance use disorder	Substance use disorder rate per 1,000 for Native Alaskan/American Indian Increase IMAT-trained PMG providers	2020: 169 2020: 4 IMAT-trained PMG providers in Polson/Ronan	130 2023: 6 IMAT-trained providers on staff with PMG

Evidence Based Sources

[Medication-assisted treatment access enhancement initiatives](#)

[Behavioral Health Services for American Indians and Alaska Natives: For Behavioral Health Service Providers, Administrators, and Supervisors](#)

Resource Commitment

Providence St. Patrick Hospital is committed to providing for the treatment needs of patients through supporting staff to obtain IMAT training and waivers. In support of our Native American population, Providence St. Patrick Hospital will develop a culturally-competent and responsive workforce.

Key Community Partners

[Behavioral Health Alliance of Montana](#)

[Open Aid Alliance](#)

[Western Montana Mental Health Center](#)

COMMUNITY NEED ADDRESSED #3: SAFE AND AFFORDABLE HOUSING

Population Served

People experiencing housing instability and at risk of homelessness; people with low incomes experiencing housing instability.

Long-Term Goals / Vision

To end homelessness by reaching functional zero, which means that the system will not have more individuals enter than exit from the homelessness system at any given time.

A sufficient supply of safe, affordable housing units to ensure that all people in the community have access to a healthy place to live that meets their needs.

A reduction in housing cost burden in the community based on increased affordable housing options and increased economic opportunities.

Table 4. Strategies and Strategy Measures for Addressing Safe and Affordable Housing

Strategy	Population Served	Strategy Measure	Baseline	2023 Target
1. Collaborate with SKC Tribal Housing Authority and COC representative to assess community need	Tribal and non-tribal residents of Lake County experiencing unstable or unaffordable housing	Severe cost burden for housing	14.2% (2013-2017 ACS)	13.5%
2. Collaborate with Continuum of Care representative to assess housing support resources	Tribal and non-tribal residents of Lake County experiencing homelessness or unstable housing	# patients reporting housing concerns in SDOH screening # ED patient encounters of people registered as homeless or unstably housed HUD Point in Time Count # people served via Montana Legal Services Association Montana Eviction Intervention Project	2020: 3.32% 2019: 7 individuals 5 people served October 2020 – December 2020	Maintain baseline of 3.32% Functional zero homeless rate in Lake County Continued legal assistance for people experiencing housing instability
3. Explore collaboration with Providence Supportive Housing	People with barriers to obtaining or maintaining housing	Discussion with Providence Supportive Housing about	Providence Montana executive team has scheduled presentation	TBD based on upcoming discussions, assessments

and Community Solutions Built for Zero		potential collaboration Discuss potential collaboration for balance of state Continuum of Care with Community Solutions Built for Zero	with Providence Supportive Housing Assessment of viability of Built for Zero for statewide COC to be planned	
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Evidence Based Sources

[Legal support for tenants in eviction proceedings](#)

[Service-enriched housing](#)

Resource Commitment

Providence recognizes the vital intersection between health care and housing and believe both are basic human rights. Providence Montana is committed to collaborating with community partners working in support of safe and affordable housing.

Key Community Partners

[Community Solutions Built for Zero](#)

[Providence Supportive Housing](#)

[Ronan Housing Authority](#)

[Salish and Kootenai Housing Authority](#)

Other Community Benefit Programs

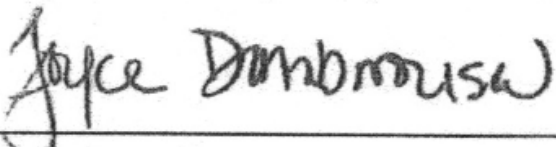
Table 5. Other Community Benefit Programs in Response to Community Needs

Initiative (Community Need Addressed)	Program Name	Description	Population Served (Low Income, Vulnerable or Broader Community)
1. Health-harming civil legal needs	Medical-Legal Partnership	Partnership between Providence Montana and Montana Legal Services Association; Providence staff can directly to MLSA	Low income, vulnerable

		attorney for civil-legal intervention	
2. Childhood obesity	CATCH	Evidence-based wellness curriculum for school-aged children	Low income, vulnerable, broader community
3. Access to care	Medication Assistance Program	Assistance for patients to obtain medications they would not otherwise be able to afford	Low income, vulnerable
4. Food insecurity, obesity, chronic disease	Prescription Produce	Medical providers can “prescribe” fresh, local produce to patients experiencing chronic disease; patients are provided with vouchers to purchase produce	Low income, vulnerable
5. Youth mental health	Work2BeWell	Empowers teens to thrive through access to mental health resources, authentic connections with peers and educators and digital platforms for resiliency	Low income, vulnerable, broader community

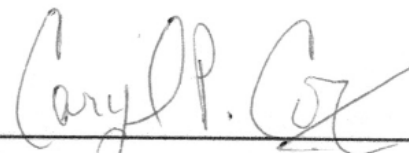
2021- 2023 CHIP GOVERNANCE APPROVAL

This Community Health Improvement Plan was adopted by the Providence St. Joseph Medical Center Advisory Council on April 28, 2021. The final report was made widely available by May 15, 2021.

 5-5-21

Joyce Dombrowski
Chief Executive, Providence Montana Service Area

Date

 5-5-2021

Caryl Cox
Chair, Providence St. Joseph Medical Center Advisory Council

Date

 5/7/2021

Justin Crowe
Senior Vice President, Community Partnerships
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To request a copy free of charge, provide comments, or view electronic copies of current and previous Community Health Improvement Plans please email CHI@providence.org.