2021 - 2023

COMMUNITY HEALTH IMPROVEMENT PLAN

Providence Valdez Medical Center

Valdez, Alaska

To provide feedback on this CHIP or obtain a printed copy free of charge, please email Nathan Johnson at Nathan.Johnson@Providence.org.

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EXECUTIVE SUMMARY

Providence continues its Mission of service in Valdez through Providence Valdez Medical Center (PVMC) and the Providence Valdez Counseling Center (PVCC). PVMC is a critical access hospital that features 11 acute-care beds and 10 long-term care beds, located in Valdez, Alaska. PVMC's service area is defined as the city of Valdez, including approximately 3,870 people.

PVMC 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 2019, Providence St. Joseph Health—Alaska provided $65 million in Community Benefit in response to unmet needs.

The Community Health Needs Assessment (CHNA) is an opportunity for PVMC 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. Through a mixed-methods approach using quantitative and qualitative data, the CHNA process used several sources of information to identify community needs. Across the Valdez community, information collected includes local community health survey responses, state and national public health data, qualitative data from stakeholder interviews, and hospital utilization data.

PVMC 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, PVMC will focus on the following areas for its 2021-2023 Community Benefit efforts:

MENTAL HEALTH/ SUBSTANCE MISUSE

Mental health is foundational to quality of life, physical health and the health of the community and includes our emotional, psychological, and social well-being. 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 mental health problems. Poor mental health and substance misuse have significant health and social impacts on the well-being of individuals and the community as a whole.

HEALTHY LIFESTLYE (E.G. CHRONIC DISEASE, OVERWEIGHT/OBESITY, PHYSICAL ACTIVITY, ETC.)

Roughly thirty percent of the determinants of an individual's health are due to their behaviors and lifestyle choices, with socioeconomic, environmental, and health care related factors combined making up the remaining seventy percent. Creating an environment that favors the adoption of healthy behaviors related to physical activity, nutrition, sleep and stress management can prevent the onset of costly chronic diseases, reduce the need for healthcare services, and substantially improve quality of life and longevity.

BARRIERS TO APPROPRIATE HEALTHCARE ACCESS (RIGHT CARE, RIGHT TIME, RIGHT PLACE)

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. Barriers to achieving

that include the lack of locally available and accessible primary care and specialty care services, lack of means to pay or being uninsured, and can include cultural, language and even transportation challenges.

SOCIAL DETERMINANTS OF HEALTH

There is substantial and increasing evidence that social factors, also known as the "social determinants of health," are just as important to an individual's health as genetics or certain health behaviors. Social determinants of health include topics such as education, discrimination, housing, social and community environment, and economic stability.

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 continues its Mission of service in Valdez through Providence Valdez Medical Center (PVMC) and the Providence Valdez Counseling Center (PVCC). PVMC is a critical access hospital that features 11 acute care beds and 10 long-term care beds, located in Valdez, Alaska. Major programs and services offered to the community include the following:

- 24-hour emergency services
- Obstetrical services, anesthesia, labor and delivery, postpartum care
- Laboratory – CLIA-certified
- Imaging services to include ultrasound, CAT scan, and bone densitometry
- Physical, occupational, and speech therapy
- Stress testing
- General medical care
- Endoscopy and minor surgical services
- Sleep disorder studies
- Specialty physician clinics

Our Commitment to Community

PVMC 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 2019, Providence St. Joseph Health—Alaska provided $65 million in Community Benefit[1] in response to unmet needs and to improve the health and well-being of those we serve.

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

[1] Per federal reporting and guidelines from the Catholic Health Association.

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.

To ensure that equity is foundational to our CHIP, we have developed an equity framework that outlines the best practices that each of our hospital will implement when completing a CHIP. These practices include, but are not limited to the following:

Figure 1. Best Practices for Centering Equity in the CHIP

Community Benefit Governance

PVMC demonstrates organizational commitment to the community benefit process through the allocation of staff time, financial resources, and collaboration with community partners. The Regional Director of Community Health Investment is responsible for coordinating implementation of State and Federal 501r requirements related to Community Benefit, CHNA and Community Health improvement Plan (CHIP). The CHNA and CHIP processes are driven by the PVMC Hospital Administrator and Hospital Advisory Council, reviewed by the Alaska Region Board Community Relations Subcommittee, and then approved by the Providence Alaska Region Board.

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 PVMC has a Financial Assistance Program (FAP) that provides free or discounted services to eligible patients.

One way PVMC 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, use the following link: https://www.providence.org/obp/ak/financial-assistance.

OUR COMMUNITY

Description of Community Served

Being the only acute care hospital in Valdez, the community served by the hospital is defined as the entirety of the city of Valdez, including approximately 3,870 people.

Figure 2. Providence Valdez Medical Center Service Area

Community Demographics

POPULATION AND AGE DEMOGRAPHICS

The city of Valdez has approximately 3,870 people, with a slightly higher percentage of males (54%) than females (46%). Almost 64% of the population is between the ages of 18 and 64 years.

POPULATION BY RACE AND ETHNICITY

The population in Valdez is primarily white (88%), although 8% of the population identify as two or more races. Almost 5% of the population identify as Hispanic or Latino.

SOCIOECONOMIC INDICATORS

In comparison to the state of Alaska, Valdez has a higher median household income and per capita income, as well as lower levels of poverty. The median household income in Valdez is $95,847 and the average household size is 2.83 persons. The median gross rent in Valdez, $1,125, is roughly equivalent to that of Alaska. Based on the 2020 Valdez Community Health Survey, 2% of residents in Valdez are experiencing homelessness.

Full demographic and socioeconomic information for the service area can be found in the [2020 CHNA for PVMC.]

COMMUNITY NEEDS AND ASSETS ASSESSMENT PROCESS AND RESULTS

Summary of Community Needs Assessment Process and Results

The Valdez CHNA Advisory Committee guided the CHNA process from inception to completion. The committee was comprised of local community leaders and health-related experts that represent the broad interests and demographics of the community. Through a mixed-methods approach using quantitative and qualitative data, the CHNA process used several sources of information to identify community needs. Across the Valdez community, information collected includes local community health survey responses, state and national public health data, qualitative data from stakeholder interviews, and hospital utilization data. Stakeholder interviews were conducted with representatives from organizations that serve people who have chronic conditions, are from diverse communities, have low incomes, and/or are medically underserved. Input was obtained from the Alaska Department of Health and Social Services Division of Public Health.

In gathering information on the communities served by the hospital, we looked not only at the health conditions of the population, but also at socioeconomic factors, the physical environment, and health behaviors. The following are a few key findings from the CHNA process:

- Stakeholders identified access to health care (primary and specialty care), housing, economic insecurity, transportation, childcare/daycare/preschool, behavioral health (mental health and substance use) as significant needs.
- Stakeholders noted that the COVID-19 pandemic has exacerbated access to care challenges, unhealthy behaviors, and mental health challenges, with increased anxiety and reduced social connection.

The Valdez CHNA Advisory Committee was also tasked with reviewing and analyzing the resulting information to identify and prioritize the top health-related needs in the community. After reviewing the quantitative and qualitative data, the Valdez CHNA Advisory Committee established the top needs for Valdez using a criteria-based prioritization process.

Significant Community Health Needs Prioritized

MENTAL HEALTH/ SUBSTANCE MISUSE

Mental health is foundational to quality of life, physical health and the health of the community and includes our emotional, psychological, and social well-being. 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 mental health problems. Poor mental health and substance misuse have significant health and social impacts on the well-being of individuals and the community as a whole.

HEALTHY LIFESTLYE (E.G. CHRONIC DISEASE, OVERWEIGHT/OBESITY, PHYSICAL ACTIVITY, ETC.)

Roughly thirty percent of the determinants of an individual's health are due to their behaviors and lifestyle choices, with socioeconomic, environmental, and health care related factors combined making up the remaining seventy percent. Creating an environment that favors the adoption of healthy behaviors related to physical activity, nutrition, sleep and stress management can prevent the onset of costly chronic diseases, reduce the need for healthcare services, and substantially improve quality of life and longevity.

BARRIERS TO APPROPRIATE HEALTHCARE ACCESS (RIGHT CARE, RIGHT TIME, RIGHT PLACE)

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. Barriers to achieving that include the lack of locally available and accessible primary care and specialty care services, lack of means to pay or being uninsured, and can include cultural, language and even transportation challenges.

SOCIAL DETERMINANTS OF HEALTH

There is substantial and increasing evidence that social factors, also known as the "social determinants of health," are just as important to an individual's health as genetics or certain health behaviors. Social determinants of health include topics such as education, discrimination, housing, social and community environment, and economic stability.

COMMUNITY HEALTH IMPROVEMENT PLAN

Summary of Community Health Improvement Planning Process

The Regional Director and internal hospital stakeholders developed strategies based on insight from stakeholder interviews and community survey responses, and input and feedback were provided by the PVMC Health Advisory Council and Providence Alaska Region Board.

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.

PVMC 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 PVMC in the enclosed CHIP.

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

COMMUNITY NEED ADDRESSED #1: MENTAL HEALTH AND SUBSTANCE USE

Population Served

People in the Valdez community with a mental health need and/or Substance Use Disorder (SUD) that may experience barriers or challenges to accessing services.

Long-Term Goal(s)/ Vision

- To reduce substance use disorders and related health conditions through evidence-based prevention, treatment, and recovery support services.[2]
- To ensure equitable access to high-quality, culturally responsive, and appropriate mental health services, especially for populations with low incomes.

Table 1. Strategies and Strategy Measures for Addressing Mental Health and Substance Use

Strategy	Population Served	Success Measure
Establish **SUD recovery supported activities** and peer support programs with education and referrals to provide enriching learning, social and physical activities in substance free environment	People with a SUD	Develop and implement 2-3 SUD recovery supported activities and secure a peer support specialist to champion each activity
Modernize behavioral health services and supports to go beyond the walls of PVMC to meet need 'in' the community	People with a mental health support need and/or SUD	Increase number of community members accessing mental health services outside the PVCC
Explore innovative opportunities to **expand local SUD treatment continuum**	People with a SUD	Implement two innovative behavioral health interventions/services to fill gaps in the continuum of care

Resource Commitment

Staffing, Community Health Investment Funding

Key Community Partners

City of Valdez, Prince William Sound College, Valdez Medical Clinic

[2] Inspired by the Substance Abuse and Mental Health Services Strategic Plan FY2019-FY2023 (samhsa.gov)

COMMUNITY NEED ADDRESSED #2: HEALTHCARE ACCESS

Population Served

The entire community of Valdez will benefit from improved access to specialty and primary care, particularly people with low incomes and those who are uninsured.

Long-Term Goal(s)/ Vision

- To ease the way for people to have access and to receive the appropriate care at the right time (right care, right time, right place).

Table 2. Strategies and Strategy Measures for Addressing Healthcare Access

Strategy	Population Served	Success Measure
Continue **health campus expansion work** (OP services expansion, PVCC redesign/expansion, Primary Care and public health, et al.)	People with low incomes and those who are uninsured	Secure funding and community support for identified projects
Nurturing healthcare workforce to ensure sustainable staffing, caregiver satisfaction, quality, and succession planning	Broader community	Reduce burnout index Improve job satisfaction scores
Develop **relationships with specialty providers** that will invest in Valdez to address unmet need	Broader community	Maintain and add to roster of visiting specialists Secure specialist provider space through Health Campus Expansion Work

Resource Commitment

Staffing, Community Health Investment Funding

Key Community Partners

City of Valdez, Prince William Sound College, Valdez Medical Clinic

COMMUNITY NEED ADDRESSED #3: HEALTH BEHAVIORS

Population Served

Families with children 18 years or younger, including those with children with mental health challenges.

Long-Term Goal(s)/ Vision

All families will have the support and knowledge needed to build healthy behaviors and wellness for themselves and their children, including access to supportive services for addressing mental health and behavioral challenges.

Table 3. Strategies and Strategy Measures for Addressing Health Behaviors

Strategy	Population Served	Success Measure
Establish **parent education and engagement opportunities** to foster healthy behaviors and lifelong wellness	Parents with children 18 years or younger	Implement two innovative parent engagement opportunities
Establish **Home Based Family Treatment Service Line**	Families with children 18 years or younger with a mental health need	Increase number of community members accessing mental health services outside the PVCC
Monitor and respond to community Children and Family wellbeing with evidence-based interventions	Families with children 19 years or younger	Establish surveillance criteria and monitoring methodology along with baseline data to measure children and family wellbeing trends

Resource Commitment

Staffing, Community Health Investment Funding

Key Community Partners

City of Valdez, Valdez School District, Valdez Medical Clinic

COMMUNITY NEED ADDRESSED #4: SOCIAL DETERMINANTS OF HEALTH

Population Served

Populations at higher risk for poor health due to SDOH, especially those associated with higher risk due to job roles in Valdez.

Long-Term Goal(s)/ Vision

To actively work to eliminate social inequities and barriers to all people living their fullest, healthiest lives.

Table 4. Strategies and Strategy Measures for Addressing Social Determinants of Health

Strategy	Population Served	Success Measure
Identify and outreach to populations at higher risk for poor health due to SDOH, especially those associated with higher risk due to job roles in Valdez	Populations at higher risk for poor health due to SDOH, especially those associated with higher risk due to job roles in Valdez	Engage two new populations and implement population specific social marketing programs to improve the health of the populations

Resource Commitment

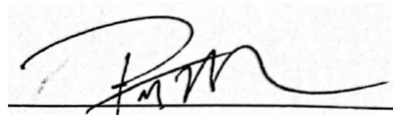
Staffing, Community Health Investment Funding

Key Community Partners

City of Valdez, Valdez School District, Valdez Medical Clinic

2021- 2023 CHIP GOVERNANCE APPROVAL

This Community Health Improvement Plan was adopted by the Providence Alaska Region Board on April 20, 2021. The final report was made widely available by May 15, 2021.



4/20/2021

Preston M. Simmons, DSc, MHA, FACHE — Date
Chief Executive, Alaska
Providence St. Joseph Health

4/20/2021

Christine Kramer, ANP — Date
Chair, Providence Alaska Region Board
Providence Health and Services Alaska

5/3/2021

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Executive 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.

APPENDIX 1

Table 5. CHNA Areas of Focus Linked with Prioritized Needs

CHNA Areas of Focus	2020 CHNA Identified Needs			
	Mental Health/ Substance Use	Healthy Behaviors	Healthcare Access	Social Determinants of Health
MENTAL HEALTH / SUBSTANCE USE Establish *SUD recovery supported activities* and peer support programs with education and referrals to provide enriching learning, social and physical activities in substance free environment *Modernize behavioral health services and supports* to go beyond the walls of PVMC to meet need 'in' the community Explore innovative opportunities to *expand local SUD treatment continuum*	X	X	X	
CHILDREN AND FAMILIES Establish *parent education and engagement opportunities* to foster healthy behaviors and lifelong wellness Establish *Home Based Family Treatment Service Line* *Monitor and respond to community Children and Family wellbeing* with evidence-based interventions	X	X	X	X
COMMUNITY AND POPULATION HEALTH (Social Determinants of Health - SDOH) *Identify and outreach to populations at higher risk* for poor health due to SDOH, especially those associated with higher risk due to job roles in Valdez	X	X	X	X
VALDEZ HEALTHCARE ACCESS Continue *health campus expansion work* (OP services expansion, PVCC redesign/expansion, Primary Care and public health, et al.) *Nurturing healthcare workforce* to ensure sustainable staffing, caregiver satisfaction, quality, and succession planning Develop *relationships with specialty providers* that will invest in Valdez to address unmet need	X		X	