COMMUNITY HEALTH IMPROVEMENT PLAN

2020 - 2022

Providence Newberg Medical Center

Yamhill County, Oregon

To provide feedback about this CHIP or obtain a printed copy free of charge, please email Joseph Ichter, DrPH, at Joseph.Ichter@providence.org

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EXECUTIVE SUMMARY

Improving the health of our communities is a fundamental commitment rooted deeply in our heritage and purpose. As expressions of God's healing love, witnessed through the ministry of Jesus, our Mission calls us to be steadfast in serving all with a special focus on our most poor and vulnerable neighbors. This core belief drives the programs we build, investments we make, and strategies we implement.

Knowing where to focus our resources starts with our Community Health Needs Assessment (CHNA), an opportunity in which we engage the community every three years to help us identify and prioritize the most pressing needs, assets and opportunities. The 2019 CHNA was approved by the Providence Newberg Medical Center (PNMC) Service Area Advisory Council on November 19th, 2019 and made publicly available on December 19th, 2019.

Based on geographic location relative to other hospitals in the area and patient demographics, the city of Newberg, Oregon and greater Yamhill County are PNMC's primary service areas. The original hospital was established in the 1994 acquisition of Newberg Community Hospital and replaced in 2006 with a new 40-bed acute care facility. Across a 56-acre campus, it includes a hospital, medical office building, and healing and wellness garden. PNMC employs more than 540 care providers and a physician staff of more than 250. Major programs and services offered to the community include general medicine, surgery, diagnostic imaging, obstetrics and gynecology, pediatrics, a sleep center, and 24/7 emergency care. PNMC provided over $22 million[1] in Community Benefit in 2019.

PNMC's Community Health Improvement Plan Priorities

As a result of the findings of our 2019 CHNA and through a prioritization process aligned with our Mission, resources, and hospital strategic plan, PNMC will focus on the bolded areas within the four priorities specified below for its 2020-2022 Community Benefit efforts:

PRIORITY 1: SOCIAL DETERMINANTS OF HEALTH AND WELL-BEING

Focus areas in **housing**, transportation, and food security; includes coordination of supportive services.

PRIORITY 2: CHRONIC CONDITIONS

Focus on prevention of obesity, **diabetes**, hypertension, and **depression**.

PRIORITY 3: BEHAVIORAL HEALTH/WELL-BEING AND SUBSTANCE USE DISORDERS

Focus on prevention (particularly for youth), **culturally responsive care** and **health education**, social isolation, and community building.

PRIORITY 4: ACCESS TO CARE

Focus on services navigation and coordination, **culturally responsive care** and **oral health**.

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[1] Unpaid costs of Medicare are included in this Community Benefit reporting

Responding to the COVID-19 Pandemic

The 2020 community health improvement process was disrupted 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 2019 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. Additionally, the data projections included were crafted based on data collection and project forecasting done prior to the COVID-19 pandemic, so may be modified as we understand adjusted resources and priorities within our communities in the aftermath of the pandemic.

This CHIP will be updated by March 2021 to better document the impact of and our response to COVID-19 in our community. 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.

MISSION, VISION, AND VALUES

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

INTRODUCTION

Who We Are

Providence Newberg Medical Center (PNMC) serves the city of Newberg, Oregon and greater Yamhill County. The original hospital was established in the 1994 acquisition of Newberg Community Hospital and replaced in 2006 with a new 40-bed acute care facility. Across a 56-acre campus, it includes a hospital, medical office building, and healing and wellness garden. PNMC employs more than 540 care providers and a physician staff of more than 250. Major programs and services offered to the community include general medicine, surgery, diagnostic imaging, obstetrics and gynecology, pediatrics, a sleep center, and 24/7 emergency care.

Our Commitment to Community

PNMC 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, PNMC provided over $22 million in community benefit[2 3] in response to unmet needs and to improve the health and well-being of those we serve in the Yamhill Service Area.

Community Benefit Governance and Management Structure

PNMC further demonstrates organizational commitment to the community benefit process through the allocation of staff time, financial resources, participation and collaboration with community partners. The PNMC leadership are responsible for coordinating implementation of State and Federal 501(r) requirements, as well as providing the opportunity for community leaders and internal hospital Executive Management Team members, physicians and other staff to work together in planning and implementing the Community Health Improvement Plan in conjunction with the Community Health Division.

As a primary source of Community Benefit advice and local leadership, PNMC's Service Area Advisory Council (SAAC) plays a pivotal role to support the Board of Trustees in overseeing community benefit issues. Acting in accordance with a Board-approved charter, the SAAC is charged with identifying policies and programs that address identified needs in the service area particularly for underserved populations, overseeing development and implementation of the Community Health Needs Assessment and

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[2] A 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.

[3] 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.

Community Health Improvement Plan Reports, and overseeing and directing the Community Benefit activities. The SAAC delegates some specific tasks to the Community Benefit Committee, a majority of members who have knowledge and experience with the populations most likely to have disproportionate unmet health needs. The Community Benefit Committee generally meets quarterly.

Planning for the Uninsured and Underinsured

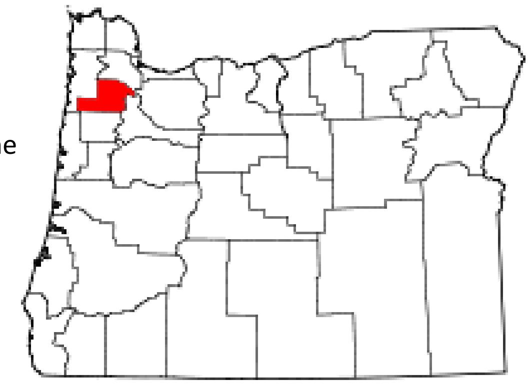
Our mission is to provide quality care to all our patients, regardless of ability to pay. We believe that no one should delay seeking needed medical care because they lack health insurance. That is why PNMC has a Financial Assistance Program (FAP) that provides free or discounted services to eligible patients based upon the following eligibility. Services must be medically necessary as defined by the Providence Financial Assistance Policy. Patients receiving emergency or medically necessary care at Providence hospitals and clinics may receive the following discounts based upon the following eligibility:

- 100% financial assistance is provided for households making up to 300% FPL
- 75% financial assistance for households between 301% and 400% FPL
- Financial assistance applies to self-pay balances and patient responsibility balances after insurance pays.

One way PNMC 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

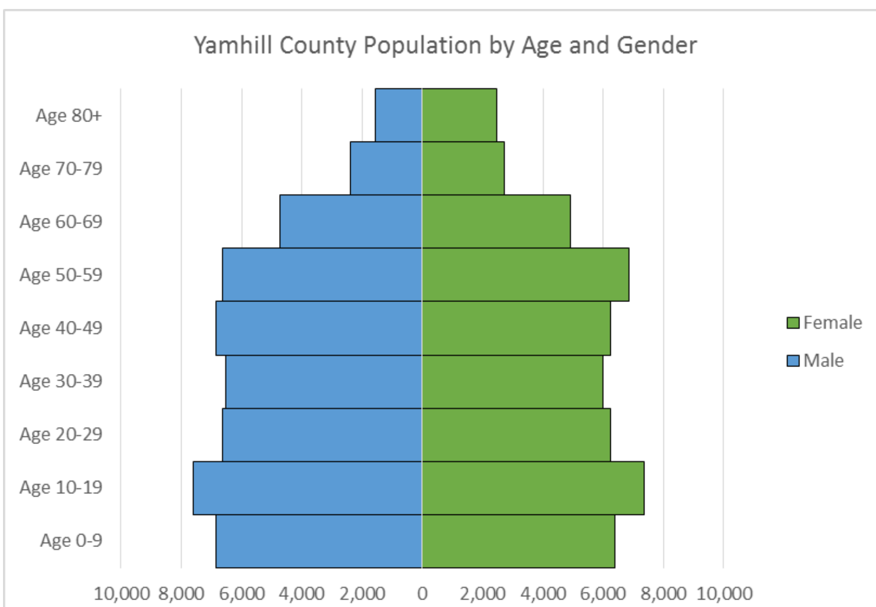


Based on geographic location relative to other hospitals in the area and patient demographics, Yamhill County (in red) is PNMC's primary service area. Washington and Clackamas counties are surrounding secondary counties that are primary served by other area hospitals.

Population and Demographics

As of 2019, Yamhill County is home to approximately 106,906 people, 23% of whom live in rural areas. The following chart shows the age and gender distribution of the current population of Yamhill County. The county follows a fairly standard distribution by age and gender, with more surviving females than males at older ages. The average age of a Yamhill County resident (38.2 years) is lower than that of the state as a whole (39.2 years).

Figure 1: 2018 Clatsop County by Age and Gender

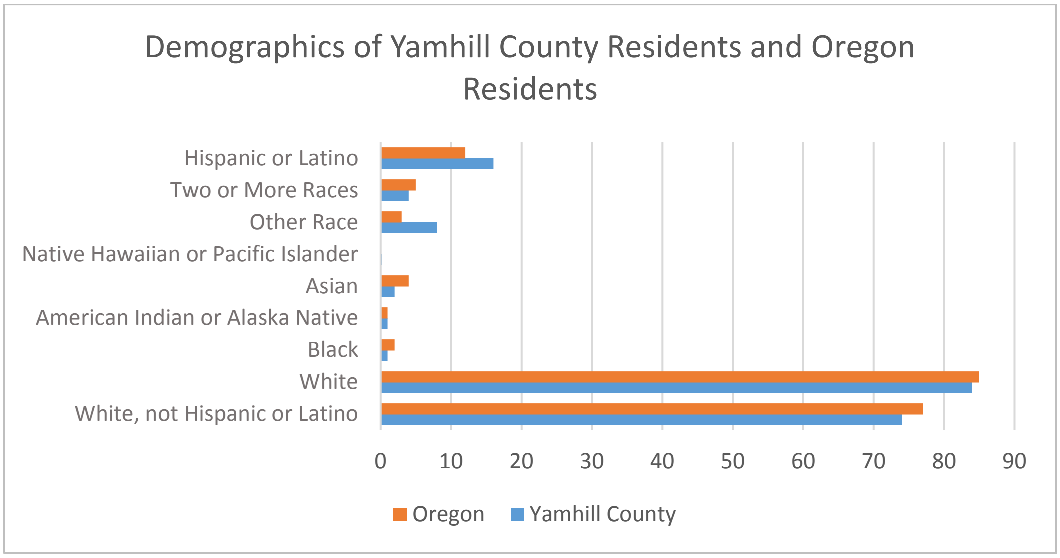


Race and Ethnicity

The county is substantially more racially and ethnically diverse than the state as a whole, representing a greater proportion of individuals identifying as Hispanic or Latino (16.3%) than the state overall (12.3%)

according to the US Census. The following table shows the self-reported race and ethnicity data from the Census for residents in Yamhill County compared to Oregon overall. The largest portion of the population identifies as white and non-Hispanic.

Figure 2: 2019 Race and Ethnicity Demographics of Clatsop County and Oregon Residents by Percentage of Total Population



Income

In 2018, the estimated median household income of Yamhill County residents was $59,484, slightly higher than the median household income for both Oregon and the United States. The Federal Reserve Bank of St. Louis in February 2020 found the unemployment rate was 3.4%, in line with Oregon's (3.3%) and the United States overall (3.5%) during that same period.

Health and Well-being

Approximately 6.4% of Yamhill County residents were estimated to be uninsured in 2018 according to the American Community Survey, slightly lower than Oregon (7.1%) and nationally (8.5%). Although there was some variation by Census tract neighborhoods in Newberg having as high as 13% uninsured rates. The Community Health Survey conducted specifically for the CHNA by CORE informing this CHIP (including 118 participants), showed that 2.3% of respondents reported having no insurance, showing that wide variations may exist. Additionally, the survey demonstrated that those with lower incomes and on Medicaid were often more likely to go without needed care.

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 the Yamhill County community, information collected includes public health status indicators related to health behaviors, hospital discharge data, hospital mortality/morbidity data, and emergency department specific primary diagnoses. In addition, two listening sessions were conducted with individuals in underserved communities, as well as 10 key stakeholder interviews with organizational and community leaders. A mailed Community Health Survey was conducted using an address-based random-sampling of Yamhill County residents, yielding 118 responses. Effort was made to gain input from medically underserved communities who are low-income and represent a diverse sampling of the Yamhill County population. Some key findings:

- Key social determinants of health challenges include housing, transportation, and food security. Approximately 1 in 10 survey respondents reported having unstable housing or food shortages in the last year.
- Substantial health disparities exist by family income, with those at 200% or below FPL having higher rates of many chronic health challenges, with diabetes, asthma, and hypertension being top reasons uninsured adults seek care in an Emergency Department.
- More than one in five survey respondents live with anxiety, with far more residents per behavioral health provider in Yamhill County compared to the Oregon ratio.
- Access to medical and dental care in rural communities is particularly challenging, with many residents having unmet health care and dental care needs.

Identification and Selection of Significant Health Needs

The prioritized needs were identified based on various community health data and identifiable gaps in available care and services. These health needs include those that have worsened over time, are worse than the state or national average, or have a disproportionate impact on those who are low-income, communities of color, or otherwise marginalized populations.

Community Health Needs Prioritized

The prioritized needs were chosen based on community health data and identifiable gaps in available care and services. In the course of our work, we determined that emphasis on these needs would have the greatest impact on the community's overall health with significant opportunities for collaboration. These interventions were prioritized based upon relative needs and opportunities, particularly those that serve identified high needs ZIP codes and neighborhoods including low-income and minority populations. The list below summarizes the significant health needs identified through the 2019 Community Health Needs Assessment process:

SOCIAL DETERMINANTS OF HEALTH AND WELL-BEING

- **Affordable housing** (or housing accessibility) is a major challenge for low- and moderate-income families in the area, particularly for those in recovery from substance use disorder. Housing and rental prices are increasing faster than the median income, making it difficult for people to stay close enough to their places of employment, care, and children's school. Despite being an area known for its relative wealth, nearly 12% of the Community Health Survey respondents reported not having stable housing, or having stable housing, but being worried about losing it, in the last year. Safe, secure housing has been proven to improve health outcomes.
- A key barrier for many of Oregon's families continues to be **healthy food access**. More than half of the state's students are on free or reduced-price lunch, with some school districts in Yamhill County serving populations where over 60 percent of the students qualify. Because nutrition is closely linked with oral health and chronic conditions, improving access to healthy food could lead to improved health outcomes in these other areas.
- Economic development and **living-wage jobs** are key opportunities to improve the health and well-being of our communities. Families expressed concern about working full-time or multiple jobs and still not being able to afford healthy food or housing. Adverse experiences and trauma are more likely in low-income households, particularly those in which the parents are stressed about resources. This also speaks to the challenge in Oregon of the "benefits cliff," whereby public benefits phase out quickly as family income increases, although the increase may not be great enough for self-sufficiency.
- **Transportation** is a challenge for some populations, particularly for the elderly and those in more rural areas. Many are dependent on others for rides to work, medical appointments, or other basic errands. Respondents to the Yamhill Community Care Organization Survey noted transportation as one of the main challenges to access to care, especially in more rural parts of the county.

CHRONIC CONDITIONS

- **Diabetes** continues to be one of the top reasons uninsured adults seek care in the Emergency Department, though the condition is likely better managed in a primary care setting. This suggests opportunities regarding prevention, education, and nutrition support.
- Twenty-six percent of Community Health Survey respondents reported having been told by a doctor that they have **high blood pressure**, with the diagnosis being far more likely amongst Medicare beneficiaries (50%).
- **Obesity** is a public health challenge, for both youth and adults. More than 33 percent of Yamhill County's adult population is considered obese, which is higher than Oregon's overall percentage of 28.6 percent according to BRFSS. The current generation of youth may be the first to have a shorter life expectancy than their parents due to complications from obesity and its associated

conditions

COMMUNITY MENTAL HEALTH/WELL-BEING AND SUBSTANCE USE DISORDERS

- **Access to mental health services** remain a barrier for many community members. There is a need to reduce stigma associated with mental health treatment and increase availability of providers and treatment services. This is particularly true amongst youth and adolescents, presenting opportunities to partner with school-based health centers.
- Access to **substance use treatment** continues to be a challenge for many. This includes alcohol and drug addiction services, both residential and outpatient treatment options. Oregon has relatively high rates of death from drug overdose, drug use (heroin, methamphetamines, and narcotics), and binge drinking.
- As we continue to learn about adverse childhood experiences (ACES) and the impacts of trauma on health later in life (i.e. child abuse, neglect, domestic violence, sexual assault, etc.), increasing **community resilience** and preventing exposure to these events in the first place has become increasingly important.

ACCESS TO CARE

- Timely and consistent access to **primary care** remains a challenge, particularly for those enrolled in the Oregon Health Plan (Medicaid) and individuals that are uninsured.
- **Dental** conditions are among the top preventable reasons uninsured individuals access the Emergency Department, which is rarely the best point of care for these conditions. This presents an opportunity for prevention education and increasing access to preventive services.
- It is important that community members feel welcome, safe, and respected in health care settings. A crucial step in improving the health and well-being of communities of color is increasing access to **culturally-responsive care**. Hispanic/Latinx households reached in the Community Health Survey were far more likely to report not having a place for regular or routine care compared to Non-Hispanic White households (31.8% vs 15.2%).

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 continuing our Mission through Community Benefit grant-making and ongoing partnerships in our community.

While we strive to care for our communities each day, we recognize that we cannot address all of needs independently, and we will focus our efforts on addressing the priorities outlined below.

Yamhill County Public Health's CHIP identifies tobacco and vaping as one of their four CHIP priorities, while the Yamhill Community Care's CHIP addresses oral health insurance benefits and tobacco cessation.

PNMC will continue to collaborate with Yamhill County Public Health, Yamhill Community Care and others that address aforementioned community needs to coordinate care and referrals to address these unmet needs. We strongly believe that together we can better address the needs of our communities by leveraging our collective strengths.

The following community health needs identified in the ministry CHNA will not be addressed at this time:

- Transportation across the county: Providence supports programs like Community Connections and Patient Support programs, and organizations like Love INC that provide local transportation. However, county-wide transportation needs to be addressed by other means.
- Access to healthy foods: even though this CHIP does not directly address the need for access to healthy foods, PNMC supports local Community Based Organizations (CBOs) like Love INC, Yamhill Community Action Partnership, Food Bank Alliance and Newberg FISH Emergency Service that address this need.
- Affordable housing: this is a much larger state-wide issue that can only be effectively addressed in partnership with state and local authorities.

In addition, PNMC will collaborate with county and state government, public health and the various CBOs 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

A subcommittee of past and present PNMC SAAC members and community leaders, PNMC leaders and Community Health Division caregivers (employees) was charged with creating the PNMC 2020 Community Health Improvement Plan (CHIP). Our initial plan was for the subcommittee to meet in person and together prioritize needs to be addressed using a deliberative and intentionally engaging process, discussing the CHNA findings and community needs over a half-day session. However, given the COVID-19 pandemic during the days and weeks leading to this meeting, the in-person meeting was shortened and held virtually.

The meeting included a review and discussion of the 2019 PNMC CHNA final report, ensuring the needs and priorities specific to Yamhill County were identified, discussed and understood. The subcommittee proceeded then to review the CHIP proposal that follows. Needs addressed were prioritized based on the following general criteria:

1. Community input
2. Severity (i.e. impact at individual, family and community level)
3. Size/magnitude (i.e. number of people impacted)
4. Subgroup disparities
5. Ability to impact those needs

Areas 1, 4 and 5 were chosen to prioritize within the discussion. After reviewing the CHIP proposal, the subcommittee passed a unanimous motion to accept the proposal with the intent to return and revise the CHIP following the current COVID-19 outbreak.

The Yamhill SAAC reviewed the final CHIP draft and had a period of one week for commentary. The SAAC board approved the final CHIP by email. PNMC 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 may require changes to the initiatives identified by PNMC in the enclosed CHIP.

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

INITIATIVE #1: SOCIAL DETERMINANTS OF HEALTH AND WELL-BEING

Community Need Addressed

Temporary housing

Goal (Anticipated Impact)

Provide temporary housing to vulnerable community members.

Scope (Target Population)

Low income and underinsured community members.

Table 1. Outcome Measures for Addressing Housing

Outcome Measure	Baseline	FY20 Target	FY22 Target
Increase access to temporary housing for unsheltered individuals.	153 individuals (707 unsheltered individuals, 2019 PITC).	25% Increase (192 individuals)	10% Increase (210 individuals)

Table 2. Strategies and Strategy Measures for Addressing Housing

Strategy(ies)	Strategy Measure	Baseline	FY20 Target	FY22 Target
Partner with Love INC to provide temporary shelter to women	# of community members served	22	20	TBD
Partner with the Community Wellness Collective to refer community members to local housing resources	# of community members served	127	150	TBD
Provide safe car camping space to community members	# of community members served	4	7	10
Pursue onsite transitional housing for the medically fragile	# of community members served	0	15	TBD

Evidence Based Sources

The Effectiveness of Housing Interventions and Housing and Service Interventions on Ending Family Homelessness: A Systematic Review by Ellen L. Bassuk, MA, Carmela J. DeCandia, MA, Alexander Tsertsvadze, and Molly K. Richard, MA.

Resource Commitment

Community Benefits grant provided to Love INC and Community Wellness Collective. PNMC provides case management, screening and coordination resources in support of safe car camping.

Key Community Partners

Community Wellness Collective, Project Access NOW, Love INC.

INITIATIVE #2: COMMUNITY MENTAL HEALTH/WELL-BEING AND SUBSTANCE USE DISORDERS

Community Need Addressed

High percentage of mental/emotional health conditions, including teen suicide.

Goal (Anticipated Impact)

Increase mental/emotional health information and educational services.

Scope (Target Population)

Youth and low income families.

Table 3. Outcome Measures for Addressing Mental/Emotional Health

Outcome Measure	Baseline	FY20 Target	FY22 Target
Increase access to mental/emotional health resources and services.	808 people	7% Increase	5% Increase

Table 4. Strategies and Strategy Measures for Addressing Mental/Emotional Health

Strategy(ies)	Strategy Measure	Baseline	FY20 Target	FY22 Target
Partner with Pacific University, Promotores de Salud and local parishes to provide Emotional Health Charlas to members of the Latinx community	# of community members served	50	50	TBD
Partner with the Newberg School District and the Better Outcomes thru Bridges program to provide outreach	# of students served connected to Behavioral Health services	15	15	TBD
Deliver behavioral health services through the adolescent wellness center	# of adolescents served	410	450	TBD
Provide early intervention education in stress management and coping skills for	# of high school athletes served	250	250	TBD

high school athletes, including expansion of services by adding small groups				
Partner with George Fox University to provide behavioral health services to fragile patients discharged from the PNMC emergency department	# of fragile patients served	83	100	TBD

Evidence Based Sources

[Community Interventions to Promote Mental Health and Social Equity]

Resource Commitment

Community Benefits grants provided to Pacific University School of Graduate Psychology and the Community Wellness Collective, and committed program coordination staff and resources.

Key Community Partners

Pacific University, St. Peter Catholic church, Mision de San Martin de Porres Catholic church, Newberg High School Newberg School District, Community Wellness Collective, George Fox University

INITIATIVE #3: ACCESS TO CARE – DENTAL CARE

Community Need Addressed

Access to dental care.

Goal (Anticipated Impact)

Provide access to emergency and preventative dental care to community members.

Scope (Target Population)

Low income, Latinx communities

Table 1. Outcome Measures for Addressing Access to Dental Care

Outcome Measure	Baseline	FY20 Target	FY22 Target
Increase access to emergency and preventative dental care to community members	165 people	140 (due to COVID-19)	12% Increase from Baseline (185 people)

Table 2. Strategies and Strategy Measures for Addressing Access to Dental Care

Strategy(ies)	Strategy Measure	Baseline	FY20 Target	FY22 Target
Partner with Pacific University School of Dental Hygiene mobile van.	# of community members served	145	120	155
Partner with Medical Teams International (MTI) mobile dental services.	# of community members served	20	20	30

Evidence Based Sources

1. Approaches for Improving Oral Health Outcomes for Low Income Americans.
2. Burden of Oral Disease among Older Adults and Implications for Public Health Priorities.

Resource Commitment

Community Benefit grants provided to Medical Teams International and Pacific University School of Dental Hygiene.

Key Community Partners

Medical Teams International, Pacific University School of Dental Hygiene, St. Peter Catholic Church, Mision de San Martin Catholic Church, St. James Catholic Church, Love INC, Community Wellness Collective.

Initiative #4: Access to Care – Culturally Responsive Care

Community Need Addressed

Culturally responsive care.

Goal (Anticipated Impact)

Increase service and culturally response navigation and coordination capacity.

Scope (Target Population)

Low income Latinx communities

Table 7. Outcome Measures for Addressing Culturally Responsive Care

Outcome Measure	Baseline	FY20 Target	FY22 Target
Increase culturally response navigation and service	170 people	145 (due to COVID-19)	10% Increase from Baseline (187)

coordination to low income Latinx community members.			

Table 8. Strategies and Strategy Measures for Addressing Culturally Responsive Care

Strategy(ies)	Strategy Measure	Baseline	FY20 Target	FY22 Target
Train new cohort of Promotores and facilitate certification as Community Health Workers with Oregon.	# of community members trained	20	25	TBD
Provide biometric screenings (BMI, glucose, cholesterol and triglycerides) and health education information to community members.	# of community members served	150	120	165

Evidence Based Sources

1. Recognizing and Sustaining the Value of Community Health Workers and Promotores, by Jim Lloyd, Kathy Moses and Rachel Davis, Center for Health Care Strategies.
2. Roles and Functions of Community Health Workers in Primary Care, by Hartzler, A.L, Tuzzio., Hsu, C., Wagner, E.H. (2018).
3. Integration of Community Health Workers into Primary Care Health Systems: The Time for New York is Now! New York, NY: NYU-CUNY Prevention Research Center, by Islam, N., Nadkarni, S., Peretz, P., Matiz, L.A., Hirsch, G., Kane, E., Collinsworth, A., Kangovi, S., Godfrey Walters, K., Hyde, J., Matos, S., Kumar, R., Lopez, P., Zhong, L., Thorpe, L., and Trinh-Shevrin, C. (2016).

Resource Commitment

Community Benefit funds provided to community partner. Providence Community Health provides staffing time, supplies, etc. to manage Promotores de Salud program

Key Community Partners

St. Peter Catholic Church, Mision de San Martin Catholic Church, St. James Catholic Church, Love INC, Adelante Mujeres, Familias en Accion, Project Access NOW, Providence Mission Integration, Pacific University.

INITIATIVE #5: CHRONIC CONDITIONS

Community Need Addressed

Community members living with diabetes or pre-diabetes.

Goal (Anticipated Impact)

Increase the number of Yamhill County residents receiving diabetes prevention services.

Scope (Target Population)

Community members at risk of developing Type 2 diabetes.

Table 9. Outcome Measures for Preventing Chronic Health Conditions

Outcome Measure	Baseline	FY20 Target	FY22 Target
Increase number of Diabetes Prevention Program (DPP) cohorts offered near ministry	0	1 new cohort (max 15 participants per cohort)	2 cohorts
Improve % of DPP participants who attend at least 3 classes in the first 6 months, then attend at least 3 classes in the second 6 months	47% in Oregon region	48%	50%

Table 10. Strategies and Strategy Measures for Addressing Chronic Disease

Strategy(ies)	Strategy Measure	Baseline	FY20 Target	FY22 Target
Increase number of community DPP information sessions	# of information sessions offered	2 Community DPP information sessions	4 Community DPP information sessions	TBD
Identify community partners as DPP referral sources	# of community partners	2	3	TBD

Evidence Based Sources

National Diabetes Prevention Program

Resource Commitment

The Prevent Diabetes Prevention Program is a Providence subsidized service. The program has committed to offering at least one DPP cohort in 2020 in the area around Providence Newberg, and expanding to two in 2022. Cohorts are provided at a cost of $17,700/cohort, with an FTE commitment of

0.3 FTE per cohort for the lifestyle coach and support staff. Providence will offer training for coaches to become certified DPP Lifestyle Coaches (LSC), and maintain skills with additional in-person training and monthly coaching calls.

This could also be a place to note working with state/county health officials to improve sampling to allow more reliable disaggregation of data based on race/ethnicity.

Key Community Partners

Yamhill County Health Department, Familias en Accion, Yamhill CCO, FQHCs in the area, CoMagine Health, Senior Centers, Retirement Homes, Oregon Health & Science University, Legacy Health, Oregon Wellness Network

Other Community Benefit Programs and Evaluation Plan

Table 11. Other Community Benefit Programs in Response to Community Needs

Initiative (Community Need Addressed)	Program Name	Description	Target Population (Low Income, Vulnerable or Broader Community)
1. Access to culturally appropriate care	Mobile Telehealth clinics	Access to basic biometric screening and Nurse Practitioner	Low income Latinx community
2. Housing	Move-in assistance fund by Love INC	Provides move-in assistance to shelter guests showing admirable effort and action toward their goals	Low income, homeless, disable women Domestic and substance abuse
3. Chronic health conditions	Chronic Disease Self-Management	Educational workshop to help people manage their chronic health conditions and live-well	Vulnerable communities
4. Access and coordination to community services	Community Wellness Collective Resource Guide	Comprehensive guide to community resources (Spanish version available)	Broader community Latinx community
5. Access to culturally appropriate care	Latina Mammo Fair	Screening mammograms to uninsured Latinx women	Low income and uninsured Latinx women

6. Food security	Newberg FISH Emergency Services	Provides emergency foods to individuals and families	Low income

2020-2022 CHIP GOVERNANCE APPROVAL

This Community Health Improvement Plan was adopted by the Service Area Advisory Council of the hospital on April 16, 2020. The final report was made widely available[4] by May 15, 2020.

05/04/2020

Brad Henry — Date

Interim Chief Executive, Providence Newberg Medical Center

May 8, 2020

Lisa Vance — Date

Chief Executive, Oregon Region

May 8, 2020

Joanne Warner — Date

Chair, Oregon Community Ministry Boards

May 11, 2020

Joel Gilbertson — Date

Senior Vice President, Community Partnerships

Providence St. Joseph Health

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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 CommunityBenefit@providence.org.

[4] Per § 1.501(r)-3 IRS Requirements, posted on hospital website

APPENDICES

Appendix 1: Definition of Terms

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

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

Community benefit includes services to persons living in poverty, persons who are vulnerable, and the broader community.

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

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

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

Social Determinants of Health: Powerful, complex relationships exist between health and biology, genetics, and individual behavior, and between health and health services, socioeconomic status, the physical environment, discrimination, racism, literacy levels, and legislative policies. These factors, which influence an individual's or population's health, are known as *determinants of health*. *Social determinants of health* are conditions in the environment in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.

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

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

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

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

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