PROVIDENCE
Newberg
Medical Center

Community Health Needs Assessment 2016

Providence Newberg Medical Center

Newberg, Oregon

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2016 Community Health Needs Assessment

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Newberg
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Community Health Needs Assessment Executive Summary

Providence Newberg Medical Center

Creating healthier communities, together

As health care continues to evolve and systems of care become more complex, Providence is responding with dedication to its Mission and a core strategy to *create healthier communities, together*. Partnering with many community organizations, we are committed to addressing the most pressing health needs in our community. In Yamhill County, Providence proudly serves the community anchored by Providence Newberg Medical Center. Our 40-bed hospital provides an array of services including primary care, surgical services, obstetrics and gynecology, diagnostic imaging, pediatrics, intensive care, and emergency care.

Our starting point: Gathering community health data and input

Through a formal community health needs assessment process Providence identified several key areas of need for Yamhill County, including:

- **23.8 percent of youth are food insecure**
- **Nearly one third of adults are obese**
- **Over 30 percent of children have been diagnosed with a behavioral health condition**
- **Over 22 percent of people are covered by the Oregon Health Plan (Medicaid)**
- **Nearly 15 percent of Yamhill County residents are Latino**

Responding to the number of needs identified, Providence developed four topic categories: access to care; behavioral health; chronic conditions; and social determinants of health and well-being. These findings are guiding development of collaborative solutions to fulfill unmet needs for some of the most vulnerable groups of people in communities we serve. Our work is also informed by population demographics, which has been diversifying. For example, Yamhill County's Latino population comprises nearly 15 percent of the total population – one of the highest proportions in the state. The current population of Yamhill County is 103,295, indicating a growth rate of approximately 21 percent growth since 2000.

Identifying top health priorities, together

Several information sources were used for this report, including: state and county public health data; hospital utilization data; a community health survey; key stakeholder interviews; and community listening sessions.

Providence top priority health needs for 2016-2018

Access to care
Behavioral health
Chronic conditions
Social determinants of health and well-being

Community health measures in 2016

Prioritized need	Measures for 2016
Access to care	▪ Dental conditions are the second-most common reason adults and children come to the emergency department ▪ A growing need for culturally and linguistically-appropriate services
Behavioral health	▪ Nearly 26 percent of adults suffer from depression ▪ Need for timely mental health and substance use treatment services for school-aged youth ▪ Nearly one in three children in surveyed households have been diagnosed with a behavioral health condition
Chronic conditions	▪ Over 32 percent of adults are obese ▪ Hypertension and diabetes are the top two reasons vulnerable adults use the Emergency Department ▪ Access to healthy, affordable food seen as a part of a healthy community, as well as a priority identified need
Social determinants of health and well-being	▪ Homelessness/affordable housing were frequently identified needs ▪ Many families struggle with generational poverty and lack of living wage jobs ▪ The Latino community identified challenges related to racism and discrimination, but expressed strong social support within their community

Measuring our success: Results from our 2013 CHNA

This report also evaluates results from our most recent CHNA in 2013. Identified prioritized needs were: access to preventive and primary care; mental health and substance use treatment services; chronic conditions prevention and management; and oral health. Providence responded by making investments of time, resources and funding to programs that were most likely to have an impact on these needs. This summary includes just a few highlights from across Yamhill County.

Name	Type of program	Outcomes	Our support
A Family Place	Relief nursery; expansion of services	Over 700 hours of classroom services provided in Q1 2016	Grant funding
Partners for a Hunger-Free Oregon	Summer meals program and general operations	7,000 children served across Oregon (322,000 summer meals) in 2015	Grant funding, policy collaboration, technical assistance
Project Access NOW	Community Care Connections/patient support program	Over 180 individuals served in Yamhill County since 2015	Funding, co-developed referral platform
Parish Health Promotors (*promotores*)	Volunteer community health worker model based in Catholic parishes	10 *promotores* trained in *Tomando Control*; hosted 16 dental clinics	Providence program supported through volunteers/lay community health workers

This assessment helps and guides our community benefit investments, not only for our own programs but also for many nonprofit partners. Please join us in making our communities healthier.

Acknowledgements
Summary of community input

We would like to thank the participants who provided feedback during the community health needs assessment process. Community member input was vital to the needs assessment and will also be used to develop our community health improvement plan. Many attendees participated more than once in various meetings and community presentations. We are grateful for your time and contribution to this project.

This section describes how the hospital collected and included input from people who represent the broad interests of the community. It summarizes the type of input provided, how the information was collected and over what time period the input was provided.

Summary of Community Health Survey

In partnership with the Center for Outcomes Research and Education (CORE), Providence's Community Health Division created a survey to assess several domains of health. The survey was fielded May through June 2016 and was sent to a random sample of residential addresses within Providence Newberg's service area (Yamhill County). Of the 875 surveys mailed, 226 were returned. Results were weighted by age based upon respondent demographics. The full survey and report from CORE are included in Appendix I.

Summary of Key Stakeholder Interviews

During the summer and early fall of 2016, Providence conducted several key stakeholder interviews with individuals willing and able to speak of the needs of the community and the populations they represent. A full list of interviewed individuals and question guide is included in Appendix II. The key themes that emerged from these conversations were homelessness and affordable housing, drug abuse and mental health amongst adolescents, generational poverty, as well as access to primary care and food security in rural areas of western Yamhill County.

Summary of Community Listening Sessions

Based upon information available through the responses received to the Community Health Survey and other information available, Providence prioritized gathering feedback from the Latino community in Yamhill County. The Community Health Division hosted a guided conversation with 12 volunteer community health workers in the county. The session was guided by three domains: vision for a healthy community, needs or barriers to achieving health, and existing resources.

Feedback around their vision for a healthy community included better communication of resources, better connections within the community, living wage jobs, ability to have leisure time, and adequate access to medical services. Key needs identified include access to medication and medical care in Spanish, immigration status, lack of inclusion, and lack of time for family. Identified community resources were the parish health promoters program (*Promotores*), Medicaid expansion, access to depression counseling, good jobs, and feeling a part of the community. The question guide is included in Appendix III. Additional sessions will be hosted as part of the Community Health Improvement Planning process in early 2017.

Summary of Written Comments

None received.

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Introduction

Creating healthier communities, together

As health care continues to evolve, Providence is responding with dedication to its Mission and a desire to *create healthier communities, together*. Partnering with others, we conduct a formal community health needs assessment to learn about the greatest needs and assets in our community. The assessment looks specifically at members of medically underserved, low-income, and minority populations or individuals.

This assessment helps us develop collaborative solutions to fulfill unmet needs and to strengthen existing local resources. It guides our community benefit investments, not only for our own programs but also for many partners. This collaboration helps us collectively focus on and align our strategies to improve the health of entire populations. Through strategic programs and donations, health education, charity care, medical research and more, Providence provided $848 million in community benefit across Alaska, California, Montana, Oregon and Washington during 2014.

Serving Yamhill County and Oregon

During 2015, Providence's Oregon Region provided $417 million in community benefit in response to unmet needs, funding programs aimed at improving the health and well-being of those we serve across the state. In Yamhill County, we provided $15.3 million in total community benefit. In Yamhill County, Providence proudly serves the community anchored by Providence Newberg Medical Center. Our 40-bed hospital provides an array of services including primary care, surgical services, obstetrics and gynecology, diagnostic imaging, pediatrics, intensive care, and emergency care. Providence Medical Group operates a network of primary, urgent, and specialty care.

About us

Providence Health & Services is a not-for-profit Catholic health care ministry committed to providing for the needs of the communities it serves – especially for those who are poor and vulnerable. Providence's combined scope of services includes 34 hospitals, 475 physician clinics, senior services, supportive housing and many other health and educational services. The health system and its affiliates employs more than 76,000 people across five states – Alaska, California, Montana, Oregon and Washington – with its system office located in Renton, Washington. Our community health activities are rooted in the charitable work the Sisters of Providence started nearly 160 years ago when they answered a call for help from a new pioneer community in the West.

Our Mission
As people of Providence, we reveal God's love for all, especially the poor and vulnerable, through our compassionate service.

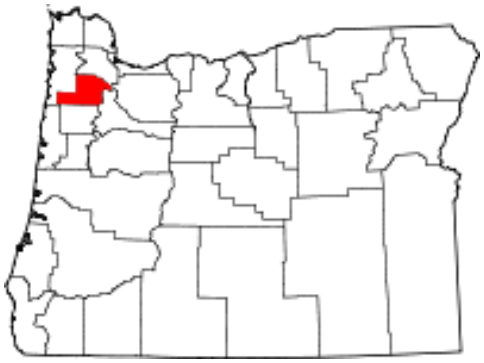
Our Values
Respect, Compassion, Justice, Excellence, Stewardship

Our Vision
Simplify health for everyone

Our Promise
Together, we answer the call of every person we serve: Know me, Care for me, Ease my way. ®

Description of community

This section provides a definition of the community served by the hospital, and how it was determined. It also includes a description of the medically underserved, low-income and minority populations.

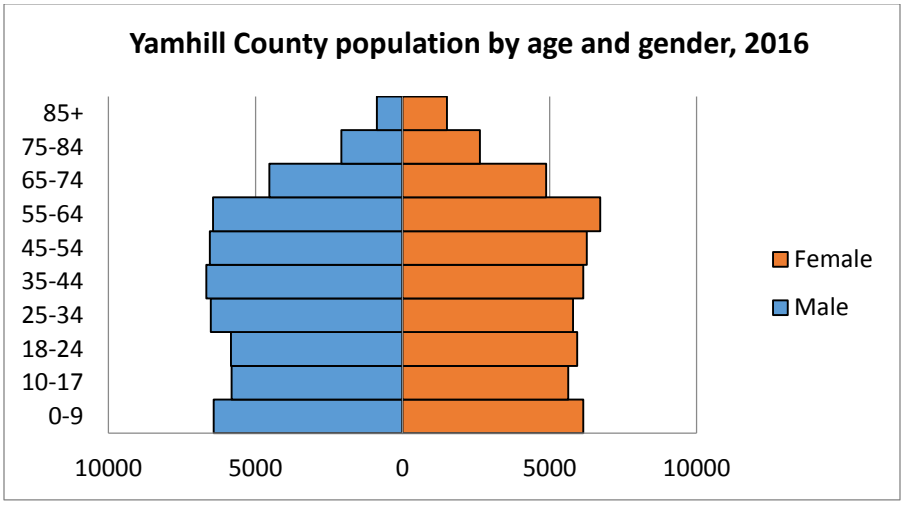


Community profile

Providence Newberg Medical Center (PNMC) primarily serves residents of Yamhill County. Cities include Sherwood, Newberg, Dundee, Dayton, and Lafayette, with some patients traveling from McMinnville. Given the geography of the area, all of Yamhill County is considered the primary service area for PNMC. The secondary service area includes bordering zip codes of nearby Washington County.

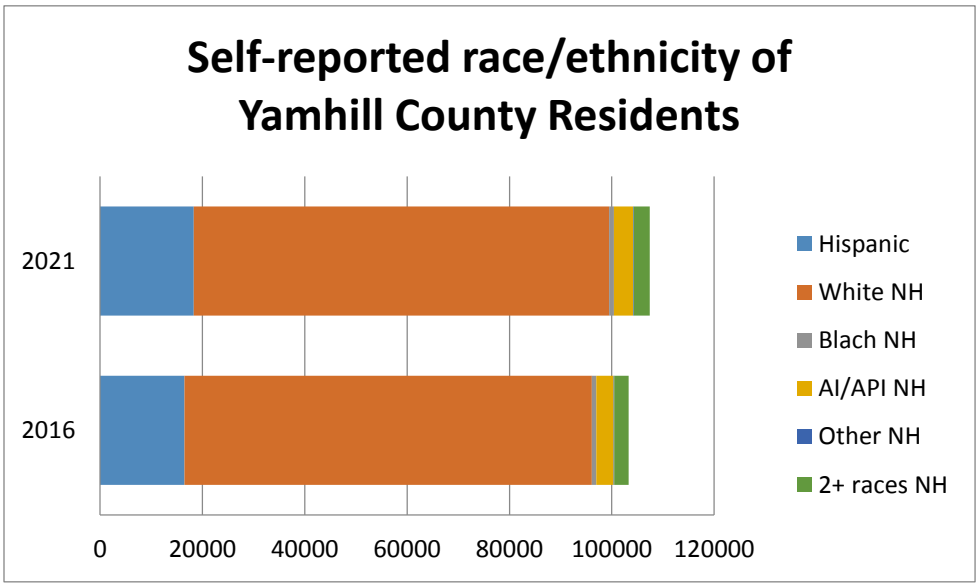
Population and age demographics

As of June 2016, the total population is 103,295, representing slightly more than 21 percent since 2000. The following chart shows the age and gender distribution of the current population of Yamhill County. The county follows a fairly normal distribution by age and gender, with more surviving females than males at older ages. Approximately 15 percent of the county's population is at or above age 65, which is in line with the national average.



Ethnicity

The following table shows the current self-reported race and ethnicity for residents in Yamhill County, as well as a five-year projection. The largest portion of the population identifies as White non-Hispanic, with Hispanic or Latino being the second-most populous group in the county. Between 2016 and 2021, the Hispanic/Latino population is expected to grow the most.



*NH denotes "non-Hispanic"

Income

In 2015, the median household income for Yamhill County was $53,864 and the unemployment rate was 4.7 percent. This is slightly lower than the median income for the state of Oregon ($54,148) and the United States ($55,755).

Health care and coverage

The share of Yamhill County residents who are uninsured was 14 percent in 2014, though there are many different estimates due to the number of migrant and seasonal farmworkers in the region. Between 2015 and 2016, 19.4 percent of survey respondents were unable to get needed care due to the cost of care.

Health and wellbeing

In Yamhill County, 27 percent of 8th grade students, 31 percent of 11th graders, and 32 percent of adults are overweight or obese according to the most recent Oregon Healthy Teens Survey and Behavioral Risk Factor Surveillance Survey. These rates are slightly higher than the state average for 8th and 11th grade, and about the same for adults.

Process, participants and health indicators

This section provides a description of the processes and methods used to conduct the assessment; this section describes data and other information used in the assessment, the methods of collecting and analyzing the information, and any parties with whom we collaborated or contracted with for assistance. This section also provides a summary of how we solicited and took into account input received from persons who represent the broad interests of the community. This description includes the process and criteria used in identifying the health needs as significant.

Assessment process

Every three years, Providence Newberg conducts a CHNA for Yamhill County. The CHNA is an evaluation of key health indicators of the community. Information for this assessment comes from both primary and secondary data.

Primary data is information that has been collected specifically for the purposes of this assessment. Secondary data is information that has been collected by others or for other purposes, but provides valuable context and information for the assessment. Each of these sources are discussed in more detail below.

Participants

Providence conducted the CHNA through its Community Health Division. A contractor, Mary Stoneman, joined to conduct key stakeholder interviews. Interviewees included a school superintendent, Yamhill Community Care Organization, as well as social service providers. Input was also collected from the Yamhill Service Area Advisory Council, which includes the director of Yamhill County Public Health, the fire chief of Newberg, mental health providers, primary care providers, specialists, and community members. Additional information regarding these interviews is available in Appendix II.

Providence Newberg Medical Center

The Providence Mission reaches out beyond the walls of care settings to touch lives in the places where relief, comfort and care are needed. One important way we do this is through community benefit spending. Providence programs and funding not only enhance the health and well-being of our patients, but the whole community. Providence is committed to supporting broader determinants of health beyond clinical care. Providence's community benefit connects families with preventive care to keep them healthy, fills gaps in community services and provides opportunities that bring hope in difficult times.

When the Sisters of Providence began our tradition of caring nearly 160 years ago, their ministry greatly depended on partnering with others in the community who were committed to doing good. Today, we collaborate with social service and government agencies, charitable foundations, community organizations, universities and many other partners to identify the greatest needs and create solutions together.

Data collection

Primary Data

This is information that was collected specifically for the purposes of this assessment. It includes a Community Healthy Survey, key stakeholder interviews, community listening session and hospital utilization data.

- Community Health Survey: this was a 43-question survey that was mailed to 875 residential addresses in Yamhill County in Spring 2016, administered by the Center for Outcomes Research and Education (CORE). A complete copy of the survey, including detailed methods and results, is available in Appendix I.
- Key stakeholder interviews: a series of interviews occurred in September and October 2016 with individuals who have particular expertise or perspective in the health of Yamhill County residents. A list of those interviewed, as well as the question guide used, is provided in Appendix II.
- Community listening session: this was a structured dialogue with participants representing the Latino community in October 2016. Based upon survey response and other information available, Providence wanted to better understand the needs of this particular community. The discussion guide used is included in Appendix III, and the findings of the session are summarized on page 6 of this document.
- Hospital utilization data: an important indicator of a community's health is its access to appropriate levels of care. The Agency for Healthcare Research and Quality (AHRQ) defined a list of conditions and diagnostic codes that should not result in an emergency department visit with appropriate access to primary care. We looked at information for emergency department utilization for these conditions amongst individuals identified as uninsured, Medicaid, or dual eligible (Medicare and Medicaid) over a one-year period from April 1, 2014 through March 31, 2015.

Secondary Data

This is information that has been collected or reported from other sources or for different reasons other than the needs assessment. This includes Yamhill County public health reports, Oregon Department of Education reports, County Health Rankings, and the Annie E. Casey Kids COUNT Data Book.

Identification of significant health needs

The previous section notes the various forms of information that were taken into account during this assessment. As much as possible, qualitative and quantitative data were treated equally. We saw the opportunities to use interviews and listening sessions to validate the quantitative data, as well as help point us to other information we might like to explore. All topics that were presented in the key stakeholder interviews and community listening session were considered significant health needs. For quantitative data, significant health needs were those that had 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.

Health Indicators and trends

We evaluated over 100 indicators and themes through county public health data, hospital utilization information, the Community Health Survey, key stakeholder interviews, and the community listening session. We also use our current community benefit-funded programs and initiatives to provide additional information. Those that demonstrated worsening trend, were worse than the state average, or those that had a disproportionate impact on communities of color, low-income, or otherwise marginalized populations were particularly important to us.

There were 13 needs identified by two or more sources of information, which have been grouped into four actionable focus areas:

1. Access to care
2. Behavioral health
3. Chronic conditions
4. Social determinants of health and well-being

Access to care

Primary care

Although greatly improved since 2013, access to primary care remains a priority. This includes insurance coverage, the number of primary care providers compared to the population, and general access to primary care.

Since Medicaid expansion in 2013, the uninsured rate in Yamhill County has fallen to approximately 14 percent. However, this is substantially higher than the state average of 5 percent. Yamhill County has fewer primary care physicians relative to population than elsewhere in the state (1,351:1 compared to 1,115:1 across Oregon). One in four respondents to the Community Health Survey did not have someone they thought of as their primary care provider. Nearly 12 percent of respondents went without needed medical care in the past year, with most people recognizing cost, not being able to get an appointment quickly enough, and not having a regular provider as the most common barriers.

Dental care

There is relatively little information available regarding dental care access through state or county public health data. However, dental conditions remain one of the top reasons vulnerable adults (uninsured, Medicaid, and dual eligible) access the emergency department for conditions that are better treated in another setting. In 2012, 255 unique individuals came to the emergency department for dental conditions. In 2014, that number had decreased to 182 adults and 20 youth. This is still higher than we would like, but demonstrates improvement.

More than nine percent of respondents to the Community Health Survey noted having to go without needed dental care because they were having trouble making ends meet. This response disproportionately represented individuals and families at or below 200 percent FPG (20 percent) and those with Medicaid, no insurance or dual eligible (33 percent).

Culturally-responsive care

While access to primary care providers, including nurse practitioners and other advanced practice providers has improved in recent years, few of them are bi-lingual or bi-cultural. This challenge was apparent in the Listening Session as well as through information regarding utilization of interpretive services. Key stakeholders expressed specific need for Spanish-language and community outreach services, highlighting Providence's *Promotores* program as an example of what is working.

Behavioral health

Mental health treatment services

There are slightly fewer mental health providers per 1,000 population than the state average in Yamhill County. Of survey respondents, approximately 27 percent of people had been told they have at least one behavioral health condition. More than 21 percent of survey respondents have been diagnosed with depression, 17 percent with anxiety, and more than 6 percent with post-traumatic stress disorder. Depression and anxiety were both more common in individuals at or below 200 percent FPG.

One in three families had been told by a doctor that at least one child had a mental or behavioral health condition, demonstrating that mental health services are needed for both the adult and pediatric population.

Substance use treatment services

There are relatively few substance use treatment options available in Yamhill County, and many people travel to Portland for treatment. Lack of access to treatment was also a theme that emerged from key stakeholder interviews, particularly for adolescents and seniors. According to the Behavioral Risk Factor Surveillance Survey (BRFSS), approximately 15 percent of adults in Yamhill County drink excessively (the average for Oregon is just below 17 percent).

Additionally, the 2015 Oregon Healthy Teens Survey found 8.4 percent of 8th grade students in Yamhill County and 23 percent of 11th grade students had used alcohol in the past 30 days, 18 percent of 11th graders had used marijuana or hashish, and 4.2 percent of 11th graders had used prescription drugs without a doctor's orders in the month prior to the survey.

Adverse experience and trauma prevention

The Community Health Survey was one of the first tools developed to assess prevalence of trauma exposure in the county population. The results from the survey responses were weighted only by age, so are likely not generalizable to the entire population. However, the survey found that nearly 29 percent of respondents had experienced at least one traumatic life event and nearly 12 percent have experienced three or more. The most common event was life-changing illness or injury (28.8 percent), followed by living with someone with mental illness or substance abuse (24 percent) and having witnessed or experienced violence 23.2 percent). Medicare beneficiaries were more likely to report having experienced a life-changing illness or injury, while those in the Medicaid/uninsured/dual eligible category were more likely to have lived with someone with mental illness or substance abuse and to have witnessed or experienced violence.

Chronic conditions

This is a broad category that includes long-term illnesses. These conditions arise from a variety of factors including genetics, lifestyle and health behaviors, and environmental factors.

Asthma

Asthma is the second leading reason for emergency department utilization among children and the third most common reason for adults, resulting in 461 visits during the study period. Nearly one in four parents reported having a child diagnosed with asthma in the Community Health Survey, and approximately 11 percent of adults reported having been diagnosed with asthma themselves. This diagnosis is most often related to and aggravated by environmental factors.

Diabetes

Type II diabetes is the second-most common reason for adult visits to the emergency department, with 634 visits recorded during the study period across 337 unique patients. Type II diabetes is generally considered a diet-related chronic condition, which can be controlled through diet, exercise, and healthy behaviors. However, use of the emergency department is a sign of poorly controlled diabetes and signals poor primary care access. About 10 percent of survey respondents in Yamhill

County have been told by a doctor that they have diabetes, slightly higher than the BRFSS estimate of 8.3 percent.

Hypertension

Hypertension, or high blood pressure, remains the most common reason for potentially avoidable emergency department utilization amongst vulnerable adults. From April 2014 through March 2015, 645 unique patients came PNMC's Emergency Department 1,144 times as a result of hypertension. More than 28 percent of survey respondents have been told by a doctor that they have high blood pressure, with the diagnosis being far more likely amongst Medicare beneficiaries (52 percent).

Obesity

More than 32 percent of the adult population in Yamhill County is obese, which is higher than Oregon's overall rate of 26 percent according to BRFSS. More than 27 percent of 8th graders and 31 percent of 11th graders are overweight or obese. These values are also higher than the state average of 26.8 and 28.6 percent, respectively. This was of particular concern to key stakeholders, particularly those that worked with school-aged youth. Obesity is often impacted by limited access to healthy foods and recreation, both of which are considered social determinants of health.

Social determinants of health and well-being

The term "social determinants of health" refers to factors that contribute to the health and well-being of individuals in a social context. In other words, variables of health occur where people live, work, learn, and play. Sometimes these factors can be related directly to health, but other times they are factors that are not commonly considered health factors, like access to affordable housing and transportation. However, all social determinants of health have a measurable impact on the health of a community.

Affordable housing

Access to safe, affordable housing has emerged as an issue across the state of Oregon in the past two years. Studies have demonstrated the importance of housing on health outcomes, which is why it is considered a social determinant of health. Despite being an area known for its relative wealth, nearly nine percent of survey respondents reported not having stable housing, or having stable housing, but being worried about losing it. These responses were particularly common amongst respondents who were at or below 200% FPG or were in the Medicaid/uninsured/dual eligible insurance category.

Healthy food access

Healthy food access, including affordability of fruits and vegetables, is an important component to keep people well. Key stakeholders reported that this was a particular challenge in rural areas of the county, and some expressed concern for seniors.

In the 2015 Oregon Health Teens survey, 21.7 percent of 11th graders in Yamhill County reported eating less food than felt they should because there wasn't enough money to buy food. This is higher than the state-reported average of 18.5 percent. The Community Health Survey identified nearly 40 percent of people having fewer than two servings of fruit per day and 37 percent of people having fewer than two servings of vegetables per day. Medicare beneficiaries and those in the Medicaid/uninsured/dual eligible category were more likely to report having less than two servings of both fruits and vegetables.

Transportation

While survey respondents did not note a specific need for transportation, key stakeholders were particularly concerned about transportation for seniors. As the elderly population in Yamhill County is growing, stakeholders and public health partners want to ensure that seniors have safe, effective means of transportation and support.

Identified priority health needs

This section describes the significant priority health needs that were identified during the CHNA. This section also describes the process and criteria used to prioritize the needs. Potential resources in the community to address the significant health needs are also described in the section.

Prioritization process and criteria

Based upon the various sources of information in this assessment, items that were corroborated by two or more sources were identified as priority health needs. These needs were then grouped into four actionable categories, which will guide our efforts in developing the Community Health Improvement Plan. Due to the nature of initial identification of needs, this prioritization included worsening trends, values worse than state averages, and a disproportionate impact on communities of color, low-income, or otherwise marginalized groups.

Additional prioritization regarding feasibility, effectiveness of interventions, and ability to partner with community organizations will be applied during CHIP development.

Priority health issues and baseline data

Priority Health Issue	Rationale/contributing factors
1. Access to care	14 percent of residents remain uninsured 19 percent went without needed dental care 25 percent of survey respondents do not have someone they think of as their primary care doctor
2. Behavioral health	23 percent of Yamhill County 11th grade students drank alcohol 29 percent of survey respondents have experienced at least one adverse life event Symptoms of depression and anxiety are more common amongst low-income populations
3. Chronic conditions	1,144 emergency department visits for hypertension 28.7 percent of adults have high blood pressure (hypertension) 32.2 percent of adults are obese
4. Social determinants of health and well-being	39.6 percent have fewer than two servings of fruit per day 37 percent have fewer than two servings of vegetables per day Housing concerns disproportionately impacted low-income households and those with Medicaid, uninsured, or dual eligible individuals

Addressing identifed needs

This section describes how Providence will develop and adopt an implementation strategy (i.e. community health improvement plan) to address the prioritized community needs.

Plan development

Providence will consider the prioritized health needs identified through this community health needs assessment and develop a strategy to address each need. Strategies will be documented in a community health improvement plan (CHIP). The CHIP will describe how Providence plans to address the health needs. If Providence does not intend to address a need, the CHIP will explain why[1].

The CHIP will describe the actions Providence intends to take to address the health need and the anticipated impact of these actions. Providence will also identify the resources the hospital plans to commit to address the health need. Because partnership is important to addressing health needs, the CHIP will describe any planned collaboration between Providence and other facilities or organizations in addressing the health need.

The CHIP will be approved by the Providence Yamhill Service Area Advisory Council by May 15, 2017. When approved, the CHIP will be attached to this CHNA report in Appendix IV.

Providence prioritized needs

Providence prioritized needs
1. **Access to care** 2. **Behavioral health** 3. **Chronic conditions** 4. **Social determinants of health and well-being**

[1]Reasons may include resource constraints, other facilities or organizations in the community addressing the need, a relative lack of expertise or competency to address the need, the need being a relatively low priority, and/or a lack of identified effective interventions to address the need.

Evaluation of impact from 2014-2016 Community Health Improvement Plan

This section evaluates the impact of actions that were taken to address the significant health needs identified in the prior community health needs assessment and associated implementation strategy (i.e. community health improvement plan).

Following the prior CHNA, Providence collaborated with community partners to develop a community health improvement plan (CHIP) to address the needs identified below. The top health issues for the 2014-2016 CHNA/CHIP were:

1. Access to preventive and primary care
2. Mental health and substance use treatment services
3. Chronic conditions prevention and management
4. Oral health

The following is an overview evaluating some of the CHIP efforts and their impact on the identified needs.

Prioritized Need #1: Access to preventive and primary care

Data Point	Previous CHNA	Current CHNA
Primary care providers	1,381:1	1,340:1
Insurance coverage	80 percent	84 to 92 percent

Key activities to improve access to preventive and primary care have included expansion of services available at Providence Newberg, particularly regarding geriatric programs and hiring advanced practice providers. Providence has maintained its commitment to serving the poor and vulnerable by offering fully discounted care for families at or below 300% FPG, and has financial counselors and insurance enrollment assisters available for patients at any time.

There are more primary care providers now than there were in 2013, with the ratio of population per provider decreasing from 1,381 in 2013 to 1,340 in 2016. Insurance coverage also increased in the county. Some estimates, such as County Health Rankings, put insurance coverage at 86 percent, while a 2014 study by Oregon Health & Science University (OHSU) *Impacts of the Affordable Care Act on Insurance Coverage in Oregon* estimated that the percentage of uninsured had fallen to 8.2 percent.

Prioritized Need #2: Mental health and substance use treatment services

Providence provides behavioral health services, including integrated behaviorists. Hospital-based behavioral health services are primarily provided by Providence St. Vincent Medical Center, with Yamhill County Health & Human Services providing the majority of local treatment options. Providence continues to partner with Yamhill Community Care Organization and Yamhill County to better understand the access-related needs and opportunities for local treatment services.

Providence partners with George Fox University and hosts three Doctorate of Clinical Psychology students during their practicum each year, as well as provides other on-call and training opportunities. Providence has provided funding to Catholic Community Services for the Rainbow Lodge Crisis Respite Center as well as Lutheran Community Services NW for A Family Place Relief Nursery. Rainbow Lodge opened in November 2015 and serves as a respite center for families with

children experiencing mental health crises. Since its opening, the Lodge has served 37 youth and estimates that their programs have prevented 196 nights of youth being held unnecessarily in an emergency department or otherwise away from their families. Lutheran Community Services NW operates A Family Place Relief Nursery in Yamhill County, which provides outreach and relief classrooms for high-risk parents and families. Providence's support allowed A Family Place to open a second "baby" classroom with staffed teacher interventionists, providing respite for parents and developmental opportunities for children. Funding was also used to conduct outreach and home visiting for high-risk families, and is being used to leverage additional resources through the Oregon Department of Education. The program's expansion exceeded initial expectations and provided over 700 classroom hours in the first three months of 2016. Both of these programs aim to reduce unnecessary emergency department utilization for mental and behavioral health conditions, as well as reduce neglect and exposure to trauma.

Prioritized Need #3: Chronic conditions prevention and management

Data Point	Previous CHNA	Current CHNA
Obesity	35 percent	32.2 percent
Type II Diabetes (Emergency Department utilization)	Not available	634 visits
Hypertension	26.9 percent	28.7 percent

Providence Medical Group has engaged in efforts to improve prevention and management of chronic conditions amongst patients. Yamhill County Health & Human Services and Yamhill Community Care Organization have also developed programs to address these challenges through their CHIP process. Noticeably, the adult obesity rate does appear to have decreased based upon results from the most recent Behavioral Risk Factor Surveillance Survey. Providence expanded its Parish health promotors (*Promotores*) program to Yamhill County to better serve the Latino community. These volunteers provide health education and movement and wellness classes as well as outreach activities, such as a Latino mammography screening fair. Many are now undergoing a formal training (*capacitation*) to qualify as certified Community Health Workers should they wish.

Type II diabetes and hypertension continue to be leading reasons for Emergency Department utilization amongst uninsured, Medicaid, and dual eligible adults in Yamhill County. There is continued opportunity to partner with public health agencies on messaging and ensuring that people know where to go for care to manage chronic conditions.

Prioritized Need #4: Oral health

Data Point	Previous CHNA	Current CHNA
Dental health services (adult emergency department utilization)	255 visits	182 visits
Medical Teams International dental van visits (5-6 days)	57 patients	61 patients

Despite there being little public health data available, Providence identified oral health as a priority need based upon emergency department utilization, survey responses, and feedback from key stakeholders. In response to this need, Providence worked with Medical Teams International, Pacific University, and Love, INC to increase access to oral health services in Yamhill County. The Medical Teams International mobile dental van program provided services 5 days in 2013 and 6 days in 2015 in partnership with Love, INC and the Providence *Promotores* program.

Resources potentially available to address the significant needs identified through the CHNA

This section inventories community partners that are addressing the identified needs in the CHNA. This table begins to outline our strategy of creating healthier communities together.

Providence and partners cannot address the significant community health needs independently. Improving community health requires collaboration across community stakeholders. Below outlines an initial list of community resources potentially available to address identified community needs.

Organization or Program	Description	Associated Community Need
Catholic Community Services NW	Rainbow Lodge Crisis Respite Center	Behavioral health
Chehalem Youth and Family Services	Counseling, youth development, family strengthening programs	Behavioral health
George Fox University	Education programs, particularly for mental health professional	Behavioral health
Love, INC	Providing a variety of resources to local families, including dental services, school supplies, clothing, and meals	Access to care; social determinants of health and well-being
Lutheran Community Services NW	A Family Place relief nursery and outreach program	Behavioral health
Newberg FISH Emergency Services	Local food pantry focused on providing healthy food options for low-income families and seniors	Social determinants of health and well-being
Pacific University	Dental assistant program	Access to care
St. Peter Parish	Catholic parish in Newberg	Access to care
Virginia Garcia	Federally-qualified health center serving Yamhill County	Access to care
Yamhill Community Care Organization	The local coordinated care organization providing care for Oregon Health Plan members	Access to care; all
Yamhill County Public Health	County public health agency with WIC and other health outreach programs	All
Yamhill Oral Health Coalition	Convenes partners to work collectively at addressing unmet oral health needs in Yamhill County	Access to care (dental)

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PROVIDENCE
Health & Services

16 December 2016

Providence's Yamhill Service Area Advisory Council has reviewed and approved the findings of the 2016 Community Health Needs Assessment.

Signed:

Lorinda Van Zanten
Chief Executive, Providence Newberg Medical Center

Joel Gilbertson
Senior Vice President, Community Partnerships, Providence Health & Services

Appendices

Appendix I – CORE Community Health Survey report

COMMUNITY HEALTH SURVEY 2016: YAMHILL SERVICE AREA

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EXECUTIVE SUMMARY

PROJECT OVERVIEW

This report gives an overview of results from the Yamhill Service Area community health needs assessment survey. The Center for Outcomes Research and Education (CORE) fielded the surveys in May and June 2016. We sent the survey to a random sample of 875 households in the Yamhill Service Area; 226 surveys were returned, giving a response rate of 26%. The survey was designed to assess community needs within five key domains of interest: **Health Status, Access to Care, Social Determinants of Health, Trauma,** and **Health Behaviors.**

KEY FINDINGS		RECOMMENDATIONS
46.6% of respondents have been diagnosed with a chronic health condition and 26.7% have a behavioral health condition. Common conditions among adults are high blood pressure, high cholesterol, depression, and anxiety. 25.2% of adults said that their child has asthma, and 32.6% report a child diagnosed with a behavioral health condition.	HEALTH STATUS	Behavioral health needs affect more than one in four adults, and low-income* adults are more likely to have a behavioral health diagnosis. **Investments in behavioral health care** could support the needs of the Yamhill Service Area population.
More than one in four respondents (28.6%) report having experienced a traumatic event; 11.7% report having experienced three or more. 28.4% of low-income respondents report having gone without a basic need (food, clothing, transportation, child care, housing, or utilities) and 37.5% report housing instability. Social support scores were low among the Medicaid/Dual/Uninsured population.	SOCIAL DETERMINANTS	**Behavioral health services** and **trauma-informed, culturally-specific care** could support those with a history of adverse life experiences. **Community-based activities and programming** could simultaneously improve community engagement, social support, and behavioral health outcomes. **Affordable housing** could support low-income families.
86.1% of respondents needed care in the last year; 11.5% of respondents needed care but did not get all the care they needed. Reasons for unmet need included cost, inconvenient office hours, and not having a regular provider. While most people had insurance, one in four did not have a personal health care provider.	ACCESS TO CARE	9.0% reported unmet dental care need. **Mobile, low cost, or integrated dental services** could help meet the need. Since many residents don't have a primary care provider, **engagement in primary care homes or behavioral health homes** could reduce unmet need. **Additional outreach** to uninsured populations could help uncover latent need.

Results from the Yamhill Service Area Community Health Survey depict a population that generally has access to basic needs and basic medical care, and that faces a prevalence of chronic disease and mental illness generally comparable to national prevalence rates. Key opportunities for health improvement include behavioral health services, low-cost and/or mobile dental services, trauma-informed care, affordable housing, community programming, engagement in primary care homes, clothing services such as a clothing bank, and transportation solutions for low-income individuals.

A random address-based sample for a mail survey is an excellent means of ensuring that survey responses can be generalized — but those generalizations apply best to people who have stable addresses and who speak English. Predictably, few surveys were returned by people without stable housing or by people who did not speak English. Additional outreach in these populations is critical for future needs assessments and future improvement planning.

*For the purposes of this paper, "low-income" will be defined as those at or below 200% FPL based on household size and self-reported income.

METHODS

This report summarizes results from a *community health survey*. The purpose of this survey was to assess health status and health needs throughout the community, including needs related to the social determinants of health. The survey was conducted by CORE in May and June 2016. Because the survey used a random sample of households in the Yamhill Service Area, results should be broadly representative of health care needs throughout the community.

SAMPLE

We used address-based sampling to capture a representative group of households in the community. Beginning with a list of all deliverable residential addresses in the community, we randomly selected 875 households to receive the survey. 226 surveys were returned, a response rate of 26%.

We referred to Census data from 2010-2014 to identify zip codes where at least 10% of households reported that Spanish was spoken at home. Addresses within these zip codes received surveys in both English and Spanish. 2 Spanish-language surveys were returned.

SURVEY DESIGN AND FIELDING

The Community Health Division worked with CORE to design a base survey consisting of 36 questions. The team also created a list of 91 optional survey questions; Yamhill Service Area leadership selected an additional 6 questions to add to the survey. The added questions collected information about reasons for not having insurance, drug use, child emergency room use, neighborhood safety and traumatic events. Most survey items were selected from nationally validated tools; a copy of the survey is available in the appendix.

Spanish translation was performed by a certified translator. Surveys and invitation letters were reviewed for plain-language.

MULTI-STAGE MAIL SURVEY PROCESS

1 INITIAL AUTO CALL

For participants with valid phone numbers, we sent an automated phone message asking participants to look for the survey in the mail and call us with any questions.

2 INITIAL SURVEY

An initial survey was sent with a letter explaining the purpose of the study, the survey and a postage-paid return envelope and a $5 cash compensation. Areas with a high enough Spanish population also received a Spanish letter and survey.

3 SECOND AUTO CALL

A second automated phone message was sent to participants who did not return the initial survey and had a valid phone number informing them we did not receive their survey and we were sending a second one.

4 SECOND SURVEY

A second survey was sent to participants that did return the initial survey. Fielding closed on July 1st, 2016.

ANALYSIS & WEIGHTING

We entered all data in tabular form and analyzed it with a statistical software package (SAS). To test for statistically significant differences between subgroups in our data, we used two-tailed chi-square tests of association, with a p-value of .10 or less flagged as "statistically significant."

Since our survey respondents are proportionally older than the actual community, we weighted for age. We did not weight results by race/ethnicity, education, or any other variable. All data tables (with the exception of the table noted on the following page) in this report display the weighted percentage (accounting for any oversampling by zip code and for age adjustments), as well as the *actual number of surveys* we received from which those weighted results were computed.

METHODS

REPRESENTATION OF SURVEY FINDINGS

For each survey question, we report the total weighted percentage of respondents who indicated a particular answer. We then report item response rates by race/ethnicity, income, and insurance.

Because few respondents identified as Native American, Black or African-American, Native Hawaiian or Other Pacific Islander, or Asian, we were not able to break down results further than Non-Hispanic White and Hispanic/Latino/Other. For similar reasons, we combine several types of respondents — including dual-eligible and those with military insurance— into the "Medicaid/Other/Uninsured" category, and we present results broken down by income in two categories. For the purposes of this report, "low-income" is defined as at or below 200% of the Federal Poverty Level based on household size and self-reported income.

For each subpopulation, we report the actual number of survey respondents in that category who responded to each question. Not all respondents answered every question; for that reason, the *n* for a subpopulation varies by question.

DEMOGRAPHICS

The table below gives the unweighted distribution of respondents across key demographic categories.

RESPONDENT DEMOGRAPHICS	%	NUMBER OF SURVEYS	RESPONDENT DEMOGRAPHICS	%	NUMBER OF SURVEYS
GENDER			**HOUSEHOLD INCOME**		
Male	42.0%	95	100% FPL or lower	7.1%	16
Female	56.6%	128	101% to 200% FPL	8.0%	18
Transgender	0.4%	1	201% FPL or higher	73.9%	167
Did not answer	0.9%	2	Did not answer	11.1%	25
AGE			**EDUCATION**		
18 to 39 years	11.5%	26	Less than high school	2.7%	6
40 to 64 years	48.7%	110	High school diploma or GED	25.2%	57
65 to 79 years	24.8%	56	Vocational or two year degree	20.8%	47
80+ years	13.3%	30	4-year college degree or more	50%	113
Did not answer	1.8%	4	Did not answer	1.3%	3
RACE & ETHNICITY			**PREFERRED LANGUAGE**		
Hispanic	2.2%	5	English	95.6%	216
White, non-Hispanic	88.5%	200	Other	2.2%	5
Native American	4.0%	9	Did not answer	2.2%	5
Other/Did not answer	5.3%	12			

Respondents to the survey tended to be older and whiter than the overall population (table below). The age distribution of respondents is of particular concern for estimating prevalence of chronic health conditions in the population; to account for this, results presented throughout this report are adjusted using post-stratification weighting that allow for estimates to be representative of the population's true age distribution.

These differences in response patterns by age and race/ethnicity are not uncommon in mail surveys. Enhanced outreach into diverse communities, where language or cultural barriers may serve to suppress response rates, could reduce these discrepancies. Future survey efforts could build in enhanced outreach to ensure better overall representativeness.

DEMOGRAPHICS	RESPONDENTS	Census Estimate	Δ	DEMOGRAPHICS	RESPONDENTS	Census Estimate	Δ
RACE				**AGE**			
White	91.9%	88.1%	3.8%	18 to 39 years	11.7%	38.6%	-26.9%
Native American	2.7%	0.8%	1.9%	40 to 64 years	49.5%	39.3%	10.2%
Other or Multiple Race *	5.4%	11.1%	-5.7%	65 to 79 years	25.2%	15.2%	10.0%
ETHNICITY				80+ years	13.5%	7.0%	6.5%
Hispanic	2.3%	13.5%	-11.2%				

ACCESS TO CARE — ADULTS

INSURANCE COVERAGE

Rates of uninsured were very low among survey respondents: 98.7% of respondents reported that they are currently insured, and most (96.3%) had been insured for all of the last twelve months. Of those who reported that they are not currently insured, the majority (82.2%) said that cost was a key barrier. The slight (0.7%) difference in uninsured rates in the two tables below is due to fewer respondents answering Q2.

Of those reporting that they currently have health insurance, 67.6% are privately insured. 20.2% are covered through Medicare, and 10.1% are covered through Medicaid or are dual-eligible.

Q1: Do you currently have any kind of health insurance?	TOTAL	RACE/ETHNICITY		INCOME	
		Non-Hispanic White n=198	Hispanic/ Latino/ Other n=21	200% FPL or lower n=32	201% FPL or higher n=167
No	1.3%	1.2%	2.3%	1.7%	1.4%

Q2: What kind of insurance do you have? (n=220)	
Private Insurance	67.6%
Medicare	20.2%
Medicaid/Dual-Eligible	10.1%
Uninsured	2.0%

CONNECTION TO CARE

Most respondents had a usual source of care: only 5.1% of respondents reported that they do not have a place to go for health care when it is not an emergency. One in four (25.0%) of all respondents reported that they do not have a person that they think of as their personal doctor or health care provider; within the Medicaid/Dual/Uninsured population, that number is one in three (34.2%).

Q5 and Q7: Usual Place of Care, Personal Health Care Provider	TOTAL	RACE/ETHNICITY		INCOME		INSURANCE		
		Non-Hispanic White n=199	Hispanic/ Latino/ Other n=21	200% FPL or lower n=34	201% FPL or higher n=166	Private n=120	Medicare n=73	Medicaid/ Other/ Uninsured n=26
Do not have a place for care that is not an emergency	5.1%	5.0%	7.4%	14.9%	3.9%	3.9%	1.4%	18.1%
Do not have a personal doctor	25.0%	20.2%	47.0%	29.5%	23.0%	**29.4%**	**5.4%**	**34.2%**

DISPARITY FLAG: *An orange box with bolded text indicates a statistically significant disparity in results by subgroup (two-tailed chi-square test, p<.10). A blue-gray box with non-bold text indicates that we were unable to test for significance.*

ACCESS TO CARE — ADULTS

GETTING CARE WHEN YOU NEED IT

Most respondents (86.0%) reported needing some kind of health care in the preceding 12 months. We found evidence of unmet need in the population—across all respondents, 11.5% reported needing care but not getting all of the care they needed during the last 12 months.

Q8-9: Access to Needed Care in the last 12 months	TOTAL	RACE/ETHNICITY		INCOME		INSURANCE		
		Non-Hispanic White n=190	Hispanic/ Latino/ Other n=19	200% FPL or lower n=34	201% FPL or higher n=158	Private n=116	Medicare n=66	Medicaid/ Dual/ Uninsured n=26
Did not need any kind of health care	13.9%	14.0%	19.6%	24.8%	12.8%	10.5%	12.3%	36.7%
Needed care; got all the care they needed	74.5%	75.3%	54.5%	70.2%	73.5%	75.4%	82.3%	57.4%
Needed care; did not get all the care they needed	11.5%	10.6%	25.9%	5.0%	13.7%	14.1%	5.5%	5.9%

REASONS FOR UNMET NEED

If a respondent indicated that they were not able to access all the care they needed, we asked them to tell us why. The most common reason given was cost (19.4%), although 12.1% reported that they couldn't get an appointment quickly enough and 10.3% said that they went without needed care because they didn't have a regular provider. Cost was less of a barrier for Medicare beneficiaries than it was for those with private insurance, and it was less of a barrier for those with private insurance than it was for those in the Medicaid/Dual/Uninsured category.

Q10: The most recent time you went without needed health care, what were the main reasons? *Mark all that apply.*	TOTAL	RACE/ETHNICITY		INCOME		INSURANCE		
		Non-Hispanic White n=172	Hispanic/ Latino/ Other n=15	200% FPL or lower n=27	201% FPL or higher n=145	Private n=106	Medicare n=64	Medicaid/ Dual/ Uninsured n=16
Cost	19.4%	17.2%	25.4%	26.5%	16.4%	**20.6%**	**6.5%**	**38.0%**
Couldn't get an appointment quickly enough	12.1%	12.8%	11.9%	19.8%	12.4%	14.0%	7.9%	4.7%
Not having a regular provider	10.3%	8.9%	22.2%	6.7%	115%	12.9%	0.0%	15.2%
Other (transportation, childcare, clinic not open, didn't know where to go)	18.5%	18.2%	25.5%	8.0%	17.2%	18.2%	14.3%	29.9%

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HEALTH STATUS — ADULTS

OVERALL HEALTH & DISEASE PREVALENCE

OVERALL HEALTH: About one in ten (9.6%) respondents rated their overall health as "Fair" or "Poor" (vs . Good, Very Good, or Excellent). Those in the Medicaid/Dual/Uninsured category were significantly more likely (28.2%) to report "fair" or "poor" health than Medicare beneficiaries (14.3%) or those with private insurance (5.2%).

Q11: Self-Reported Overall Health (Fair or Poor vs Good, Very Good, or Excellent)	TOTAL	RACE/ETHNICITY		INCOME		INSURANCE		
		Non-Hispanic White n=197	Hispanic/ Latino/ Other n=21	200% FPL or lower n=33	201% FPL or higher n=165	Private n=121	Medicare n=71	Medicaid/ Dual/ Uninsured n=26
Percent Fair or Poor	9.6%	10.6%	4.9%	13.0%	7.3%	**5.2%**	**14.3%**	**28.2%**

CHRONIC DISEASE: Nearly half (46.6%) of respondents report having been diagnosed with a chronic physical condition, and 26.7% report a chronic behavioral health condition. The most common chronic conditions reported by the Yamhill Service Area population are high blood pressure (28.3%) and high cholesterol (22.3%). All prevalence estimates are age-adjusted.

Q12. Have you ever been told by a doctor or other health professional that you have any of the following? *Mark all that apply.*	TOTAL	RACE/ETHNICITY		INCOME		INSURANCE		
		Non-Hispanic White n=197	Hispanic/ Latino/ Other n=20	200% FPL or lower n=34	201% FPL or higher n=164	Private n=121	Medicare n=69	Medicaid/ Dual/ Uninsured n=26
High Blood Pressure	28.3%	30.1%	23.4%	31.6%	26.9%	**22.2%**	**52.1%**	**24.1%**
High Cholesterol	22.3%	23.5%	18.0%	33.1%	19.9%	**13.5%**	**57.2%**	**18.5%**
Depression	21.4%	**24.4%**	**3.6%**	**43.3%**	**16.3%**	20.3%	15.3%	37.3%
Anxiety	17.0%	**19.3%**	**3.6%**	**33.2%**	**13.4%**	16.1%	12.2%	32.1%
Asthma	10.8%	9.7%	24.8%	**1.9%**	**11.9%**	11.3%	9.4%	12.2%
Diabetes	9.9%	7.4%	22.1%	**27.4%**	**5.6%**	**2.6%**	**16.5%**	**28.9%**
PTSD	6.5%	6.2%	0.0%	9.5%	2.5%	2.1%	5.7%	23.3%
Another behavioral health condition	2.2%	2.2%	2.7%	4.4%	1.3%	0%	9.6%	2.9%
At least 1 physical condition	46.6%	46.7%	62.1%	53.4%	43.5%	**37.1%**	**75.9%**	**56.4%**
At least 1 behavioral health condition	26.7%	**29.9%**	**9.9%**	**45.2%**	**21.8%**	24.0%	28.7%	40.2%
At Least 1 behavioral health condition AND physical chronic condition	13.9%	15.4%	6.3%	**22.8%**	**9.6%**	**8.3%**	**25.8%**	**25.5%**

Those in the non-Hispanic white category were more likely to report a behavioral health condition. Low-income respondents were generally sicker than those with incomes above 200% FPL. Medicare beneficiaries were more likely to have high blood pressure or high cholesterol; those in the Medicaid/Dual/Uninsured category were more likely to have diabetes.

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HEALTH STATUS — ADULTS

ANXIETY AND DEPRESSION SYMPTOMS

The survey included a short series of questions designed to assess whether a respondent might currently be experiencing symptoms of anxiety or depression (as opposed to having received a diagnosis of depression). 8.7% of respondents reported currently experiencing symptoms of anxiety, and 5.1% reported active symptoms of depression.

Q14: Symptoms of Anxiety or Depression (GAD-2 and PHQ-2 Screening Tools).	TOTAL	RACE/ETHNICITY		INCOME		INSURANCE		
		Non-Hispanic White n=187	Hispanic/ Latino/ Other n=19	200% FPL or lower n=32	201% FPL or higher n=164	Private n=118	Medicare n=66	Medicaid/ Dual/ Uninsured n=22
Current symptoms of anxiety	8.7%	10.1%	0.0%	20.5%	5.5%	5.4%	2.9%	39.7%
Current symptoms of depression	5.1%	5.6%	2.7%	16.7%	3.4%	2.7%	7.0%	16.4%

OBESITY/BMI

The survey asked respondents to report their height and weight, which allowed us to calculate self-reported Body Mass Index (BMI). We used these data to estimate age-adjusted estimates of obesity rates (BMI 30+), detailed below.

Q33-34: Body Mass Index (Based on Self Reported Height and Weight)	TOTAL	RACE/ETHNICITY		INCOME		INSURANCE		
		Non-Hispanic White n=194	Hispanic/ Latino/ Other n=21	200% FPL or lower n=32	201% FPL or higher n=164	Private n=117	Medicare n=72	Medicaid/ Dual/ Uninsured n=24
Overweight (BMI 25-29)	33.7%	31.3%	48.2%	32.1%	33.5%	33.4%	33.2%	38.4%
Obesity (BMI 30+)	27.3%	29.9%	15.8%	24.5%	27.6%	25.0%	27.3%	40.3%

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HEALTH STATUS — CHILDREN

CHRONIC DISEASE AMONG CHILDREN

We asked respondents about the health of their children . Overall, 40.5% (n=60) of respondents reported that they had children under 18 years of age; of those, 25.2% report that at least one of their children has a chronic physical health condition and 32.6% reported a behavioral health condition. The most common physical illness among children is asthma, with 25.2% of respondents who have children under 18 reporting a diagnosis for at least one of their children. The most common behavioral health diagnosis among children is anxiety; 18.7% of respondents with children report that at least one of their children has received an anxiety diagnosis.

Q25. Have you ever been told by a doctor or other health professional that any of your children have the following? *Mark all that apply.*	TOTAL	RACE/ETHNICITY		INCOME		INSURANCE		
		Non-Hispanic White n=51**	Hispanic/ Latino/ Other n=4	200% FPL or lower n=5	201% FPL or higher n=45	Private n=52	Medicare n=0	Medicaid/ Dual/ Uninsured n=4
Asthma	25.2%	27.1%	*	*	22.1%	20.1%	N/A	*
A behavioral health diagnosis	22.5%	25.0%	*	*	26.1%	25.6%	N/A	*
Anxiety	18.7%	19.8%	*	*	23.5%	21.3%	N/A	*
Depression	7.4%	8.3%	*	*	9.8%	8.5%	N/A	*
Diabetes	4.7%	5.2%	*	*	6.2%	5.4%	N/A	*
A developmental delay or learning disability	2.7%	3.1%	*	*	2.4%	3.1%	N/A	*
PTSD	0.0%	0.0%	*	*	0.0%	0.0%	N/A	*
Another ongoing health condition	15.9%	16.7%	*	*	13.6%	13.8%	N/A	*
At least 1 physical condition	25.2%	27.1%	*	*	22.1%	20.1%	N/A	*
At least 1 behavioral health condition	32.6%	34.4%	*	*	33.3%	32.9%	N/A	*

***** *We did not report results when five or fewer respondents from a subgroup answered the question.*

*** Not all respondents completed demographic information; responses for subpopulations will not total to 60.*

DISPARITY FLAG: *An orange box with bolded text indicates a statistically significant disparity in results by subgroup (two-tailed chi-square test, p<.10). A blue-gray box with non-bold text indicates that we were unable to test for significance.*

ACCESS TO CARE — CHILDREN

EMERGENCY ROOM USE FOR CHILDREN

More than one in four (28.3%) parents reported that their child had gone to the emergency room in the last 12 months.

Q 23: In the last 12 months, how many times did your child go to the emergency room to get care?	TOTAL	RACE/ETHNICITY		INCOME		INSURANCE		
		Non-Hispanic White n=52	Hispanic/ Latino/ Other n=5	200% FPL or lower n=5	201% FPL or higher n=47	Private n=54	Medicare n=0	Medicaid/ Dual/ Uninsured n=4
None	68.0%	69.2%	*	*	76.1%	72.0%	N/A	*
One or two times	28.3%	30.8%	*	*	23.9%	28.0%	N/A	*
Three or more times	3.7%	0.0%	*	*	0.0%	0.0%	N/A	*

We asked parents who had taken their child to the emergency room in the last year (n=9) to tell us why they had taken their children to the emergency room instead of somewhere else. The most common answer was that their child had needed care; another common response was that the doctor's office or clinic was closed.

Q24: The most recent time your child went to the ER, what was the main reason you went there instead of somewhere else for health care?	TOTAL	RACE/ETHNICITY		INCOME		INSURANCE		
		Non-Hispanic White n=9	Hispanic/ Latino/ Other n=0	200% FPL or lower n=1	201% FPL or higher n=7	Private n=1	Medicare n=0	Medicaid/ Dual/ Uninsured n=8
My child needed medical care	61.3%	61.3%	N/A	*	85.0%	*	N/A	0.0%
Doctor's office/clinics were closed	38.7%	38.7%	N/A	*	15.0%	*	N/A	100.0%
I couldn't get an appointment soon enough	5.4%	5.4%	N/A	*	7.5%	*	N/A	0.0%
My child needed a prescription drug	5.4%	5.4%	N/A	*	7.5%	*	N/A	0.0%
Another reason	0.0%	0.0%	N/A	*	0.0%	*	N/A	0.0%

***** *We did not report results when five or fewer respondents from a subgroup answered the question.*

DISPARITY FLAG: *An orange box with bolded text indicates a statistically significant disparity in results by subgroup (two-tailed chi-square test, p<.10). A blue-gray box with non-bold text indicates that we were unable to test for significance.*

SOCIAL DETERMINANTS OF HEALTH

BASIC NEEDS

We asked respondents to tell us whether they had recently had difficulty meeting basic needs. 8.2% of respondents reported that they or someone in their household had gone without one or more basic needs (food, utilities, transportation, clothing, or child care) in the past 12 months.

Q28: In the past 12 months, have you or someone in your household had to go without any of the following when it was really needed because you were having trouble making ends meet?	TOTAL	RACE/ETHNICITY		INCOME		INSURANCE		
		Non-Hispanic White n=194	Hispanic/ Latino/ Other n=21	200% FPL or lower n=33	201% FPL or higher n=163	Private n=118	Medicare n=70	Medicaid/ Dual/ Uninsured n=26
Basic Needs								
Food	4.6%	5.0%	3.5%	13.2%	1.4%	1.6%	0.0%	29.3%
Clothing	2.6%	3.0%	0.0%	13.2%	0.5%	1.1%	0.0%	15.2%
Transportation	2.5%	1.1%	14.5%	15.1%	0.5%	0.5%	0.0%	17.4%
Child Care	1.5%	0.9%	7.0%	0.0%	1.5%	2.2%	0.0%	0.0%
Utilities	1.1%	0.8%	3.5%	2.6%	0.9%	1.1%	0.0%	2.9%
Stable Housing or Shelter	0.4%	0.0%	3.5%	0.0%	0.5%	0.5%	0.0%	0.0%
One or more basic needs (food, utilities, transport, clothing, child care)	8.2%	7.0%	21.5%	**28.4%**	**2.3%**	3.8%	0.0%	46.7%
Health Needs								
Dental Care	9.0%	6.9%	15.4%	**20.0%**	**3.3%**	**5.4%**	**4.0%**	**33.0%**
Medical Care	2.5%	2.1%	7.0%	2.6%	2.8%	2.7%	0.0%	2.9%
Medicine	2.1%	1.2%	9.6%	2.6%	1.9%	1.6%	1.4%	2.9%
One or more health needs (medical, medicine, dental care)	9.7%	7.7%	15.4%	**20.0%**	**4.2%**	**6.5%**	**4.0%**	**32.6%**

The most common unmet needs were dental care (9% of respondents went without) and food (4.6% of respondents went without). Low-income respondents were significantly more likely to have gone without some basic need; nearly one in three reported having gone without one or more basic need, compared to 2.3% of those with incomes above 200% FPL. Low-income respondents were significantly more likely to have gone without dental care; 20% had gone without needed dental care in the past year, compared to only 3.3% of those with higher incomes. Rates of unmet health needs varied significantly by income and insurance type; this was likely driven by unmet dental needs as opposed to unmet need for medical care or prescriptions.

DISPARITY FLAG: *An orange box with bolded text indicates a statistically significant disparity in results by subgroup (two-tailed chi-square test, p<.10). A blue-gray box with non-bold text indicates that we were unable to test for significance.*

SOCIAL DETERMINANTS OF HEALTH

HOUSING STABILITY

6.9% of respondents reported that they had housing but were worried about losing it, while 1.5% of respondents reported that they are currently staying in a hotel, in a shelter, in their cars, or with friends. This low percentage of respondents without housing is not surprising, since the survey sample was based on residential addresses. Future data collection efforts could include outreach designed to capture responses from those in less-secure housing situations.

Q27: Housing Insecurity	TOTAL	RACE/ETHNICITY		INCOME		INSURANCE		
		Non-Hispanic White n=192	Hispanic/ Latino/ Other n=19	200% FPL or lower n=31	201% FPL or higher n=164	Private n=119	Medicare n=69	Medicaid/ Dual/ Uninsured n=23
Have housing, not worried about losing it	91.6%	92.0%	84.0%	**62.5%**	**95.8%**	**96.2%**	**92.2%**	**58.4%**
Have housing, but worried about losing it	6.9%	7.2%	7.5%	**34.5%**	**2.7%**	**3.8%**	**4.0%**	**34.4%**
Do not have stable housing	1.5%	0.9%	8.5%	**3.0%**	**1.4%**	**0.0%**	**3.8%**	**7.2%**

Housing stability varied significantly by income. More than a third (37.5%) of low income respondents reported housing instability compared to just 4.1% of those with higher income. Housing stability also varied significantly by insurance type

NEIGHBORHOOD SAFETY

Overall respondents report feeling safe in their neighborhoods. However, Medicaid/Dual/Uninsured respondents were more likely to report feeling safe in their neighborhoods "none of the time" or "some of the time" than Medicare beneficiaries, and Medicare beneficiaries were in turn less likely to report feeling safe than those with private insurance.

Q26: Respondents who report feeling safe in their neighborhoods "none of the time" or "only some of the time" (vs all of the time)	TOTAL	RACE/ETHNICITY		INCOME		INSURANCE		
		Non-Hispanic White n=200	Hispanic/ Latino/ Other n=21	200% FPL or lower n=34	201% FPL or higher n=167	Private n=121	Medicare n=73	Medicaid/ Dual/ Uninsured n=26
During the day	2.8%	2.3%	8.4%	6.7%	1.8%	**1.1%**	**5.0%**	**9.7%**
During the night	2.9%	2.3%	9.0%	7.7%	1.8%	**0.5%**	**6.4%**	**11.0%**

DISPARITY FLAG: *An orange box with bolded text indicates a statistically significant disparity in results by subgroup (two-tailed chi-square test, p<.10). A blue-gray box with non-bold text indicates that we were unable to test for significance.*

SOCIAL SUPPORT

We asked participants a series of questions designed to measure the extent to which they had adequate social support. These questions are drawn from the Medical Outcomes Study Social Support Index (SSI). The questions are designed to assess emotional support, tangible support, affectionate support, and positive social interaction. Note: A higher percentage indicates lower reported social support.

Q29: Would have someone available some or none of the time (as opposed to most of all of the time) to:	TOTAL	RACE/ETHNICITY		INCOME		INSURANCE		
		Non-Hispanic White n=191	Hispanic/ Latino/ Other n=20	200% FPL or lower n=30	201% FPL or higher n=162	Private n=117	Medicare n=72	Medicaid/ Dual/ Uninsured n=22
Love and make them feel wanted	14.3%	12.2%	36.8%	14.0%	15.0%	13.2%	17.6%	16.6%
Give them good advice about a crisis	14.4%	13.5%	27.4%	18.9%	11.6%	**9.3%**	**20.3%**	**36.2%**
Get together with for relaxation	19.6%	17.2%	46.7%	32.4%	14.7%	**12.8%**	**24.8%**	**53.3%**
Confide in or talk about problems	16.6%	15.2%	34.5%	14.3%	13.5%	13.5%	19.3%	32.9%

Those in the Medicaid/Dual/Uninsured category reported much lower social support than their counterparts. 53.3% of those in the Medicaid/Dual/Uninsured category reported that they would not reliably have someone to get together with for relaxation, in comparison to 24.8% of Medicare beneficiaries and 12.8% of those with private insurance. 36.2% of those in the Medicaid/Dual/Uninsured category reported that they would not reliably have someone to give them good advice about a crisis, in comparison with 20.3% of Medicare beneficiaries and 9.3% of those with private insurance.

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TRAUMA

ADVERSE LIFE EXPERIENCES

Since adverse life experiences have been associated with poor health outcomes later in life, we asked participants to tell us the extent to which they had experienced hardship, difficulty, or traumatic events. More than one in four (28.6%) respondents report experiencing at least one traumatic event; 11.7% have experienced three or more.

Q13. To what extent have you experienced hardship, difficulty or traumatic events in your life?	TOTAL	RACE/ETHNICITY		INCOME		INSURANCE		
		Non-Hispanic White n=191	Hispanic/ Latino/ Other n=20	200% FPL or lower n=31	201% FPL or higher n=161	Private n=119	Medicare n=68	Medicaid/ Dual/ Uninsured n=23
Life-changing illness or injury	28.8%	**31.7%**	**11.7%**	39.4%	24.5%	**23.5%**	**43.0%**	**32.8%**
Lived with someone with mental illness or substance abuse	24.6%	26.1%	21.5%	28.7%	23.0%	**23.2%**	**15.9%**	**51.7%**
Witnessed or experienced violence	23.2%	25.0%	17.0%	22.2%	23.9%	**26.1%**	**9.8%**	**31.9%**
Abuse of any kind	16.1%	16.5%	15.3%	23.3%	13.1%	14.1%	15.1%	32.8%
Other traumatic event	16.1%	**17.6%**	**2.7%**	12.6%	16.6%	17.4%	12.4%	16.9%
Neglect of any kind	9.0%	9.0%	12.5%	12.0%	6.9%	7.6%	5.3%	25.5%
Physically hurt or threatened by an intimate partner	8.1%	8.3%	9.8%	4.5%	7.9%	6.5%	7.9%	19.8%
Forced to do something sexual that you didn't want to do	7.2%	8.4%	0.0%	7.2%	5.7%	5.3%	5.3%	23.0%
At least one traumatic event	28.6%	**63.6%**	**28.7%**	66.5%	57.8%	57.8%	58.2%	61.5%
3 or more traumatic events	11.7%	15.8%	15.3%	17.4%	13.4%	13.5%	12.2%	36.0%

The most common adverse life experiences reported were a life-changing illness or injury (28.8%), living with someone with mental illness or substance abuse (24.6%), and witnessing or experiencing violence (23.2%). The proportion of respondents who had experienced at least one traumatic event was higher among non-Hispanic whites (63.6%) than among those in the Hispanic/ Latino/Other category (28.7%). Medicare beneficiaries were more likely to report a life-changing illness or injury; those in the Medicaid/Dual/Uninsured category were more likely to report living with someone with mental illness or substance abuse and witnessing or experiencing violence.

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HEALTH & LIFESTYLE BEHAVIORS

DIETARY INDICATORS

Participants were asked several questions aimed at assessing diet, including how often they consumed fruit and vegetables in a typical day. More than one in three (39.6%) respondents gets fewer than two servings of fruit per day, and 37.0% get fewer than two servings of vegetables per day.

Fruit and vegetable consumption varied significantly by insurance group. Over half of Medicare recipients consume fewer than two servings of vegetables per day. In the Medicaid/Dual-Eligible/Uninsured category, 58.5% do not get two servings of vegetables per day, and 68.3% do not get two servings of fruit per day.

Q15-16: Fruit and Vegetable Consumption (per day)	TOTAL	RACE/ETHNICITY		INCOME		INSURANCE		
		Non-Hispanic White n=197	Hispanic/ Latino/ Other n=19	200% FPL or lower n=33	201% FPL or higher n=165	Private n=119	Medicare n=71	Medicaid/ Dual/ Uninsured n=25
Fewer than two servings of fruit	39.6%	42.6%	23.8%	50.2%	36.2%	**33.2%**	**47.7%**	**68.3%**
Fewer than two servings of vegetables	37.0%	39.8%	24.2%	40.1%	35.5%	**29.4%**	**53.1%**	**58.5%**

OTHER HEALTH RISK BEHAVIORS

We assessed the prevalence of other health risk behaviors, including tobacco, alcohol, and drug use. Only a small percentage (3.6%) of respondents report that they currently use tobacco at least some days. 21.1% of respondents report drinking alcohol on 4 or more days per week, and 9.4% of respondents report drinking 3 or more drinks per day on days that they do drink. 13.3% report using marijuana, but only 1.1% report using any other drug. 37.9% of Medicare beneficiaries reported drinking more than three times per week compared to 21.5% of those in the Medicaid/Dual/Uninsured category and 17.9% of those with private insurance.

Q17-21: Health Risk Behaviors	TOTAL	RACE/ETHNICITY		INCOME		INSURANCE		
		Non-Hispanic White n=198	Hispanic/ Latino/ Other n=21	200% FPL or lower n=34	201% FPL or higher n=165	Private n=120	Medicare n=72	Medicaid/ Dual/ Uninsured n=26
Current smoker	3.6%	4.2%	0.0%	6.9%	3.1%	2.5%	6.6%	5.2%
Four or more drinks per week	21.1%	23.4%	8.6%	15.6%	22.8%	**17.9%**	**37.9%**	**21.5%**
Three or more drinks per day of drinking	9.4%	11.1%	0.0%	8.1%	9.9%	10.1%	6.9%	5.2%
Marijuana only	13.3%	10.1%	14.5%	13.4%	12.3%	15.3%	7.0%	14.9%
Any other drug use	1.1%	1.3%	0.0%	2.6%	1.0%	1.1%	0.0%	3.6%

DISPARITY FLAG: *An orange box with bolded text indicates a statistically significant disparity in results by subgroup (two-tailed chi-square test, p<.10). A blue-gray box with non-bold text indicates that we were unable to test for significance.*

CONCLUSIONS

KEY FINDINGS

HEALTH Most (90.4%) respondents report that they are in good, very good, or excellent health. 46.6% have a chronic physical condition and 26.7% have a behavioral health condition. For adults, high blood pressure, high cholesterol, anxiety and depression are the most common diagnoses. Among children, asthma and anxiety are the most common diagnoses. 25.2% of parents have a child with asthma, and 18.7% have a child with anxiety. 32.6% of parents have a child with a mental health condition. Disparities related to income were present; low-income respondents were more likely to be diagnosed with a behavioral health condition or diabetes, and less likely to be diagnosed with asthma. Those in the Medicaid/Dual/Uninsured category were more likely to have diabetes (28.9%) than the Medicare (16.5%) or privately insured (2.6%) populations.

SOCIAL DETERMINANTS OF HEALTH 8.2% of respondents report having to go without one or more basic needs (food, utilities, transportation, clothing, housing, or child care). Most (91.6%) respondents report having secure housing, though that number is significantly lower among low-income respondents (62.5%) and those in the Medicaid/Dual/Uninsured category (58.4%). Respondents generally report feeling safe in their neighborhoods, but roughly one in five report low social support.

HEALTH BEHAVIORS Fruit and vegetable intake varied significantly by insurance type; Medicaid and Medicare recipients report eating fewer fruits and vegetables than those with private insurance. 9.4% of respondents reported drinking 3 or more drinks on days that they drink alcohol. 13.3% said they smoke marijuana, while only 3.6% smoke cigarettes. 1.1% report drug use other than marijuana. 37.9% of respondents with Medicare reported drinking more than three times per week compared to only 17.9% of those with private insurance.

ACCESS TO CARE Only 1.3% of respondents do not have health insurance, and only 5.1% do not have a place to go for care that is not an emergency. Still, one in four (25.0%) do not have someone they think of as their personal provider. 86.1% of respondents needed some kind of health care in the last year; 11.5% of all respondents said they did not get all the care they needed. Cost was the most common barrier to care, but not being able to get a timely appointment and not having a personal provider were also common challenges. 9.0% report having gone without dental care because they were "having trouble making ends meet." 28.3% of parents reported needing to bring a child to the emergency room in the past year; only 3.7% of parents said that they had gone to the ER more than twice in that period. When asked why they had gone to the ER, most parents (61.3%) said that their child needed medical care, and one in three (38.7%) said that the doctor's office or clinics were closed.

PATTERNS & TRENDS

The relationships among cumulative life experiences, income, and health are demonstrated throughout this report. More low-income respondents and Medicaid/Dual/Uninsured respondents report adverse life experiences such as witnessing/experiencing violence, abuse, neglect, or living with someone who struggled with mental illness or addiction. The prevalence of behavioral health conditions — especially anxiety and depression— are significantly higher for low-income respondents. Even as low-income respondents are more likely to struggle with a history of trauma and with current behavioral health challenges, they are also more likely to struggle with meeting basic needs — such as food, housing, clothing, and transportation as well as health care needs. Furthermore, they are less likely to have social support to aid them. They were also less likely to have a usual source of care or a personal provider.

According to these survey results, low-income respondents are less healthy — physically — than others. They face higher rates of diabetes, but are neither more likely to be obese nor significantly more likely to have a chronic physical condition. That said, they are much more likely (22.8%) to have both a mental health condition and a physical health condition than those with higher incomes (9.6%).

These results suggest that programming and services created especially for low-income families may be a key way to support the health needs of the Yamhill Service Area. It should be noted that low-income individuals were less likely to respond to this survey; additional listening sessions within this community could specify the kinds of services and programming that might have the greatest impact.

COMMUNITY HEALTH SURVEY

INSTRUCTIONS: For each question, please fill in the circle that best represents your answer. Your results are completely private, and you can skip any question you do not want to answer. When you are finished, place the survey in the postage-paid envelope we have provided and drop it in the mail. If you have questions about this survey, please read the included letter or call us at 1-877-215-0686.

PART 1 YOUR HEALTH CARE

These questions help us understand your health and health care.

1 Do you currently have any kind of health insurance?

- ◯ Yes
- ◯ No → **(Skip to Question 3)**

2 What kind of health insurance do you have? *Mark all that apply.*

- ◯ Medicaid/Oregon Health Plan (OHP)
- ◯ Medicare
- ◯ VA, TRICARE or other military health care
- ◯ Private coverage through an employer or family member's employer
- ◯ A private plan I pay for myself
- ◯ Other (tell us): _____
- ◯ I don't have any insurance now
- ◯ I don't know

3 If you **don't** currently have any kind of health insurance, what are the main reasons why? *Mark all that apply.*

- ◯ It costs too much
- ◯ I don't think I need insurance
- ◯ I am waiting to get coverage through a job
- ◯ Signing up is too confusing
- ◯ I haven't had time to deal with it
- ◯ Other (tell us): _____

4 For how many of the **last 12 months** did you have some kind of health insurance?

- ◯ Not insured during the last 12 months
- ◯ 1-3 months
- ◯ 4-6 months
- ◯ 7-9 months
- ◯ 10-11 months
- ◯ Insured for ALL of the last 12 months

5 Do you have a place to go for health care when it is not an emergency?

- ◯ Yes
- ◯ No → **(Skip to Question 7)**

6 Where do you usually go to receive health care when it is not an emergency? *Mark only one.*

- ◯ A private doctor's office or clinic
- ◯ A public health clinic or community health center
- ◯ A tribal health clinic
- ◯ A VA facility
- ◯ A hospital-based clinic
- ◯ A hospital emergency room
- ◯ An urgent care clinic
- ◯ Other (tell us): _____
- ◯ I don't have a usual place

7 Do you have **one person** you think of as your personal doctor or health care provider?

- ◯ Yes ◯ No

8 Was there a time in the **last 12 months** when you needed any type of health care?

- ◯ Yes ◯ No → **(Skip to Question 11)**

9 If you needed health care in the **last 12 months**, did you get **all** the care you needed?

- ◯ I got **all** the care I needed
- ◯ I got **some but not all** needed care
- ◯ I got **no care at all**
- ◯ I don't know

10 The **most recent time** you went without needed health care, what were the main reasons? *Mark all that apply.*

- ◯ Cost
- ◯ Not having a regular provider
- ◯ Not knowing where to go
- ◯ Couldn't get appointments quickly enough
- ◯ Offices aren't open when I can go
- ◯ Needed childcare
- ◯ Needed transportation
- ◯ Not having a provider that understands my culture or speaks my language
- ◯ Other reasons (tell us): _____

PART 2 YOUR HEALTH & LIFESTYLE

These questions give us a picture of your overall health.

11 In general, would you say your health is:

- ◯ Excellent
- ◯ Very Good
- ◯ Good
- ◯ Fair
- ◯ Poor

12 Have you **ever** been told by a doctor or other health professional that you have any of the following?

	Yes	No
Diabetes or sugar diabetes	◯	◯
Asthma	◯	◯
High blood pressure	◯	◯
High cholesterol	◯	◯
Depression	◯	◯
Post-traumatic stress disorder	◯	◯
Anxiety	◯	◯
Another mental health condition	◯	◯

13 To what extent have you experienced hardship, difficulty or traumatic events in your life?

	Not at all	Some	A lot
Life changing illness or injury	◯	◯	◯
Neglect of any kind	◯	◯	◯
Lived with someone with mental illness or substance abuse	◯	◯	◯
Witnessed or experienced violence	◯	◯	◯
Forced to do something sexual that you didn't want to do	◯	◯	◯
Physically hurt or threatened by an intimate partner	◯	◯	◯
Abuse of any kind	◯	◯	◯
Other traumatic event (tell us):_____	◯	◯	◯

14 During the **past 2 weeks**, about how often have you been bothered by the following problems:

	Not at all	Several days	Over half the days	Nearly every day
Little interest or pleasure in doing things	◯	◯	◯	◯
Feeling down, depressed or hopeless	◯	◯	◯	◯
Feeling nervous, anxious, or on edge	◯	◯	◯	◯
Not being able to stop or control worrying	◯	◯	◯	◯

15 During a **typical** day, how many servings of fruit do you usually eat? *A serving is one piece of fruit or about a cup of cut-up fruit. Don't count juices.*

↳ _____ servings per day

16 During a **typical** day, how many servings of vegetables do you usually eat? *A serving is about a cup of vegetables like green beans, salad or potatoes. Don't include fried foods like french fries.*

↳ _____ servings per day

17 Do you **currently** smoke cigarettes or e-cigarettes?

- ◯ Every day
- ◯ Some days
- ◯ Not at all

18 How often did you have a drink containing alcohol in the **past year**?

- ◯ Never → **(Skip to Question 21)**
- ◯ Monthly or less
- ◯ 2-4 times a month
- ◯ 2-3 times a week
- ◯ 4 or more times a week

19 How many days per week do you drink alcohol?

- ◯ 0 to 1
- ◯ 2 to 3
- ◯ 4 to 5
- ◯ 6 to 7

20 On the days when you did drink alcohol, how many drinks did you usually have **per day**? *A 'drink' is one beer, one glass of wine or one shot of liquor.*

- ◯ 1 or 2
- ◯ 3 or 4
- ◯ 5 or 6
- ◯ 7 to 9
- ◯ 10 or more

21 In the **last 12 months**, have you or anyone in your household used any of the following? *Mark all that apply.*

- ◯ Marijuana, pot, grass, hash or hash oil
- ◯ Opioids not as prescribed (oxycodone, heroin, morphine, methadone, codeine, etc.)
- ◯ Amphetamine-type stimulants (meth, speed, diet pills, ecstasy, etc.)
- ◯ Any other street drug
- ◯ I did not use any of these in the last 12 months

22 Do you have any children (under 18 years of age)?

- ◯ Yes
- ◯ No → **(Skip to Question 26)**

23 In the **last 12 months**, how many times did your child go to the emergency room to get care? *Your best estimate is fine.*

- ◯ None → **(Skip to Question 25)**
- ◯ 1 time
- ◯ 2 times
- ◯ 3 times or more

24 The **most recent time** your child went to the emergency room, what was the main reason you went there instead of somewhere else for health care? *Mark all that apply.*

- ◯ My child needed medical care
- ◯ Doctors' offices/clinics were closed
- ◯ I couldn't get an appointment to see a regular doctor soon enough
- ◯ My child didn't have a regular doctor
- ◯ I couldn't afford the co-pay for my child to see the doctor
- ◯ My child needed a prescription drug
- ◯ I didn't know where else to take my child
- ◯ Other (tell us): _____
- ◯ My child did not go to the emergency room in the last 12 months
- ◯ I don't know

25 Have you **ever** been told by a doctor or other health care professional that any of your children have any of the following?

	Yes	No
Diabetes or sugar diabetes	◯	◯
Asthma	◯	◯
A behavioral or mental health diagnosis (such as depression, anxiety or ADHD).	◯	◯
A developmental delay or learning disability (such as Autism or Dyslexia)	◯	◯
Depression	◯	◯
Post-traumatic stress disorder	◯	◯
Anxiety	◯	◯
Another ongoing health condition	◯	◯

(tell us): _____

26 How often do you feel safe in your neighborhood at the following times?

	None of the time	Some of the time	Most of the time	All of the time
During the day	◯	◯	◯	◯
During the night	◯	◯	◯	◯

PART 3 YOUR HOUSEHOLD FINANCES

These questions help us understand finances for you and your family.

27 Which of the following best describes your housing situation today? *Mark all that apply.*

- ◯ I have housing of my own, and I'm NOT worried about losing it
- ◯ I have housing of my own, but I AM worried about losing it
- ◯ I'm staying in a hotel
- ◯ I'm staying with friends or family
- ◯ I'm staying in a shelter, in a car or on the street
- ◯ Other (tell us): _____

28 In the past 12 months, have you or someone in your household had to **go without** any of the following when it was really needed because you were having trouble making ends meet?

	Yes	No
Food	◯	◯
Utilities	◯	◯
Transportation	◯	◯
Clothing	◯	◯
Stable Housing or Shelter	◯	◯
Medical Care	◯	◯
Medicine	◯	◯
Child Care	◯	◯
Dental Care	◯	◯

PART 4 ABOUT YOU & YOUR FAMILY

These questions help us understand more about you, your living situation and your family.

29 How often do you think you would have someone available to do each of the following?

	None of the time	Some of the time	Most of the time	All of the time
Love you and make you feel wanted?	◯	◯	◯	◯
Give you good advice about a crisis?	◯	◯	◯	◯
Get together with for relaxation?	◯	◯	◯	◯
Confide in or talk to about your problems?	◯	◯	◯	◯
Help you if you were confined to a bed?	◯	◯	◯	◯

30 Are you male, female or transgender?

◯ Male ◯ Female ◯ Transgender

31 What year were you born? 19____

32 What is your height? _____ Feet _____ Inches

33 About how much do you currently weigh? _____ pounds

34 Are you Hispanic or Latino?

◯ Yes ◯ No

35 Which one or more of the following would you say is your race? *Mark all that apply.*

◯ White
◯ Black or African-American
◯ Asian
◯ Native Hawaiian or Other Pacific Islander
◯ American Indian or Alaska Native
◯ Don't know / Not sure
◯ Prefer not to answer

36 What language do you speak best? *Mark only one.*

◯ English
◯ Spanish
◯ Vietnamese
◯ Russian
◯ Other (tell us): _____

37 What is the highest level of education you have completed? *Mark only one.*

◯ Less than high school
◯ High school diploma or GED
◯ Vocational training or 2-year degree
◯ A 4-year college degree
◯ An advanced or graduate degree

38 Are you currently employed or self-employed?

◯ Yes, employed by someone else
◯ Yes, self-employed
◯ Not currently employed
◯ Retired

39 About how many hours per week, on average, do you work at your current job(s)? *Your best estimate is fine.*

◯ I don't currently work
◯ Less than 20 hours per week
◯ 20-39 hours per week
◯ 40 or more hours per week

40 What is your gross household income (before taxes and deductions are taken out) for last year (2015)? *Your best estimate is fine.*

◯ $0
◯ $1 to $10,000
◯ $10,001 to $20,000
◯ $20,001 to $30,000
◯ $30,001 to $40,000
◯ $40,001 to $50,000
◯ $50,001 to $60,000
◯ $60,001 to $70,000
◯ $70,001 to $80,000
◯ $80,001 to $90,000
◯ $90,001 to $100,000
◯ $100,001 or more

41 Altogether, how many people currently live in your home? *Count adults and children under 18.*

↳ Me, plus ___ other adults and ___ children.

42 We may ask some participants to participate in listening sessions or other research (and be compensated for their time). Would you be interested in participating?

◯ No
◯ Yes → *Is there a good phone number to reach you? (include area code):*

_____

and/or E-mail:

_____

STOP HERE

Thank you very much for taking time to complete this survey.
Please place the survey in the postage-paid envelope and mail it.
Contact us at 1-877-215-0686 or core@providence.org with any questions.

Appendix II – Key stakeholder interviews

Key Community Stakeholder Interview	Providence Representatives
Date and Time Of Interview **Location**	*(please list all attendees)*
Key Community Stakeholder Names/Titles *(please list all attendees)*	
Organization Name	
Address	
Phone(s)/Email	
How would you describe your race and ethnicity?	
How would you describe your organization's role within the community?	
How would you describe the geographic area your organization serves?	
Please identify and discuss specific unmet health needs in your community for the persons you serve:	
Can you prioritize these issues? What are your top concerns?	
Please identify and discuss specific gaps in community services for the persons you serve that contribute to the unmet health needs cited above. We have a particular concern for those that are low income, vulnerable or are experiencing health inequities.	
What existing community health initiatives or programs in your community are helpful in addressing the health needs of the persons you serve, especially with identifying health needs earlier? Can you rank them in terms of effectiveness?	
What other things do you think we should hear about?	
Other comments:	

Stakeholders interviewed for 2016 Newberg CHNA:

Jennifer Jackson, Member Engagement Supervisor, Yamhill Community Care Organization

Kym LeBlanc-Esparza, Superintendent, Newberg School District

Seamus McCarthy, Director of Operation and Integration, Yamhill Community Care Organization

Beth Wasson, Executive Director, Newberg FISH Emergency Services

Appendix III – Community listening session guide (English)

Community Listening Session Guide

(adapted from Healthy Columbia Willamette Collaborative, 2016 for Providence Newberg Medical Center)

INTRODUCTION

We have just under an hour to talk about the vision, needs, and strengths within your community, which will help inform Providence's Community Health Needs Assessment and how we should develop our programs. I'd like you to start by thinking about your community. People might think of "community" in different ways. Maybe it's family, or maybe it's neighbors, or maybe it's coworkers or friends.

Take a couple minutes to think about this, and then we will ask each person to share what first comes to your mind when you think of "community".

Pause to share.

Thank you. That leads into what we're going to talk about next: the health of your community. This is going to be an informal discussion. We want to hear about your ideas, experiences and opinions. Everyone's comments are important. They might be similar or very different, but they all should be heard. The goal today is to record everyone's opinions.

CONTEXT

What we are hoping to talk about today is: ***What makes a healthy community?***

PAUSE, but not long enough for people to pipe up with answers.

That's a difficult question, because it involves two ideas. First, there's ***HEALTH***. What do we mean by health? Do we mean freedom from disease? Having enough to eat? Feeling generally good about life? Being financially healthy?

PAUSE, but not long enough for people to pipe up with answers.

Then there's the idea of ***COMMUNITY***, which we just discussed as a group can mean many things to different people.

QUESTION 1. VISION . Now take a minute to think about your community, whatever that word represents to you. How can you tell when your community is healthy?

Instructions: write ideas on the poster.

QUESTION 2. NEEDS.

So we've talked about what a healthy community looks like. Now let's talk about what may be keeping your community from matching to that description.

What's needed? What could be done to help your community be healthy? What are the barriers to your community being healthy?

Instructions: write ideas on the poster.

QUESTION 3. STRENGTHS. Now that you've told us what a healthy community looks like and what the needs are in your community, let's look at the strengths and resources that already exist in your community. What should we know about, what should we be building upon to help your community meet that vision of health we discussed? It might be programs. It might be a park or a community center. It might be a really great teacher at your local school. It might be a local business or a local organization that helps people be healthy.

My question for you is:

What's working? What are the resources that CURRENTLY help your community to be healthy?

Instructions: write ideas on the poster.

Thank you all for your participation and sharing with us today. This information will be used as an important part of the Community Health Needs Assessment, which will be completed by the end of this year. Please let me know if any of you would like to see the assessment when it is completed, and we will be happy to share it with you.

Appendix IV – Community Health Improvement Plan

PROVIDENCE
Newberg
Medical Center

Community Health Improvement Plan
2017-2019

Providence Newberg Medical Center
Yamhill County, Oregon

Table of contents

Community Health Improvement Plan
2017-2019

Providence Newberg Medical Center
1001 Providence Drive
Newberg, OR 97132

TO OUR COMMUNITY MEMBERS,

It is with great pleasure that we present the findings of our Community Health Needs Assessment and resulting Community Health Improvement Plan. Over 160 years ago, the Sisters of Providence came to the Northwest with the goal of addressing the most pressing needs of the time. Today, through their *Hopes and* Aspirations document, the Sisters call us to "be open to the call of those who suffer by addressing emerging needs with wise and discerning responses". Providence is pleased to partner with many agencies in our communities to address the most pressing health and social determinant needs in each of our service areas. We are uniquely positioned to use our role as a primary, acute, and specialty care provider, insurer, and the largest employer in the state to truly impact the health of our communities.

We are grateful for the partnership of community organizations, survey respondents, listening session participants, interviewees, and many others in the development of these needs assessments and plans. We know that addressing these challenges will require long-term commitment, systemic change, and expertise outside of the health system. Our communities have many strengths, and it is our privilege to support programs and organizations actively addressing these needs, as well as generating momentum to think differently about these services within our own organization.

Finally, let us thank you for your interest in reviewing this plan and engaging in our community health improvement efforts. We believe that this work is central to our strategic vision of creating healthier communities, together.

Sincerely,

Pamela Mariea-Nason, RN, MBA
Executive, Community Health Division
Providence Health & Services – Oregon

Executive summary

Purpose

This Community Health Improvement Plan is based upon the findings of our 2016 Community Health Needs Assessment. This plan is specifically designed to serve the Yamhill County area, which is Providence Newberg Medical Center's primary service area. Each of these interventions will be prioritized based upon relative needs and opportunities, particularly those that serve identified high needs ZIP codes and neighborhoods.

This plan is intended to serve as a guiding document for community investment, community building and development, and community health efforts through 2019. It will be reviewed and updated annually or as needed to recognize new partners, initiatives, and metrics as they are available. Importantly, this plan is not intended to be an exhaustive inventory of all of Providence's efforts to address these needs. Rather, this document highlights those efforts that are measurable and community-based. This plan should be reviewed in conjunction with our annual Community Benefit report, which will provide additional narrative and will be updated in June of each year.

Summary of prioritized needs

Access to care

- Primary care
- Dental care
- Culturally-responsive care

Behavioral health

- Mental health services (including youth and adolescent suicide)
- Substance use treatment
- Trauma/adverse experience prevention and building resilience

Chronic conditions

- Diabetes
- Hypertension
- Obesity (particularly amongst youth and adolescents)

Social determinants of health and well-being

- Affordable housing
- Healthy food access
- Living wage jobs
- Transportation

Many of these needs will be directly addressed through internal initatives and community partnerships over the next three years. You will find additional information about our specific actions and how we will measure our success in the following sections

.

Introduction

CREATING HEALTHIER COMMUNITIES, TOGETHER

As health care continues to evolve, Providence is responding with dedication to its Mission and a core strategy to *create healthier communities, together*. Partnering with others of goodwill, we conduct a formal community health needs assessment to learn about the greatest needs and assets from the perspective of some of the most marginalized groups of people in communities we serve. This assessment helps us develop collaborative solutions to fulfill unmet needs while continuing to strengthen local resources. It guides our community benefit investments, not only for our own programs but also for many partners, toward improving the health of entire populations. Through strategic programs and donations, health education, charity care, medical research and more, Providence Health & Services provided over $1.1 billion in community benefit across Alaska, California, Montana, Oregon and Washington during 2016..

Serving Yamhill County

About us

Providence Health & Services is a not-for-profit Catholic health care ministry committed to providing for the needs of the communities it serves – especially for those who are poor and vulnerable. Providence's combined scope of services includes 34 hospitals, 475 physician clinics, senior services, supportive housing and many other health and educational services. The health system and its affiliates employs more than 76,000 people across five states – Alaska, California, Montana, Oregon and Washington – with its system office located in Renton, Washington. Our community health activities are rooted in the charitable work the Sisters of Providence started nearly 160 years ago when they answered a call for help from a new pioneer community in the West.

Mission
As people of Providence, we reveal God's love for all, especially the poor and vulnerable, through our compassionate service.

Vision
Together, we answer the call of every person we serve: Know me, Care for me, Ease my way. ®

Values
Respect, Compassion, Justice, Excellence, Stewardship

Purpose of this plan

In 2016 Providence Newberg Medical Center conducted a community health needs assessment. This community health improvement plan is designed to address key health needs identified in that assessment. 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 are:

Providence prioritized needs
Access to care • Primary care • Dental care • Culturally-responsive care **Behavioral health** • Mental health services • Substance use treatment • Trauma/adverse experience prevention and resilience building **Chronic conditions** • Diabetes • Hypertension • Obesity (particularly youth and adolescents) **Social determinants of health and well-being** • Affordable housing • Healthy food access • Living wage jobs • Transportation

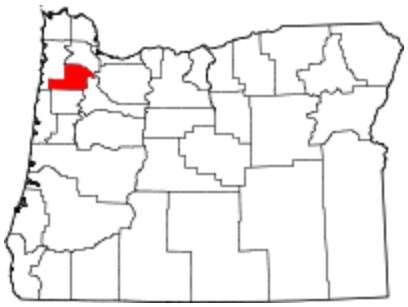
Our overall goal for this plan

As we work to create healthier communities, together, the goal of this improvement plan is to measurably improve the health of individuals and families living in the areas served by Providence Newberg Medical Center and across Yamhill County. The plan's target population includes the community as a whole, and specific population groups including minorities, low-income, and other underserved demographics living in high needs areas.

This plan includes components of education, outreach, prevention, and treatment, and features collaboration with other community organizations working in alignment with the Providence Mission to address these identified needs. The plan's implementation will be facilitated by the hospital through the regional Community Health Division, hospital executive leadership, and members of the Service Area Advisory Council.

Community Profile

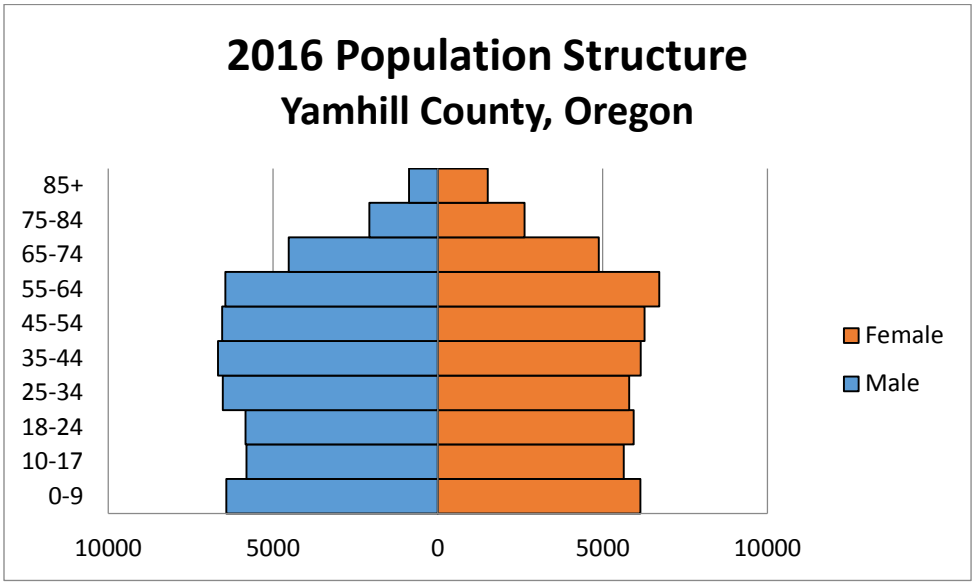
Yamhill County, Oregon



Providence Newberg Medical Center primarily serves Yamhill County in Oregon. Providence has one hospital serving neighboring Washington County and six additional hospitals around the state.

Population and Demographics

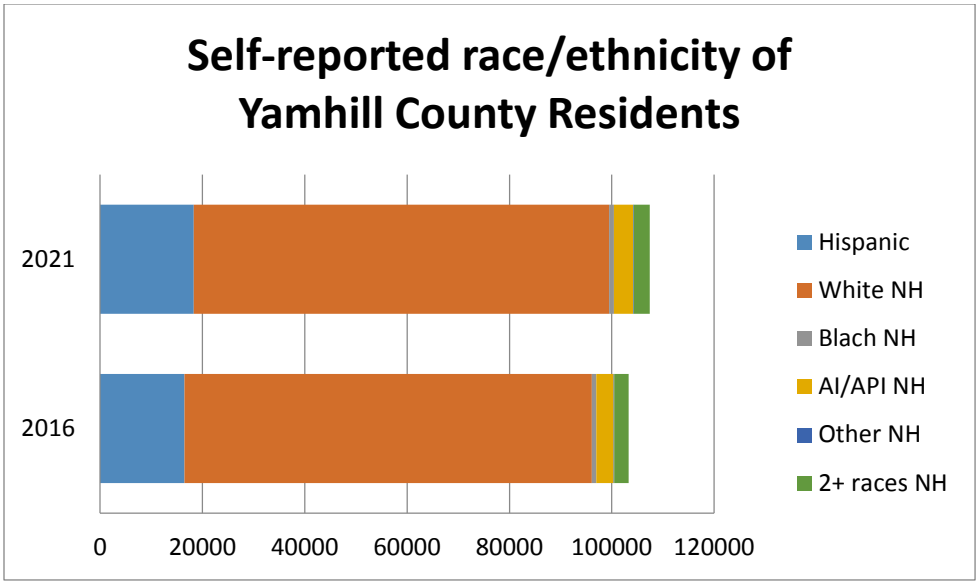
As of June 2016, the total population is 103,295, representing slightly more than 21 percent since 2000. The following chart shows the age and gender distribution of the current population of Yamhill County. The county follows a fairly normal distribution by age and gender, with more surviving females than males at older ages. Approximately 15 percent of the county's population is at or above age 65, which is in line with the national average.



The age distribution is fairly normal, with the male-to-female ratio being approximately 1:1 until age 65, when females become a greater proportion of the population. This difference is clearest over the age of 85, where there are slightly more than two surviving females for each male.

Ethnicity

The following table shows the current self-reported race and ethnicity for residents in Yamhill County, as well as a five-year projection. The largest portion of the population identifies as White non-Hispanic, with Hispanic or Latino being the second-most populous group in the county. Between 2016 and 2021, the Hispanic/Latino population is expected to grow the most.



Income

In 2015, the median household income for Yamhill County was $53,864 and the unemployment rate was 4.7 percent. This is slightly lower than the median income for the state of Oregon ($54,148) and the United States ($55,755).

Health and Wellbeing

In Yamhill County, 27 percent of eighth grade students, 31 percent of eleventh graders, and 32 percent of adults are overweight or obese according to the most recent Oregon Healthy Teens Survey and Behavioral Risk Factor Surveillance Survey. These rates are slightly higher than the state average for eighth and eleventh grade, and about the same for adults.

SUMMARY OF PROVIDENCE PRIORITIZED NEEDS AND ASSOCIATED ACTION PLANS

The prioritized needs were chosen based on various community health data and identifiable gaps in available care and services. These health needs were those that had 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. 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 will be prioritized based upon relative needs and opportunities, particularly those that serve identified high needs ZIP codes and neighborhoods including low-income and minority populations.

ACCESS TO CARE

- Timely and consistent access to **primary care** remains a challenge, particularly for those on the Oregon Health Plan (Mediciad) and the remaining 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 opportunity for prevention education and increasing access to preventive services.
- As the population is diversifying, it is increasingly important that community members feel welcome, safe, and respected in healthcare settings. One of the greatest opportunities to improve health amongst low-income and minority communities is to increase access to **culturally-responsive care**.

BEHAVIORAL HEALTH

- **Mental health services** remain a barrier for many community members. There is 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.

CHRONIC CONDITIONS

- **Diabetes** continues to be one of the top reasons uninsured adults seek care in an Emergency Department, though the condition is likely better managed in a primary care setting. This suggests opportunities regarding prevention, education, and nutrition support.
- Similarly, **hypertension** is among the top three diagnosed conditions in uninsured adults using the Emergency Department. The fact that emergency care was required suggests need for primary care, education regarding self-management, medication access, and nutrition support.
- **Obesity** is a public health challenge, for both youth and adults. 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.

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. 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. 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. Improvements in nutrition can further improve oral health and chronic conditions.
- 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 families lose many of their social service benefits at the same point.
- **Transportation** is a challenge for some populations, particularly for the elderly and those in more rural areas. Many are dependent on public transit for work, medical appointments, or other basic errands.

ACCESS TO CARE

Goals

- Community members will have improved access to timely, consistent primary care
- Community members will experience more accessible preventive and primary dental care and improved oral health
- Community members will be able to receive healthcare services in a culturally-responsive and welcoming setting

Objectives

- Providence Medical Group will continue to provide care for over 2,000 Oregon Health Plan members
- Support federally-qualified health centers (FQHC) and school-based health centers (SBHC) to extend hours and services to improve primary care access
- Partner with Pacific University, Medical Teams International, and other dental care providers to host at least 8 free- or reduced-cost dental clinics per year and reduce Emergency Department visits for dental conditions
- Provide free breast cancer screening for 30 women in partnership with the *Promotores* annually
- At least 60 uninsured Latino community members will receive screenings for blood pressure, cholesterol, and blood sugar annually and be directly connected to care if needed

Action plan and baseline or proposed measurement

Action	2016 baseline or proposed measurement
Improve access by providing primary care homes for Oregon Health Plan members in Providence Medical Group	Current CCO enrollment (December 2016): 2,097
Identify potential FQHC or SBHC partners to offer technical assistance and develop ideas for further partnership	Partnership plan developed
Support Pacific University dental program and Medical Teams International to provide free or low-cost dental services	8 clinics and/or mobile dental "van days"; Emergency department utilization for dental conditions
Host Latina Mammography fair and provide free breast cancer screenings	2016 screenings: 30 (uninsured)
Enhance culturally-responsive care through parish health promoters (*Promotores*) telehealth clinics.	3 clinics scheduled; number served
Parnter with St. Peter Catholic School to provide health professions scholarship program	Scholarships provided

Existing partners

This is not an exhaustive list of community organizations working to meet these needs, but highlights existing partnerships in place in our community.

Organization	Primary Care	Dental Care	Culturally-Responsive
Love, INC		x	
Medical Teams International		x	
Pacific University		x	x
St. Peter Catholic School			x
Virginia Garcia Memorial Health Center	x	x	x

BEHAVIORAL HEALTH

Goals

- Community members will have increased access to timely and affordable mental health treatment, including supportive services and therapy
- Stigma associated with mental health and substance use will be reduced
- Youth and teen suicide attempt and completion rates will be reduced
- Community members will have improved access to substance use treatment when needed, including residential or outpatient services as appropriate
- Fewer children will experience abuse, neglect, racism, discrimination, and other adverse experiences that are harmful throughout life and negatively impact health outcomes. Adults with traumatic experiences will be supported in their recovery through resilient communities.

Objectives

- At least three Mental Health First Aid trainings will be provded in a train-the-trainer model
- Implement stigma reduction training and social media campaign through high schools and school-based health centers beginning Fall 2018
- All providers will have access to trauma-informed care training; all Emergency Department providers will have received training in trauma-informed care by December 2019
- Reduce opiate prescription, abuse, and overdose rates
- Child abuse and foster care placements will decrease

Action plan and baseline or proposed measurement

Action plan	2016 baseline or proposed measurement
Mental wellness and anti-stigma campaign in schools	Number of youth reached by peer-generated messages; uptake of mental health/crisis services
Mental Health in Media campaign	Number of visits to Get Trained to Help website; media toolkit released
Mental Health First Aid training (train-the-trainer)	Number of trainees certified as trainers
Provide training in trauma-informed care for Emergency Department and other providers	Number of staff trained (ED and other)
Partner with Newberg schools and George Fox University to prevent adolescent suicides	Number of adolescent suicides/year
Provide reduced or no-cost access to the “Persistent Pain” program	Number served
Work with Providence Medical Group to reduce opiate prescription rates	Number of prescriptions written
Support Yamhill County to implement Narcan Initiative to reduce opiate deaths	Incidence of Narcan administration
Parnter with Luthern Community Services NW’s “A Family Place” relief nursey	122 children served; 23% decrease in incidence of child abuse

Existing partners

This is not an exhaustive list of community organizations working to meet these needs, but highlights existing partnerships in place in our community.

Organization	Mental health services	Substance use treatment	Adverse experience prevention
Newberg School District	x		x
Lutheran Community Services	x	x	x
George Fox University	x	x	
NAMI Oregon	x	x	
Trillium Family Services	x		
Yamhill County	x	x	

CHRONIC CONDITIONS

Goals

- Community members will have improved access to education and self-management cirriculums for chronic disease in both English and Spanish
- Chronic disease burden will be reduced, particularly within communities of color
- Community members will have increased opportunity for physical acticity and nutritious eating, particularly youth and adolescents

Objectives

- Emergency department utilization for chronic conditions, particularly diabetes and hypertension, will be reduced through increased access to primary care and meeting social determinant needs
- Patients with diagnosed conditions will have access to chronic condition self-management education
- Individuals with diagnosed chronic conditions will have unmet social needs addressed as part of care
- More youth will report adequate physical activity and healthy behaviors due to Providence's Healthier Kids, Together Initiative

Action plan and baseline or proposed measurement

Action plan	2016 baseline or proposed measurement
Provide *Tomando control de su Salud* to Spanish-speaking community members	40 indivuduals trained
Provide subsidized chronic conditions self-management education	Number served; behavior change
Implement 5-2-1-0 messaging in clinics and with community parnters	Clinics providing 5-2-1-0 messaging; health behavior change
Partner with Yamhill County on Physical Activity/Nutrition Collaborative to implement best practice nutrition and activity education in schools	294 students served; health behavior change; health status

Existing partners

This is not an exhaustive list of community organizations working to meet these needs, but highlights existing partnerships in place in our community.

Organization	Diabetes	Hypertension	Obesity
Parish?	x		x
Providence Health Education	x		x
Yamhill County Health & Human Services	x	x	x

SOCIAL DETERMINANTS OF HEALTH AND WELL-BEING

Goals

- Community members will have improved access to safe, stable housing
- Community members will have increased access to affordable healthy food
- Community members will be able to support themselves and their families on one full-time job (or equivalent)
- Community members, particularly elderly and those in rural communities, will have access to convenient, frequent public transit or ride share services

Objectives

- Provide safe and secure discharge for at least 150 individuals needing short-term social service support annually
- Provde fresh produce from community garden to improve healthy food access
- Fewer working families will report having to work multiple jobs to make ends meet
- Fewer elderly adults and community members will recognize transportation as a barrier to receiving needed primary care and safe discharge
- Community members and providers will have increased awareness of available social service resources

Action plan and baseline or proposed measurement

Action plan	2016 baseline or proposed measurement
Parnter with Helping Hands Re-Entry Outreach Centers to provide emergency shelter and re-entry services	75 active re-entry clients supported with wrap-around services
Partner with Project Access NOW to connect eligible clients to Patient Support Program	180 patients supported with social needs for safe discharge
Grow produce to donate to Newberg FISH Emergency Services in Community Garden	2,000 lbs donated
Support the Oregon Business Council's Poverty Reduction Task Force, including policy reform for working families	Legislation that supports working families and eases the "benefits cliff"
Partner with Partners for a Hunger-Free Oregon to support summer meal sites	Number served; enrichment activities
Support 211-info to provide community and provider trainings on local social service resources	Trainings completed; number of attendees

Existing partners

This is not an exhaustive list of community organizations working to meet these needs, but highlights existing partnerships in place in our community.

Organization	Housing	Food	Jobs	Transportation
211-Info	x	x	x	x
Newberg FISH		x		
Oregon Business Council			x	
Partners for a Hunger-Free Oregon		x		
Project Access NOW	x	x		x

Healthier Communities Together

As outlined, Providence is working to address each of the identified needs in a variety of ways over the next three years. That said, it is important to note that some of this work will be completed in more indirect ways than others. To address systematic issues, like living wage jobs, Providence will work with a diverse coalition of stakeholders to move this issue forward. Utilizing our relationships with elected officials, business leaders and union representatives – we are well positioned to promote public policy changes that support Oregon families.

Although the built environment was not specifically called out, we recognize that it is an important component of the health and well-being of our communities. Our priority areas and initiatives were selected based on our findings from relevant data, conversations with people living in our community and the opportunities we have to make marked improvements in the coming years. We will seek out opportunities to support local jurisdictions and community organizations focused on access to safe parks, pedestrian and bicycle-friendly transportation, and other components of the built environment that lead to improved health outcomes.

PLAN APPROVAL

Lori Van Zanten — 5-2-17

Lori Van Zanten
Chief Executive, Providence Newberg Medical Center
Providence Health & Services – Oregon

Date

Eileen Kunze — 5-2-17

Eileen Kunze
Chair
Yamhill Service Area Advisory Council
Providence Health & Services – Oregon

Date

Joel Gilbertson
SVP Community Partnerships
Providence St. Joseph Health

Date 5/1/17

This plan was adopted on March 21, 2017.

CHNA/CHIP contact:

Megan McAninch-Jones, MSc
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Providence Health & Services – Oregon
4400 NE Halsey Street, Building 2
Portland, OR 97213