COMMUNITY HEALTH IMPROVEMENT PLAN

2020 - 2022

Providence Seaside Hospital

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

PROVIDENCE
Seaside
Hospital

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EXECUTIVE SUMMARY

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

Knowing where to focus our resources starts with our community health needs assessment, an opportunity in which we engage the community every three years to help us identify and prioritize the most pressing needs, assets and opportunities. The 2019 Community Health Needs Assessment was approved by the Providence Seaside Hospital (PSH) Service Area Advisory Council on October 23, 2019 and made publicly available on December 19, 2019.

Based on geographic location relative to other hospitals in the area and patient demographics, Seaside, Oregon, and greater Clatsop County are PSH's primary service areas. The facility is a 25-bed critical access hospital offering primary and specialty care, birth center with family suites, general surgery, radiology, diagnostic imaging, pathology and 24/7 emergency medicine. Residents along the North Oregon Coast have access to family practice and internal medicine with physicians and primary care providers at clinics in Seaside, Warrenton, Cannon Beach, heart clinics in Astoria and Seaside, and a full continuum of therapy, rehabilitation and home health services. PSH provided over $15 million[1] in Community Benefit in 2019.

Providence Seaside Hospital's Community Health Improvement Plan Priorities

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

PRIORITY 1: SOCIAL DETERMINANTS OF HEALTH AND WELL-BEING

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

PRIORITY 2: CHRONIC CONDITIONS

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

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

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

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

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

Responding to the COVID-19 Pandemic

The 2020 community health improvement process was disrupted by the SARS-CoV-2 virus and COVID-19, which has impacted all of our communities. While we have focused on crisis response, it has required a significant re-direction of resources and reduced community engagement in the CHIP process.

This CHIP is currently designed to address the needs identified and prioritized through the 2019 CHNA, though COVID-19 will have substantial impacts on our community needs. These impacts are likely to exacerbate some of the needs identified, and cause others to rise in level of priority. While this is a dynamic situation, we recognize the greatest needs of our community will change in the coming months, and it is important that we adapt our efforts to respond accordingly. Additionally, the data projections included were crafted based on data collection and project forecasting done prior to the COVID-19 pandemic, so may be modified as we understand adjusted resources and priorities within our communities in the aftermath of the pandemic.

This CHIP will be updated by March 2021 to better document the impact of and our response to COVID-19 in our community. We are committed to supporting, strengthening, and serving our community in ways that align with our Mission, engage our expertise, and leverage our Community Benefit dollars in the most impactful ways.

MISSION, VISION, AND VALUES

Our Mission	As expressions of God's healing love, witnessed through the ministry of Jesus, we are steadfast in serving all, especially those who are poor and vulnerable.
Our Vision	Health for a Better World.
Our Values	Compassion — Dignity — Justice — Excellence — Integrity

INTRODUCTION

Who We Are

Providence Seaside Hospital (PSH) serves the city of Seaside, Oregon, and greater Clatsop County. The facility is a 25-bed critical access hospital offering primary and specialty care, birth center with family suites, general surgery, radiology, diagnostic imaging, pathology and 24/7 emergency medicine. Residents along the North Oregon Coast have access to family practice and internal medicine with physicians and primary care providers at clinics in Seaside, Warrenton, Cannon Beach, heart clinics in Astoria and Seaside, and a full continuum of therapy, rehabilitation and home health services.

Our Commitment to Community

PSH dedicates resources to improve the health and quality of life for the communities it serves, with special emphasis on the needs of the economically poor and vulnerable. During 2019, PSH provided over $15 million in community benefit[2,3] in response to unmet needs and to improve the health and well-being of those we serve in Clatsop County. PSH is a part of Providence Health & Services Oregon Region, which includes the following hospital facilities: Providence Portland Medical Center, Providence Medford Medical Center, Providence St. Vincent's Medical Center, Providence Milwaukie Hospital, Providence Willamette Falls Medical Center, Providence Newberg Medical Center and Providence Hood River Memorial Hospital.

Community Benefit Governance and Management Structure

PSH further demonstrates organizational commitment to the community benefit process through the allocation of staff time, financial resources, participation and collaboration with community partners. PSH utilizes a collaborative local and Regional approach to community benefit standards and approaches. Several roles work together to cover a variety of community benefit activities.

- The Director of Financial Counseling/Assistance for the Oregon Region works to implement State and Federal 501r requirements, including the implementation of new financial assistance policy and debt collection requirements specified in Oregon law HB 3076 beginning in January 2020.
- The Director of Financial Operations at PSH oversees the portfolio of Community Benefit efforts occurring on the North Coast. This includes community benefit classification, reporting and

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[2] A community benefit is an initiative, program or activity that provides treatment or promotes health and healing as a response to identified community needs and meets at least one of the following community benefit objectives: a. Improves access to health services; b. Enhances public health; c. Advances increased general knowledge; and/or d. Relieves government burden to improve health. Note: Community benefit includes both services to the economically poor and broader community.

[3] To be reported as a community benefit initiative or program, community need must be demonstrated. Community need can be demonstrated through the following: 1) community health needs assessment developed by the ministry or in partnership with other community organizations; 2) documentation that demonstrates community need and/or a request from a public agency or community group was the basis for initiating or continuing the activity or program; 3) or the involvement of unrelated, collaborative tax-exempt or government organizations as partners in the community benefit initiative or program.

providing orientation for all new Hospital employees on Community Benefit programs and activities, including opportunities for community participation.

- The Community Health Division (CHD) Program Manager who works closely with the service area, in coordination with the Director of Community Health Investment, is responsible for providing the opportunity for community leaders and internal hospital Executive Management Team members, physicians and other staff to work together in planning and implementing the Community Health Improvement Plan.

The following describes how hospital leadership, Community Health Division staff and community members' work together to develop, discussion and approve community benefit initiatives annually:

- PSH leadership meets with CHD staff every other month to review and discuss updates on current community benefit efforts and initiatives.
- The Providence Seaside Hospital Service Area Advisory Council (henceforth referred to as the SAAC) assembles a sub-committee each year to participate in community benefit and regulatory activities. These tasks include consulting on the Community Health Needs Assessment (CHNA) and Community Health Improvement Plans, as well as participatory discernment and decision-making on community grant investments. In the 2019 CHNA process, along with PSH and CHD, one of the SAAC sub-committee members actively participated in the hospital and Coordinated Care Organization collaborative CHNA efforts.
- After discerning organizations to invite and approve for funding, the entire SAAC votes to approve community benefit grant allocations annually.
- Each quarter, the entire SAAC will review summarized quarterly reports from community based organizations who received community benefit grants. The SAAC sub-committee will receive copies of the quarterly reports to review in full each quarter as they are received. Additionally, once per year, each community based organization is invited to present to the entire SAAC on what they have accomplished in the prior year with the funds they received.

Planning for the Uninsured and Underinsured

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

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

One way PSH informs the public of FAP is by posting notices. Notices are posted in high volume inpatient and outpatient service areas. Notices are also posted at locations where a patient may pay their bill. Notices include contact information on how a patient can obtain more information on financial assistance as well as where to apply for assistance. These notices are posted in English and Spanish and any other languages that are representative of 5% or greater of patients in the hospital's service area. Additionally, on-line publicly available resources include plain language FAP summaries in 25 different languages. All patients who demonstrate lack of financial coverage by third party insurers are offered an opportunity to complete the Patient Financial Assistance Application and are offered information, assistance, and referral as appropriate to government sponsored programs for which they may be eligible. Find more information on our Financial Assistance Program here https://www.providence.org/obp/or/financial-assistance.

OUR COMMUNITY

Description of Community Served

Based on geographic location relative to other hospitals in the area and patient demographics, Clatsop County (in red) is PSH's primary service area. The secondary service area includes towns in Washington State that are primarily served by other hospitals.

Population and Demographics

As of 2019, Clatsop County is home to just under 40,000 permanent residents, though the population swells to more than twice that during the summer months. Clatsop County residents are also substantially older on average (43.7 years) than the state as a whole (39.2 years). There is a "bubble" of the population between ages 55 and 64, suggesting that older populations may come to Clatsop County to retire, or purchase second homes in the area around that age. Clatsop County also has a lower birth rate than Oregon's average, which contributes to the proportion of older residents being so high. The following chart shows the age and gender distribution of the current population of Clatsop County.

Figure 1: 2018 Clatsop County by Age and Gender
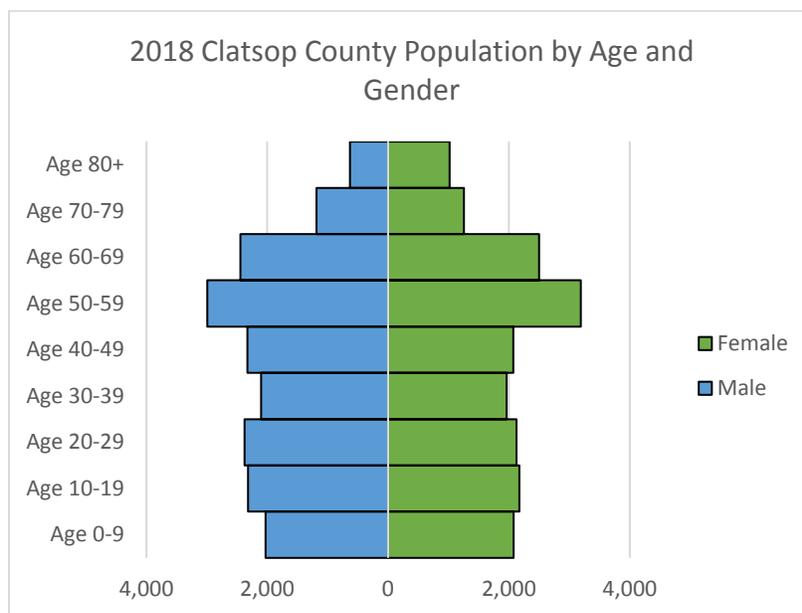
Race and Ethnicity

The county is less racially and ethnically diverse than the state as a whole. The following chart shows the self-reported race and ethnicity for residents in Clatsop County compared to Oregon overall based on the US Census. As of July 2019, the largest portion of the population identifies as white and non-Hispanic, with Hispanic or Latino being the second-most populous group in the County.

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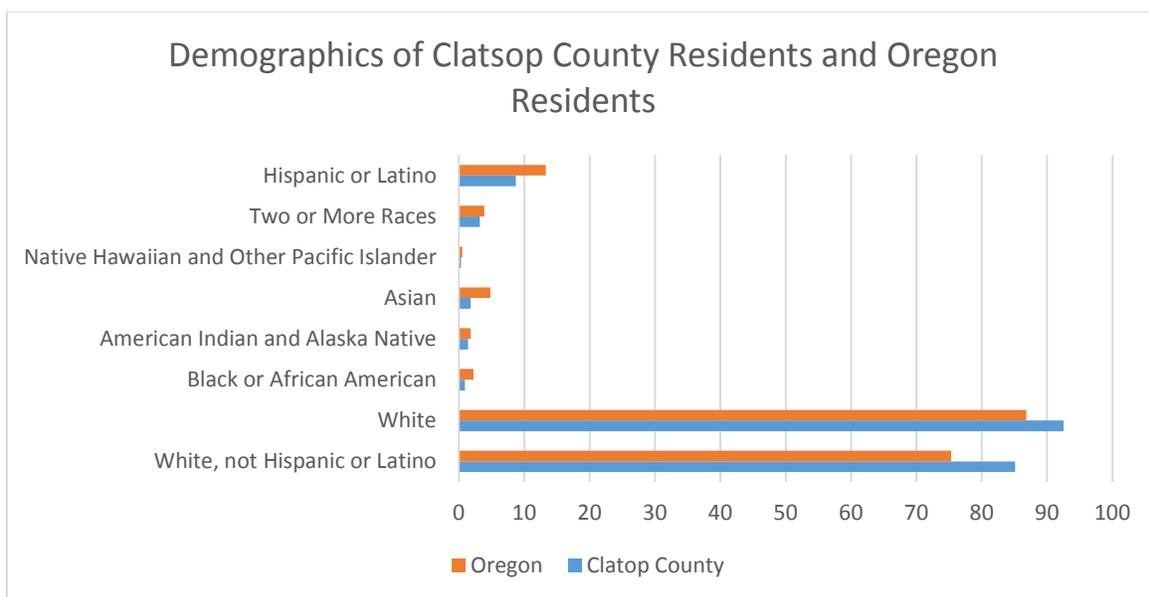
Income

In 2018, both the median household income and per capita income are lower in Clatsop County than Oregon as a whole according to US Census data. The median household income in Clatsop County is $49,828, 13% lower than Oregon's median of $56,119.

Health and Well-being

In Clatsop County, the combined 2014-2017 Oregon Behavioral Risk Factor Surveillance System (BRFSS) results found that 27.7 percent of adults are obese and there are fewer primary care providers than the state average. Nearly 20% of the CORE survey respondents went without needed dental care, and dental conditions are the second-most common reason that vulnerable populations come to the Providence Seaside Hospital Emergency Department. Over 29% of adults suffer from depression according to combined 2014-2017 Oregon BRFSS data.

COMMUNITY NEEDS AND ASSETS ASSESSMENT PROCESS AND RESULTS

Summary of Community Needs Assessment Process and Results

Through a mixed-method approach employing quantitative and qualitative data, the CHNA process used several sources of information to identify community needs. Across the North Coast community in Clatsop County, information data collected includes: public health data regarding health behaviors, hospital discharge data, hospital mortality/morbidity, and emergency department specific primary diagnoses. Community input was received through 7 key stakeholder interviews held with organizational and community leaders.

Two further methods were employed to gain more diverse and direct community representation. A mailed Community Health Survey was conducted using an address-based random-sampling of Clatsop County residents, yielding 160 responses. Effort was made to advance input from medically underserved communities who are low-income and represent a diverse sampling of the Clatsop County population. A community-wide effort was accomplished in the implementation of a micro-narrative story collection process, including over 1,200 North Coast residents. Some key findings:

- Key social determinants of health challenges include housing, transportation and food security. Approximately 1 in 10 survey respondents reported not having stable housing or had food shortages in the last year.
- Significant health disparities exist by family income, with those at 200% or below FPL having higher rates of many chronic health challenges, with diabetes, asthma, and hypertension being top reasons uninsured adults seek care in an Emergency Department.
- More than one in four survey respondents live with anxiety, with far more residents per behavioral health provider in Clatsop County compared to the Oregon ratio.
- Access to medical and dental care in rural communities is particularly challenging, with many residents having unmet health care and dental care needs.

Identification and Selection of Significant Health Needs

The prioritized needs were 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.

Community Health Needs Prioritized

The prioritized needs were chosen based on community health data and identifiable gaps in available care and services. In the course of our work, we determined that emphasis on these needs would have the greatest impact on the community's overall health with significant opportunities for collaboration.

These interventions were prioritized based upon relative needs and opportunities, particularly those that serve identified high needs ZIP codes and neighborhoods including low-income and minority populations. The list below summarizes the significant health needs identified through the 2019 Community Health Needs Assessment process:

SOCIAL DETERMINANTS OF HEALTH AND WELL-BEING

- **Affordable housing** (or housing accessibility) is a major challenge for low and moderate income families in the area, particularly for those in recovery from substance use disorder. Housing and rental prices are increasing faster than the median income, making it difficult for people to stay close enough to their places of employment, care, and children's school. Safe, secure housing has been proven to improve health outcomes. Homelessness is especially prevalent in Clatsop County, which experiences the second highest rate in Oregon
- 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. Clatsop Community Action, which administers the regional Food Bank reported that in 2019 they gave away three times more food than they were in 2012, indicating an unmet need for improved health food access.
- 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 others for rides to work, medical appointments, or other basic errands. Reliable, timely transportation was an unmet need mentioned by many stakeholders.

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. 12.6% of survey respondents in Clatsop County have been told by a doctor that they have diabetes, higher than the national prevalence of 9.5%.
- 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. Heart failure represents PSH's highest admission rate, measured at 64 per 1,000 discharges, significantly higher than the Providence Oregon Region's average of 48 per 1,000 discharges.

- **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.

COMMUNITY MENTAL HEALTH/WELLBEING AND SUBSTANCE USE DISORDERS

- **Access to 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. Just over 2 in 10 (22.5%) of survey respondents reported needing mental health care, and 7.5% of respondents did not get all the mental health care they needed.
- Access to **substance use treatment** continues to be a challenge for many. This includes alcohol and drug addiction services, both residential and outpatient treatment options. Oregon has relatively high rates of death from drug overdose, drug use (heroin, methamphetamines, and narcotics), and binge drinking.
- As we continue to learn about adverse childhood experiences (ACES) and the impacts of trauma on health later in life (i.e. child abuse, neglect, domestic violence, sexual assault, etc), increasing **community resilience** and preventing exposure to these events in the first place has become increasingly important.

ACCESS TO CARE

- Timely and consistent access to **primary care** remains a challenge, particularly for those enrolled in the Oregon Health Plan (Medicaid) and individuals that are uninsured. Nearly one in three (30%) respondents to the Community Health Survey did not have someone they thought of as their primary care provider, and 7.8% of respondents were uninsured.
- **Dental** conditions are among the top preventable reasons uninsured individuals access the Emergency Department, which is rarely the best point of care for these conditions. This presents an opportunity for prevention education and increasing access to preventive services. Just under one in five (17.4%) of survey respondents experienced an unmet need for dental care in the last year.
- 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**.

Needs Beyond the Hospital's Service Program

No hospital facility can address all of the health needs present in its community. We are committed to continuing our Mission through Community Benefit grant-making and ongoing partnerships in our community. While we care for our community each day, we recognize that we cannot address all needs effectively or independently, and some of the areas identified in our CHNA may be out of scope for us.

However, we are confident these needs will also be addressed by other in the community. For example, we will continue to support organizations addressing housing, including transitional housing with Helping Hands Re-entry Outreach and supportive housing with Clatsop Community Action, although we will not be focusing on all aspects of housing. Columbia Pacific CCO has pledged to invest in areas related to housing, and we will continue to leverage our long-standing partnerships, as well as our close relationship with the CCO, to develop community-wide strategies to address housing shortages. This will allow Providence to focus on addressing other social determinant needs, such as food insecurity, transportation and social isolation.

In a small community, such as Clatsop County, we recognize the importance of not duplicating efforts in specific areas of need at the potential expense of others. Thus, we will continue to collaborate with critical partners across our community that address aforementioned community needs to coordinate care and referrals to address unmet needs. We strongly believe that together we can better address the needs of our communities by leveraging our collective strengths.

We will also continue to explore opportunities for us to collaborate on efforts focused on areas including chronic condition management and prevention, as well as substance use disorder treatment through partnerships with organizations like CODA, who has only been present in Clatsop County since January 2020.

COMMUNITY HEALTH IMPROVEMENT PLAN

Summary of Community Health Improvement Planning Process

Efforts to develop the Providence Seaside Hospital (PSH) 2020-2022 Community Health Improvement Plan (CHIP) began in early 2020 to assemble a team of hospital caregivers and leadership, Community Health Division (CHD) staff and community partners to develop a guide for the next three years.

The CHD started by compiling an inventory of known various initiatives and efforts occurring in each of the four priority areas identified in the 2019 Community Health Needs Assessment. In mid-February this list was brought to PSH leadership with the proposal to assemble a group to meet in person to complete the inventory and prioritize the initiatives listed to focus on over the next three years.

A small planning team was assembled to review and populate the inventory, which was convened on March 9th, 2020. The group reviewed the required elements of the CHIP document and completed an inventory of activities, both community benefit and not community benefit funded efforts, which fell within the four priority areas, as well as efforts that would be occurring in 2020. From there, the group reviewed the inventory and identified five priorities to draft initiatives within the CHIP, which would be narrowed down to three or four by a larger committee of internal staff and community representatives. The discussion and prioritization process focused on severity of the need in the community and any disproportionate impact on vulnerable subpopulations (as informed by the 2019 CHNA), the size/magnitude of the need (i.e. number of people impacted), disparities of subpopulations, heightened vulnerability within subpopulations to be impacted by these needs (like homebound older adults) and the ability of PSH to impact these needs.

The following week, social distancing recommendations increased significantly in Oregon and across the United States due to SARS-CoV-2 virus and COVID-19 pandemic. This was followed by Oregon Governor Brown's Shelter in Place "Stay home, stay healthy" mandate later in the week, which prohibited gatherings changed the originally planned process for the initial iteration of the CHIP.

Due to the 2020 COVID-19 pandemic, the original CHIP planning process was altered to accommodate a travel ban, social distance requirements, and unforeseen time commitments of key leaders. PSH leadership approved the proposal for the CHD to populate the CHIP and submit it to the SAAC group via email for consideration and approval, recognizing the document would be revisited in late 2020 to early 2021 with a more traditional and collaborative review process.

In collaboration with PSH staff and community partner organizations, CHD staff drafted the PSH CHIP to present to hospital leadership and the SAAC sub-committee for initial review. Input was then gathered and incorporated into the final PSH CHIP document, which was then sent via email to the entire SAAC for approval.

PSH anticipates that implementation strategies may change, especially because of the COVID-19 situation, and therefore, a flexible approach is best suited for the development of its response to the CHNA. For example, certain community health needs may become more pronounced and may require changes to the initiatives identified by Providence Seaside Hospital in the enclosed CHIP. Additionally, the data projections included were crafted based on data collection and project forecasting done prior to the COVID-19 pandemic, so may be modified as we understand adjusted resources and priorities within our communities in the aftermath of the pandemic.

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

INITIATIVE #1: ACESSS TO ORAL HEALTH SERVICES AND EDUCATION

Community Need Addressed

Access to health services – oral health.

Goal (Anticipated Impact)

Improve the ability for adults and children to receive access to oral health services and education, regardless of income.

Scope (Target Population)

The entire community will benefit from additional oral health services, but it will be a particular service for low-income individuals (those living at or below 200% federal poverty guidelines), specifically those who have Medicaid insurance, are uninsured and/or unhoused.

Table 1. Outcome Measures for Addressing Oral Health Needs

Outcome Measure	Baseline	FY20 Target	FY22 Target
1. **Increase access to oral health treatment services**	250 individuals	300 individuals	400 individuals
2. **Enhance oral health education and awareness**	1,218 individuals	759 individuals *(Due to COVID-19)*	1,378 individuals

Table 2. Strategies and Strategy Measures for Addressing Oral Health Needs

Strategy(ies)	Strategy Measure	Baseline	FY20 Target	FY22 Target
Offer mobile dental van services in partnership with Medical Teams International	# clinics offered # individuals served	18 clinics 196 patients	15 clinics 165 patients *(Due to COVID-19)*	20 clinics 200 patients
Locate a mobile dental van on the Oregon Coast	# clinics offered during winter months	0 clinics offered	1 clinic offered (December 2020)	3 clinics offered (at least one every other month in winter 2022)

during winter months				
Provide oral health education and screenings in classrooms with Providence Healthy Smiles program	# students educated # students screened	1,134 students educated 646 students screened *(Based on 2018-2019 academic school year)*	670 students educated 477 students screened *(For 2019-2020 academic school year, impacted by COVID-19)*	1,300 students educated 660-765 students screened *(Based on pre-COVID-19 operations)*
Increase dental access for people with Medicaid	# dental providers who take Medicaid insurance	1 dental provider	2 dental providers	3 dental providers

Evidence Based Sources

https://www.orohc.org/early-childhood
Oral Health Integration in Oregon: Environmental scan and recommendations
Oral Health Toolkit: Resources for supporting oral health integration in Oregon
Oregon Health Authority Oral Health Roadmap
The Impact of Dental Integration in Oregon's Medicaid Program
Taking a Bite Out of Oral Health Inequities
United States Oral Health and Well-Being

Resource Commitment

Community benefit investment, dedicated staffing time, printed materials, and in-kind space and electricity to host dental van clinics.

Key Community Partners

Medical Teams international, Astoria School Districts, Seaside School District, Warrenton-Hammond School District, Knappa School District, Columbia Pacific CCO, Oregon Oral Health Coalition, Oregon Health Authority, Clatsop County Health Department, Clatsop Community Action.

INITIATIVE #2: FOOD SECURITY

Community Need Addressed

Social determinants of health results from poverty and inequity – food security

Goal (Anticipated Impact)

Increase food security access by focusing on intersectional initiatives that simultaneously address issues that impact nutritious food access and affordability, as well as combat chronic health conditions like diabetes or obesity among adults and children, as well as mental health conditions like depression and social isolation.

Increase healthy food access to everyone in the community, with particular initiatives targeted to those disproportionately impacted by food insecurity like low-income individuals and families, youth and children, older adults (especially homebound seniors) and those living with chronic conditions.

Table 3. Outcome Measures for Addressing Food Security

Outcome Measure	Baseline	FY20 Target	FY22 Target
1. **Reduce the number of households who experience food insecurity County-wide**	12.5% *(Oregon Hunger Task Force data published in 2019 based on 2017 figures)*	At or below Oregon state level *(Considering COVID-19)*	At or below Oregon state level

Table 4. Strategies and Strategy Measures for Addressing Food Security

Strategy(ies)	Strategy Measure	Baseline	FY20 Target	FY22 Target
Partner with Clatsop Community Action Regional Food Bank to offer their Food Bank Fresh Mobile Produce Pantry.	Pounds of food provided # people served	500,113 pounds 25,994 individuals (9,524 households)	5% increase annually	5% increase annually
Implement Food Farmacy program	# individuals served	0	15 served	TBD
Explore opportunities to partner with food-focused agencies to support food home delivery initiatives serving older adults	Program implementation landmarks	Discuss opportunities for intervention	Initiative conversations with food-focused agencies	If deemed feasible, meal delivery occurring with 2 food-focused agencies

Evidence Based Sources

https://www.geisinger.org/freshfoodfarmacy/learn-more
Food Insecurity and the Role of Hospitals
Food Insecurity and Health: Overcoming Food Insecurity Through Healthcare-Based Interventions
https://www.feedingamerica.org/hunger-in-america
Food Insecurity Is Associated with Chronic Disease among Low-Income NHANES Participants
Food Resource & Action Center - The Impact of Poverty, Food Insecurity, and Poor Nutrition on Health and Well-Being
What are the Connections Between Food Insecurity and Health?

Resource Commitment

Grant funding and staff time.

Key Community Partners

Clatsop Community Action, Columbia Pacific CCO, North Coast Food Web.

INITIATIVE #3: SOCIAL DETERMINANTS OF HEALTH - TRANSPORTATION

Community Need Addressed

Social determinants of health resulting from poverty and inequity – transportation

Goal (Anticipated Impact)

Offer transportation to vulnerable populations to increase accessibility to essential services like medical appointments and food (grocery stores and food bank visits).

Scope (Target Population)

People with transportation barriers to essential services, particularly low-income individuals and families and older adults.

Table 5. Outcome Measures for Addressing Transportation Needs

Outcome Measure	Baseline	FY20 Target	FY22 Target
1. Improve access to transportation	128 households served	139 households served	154 households served

Table 6. Strategies and Strategy Measures for Addressing Transportation Needs

Strategy(ies)	Strategy Measure	Baseline	FY20 Target	FY22 Target
Provide rides with Providence Community Connections program	# rides offered # miles driven	1,798 rides offered 71,167 miles driven	1,446 rides *(Due to COVID-19)* 56,466 miles driven *(Due to COVID-19)*	2,000 rides offered 78,000 miles driven
Connect with transportation services through the Community Resource Desk	# service referrals	146 service referrals	156 service referrals	172 service referrals

Transportation and the Role of Hospitals
Impact of Transportation Interventions on Health Care Outcomes: A Systematic Review
Humana Transportation Issue Brief
Transportation to Support Rural Healthcare
Can Subsidized Transportation Options Slow Diabetes Progression?
Traveling Towards Disease: Transportation Barriers to Health Care Access
The transportation prescription: bold new ideas for healthy equitable transportation reform in America
https://www.apha.org/topics-and-issues/transportation

Resource Commitment

Financial and staffing contributions

Key Community Partners

Clatsop Community Action

INITIATIVE #4: CULTURALLY RESPONSIVE SUPPORTIVE SERVICES

Community Need Addressed

While the largest proportion of Clatsop County residents identify as white and non-Hispanic, the Latinx community represents the second most populous group, and the largest community of color, representing 8.3 percent of the County's population. However, there is limited culturally responsive services and service navigation in the community.

Goal (Anticipated Impact)

Improve culturally responsive navigation services available to communities of color living in Clatsop County.

Scope (Target Population)

Communities of color living in Clatsop County, particularly the Latinx community.

Table 7. Outcome Measures for Addressing Culturally Responsive Supportive Services

Outcome Measure	Baseline	FY20 Target	FY22 Target
1. **Increase access to bilingual and bicultural culturally responsive navigation services**	1:233 ratio	1:194 ratio	1:140 ratio

Table 8. Strategies and Strategy Measures for Addressing Culturally Responsive Supportive Services

Strategy(ies)	Strategy Measure	Baseline	FY20 Target	FY22 Target
Support community based organizations offering culturally responsive services	# agencies who offer bilingual culturally responsive services	3 agencies	3 agencies	4 agencies
Offer bilingual resource navigation via the Community Resource Desks	# of households who primary language is other than English	25% households	27% households	30% households
Explore opportunities to improve culturally-specific behavioral health services available in Clatsop County	# of trained resources/services available (may include trained traditional health workers and/or mobile services)	0 trained	1 trained resource	3 trained resources
Work with state and County public health to improve data collection and reporting to promote health equity	Availability of reliable data	Health equity metrics recommended to Oregon Health Policy Board	Collecting and reporting reliable data from metrics statewide	Reliable data available at County level

Evidence Based Sources
Protocol for Culturally Responsive Organizations
https://lulac.org/programs/health/health_disparities/
https://orlhc.org/
Community Interventions to Promote Mental Health and Social Equity
Collaborations Bring Emotional Health & Wellbeing Conversations to the Latinx Community
Mobilizing Community Health Workers to Address Mental Health Disparities for Underserved
Populations: A Systematic Review
Using Traditional or Community Health Workers to Support Community-Clinical Partnerships and Patient
Engagement
Why being bilingual isn't enough to be a translator or interpreter

Resource Commitment

Community benefit investments, in-kind space, technology and materials provided.

Clatsop Community Action, Lower Columbia Hispanic Council, The Harbor, Pacific University School of Psychology, Oregon Community Health Workers Association, Columbia Pacific CCO.

Other Community Benefit Programs and Evaluation Plan

Table 9. Other Community Benefit Programs in Response to Community Needs

Initiative (Community Need Addressed)	Program Name	Description	Target Population (Low Income, Vulnerable or Broader Community)
1. Access to care	Rural Health Walk-in Clinics	Offer primary care access to members of the community	Entire community, with particular focus on low-income and uninsured
2. Social determinants of health – housing	Community match housing grants	Provide community benefit support to Clatsop Community Action to receive federal HUD grants.	Low-income individuals and families, specifically chronically houseless families, houseless youth and people fleeing domestic violence.
3. Chronic conditions – diabetes	Diabetes education sessions	Utilize the skills of the diabetes educator on campus to support those living with diabetes or prediabetes	People living with diabetes or prediabetes
4. Social determinants of health – housing	Transitional housing operational support	Support Helping Hands Re-entry operate their unhoused reentry program, long-term transitional housing and emergency shelter services.	Houseless
5. Community mental health & well-being	PeerUP!	Support FosterClub to provide weekly peer support sessions to foster resilience and self-determination.	Youth living in Foster Care.

6. Community mental health & well-being	Safe Shelter: Building Advanced Services for Survivors in Shelter	Support The Harbor operate their shelter for survivors of domestic, interpersonal or sexual violence and their families	Survivors of domestic, interpersonal or sexual violence. People who have experienced trauma (current or past).

2020-2022 CHIP GOVERNANCE APPROVAL

This Community Health Improvement Plan was adopted by the Service Area Advisory Council of the hospital on April 29, 2020. The final report was made widely available[1] by May 15, 2020.

(signature)   4/30/2020

Donald Lemmon   Date

Chief Executive, Providence Seaside Hospital

(signature)   May 8, 2020

Lisa Vance   Date

Chief Executive, Oregon Region

(signature)   May 8, 2020

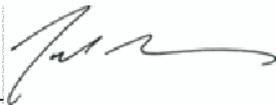Joanne Warner   Date

Chair, Oregon Community Ministry Boards

(signature)   May 11, 2020

Joel Gilbertson   Date

Senior Vice President, Community Partnerships

Providence St. Joseph Health

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To request a copy free of charge, provide comments, or view electronic copies of current and previous Community Health Improvement Plans please email CommunityBenefit@providence.org.

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

APPENDICES

Appendix 1: Definition of Terms

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

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

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

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

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

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

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

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

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

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

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

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