

2023 - 2025

COMMUNITY HEALTH IMPROVEMENT PLAN

Providence St. Vincent Medical Center

Portland, Oregon



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

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EXECUTIVE SUMMARY

Providence continues its mission of service in Washington County through Providence St. Vincent Medical Center (PSVMC). The facility and campus include 523 acute care beds, offering primary and specialty care, a birth center with family suites, general and specialty surgery, radiology, diagnostic imaging, pathology and 24/7 emergency medicine. The hospital's service area is the entirety of Washington County.

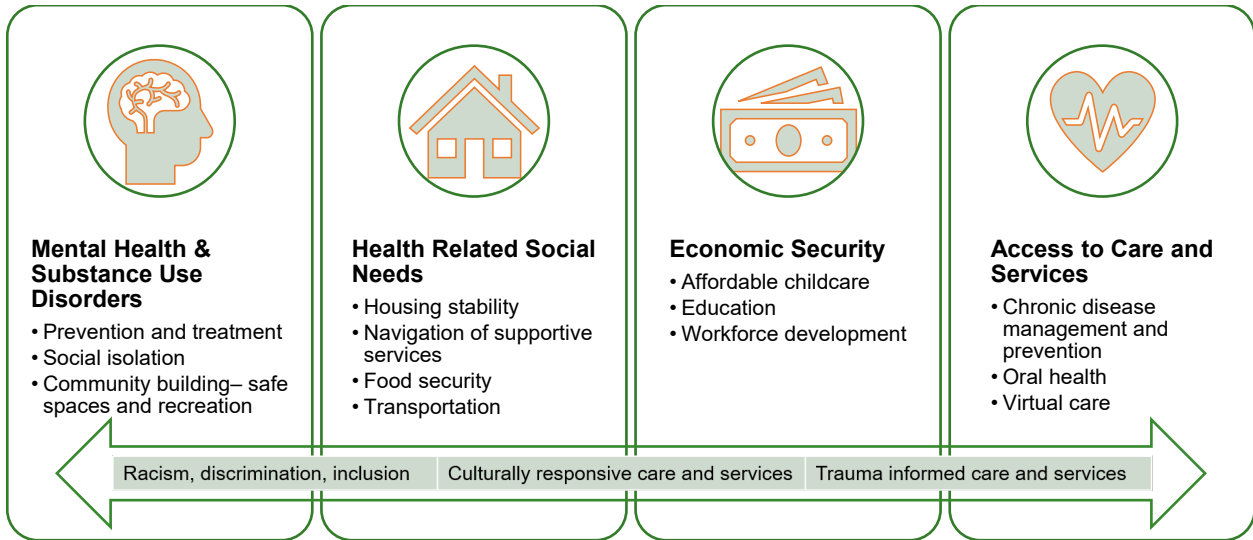
PSVMC dedicates resources to improve the health and quality of life for the communities it serves, with special emphasis on the needs of people experiencing social inequities and health disparities. During 2021, the hospital provided \$196,547,479 in community benefit in response to unmet needs.

The Community Health Needs Assessment (CHNA) is an opportunity for PSVMC to engage the community every three years with the goal of better understanding community strengths and needs. The results of the CHNA are used to guide and inform efforts to better address the needs of the community. Through a mixed-methods approach, using quantitative and qualitative data, the CHNA process relied on several sources of information: Oregon Health Authority, American Community Survey, Behavioral Health Risk Factor Surveillance Survey, Oregon Student Health Survey, Health statistics and vital records, Department of Education, Washington Healthy Youth Survey, and recent community assessments such as public health data regarding health behaviors; morbidity and mortality; and hospital-level data. Additionally, qualitative data was collected through community engagement sessions and a community health survey.

PSVMC Community Health Improvement Plan Priorities

A wide spectrum of significant health needs was identified in the 2022 CHNA, some of which are most appropriately addressed by other community organizations. The following graphic summarizes Providence Oregon's priority areas, and PSVMC will focus on the following bolded pillars for its 2023-2025 community benefit efforts:

Oregon Region 2022 CHNA Priorities



INTRODUCTION

Who We Are

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

Providence St. Vincent Medical Center (PSVMC) is a facility and campus including 523 acute care beds, offering primary and specialty care, a birth center with family suites, general and specialty surgery, radiology, diagnostic imaging, pathology and 24/7 emergency medicine. PSVMC is renowned for its many centers of excellence including Providence Heart Institute, Providence Brain and Spine Institute and Providence Center for Health Care Ethics, among others. Clackamas, Multnomah, and Clark (WA) counties are surrounding secondary counties that are primarily served by other area hospitals.

Our Commitment to Community

PSVMC 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 2021, PSVMC provided \$196,547,479 in community benefit¹ in response to unmet needs and to improve the health and well-being of those it serves in the Portland metro area.

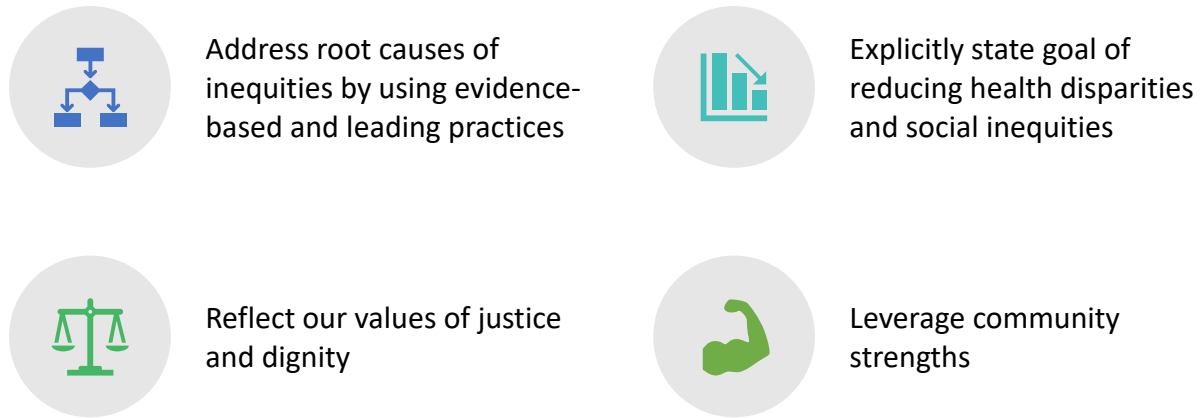
Health Equity

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

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

¹ Community benefit giving and reporting is based on Oregon Health Authority instructions for 2021.

Figure 1. Best Practices for Centering Equity in the CHIP



Community Benefit Governance

PSVMC further demonstrates organizational commitment to the community benefit process through the allocation of staff time, financial resources, and participation and collaboration with community partners. The Community Health Division, in collaboration with PSVMC leadership, is responsible for coordinating implementation of state and federal 501r requirements as well as providing the opportunity for community leaders and internal hospital executive leadership members, physicians and other staff to work together in planning and implementing the Community Health Improvement Plan.

As a primary source of community benefit advice and local leadership, the Portland Service Area Advisory Council (SAAC) plays a pivotal role in supporting the hospital’s board of trustees to oversee community benefit issues. Acting in accordance with a board-approved charter, the SAAC is charged with identifying policies and programs that address identified needs in the service area, particularly for underserved populations, overseeing development and implementation of the Community Health Needs Assessment and Community Health Improvement Plan Reports, and overseeing and directing the community benefit activities. The SAAC delegates some work to the Community Benefit Committee, a majority of whose members have knowledge and experience with the populations most likely to have disproportionate unmet health needs. The Community Benefit Committee usually meets quarterly.

Planning for the Uninsured and Underinsured

Providence’s 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 PSVMC has a Financial Assistance Program (FAP) that provides free or discounted services to eligible patients.

One way PSVMC informs the public of our FAP is by posting notices on site at the hospital. The notices are posted in high volume inpatient and outpatient service areas. Notices also are posted at locations where a patient may pay their bill. Notices include information about how to obtain more information on

financial assistance, as well as where to apply for assistance. These notices are posted in English and Spanish and any other languages that are representative of 5% or greater of patients in the hospital's service area. All patients who demonstrate lack of financial coverage by third- party insurers are offered an opportunity to complete the Patient Financial Assistance Application and are offered information, assistance, and referrals as appropriate to government-sponsored programs for which they may be eligible. Notices and information also are available on our website in multiple languages.

For information on our Financial Assistance Program click [here](#).

OUR COMMUNITY

Description of Community Served

Based on geographic location relative to other hospitals in the area and patient demographics, Washington County (in red) is PSVMC’s primary service area. Neighboring Clackamas, Multnomah, and Clark (WA) counties are considered secondary services areas that are primarily served by other area hospitals.



Community Demographics

POPULATION AND AGE DEMOGRAPHICS

The current population of Washington County is over 600,000 people according to the 2021 U.S. Census, representing an increase of over 12 percent in population since 2010. The largest age group in the county by percentage is ages 30 to 39 years (15.8%).

Age Group	Percentage
0 to 9 years	12.6%
10 to 19 years	12.7%
20 to 29 years	13.7%
30 to 39 years	15.8%
40 to 49 years	14.3%
50 to 59 years	12.3%
60 to 69 years	10.2%
70 to 79 years	5.4%
80 years and older	3.0%

Data Source: 2019 American Community Survey 5-year estimate

POPULATION BY RACE AND ETHNICITY

Among Washington County Census Data, residents in 2021 identified as 63.2 percent white non-Hispanic, 17.6 percent as Hispanic/Latino, 12.2 percent as Asian, 2.7 percent as African American or Black, 1.2 percent as Alaska Native or American Indian, and 4.8 percent as two or more races.

SOCIOECONOMIC INDICATORS

Table 1. Income Indicators for Washington County

Indicator	Washington County	Oregon
Median Income Data Source: 2019 American Community Survey, 5-year estimate	\$81,176	\$62,818
Percent of Renter Households with Severe Housing Cost Burden Data Source: 2019 American Community Survey, 5-year estimate	21.1%	24%

The median household income in Washington County (\$81,176) is higher than Oregon’s median income of \$62,818. Low-income households have an increased chance of experiencing a severe housing cost burden, which is defined as households that spend 50% or more of their income on housing. In Oregon, 24% of renter households experience severe housing cost burden compared to 21.1% in Washington County.

Full demographic and socioeconomic information for the service area can be found in the 2022 CHNA for [PSVMC](#).

COMMUNITY HEALTH NEEDS ASSESSMENT PROCESS AND RESULTS

Summary of Community Needs Assessment Process and Results

In the Portland metro area, PSVMC is a member of the Healthy Columbia Willamette Collaborative (HCWC). The collaborative is a unique coalition of 13 organizations in Washington, Clackamas and Multnomah counties in Oregon and Clark County in Washington state. HCWC is dedicated to advancing health equity in the four-county region, serving as a platform for collaboration around health improvement plans and activities that leverage collective resources to improve the health and well-being of local communities.

Through a mixed-methods approach, using quantitative and qualitative data, we collected information from the following sources: Oregon Health Authority, American Community Survey, Behavioral Health Risk Factor Surveillance Survey, Oregon Student Health Survey, Health statistics and vital records, Department of Education, Washington Healthy Youth Survey, and recent community assessments such as public health data regarding health behaviors; morbidity and mortality; and hospital-level data.

We conducted a community health survey that engaged 508 individuals. Additionally, we conducted 38 community engagement sessions, seven of which were conducted in a language other than English, with 311 individuals representing the following communities:

- Black, Indigenous, People of Color, and American Indian/Alaska Native people
- People who identify as LGBTQIA+
- People with disabilities
- Older adults, 65 years and older people affected by incarceration
- Rural communities
- Unhoused or people experiencing houselessness
- Immigrant populations
- Non-English-speaking communities
- People with substance use disorders
- Youth

Below is a short list of highlights from our quantitative and qualitative data collection:

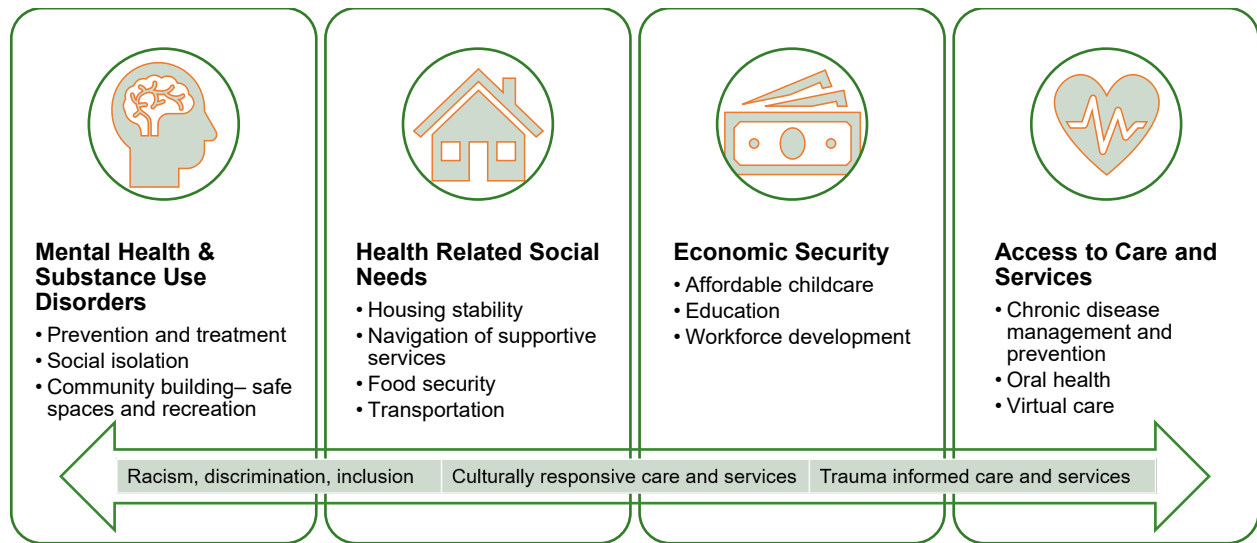
- People of color and people with disabilities are historically more likely to experience barriers to employment. The unemployment rate among Black/African Americans and people with disabilities was nearly twice as high as the general population in both 2019 and 2021.
- While 13% of community survey respondents reported being discriminated against by the health care system, this increased to between 20% and 30% among the CHNA's priority populations.
- The CHNA's priority populations reported delaying health care due to fear or discomfort at nearly twice the rate of all respondents and were more likely to report lack of trust with the health care system.

While care was taken to select and gather data that would tell the story of the hospital’s service area, it is important to recognize the limitations and gaps in information that naturally occur. A full accounting of data limitations can be found in the full CHNA.

Significant Community Health Needs Prioritized

A wide spectrum of significant health needs was identified in the 2022 CHNA, some of which are most appropriately addressed by other community organizations. The following graphic summarizes Providence Oregon’s priority areas, and PSVMC will focus on the following bolded pillars for its 2023-2025 Community Benefit efforts:

Oregon Region 2022 CHNA Priorities



Needs Beyond the Hospital’s Service Program

While we strive to care for our communities each day, we recognize that we cannot address all needs effectively or independently. For example, we simply will not have enough resources to solve the housing crisis in the Portland metro area. However, we are confident that these needs will be addressed by others in the community. For instance, our partnership with Meals on Wheels People in the Portland metro area not only offers healthy meals to address food insecurity, but also provides an avenue for seniors experiencing social isolation to connect with one another.

While not constituting a direct intervention, PSVMC will collaborate with community partners that address the aforementioned health and social needs to coordinate care and referrals that may positively affect these unmet needs. We strongly believe that together we can better address the needs of our communities by leveraging our collective strengths.

COMMUNITY HEALTH IMPROVEMENT PLAN

Summary of Community Health Improvement Planning Process

Through a collaborative process, the Portland Service Area Advisory Council (SAAC), representing internal staff and community members, selected the significant health needs to be addressed in the CHIP. As a first step in identifying key strategies to address those needs, the Providence Community Health team did a cross analysis of community health programs, grants to community partners and key partnerships that could make an impact. A brainstorming tool describing the level of intervention and population-level for each specific need served as an essential step in generating feasible CHIP strategies.

After populating the CHIP with strategies and measures, the SAAC along with PSVMC hospital leadership provided input and gave feedback on the initial strategies and measures. This was an iterative process resulting in multiple rounds of feedback and modification ultimately leading to final approval. Since several strategies to address the prioritized needs will be one-year community grants, the 2023-2025 PSVMC CHIP will be updated annually to include new strategies and strategy measures to address prioritized needs.

Addressing the Needs of the Community: 2023- 2025 Key Community Benefit Initiatives and Evaluation Plan

COMMUNITY NEED ADDRESSED #1: MENTAL HEALTH AND SUBSTANCE USE DISORDERS

Population Served

Adults with low income in need of access to mental health and/or substance use disorder services

Long-Term Goal(s)/ Vision

- To reduce substance use disorders and related health conditions through evidence-based prevention, treatment and recovery support services.
- To ensure equitable access to high-quality, culturally responsive, and linguistically appropriate mental health services, especially for populations with low incomes.
- To improve a workforce of mental health professionals that is representative of the community served, so that it can effectively and compassionately respond to the community's mental health and substance use needs.

Table 2. Strategies and Strategy Measures for Addressing Mental Health and Substance Use Disorder

Strategy	Population Served	Strategy Measure	Baseline	2025 Target
BOB Program - Caring Contacts Peer Support connects patients to community resources and BH programs while providing needed support services along the way	Adults recently discharged from the ED in behavioral health crisis	# of calls made	2,290 calls	2023 – 2,200 calls 2024 – 2,200 calls 2025 – 2,200 calls
BOB Program ED Outreach - identify behavioral health patients with frequent ED visits that may need additional support and services after discharge	Adults with frequent ED visits discharging from PSVMC ED with low income and in need of access to mental health/substance use disorder services	ED utilization (% change at 3 months post-BOB)	-2.6%	2023 – -10% 2024 – -12% 2025 – -15%
Grant to Raices de Bienestar	Latinx adults in need of mental health services	# of people served	36 people	2023 – 135 people
Grant to Adelante Mujeres	Latinx adults in need of mental health services	% of participants referred initiate care	0	2023 – 70%

Evidence Based Sources

Healthy People 2030 Evidence-Based Resources: <https://health.gov/healthypeople/tools-action/browse-evidence-based-resources>

County Health Rankings and Roadmaps Evidence-Based Strategies: <https://www.countyhealthrankings.org/take-action-to-improve-health/what-works-for-health/strategies>

AHA White Papers on SDOHs: <https://www.aha.org/social-determinants-health/populationcommunity-health/community-partnerships>

Resource Commitment

Community benefit funds, operational funds, outside grant sources

Key Community Partners

BOB Program, NAMI Multnomah, Raices de Bienestar, and Adelante Mujeres

COMMUNITY NEED ADDRESSED #2: ACCESS TO CARE AND SERVICES

Population Served

Individuals who are un- and under-insured

Long-Term Goal(s)/ Vision

- To improve access to health care and preventive resources for people with low incomes and those uninsured by deploying programs to assist with navigating the health care system.

Table 3. Strategies and Strategy Measures for Addressing Access to Health Care and Services

Strategy	Population Served	Strategy Measure	Baseline	2025 Target
EyeVan Program: partner with Pacific University to increase access to vision screening and prescription glasses	Un- and under-insured individuals	# of people served	80 people	2023 – 90 people 2024 – 90 people 2025 – 90 people
Smile Everywhere Program: partner with Pacific University to increase access to preventive oral health services	Un- and under-insured individuals	# of people served	100 people	2023 – 100 people 2024 – 110 people 2025 – 110 people
Partner with Medical Teams International to provide mobile emergency dental services	Un- and under-insured individuals	# of patients served # of community clinics held	197 patients 27 clinics	2023 – 210 patients; 30 clinics 2024 – 210 patients; 30 clinics 2025 – 210 patients; 30 clinics
Diabetes Self-Management Education Program	Community members living with diabetes	# of patients served	1,401 patients	2023 – 1,857 patients 2024 – 1,857 patients 2025 – 1,857 patients

Grant to Volunteers of America	Women affected by domestic and sexual violence	# of patients served	0 patients	2023 – 50 patients
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Evidence Based Sources

Healthy People 2030 Evidence-Based Resources: <https://health.gov/healthypeople/tools-action/browse-evidence-based-resources>

County Health Rankings and Roadmaps Evidence-Based Strategies: <https://www.countyhealthrankings.org/take-action-to-improve-health/what-works-for-health/strategies>

AHA White Papers on SDOHs: <https://www.aha.org/social-determinants-health/populationcommunity-health/community-partnerships>

Resource Commitment

Community benefit funds, operational funds, outside grant sources

Key Community Partners

Pacific University, Medical Teams International, Volunteers of America

COMMUNITY NEED ADDRESSED #3: HEALTH RELATED SOCIAL NEEDS – HOUSING INSTABILITY

Population Served

Individuals experiencing housing instability

Long-Term Goal(s)/ Vision

- A seamless connection between health care and homeless services, ensuring that people experiencing homelessness receive timely and appropriate linkage to community-based homeless services.
- Continue participating as a dedicated member of local coalitions to ensure coordination of homeless support services, including recuperative care, and that there are increased connections to supportive services for individuals experiencing homelessness.
- A coordinated and holistic community approach to providing increased linkages to supportive services for people experiencing homelessness.

Table 4. Strategies and Strategy Measures for Addressing Housing Instability

Strategy	Population Served	Strategy Measure	Baseline	2023-2025 Targets
Patient Support Program: increase access to supportive services	Unhoused individuals	# of clients served	2,786 clients	2023 – 2,786 clients
Community Resource Desk: connect families in need to appropriate housing resources	Individuals and families with unmet social needs	# of clients connected to housing resources post-30 day intake	1,143 clients	2023 – 1,257 clients 2024 – 1,383 clients 2025 – 1,521 clients
Healthcare + Homelessness Initiative: ease care coordination	People experiencing homelessness or housing instability	# of clients served	0	TBD

Evidence Based Sources

Healthy People 2030 Evidence-Based Resources: <https://health.gov/healthypeople/tools-action/browse-evidence-based-resources>

County Health Rankings and Roadmaps Evidence-Based Strategies: <https://www.countyhealthrankings.org/take-action-to-improve-health/what-works-for-health/strategies>

AHA White Papers on SDOHs: <https://www.aha.org/social-determinants-health/populationcommunity-health/community-partnerships>

Resource Commitment

Community benefit funds, operational funds, outside grant sources

Key Community Partners

Project Access NOW, Impact NW

COMMUNITY NEED ADDRESSED #4: ECONOMIC SECURITY

Population Served

Individuals with low income facing economic uncertainty and in need of new education or job skills

Long-Term Goal(s)/ Vision

The overall goal is:

- To reduce the burden of financial stress by increasing access to education, workforce development and job skills training opportunities

Table 5. Strategies and Strategy Measures for Addressing Economic Security

Strategy	Population Served	Strategy Measure	Baseline	2023-2025 Targets
Grant to Serendipity Center to expand student job skills and teacher incentives	Students with mental health conditions and/or developmental disabilities	# of students provided with workforce development support	0	2023 – 83 students
Grant to ASSIST to optimize client enrollment for SSI benefits	Adults with severe diagnosed mental or physical disabilities	# of high needs individuals assisted with social security benefits	0	2023 – 35 individuals
My Little Waiting Room	General community: parents and children accessing care	Milestones	0	2023 – develop sustainable mechanism to relaunch program

Evidence Based Sources

Healthy People 2030 Evidence-Based Resources: <https://health.gov/healthypeople/tools-action/browse-evidence-based-resources>

County Health Rankings and Roadmaps Evidence-Based Strategies: <https://www.countyhealthrankings.org/take-action-to-improve-health/what-works-for-health/strategies>

AHA White Papers on SDOHs: <https://www.aha.org/social-determinants-health/populationcommunity-health/community-partnerships>

Resource Commitment


Community benefit funds, operational funds, outside grant sources

Key Community Partners

Serendipity Center, ASSIST

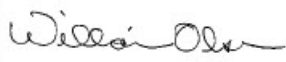
2023 – 2025 CHIP GOVERNANCE APPROVAL

This Community Health Improvement Plan was adopted by the Portland Service Area Advisory Council on April 21, 2023. The final report was made widely available by May 15, 2023.



Jennifer Burrows
Chief Executive, PSVMC and Western Oregon Division

4/27/23
Date



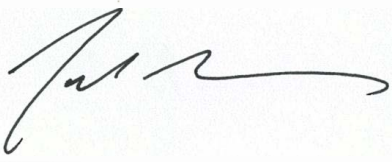
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Date



Joel Gilbertson
Chief Executive, Central Division

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