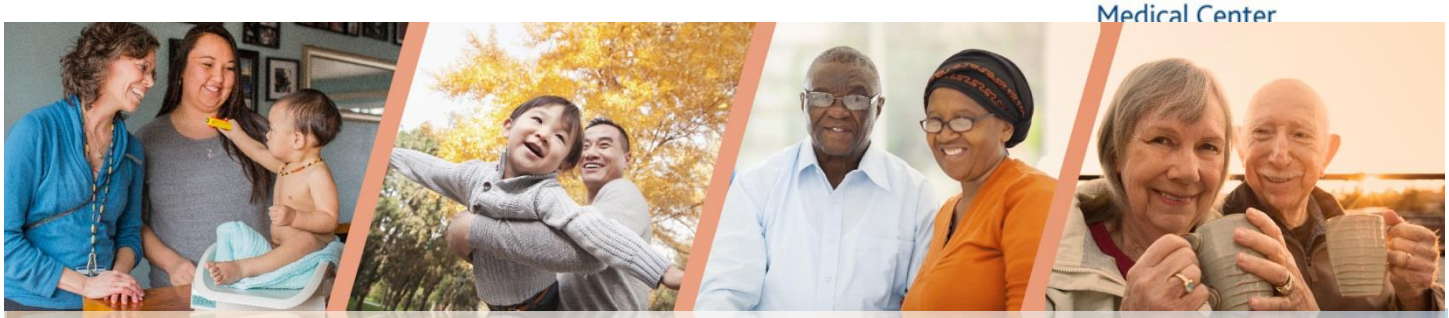
PROVIDENCE
St. Vincent
Medical Center



Community Health Needs Assessment Executive Summary

Providence St. Vincent 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 the Portland metropolitan area, Providence is a proud member of the Healthy Columbia Willamette Collaborative, a public-private partnership that brings together 15 hospitals, four counties, and two coordinated care organizations to produce a shared regional needs assessment. The full, four-county assessment was completed July 31, 2016. This overview looks at findings for Washington County, which includes the service area for Providence St. Vincent Medical Center.

Our starting point: Gathering community health data and input

Through a formal community health needs assessment process HCWC identified 46 health needs in Washington County, including:

- **17.5 percent of youth are living in poverty**
- **Nearly 60 percent of adults are overweight or obese**
- **Lower rates of physical activity in youth than the State average**
- **Nearly 18 percent of people are covered by the Oregon Health Plan (Medicaid)**
- **Over 12 percent of survey respondents reported homelessness and lack of safe/affordable housing**

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 and more are helping us develop 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 have been diversifying. For example, Washington County's foreign-born population increased over 11% since 2005, and the Latino population increased 67.4% from 2000 to 2010. The current population of Washington County is over 563,000, which represents about 19% growth since 2000.

Identifying top health priorities, together

Across the HCWC region, collected information included county public health data regarding health behaviors, morbidity, and mortality; hospital utilization and CCO data for the uninsured and members of the Oregon Health Plan; and community engagement activities that included listening sessions, literature review, and a community health survey. A detailed list is available from page 266 of the HCWC CHNA.

Providence top priority health needs for 2016-2018

Access to Care
Behavioral Health
Chronic Conditions
Social determinants of health and well-being

2016 Community health measures (data from 2014-2016)

Prioritized need	Washington County measures for 2016
Access to care	• Including primary care and dental health services • A growing need for culturally and linguistically appropriate services
Behavioral health	• Nearly 22 percent of adults have depression • About 5 percent of CCO-enrolled youth have been diagnosed with Attention Deficit Disorder and 2 percent with post-traumatic stress disorder. • Need for timely and accessible substance use treatment services
Chronic conditions	• Nearly 60 percent of adults are overweight or obese • Diabetes and hypertension are the top two reasons uninsured adults use the Emergency Department • Access to healthy, affordable food seen as part of a healthy community, as well as a priority identified need
Social determinants of health and well-being	• Recognized the need for policies, systems, and environments that support healthy behaviors • Homelessness/lack of housing was a frequently identified need • Unemployment and lack of living wage jobs second-most identified need

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 the three-county Portland Service Area.

Name	Type of program	Outcomes	Our support
Impact NW: Community Resource Desks	Co-location of staff in high needs clinics	Over 1,300 unique individuals served	Grant funding, in-kind support and technical assistance
Medical Teams International	Mobile dental van services	Over 1,000 served across Portland area	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 5,000 individuals served, including 2,088 in Washington County	Funding, co-development of referral platform
Virginia Garcia Memorial Health Center	Federally-qualified health center	Over 7,800 patients served in 2015	Funding partnership

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.

PROVIDENCE
Health & Services

2016 Community Health Needs Assessment: Additional Information

The 2016 CHNA was conducted along with partners in the Healthy Columbia Willamette Collaborative. This partnership includes fifteen hospital, two coordinated care organizations, and four public health agencies in two states. The region covered includes Clackamas, Multnomah, and Washington counties in Oregon as well as Clark County, Washington. While Providence's key findings are shared with those identified through the Collaborative assessment, this addendum provides additional information specific to Providence's Portland Service Area regarding service area definition and action taken since the 2013 CHNA.

Service Area Definition

The Portland Service Area for Providence in Oregon includes primarily Clackamas, Multnomah, and Washington counties. Clark County, Washington is considered a secondary service area. Per Oregon Revised Statutes, service areas are based upon market share, patient origin ZIP codes, and other surrounding or embedded geographies. Providence has four hospitals in the Portland Service Area:

- Providence Milwaukie Hospital, a 77-bed hospital serving primarily northern Clackamas County
- Providence Portland Medical Center, a 483-bed hospital serving primarily Multnomah County
- Providence St. Vincent Medical Center, a 523-bed hospital serving primarily Washington County
  Providence Willamette Falls Medical Center, a 143-bed hospital serving central and eastern Clackamas County.

Additionally, Providence Medical Group has 29 clinics across the 4-county Portland metropolitan area.

Actions taken since 2013 CHNA

The culture of Providence supports caregivers being engaged in their communities in a variety of ways. This list is not exhaustive, but highlights several of the key activities taken to address the priority health needs identified in the 2013 CHNA across the Portland area.

Access to preventive and primary care

To address access to preventive and primary care, Providence has taken a multi-pronged approach. Internal programs include a robust medical residency program that includes a rural track option and operation of five negative margin clinics in the Portland area. These clinics provide much-needed services to the community despite operating at a loss. Providence continues its commitment to serving the poor and vulnerable by welcoming Medicaid, Medicare, and uninsured individuals. Financial assistance programs are available, as are certified insurance enrollment assisters for patients seeking assistance.

However, Providence recognizes that internal programs alone will not "solve" the problem of access given the magnitude of the need. Despite the seven hospitals and health systems present in the

Portland metro area, the need for access to care remains a challenge for many. Through partnership with others, Providence supports non-profit clinics and health centers to see more patients and improve the quality of care delivered. Supported Federally-Qualified Health Centers (FQHCs) include Virginia Garcia in Washington County, Neighborhood Health Center in Clackamas and Washington counties, and Wallace Medical Concern in Multnomah County. Virginia Garcia serves nearly 8,000 patients per year at their Beaverton clinic, which is in the process of expanding to increase its capacity. Neighborhood Health Center has moved their Washington County location to Tanasbourne to expand access, including the addition of nine dental chairs and capacity for 1,400 new patients for integrated primary and behavioral health services. Wallace Medical Concern has also expanded services and partnered with Human Solutions to build new affordable housing units and relocate their administrative space, opening up more space for patient rooms.

In a unique partnership, Providence and Kaiser Permanente NW awarded funds to nine Community Supported Clinics for capacity-building and board development. This is a two-year initiative focused on supporting these clinics to remain viable in the post-ACA healthcare environment or begin the process of transitioning to FQHC "look-alikes". A key community partner in access efforts is Project Access NOW, which began prior to Medicaid expansion with the goal of connecting patients in need with physicians and health systems that were willing to provide pro-bono care. Their programs have now expanded to include premium support as well as outreach and enrollment for insurance efforts. Funding partners include all health systems and hospitals in the Portland metro area. The premium support program is targeted for individuals with chronic conditions who are between 139 and 200 percent FPL and has thus far helped 198 households maintain insurance coverage.

Mental health and substance use services

Again, Providence has invested in internal change and supported external programs and partners to increase access to mental health and substance use services across the Portland Service area. Internal programs include the integration of behaviorists in primary care clinics and continued operation of a behavioral health and chemical dependency services program. Other internal programs developed since 2013 include a geriatric psychiatry program at Providence Milwaukie Hospital with 19 in-patient beds as well as the Child and Adolescent Psychiatric Unit at Providence Willamette Falls Medical Center, providing 6 beds for children and 16 for adolescents. Providence Portland Medical Center operates 33 adult in-patient mental health beds and 20 adult detox beds, and Providence St. Vincent has 33 adult inpatient psychiatric beds. Providence Portland and Providence St. Vincent also operate adult outpatient and intensive outpatient mental health services.

Providence also supports other organizations in the community to provide mental and behavioral health services. One unique program is supporting Mental Health Association of Oregon to embed a peer support specialist and trained doula in Providence's Milwaukie Family Medicine clinic. The peer support specialist is available to pregnant women and mothers who are high-risk due to drug or substance dependency, particularly opiates and provides one-on-one support as well as group sessions throughout the course of pregnancy and through delivery. Other community-based programs that Providence supports include Central City Concern, LifeWorks NW, NAMI Oregon, and NAMI SW Washington. Central City Concern has operated the Recuperative Care Program for several years, and in 2016 initiated plans

to further expand services by adding 386 units of affordable housing, including a new Eastside location that will be an integrated health and wellness center. LifeWorks NW operates relief nurseries and family support programs for women of color through Project Network as well as prevention, mental health, and substance use services. Providence supports NAMI in Oregon as well as SW Washington to provide their family-to-family and mental health first aid trainings.

Other funded community programs in partnership with public health partners include Tri-County 911 through Multnomah County Health Department, and a mental health and media campaign through Clackamas County to reduce stigma related to mental health in adolescents. Tri-County 911 has been supported by the local coordinated care organizations for Oregon Health Plan members, and Providence's funding has been used to provide case management and outreach services to frequent EMS utilizers who remain uninsured.

Chronic conditions prevention and management

In addition to expanding access to primary care as discussed above, Providence has also engaged directly in increasing opportunities for chronic prevention and management. While most of these services are provided through primary care, Providence Milwaukie Hospital opened a new food pharmacy and community teaching kitchen for individuals with diet-related chronic conditions. The food pharmacy is available to Providence providers as well as those from nearby NW Primary Care Associates and Neighborhood Health Center. It is staffed by a registered dietician who provides cooking classes and instructions for preparing meals, regardless of whether a family is cooking on a hot-plate or in a gourmet kitchen. Providence has also piloted the universal Screen-and-Intervene protocol for food security in two clinics and is seeking to expand it, and its embedded connection to resources, to others. Providence also operates a parish-based health promotion program, or *Promotores*. These are lay community health workers, some of whom have been certified per the State of Oregon curriculum that provide movement and wellness classes for the Latino community. The *promotres* also offer the Tomando Control program, the Spanish-language translation of Stanford's Living Well with Chronic Disease curriculum as well as offer telehealth clinics that have provided screenings for over 363 Latinos and 87 telehealth visits with a nurse practitioner. Providence also operates a Program for All-inclusive Care for the Elderly (PACE) through ElderPlace, which increases access to care and improve quality of life for seniors.

External partners addressing chronic conditions include Impact NW, Partners for a Hunger-Free Oregon, and Project Access NOW. Impact NW runs the Community Resource Desk, which began as a pilot at two high needs clinics in Multnomah County in 2014. They are co-located in the clinics where they provide services, and in the first two years served over 1,800 unique individuals with connection to basic needs and other resources. In October of 2016, the Community Resource Desk expanded to western Washington County with Impact NW as the implementing partner, and we plan to open a desk in Clackamas County in 2017. Partners for a Hunger-free Oregon has been a policy partner related to many income- and food-related challenges, such as Oregon's elimination of the "co-pay" for reduced price lunches through the Free and Reduced Lunch program. They support summer meal sites across the state that in 2015 provided over 322,000 meals to 7,000 children. Providence has provided financial support for program operations, summer meals sites, and technical assistance through the Center for Outcomes Research and Education (CORE). Providence piloted and co-developed a referral platform with Project

Access NOW for their Community Care Connections program. At Providence, this is called the "Patient Support Program" and began as a pilot to provide safe and secure discharge for patients for the first 30 days. The platform is now being used by other providers and hospitals across the Portland area. This program is currently hospital-based, but there is opportunity for the program to expand to pilot clinic sites by 2018.

Oral health services

While Providence is not a traditional oral health provider, it operates a pediatric specialty dental clinic as part of the Providence Child Center at Providence Portland Medical Center. This is a clinic that provides dental care for children with special needs across the metro area, including residents at the Child Center. Two clinics have piloted the First Tooth dental sealant program for pediatric patients, which includes the application of fluoride varnish to prevent dental caries in children.

External partners addressing oral health services include Medical Teams International, Neighborhood Health Center, Oregon Community Foundation's Children's Dental Health Initiative, and the Oregon Oral Health Coalition. Medical Teams International operates mobile dental vans that serve over 1,000 patients per year. They provide oral health services primarily for the uninsured, but with Medicaid expansion have increased access to include members who are unable to get a dental appointment. Providence is a funding partner in the Oregon Community Foundation's five-year Children's Dental Health Initiative in 2014, which provided funding for 15 programs to expand access to oral health prevention programs for youth across Oregon. As noted in the Access to care section, Providence has also supported Neighborhood Health Center to expand programs in Washington County to include nine new dental chairs, and welcomed the Joseph Bernard Dental Clinic, which is co-located on the campus of Providence Milwaukie Hospital.

PROVIDENCE
Health & Services

16 December 2016

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

Signed:

Janice Burger
Chief Executive, Providence St. Vincent Medical Center
Co-Chair, Portland Service Area Advisory Council

Paul Gaden
Chief Executive, Providence Portland Medical Center

Keith Hyde
Chief Executive, Providence Milwaukie Hospital

Russ Reinhard
Chief Executive, Providence Willamette Falls Medical Center

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

PROVIDENCE
St. Vincent
Medical Center

Community Health Improvement Plan
2017-2019

Providence St. Vincent Medical Center
Washington County, Oregon

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Community Health Improvement Plan
2017-2019

Providence St. Vincent Medical Center
9205 SW Barnes Road
Portland, OR 97225

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 Community Health Needs Assessment conducted by Healthy Columbia Willamette Collaborative (HCWC), which serves the four-county region of the Portland Metropolitan area. This plan is specifically designed to serve Washington County, which is Providence St. Vincent 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. This plan will be reviewed and updated annually or as needed to recognize new partners, initiatives, efforts, 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 and associated action plans

While HCWC identified 46 specific health related needs in Washington County, Providence has grouped these needs into thematic categories and identified specific focus areas within those categories:

Access to care

- Primary care
- Dental care
- Culturally-responsive care

Behavioral health

- Mental health services
- 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 investment initiatives over the next three years. You will find additional information about our specific tactics and metrics 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 our communities

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 St. Vincent Medical Center conducted a community health needs assessment as a member of the Healthy Columbia Willamette Collaborative (HCWC). 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 St. Vincent Medical Center and across the Portland metropolitan area. 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.

This plan is intended to serve as a guiding document for community investment, community building and development, and community health efforts through 2019. This plan will be reviewed and updated annually or as needed to recognize new partners, initiatives, efforts, 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.

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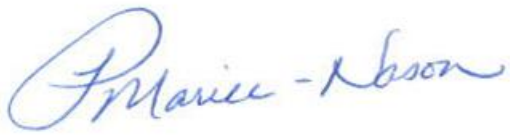
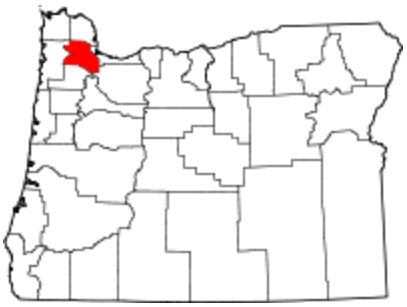


Pamela Mariea-Nason, RN, MBA
Executive, Community Health Division
Providence Health & Services – Oregon

Community Profile

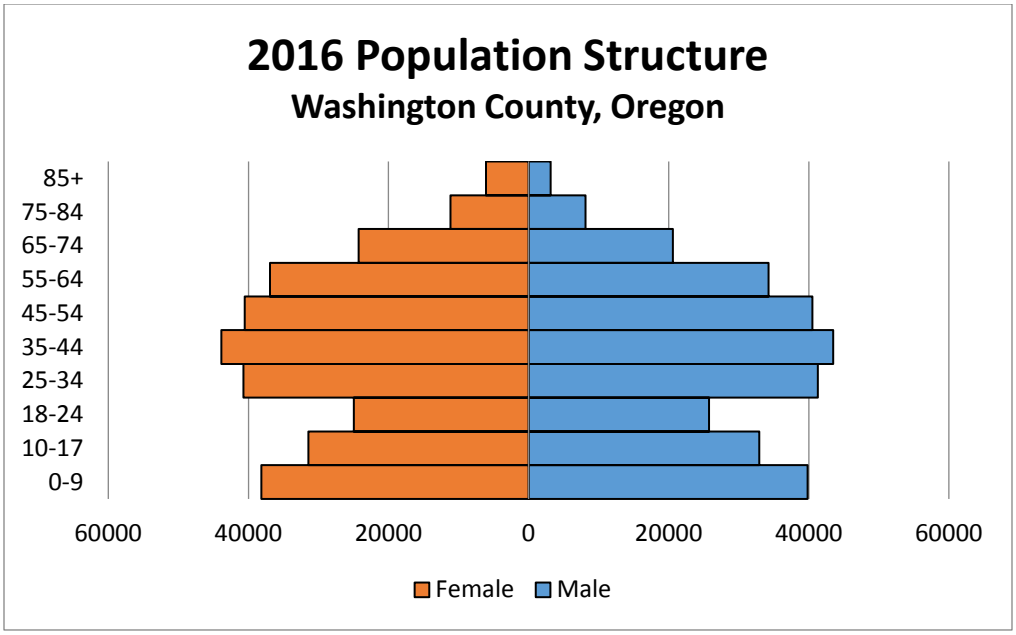
Washington County, Oregon



Providence St. Vincent Medical Center primarily serves residents of Washington County in Oregon. Providence has two other hospitals serving neighboring Multnomah and Clatsop counties and five additional hospitals around the state.

Population and Age Demographics

The current population of Washington County is over 585,000, which represents slightly over 20 percent growth since 2000. Washington County has been diversifying, with the foreign-born population increasing nearly 11 percent since 2005, and the Latino population increasing over 67 percent from 2000 to 2010. 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 nearly 2 surviving females for each male.



Ethnicity

Among Wahington County residents in 2016, 67.4 percent identified as White non-Hispanic, 16.2 percent were Hispanic or Latino, 10.2 percent Asian or Pacific Islander, slightly less than 2 percent were African American or Black, less than one percent were Alaska Native or American Indian, and 3.6 percent identified as two or more races.

Income

In 2015, the median household income for Washington County was $66,754, which is nearly $12,000 higher than neighboring Multnomah County and more than $12,000 above the national average. Washington County's unemployment rate was 3.4 percent in December 2016. The state's overall unemployment rate was 4.5 percent, compared to the national average of 4.7 percent at the same time.

Health and wellbeing

In Washington County, nearly 60 percent of adults are overweight or obese, as are 22.8 percent of eighth grade students and 26.8 percent of eleventh grade students. Diabetes and hypertension remain the top two reasons uninsured adults access the Emergency Department for conditions that could be managed in primary care settings. Nearly 18 percent of youth are living in poverty and 22 percent of adults have depression.

SUMMARY OF PROVIDENCE PRIORITIZED NEEDS AND ASSOCIATED ACTION PLANS

In the Portland Metropolitan area, Providence is a proud member of the Healthy Columbia Willamette Collaborative (HCWC), a public-private partnership that brings together 15 hospitals, four counties, and two coordinated care organizations (CCOs) to produce a shared regional Needs Assessment. The complete assessment for the four-county region was completed July 31, 2016. Across the HCWC region, collected information included county public health data regarding health behaviors, morbidity, and mortality; hospital utilization and CCO data for the uninsured and members of the Oregon Health Plan; and community engagement activities that included 29 listening sessions, a literature review, and a community health survey with over 3,600 responses. A detailed list is available from page 266 of the full CHNA (available here).

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 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 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 Washington County serving populations where over 50 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 homebound or dependent on others for rides to 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 receive healthcare services in a culturally-responsive and welcoming setting

Objectives

- Providence Medical Group will continue to provide care for over 25,000 Oregon Health Plan members in the Portland Metropolitan area.
- Support community-supported clinics, federally-qualified health centers, and school-based health centers to extend hours and services to support primary care access
- At least 400 indivduals with chronic conditions will receive support to purchase a silver-level plan on the health insurance exchange through the Premium Support Program annually
- Medical Teams International will provide at least 18 dental van days at Providence St. Vincent Medical Center to provide free basic dental procedures and oral hygiene education
- School-aged childen will have improved access to oral health services and education
- At least 320 uninsured Latino individuals 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 plan	2016 baseline or proposed measurement
Improve access by providing primary care homes for Oregon Health Plan members in Providence Medical Group through collaboration with Providence Health Plan and Health Share of Oregon.	Current CCO enrollment (December 2016): 28,610
Improve access by partnering with community-supported clinics, federally qualified health centers, and school-based health centers to extend hours, provide new services, and offer technical assistance.	Southwest Community Health Center services provided; Virginia Garcia serving 7,800 patients in Beaverton; Neighborhood Health Center serving 6,000
Partner with Project Access NOW to increase insurance enrollment and access to care through the Premium Support Program and Outreach & Enrollment Alliance.	Over 600 individuals enrolled in insurance through Premium Support Program
Partner with Medical Teams International to provide basic dental care and procedures for remaining uninsured and Oregon Health Plan members without established dental providers.	26 dental van days providing dental services to over 220 adults
Parnter with the Oregon Community Foundation's Children's Dental Health Initiative to fund and support youth oral health across the state.	Virginia Garcia Memorial Health Foundation providing education and dental services for school-aged youth

Enhance culturally-responsive care through parish health promoters (*Promotores*) telehealth clinics.	16 clinics scheduled; number served
Promote enhanced diversity in hiring practices within Providence to better reflect the community being served.	Partner with HR to enhance cultural competency in our workforce

Existing partners

Partners listed above are highlighted here to note the specific area their program(s) address. A more complete list of potential partners is provided at the end of this document.

Organization	Primary care	Dental care	Culturally-responsive
Children's Dental Health Initiative		x	
Medical Teams International		x	
Neighborhood Health Center	x	x	x
Oregon Community Health Worker's Association			x
Project Access NOW	x		
Southwest Community Health Center	x		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
- 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 each year in a train-the-trainer model
- Partner with Trillium Family Services to decrease stigma associated with mental health conditions in high schools through social media campaign involving at least four school districts by 2018
- All providers will have access to trauma-informed care training; at least 80% of Emergency Department providers will have received training in trauma-informed care by December 2019
- Pregnant women experiencing addiction will be supported through their pregnancy and post-partum with peer support programs to improve birth outcomes

Action plan and baseline or proposed measurement

Action plan	2016 baseline or proposed measurement
Partner with Trillium Family Services to pilot mental wellness and anti-stigma campaign in schools	Number of youth reached by peer-generated messages; uptake of mental health/crisis services
Implement peer and recovery support specialist/doula for pregnant women experiencing addiction	Number served; birth outcomes
Partner with NAMI Oregon to support 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)

Existing partners

Partners listed above are highlighted here to note the specific area their program(s) address. A more complete list of potential partners is provided at the end of this document.

Organization	Mental health services	Substance use treatment	Trauma prevention
Lifeworks Northwest	x	x	x
Mental Health Association of Oregon	x	x	x
NAMI Oregon	x	x	
Neighborhood Health Center	x		
Trillium Family Services	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	75 indivuduals trained
Provide subsidized chronic conditions care management education	Number served
Partner with American Diabetes Association on Let's Play, Portland!	Students served; health behavior change
Partner with Friends of Zenger Farm on CSA Partnerships for Health	CSA shares distributed; youth engagement in physical activity; health status
Partner with The FIT Project on family-based pediatric weight management program	Number of families participating; health behavior change
Implement 5-2-1-0 messaging in clinics and with community parnters	Clinics providing 5-2-1-0 messaging; health behavior change

Existing partners

Partners listed above are highlighted here to note the specific area their program(s) address. A more complete list of potential partners is provided at the end of this document.

Organization	Diabetes	Hypertension	Obesity
American Diabetes Association	x		x
Friends of Zenger Farm			x
The FIT Project			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 eldelrly and those in rural communities, will have access to convenient, frequent public transit or ride share services

Objectives

- Increase affordable housing stock by at least 385 units, including recuperative care, permanent housing, and family units by 2018
- Implement food security screening questions at 50 percent of family medicine and pediatric clinics by 2019
- Implement community partner referral system in Epic and pilot with at least two clinics
- Provide safe and secure discharge for at least 2,000 individuals needing short-term social service support
- 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
- Social service agencies and healthcare will be better connected through the Regional Social Determinants of Health Network

Action plan and baseline or proposed measurement

Action plan	2016 baseline or proposed measurement
Partner with Central City Concern and other health systems to build new affordable housing units	Completion of units; occupancy rates
Partner with Meals on Wheels to provide meals for eligible patients upon discharge	Number served; health outcomes (decreased ED utilization)
Partner with Project Access NOW to connect eligible clients to Patient Support Program	2,088 patients supported for safe discharge
Pilot social service referral system and social needs sceening into Epic	Screening rates, % of referrals closed
Partner with Impact NW to operate Community Resource Desk program	600 individuals served (5 months)
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"
Support Project Access NOW to develop Regional Social Determinants of Health Network	Implementation complete; % of referrals closed
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

Partners listed above are highlighted here to note the specific area their program(s) address. A more complete list of potential partners is provided at the end of this document.

Organization	Housing	Food	Jobs	Transportation
211-Info	x	x	x	x
Central City Concern	x		x	
Impact NW	x	x	x	x
Meals on Wheels People		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.

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

Organization	Associated Community Need(s)*
211-Info	SDH
American Diabetes Association	CC
Catholic Charities	SDH
Central City Concern	BH, SDH
FamilyCare Health	AC
FolkTime	BH
Friends of Zenger Farm	CC
Health Share of Oregon	AC
Impact NW	SDH
Kaiser Permanente NW	Funding/coordinating partner
Legacy Health	Funding/coordinating partner
Lifeworks Northwest	BH
Meals on Wheels People	SDH
Medical Teams International	AC
Mental Health Association of Oregon	BH
NAMI Oregon	BH
Neighborhood Health Center	AC, BH, CC
Oregon Business Council	SDH
Oregon Community Foundation	Funding/coordinating partner
Oregon Community Health Worker's Association	AC
Oregon Health & Science University/Partnership Project	AC, CC
Partners for a Hunger-Free Oregon	SDH
Project Access NOW	AC, SDH
Southwest Community Health Center	AC
The FIT Project	CC

Trillium Family Services	BH
Tuality Healthcare	Funding/coordinating partner
Tualatin Hills Parks & Recreation District	CC
Tualatin Valley Fire & Rescue	AC, BH
Virginia Garcia Memorial Health Center	AC, BH, CC
Volunteers of America	AC, BH, SDH
Washington County Community Action	SDH
Washington County Health & Human Services	AC, BH, CC

PLAN APPROVAL

Janice Burger
Chief Executive, Providence West Division
Co-Chair, Portland Service Area Advisory Council
Providence Health & Services – Oregon

Date 4-26-17

Joanne Truesdell
Co-Chair
Portland Service Area Advisory Council
Providence Health & Services – Oregon

Date 4-27-17

Joel Gilbertson
SVP Community Partnerships
Providence St. Joseph Health

Date 5/1/17

This plan was adopted on April 21, 2017.

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