Providence St. Vincent Medical Center, Fiscal Year Ended 12/31/2022

1. The year of publication for the current community health needs assessment

The year of publication for the most recent community health needs assessment was 2022.

2. State the top health needs identified in the hospital's most recent community health needs assessment. Include information on geographies, populations or demographic groups affected.

In the Portland metro area, Providence St. Vincent (PSVMC) is a member of the Healthy Columbia Willamette Collaborative (HCWC). The collaborative is a unique coalition of 13 organizations such as CCOs, health systems, and public health departments 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. As a contributing health system, Providence served in an advisory role to help guide completion of the needs assessment including community engagement2, data management, and report development.

Based on geographic location relative to other hospitals in the area and patient demographics, Washington County is PSVMC's primary service area. Clackamas, Multnomah, and Clark (WA) counties are surrounding secondary counties that are primarily served by other area hospitals. The facility and campus include 523 acute care beds, offering primary and specialty care, 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.

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 impact by incarceration
- Rural communities
- Unhoused or people experiencing houselessness
- Immigrant populations
- Non-English-speaking communities
- People with substance use disorders

- Youth

Below are 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.

Through a collaborative process, HCWC used a modified version of the Mobilizing for Action through Planning and Partnerships (MAPP) model to create the CHNA. The modified MAPP model is an iterative process combining health data and community input to identify and prioritize community health needs. Results were distilled through discussions with the Community Action Team (CAT), in partnership with the Oregon Equity Alliance, to ensure the stories and information collected and presented in this report are aligned with our communities' experiences. Through this community-informed approach, the following priority areas were identified: Safe and Affordable Housing, Physical Safety in Community, Cultural Displacement Due to Gentrification, Economic Opportunity, Educational Opportunity, Culturally-Specific and Healthy Foods, Transportation, Virtual Resources, Affordable Health Care, Culturally- and Linguistically-responsive Health Care, Trauma-Informed Care, Delayed or Avoided Health Care, and Social Connection.

HCWC identified a wide spectrum of significant health needs, some of which are most appropriately addressed by other community organizations. Considering PSV's unique capabilities, community partnerships and potential areas of collaborative community impact, we are committed to addressing the following priorities as aligned with the collaborative priority areas:

Mental Health and Substance Use Disorder: Focus on prevention and treatment, social isolation, and community building related to safe spaces and recreation. This priority area refers to the growing challenges of accessing care due to workforce shortages, a lack of culturally responsive care and affordability.

Health Related Social Needs: Focus on housing stability, navigation of supportive services, food insecurity and transportation. This priority area refers to the unmet social needs that exacerbate poor health and quality-of-life outcomes.

Economic Security: Focus on affordable childcare, education, and workforce development. This priority area affects nearly every aspect of a person's life and refers to the challenge of affording basic living expenses and obtaining affordable education.

Access to Care and Services: Focus on chronic disease management and prevention, oral health, and virtual care. This priority area refers to the lack of timely access to care and services due to physical, geographic, and systemic limitations, among others.

Three consistent cross-cutting themes surfaced during the assessment process and analysis, affecting all four priority areas:

- Racism, discrimination, and inclusion
- Culturally responsive care and services
- Trauma-informed care and services

As documented in the CHNA, there are several indicators that may have affected health in the region:

- Multnomah County has a significantly higher unhoused rate at 51.2 per 100,000 people compared to the State of Oregon at 30 per 100,000 people.
- In the Portland metro area from 2016-2020, the violent crime rate was 342.7 crimes per 100,000 residents compared to 293.7 per 100,000 in the State of Oregon. Multnomah County has the highest rate of violent crime at 541.0 crimes per 100,000 residents.

3. Identify the significant community benefit activities the hospital engaged in that addressed the health needs identified above.

In 2022, Providence St. Vincent Medical Center contributed $96.0 million in statewide community benefit across all categories including financial assistance. Outside of charity care and unreimbursed Medicaid costs, our proactive community benefit, such as community health improvement services, subsidized health services, health professions education, and research totaled $17.9 million. Community Health Investment (CHI) allocated $1.6 million to community health programs, grants, and sponsorships/donations across the Portland metro area.

The following 2-3 activities under each health need represent a snapshot of PSVMC's community benefit. Due to several programs being offered regionally, the title indicates whether the program is hospital specific or Oregon region.

Mental Health and Substance Use Disorder

Select examples of community benefit activities

Community Health Improvement Services (CHIS): Providence Assessment, Intake & Referral (Prov AIR) - $1.6 million (Oregon Regional Services)

Every year over 30,000 Oregonians enter an emergency department in behavioral health crisis. Prov AIR was implemented in 2017 to make acute inpatient psychiatric care more accessible and equitable for patients throughout Oregon. Prov AIR collaborates via a daily huddle call with other community partners like Unity, Albertina Kerr, Trillium, Lines for Life, and Cedar Hills Hospital to keep the referral process organized across other agencies in the state, regardless of where the patient ultimately needs care. Since the program's advent, this 24-hour team of master's level clinicians have worked around the clock to process an average of 600+ referrals a month for patients in need of acute, subacute, and residential levels of care. Through these efforts, the team coordinated 300+ admissions a month for high-risk Oregonians in need of acute psychiatric care at one of Providences four inpatient units.

CHIS: Better Outcomes through Bridges (BOB) Program - $1.4 million (Oregon Regional Services excluding Providence Hood River Memorial Hospital)

The BOB program focuses on serving some of the community's most vulnerable and underserved people with the goal to empower individuals on their journey toward better well-being by engaging with compassion, dignity, and integrity. Peer support specialists work with patients discharged from the emergency department in behavioral health crisis and facilitate connection to community resources and

behavioral health programs. Furthermore, emergency department staff and peer support specialists work collaboratively to identify behavioral health patients with frequent ED visits that may need additional support and services. Much of a peer's time is spent in the community alongside clients.

The program includes several components at PSVMC including peer support outreach through Caring Contacts & Behavioral Health Follow-up serving 2290 people in 2022 and Emergency Department Outreach serving 25 individuals.

Cash and In-Kind Contributions: Community Health Grants - $1.1 million (Portland Metro Area)

In the Portland metro area, grants were given to 10 community partners to address the area of mental health and substance use disorder. See below for select examples.

- Rose Haven - $200K
    - The Mental Health Advocacy Program offers accessible mental health services to women experiencing poverty and intersecting traumas. The program will bridge the gaps in mental health services to a population currently lacking accessibility, building on a proven program model.
- Northwest Catholic Counseling Center (NCC) - $100K
    - NCC provides mental health care in person, by phone, and by video to anyone in need, regardless of their personal or financial situation. The *For All in Need* program has a special focus on Latinx neighbors. The Levantar program provides culturally and linguistically tailored mental health care to the Latinx community, regardless of ability to pay, legal or immigration status, employment situation, or background.
- Lines for Life - $100K
    - This funding supported the YouthLine and outreach to underserved youth across Portland metro. The YouthLine is a resource staffed by youth for youth experiencing stress, anxiety, isolation, and other mental health challenges. In addition, Lines for Life increased outreach activities, crisis lines staffing, and implemented a mini-grant program to provide direct, in-person support to youth and help schools respond to student need.
- Black Parent Initiative (BPI) - $100K
    - BPI launched an internal mental health and wellness initiative in 2020 directly in response to community need and feedback. This funding will help sustain and expand this important programming that has a demonstrated benefit for the families that BPI serves.
- Lutheran Community Services Northwest (LCSNW) - $100K
    - LCSNW implemented a rapid engagement model. This model offers culturally specific pre-treatment services and case management to refugee and immigrant community members and facilitates their access to mental health and substance use disorder services. Rapid Engagement focuses on outreach, engagement and intensive case management which may or may not lead to enrollment into clinical programs.

Health Related Social Needs

This section also addresses question 4a.

Select examples of community benefit activities

Cash and In-Kind Contributions: Patient Support Program - $996,361 (Oregon Regional Services)

Serving low-income patients in all eight Providence Oregon hospitals, the Patient Support Program (PSP) is another example of leveraging a community partnership to address barriers to care and help patients safely transition home or participate in treatment without worrying about basic needs. This program has expanded to include pregnant moms, heart patients, and vulnerable seniors. In 2022, the top need was transportation followed by food costs and medication. PSP is solely operated by Project Access NOW.

Cash and In-Kind Contributions: Community Resource Desk - $491,927 (Portland Metro Area)

In an active partnership with Impact NW, Providence continues to co-locate staff through the Community Resource Desk (CRD) program. The CRD helps individuals and families who need support connect with community resources. It is free, confidential, and open to anyone who approaches the desk (staffed by bilingual Spanish/English speakers). In 2022, 1,143 individuals were served across Washington County. For the entire CRD program, 70% of clients had Medicaid or Medicare, 22% had an income less than 50% the federal poverty limit, and 34% identified as a person of color.

Economic Security

Select examples of community benefit activities

Cash and In-Kind Contributions: Partnership with Providence CORE – (Oregon Regional Services)

Data for Change is an innovative Program designed to strengthen community-based organizations' (CBOs) capacity to use data to address community needs and sustain promising programs. Data is essential to design policies, systems, and programs that work for communities. However, many small and mid-sized CBOs working to advance community health and equity face barriers and capacity challenges for using data to demonstrate their impact and strengthen their initiatives. Building data capacity across CBOs helps them support their communities to ensure a healthier, more equitable future. To date, CORE has provided technical assistance, mentoring, and shared learning opportunities to nearly 20 of Providence's grantees.

Access to Care and Services

Select examples of community benefit activities

CHIS: Providence Beginnings Case Management - $2.7 million (Providence Portland Medical Center, Providence St. Vincent Medical Center)

Providence Beginnings Case Management began 23 years ago to serve patients during pregnancy and postpartum. The Providence Beginnings team of licensed clinical social workers and two registered nurses provide behavioral health referral coordination; referrals to critical community resources including WIC, TANF, SNAP, substance abuse treatment, domestic violence services, parenting support, new moms' groups, and breastfeeding education and support; care plan coordination with the medical team; emotional support; and assistance with understanding health insurance and accessing supplemental health insurance through the Oregon Health Plan. The Providence Beginnings case management team provides critical services to over 1,200 of the most vulnerable patients every year.

SHS: Children's Development Institute - $2.3 million (Providence Portland Medical Center, Providence St. Vincent Medical Center, Providence Newberg Medical Center)

Providence Children's Development Institute provides a comprehensive, family-centered approach to helping children with developmental needs, from infancy through adolescence. Developmental pediatricians work together with psychologists, therapists, audiologists, dietitians, and social workers to create individualized programs for each child. This collaboration allows us to improve outcomes by evaluating each child's ongoing needs and responding with emergent therapies.

SHS: Palliative Care - $2.2 million (Oregon Regional Services)

Providence Outpatient Palliative Care Program is a specialty consultation service that supports seriously ill patients with virtual and in-home consultations and care. There are four outpatient teams offering an interdisciplinary approach to patients who present with limited mobility, limited ability to get to appointments, who often have multiple co-morbidities and are therefore high utilizers of health care systems. This program coordinates care and fills gaps in care by communicating with involved providers and family members. Treatments include medical interventions, psycho-social support, communication with the patient about how/what they want, family support with a focus on developing a care team that includes the family to build effective communication, to close gaps and to optimize care. 25-30% of patients are referred to hospice, resulting in continuity of care.

In addition to the programs listed above, the following community benefit activities were also reported: Regional Medication Assistance, Telestroke, Diabetes Health Education, Athletic Trainer Program, and the Medical Forensic Program.

4. ***Identify any community benefit activity that addresses the social determinants of health. Separate activities into those that:***
    a. ***Address individual health-related social needs***
    b. ***Address systemic issues or root causes of health and health equity***

At Providence, we recognized that long-standing inequities and systemic injustices exist in the world. This has led to health disparities among communities that have been marginalized because of their race, ethnicity, gender, sexual orientation, age, ability, religion, or socioeconomic status. Our vision, Health for a Better World, is driven by a belief that health is a human right.

In 2022, Providence Community Health Investment issued 66 grants to community organizations across all five of our Oregon service areas, many of which address health-related social needs and systemic issues of health and health equity. Nineteen grants were awarded in the Portland metro area, six of which are detailed in question 3. This funding directly supports underserved and marginalized populations including immigrants and refugees, communities of color, and youth. These grants are classified under the appropriate funding priorities by year, and in 2022, our largest funding priorities were access to care and services and mental health and substance use disorder services.

Select examples of health equity work

Supporting Federally Qualified health Centers with COVID Screening, Education, Testing and Vaccinations

Providence partnered with Virginia Garcia to provide COVID-19 education and vaccinations and address vaccine hesitancy to community members disproportionately impacted by the pandemic. The focus population for this intervention was members of the Latinx community, especially agricultural workers.

Providence Medical Group (PMG): Addressing Disparities in High Blood Pressure and Diabetes Control for Black/African American Patients

PMG was awarded a grant to address disparities in diabetes and hypertension control between black and white patients at seven eastside clinics. The equity grant covers community partnership support, internal staff training, clinic resources, administrative support, and supplies and materials.

Birth Equity Community Advisory Committee

The Providence Birth Equity Community Advisory Committee has been organized to promote birth equity in Portland by creating a regular forum for open, honest dialog and information sharing between Providence Perinatal teams and the communities they serve, with specific attention to Black, Indigenous, Latinx, Asian, Pacific Islander and all birthing people of color and the intersectionality with sexual orientation and gender identity bias they experience. This collaboration will inform care, priority setting, and measurement of birth outcomes in Providence Oregon hospitals, starting with Portland area hospitals.