Providence Portland Medical Center, Fiscal Year Ended 12/31/2023

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 Portland Medical Center (PPMC) 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 engagement, data management, and report development.

Based on geographic location relative to other hospitals in the area and patient demographics, Multnomah County is PPMC's primary service area. Clackamas, Washington, and Clark (WA) counties are surrounding secondary counties that are primarily served by other area hospitals. The facility and campus include 483 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. We are recognized for excellence in patient care and research in areas such as cancer, heart, orthopedics, women's health, rehabilitation services and behavioral health.
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 PPMC'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 2023, Providence Portland Medical Center contributed more than $114.5 million in 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 $43.3 million. Community Health Investment (CHI) allocated $1.3 million in grants across the Portland metro area.

The following 2-3 activities under each health need represent a snapshot of PPMC'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

In the Portland metro area, grants were given to 5 community partners to address this need area. Here are three examples.

Cash and In-Kind Contributions: Community Health Grants - (Portland Metro Service Area)

- Rose Haven
    - Providence provided Rose Haven $200,000 to continue expanding its advocacy program offering accessible mental health services to women experiencing poverty and intersecting traumas. This program bridges gaps in mental health services to a population currently lacking accessibility. With multiple services including support groups, one-on-one counseling, de-escalation and crisis stabilization, one client with childhood trauma and a domestic violence survivor "continues to seek guidance from Rose Haven's peer supports, advocacy team, and mental health team."

      Client Success Story
      "There's an individual who I have weekly one-on-one emotional support meetings with, who has been working incredibly hard to become the best version of herself. She is actively living on the streets due to circumstances beyond her control. She works full time, cares for her animals, and has often expressed, "I feel like I just can't get ahead." We have been working together for six months, and I have seen her grow and heal. When she comes to Rose Haven she'll focus on her laundry, going shopping, and showering, but the reason she comes in is for the emotional support meetings. She

expressed, “It’s the one time a week I get to focus on me, no one else is calling for my attention, no disaster I have to fix for someone else; my time for me to love me.”

- Adelante Mujeres
    - Providence awarded Adelante Mujeres $100,000 to support development of their new mental health department serving low-income Latine families with access to low-cost services. By providing culturally and linguistically responsive mental health services, Adelante is able to reduce biases commonly associated with mental health. This multi-faceted department has three approaches to address mental health: community campaign to reduce stigma, community connections through peer support, and therapeutic interventions for individual and families. The engagement level was high with a 79% show rate for appointments and 72% of individuals being referred to mental health services actually initiating care. One participant in the Beyond Trauma Workshop mentioned, *“I wish I would have known this while growing up, it would have saved me so many problems.”*
- Raices de Bienestar
    - Providence awarded Raices de Bienestar with a $100,000 grant to hire a third clinician to support the mental and emotional health needs of the Latine community. This clinician expanded bilingual clinical services to low-income community members throughout the Portland metro and also focused time facilitating community programs. Over the course of this grant period, 78 new patients were engaged with a 67% retention in treatment rate. Additionally, 15-20% of people who participated in community programs further engaged in clinical services.

Community Health Improvement Services (CHIS): Providence Assessment, Intake & Referral (Prov AIR) - $1.5 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. 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 is a Community Health Improvement Service that resulted in $1.4 million in community benefit in 2023. With a focus on helping some of our community’s most underserved, the BOB program has a goal of empowering individuals on their journey toward better well-being by serving 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. In 2023, there was a 17.5% decrease in ED utilization after six months for patients pre-and post-BOB program.

Subsidized Health Services (SHS): Psychiatric Unit - $355K (Providence Portland Medical Center)

PPMC's inpatient psychiatric care offers 24-hour care to treat seniors and adults 18 years and older. The psychiatric unit provides patients with a safe environment and an effective treatment program. The goal is to provide compassionate crisis intervention and stabilization. Family involvement is highly encouraged to ease the patient's return to a healthy life. Our care team stays in close contact with relatives to have a smooth transition back home or to a residential care facility.

Health Related Social Needs

This section also addresses question 4a.

Select examples of community benefit activities

Cash and In-Kind Contributions: Patient Support Program - $907k (Providence Portland Medical Center)

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 2023, the top need was food costs followed by medication and transportation costs. PSP is solely operated by Project Access NOW and served 3,562 clients by issuing 12,565 vouchers for services.

Cash and In-Kind Contributions: Community Resource Desk - $552k (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 2023, the CRD served 2,413 individuals and achieved an 86% resource connection rate. The top requested resource was food.

Cash and In-Kind Contributions: Providence Gateway Food Pantry

The Gateway Food Pantry, embedded within the Gateway Internal Medicine clinic, serves both Gateway Family Medicine and Gateway Internal Medicine patients who screen positive for food insecurity the day of their appointment. Using the "Client Choice" best practice model, patients who state they are in need of food are invited to choose three days' worth of healthy and culturally appropriate food for their entire household. The food pantry offers a variety of foods including fruits, vegetables, legumes, meats, grains, nuts, and dairy products in different forms (fresh, frozen, canned, dried). With a $70,000 grant and additional investments, 737 households were served (50% with children), 2,500 people were served, and 22,500 meals were distributed.

<u>Patient Success Story</u>

Emilio, a six-year-old Gateway FM patient, along with his mother, Karla, were screened for health-related social needs during a recent medical appointment. This screen was positive for food insecurity, and Emilio and Karla were invited to visit the Gateway Food Pantry. Emilio was excited to see all the different kinds of food he and his mother would be able to take home.

When Roberto called Karla to check in a few days after Emilio's appointment, Karla shared the following, "I really enjoyed our visit to the pantry. I was treated with respect and received everything I needed at the pantry. Sometimes we are missing some essentials at home and don't have the resources to go grocery shopping. At the pantry we received food that we eat daily; the fruit and potatoes really helped.

I made potato empanadas that day and my children really enjoyed them. Recently, I made spaghetti with meat sauce from the items I got at the pantry. It was such a relief because I didn't have to think about getting groceries for the week."

Economic Security

Select examples of community benefit activities

Cash and In-Kind Contributions: Community Health Grants - (Portland Metro Service Area)

In the Portland Metro service area, two community partners were awarded grants to address economic security.

- ASSIST
    - Providence awarded a $90,000 grant to ASSIST who represents individuals with severe disabilities that are applying for Social Security Disability benefits (SSI, SSDI) at all levels of the federal administrative claims process. Securing this regular income improves people's lives dramatically as they become eligible for housing programs, can afford nutritious food, and have the stability that allows them to regularly access healthcare. ASSIST helped expedite this application process for 111 individuals and avoid the common multi-year appeals process that delays people accessing benefits.
- Serendipity Center
    - With an $80,000 grant to Serendipity Center, Providence supported greater access to therapeutic education and workforce development opportunities for students suffering from mental illness and trauma. The youth who attend Serendipity Center have disabilities that create barriers to employment. Grant funds put an emphasis on workforce development by offering on-site skills-based training opportunities, establishing partnerships with business and employment agencies, and improving work/life-skills including access to technology. Serendipity served 85 students during the 2022-2023 school year with an average attendance rate of 84%.
- Center for Outcomes, Research and Education (CORE)
    - Providence continued its partnership with CORE by awarding a $157,000 grant for Data for Change, an innovative program designed to strengthen community-based organizations' (CBOs) capacity to use data that addresses community needs and sustains 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. In 2023, CORE provided 446 hours of technical assistance to 12 grantees not including additional webinars and annual Data Summit. To emphasize the impact of this program, a Data Summit participant said, *"This helped push us into a space that's often neglected. We are so busy working, looking ahead and responding, that we deprioritize reflection and assessment. I am excited to have more tools and more language that help us know we are doing the work in the way we intended."*

Access to Care and Services

Select examples of community benefit activities

Cash and In-Kind Contributions: Community Health Grant - (Portland Metro Service Area)

Providence awarded Todos Juntos' a $100,000 grant to support Family Resource Advocates (FRAs) that deliver wraparound services to families in rural Clackamas County. This includes coordinating services, offering referrals, and supplying families with a system of care in the rural towns of Sandy, Estacada, Canby, and Molalla. Furthermore, this grant allowed Todos Juntos to serve families with children 0-18 years of age by directly providing food, clothing, school supplies, diapers, home furnishings, gas cards, and other supplies. With this additional funding, Todos Juntos served 352 families, 73 which had youth. A survey showed 100% of clients reporting that they received services or were referred to services that met their needs. One client's firsthand account helps summarize this work, *"In Molalla we don't have services like this and it helps family tremendously to have the help with diapers and classes for my kids and entertainment which I can't afford on my own as a single parent. It has enriched our lives and given them more opportunities to strive. Thank you all."*

SHS: Children's Development Institute - $3.2 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.

CHIS: Providence Beginnings Case Management - $2.5 million (Providence Portland Medical Center, Providence St. Vincent Medical Center, Providence Willamette Falls 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 (OHP). The Providence Beginnings case management team at PPMC served approximately 1,200 individuals with 2,400 consults/encounters, 50% of which were enrolled in OHP.

In addition to the programs listed above and 6 community health grants, the following community benefit activities were also reported: Regional Medication Assistance Program, 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 2023, Providence Community Health Investment issued 38 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. Fifteen grants were awarded in the Portland metro area, three 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 2023, our largest funding priorities were access to care and services and mental health and substance use disorder services.

Select examples of health equity work

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

Providence Medical Group (PMG) was awarded a Providence System Health Equity grant to address disparities in Diabetes and Hypertension control between Black/AA patients and their White counterparts at seven eastside clinics. North by Northeast Community Health Center (NxNE), a community-based organization in NE Portland devoted to Black/AA health and outcomes, received $125,000 to advise on current/future state of patient care and outreach for Black/AA patients. PMG modified Gateway Community Health Center's Advancing Diabetes Self-Management program to be culturally responsive for the identified population with the aim of 1) eliminating Hypertension and Diabetes control performance disparities between Black and white patients, and 2) meeting or exceeding established PMG hypertension and diabetes control performance metrics for of A1c control (<8.0%) and blood pressure control (<140/90 mm Hg). This project is ongoing with 2,531 individuals served to date.

Birth Equity Community Advisory Committee

The Providence Birth Equity Community Advisory Committee was 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. With donations totaling $3,500 to Black Parent Initiative and Doulas Latinas International and others, this collaboration informs care, priority setting, and measurement of birth outcomes in Providence Oregon hospitals, starting with Portland area hospitals.