2025

COMMUNITY HEALTH NEEDS ASSESSMENT

Providence Newberg Medical Center

Newberg, Oregon

To provide feedback about this CHNA or obtain a free printed copy, please email Sonya Kauffman Smith at *CHI@providence.org*

Providence

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EXECUTIVE SUMMARY

Understanding and Responding to Community Needs

The Community Health Needs Assessment (CHNA) is an opportunity for Providence Newberg Medical Center (PNMC) to engage the community every three years with the goal of better understanding community strengths and needs. At Providence, this process informs our partnerships, programs, and investments. Improving the health of our communities is fundamental to our Mission and deeply rooted in our heritage and purpose.

The 2025 CHNA was approved by the Providence Newberg Service Area Advisory Council on November 18, 2025 and made publicly available by December 28, 2025.

Gathering Community Health Data and Community Input

Through a mixed-methods approach, using quantitative and qualitative data, we collected information from the following sources: American Community Survey, Behavioral Risk Factor Surveillance System, Environmental Justice Index, local public health data, and County Health Rankings & Roadmaps. To actively engage the community, we conducted 4 listening sessions with people who have chronic conditions, are from diverse communities, have low-incomes, and are medically underserved. We also conducted 10 key informant interviews with representatives from organizations that serve these populations, specifically seeking to gain deeper understanding of community strengths and opportunities. Some key findings include the following:

- Behavioral Health
- Access to health care including dental care
- Homelessness and housing stability
- Economic security
- Food security
- Environmental concerns

While care was taken to select and gather data that would tell the story of the hospital's service area, it is important to recognize the limitations and gaps in information that naturally occur.

Identifying Top Health Priorities

Through a collaborative process, the Providence Newberg Medical Center Providence Newberg Service Area Advisory Council (SAAC) used a health equity framework and a modified Mobilizing for Action through Planning and Partnerships (MAPP) model to create the CHNA. The modified MAPP model is a strategic planning process that relies on collaborative partnership and includes five assessment components to inform planning: Population Health Status Assessment, Community Engagement, Internal Utilization Data, Community Strengths and Assets, and Prioritization Protocol. Using this model, the following community needs were identified: behavioral health challenges and access, access to

health care including dental care, homelessness and housing stability, economic security, food security, and environmental concerns.

Providence's Newberg Service Area Advisory Council reviewed the community needs and associated data. Considering PNMC's unique capabilities, community partnerships and potential areas of community impact, we are committed to addressing the following priorities as aligned with the full list of community needs identified:

ACCESS TO CARE AND SERVICES: Focus on primary care and preventative health, chronic health conditions, and oral health. This priority area refers to the lack of timely access to care and services due to physical, geographic, and systemic limitations, among others.

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 affordable basic living expenses and obtaining affordable education.

HEALTH RELATED SOCIAL NEEDS: Focus on housing stability, navigation of supportive services, food security, and transportation. This priority area refers to the unmet social needs that exacerbate poor health and quality of life outcomes.

MENTAL HEALTH & SUBSTANCE USE DISORDER: Focus on access, capacity, prevention, and treatment. This priority area refers to the growing challenges of accessing care due to workforce shortages, a lack of culturally responsive care, and affordability.

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

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

Providence Newberg Medical Center will develop a three-year Community Health Improvement Plan (CHIP) to respond to these prioritized needs in collaboration with community partners considering resources and community strengths and capacity. The 2026-2028 CHIP will be approved and made publicly available no later than May 15, 2026.

Results from the 2022 CHNA and 2023-2025 CHIP

PNMC responded to community needs by making investments of direct funding, time, and resources to internal and external programs dedicated to addressing the previously prioritized needs using evidence-based and leading practices. In addition, we invited written comments on the 2022 CHNA and 2023-2025 CHIP, made widely available to the public through posting on our website and distribution to community partners. No written comments were received on the most recent CHNA and CHIP. The 2022 CHNA and 2023-2025 CHIP priorities were the following: **mental health and substance use disorder, health related social needs, economic security and access to care and services.**

A few of the key outcomes from the previous CHIP are listed below:

- As a result of the Better Outcomes Thru Bridges program, emergency department utilization decreased
- Providence issued two grants were to support the area of mental health and substance use
- Providence issued two grants to support the area of food security
- Providence issued two grants to support the area of housing stability and homelessness
- Providence issued one grant to support the area of economic security

INTRODUCTION

Who We Are

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

Based on geographic location relative to other hospitals in the area and patient demographics, the City of Newberg and greater Yamhill County is PNMC's primary service area. Our hospital provides an array of services including primary care, surgical services, birth center, cancer care, heart care, neurological care, diagnostic imaging, and 24/7 emergency care.

For more information on the resources invested to improve the health and quality of life for the communities we serve, please refer to our Annual Report to our Communities: https://www.providence.org/about/annual-report.

SECTION I: CHNA FRAMEWORK AND PROCESS

Equity Practices in the CHNA

At Providence, we are committed to addressing the underlying and root causes of health disparities and inequities in the communities we serve. We work to address not only the clinical factors that determine a person's length and quality of life, but also the social and economic dimensions, physical environment, and other factors that play a role in determining health outcomes. Addressing these factors includes leveraging community strengths and utilizing evidence-based, leading practices.

The CHNA is an important process for better understanding health disparities and social inequities, including how racism and discrimination have detrimental effects on community health and wellbeing. Through literature and our community partners, we recognize that long-standing systemic inequities exist and that they can lead to health disparities. To ensure we are taking a holistic approach to understanding the health of the communities we serve, we define health broadly including social, cultural, and environmental factors that affect wellbeing, and engage community members from diverse backgrounds in the CHNA process. We routinely evaluate health disparities in the communities we serve and use qualitative and quantitative data to inform how we enhance access to high-quality, evidence-based care.

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

Approach

Share equity practices in the CHNA

Highlight community strengths

Use people first and non-stigmatizing language

Community Engagement

Use multiple methods to engage with community members

Implement equitable practices for community participation

Share findings back with communities

Quantitative Data

Report data at the local level to avoid masking

Disaggregate data when responsible

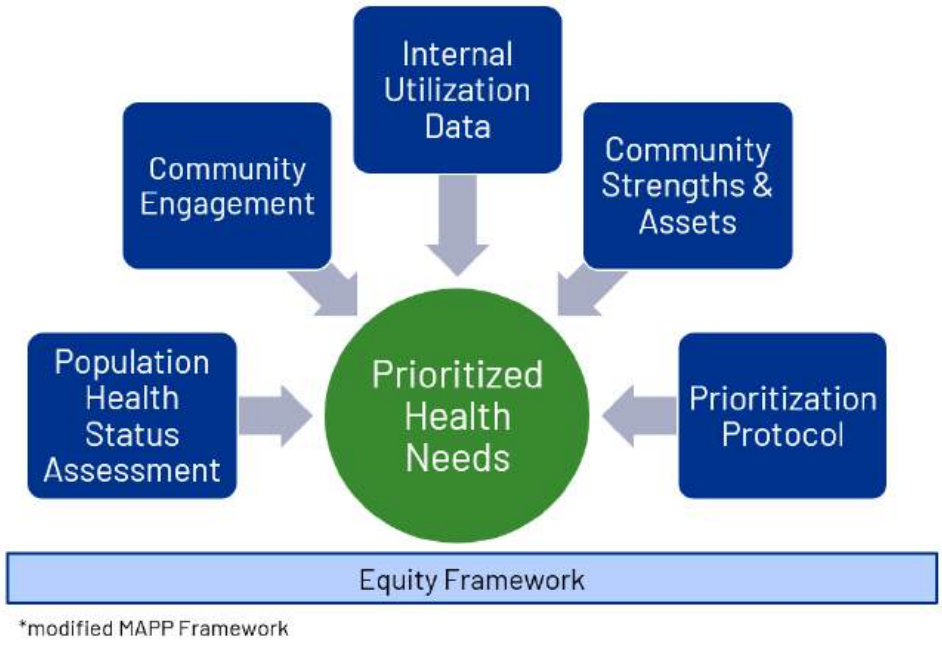
Acknowledge inherent bias in data and screening tools

We took particular care when conducting listening sessions for our Spanish-speaking community. We had clearly defined the objectives and leveraged partnerships with community partners to recruit participants. We conducted the sessions in Spanish with bilingual and culturally competent moderators, which helped ensure comfort and clarity for participants. We selected a convenient, safe location and time, and offered incentives for participation. Post-session, we provided feedback in Spanish,

demonstrating appreciation and transparency, and our evaluation helped identify areas for improving future engagements. Through these strategies, the process was inclusive and effective, ensuring that Spanish-speaking voices were heard and valued.

CHNA Framework

The equity framework is foundational to our overall CHNA framework, a modified version of the Mobilizing for Action through Planning and Partnerships 2.0 (MAPP 2.0) developed by the National Association of County and City Health Officials (NACCHO). The modified MAPP framework takes a mixed methods approach to prioritize health needs, considering population health data, community input, internal utilization data, community strengths and assets, and a prioritization protocol.



Data Collection and Analysis Methods

Providence conducted key informant interviews and contracted with the Rede Group to conduct community listening sessions. Listening to and engaging with the people who live and work in the community is a crucial component of the CHNA, as these individuals have firsthand knowledge of the needs and strengths of the community. We conducted 10 stakeholder interviews including 11 participants with people who are invested in the well-being of the community and have first-hand knowledge of the community's needs and strengths. The Rede Group conducted 4 listening sessions with a total of 28 community members. The goal of the interviews and listening sessions was to identify what needs are currently not being met in the community and what assets could be leveraged to address these needs.

Key Informant interviews and listening sessions were conducted between April and July of 2025. Stakeholders were selected based on their knowledge of the community and engagement in work that directly serves people who are economically disadvantaged, or otherwise marginalized or vulnerable. Providence aimed to engage stakeholders from social service agencies, health care, education, housing, and government, among others, to ensure a wide range of perspectives. Included in the interviews was the Prevention Manager from Yamhill County Public Health.

Full details on the protocols, findings, and attendees are available in Appendix 1.

A community health survey was conducted electronically and open from May 1 to July 14 of 2025. The survey was conducted in both English and Spanish and attempted to capture key information on health and lifestyle factors, community needs, and barriers to accessing health and social services in Yamhill County. Despite multiple marketing methods such as newsletters, email distribution, and social media posts, we only received 44 responses. Due to the low number of responses, none of the data will be included in this report.

Data Sources

In gathering information on the communities served by the hospital, we looked not only at the health conditions of the population, but also at socioeconomic factors, the physical environment, and health behaviors. In addition, we recognize that there are often geographic areas where the conditions for supporting health are poorer than nearby areas. Whenever possible and reliable, data are reported at census tract level. These smaller geographic areas allow us to better understand the neighborhood level needs of our communities and better address inequities within and across communities.

We reviewed data from the following sources:

CHNA Data Sources

- Key informant interviews
- Community listening sessions
- Internal hospital utilization data
- American Community Survey from the U.S. Census Bureau
- Behavioral Risk Factor Surveillance System (BRFSS)
- CDC Places
- Environmental Justice Index
- County Health Rankings & Roadmaps

Data Limitations and Information Gaps

While care was taken to select and gather data that would tell the story of the hospital's service area, it is important to recognize the limitations and gaps in information that naturally occur, including the following:

- Not all desired data were readily available, so sometimes we had to rely on tangential or proxy measures or not have any data at all.
- While most indicators are relatively consistent from year to year, other indicators are changing quickly and the most recent data available are not a good reflection of the current state.
- Reporting data at the county level can mask inequities within communities. This can also be true when reporting data by race, which can mask what is happening within racial and ethnic subgroups. Therefore, when appropriate and available, we disaggregated the data by geography and race.
- Data that are gathered through interviews and surveys may be biased depending on who is willing to respond to the questions and whether they are representative of the population as a whole.
- The accuracy of data gathered through interviews and surveys depends on how consistently the questions are interpreted across all respondents and how honest people are in providing their answers.

Process for Gathering Comments on Previous CHNA and Summary of Comments Received

Written comments were solicited on the 2022 CHNA and 2023-2025 CHIP reports, which were made widely available to the public via posting on the internet in December 2022 (CHNA) and May 2023 (CHIP), as well as through various channels with our community-based organization partners.

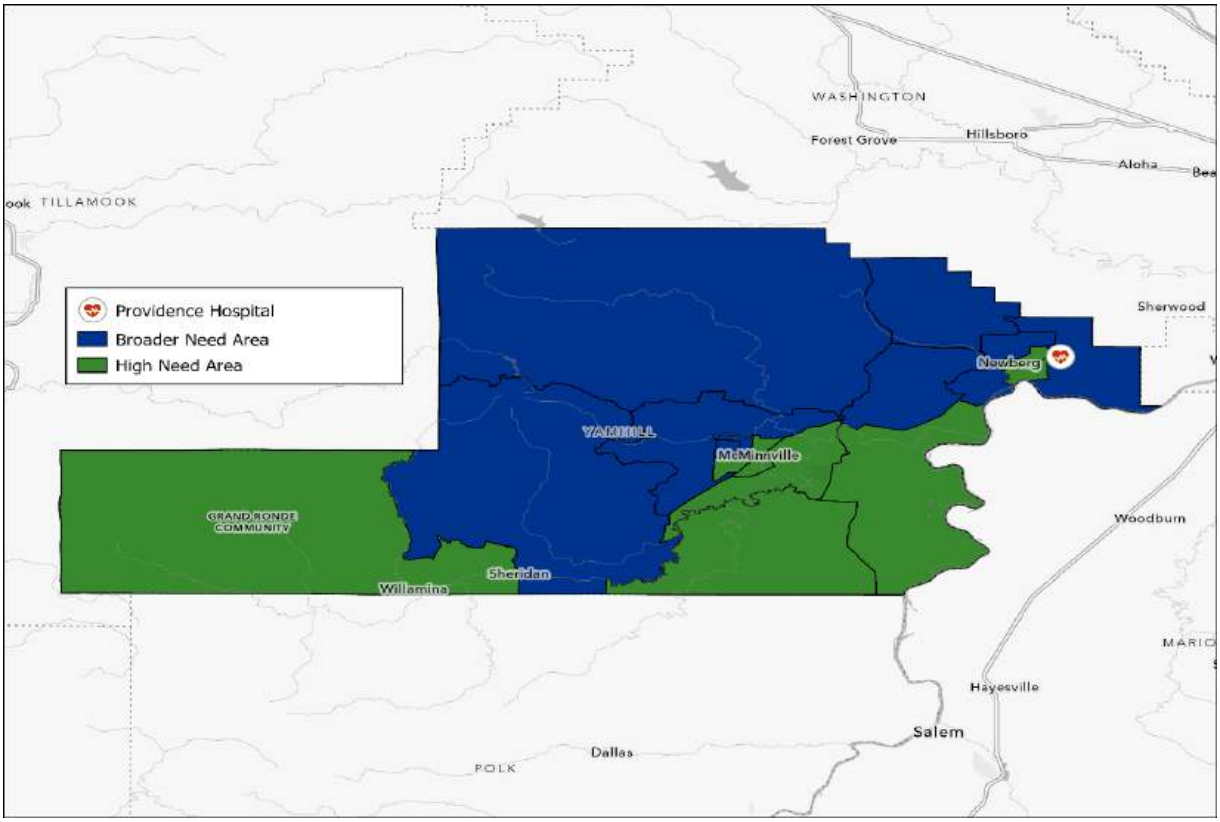
No comments were received.

SECTION II: DESCRIPTION OF COMMUNITY

CHNA Service Area

Based on the availability of data, geographic access to the facility, and other hospitals in neighboring counties, Yamhill County serves as the boundary for the hospital service area. Yamhill County has a diverse demographic profile that reflects both its agricultural roots and its evolving community dynamics. As of the most recent census, the county has a population of approximately 108,000 people. The demographic composition includes a predominance of White residents, alongside growing Hispanic and Latino communities, which contribute to the county's cultural richness and diversity. The age distribution is varied, with a mix of families, young professionals, and retirees drawn to the area for its quality of life, educational opportunities, and scenic environment. Yamhill County's rural and semi-rural nature is complemented by pockets of urban development, particularly in cities like McMinnville and Newberg, where a blend of educational institutions, such as George Fox University, and thriving local businesses contribute to the demographic tapestry. The population is characterized by a balanced gender distribution and an increasing trend toward higher educational attainment, mirroring broader state and national trends. This demographic diversity, coupled with the county's strong sense of community, underpins its economic vitality and cultural vibrancy.

Figure 1. Map of Yamhill Service Area



Source: 2025 Newberg CHNA Datahub

Community Demographics

The graphs below provide demographic and socioeconomic information about the service area and how the high need area compares to the broader service area. We have developed a data hub that maps each CHNA indicator at the census tract level: 2025 Newberg CHNA Datahub.

Table 1. Percentage of Population by Age Groups, Sex, Race, and Ethnicity, by County, 2019-2023

Indicator	Yamhill County
Population by Age Groups	
Total Population	108,122
Population Under Age 5	5.1% (5,526)
Population Under Age 18	21.4% (23,154)
Population Ages 18 to 34	22.7% (24,514)
Population Ages 35 to 54	25.2% (27,203)
Population Ages 55 to 64	12.4% (13,440)
Population Ages 65 and Over	18.3% (19,811)
Population by Sex	
Female	49.4% (53,418)
Male	50.6% (54,704)
Population by Race	
American Indian and Alaska Native	1.0% (1,083)
Asian Population	1.8% (1,938)
Black or African American Population	0.7% (760)
Native Hawaiian and Other Pacific Islander Population	0.2% (225)
Other Race Population	5.7% (6,149)
Two or more Races Population	12.2% (13,186)
White Population	78.4% (84,781)
Population by Ethnicity	
Hispanic Population	17.1% (18,490)

Source: US Census Bureau, American Community Survey 5-Year Estimates, 2019-2023

HEALTH PROFESSIONAL SHORTAGE AREA

The Federal Health Resources and Services Administration designates a Health Professional Shortage Area (HPSA) as an area with a shortage of primary medical care, dental care, or mental health providers. They are categorized into three types: geographic, population, and facility.

Yamhill County has several geographic areas, population segments, and facilities that are designated as shortage areas. This information can be used to understand access issues, guide state and local health care planning, determine placement of providers, and influence allocation of limited health care resources.

Table 3. Health Professional Shortage Areas, Yamhill County

Indicator	Primary Care	Dental Care	Mental Health
Migrant Seasonal Work (MSFW) Population HPSA	16	16	18
Federally Qualified Health Center HPSA	18	20	23
Correctional Facility HPSA	6	6	12

This attribute represents the Health Professional Shortage Area (HPSA) Score developed by the National Health Service Corps (NHSC) in determining priorities for assignment of clinicians. The scores range from 0 to 26 where the higher the score, the greater the priority.

Source: HPSA Find (hrsa.gov), 2024

See Appendix 1 for additional quantitative data.

SECTION III: COMMUNITY INPUT

Summary of Community Input

To better understand the unique perspectives, opinions, experiences, and knowledge of community members, representatives from Providence Newberg Medical Center conducted 10 key informant interviews with 11 representatives from community-based organizations and four listening sessions with 28 community members. The stakeholder interviews and listening sessions were conducted between April and July of 2025. During these interviews and listening sessions, community members and nonprofit and government key informants discussed the issues and opportunities of the people, neighborhoods, and cities of the service area. Below is a high-level summary of the findings of these sessions. Full details on the methodology and participants are available in Appendix 2.

Partner organizations that supported this report include:

- Community Wellness Collective
- Encompass Valley
- George Fox University
- Lutheran Community Services Northwest
- Provoking Hope
- Unidos Bridging Community
- Virginia Garcia Memorial Health Center
- Willamette Educational Services District
- Yamhill County Public Health
- Yamhill Community Action Partnership
- Yamhill Community Care
- Yamhill Promotores

These organizations provide services to the medically underserved, low-income, and minorities in the county.

Community-Defined Health and Strengths

Key informants were asked to highlight community strengths and describe their vision for a healthy community:

Community Strengths
•Safety and Security •Supportive Community Bonds •Access to Health and Wellness Resources •Educational Opportunities •Active Community Engagement •Community Partnerships and Collaboration •Resilience and Self-Sufficiency

Community Needs

Key Informants discussed a variety of needs. The highest priority needs were **behavioral health (mental health and substance use), access to health care services including dental care, and homelessness and housing stability**. Medium priority needs were identified as **economic security, food security**, and **environmental concerns**. Community members also identified **transportation, workers rights' and support,** and **immigration challenges and discrimination** as needs. Additional detail can be found in the Significant Health Needs section below.

See Appendix 2 for methodology and participant details

SECTION IV: SIGNIFICANT HEALTH NEEDS

After careful review of the qualitative and quantitative data, we developed a preliminary list of identified community health needs. These needs were identified by interview participants through a weighted ranking process and by community members through discussion and theming of the data. Additionally, needs were identified after reviewing the quantitative data.

Please refer to the Providence Newberg Data Hub 2025 to review each of the following health indicators mapped at the census tract level: 2025 Newberg CHNA Datahub

The hub provides data on each indicator in Yamhill County, high need and broader need service areas, and Oregon, as well as information about the importance of each indicator.

The Yamhill Service Area Advisory Council (YSAAC) reviewed the quantitative and qualitative data collected for each of the following community health-related needs:

- Behavioral Health (Mental Health and Substance use)
- Access to Health Care Services (including Dental Care)
- Homelessness and Housing Stability
- Economic Security
- Food Security
- Environmental Concerns
- Chronic Health Conditions

Behavioral Health (Mental Health and Substance Use)

Qualitative Data

> *"I think that is a real shortfall is the ability to coordinate individuals' needs and resources across the whole system, including lots of different agencies. So that we are using the resources effectively, we are sharing information, and not duplicating services."— Key Informant*

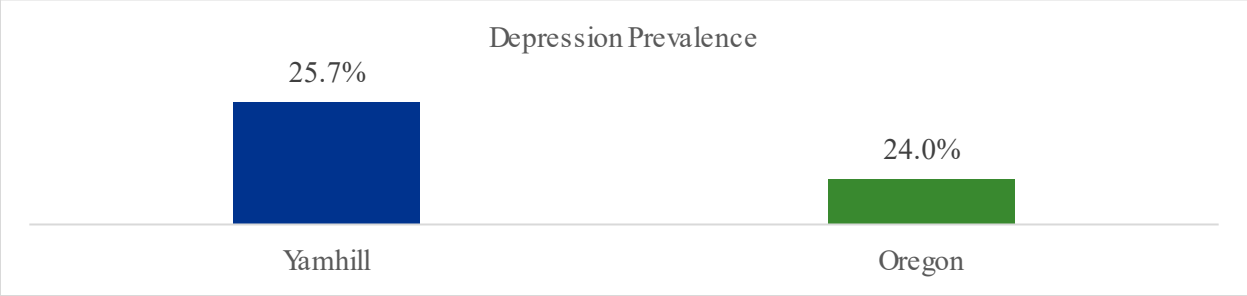
Key Informants and community members reported that substance use and mental health issues often occur together, making recovery challenging for people experiencing homelessness, who also face obstacles to stable housing. In rural areas, stigma makes accessing services difficult. They expressed frustration with limited treatment services and complex service systems that include difficult forms and online barriers. The pandemic worsened social isolation, increasing mental health challenges for rural communities and immigrants. They noted insufficient service availability in rural areas and the need for linguistically and culturally sensitive options for immigrant communities. Poor coordination between agencies disrupts care, and poverty further limits access. People experiencing homelessness, those with low income, women, especially mothers aged 25-35, and Indigenous Peoples face unique challenges. Participants recommended expanding treatment

facilities, simplifying enrollment, improving agency coordination, addressing economic and cultural barriers, and fostering community-building initiatives to reduce isolation and stigma.

Quantitative Data

According to the CDC "Depression is a common and serious mood disorder. It causes severe symptoms that affect how you feel, think, and handle daily activities, such as sleeping, eating, or working." The prevalence of depression in adults 18 years and older was higher in Yamhill County compared to Oregon State.

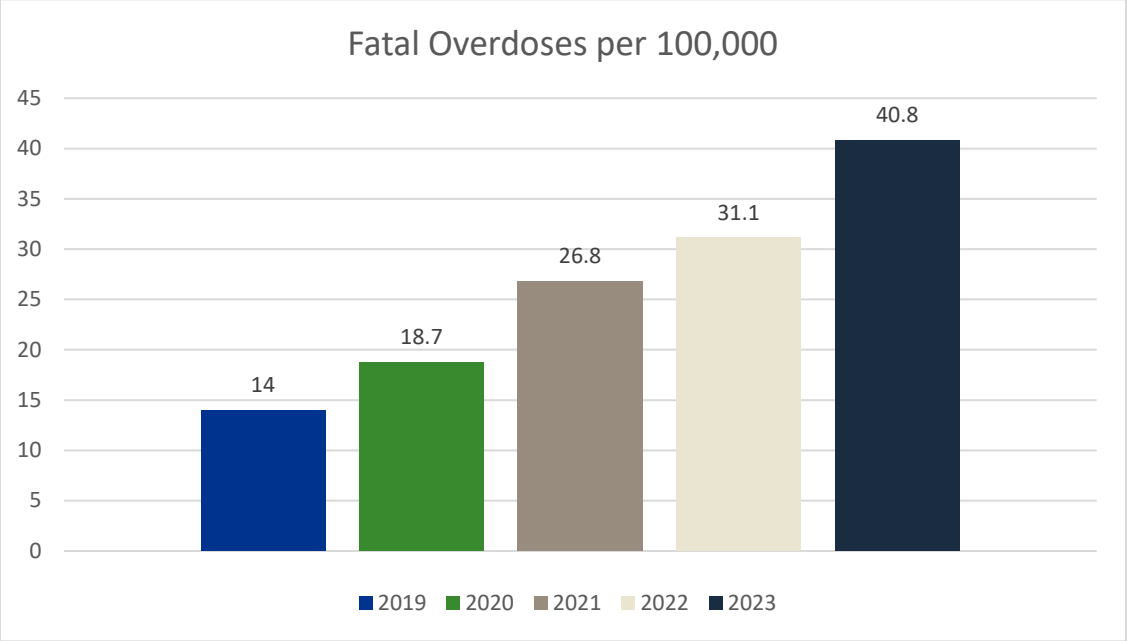
Figure 4. Percentage of Adults Reporting Having Had a Depressive Disorder, by County and State, 2022



SOURCE: PLACES. Center for Disease Control and Prevention Indicator uses crude prevalence for year 2022 estimates

The rate of fatal overdoses in Oregon increased between 2019 and 2023.

Figure 5. Fatal Overdoses in Oregon per 100,000 population, 2019-2023



Source: Centers for Disease Control and Prevention, 2019-2023

Access to Health Care Services (including Dental Care)

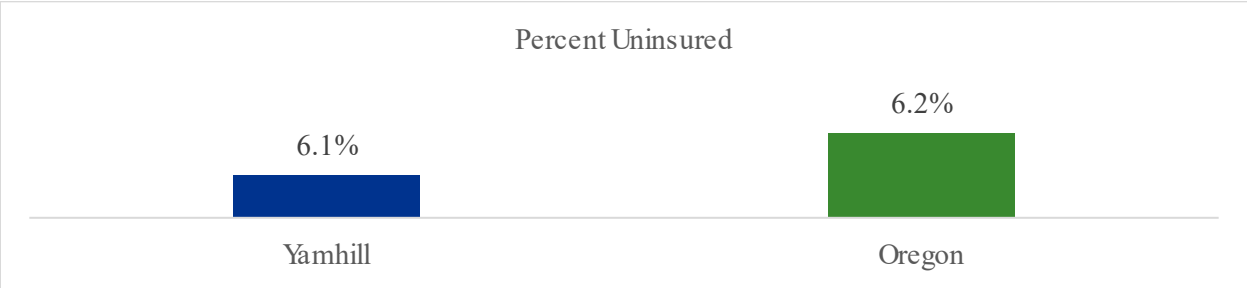
Qualitative Data

Key informants and community members discussed experiences with healthcare access, noting challenges like shortages in dental, medical, and pharmacy services, causing many to travel outside the county. This situation is especially worrying for those who are pregnant and concerned about distance from hospitals during labor. Insurance delays affect recovery, creating frustration, while long appointment wait times, particularly for older adults and infants, hinder timely care. Language barriers impact people who do not speak English, affecting their healthcare experience, and those without insurance are anxious about costs, discouraging them from seeking needed care. They pointed out financial constraints, transportation issues in rural areas, and the necessity for culturally and linguistically sensitive services. Environmental challenges like wildfires and power outages disrupt healthcare access, underscoring the need for improved emergency preparedness. Federal regulations create fear among marginalized groups, and lower health literacy limits service understanding. Disparities persist due to race, ethnicity, language, and socioeconomic status, especially affecting people experiencing homelessness, undocumented individuals, and rural residents. Participants advocated for broader service distribution, peer support programs, home visiting services, trauma-informed care, and health literacy initiatives to enhance access and equity, emphasizing community strengths and diverse workforce engagement for better service delivery.

Quantitative Data

In Yamhill County 6.1% of individuals are reported to be uninsured while 6.2% of individuals are uninsured in Oregon. Adults without insurance are less likely to access preventive care for chronic diseases like diabetes, cancer, and heart disease. In the same vein, children lacking health coverage are less likely to receive proper treatment for issues like asthma or essential preventive care such as dental services, vaccinations, and well-child check-ups that monitor developmental progress.

Figure 6. Percentage of Population Without Health Insurance, by County and State, 2023

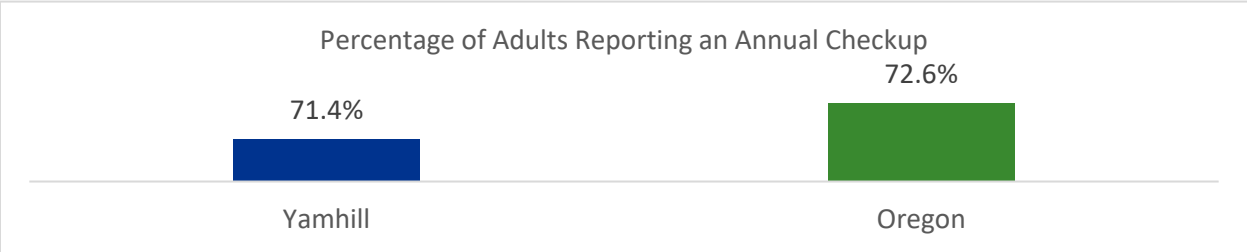


SOURCE: 2023 American Community Survey, 5-year estimates

Obtaining preventive healthcare services, including regular physical examinations, adhering to recommended vaccination schedules, and monitoring blood pressure and cholesterol to keep them at healthy levels, can lower the rates of illness and death associated with chronic diseases. The percentage

of adults reporting having an annual checkup was slightly lower in Yamhill County compared to Oregon at 71.4% and 72.6%, respectively.

Figure 7. Percentage of Adults Reporting an Annual Checkup, by County and State, 2023



SOURCE: PLACES. Centers for Disease Control and Prevention. Indicator Uses Crude Prevalence for Year 2022 Estimates.

In addition to public health surveillance data, our hospitals can provide timely information regarding access to care and disease burden across the service area. Avoidable Emergency Department (AED) use is reported as a percentage of all Emergency Department visits over a given period, which are identified based on an algorithm developed by Providence's Population Health Care Management team based on NYU and Medi-Cal definitions. AED use serves as a proxy for inadequate access to or engagement in primary care. We review and stratify utilization data by a several factors including self-reported race and ethnicity, patient origin ZIP Code, age, and sex. This detail helps us identify disparities to better improve our outreach and partnerships.

In 2024, our data showed the following key insights:

- Avoidable emergency department cases increased from 2022 to 2024
- The top three primary diagnosis groupings in 2024 were urinary tract infection, skin infection, bronchitis and other upper respiratory diseases
- The percentage of behavioral health emergency department cases decreased from 2022 to 2024

Homelessness and Housing Stability

Qualitative Data

> *"Someone had a health issue and then they couldn't work for a few months, so they fell behind on rent. Now they're facing homelessness." –Key Informant*

Participants identified homelessness and housing stability as pressing needs in Yamhill County. They reported a lack of affordable housing, with high deposit requirements and short-term rentals affecting availability for year-round residents. Eviction prevention programs and better service coordination are essential, but current resources for health and substance use are insufficient. Environmental challenges, such as climate disasters worsening conditions for the unsheltered, highlight the need for better emergency preparedness. Homelessness manifests

differently in communities, with cultural differences impacting visibility, particularly in immigrant families. Rising housing costs, transportation barriers, and stagnant incomes contribute to housing instability, affecting older adults, people with disabilities, and mothers with children. People with criminal records and evictions struggle to find stable housing and jobs, while untreated health conditions among those experiencing homelessness demand improved healthcare access. Concerns about homelessness near parks affect community safety and comfort, underscoring the need for supportive housing solutions. Suggestions included recovery centers and tiny house communities offering counseling, job training, healthcare, and stable housing.

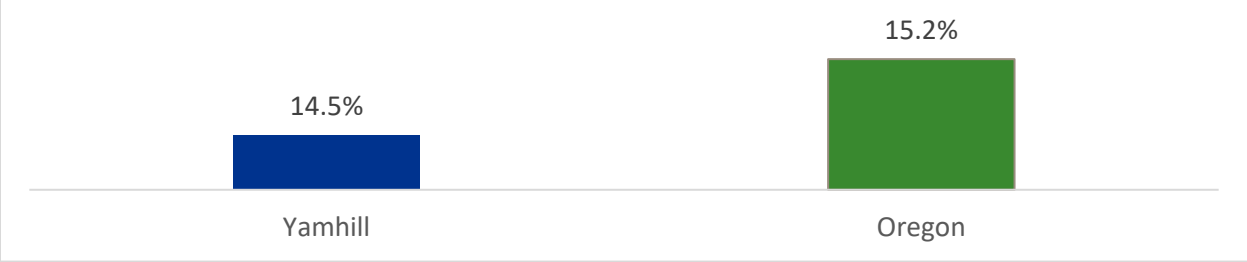
Quantitative Data

The median household income in Yamhill County ($87,084) is higher than Oregon's median income of $80,426. Low-income households have an increased chance of experiencing severe housing cost burden, which is defined as renters that spend 50% or more of their income on housing. In Yamhill County, 14.5% or 5,498 households experience severe housing cost burden.

Figure 8. Median Household Income

SOURCE: Providence Data Hub, 2023 American Community Survey, 5-Year Estimates

Figure 9. Housing Cost Burden



SOURCE: Providence Data Hub, 2023 American Community Survey, 5-Year Estimate

Economic Security

Qualitative Data

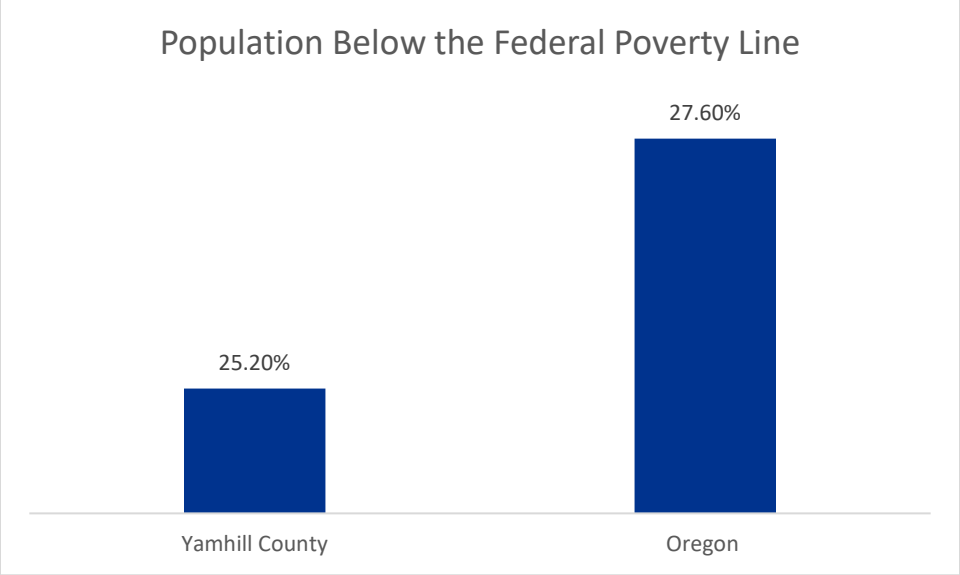
> *"But they cannot afford day-to-day living. The cost of rent is too high. Food is too much. Utilities are going through the roof." –Key Informant*

Participants highlighted economic security as a pressing need, expressing concerns over the rising cost of living, including rent, food, and utilities, which are becoming less affordable. Access to culturally and linguistically appropriate health services is limited, particularly for immigrants who are undocumented, and poverty along with isolation in rural areas may prevent people from using community resources due to stigma. Weather conditions can affect work opportunities, causing income loss and housing insecurity. Participants emphasized leveraging community strengths to improve health equity, suggesting peer support programs to reduce stigma and promote cultural connections, as well as employing a diverse workforce to provide job opportunities. Some groups, such as older adults and people with disabilities, face challenges in increasing their income. Community members seek diverse job opportunities and propose employment and education initiatives, including support programs for people with criminal records and financial assistance for students, given the economic pressures of high housing costs and low wages.

Quantitative Data

According to the U.S. Census Bureau, the total number of people below the poverty level is the sum of people in families and the number of unrelated individuals with incomes in the last 12 months below the poverty threshold. Yamhill County has fewer individuals below the federal poverty level than Oregon as a whole.

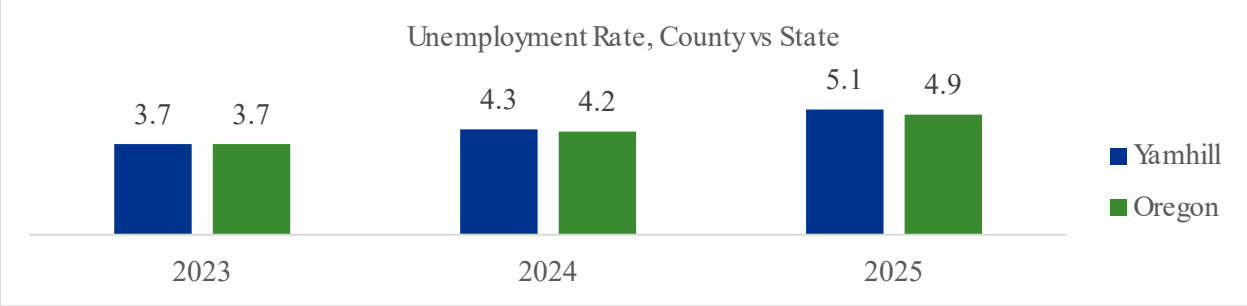
Figure 9. Percentage of Population Below the Federal Poverty Level



SOURCE: 2023 American Community Survey, 5-year estimates

Civilians aged 16 and older are considered unemployed if, during the reference week, they were neither working nor temporarily absent from a job, actively sought employment in the past four weeks, and were ready to start working. Additionally, those classified as unemployed include individuals who did not work during the reference week, were awaiting recall to a job from which they were laid off and were available for work except when temporarily ill. The unemployment rate in Yamhill has remained slightly higher in Yamhill compared to Oregon state.

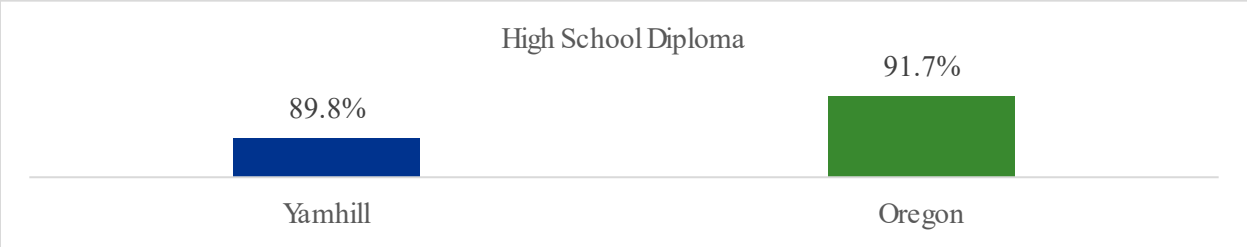
Figure 10. Unemployment Rate, by County and State, July 2023-2025



SOURCE: Bureau of Labor Statistics, Month of July, 2023-2025

The population with a minimum of a high school diploma comprises adults aged 25 and older who attained a high school diploma or its equivalent, attended college without earning a degree, or obtained an associate, bachelor, master, professional, or doctorate degree. Individuals who completed 12th grade without receiving a diploma are not included in this category.

Figure 11. Percentage of Population with at Least a High School Diploma, by County and State, 2023



SOURCE: 2023 American Community Survey, 5-year estimate

Food Security

Qualitative Data

> *"And then I think we can't hide from or ignore the fact that a lot of Yamhill County is this agricultural field after field of food and agricultural workers and vineyards and land of bountiful plenty. And yet there's a lot of hunger in that county. And how we provide access to healthy [food]?"—Key Informant*

Participants discussed how rising food costs and financial constraints affect various groups in the community. Families and people with low incomes struggle to maintain healthy diets, relying on Medicaid to cope with increasing prices. College students living off-campus find it hard to afford sufficient food due to the absence of meal plans. Agricultural and vineyard workers face financial instability from seasonal work, affecting their consistent access to nutritious food. Children and adolescents, with about half on Medicaid, experience limited nutrition from family economic hardships. People experiencing homelessness encounter barriers to accessing food, especially on weekends. Participants noted the need for supportive programs and resources to improve food security. Community members showed interest in enhancing health through nutrition and desired more educational resources on healthy eating. They pointed out challenges in accessing healthy food options and requested practical guidance on meal preparation. Participants acknowledged existing programs but called for better communication and wider participation in nutrition education, along with suggestions to improve school meal quality to support children's health.

Quantitative Data

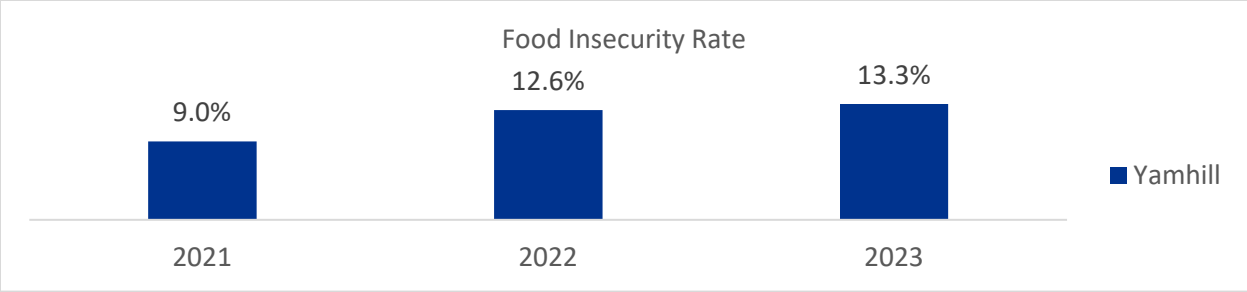
The Supplemental Nutrition Assistance Program (SNAP) is administered through the Food and Nutrition Service of the US Department of Agriculture. Households receiving SNAP is used as a proxy measure to identify households that may be experiencing food insecurity. A slightly higher percentage of households receive SNAP benefits in Yamhill County compared to the state of Oregon.

Figure 12. Percentage of Households Receiving Supplemental Nutrition Assistance Program (SNAP) Benefits, by County and State, 2023

SOURCE: 2023 American Community Survey, 5-year estimates

Yamhill County saw an increase in the food insecurity rate from 2021 to 2023.

Figure 13. Food Insecurity Rate, by County, 2021-2023



SOURCE: Feeding America, 2023

Environmental Concerns

Qualitative Data

Participants highlighted environmental concerns impacting their community, especially in agriculture, healthcare, and emergency readiness. Agriculture faces challenges from wildfires, climate change, and water shortages, affecting productivity and health services. People with fewer resources are at greater risk from environmental factors like wildfire smoke, due to limited access to air conditioning and safe housing. There is a need for improved emergency preparedness through more resident training and family self-preparation, as managing emergencies can be difficult due to limited staff and reliance on volunteers. Wildfire readiness is particularly important for low-income and isolated areas, where some residents lack preparation resources. Local fire departments work on prevention and resource provision but face staffing issues. Respiratory health has deteriorated due to wildfires, and while masks help protect against smoke, stigma can hinder their use. The community offers support with air filtration systems and air conditioning units, but there is a call for increased reminders and wellness checks.

Quantitative Data

In 2020, Yamhill County Emergency Management released a multi-jurisdictional hazard mitigation plan, valid through 2025, to address the long-term impacts of extreme weather and environmental hazards. Within this plan, each hazard is assigned a total threat score derived from historical weather data, community vulnerability, the maximum potential threat or worst-case scenario, and the likelihood of occurrence. Hazards are then ranked from most to least threatening and categorized into “hazard tiers”: top tier, middle tier, and bottom tier. The most significant threats to Yamhill County are flooding, winter storms, and earthquakes in the Cascadia subduction zone, which extends from Seattle, WA, to Eugene, OR. By assessing and prioritizing these extreme weather events and hazards, the community can better plan and prepare for them.

Table 4. Hazard and Vulnerability Assessment Scores and Ranking for Yamhill County 2020

Hazard	History	Vulnerability	Maximum Threat	Probability	Total Threat Score	Hazard Rank	Hazard Tiers
Flood	**18**	**40**	**90**	**63**	**211**	**#1**	**Top Tier**

Winter Storm	**16**	**40**	**80**	**56**	**192**	**#2**	
Earthquake – Cascadia	**6**	**45**	**100**	**35**	**186**	**#3**	
Drought	**8**	**25**	**80**	**56**	**169**	**#5**	**Middle Tier**
Windstorm	**16**	**25**	**70**	**56**	**167**	**#6**	
Wildfire	**8**	**15**	**80**	**21**	**124**	**#7**	
Landslide	**16**	**15**	**30**	**56**	**117**	**#8**	**Bottom Tier**
Earthquake – Crustal	**6**	**20**	**60**	**21**	**107**	**#9**	
Volcanic Event	**4**	**10**	**30**	**7**	**51**	**#10**	

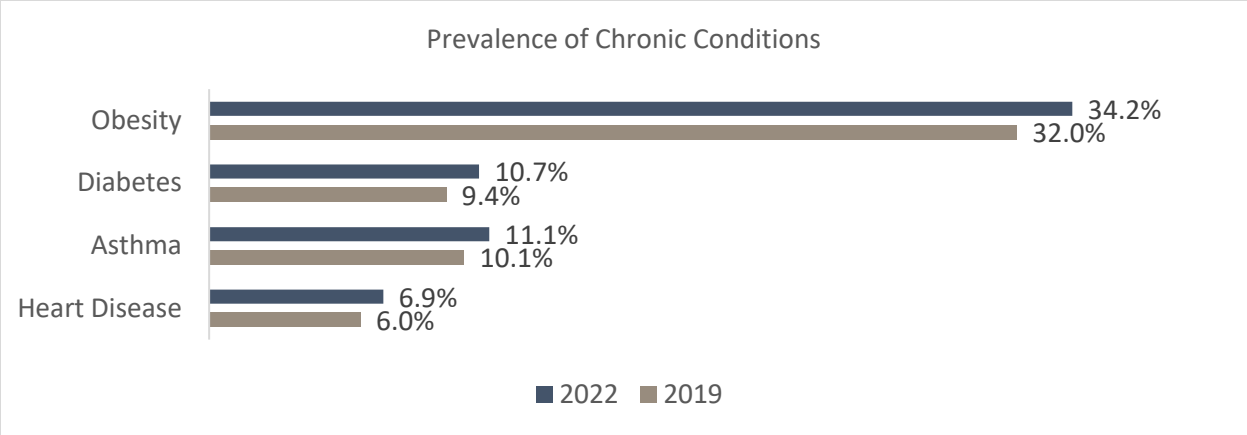
Source: Yamhill County Multi-Jurisdictional Hazard Mitigation Plan, 2020

Chronic Health Conditions

Quantitative Data

Extended care services, which encompass specialty care, are designed to address specific diseases. Primary and specialty care work hand in hand, and without the availability of specialists, individuals often must manage chronic conditions like diabetes, hypertension, obesity, and heart disease on their own. When access to primary care, specialists, or adequate information regarding prevention, management, and control of health issues is insufficient, these conditions can worsen. Additionally, those who are focused on meeting basic needs, such as dealing with financial instability, securing housing, arranging childcare, facing food insecurity, or other essential requirements, may find themselves lacking the time, resources, and energy needed to effectively manage their health conditions. Figure 14 shows an increase in prevalence obesity, diabetes, asthma, and heart disease from 2019 to 2022.

Figure 14. Percentage of Adults with a Chronic Condition by Type, Yamhill County, 2019 and 2022



SOURCE: PLACES. Center for Disease Control and Prevention. Indicator uses crude prevalence for year 2022 estimates.

The mortality data available on CDC WONDER are national mortality and population data produced by the National Center for Health Statistics (NCHS) at the Centers for Disease Control and Prevention (CDC). Mortality information is collected by state registries and provided to the National Vital Statistics System. Data are based on death certificates for U.S. residents. Each death certificate contains a single underlying cause of death, and demographic data. The number of deaths and death rates can be obtained by place of residence (United States national, state, and county when available), age group, race, Hispanic ethnicity, sex, and cause of death (4-digit ICD-10 codes, 113 selected causes of death, 130 selected causes of death for infants, and categories for injury intent and mechanism, or drug / alcohol induced causes of death, when available). For more information, refer to National Vital Statistics System - Mortality Data.

Table 2. Leading Causes of Death, by County and State, crude rates per 100,000 population

	Cause of Death	Yamhill County (Crude Rate)	Oregon (Crude Rate)
1st	Diseases of heart	208.2	177.9
2nd	Malignant neoplasms	190	197.1
3rd	Cerebrovascular diseases	58.1	54.1
4th	Accidents (unintentional injuries)	54	66.1
5th	Alzheimer disease	49.9	46.9
6th	Chronic lower respiratory diseases	45.9	47.1
7th	COVID-19	31.5	30.2
8th	Diabetes mellitus	27.4	31.9
9th	Chronic liver disease and cirrhosis	20.4	19.2
10th	Intentional self-harm (suicide)	18.7	20.7

Centers for Disease Control and Prevention, National Center for Health Statistics. National Vital Statistics System, Mortality 2018-2023 on CDC WONDER Online Database, released in 2024. Data are from the Multiple Cause of Death Files, 2018-2023, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program.

Identification and Prioritization of Significant Health Needs

Through a collaborative process of data collection, analyzing community input, and cross-referencing qualitative and quantitative data, Providence identified the following key themes: **Access to Care and Services, Economic Security, Health Related Social Needs, and Mental Health and Substance Use Disorder**.

By engaging the Providence Yamhill Service Area Advisory Council, council members representing staff and community members selected the top four priority needs through an anonymous voting system. Prior to voting, the council reviewed and discussed key data points and highlights from the CHNA process. After attending a presentation of overall CHNA methods, processes, and findings, the council engaged in a robust discussion of findings in preparation to vote on the service area's priority needs.

The council considered the following criteria when going through the prioritization process:

- Worsening trend over time
- Disproportionate impact on low income and/or Black, Brown, Indigenous, and People of Color (BBIPOC) communities
- Providence service area rates worse than state average and/or national benchmarks
- Opportunity to impact: organizational commitment, partnership, severity, and/or scale of need
- Alignment with existing health system priorities

2025 Priority Needs

The list below summarizes the rank ordered significant health needs identified through the 2025 Community Health Needs Assessment process (listed in alphabetical order):

ACCESS TO CARE AND SERVICES: Focus on primary care and preventative health, chronic health conditions, and oral health. This priority area refers to the lack of timely access to care and services due to physical, geographic, and systemic limitations, among others.

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 affordable basic living expenses and obtaining affordable education.

HEALTH RELATED SOCIAL NEEDS: Focus on housing stability, navigation of supportive services, food security, and transportation. This priority area refers to the unmet social needs that exacerbate poor health and quality of life outcomes.

MENTAL HEALTH & SUBSTANCE USE DISORDER: Focus on access, capacity, prevention, and treatment. This priority area refers to the growing challenges of accessing care due to workforce shortages, a lack of culturally responsive care, and affordability.

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

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

Potential Resources Available to Address Significant Health Needs

Understanding the potential resources to address significant health needs is fundamental to determining current state capacity and gaps. The organized health care delivery systems include the Department of Public Health and Willamette Valley Medical Center. In addition, there are numerous social service non-profit agencies, faith-based organizations, and private and public-school systems that contribute resources to address these identified needs.

See Appendix 3 for a full list of resources potentially available to address the significant health needs

SECTION V: EVALUATION OF 2023-2025 CHIP

The 2022 CHNA and 2023-2025 CHIP priorities were the following: health related social needs with a focus on homelessness and housing stability and food security, mental health and substance use disorders, economic security with a focus on workforce development, and access to care with a focus on oral and vision care. This report evaluates the impact of the previous Community Health Improvement Plan (CHIP). PNMC responded to community needs by making investments of direct funding, time, and resources to internal and external programs dedicated to addressing the previously prioritized needs using evidence-based and leading practices. Below is a summary of the outcomes for each priority.

Table 5. Outcomes from 2023-2025 CHIP

This table identifies key initiatives Providence supported to address the 2023-2025 CHIP priorities; however, it is not an exhaustive list. The results below reflect data over a three-year period from 2023 to 2025 unless otherwise noted.

Priority Need	Program or Service Name	Program or Service Description	Results/Outcomes
Access to Care and Services	Patient Support Program	Providing patients with resources necessary for a safe and secure discharge from the hospital	360 patients served and 475 resource vouchers provided
Access to Care and Services	Medical Teams International Mobile Dental Clinics	Providing free emergency dental services to uninsured and underinsured community members	135 community members served
Food Insecurity	Northwest Christian Church	Increasing access to healthy food for food insecure community members	2,692 people served over a two-year grant period (2023-2024)
Mental Health and Substance Use Disorders	Better Outcomes Through Bridges Emergency Department Outreach	Peer Support Specialists identify patients who frequently visit the emergency department, and connect them with resources to address unmet needs while providing trusted support and advocacy	42 patients supported in 2024

Mental Health and Substance Use Disorders	Lutheran Community Services NW	Providing mental health services to children and families	188 people received services through a one-year 2024 grant
Economic Security	Promotores de Salud	Providing community health worker (CHW) training for Spanish speaking community members	9 community members received CHW training in 2024

This is not an exhaustive list.

Addressing Identified Needs

The Community Health Improvement Plan (CHIP) developed for the Yamhill service area will consider the prioritized health needs identified in this CHNA and develop strategies to address needs considering resources, community capacity, and core competencies. Those strategies will be documented in the CHIP, describing how PNMC plans to address the health needs. If the hospital does not intend to address a need or plans to have limited response to the identified need, the CHIP will explain why. The CHIP will not only describe the actions PNMC intends to take, but also the anticipated impact of these actions and the resources the hospital plans to commit to address the health needs.

Because partnership is important when addressing health needs, the CHIP will describe any planned collaboration between PNMC and community-based organizations in addressing the health need. The CHIP will be approved and made publicly available no later than May 15, 2026.

Providence

2025 CHNA GOVERNANCE APPROVAL

This Community Health Needs Assessment was adopted by the Yamhill Service Area Advisory Council on November 18, 2025. The final report was made widely available by December 28, 2025.

11/24/25

Andrew Haslam — Date
Chief Administrative Officer, Providence Newberg Medical Center
Providence

11/24/2025

Dan Kang, DPT — Date
Chair, Yamhill Service Area Advisory Council

12/8/2025

Jennifer Burrows — Date
Chief Executive, Oregon
Providence

CHNA/CHIP Contact:

Sonya Kauffman Smith
Manager, Community Health – Oregon
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Contact CHI@providence.org to provide feedback about this CHNA or to request a free printed copy.

APPENDICES

Appendix 1: Quantitative Data

POPULATION LEVEL DATA

Population Below 200% Federal Poverty Level

Indicator	Yamhill County	Combined Broader Service Area	Combined High Need Service Area	Oregon
Percent of Population Below 200% Federal Poverty Level	25.2% (25,944 individuals)	20.1% (11,833 individuals)	31.8% (14,111 individuals)	27.6% (1,146,463 individuals)

Data Source: 2023 American Community Survey, 5-Year Estimates

Households Experiencing Severe Housing Cost Burden

Indicator	Yamhill County	Combined Broader Service Area	Combined High Need Service Area	Oregon
Households Experiencing Severe Housing Cost Burden	14.5% (5,498 households)	11.5% (2,398 households)	17.7% (3,100 households)	15.2% (251,493 households)

Data Source: 2023 American Community Survey, 5-Year Estimates

Limited English Households

Indicator	Yamhill County	Combined Broader Service Area	Combined High Need Service Area	Oregon
Percent of Population Age 5+ Living in a Limited English-Speaking Household	2.2% (844 households)	0.6% (166 households)	3.7% (678 households)	2.3% (38,607 households)

Data Source: 2023 American Community Survey, 5-Year Estimates

Percent of Population with A High School Education

Indicator	Yamhill County	Combined Broader Service Area	Combined High Need Service Area	Oregon
Percent of Population Age 25+ With at Least a High School Education	89.8% (66,531 individuals)	92.3% (39,061 individuals)	86.0% (27,470 individuals)	91.7% (2,770,789 individuals)

Data Source: 2023 American Community Survey, 5-Year Estimates

Percent of Households Receiving SNAP Benefits

Indicator	Yamhill County	Combined Broader Service Area	Combined High Need Service Area	Oregon
Percent of Households Receiving Supplemental Assistance Program (SNAP) Benefits	15.7% (6,092 households)	10.2% (2,147 households)	21.6% (3,945 households)	15.4% (261.284 households)

Data Source: 2023 American Community Survey, 5-Year Estimates

Asthma Prevalence

Indicator	Yamhill County	Combined Broader Service Area	Combined High Need Service Area	Oregon
Asthma Crude Prevalence	11.1%	11.1%	11.9%	11.5%

Data Source: PLACES. Center for Disease Control and Prevention - Indicator uses crude prevalence for year 2022 estimates

Obesity Prevalence

Indicator	Yamhill County	Combined Broader Service Area	Combined High Need Service Area	Oregon
Obesity Crude Prevalence	34.2%	33.3%	34.7%	30.9%

Data Source: PLACES. Center for Disease Control and Prevention - Indicator uses crude prevalence for year 2022 estimates

Tobacco Use (Current Smoking)

Indicator	Yamhill County	Combined Broader Service Area	Combined High Need Service Area	Oregon
Smoking Crude Prevalence	13.9%	13.2%	15.6%	12.4%

Data Source: PLACES. Center for Disease Control and Prevention - Indicator uses crude prevalence for year 2022 estimates

Alcohol Consumption (Binge Drinking)

Indicator	Yamhill County	Combined Broader Service Area	Combined High Need Service Area	Oregon
Binge Drinking Crude Prevalence	18.4%	17.9%	18.1%	18.0%

Data Source: PLACES. Center for Disease Control and Prevention - Indicator uses crude prevalence for year 2022 estimates

Physical Inactivity

Indicator	Yamhill County	Combined Broader Service Area	Combined High Need Service Area	Oregon
Physical Inactivity Crude Prevalence	21.0%	19.7%	23.1%	19.0%

Data Source: PLACES. Center for Disease Control and Prevention - Indicator uses crude prevalence for year 2022 estimates

Diabetes Prevalence

Indicator	Yamhill County	Combined Broader Service Area	Combined High Need Service Area	Oregon
Diabetes Crude Prevalence	10.7%	11.0%	11.1%	11.8%

Data Source: PLACES. Center for Disease Control and Prevention - Indicator uses crude prevalence for year 2022 estimates

Households without Internet Access

Indicator	Yamhill County	Combined Broader Service Area	Combined High Need Service Area	Oregon
Households without Internet Access	5.1% (1,985 households)	4.3% (886 households)	5.7% (1,099 households)	5.6% (95,898 households)

Source: 2023 American Community Survey, 5-Year Estimates

Depression

Indicator	Yamhill County	Combined Broader Service Area	Combined High Need Service Area	Oregon
Depression	25.7%	25.1%	27.3%	24.0%

Source: PLACES. Center for Disease Control and Prevention. Indicator uses crude prevalence for year 2022 estimates

Coronary Heart Disease

Indicator	Yamhill County	Combined Broader Service Area	Combined High Need Service Area	Oregon
Coronary Heart Disease	6.9%	7.4%	7.2%	7.2%

Source: PLACES. Center for Disease Control and Prevention. Indicator uses crude prevalence for year 2022 estimates

Chronic Obstructive Pulmonary Disease (COPD)

Indicator	Yamhill County	Combined Broader Service Area	Combined High Need Service Area	Oregon
Chronic Obstructive Pulmonary Disease (COPD)	6.9%	7.2%	7.9%	6.6%

Source: PLACES. Center for Disease Control and Prevention. Indicator uses crude prevalence for year 2022 estimates

Fair or Poor Health

Indicator	Yamhill County	Combined Broader Service Area	Combined High Need Service Area	Oregon
Fair or Poor Health	17.9%	17.2%	20.7%	17.7%

Source: PLACES. Center for Disease Control and Prevention. Indicator uses crude prevalence for year 2022 estimates

Appendix 2: Community Input

METHODOLOGY

Participants

The hospital completed four listening sessions that included a total of 28 participants. The sessions took place between April and July 2025.

Table_Apx 1: Community Input

Community Input Type	Population	Community Partner	Location	Date	Language

Listening Session	People who are homeless	Community Wellness Collective	Community Wellness Collective	6/11	English
Listening Session	Spanish-speaking community members	Promotores	Virtual	6/4	English
Listening Session	Spanish-speaking community members	Unidos Bridging Community	Unidos Bridging Community	6/4	Spanish
Listening Session	Spanish-speaking patients	Virginia Garcia Memorial Center	Virginia Garcia Memorial Center	5/29	Spanish

The hospital completed 10 key informant interviews that included a total of 11 participants. The interviews took place between April and July 2025.

The goal was to engage representatives from social service agencies, health care, education, housing, and government, among others, to ensure a wide range of perspectives. The hospital included the Prevention Supervisor from Yamhill County Public Health as a key informant to ensure the input from a state, local, tribal, or regional governmental public health department.

Table_Apx 2. Key Community Key Informant Participants

Organization	Name	Title	Sector
Community Wellness Collective	Kate Stokes	Executive Director	Housing, social services
Encompass Valley	Carrie Martin	Executive Director	Housing, social services
George Fox University	Bill Buhrow	Dean of Student Services	Education
Lutheran Community Services Northwest	Jordan Robinson	District Director	Behavioral health
Provoking Hope	Diane Reynolds	Founder/President	Behavioral health
Virginia Garcia Memorial Health Center	Angela Hurley	Director of Operations	Federally Qualified Health Center
Willamette Educational Services District	Cassie Stafford	School Safety and Mental Health Coordinator	Education

Yamhill Community Care	Emily Johnsen Tami Tigner	Community Health Program Manager Clinical Care Manager Supervisor	Access to healthcare
Yamhill County Action Partnerships	Amber Hansen-Moore	Deputy Director	Social services
Yamhill County Public Health	Laura Bivens	Prevention Supervisor	Public health

Facilitation Guides

For the listening sessions, participants were asked an icebreaker and three questions:

- Community members' definitions of health and well-being
- The community needs
- The community strengths

For the key informant interviews, Providence developed a facilitation guide that was available for use across all hospitals completing their 2025 CHNAs:

- The community served by the key informant's organization
- The community strengths
- Prioritization and discussion of unmet health related needs in the community, including social determinants of health
- Suggestions for how to leverage community strengths to address community needs
- Successful community health initiatives and programs
- Opportunities for collaboration between organizations to address health equity

Training

The facilitation guides provided instructions on how to conduct a key informant interview and listening session, including basic language on framing the purpose of the sessions. Facilitators participated in trainings on how to successfully facilitate a key informant interview and listening session and were provided question guides.

Data Collection

Key informant interviews were conducted virtually, and information was collected in one of two ways: 1) recorded with the participant's permission or 2) a note taker documented the conversation. Two note takers documented the listening session conversations.

Analysis

Qualitative data analysis was conducted by Providence using Atlas.ti, a qualitative data analysis software. The data were coded into themes, which allows the grouping of similar ideas across the interviews, while preserving the individual voice.

If applicable, the recorded interviews were sent to a third party for transcription, or the notes were typed and reviewed. The key informant names were removed from the files and assigned a number to reduce the potential for coding bias. The files were imported into Atlas.ti. The analyst used a standard list of codes, or common topics that are mentioned multiple times. These codes represent themes from the dataset and help organize the notes into smaller pieces of information that can be rearranged to tell a story. The analyst developed a definition for each code which explained what information would be included in that code. The analyst coded eight domains relating to the topics of the questions: 1) name, title, and organization of key informant, 2) population served by organization, 3) greatest community strength and opportunities to leverage these strengths 4) unmet health-related needs, 5) disproportionately affected population, 6) effects of COVID-19, 7) successful programs and initiatives, and 8) opportunities to work together.

The analyst then coded the information line by line. All information was coded, and new codes were created as necessary. All quotations, or other discrete information from the notes, were coded with a domain and a theme. Codes were then refined to better represent the information. Codes with only one or two quotations were coded as “other,” and similar codes were groups together into the same category. The analyst reviewed the code definitions and revised as necessary to best represent the information included in the code.

The analyst determined the frequency each code was applied to the dataset, highlighting which codes were mentioned most frequently. Codes for unmet health-related needs were cross-referenced with the domains to better understand the populations most affected by a certain unmet health-related need. The analyst documented patterns from the dataset related to the frequency of codes and codes that were typically used together.

This process was repeated for the listening sessions using a merged set of notes. The analyst coded three domains related to the topics of the questions: 1) vision, 2) needs, and 3) strengths.

Limitations

While key informants and listening sessions participants were intentionally recruited from a variety of types of organizations, there may be some selection bias as to who was selected as a key informant. Multiple interviewers may affect the consistency in how the questions were asked. Multiple note-takers may affect the consistency and quality of notes across the different sessions.

Some listening sessions were conducted virtually, which may have created barriers for some people to participate. Virtual sessions can also make facilitating conversation between participants more challenging.

The analysis was completed by only one analyst and is therefore subject to influence by the analyst’s unique identities and experiences.

FINDINGS FROM COMMUNITY LISTENING SESSIONS

Community Strengths

Safety and Security: Participants expressed appreciation for the peaceful and safe environment in their community. People feel safe walking at night, free from the threat of violence and crime. The community's low crime rate, especially compared to larger nearby cities, contributes to a sense of security for everyone.

Supportive Community Bonds: Community members value the strong bonds formed through neighborly support and local events. These gatherings create connections and friendships among residents. People often help each other in times of need, reinforcing the community's supportive and welcoming atmosphere. The community feels like a big family where everyone belongs and looks out for each other.

Access to Health and Wellness Resources: Participants noted the availability of resources like free meals and public transportation, which provide support for those facing economic challenges. Health services, including accessible mammogram screenings for women, are available and help residents maintain their well-being. Health promoters keep residents informed about available resources and health programs. Hospitals, parks, and schools offer healthcare and recreational opportunities that help residents maintain their physical health.

Educational Opportunities and Workshops: Community members appreciate workshops on nutrition and health that provide useful information and encourage community participation. Organizations offer classes focused on health and wellness. Community members discussed improving outreach and increasing attendance at these educational programs.

Strong Community Engagement: Participants highlighted programs that foster an inclusive environment, particularly for Hispanic community members. These programs make everyone feel welcome and encourage active involvement, helping people from diverse backgrounds feel they belong in the community.

Unmet Health-Related Needs

Community members were asked to discuss community health-related needs. Needs that were talked about in detail in a majority of the sessions were prioritized as high priority. The following themes emerged:

High priority unmet health-related needs

Access to Healthcare Services: Community members identified access to healthcare as a need. Insurance approval delays affect recovery, leading to frustration. Long wait times for appointments, especially for older adults and infants, further complicate access to timely care. Language barriers make communication difficult for who do not speak English as first language, impacting their healthcare experience. People without insurance are concerned about medical costs, which discourages them from seeking necessary care.

Affordable housing and Homelessness: Community members are concerned about the rise in homelessness around parks. This affects safety and families' ability to comfortably use public spaces. There is a need for supportive housing solutions. Unstable housing makes accessing healthcare difficult and complicates health management, such as storing medications like insulin.

Food Security: Participants expressed interest in improving health through nutrition. They want more educational resources on healthy eating. Community members discussed how access to healthy food options remains challenging, and practical guidance on meal preparation is needed. While current programs are recognized, there is a call for better communication and broader participation in nutrition education. The need for essential services was highlighted through proposed solutions, such as improving the quality of school meals to promote children's health.

Access to Behavioral Health Services: Participants highlighted the need for better accessible mental health services. They discussed how fear, stress, and isolation impact mental well-being. There is a need for behavioral health resources to be available in Spanish.

Transportation: Community members identified the need for better public transportation. Existing options, like local buses and free church rides, are helpful, but more comprehensive services could improve access to healthcare, work, and social activities. Community members discussed how more transportation options, such a shuttle services, are necessary to reduce isolation and enhance access to essential resources.

Economic Security: While community growth and job availability are viewed positively, participants want more diverse employment options. High housing rental costs, paired with low wages create financial stress, leading to housing instability. These economic pressures affect the ability to afford healthcare and increase stress levels.

Medium priority unmet health-related needs

Workers' Rights and Support: Participants raised concerns about workers' rights, particularly regarding injury recovery and insurance approvals. Prolonged suffering and difficulty accessing medical care are common issues. There is a desire for stronger advocacy and support systems to improve worker welfare, as existing unions may not fully address these needs.

Immigration Challenges and Discrimination: Immigration issues cause fear and stress, affecting daily life and employment engagement. While local churches and organizations offer support, these resources are not widely known. Discrimination impacts access to housing and healthcare, particularly for families with mixed migratory status, complicating their ability to obtain benefits and support.

Leveraging Community Strengths

Participants shared solutions for creating a community where people feel safe, supported, and connected. They aim for a welcoming environment where everyone has access to the resources and opportunities they need.

Supportive Housing and Recovery Initiatives: Participants proposed supportive housing solutions to aid people experiencing homelessness. They suggested creating recovery centers and tiny house communities that offer services like counseling, job training, healthcare, and stable housing.

Healthcare Access: Community members focused on improving healthcare access. They expressed a desire for more clinics and medical staff to reduce wait times and highlighted the role of health navigators to help people connect with necessary resources. The importance of direct healthcare services was reiterated to ensure fair treatment in service delivery.

Education and Employment Support: Participants proposed solutions for better employment and education opportunities. They called for job support programs that include people with criminal records to improve integration. Financial assistance for students was also identified as a priority, particularly due to funding cuts affecting higher education.

Community Engagement and Unity: Community members underscored the importance of community connection through proposed solutions like face-to-face meetings to build stronger bonds and improve communication. They suggested sharing success stories and introducing role models to inspire individuals facing challenges.

Mental Health and Well-being: Community members discussed improving access to counseling and group therapy to help manage stress and improve emotional well-being.

Advocacy: Participants discussed creating a community free from discrimination, emphasizing advocacy to ensure community needs are met.

FINDINGS FROM KEY INFORMANT INTERVIEWS

Community Strengths

The interviewer asked key informants to share one of the strengths they see in the community and discuss how we can leverage these strengths to address needs. This is an important question because all communities have strengths. While a CHNA is primarily used to identify gaps in services and challenges, we also want to ensure that we highlight and leverage the community strengths that already exist.

Participants highlighted Yamhill County's close-knit community and effective collaboration across sectors. The following strengths emerged as themes:

Quality of Life

- **Safety and Security:** Community members feel safe in Yamhill County, experiencing lower rates of violent and property crimes compared to other areas. This contributes to a sense of security and well-being, enhancing their overall quality of life.
- **Income and Health:** Income and health are seen as stable in Yamhill County. This stability helps residents maintain a sustainable lifestyle.

Strong Community Bonds

- **Neighborly Support:** Neighbors often help each other, creating a supportive and interconnected community. Towns like Sheridan, McMinnville, and Newberg showcase active engagement in local events and initiatives.
- **Community Engagement:** Residents participate in various programs and organizations, contributing to a thriving community environment. Platforms like neighborhood apps and social media support community networking, fostering connection among residents.
- **Community Pride and Retention:** Employees and healthcare providers prefer working in Yamhill County, showing pride and dedication to their community. Local-born healthcare providers often return to serve their community, influenced by educational pathways. Attracting outside talent is challenging due to the rural nature of the area.

Community Partnerships and Collaboration: A strong network of agencies and nonprofit organizations collaborate effectively, enhancing service delivery and resource allocation. Organizations in Yamhill County show a commitment to community welfare and development. Partner organizations share a vision to improve quality of life and address community challenges.

Education and Support Services: Schools in larger districts such as Newberg and McMinnville collaborate with mental health and public health sectors to address community needs proactively. Universities and local colleges provide educational support, promoting community engagement and development.

Resilience and Self-Sufficiency: Towns show resilience, with residents addressing local needs and promoting a self-sufficient spirit through community clean-ups and events. Establishments offering free Thanksgiving and Christmas dinners reflect strong social solidarity and mutual support in smaller communities.

Access to Health and Wellness Resources

- **Drug Court System:** The drug court treatment system is seen as a strong collaborative effort, providing accountability and transformative opportunities for participants. It addresses complex social issues with effective solutions.

Overall, Yamhill County's strengths lie in its community values and collaborative efforts across sectors. Residents and organizations are committed to maintaining a thriving, supportive, and interconnected community.

High Priority Unmet Health-Related Needs

Three needs were talked about in detail or ranked highly by a majority of key informant interview participants. Three additional needs were categorized as medium priority because they were discussed less frequently and in less detail. Key informants were most concerned about the following health-related needs:

1. Behavioral health challenges and access (mental health and substance use/misuse)
2. Access to health care services
3. Homelessness and housing stability

Behavioral health challenges and access (mental health and substance use/misuse)

Key Informants discussed behavioral health needs in their community, highlighting mental health, substance use disorders, and overall well-being. They shared concerns about how these issues affect stable housing for people experiencing homelessness. Many noted the need for more supportive services and better coordination among providers. They also emphasized the importance of culturally sensitive approaches.

Intersection of Homelessness, Mental Health, and Substance Use/Misuse: Substance use and mental health issues often occur together, making recovery challenging. People experiencing homelessness face multiple challenges, including substance use and mental health issues, impacting their housing stability. In rural communities, stigma around these problems makes accessing services difficult.

Limited Access to Behavioral Health Services: Community members expressed frustrations about limited access to treatment services, including detox facilities and long-term support. They pointed out difficulties in navigating service systems, with complicated forms and online barriers that make it difficult for people to access help. Social isolation, worsened by the pandemic, has heightened mental health challenges, affecting rural communities and immigrants. Service availability is especially a concern in rural areas where there are fewer providers. Participants discussed the need for more linguistically and culturally sensitive services, especially for immigrant communities. They mentioned the lack of coordination between agencies, leading to inefficient service delivery and interrupted care. Poverty further limits access to services, with environmental hazards straining local funding.

> *"I think that is a real shortfall is the ability to coordinate individuals' needs and resources across the whole system, including lots of different agencies. So that we are using the resources effectively, we are sharing information, and not duplicating services."—Key Informant*

Barriers to accessing care include:

- **Stigma**: Stigma around mental health and substance use discourages many from seeking support
- **System Navigation**: Forms and online barriers make it difficult for residents to access services
- **Environmental concerns**: Natural disasters and other environmental hazards strain local funding

Populations disproportionately impacted:

- **People experiencing homelessness:** Behavioral health conditions contribute to the difficulty of securing stable housing. Participants estimated that about one-third of this group self-reports substance use disorders.

- **People with low income** are less likely to receive early or preventative mental healthcare due to cost, access, or systemic inequities.
- **Women,** particularly mothers aged 25-35, deal with social stigma related to mental health, homelessness and substance use disorders.
- **Indigenous Peoples of the US** encounter barriers to education and mental health supports.
- **People working blue collar or agricultural jobs**

> *"Like we picture substance use disorders as people lounging on the street, injecting drugs into their veins. Whereas rural communities tend to see a different kind of epidemic that sometimes ends up in that demographic. But I think the stigmas around it are different. I think providing substance use disorder and alcohol use disorder services to farmers and people who work in rural blue-collar areas is just different. How you have to approach those services and how they accept them seems to be a pretty significant barrier." –Key Informant*

Participants recommended improving service accessibility by increasing treatment facilities and simplifying enrollment processes. They called for better coordination among agencies, using technology to optimize resources. Addressing economic and cultural barriers is crucial, with a focus on engaging immigrant populations and reducing poverty-related obstacles. Community-building initiatives could help reduce social isolation and stigma, fostering a sense of belonging among the most impacted populations.

Access to health care services, including dental care

Participants shared their experiences and challenges related to accessing healthcare in the community. Many noted a shortage of healthcare providers, especially in dental, medical, and pharmacy services. People often need to travel outside the county to receive care, which can lead to delays or discouragement in seeking treatment. This is a particular concern for people who are pregnant, who worry about being far from hospitals when labor begins.

> *"If I get pregnant and I have to have regular prenatal care, how far do I have to travel to get there? And then what happens when I go into labor suddenly? At 2:00 AM, 45 minutes away on dark roads? With or without a car, there's just a lot of worry about access to maternal care, prenatal care."—Key Informant*

Barriers to accessing care include:

- **Insurance and financial barriers**: Community members face financial barriers, with insurance limitations leading to higher out-of-network costs.
- **Transportation:** Transportation is another challenge, especially in rural areas, where getting to appointments without a car is difficult.

> *"Taking a bus with six children into an appointment where you don't have anybody to take care of your children. Or three children. Or even two children, right? Like having*

to take them into the exam room and see your doctor while you don't have somebody to take care of those kids, and you have to get public transportation, but you're in a rural area. Those things can be huge barriers. So you just don't go. You just don't take care of it. And then we have late-stage findings instead of preventative findings." — Key Informant

- **Language and cultural barriers:** There is a need for culturally and linguistically sensitive services to bridge these gaps.
- **Environmental barriers:** Climate hazards, such as wildfires and power outages, disrupt access to healthcare by causing clinic closures and risking medicine stability. Participants highlighted the need for better emergency preparedness and resources to handle large-scale crises effectively.
- **Policy/Regulatory barriers**: Participants expressed concern about federal regulations that create fear among marginalized groups, impacting their willingness to seek healthcare. They stressed the importance of community togetherness to counter these challenges and support local populations.
- **Health Literacy**: Lower health literacy impacts people's ability to understand and use available services.

Participants emphasized disparities in healthcare access due to factors such as race, ethnicity, language, and socioeconomic status. Populations especially impacted include:

- **People experiencing homelessness** and **people who are undocumented** face additional barriers in accessing care.

"There might say you need to use your CPAP every night. Well, that sounds great, doesn't it? But where do they plug in every night? They sleep outside."—Key Informant

- **People living in rural areas:** The distribution of services favors urban areas, leaving rural communities with limited access and relying on self-sufficiency. Participants called for broader service distribution to ensure everyone can access the care they need.
- **People who are pregnant:** People who are pregnant worry about accessing services in time.

Community members called for stronger support systems, such as peer support programs and home visiting services, to improve access and equity. They advocated trauma-informed care and health literacy initiatives. Utilizing community strengths and engaging a diverse workforce can enhance service delivery.

Homelessness and housing stability

Most Key informants identified homelessness and housing stability as a need in Yamhill County. They discussed significant challenges related to housing affordability and homelessness, which intersect with health and social services.

Housing Accessibility: Key informants share that there is not enough affordable housing available. High deposit requirements prevent some from renting homes. Community growth and tourism affect housing options, with more homes rented short-term to visitors rather than year-round residents. Participants suggest that new rules are needed to protect renters and ensure safe living conditions.

Community Services: Key informants stress the importance of eviction prevention programs to help people stay housed. They report a lack of coordination between services, making it hard for people to find the help they need. Although some health and support networks exist, people say they need more resources to address substance use, health, and disability issues.

"Nothing else can be addressed until somebody has a safe place to sleep and keep their belongings."—Key Informant

"Someone had a health issue and then they couldn't work for a few months, so they fell behind on rent. Now they're facing homelessness." –Key Informant

Environmental Concerns: Participants note that climate disasters, like wildfires, worsen conditions for those without housing. Bad weather leads to shelter closures, leaving people with nowhere safe to go. They suggest that communities need to prepare better to keep unsheltered people safe during these events.

Social Dynamics: Key informants share that homelessness looks different in various communities. People from immigrant communities might live with family when losing their homes, making homelessness less visible. Participants see the need for better understanding and support in these situations.

Barriers to accessing housing include:

- **Rising costs:** Participants report that rising housing costs and unchanged incomes lead to more homelessness.
- **Transportation:** Transportation challenges limit access to detox services and medical appointments, especially for those with low income. This contributes to housing instability.
- **Literacy:** Complex procedures and intricate paperwork can hinder individuals from maintaining housing or effectively managing lease agreements and eviction processes.

"But the fact is that when I look at a form that one of our clients has to fill out, it is so beyond their capacity that it's, it's, it's absurd. And that's across, you know, whether they are dealing with eviction court and they are going through the court systems, either municipal or circuit, and they're asked to fill out forms or read things that they are completely unclear on, or even lease agreements." –Key Informants

Some populations are particularly impacted:

- Participants mention that **older adults** and **people with disabilities** face high risks of losing their housing.

- **Mothers**, especially between ages 25 to 35, and their **children** often face homelessness. People feel that stigma and frequent moves harm these families, and they see the need for more support programs.
- Participants mentioned that **people with criminal legal system involvement** and **people with eviction records** face additional barriers to finding stable jobs and housing.
- Key informants note that **people experiencing homelessness** often also deal with disabilities and untreated health conditions. Those who are unsheltered and living on the streets find it difficult to maintain their health without safe housing or medical equipment, such as CPAP machines. Key informants discussed the need for better access to health care to improve their situation.

Medium Priority Unmet Health-Related Needs

Three additional needs were often discussed by key informants:

4. Economic Security
5. Food Insecurity
6. Environmental Concerns

Economic Security

Key informants highlighted economic security as a need in the community, with impacts felt across age groups and sectors.

Rising Cost of Living and Basic Needs: Participants shared concerns about the rising cost of living in their community. They noted that rent, food, and utilities are becoming less affordable. High utility costs add to the financial burden, leaving residents with limited options to improve their situation.

> *"But they cannot afford day-to-day living. The cost of rent is too high. Food is too much. Utilities are going through the roof." –Key Informant*

Health Equity and Access to Services: Key informants expressed concerns about accessing services that meet cultural and language needs. Legal status can restrict access to health care and support for immigrants who are undocumented. Isolation in rural areas and poverty may keep people from using community resources, due to feelings of stigma.

Environmental Concerns: Key informants discussed the impact of weather and environmental conditions on work opportunities. When workplaces close, people lose income, making it hard to pay bills and risking eviction. The COVID-19 pandemic was cited as an example of unforeseen challenges, with income loss during shutdowns leading to housing insecurity once eviction moratoriums ended.

Community Strengths and Solutions: Participants believe in leveraging community strengths to address needs and improve health equity. Peer support programs can reduce stigma and connect people across cultures. Employing a diverse workforce can engage individuals and provide job opportunities. There is a call for community leadership to address housing challenges and strengthen support networks.

Some populations are especially impacted:

- **Older adults** and **people with disabilities** face challenges in increasing their income, impacting their ability to cover daily expenses.
- **People who are undocumented** may be restricted from accessing some services or do not access services due fear.

Community Strengths and Solutions: Participants believe in leveraging community strengths to address needs and improve health equity. Peer support programs can reduce stigma and connect people across cultures. Employing a diverse workforce can engage individuals and provide job opportunities. There is a call for community leadership to address housing challenges and strengthen support networks.

Food Security

Key informants discussed how food insecurity due to rising food costs and financial constraints impacts multiple populations across generations:

- **Families and people with low-income** face difficulties due to economic constraints, relying on Medicaid and struggling with rising food costs. These challenges make it hard for them to maintain a healthy diet.
- **College students** living off-campus often find it difficult to afford enough food because they do not have meal plans like their on-campus counterparts.
- **Agricultural and vineyard workers** experience financial challenges due to seasonal work and varying incomes, which affect their ability to access nutritious food consistently.
- **Children and adolescents** in the county are also affected, with about half receiving Medicaid benefits. Economic hardships within their families limit their access to necessary nutrition for healthy growth.
- **People experiencing homelessness** encounter significant barriers to accessing food, especially on weekends when community meals are less available, resulting in "food desert" conditions.

> *"And then I think we can't hide from or ignore the fact that a lot of Yamhill County is this agricultural field after field of food and agricultural workers and vineyards and land of bountiful plenty. And yet there's a lot of hunger in that county. And how we provide access to healthy [food]?"—Key Informant*

Key informants highlight the need for supportive programs and community resources to address food insecurity among these groups.

Environmental Concerns

Key informants identified several environmental concerns affecting their community, focusing on agriculture, healthcare, and emergency readiness.

Agriculture: Agriculture plays a central role in the local economy, but environmental issues like wildfires, climate change, and water shortages impact productivity. These changes affect health access and service availability, as agriculture is closely linked to

Economic Disparities: Participants noted that people with fewer resources are more vulnerable to environmental factors like wildfire smoke. Limited access to air conditioning and safe housing increases risk.

Emergency Preparedness: Informants note that the community could improve its readiness. They suggest more training for residents and greater self-preparation for families. Managing mass casualty events or outbreaks is challenging due to limited staff and dependence on volunteers, highlighting the need for support from nearby counties or state resources during widespread emergencies.

Wildfire Readiness and Prevention: Wildfire readiness is a concern, particularly for areas which are low-income and isolated. Some residents believe disasters won't impact them, while others lack resources for preparation. Local fire departments actively work on prevention and resource provision but face staffing challenges.

Respiratory Health: Respiratory health has worsened due to wildfires. Masks from the COVID-19 pandemic help protect against smoke, but stigma sometimes hinders their use. The community supports populations most impacted with air filtration systems and air conditioning units, but more reminders and wellness checks are needed.

Appendix 3: Community Resources Available to Address Significant Health Needs

PNMC cannot address all of the significant community health needs by working alone. Improving community health requires collaboration across community key informants and with community engagement. Below outlines a list of community resources potentially available to address identified community needs.

Table_Apx 3. Community Resources Available to Address Significant Health Needs

Area of Need	Program, Initiative, or Other Resource
Access to Healthcare Services	• CaCOON nursing home visiting program for children with special health needs • Collaboration efforts between Yamhill County Public Health, Yamhill Community Care, and local health systems • Yamhill County Public Health's Community Connect Events
Behavioral Health	• Provoking Hope • Transitional Treatment Recovery Services (TTRS)

Chronic Health Conditions	• Providence Newberg Medical Center
Food Security	• Northwest Christian Church • Newberg and McMinnville Food Pantries
Homelessness and Housing Instability	• Yamhill Community Action Partnership (YCAP)
Economic Security	• Unidos Bridging Community
Environmental Concerns	• Yamhill County Public Health

Appendix 4: Service Area Advisory Council Community Health Needs Assessment Committee

Table_Apx 4. Community Health Needs Assessment Committee Members

Name	Title	Organization	Sector
Dan C. Kang	Associate Provost and Professor of Physical Therapy	George Fox University	Education
James Smario	Division Chief EMC	Tualatin Valley Fire & Rescue	Emergency Services
Miriam Vargas-Corona	Executive Director	Unidos Bridging Community	Community Services
Elaine Owen	Owner	Lady Hill Winery	Business
Captain Ryan Simmons	Captain	Newberg-Dundee Police Department City of Newberg	Emergency Services

Andrew Haslam	Chief Administrative Officer	Providence Newberg Medical Center	Healthcare
Sarah Rahkola	Home MEC Staff President	Providence Medical Group	Healthcare
Mike King	Chief Financial Officer	Providence Newberg Medical Center	Healthcare
Melissa Burns	Chief Operating Officer and Chief Nursing Officer	Providence Newberg Medical Center	Healthcare
Julie Dir-Munoz	Chief Medical Officer	Providence Newberg Medical Center	Healthcare