2026-2028

COMMUNITY HEALTH IMPROVEMENT PLAN

Providence Seaside Hospital

Seaside, Oregon

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

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EXECUTIVE SUMMARY

Providence continues its Mission of service in Clatsop County through Providence Seaside Hospital (PSH). The following Community Health Improvement Plan (CHIP) outlines our strategic response to addressing the prioritized needs from the 2025 Community Health Needs Assessment (CHNA).

PSH dedicates resources to improve the health and quality of life for the communities it serves, with special emphasis on the needs of people experiencing social inequities and health disparities. The Community Health Needs Assessment (CHNA) is an opportunity for PSH to engage the community every three years with the goal of better understanding community strengths and needs.

The results of the CHNA are used to guide and inform efforts to better address the needs of the community. Through a mixed-methods approach, using quantitative and qualitative data, the CHNA process relied on several sources of information: state and national public health data, qualitative data from interviews with community stakeholders and listening sessions with community members, primary data from a community survey, hospital utilization data, and more.

Our commitment to improving the health of our community extends beyond patient care. Through community health improvement and strategic partnerships, health professions education and research, free, discounted and subsidized care, and other means of outreach, we commit to caring for those we serve through high-impact community benefit programs and investments.

Providence Seaside Hospital Community Health Improvement Plan Priorities

As a result of the findings of our 2025 CHNA and through a prioritization process aligned with our Mission, resources, and hospital strategic plan, PSH will focus on the following areas for its 2026-2028 Community Benefit efforts. The priorities from the CHNA have been refined to better address the identified need and opportunity.

ACCESS TO CARE AND SERVICES: PRIMARY CARE AND PREVENTATIVE HEALTH

Access to care and services refers to the ability of individuals to obtain timely, affordable, culturally responsive, and linguistically appropriate health care. This includes having available providers and services, insurance or financial assistance, transportation, and the knowledge and support needed to navigate the health system—particularly for populations facing economic, cultural, or systemic barriers.

HEALTH RELATED SOCIAL NEEDS: HOUSING STABILITY

Housing stability refers to having safe, stable, and affordable housing that allows individuals and families to remain housed over time. Housing instability, including risk of homelessness, frequent moves, housing cost burden, or unsafe living conditions, can negatively affect physical and mental health, disrupt daily life, and create barriers to accessing care and other essential resources.

HEALTH RELATED SOCIAL NEEDS: TRANSPORTATION

Transportation refers to the availability of reliable, affordable, and accessible transportation that enables people to reach health care, supportive services, and basic needs. Transportation barriers, such as long distances, limited public transit, mobility challenges, and costs, can prevent timely access to care, particularly for older adults, people with disabilities, rural residents, and individuals experiencing housing instability.

MENTAL HEALTH/SUBSTANCE USE DISORDERS: PREVENTION AND TREATMENT

Poor mental health and substance use disorders affect emotional, psychological, and social well-being and influence how individuals manage stress, relate to others, and make healthy choices. Limited access to prevention, early intervention, and treatment services contributes to poor health outcomes and disproportionately impacts vulnerable and underserved populations.

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

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

INTRODUCTION

Who We Are

Our Mission As expressions of God's healing love, witnessed through the ministry of Jesus, we are steadfast in serving all, especially those who are poor and vulnerable.

Our Vision Health for a Better World.

Our Values Compassion — Dignity — Justice — Excellence — Integrity

Providence Seaside Hospital (PSH) is a critical-access hospital founded in 1934 and located in Seaside, Oregon. The hospital has 25 licensed beds, a staff of more than 350, and employs more than 100 providers. Major programs and services offered to the community include the following: Primary care and specialty care, general surgery, diagnostic imaging, orthopedics, cardiology, oncology, urology, and 24/7 emergency care.

Our Commitment to Community

PSH dedicates resources to improve the health and quality of life for the communities and people we serve. For more information, refer to the Annual Report to our Communities and Community Health Needs Assessments/Community Health Improvement Plans.

Equity Practices in the CHIP

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.

Through literature and our community partners, we recognize that long-standing systemic inequities exist and that they can lead to health disparities. 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. The purpose of the CHIP is to respond to and address the needs identified by our communities. The CHIP strategies are based on the CHNA data to meet the highest level of need, which is ultimately in service to all our community members.

Financial Assistance Program

Our mission is to improve the health and well-being of each person we serve, regardless of ability to pay. We believe no one should delay seeking needed medical care because they lack health insurance. Providence has a Financial Assistance Program (FAP) that provides free or discounted services to eligible patients.

COMMUNITY HEALTH NEEDS ASSESSMENT PROCESS AND RESULTS

Our Community and the Community Health Needs Assessment Process and Results

Providence Seaside Hospital (PSH) conducted a 2025 Community Health Needs Assessment (CHNA) in partnership with Clatsop County Public Health and Columbia Memorial Hospital. The CHNA service area is the entirety of Clatsop County.

The CHNA is an opportunity for Providence hospitals to engage the community every three years with the goal of better understanding strengths and needs. Through a mixed-methods approach, using quantitative and qualitative data, the CHNA process relies on several sources of information: state and national public health data, qualitative data from key informant interviews and community listening sessions, hospital utilization data, and more. An oversight committee reviews all the data from the CHNA and identifies priority needs to address in the 2026-2028 Community Health Improvement Plan (CHIP).

More information on the CHNA process and findings can be found in the 2025 PSH CHNA.

Significant Community Health Needs Prioritized

PSH will focus on the following priority areas identified in the 2025 CHNA to best leverage their capacity, expertise, and resources for greatest impact. The priorities from the CHNA have been refined to better address the identified need and opportunity.

ACCESS TO CARE AND SERVICES: PRIMARY CARE AND PREVENTATIVE HEALTH

Access to care and services refers to the ability of individuals to obtain timely, affordable, culturally responsive, and linguistically appropriate health care. This includes having available providers and services, insurance or financial assistance, transportation, and the knowledge and support needed to navigate the health system—particularly for populations facing economic, cultural, or systemic barriers.

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Poor mental health and substance use disorders affect emotional, psychological, and social well-being and influence how individuals manage stress, relate to others, and make healthy choices. Limited access to prevention, early intervention, and treatment services contributes to poor health outcomes and disproportionately impacts vulnerable and underserved populations.

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

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

Needs Beyond the Hospital's Service Program

Providence is committed to improving the health of the communities we serve and investing in spaces where we can have the greatest impact. By leveraging our expertise and core competencies as health care providers, we can meaningfully contribute to high-impact solutions for expanded access to high-quality, equitable health care.

The following community health needs identified in the 2025 CHNA will not be addressed and an explanation is provided below:

- Economic Security: PSH will not directly address this need due to resource constraints and other facilities or organizations in the community are addressing them.

COMMUNITY HEALTH IMPROVEMENT PLAN

Summary of Community Health Improvement Planning Process

The 2025 CHNA completed for Providence Seaside Hospital (PSH) was the basis for the 2026-2028 CHIP. The assessment, which was completed as part of a collaborative, identified community needs, assets, resources, and strategies to improve health for Clatsop County residents.

The service area advisory council evaluated the needs and supporting data identified in the 2025 CHNA and selected the following areas of focus for PSH: Mental health and substance use disorders, health related social needs, economic security, and access to care and services. Prioritizing these needs allows PSH to focus on leveraging their strengths, expertise, and resources for greatest impact.

Multi-disciplinary professionals spanning clinical care, community health, and behavioral health provided input as part of the 2026-2028 CHIP to identify strategies, programs, and initiatives that respond to the prioritized needs. Individuals bring their deep knowledge of the prioritized needs, clinical and community based best practices, and Clatsop County communities.

Based on dialogue and feedback from internal subject matter experts, a set of core CHIP strategies were presented to the service area advisory council for additional review, feedback, and alignment.

In March 2026, the North Coast Service Area Advisory Council adopted the 2026-2028 CHIP, including the following strategies for addressing the priority community needs.

Addressing the Needs of the Community: 2026- 2028 Key Community Benefit Initiatives and Evaluation Plan

The following strategies for addressing priority needs consider how communities change over time, as well as their existing strengths and capacity. They were intentionally selected with the understanding that some community health needs may evolve during the duration of the CHIP, and that subsequent implementation strategies may require adjustment based on resources and to best meet the needs of our communities. While our response to community needs must remain flexible to changing dynamics, our commitment to improving the health of our communities is unwavering.

COMMUNITY NEED ADDRESSED #1: ACCESS TO CARE AND SERVICES: PRIMARY CARE AND PREVENTATIVE HEALTH

Population Served

In line with our mission, we are focused on underserved populations, including those with low incomes, uninsured, and underinsured. Within these populations, we aim to serve people experiencing barriers to timely and affordable health care, particularly people living in rural areas, who lack a usual source of care, or face cultural, linguistic, or systemic barriers.

Long-Term Goal(s)/ Vision

Increase equitable access to timely, affordable, culturally responsive, and linguistically appropriate primary health care including preventative health measures.

Table 1. Strategies and Measures for Addressing Access to Care and Services: Primary Care and Preventative Health

Identified need: ACCESS TO CARE AND SERVICES: PRIMARY CARE AND PREVENTATIVE HEALTH				
Strategy	**Population Served**	**Strategy Measure(s)**	**2025 Baseline**	**2028 Target**
Diabetes Prevention Program: An evidence-based lifestyle change program supporting people with prediabetes or at high risk for type 2 diabetes in making sustainable nutrition, physical activity, and behavior changes to prevent or delay the onset of type 2 diabetes and improve overall health	People living with pre-diabetes in Clatsop County	Number of people enrolled in program	N/A	Enroll at least 2 people in program
Mobile Dental Clinics: Partner with Medical Teams International to provide free emergency dental services via mobile dental clinics to help close gaps in access to care for underserved communities	Under-insured or uninsured community members experiencing oral pain and in need of dental services	Number of people served in Clatsop County	171 people served	Maintain Baseline (171 people served)
Patient Support Program: Partner with Project Access NOW to reduce discharge barriers and support safe, timely hospital discharges	Low-income patients discharged from PSH	Number of patients receiving resources	204 patients receiving resources	Maintain baseline (204 patients receiving resources)

Community Benefit Grants: Partner with community-based organizations in Clatsop County to improve access to care and services, with a focus on expanding equitable, culturally responsive, community-driven prevention efforts and strengthening sustainable, locally led solutions	Underserved Clatsop County community members in need of medical care	Number of community benefit grants supporting community-based organizations	N/A	1-3 grants to community-based organizations

Community and Research Informed Resources

- Improving Access to Oral Health Care for Vulnerable and Underserved Populations | Healthy People 2030
- Medicare Diabetes Prevention Program Expanded Model - Healthy People 2030 | odphp.health.gov

Resource Commitment

PSH will commit staff time, cash and in-kind donations to support these strategies.

Key Community Partners

PSH works with many community partners across Clatsop County to help address needs for those who are underserved. Examples of the partners we work with as part of our commitment to addressing access to care and services, include Medical Teams International, Project Access NOW, Clatsop Community Action, and Hat Creek Consulting LLC.

COMMUNITY NEED ADDRESSED #2: HEALTH RELATED SOCIAL NEED: HOUSING STABILITY

Population Served

In line with our mission, we are focused on underserved populations, including those with low incomes, uninsured, and underinsured. Within these populations, we aim to serve people experiencing housing instability and at risk of homelessness.

Long-Term Goal(s)/ Vision

A coordinated and holistic community approach to providing supportive services for people experiencing housing instability.

Table 2. Strategies and Measures for Addressing Health Related Social Needs: Housing Stability

Identified need: HEALTH RELATED SOCIAL NEEDS: HOUSING STABILITY				
Strategy	**Population Served**	**Strategy Measure(s)**	**2025 Baseline**	**2028 Target**
Collective Impact Health Specialist: Providence partners with Hat Creek Consulting to support the Seaside community by providing technical assistance to community-based organizations (project strategy, design, and grant writing) to strengthen cross-sector collaboration, identify shared priorities, and secure coordinated funding to improve community health outcomes	Community members experiencing housing instability	Number of projects supported through strategy and design Number of grant applications submitted Number of grants received by community-based organizations addressing housing instability	2 projects supported 2 grant applications submitted N/A	4 projects supported 4 grant applications submitted 3 grants received
Community Resource Desk Program: Providence partners with ACCESS to support individuals and families in navigating housing resources	Individuals and families experiencing housing instability	Number of clients and household members served Percentage of clients connected to resources	108 clients 191 household members 61% clients connected to resources	155 clients 274 household members 75% of clients connected to resources
Community Benefit Grants: Partner with community-based organizations (CBO) in addressing housing instability and homelessness in Washington County, with a focus on eviction prevention, housing stabilization, and access to supportive services for populations disproportionately impacted by housing cost burden and economic insecurity	Clatsop County community members experiencing housing instability	Number of community benefit grants supporting community based organizations	N/A	1-3 grants (2026-2028)

Community and Research Informed Resources

- Patient Navigators | County Health Rankings & Roadmaps
- Understanding the Value of Backbone Organizations in Collective Impact - FSG
- When Collective Impact has an Impact: A Cross-Site Study of 25 Collective Impact Initiatives - Collective Impact Forum

Resource Commitment

PSH will commit staff time, cash and in-kind donations to support these strategies.

Key Community Partners

PSH works with many community partners across Clatsop County to help address needs for those who are underserved. Examples of the partners we work with as part of our commitment to addressing housing stability include Clatsop Community Action, Project Access NOW, and Hat Creek Consulting LLC.

COMMUNITY NEED ADDRESSED #3: HEALTH RELATED SOCIAL NEEDS: TRANSPORTATION

Population Served

In line with our mission, we are focused on underserved populations, including those with low incomes, uninsured, and underinsured. Within these populations, we aim to serve people facing geographic, economic, mobility, or systemic barriers.

Long-Term Goal(s)/ Vision

Increase equitable access to reliable, affordable, and accessible transportation so community members can obtain timely health care, supportive services, and basic needs.

Table 3. Strategies and Measures for Addressing Health Related Social Needs: Transportation

Identified need: HEALTH RELATED SOCIAL NEEDS: TRANSPORTATION				
Strategy	**Population Served**	**Strategy Measure(s)**	**2025 Baseline**	**2028 Target**
Collective Impact Health Specialist: Providence partners with Hat Creek Consulting to support the Seaside community by providing technical assistance to community-based	Community members experiencing transportation barriers	Number of projects supported through strategy and design Number of grant applications submitted Number of grants received by	2 projects 2 grant applications submitted N/A	4 projects 4 grant applications submitted

organizations (project strategy, design, and grant writing) to strengthen cross-sector collaboration, identify shared priorities, and secure coordinated funding to improve community health outcomes		community-based organizations addressing transportation barriers		3 grants received
Community Resource Desk Program: Providence partners with ACCESS to support individuals and families to navigate transportation resources	Individuals and families with unmet social needs	Number of clients and household members provided transportation resources Percent of clients connected to resources	86 clients 122 household members 86% of clients connected to resources	125 clients 190 household members 90% of clients connected to resources
Community Connections Medical & Wellness Program: Free transportation for low-income community members for the following needs: medical care, personal care, food (grocery store or food pantry), legal support, etc.	Low-income community members with transportation barriers	Number of patients served Number of rides provided	137 patients served 3,293 rides provided	342 patients served 8,232 rides provided
Community Benefit Grant Making: Partner with community-based organizations (CBO) in Clatsop County addressing transportation barriers	Low-income Clatsop County community members with transportation barriers	Number of community benefit grants supporting transportation initiatives	N/A	1-3 grants (2026-2028)

Community and Research Informed Resources

- Carpool & Rideshare programs | County Health Rankings & Roadmaps
- Patient Navigators | County Health Rankings & Roadmaps
- Understanding the Value of Backbone Organizations in Collective Impact - FSG

- [When Collective Impact has an Impact: A Cross-Site Study of 25 Collective Impact Initiatives - Collective Impact Forum]

Resource Commitment

PSH will commit staff time, cash and in-kind donations to support these strategies.

Key Community Partners

PSH works with many community partners across Clatsop County to help address needs for those who are underserved. Examples of the partners we work with as part of our commitment to addressing transportation include Sunset Empire Transportation District, Clatsop Community Action, and Hat Creek Consulting LLC.

COMMUNITY NEED ADDRESSED #4: MENTAL HEALTH AND SUBSTANCE USE DISORDERS

Population Served

In line with our mission, we are focused on underserved populations, including those with low incomes, uninsured, and underinsured. Within these populations, we aim to serve people in need of mental health therapy or counseling; people experiencing mental health crisis; youth in need of mental health support.

Long-Term Goal(s)/ Vision

To ensure equitable access to high-quality, culturally responsive, and linguistically appropriate behavioral health services, especially for populations with low incomes.

Table 4. Strategies and Measures for Addressing Mental Health and Substance Use Disorders

Identified need: MENTAL HEALTH AND SUBSTANCE USE DISORDERS				
Strategy	**Population Served**	**Strategy Measure(s)**	**2025 Baseline**	**2028 Target**
Providence Assessment, Intake, and Referral (AIR) Program: Assesses and connects individuals to the appropriate level of behavioral health care	Individuals in need of behavioral health care	Number of referrals received for Providence Oregon behavioral health services	8,263 referrals received	9,089 referrals received
Work2BeWell (W2BW) Program: Youth-driven mental health resources, curriculum, advocacy opportunities, and peer	Oregon Youth (11-18) and Oregon Young Adults (18-22)	Number of middle and high school W2BW clubs	12 W2BW Clubs	24 W2BW Clubs

support, designed to empower teens and their communities to improve mental wellness and reduce stigma		Number of student-centered presentations	10 student-centered presentations	22 student-centered presentations
Community Benefit Grants: Partner with community-based organizations (CBO) addressing mental health and substance use disorders in Clatsop County, with a focus on expanding equitable access to culturally responsive, community-driven prevention, treatment, and recovery supports while building sustainable, locally led behavioral health interventions	Underserved Clatsop County community members in need of mental health/SUD support	Number of community benefit grants supporting CBOs	2 community benefit grants supporting CBOs	1-3 community benefit grants supporting CBOs (2026-2028)

Community and Research Informed Resources

- Youth leadership programs | County Health Rankings & Roadmaps
- The effectiveness of peer support for individuals with mental illness: systematic review and meta-analysis | Psychological Medicine | Cambridge Core
- Recommendation: Depression and Suicide Risk in Adults: Screening | United States Preventive Services Taskforce

Resource Commitment

PHRMH will commit staff time, supplies and equipment, cash and in-kind donations to support these strategies.

Key Community Partners

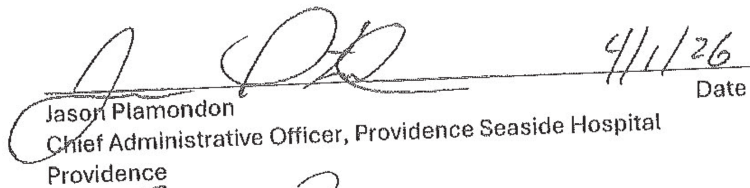
PHRMH works with many community partners across Hood River County to help address needs for those who are underserved. Examples of the partners we work with as part of our commitment to addressing mental health/substance use disorders include the Columbia Gorge Health Council, Next Door, Inc., and CultureSeed.

Clatsop County Rural Health Coalition

The Clatsop County Rural Health Coalition works to improve community health in Clatsop County by bringing together healthcare providers, public health, and community-based organizations to collaborate on shared goals addressing healthcare needs and social drivers of health. The coalition strengthens coordination, communication, and use of local resources, building on partnerships formed during the COVID19 response and focusing on priorities identified through the most recent Community Health Needs Assessment. As a member of the Clatsop County Rural Health Coalition, Providence Seaside will also be collaborating with the coalition on priorities found in Appendix 1.

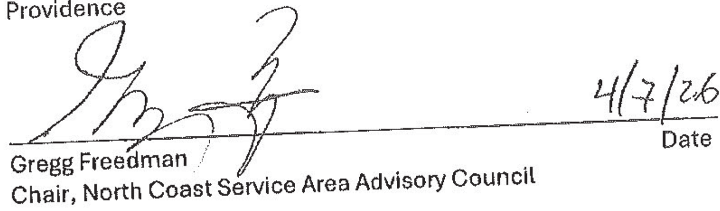
2026- 2028 CHIP Governance Approval

This Community Health Improvement Plan was adopted by the North Coast Service Area Advisory Council of the hospital on March 25, 2026. The final report was made widely available by May 15, 2026.



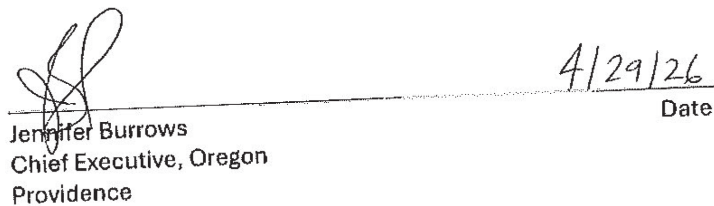
4/1/26
Date

Jason Plamondon
Chief Administrative Officer, Providence Seaside Hospital
Providence



4/7/26
Date

Gregg Freedman
Chair, North Coast Service Area Advisory Council



4/29/26
Date

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Contact CHI@providence.org to provide feedback/comments about this CHIP or to request a free printed copy.

APPENDIX 1

2026 PSH Rural Health Coalition CHIP

Community Health Improvement Plan (CHIP)

Clatsop County Rural Health Coalition
Our Coalition would like to emphasize that health equity and Limited English Proficiency (LEP) considerations are embedded across all priority areas.

Priority Area 1: Improve Access to Primary Care and Behavioral Health Services

Goal:
Increase equitable access to primary care, public health services, and mental and behavioral health resources to improve overall community health outcomes.

Objectives & Strategies:

1.1 Expand Primary Care Access

- Increase the total number of primary care visits within a 12-month period through expanded capacity, improved referral pathways, and outreach to underserved populations.
- Identify and address barriers related to language access, transportation, workforce availability, and health literacy.

1.2 Increase Community Awareness of Public Health Resources

- Provide culturally and linguistically appropriate education to community members regarding available services, including reproductive health, vaccination programs, SUD/AUD services, WIC, and food insecurity resources.
- Implement education sessions for both healthcare providers and community stakeholders to improve coordination and referral processes.

1.3 Strengthen Mental and Behavioral Health Access

- Expand access to mental health and substance use disorder treatment through coordinated care models and cross-sector partnerships.
- Improve screening, referral, and follow-up processes across Coalition partner organizations.

Priority Area 2: Increase Access to Preventative Care and Early Detection

Goal:
Improve utilization of preventative services and early detection strategies to reduce preventable disease burden and health disparities.

Objectives & Strategies:

2.1 Improve Immunization Rates

- Increase childhood vaccination rates using targeted outreach, community education, and coordinated vaccination events. (Establish and monitor baseline vaccination rates for Clatsop County (2025 data) and track annual progress.)

2.2 Expand Cancer Prevention and Screening

- Implement coordinated, community-wide cancer prevention initiatives focused on education and early detection.
- Increase screening rates for breast, colorectal, and prostate cancer through provider engagement, community outreach, and reduced access barriers.

Priority Area 3: Address Social Drivers of Health

Goal:
Improve health outcomes by addressing key social drivers that influence access to care and overall wellbeing.

Objectives & Strategies:

3.1 Reduce Food Insecurity

- Strengthening collaboration with Coalition Members and community partners such as Clatsop Community Action (CCA) Food Bank and the Public Health Department (WIC). Measure: (Increase enrollment of eligible community members in WIC and other nutrition assistance programs.)
- Utilize SDOH screening tools to track patients who screen positive for food insecurity and measure successful connections to community resources. (Improve percent of patients who screen positive who are being connected with resources.)

3.2 Improve Transportation Access

- Collect and analyze data related to transportation barriers impacting access to healthcare and social services.
- Develop collaborative strategies with Coalition partners to address identified transportation gaps.

3.2 Expand Childcare Access

- Support initiatives that increase childcare availability for children ages 0–2. (Measure: Collaborate with regional partners to reduce Clatsop County's designation as a childcare desert as defined by the State of Oregon.)

Cross-Cutting Principles (Applied Across All Priority Areas)

- Advance health equity through culturally and linguistically responsive strategies.
- Integrate Limited English Proficiency (LEP) considerations into outreach, service delivery, and evaluation.
- Utilize shared data and performance metrics to guide continuous improvement that will be shared with our community.
- Strengthen cross-sector partnerships to maximize community impact.