

2026-  
2028

# COMMUNITY HEALTH IMPROVEMENT PLAN



## Providence St. Vincent Medical Center

Portland, Oregon

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



# CONTENTS

Executive Summary.....	3
Providence St. Vincent Medical Center Community Health Improvement Plan Priorities.....	3
Introduction .....	5
Who We Are.....	5
Our Commitment to Community.....	5
Financial Assistance Program.....	6
Community Health Needs Assessment Process and Results .....	7
Our Community and the Community Health Needs Assessment Process and Results .....	7
Significant Community Health Needs Prioritized.....	7
Needs Beyond the Hospital’s Service Program.....	8
Community Health Improvement Plan .....	9
Summary of Community Health Improvement Planning Process .....	9
Addressing the Needs of the Community: 2026- 2028 Key Community Benefit Initiatives and Evaluation Plan.....	9
2026- 2028 CHIP Governance Approval.....	18

# EXECUTIVE SUMMARY

Providence continues its Mission of service in Washington County through Providence St. Vincent Medical Center (PSVMC). The following Community Health Improvement Plan (CHIP) outlines our strategic response to addressing the prioritized needs from the 2025 Community Health Needs Assessment (CHNA).

PSVMC 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 PSVMC 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 St. Vincent Medical Center 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, PSVMC 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.

### HEALTH RELATED SOCIAL NEEDS: FOOD SECURITY

Food security is the ability for all people to consistently access affordable, nutritious, and culturally appropriate food. Food insecurity undermines physical and mental health and disproportionately affects low-income households, seniors, families with children, and historically marginalized communities.

### HEALTH RELATED SOCIAL NEEDS: HOUSING STABILITY

Housing stability refers to having safe, affordable, and consistent housing. Housing instability, including homelessness, frequent moves, or cost burdened housing, is closely linked to poor physical and mental health outcomes and disproportionately affects low-income and vulnerable populations.

## MENTAL HEALTH/SUBSTANCE USE DISORDERS: ACCESS AND CAPACITY

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.

### ACCESS TO CARE AND SERVICES

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.

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 St. Vincent Medical Center (PSVMC) is a tertiary care hospital founded in 1875 and located in Portland, Oregon. The hospital has 523 licensed beds, a staff of more than 4,400, and professional relationships with approximately 500 local physicians. Major programs and services offered to the community include the following: Primary and specialty care, a birth center with family suites, general and specialty surgery, radiology, diagnostic imaging, pathology, and 24/7 emergency medicine. PSVMC is renowned for its many centers of excellence, including Providence Heart Institute, Providence Neuroscience Institute and Providence Center for Health Care Ethics, among others. Its maternity services are also highly regarded.

## Our Commitment to Community

PSVMC 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 St. Vincent Medical Center (PSVMC) conducted a 2025 Community Health Needs Assessment (CHNA) in partnership with the Healthy Columbia Willamette Collaborative including the following organizations: CareOregon, Clackamas County Health, Housing and Human Services, Health Share of Oregon, Hillsboro Medical Center, Kaiser Permanente, Legacy Health, Multnomah County Health Department, Oregon Health & Science University, Portland Adventist Medical Center, Trillium Community Health Plan, and Washington County Public Health. The CHNA service area is the entirety of Clackamas, Multnomah, and Washington counties in Oregon and Clark County in Washington state.

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 PSVMC CHNA](#).

## Significant Community Health Needs Prioritized

PSVMC 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.

### HEALTH RELATED SOCIAL NEEDS: FOOD SECURITY

Food security is the ability for all people to consistently access affordable, nutritious, and culturally appropriate food. Food insecurity undermines physical and mental health and disproportionately affects low-income households, seniors, families with children, and historically marginalized communities.

### HEALTH RELATED SOCIAL NEEDS: HOUSING STABILITY

Housing stability refers to having safe, affordable, and consistent housing. Housing instability, including homelessness, frequent moves, or cost-burdened housing, is closely linked to poor physical and mental health outcomes and disproportionately affects low-income and vulnerable populations.

### MENTAL HEALTH/SUBSTANCE USE DISORDERS

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.

## ACCESS TO CARE AND SERVICES

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.

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: PSVMC 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 Community Health Needs Assessment (CHNA) completed for Providence St. Vincent Medical Center was the basis for the 2026-2028 CHIP. The assessment, which was completed as part of the Healthy Columbia Willamette Collaborative, identified community needs, assets, resources, and strategies to improve health for residents of Clackamas, Multnomah, and Washington counties in Oregon and Clark County in Washington state.

The service area advisory council evaluated the needs and supporting data identified in the 2025 CHNA and selected the following areas of focus for PSVMC: Mental health and substance use disorders, health related social needs, economic security, and access to care and services. Prioritizing these needs allows PSVMC 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 the Washington County community.

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 Washington County 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: HEALTH RELATED SOCIAL NEEDS – FOOD SECURITY

#### *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 community members experiencing food and nutrition insecurity.

#### *Long-Term Goal(s)/ Vision*

To increase the percentage of community members who have access to affordable, nutritious, culturally appropriate, and easily accessible food.

**Table 1. Strategies and Measures for Addressing Health Related Social Needs: Food Security**

Identified need: HEALTH RELATED SOCIAL NEEDS: FOOD SECURITY				
Strategy	Population Served	Strategy Measure(s)	2025 Baseline	2028 Target
<p><b>Community Resource Desk Program:</b> Partner with Impact Northwest supporting individuals and families in navigating food resources</p>	Individuals and families with unmet social needs	<p># of clients and household members provided food resources</p> <p>% resource connection rate</p>	<p>361 clients</p> <p>867 household members</p> <p>60% of clients connected to resources</p>	<p>400 clients</p> <p>1,000 household members</p> <p>75% of clients connected to resources</p>
<p><b>Patient Support Program:</b> Partner with Project Access NOW to facilitate safe and timely discharges while addressing health related- social needs</p>	Low-income patients discharged from PSVMC experiencing food insecurity	Number of patients receiving food resources	289 patients receiving food resources	364 patients receiving food resources
<p><b>Transition Project - Doreen’s Place:</b> PSVMC employees prepare and deliver a meal twice monthly for residents</p>	Community members living in a 90-bed, short-term residential program for men	Number of meals donated per year	240 meals donated	Maintain baseline (240 meals donated)
<p><b>Community Benefit Grants:</b> Partner with community-based- organizations (CBO) addressing food security in Washington County, with a focus on expanding equitable access to healthy and culturally responsive food</p>	Washington County community members experiencing food/nutrition insecurity	Number of community benefit grants supporting CBO between 2026-2028	N/A	1-3 grants (2026-2028)

*Community and Research Informed Resources*

- [Groundbreaking Study By WellSky® Foundation And Meals on Wheels America Reveals Meal Delivery Services Significantly Reduce Senior Hospitalizations](#)
- [Patient Navigators | County Health Rankings & Roadmaps](#)

*Resource Commitment*

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

*Key Community Partners*

PSVMC works with many community partners across Washington County to help address needs for those who are underserved. Examples of the partners we work with as part of our commitment to addressing food security, include Meals on Wheels People and Impact NW.

**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**

<b>Identified need: HEALTH RELATED SOCIAL NEEDS: HOUSING STABILITY</b>				
<b>Strategy</b>	<b>Population Served</b>	<b>Strategy Measure(s)</b>	<b>2025 Baseline</b>	<b>2028 Target</b>
<p><b>Project Homeless Connect:</b> Take part in community-wide, one-day events in Washington County, Oregon provide coordinated health, housing, employment, and social services in a welcoming, low barrier setting</p>	<p>Low-income individuals and families experiencing homelessness</p>	<p>Number of community events supported per year</p>	<p>4 community events</p>	<p>Maintain baseline (4 community events)</p>

<p><b>Recuperative Care Program (RCP):</b> Partner with Central City Concern to provide access to medical respite in Multnomah, Clackamas, and Washington Counties</p>	<p>Unhoused patients discharging from hospital inpatient units who are too medically fragile to discharge to shelter or unsheltered</p>	<p>Number of patients placed at RCP</p>	<p>25 patients placed at RCP</p>	<p>30-35 patients placed at RCP</p>
<p><b>Community Resource Desk Program:</b> Partner with Impact NW supporting individuals and families to navigate housing resources</p>	<p>Individuals and families with unmet social needs</p>	<p>Number of clients and household members</p> <p>Percentage resource connection rate</p>	<p>338 clients</p> <p>789 household members</p> <p>43% of clients connected with resources</p>	<p>412 clients</p> <p>960 household members</p> <p>60% of clients connected with resources</p>
<p><b>Washington County LATS (Low Acuity Transitional Support):</b> Partnering with Virginia Garcia to provide short-term housing, case management, and on-site medical care</p>	<p>Unhoused patients discharging from PSVMC who are too medically fragile to discharge to shelter or unsheltered</p>	<p>Number of patients receiving housing services post hospital discharge</p>	<p>25 patients received housing services</p>	<p>30 patients receiving housing services</p>
<p><b>Community Benefit Grants:</b> Partner with community-based organizations (CBO) 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</p>	<p>Washington County community members experiencing housing instability</p>	<p>Number of community benefit grants supporting CBOs</p>	<p>N/A</p>	<p>1-3 grants</p>

*Community and Research Informed Resources*

- [Patient Navigators | County Health Rankings & Roadmaps](#)
- [How a Medical Respite Care Program Offers a Pathway to Health and Housing for People Experiencing Homelessness - Center for Health Care Strategies](#)

*Resource Commitment*

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

*Key Community Partners*

PSVMC works with many community partners across Washington 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 Impact NW, Washington County Housing Department, and Virginia Garcia.

**COMMUNITY NEED ADDRESSED #3: MENTAL HEALTH AND SUBSTANCE USE DISORDERS: ACCESS AND CAPACITY**

*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 3. Strategies and Measures for Addressing Mental Health and Substance Use Disorders: Access and Capacity**

Identified need: MENTAL HEALTH AND SUBSTANCE USE DISORDERS- ACCESS AND CAPACITY				
Strategy	Population Served	Strategy Measure(s)	2025 Baseline	2028 Target
<b>Behavioral Health Intervention Team (BHIT):</b> Specially trained behavioral health social workers who proactively identify, assess, intervene, and discharge plan for a vulnerable patient population	Individuals admitted to a PPMC inpatient medical unit who have behavioral health-related concerns or challenges	Number of unique patients served	453 unique patients served	500 unique patients served

<p><b>BOB Folktime Program:</b> Peer support specialists serve patients who present to the emergency department in psychiatric distress</p>	<p>Adults presenting to the emergency department in psychiatric distress in need of mental health/substance abuse services</p>	<p>Number of unique patients served  Emergency department utilization % change</p>	<p>3 patients served  TBD</p>	<p>110 patients served  25% decrease from 2025</p>
<p><b>Providence Assessment, Intake, and Referral (AIR) Program:</b> Assesses and connects individuals to the appropriate level of behavioral health care</p>	<p>Individuals in need of behavioral health care</p>	<p>Number of referrals received for Providence Oregon region behavioral health services</p>	<p>8,263 referrals received</p>	<p>9,089 referrals received</p>
<p><b>Work2BeWell (W2BW) Program:</b> Youth-driven mental health resources, curriculum, advocacy opportunities, and peer support, designed to empower teens and their communities to improve mental wellness and reduce stigma</p>	<p>Oregon Youth (11-18) and Oregon Young Adults (18-22)</p>	<p>Number of middle and high school W2BW clubs  Number of student-centered presentations</p>	<p>12 W2BW Clubs  10 presentations</p>	<p>24 W2BW Clubs  22 presentations</p>
<p><b>Community Benefit Grants:</b> Partner with community-based organizations (CBO) addressing mental health and substance use disorders in Washington County, with a focus on expanding equitable access to culturally responsive, community driven prevention, treatment, and recovery support while building sustainable, locally led behavioral health interventions</p>	<p>Underserved Washington County community members in need of mental health/SUD support</p>	<p>Number of community benefit grants supporting CBOs</p>	<p>3 community benefit grants</p>	<p>1-3 community benefit grants</p>

### 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

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

### Key Community Partners

PSVMC works with many community partners across Washington 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 North by Northeast Community Health Center, Maybelle Center, and Rahab’s Sisters.

## COMMUNITY NEED ADDRESSED #4: ACCESS TO CARE AND SERVICES

### 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 4. Strategies and Measures for Addressing Access to Care and Services**

Identified need: ACCESS TO CARE AND SERVICES				
Strategy	Population Served	Strategy Measure(s)	2025 Baseline	2028 Target
<b>Diabetes Prevention Program:</b> An evidence-based lifestyle change program supporting people with	People living with pre-diabetes in Washington County	Number of people enrolled in program	33 people enrolled in program	37 people enrolled in program

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				
<p><b>Health Systems Access to Care Fund:</b> Providence participates in a collaborative funding model to strengthen health care safety net- capacity by providing grant funding to ten community supported- clinics, sustaining core operations and ensuring continued access</p>	Uninsured or under-insured people who face barriers to accessing healthcare	Yearly financial support	Provided funding to support ten safety net clinics	Continue to provide grant funding to ten safety net clinics
<p><b>Community Health Worker (CHW) Training:</b> Provided by Providence Promotores staff to train community members to support care navigation, health education, and resource connection</p>	Spanish speaking community members interested in becoming a state certified CHW	<p>Number CHW's trained</p> <p>Number of CHW's certified through the Oregon Health Authority (OHA)</p>	<p>20 CHWs</p> <p>TBD</p>	<p>60 CHWs (2027)</p> <p>50 CHWs (2027)</p>
<p><b>Smile Care Everywhere Program:</b> Partnering with Pacific University to provide free and accessible dental hygiene and dental therapy services</p>	Under or uninsured, low-income and Spanish-speaking community members in need of dental care	Number of community members provided dental care (Dental Hygiene and Dental Therapy)	<p>Dental Hygiene: 108</p> <p>Dental Therapy: 48</p>	<p>Dental Hygiene: Maintain baseline (108)</p> <p>Dental Therapy: Maintain baseline (48)</p>

<p><b>Mobile Vision Clinic:</b> Partner with Pacific University College of Optometry to provide free vision screenings, examinations, education, and prescription eye wear (if needed)</p>	<p>Under or uninsured, low-income and Spanish-speaking community members in need of vision care</p>	<p>Number of community members provided vision care</p>	<p>88 community members</p>	<p>Maintain Baseline (88 community members)</p>
<p><b>Mobile Dental Clinics:</b> 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</p>	<p>Under-insured or uninsured community members experiencing oral pain and in need of dental services</p>	<p>Number of people served in Washington County</p>	<p>176 people served</p>	<p>Maintain Baseline (176 people)</p>

*Community and Research Informed Resources*

- [Medicare Diabetes Prevention Program Expanded Model - Healthy People 2030 | odphp.health.gov](https://odphp.health.gov/medicare-diabetes-prevention-program-expanded-model)
- [Patient navigators | County Health Rankings & Roadmaps](#)
- [Improving Access to Oral Health Care for Vulnerable and Underserved Populations | Healthy People 2030](#)
- [Screening and Preventive Interventions for Oral Health in Adults - Healthy People 2030 | odphp.health.gov](https://odphp.health.gov/screening-and-preventive-interventions-for-oral-health-in-adults)

*Resource Commitment*


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

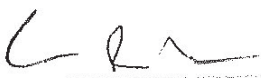
*Key Community Partners*

PSVMC works with many community partners across Washington County to help address needs for those who are underserved. An example of the partners we work with as part of our commitment to addressing access to care and services include Project Access NOW, Medical Teams International, and Pacific University.

## 2026- 2028 CHIP Governance Approval

This Community Health Improvement Plan was adopted by the Washington County Service Area Advisory Council of the hospital on March 31, 2026. The final report was made widely available by May 15, 2026.

  
4/2/26  
Date  
Dr. Raymond Moreno  
Chief Executive, Providence St. Vincent Medical Center &  
West Service Area

  
4/6/2026  
Date  
Eric Stark  
Oregon Community Ministry Board Chair

  
4/29/26  
Date  
Jennifer Burrows  
Chief Executive, Oregon  
Providence

### CHNA/CHIP Contact:

Sonya Kauffman Smith  
Manager, Community Health - Oregon  
Sonya.kauffmansmith@providence.org

Contact [CHI@providence.org](mailto:CHI@providence.org) to provide feedback/comments about this CHIP or to request a free printed copy.