

FY 2024 Community Benefit Narrative (January – December 2024)

[Santiam Hospital & Clinics Community Benefit weblink](#)

Introduction

Santiam Hospital & Clinics (SH&C) is a small, independent, trauma level IV, Type B acute-care community hospital in Stayton, Oregon. As the anchor institution for the Santiam Canyon region, SH&C serves over 50,000 patients each year and strives to be the healthcare provider at the heart of its communities. Our mission is to deliver high-quality care to those suffering illness, injury, or disability, while promoting overall community health through education, support, and medical services.

Covering roughly 200 square miles of rural Marion and Linn counties, SH&C has twelve clinics, including six federally designated Rural Health Clinics, and employs more than 600 staff members, among them 60 credentialed medical providers. As a non-governmental, not-for-profit, non-teaching facility, we do not receive federal hospital funding. Yet we continually invest in advanced equipment, specialized procedures, and student partnerships to broaden care options for our patients.

The geography and social landscape of the Santiam Canyon introduce unique health challenges:

- Long travel distances, mountain roads, and inclement weather (wildfires, wind events, ice storms) can delay access to care.
- Lower average income levels and localized pockets of high-risk behaviors raise the need for targeted outreach.

These factors drive our focused efforts to overcome barriers and improve health outcomes across the region.

Marion County (population ~347,000, 8% growth over ten years) and Linn County (~132,000, 11% growth) both exceed Oregon's average population density. Approximately one in six residents live with a disability, and the share of older adults is rising; trends that may constrain access to services such as healthy food, especially outside major towns.

Santiam Service Region	Population	Distance to Santiam Hospital
• Stayton:	8,244	
• Aumsville:	4,234	6 miles
• Sublimity:	2,967	2 miles
• Turner:	2,944	10 miles
• Mill City:	1,971	18 miles
• Scio:	956	8 miles
• Gates:	548	20 miles
• Mehama:	317	10 miles
• Detroit:	203	38 miles
• Idanha:	156	42 miles

Smaller, more isolated communities often face greater hurdles in obtaining healthcare and basic necessities.

SH&C’s patient population reflects the area’s diversity: about 17% are seniors, 8% veterans, 6% speak a language other than English (most commonly Spanish), and 14% identify as non-White. Marion County reports a higher share of Hispanic/Latino (28%) and Native Hawaiian/Pacific Islander residents than the state average, while Linn County remains predominantly white, non-Hispanic. Recognizing these demographic differences is essential for tailoring health and public-health initiatives to reduce disparities and meet each community’s need.

Community Health Needs Assessment (CHNA)

Key Findings

- Marion County: Ranked 10th healthiest out of 36 counties in Oregon.
- Linn County: Ranked 16th healthiest out of 35 counties in Oregon.

The Community Health Assessment (CHA) is a core component of NACCHO’s MAPP framework (Mobilizing for Action through Planning and Partnerships), an evidence-based model for gathering local health data and pinpointing priorities in the Community Health Improvement Plan (CHIP).

Our region’s CHIP follows a five-year cycle, with CHA updates timed to meet hospitals’ three-year Community Health Needs Assessment (CHNA) reporting requirements. SH&C is part of both regional collaboratives, meeting monthly with CCOs- specifically PacificSource and IHN, public health agencies-specifically Marion, Polk, Linn, Benton and Lincoln counties, and other key representatives. A full description of the collaborative process can be found at:

[Marion County Health Collaborative & Linn County Health Collaborative.](#)

The CHA is updated through a combination of vital statistics, surveys, community town halls, input sessions, committee groups, and data assessments. Annually, each region works through the various phases of the MAPP process from building structure to conducting assessments, and compiling the data, resulting in a new regional CHA every five years.

The CHA process follows the MAPP framework, utilizing:

1. **Community Status Assessment:** Demographics, health status, disparities.
2. **Community Partner Assessment:** Roles and capacities of organizations.
3. **Community Health Survey:** Community thoughts on health concerns and needs.

Community Health Improvement Plan (CHIP)

By combining the three assessments, the CHA provides a comprehensive understanding of the community's health needs and informs the development of the 5-year CHIP, identifying key priorities, goals, and methods to address the priorities.

Regional CHIP

- [Marion-Polk Regional CHIP](#) (2021-2025)
- [LBL Regional CHIP](#) (2024-2028)

Santiam Hospital & Clinics Community Benefit Plan

Santiam Hospital & Clinics is committed to directing its community benefit efforts toward addressing the identified local priority areas, from the CHIP, through service, outreach, prevention, education, and social support.

Santiam Hospital & Clinics Priority Areas

1. **Access to Quality Care**
2. **Behavioral Health Supports**
3. **Inclusion, Diversity, Anti-Racism, and Equity**
4. **Substance Use Reduction**
5. **Access to Affordable Housing**

Community Benefit encompasses a wide range of activities, including:

- **Health Profession Education**

We contribute to the training and education of future healthcare professionals, supporting the workforce that serves our region. This includes a Pharmacy Residency program, host site for nursing and medical assistant students, and host site for CHW interns.

- **Internal Programs including Community Benefit Operations**

We host educational classes, coordinate health fairs and vaccine clinics, and operate an extensive service integration program to connect individuals with the social care and resources they need.

- **Subsidized Health Services, Charity Care and Unreimbursed Medicaid Costs**

Subsidized health services: Services such as Emergency Medical Ambulance Services and Santiam Medical Clinic in Mill City are maintained, despite operating at a financial loss, because they address an identified community need, and it is reasonable to conclude that if they were discontinued, no alternative provider would fill the gap.

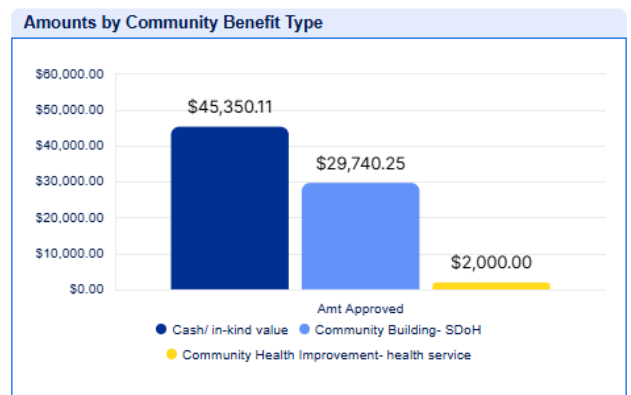
Charity care and unreimbursed care make up the largest portion of SH&C community benefit spending.

Community Support: Community Health Improvement, Community Building, Cash and In-Kind, Community Benefit Operations

We provide meeting space and financial contributions to local partners whose work aligns with our Community Health Improvement Plan (CHIP). Additionally, we support community-building activities that foster connection and well-being while addressing social determinants of health (SDoH).

Our community health services include hospital hosted events offering vaccines, sports physicals and screenings for diabetes and cholesterol.

SH&C has participated in approximately 30 community-building events aimed at improving health outcomes by addressing upstream social determinants of health. These events, hosted by community partners, respond to identified local needs. SH&C maintains a strong relationship with its service area, engaging in numerous



events to honor historical connections and cultivate new ones. While these activities may not always constitute direct healthcare services, they frequently address pressing SDoH concerns.

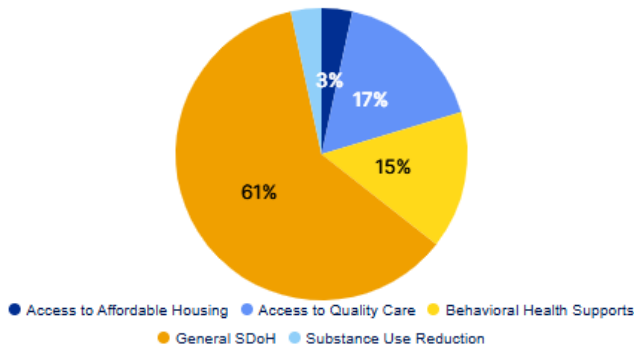
Cash and in-kind support requests may involve access to the Freres Auditorium or other meeting spaces for educational purposes, such as dementia education with the Alzheimer's Association or suicide prevention training with County Health and Human Services. Additional contributions include employee volunteer time at community events like fun runs, National Night Out for safety education, or hosting a table at local fairs and the Rodeo. SH&C also provides supplies to community-based organizations (CBOs) and schools for events and allocates funding for city or Chamber sponsored community programs.

Our community benefit operations encompass staffing and related expenses necessary to carry out these initiatives. Staff time includes time dedicated to supporting the Community Health Assessment (CHA) and CHIP efforts at a regional level.

Community Benefit Priorities:

SH&C remains committed to improving community health through targeted initiatives,

CHIP priority type



partnerships, and programs by addressing priority needs identified in the CHIP. SH&C does not have a formal granting process. We support our community through intentional charitable gifts to community partners directly addressing priority needs identified by the community health improvement plan. Addressing

identified health needs, contributes to the overall health and well-being of marginalized community members to enhance the well-being of the Santiam Canyon community.

Priority: Access to Quality Care

Community Health Improvement Services

To expand awareness, access, and medical services including utilization of Medicaid and Medicare, our Community Health Improvement Service deployed targeted enrollment and navigation support, educational events, integrated care referrals, chronic disease programs, and community-based vaccination and screening clinics.

- Certified OHP Assistance
 - Supported nearly 400 individuals with Medicaid applications and navigation
 - Achieved 56 new Oregon Health Plan enrollments in 2024

- Medicare Rodeo
 - Convened 50 service partners and 200 attendees for Medicare education, registration, and one-on-one navigation
- Integrated Care Referrals
 - Case management by Community Health Workers including facilitating approximately 1,000 referrals to community services. CHWs were grant funded.
- Wheels of Change Chronic Disease Program
 - Ten-month interdisciplinary curriculum led by pharmacists, providers, dieticians, BHCs, and CHWs
 - Served 25 low-income older adults, with monthly CHW check-ins addressing barriers
 - Measured progress through lifestyle assessments and clinical screenings
 - Grant-funded
- Community Vaccination Clinics
 - Two large community vaccination events
 - Delivered approximately 500 vaccinations
- Sports Physical Events
 - Three school-based clinics serving 350 student athletes
- Seasons for Safety & Health Fairs
 - Four events reaching 500 individuals
 - Collaborated with 12+ partners for each event to provide health insurance enrollment, mental health resources, housing support, substance use programs, and family services
 - Conducted car-seat checks and distributed free seats
 - Grant-funded
- SCOPE Testing Outreach
 - Approximately 200 respiratory and STI tests delivered via community events, vending machines, and partner sites
 - Grant-funded

Health Professions Education

To strengthen our regional health workforce pipeline, we partnered with educational programs across multiple disciplines:

- Pharmacy Residency
 - Hosted two pharmacy residents in 2024

- Nursing Clinical Training
 - Served as a clinical training site for nursing students
- Allied Health Internships
 - Precepted medical assistants and six CHW interns through formal training programs
- Student Job Shadowing
 - Coordinated observational rotations for Stayton and Cascade high school students

Community Building Activity

Our Community Building Activities focused on outreach and education, equipping residents with knowledge and resources without providing direct services:

- Participated in 30 community outreach events
 - Distributed educational materials such as health insurance options, mental health awareness, and substance use prevention, climate-health related information and emergency preparedness

Priority: Behavioral Health Supports

Community Health Improvement Service

SH&C provides direct Behavioral Health Clinician and Community Health Worker services.

CHIP progress: we are currently at about 50% of our staffing goals to staff six rural health clinics and the Emergency Department with BHCs and CHWs. Recruitment and retention challenges remain a barrier to full coverage in all six clinics.

- Behavioral health–related concerns, including counseling needs, account for roughly 25% of CHW referrals.

Measurable progress includes:

- Screenings PQH-9 and SBIRT
- Current screening rate: SBIRT= 33-49% with a screening goal of 66%

- Direct services include Dementia & Cognitive Care Coordination including partnering with the Alzheimer’s Association to deliver monthly public presentations on memory topics (average attendance: 10 older adults)

Health Professions Education

Hosted 4 mental health students

Community Building Activity

- SH&C staff participated in the annual Walk to End Alzheimer’s and the Alzheimer’s Association participated in two SH&C–hosted off-site outreach events.
- QPR Suicide Prevention Training: Partnered with Marion County to host two QPR (Question-Persuade-Refer) trainings at SH&C, each with about one dozen attendance.
- Participated in and promoted the “Life Is Better With You Here” outreach campaign
- Provided funding to First Responder Therapy Dogs, Garten Services youth mental health activities, and Willamette Valley First Responder Chaplains to support first responders’ well-being

Priority: Inclusion, Diversity, Anti-Racism, and Equity

Community Building Activity

At SH&C, we’ve deepened our commitment to equity and inclusion as the foundation of community health. Over the past year, we have continued inclusion training for all staff and reinforced equity principles through education modules, ensuring that cultural competence and social justice guide our interaction. By engaging directly with diverse community groups, we have strengthened mutual trust and fine-tuned our strategies to meet the nuanced needs of those we serve.

Simultaneously, we improve efforts to remove language barriers by utilizing digital interpretation services that deliver real-time support across dozens of languages. Recognizing that health extends beyond clinical care, we aim for warm-handoffs and leveraged the Unite Us platform to connect individuals with culturally specific community-based organizations, linking them to utility assistance programs, food banks, social services, and employment resources. These coordinated efforts have weaved a stronger safety net around our region.

Priority: Substance Use Reduction

SH&C is a smoke-free campus and aims to screen all patients for substance and tobacco use.

Substance Use Indicators: Marion & Linn Counties (2014 vs. 2024)

Indicator	Marion 2014	Marion 2024	Linn 2014	Linn 2024
Tobacco Use (%)	22.3%	19.1%	23.5%	20.4%
Adult Binge Drinking (%)	20.1%	18.3%	21.2%	18.9%

Indicator	Marion 2014	Marion 2024	Linn 2014	Linn 2024
Teen Alcohol Use (past 30 days)	27.4%	22.8%	28.6%	24.1%
Opioid Hospitalizations (/10k)	10.2	11.7	11.3	12.9
Opioid Deaths (/100k)	6.7	7.6	7.4	8.8
Substance Use (%)	19.6%	17.2%	21.1%	18.4%

- Positive Progress: Declines in tobacco use, alcohol consumption, and overall substance use signal healthier behaviors.
- Growing Concern: The uptick in opioid-related hospitalizations and deaths underscores the need for continued intervention.

Community Health Improvement Services

Our targeted interventions focus on direct clinical and preventive services to reduce mental health and substance-use burdens across the region.

- Contracted with Germane and Wise for psychiatric medication navigation services
- Conducted SBIRT screenings to identify and address substance-use issues
- Distributed Narcan kits to prevent opioid overdoses
- Tracked declines in tobacco use, alcohol consumption, and overall substance use via annual CHA updates
- Achieved warm handoffs in approximately 15% of CHW/BHC referrals to regional treatment programs

Community Building

By weaving partnerships, mentorship, and resource networks into our approach, we strengthen the network that creates lasting health improvements.

- Community Health Workers offering personalized connections to AA/Al-Anon, PRIME, and LEAD programs. Provide smoking cessation resources and promoted partner cessation programs
- Warm-handoff protocols ensuring seamless linkage to regional substance-use treatment providers
- Joint initiatives with partner behavioral-health programs such as county health and human services

Priority: Access to Affordable Housing

The relationship between housing and healthcare is critical in addressing homelessness. When individuals have stable housing, healthcare services are more effective and better delivered. Unfortunately, homelessness rates have been rising, including youth rates of homelessness, which can lead to inadequate healthcare, difficulties in accessing services, and a higher risk of chronic diseases. Additionally, individuals may develop or exacerbate behavioral health issues such as depression, alcoholism, or substance use disorders in unstable living situations. Santiam Hospital & Clinics supports housing goals through programs such as Disaster Services, Service Integration and the CHW program. Since 2020, Santiam Disaster Services have assisted in wildfire recovery in the form of rebuilding or relocating for safe housing.

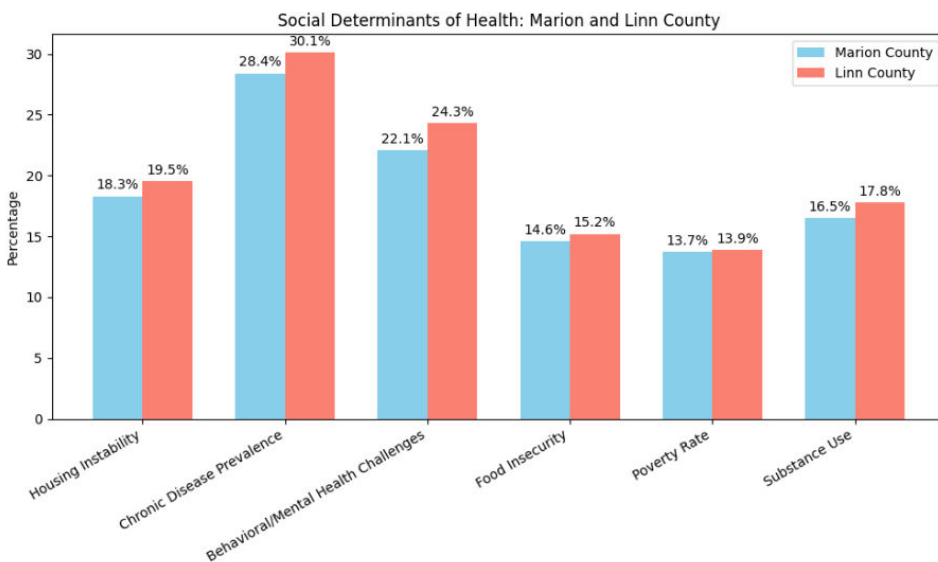
Community Building

In partnership with local agencies and task forces like the Mid-Willamette Valley Homeless Alliance, our Service Integration team and Community Health Workers have helped nearly 300 neighbors navigate housing vouchers, rent assistance, coordinated entry, daily supplies and counseling.

One in five CHW referrals addresses housing needs.

Disaster Case Managers have supported 1,221 families impacted by the 2020 Beachie Creek fires, guiding them through recovery plans that have already placed 330 households into stable housing, strengthening community resilience and reducing both homelessness and rent burden across our region.

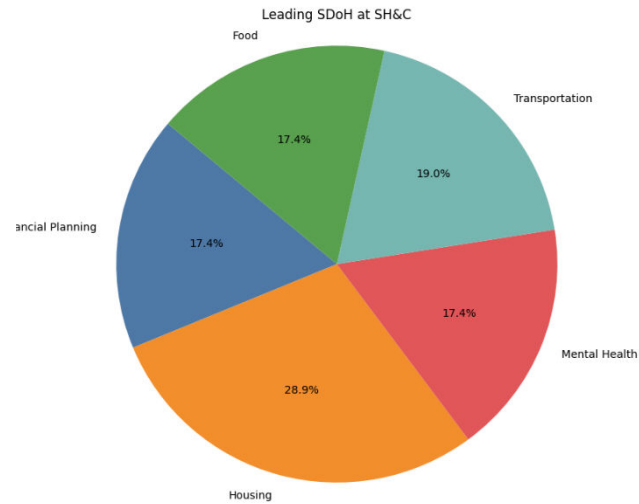
Social Determinants of Health (SDoH)



Social determinants of health (SDoH) refer to the economic, social, and environmental factors that influence an individual's health and well-being. These factors can have a significant impact on health outcomes. Addressing SDoH needs is key to addressing the identified community benefit priority areas.

SH&C Challenges

- High poverty rates with about 1 in 7 community members living below the poverty line for each Marion and Linn counties.
- Food insecurity, worsened by rural geography
- Limited access to affordable housing, with over half of renters paying high rent relative to income.
- Higher rates of chronic diseases, such as heart disease, stroke, and diabetes; compounded by limited access to healthcare and other essential services.
- Disparities in educational achievement, with lower rates of educational attainment among communities of color and females.



Efforts

Most requests to Santiam Hospital & Clinics (SH&C) are for support of organizations that address systemic or root causes of social determinants of health (SDoH). These include programs for early childhood education, parenting support,

Veteran services, school and city-sponsored family events, and safe, healthy activities for youth and families, such as fun runs.

Programs at SH&C that aim to address individual health-related social needs include Service Integration, Community Health Workers and Disaster Case Managers.

Service Integration Teams:

SH&C provides funding for Santiam Service Integration and has staff attend meetings regularly.

Community Building: SH&C contributed \$10,083 for four SI teams for the 2024-2025 school year.

Additionally, \$6,000 was provided for SI orchestrated warming center (5 days), a community partner education event and the Santiam Santa program which provided gifts and grocery cards to 65 under resourced families.

Since 2017, Santiam Hospital & Clinics has supported Service Integration Teams to connect community members with coordinated resources and support community building activities and SDoH needs. In 2024, four teams, aligned with local school district boundaries, met in person each month, bringing together more than 150 partner organizations.

The Service Integration Program's purpose is to facilitate collaboration among agencies and community groups to:

- Pool and share resources and event information
- Advocate for individual and family needs
- Match clearly defined needs with appropriate services, reducing duplication

Partners include school districts, faith groups, non-profits, social service agencies, local clubs, government entities, businesses, and community members. Each team adapts its focus to local priorities through monthly networking, resource-sharing, and problem-solving sessions. With community partners, funds are leveraged to provide rent assistance, utility bill assistance, access to food resources and health related services such as mobility scooters, lift-chairs, shower benches, etc.

In the 2023–2024 fiscal year (aligned with the school calendar), Service Integration Teams:

- Assisted 707 individuals with funding for social determinants of health needs
- Produced \$319,525 in total resource value, comprising \$19,895 in direct SIT funds and \$299,630 in leveraged contributions (cash and in-kind donations)

Community Health Worker (CHW) Program:

Throughout 2024, the hospital strengthened its approach to identifying social determinants of health by embedding a standardized social needs screener directly into the EPIC electronic medical record. When the screener flags a need, such as food insecurity, housing instability, or transportation barriers, providers place a referral for community health workers to step in to coordinate resources, make referrals, and provide one-on-one navigation support.

- In 2024, CHWs directly assisted 978 individuals with identified social needs.

Outreach:

Another key aspect of Community Health Worker (CHW) work is outreach. Santiam's CHW team is actively involved in partner-hosted events, where they offer services such as OHP Assister support, Cholestech diabetes and cholesterol education and

screening, car seat checks, helmet fittings, and health education on topics including mental health and suicide awareness, hot weather preparedness, and the “Be 2 Weeks Ready” emergency planning program. Through grant funds, community health improvement activities included hosting two health fairs, and a monthly chronic disease educational series. Community building activity included two “Seasons for Safety” events promoting bike and water safety.

Advocacy and Collaboration:

Community health workers don’t just work at the point of care; they also lend their expertise to regional collaboratives and committees. Community building through coalition-building ensures that community voices shape funding decisions and service delivery. In 2024, CHWs held active roles in:

- The regional Steering Committee
- The THW Alliance Network (Traditional Health Worker)
- The CHW Learning Collaborative
- The Oregon Community Health Workers Association (ORCHWA)

Disaster Case Management (DCM) program:

The DCM program was initiated in 2020 in response to the Beachie Creek wildfires. The disaster case managers and SIT’s network of collaborative community partners were able to disseminate information, case manage, and permanently re-house 13% of wildfire-displaced households within the first year, despite a lack of available permanent housing in the region. Santiam DCM assisted 400+ households and coordinated more than \$10.7 million in relief efforts, being recognized locally, and nationally, by After the Fire USA and FEMA for disaster management. Santiam DCMs are funded by outside sources and continue to work on SDoH needs of Santiam Canyon wildfire survivors. Their community building work is an integral part of Santiam community work.

Community Benefit Operations:

The Service Integration coordinator, and CHW leadership position are both community benefit costs to manage and oversee these programs, associated activities and activities related to the community needs assessment and implementation plans.

In conclusion, Santiam Hospital and Clinics continues to refine its community benefit program and aims to best meet the needs of the local community while aligning with the greater regional community health improvement plans.