2023 - 2025

COMMUNITY HEALTH IMPROVEMENT PLAN

Providence Medford Medical Center

Medford, Oregon

To provide feedback on this CHIP or obtain a printed copy free of charge, please email Joe Ichter at joseph.ichter@providence.org.

Photo courtesy of The Written Palette.

Providence

CONTENTS

EXECUTIVE SUMMARY

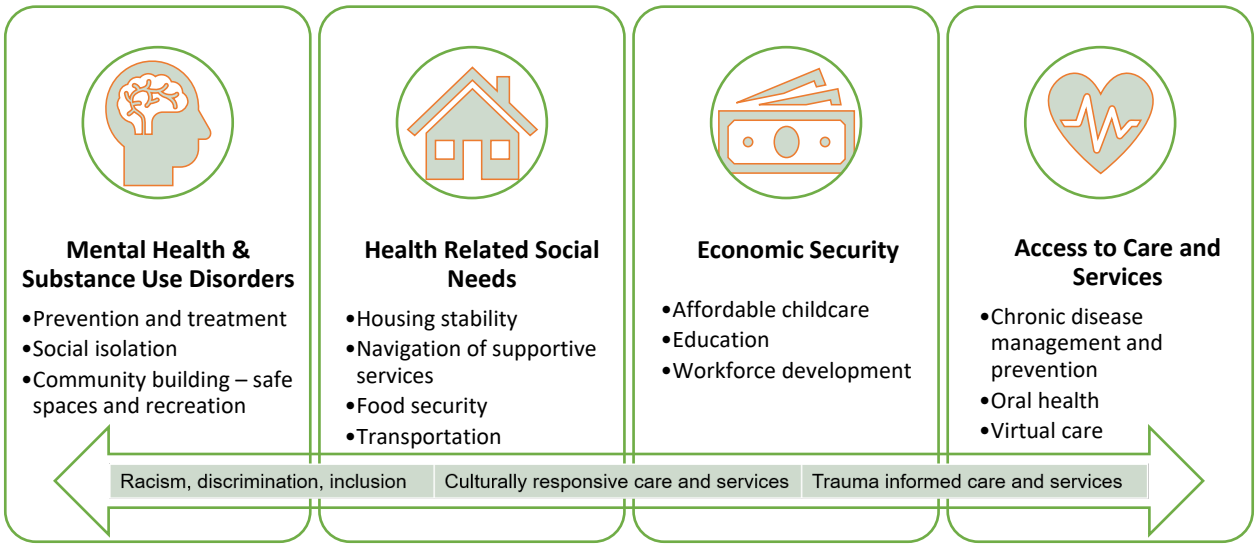
Providence continues its mission of service in Jackson County through Providence Medford Medical Center (PMMC). PMMC is an acute-care hospital with 120-149 licensed beds, founded in 1911 and located in Medford, Oregon. The hospital's service area is the entirety of Jackson County, including 223,734 people.

PMMC 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. During 2021, the hospital provided $64,255,474 million in community benefit in response to unmet needs.

The Community Health Needs Assessment (CHNA) is an opportunity for PMMC 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, interviews with key stakeholders, listening sessions with community members, data from a community survey and hospital utilization data.

Providence Medford Medical Center Community Health Improvement Plan Priorities

As a result of the findings of our 2022 CHNA and through a prioritization process aligned with our Mission, resources and strategic plan, Providence Oregon will focus on the following bolded pillars for its 2023-2025 community benefits efforts:



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 Medford Medical Center (PMMC) is an acute-care hospital founded in 1911 and located in Medford, Oregon. The hospital has 168 licensed beds, a staff of 1,085, and professional relationships with approximately 350 local physicians. Services offered include emergency services, stroke care, cardiac and vascular care, birth center, total joint replacement and spine health programs, robotic surgery, pain management services and one of the most comprehensive rehabilitation programs in the region.

Our Commitment to Community

PMMC dedicates resources to improve the health and quality of life for the communities we serve. During 2021, PMMC provided $64,255,474 million in community benefit[1] in response to unmet needs and to improve the health and well-being of those we serve in Oregon.

Health Equity

At Providence, we acknowledge that all people do not have equal opportunities and access to live their fullest, healthiest lives due to systems of oppression and inequities. We are committed to ensuring health equity for all by addressing the underlying causes of racial and economic inequities and health disparities. Our vision is "Health for a Better World." To achieve that, we believe we must address not only the clinical care factors that determine a person's length and quality of life, but also the social and economic factors, the physical environment, and the health behaviors that all play an active role in determining health outcomes.

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

[1] Community benefit giving and reporting is based on Oregon Health Authority instructions for 2021.

Figure 1. Best Practices for Centering Equity in the CHIP

Community Benefit Governance

PMMC further demonstrates organizational commitment to the community benefit process through the allocation of staff time, financial resources, participation and collaboration with community partners. The PMMC administration is ultimately responsible for coordinating implementation of state and federal 501r requirements as well as providing the opportunity for community leaders and internal hospital executive management team members, physicians and other staff to work together in planning and implementing the CHIP in conjunction with the Providence Community Health team.

As a primary source of community benefit advice and local leadership, PMMC's Service Area Advisory Council (SAAC) plays a pivotal role in supporting the hospital's bboard of trustees to oversee community benefit issues. Acting in accordance with a board-approved charter, the SAAC is charged with identifying policies and programs that address identified needs in the service area, particularly for underserved populations, overseeing development and implementation of the CHNA and CHIP reports, and overseeing and directing the community benefit activities. The SAAC delegates some work to the Community Benefit Committee, a majority of whose members have knowledge and experience with the populations most likely to have disproportionate unmet health needs. The Community Benefit Committee usually meets quarterly.

Planning for the Uninsured and Underinsured

Providence's Mission is to provide quality care to all our patients, regardless of ability to pay. We believe that no one should delay seeking needed medical care because they lack health insurance. That is why PMMC has a Financial Assistance Program (FAP) that provides free or discounted services to eligible patients.

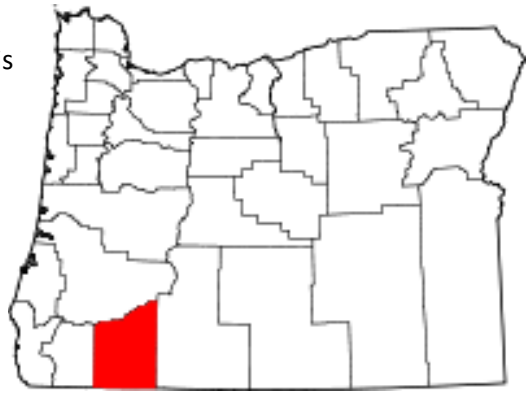
One way PMMC informs the public of our FAP is by posting notices on site at the hospital. The notices are posted in high volume inpatient and outpatient service areas. Notices also are posted at locations where a patient may pay their bill. Notices include information about how to obtain more information on

financial assistance, as well as where to apply for assistance. These notices are posted in English and Spanish and any other languages that are representative of 5% or greater of patients in the hospital's service area. All patients who demonstrate lack of financial coverage by third- party insurers are offered an opportunity to complete the Patient Financial Assistance Application and are offered information, assistance, and referrals as appropriate to government-sponsored programs for which they may be eligible. Notices and information also are available on our website in multiple languages. For information on our Financial Assistance Program click https://www.providence.org/obp/or.

OUR COMMUNITY

Description of Community Served

Based on geographic location relative to other hospitals in the area and patient demographics, Jackson County (in red) is PMMC's primary service, with Josephine County considered as a secondary service area.



Community Demographics

POPULATION AND AGE DEMOGRAPHICS

According to Vintage 2022 U.S. Census data, Jackson County is home to 221,644 residents, with a nearly even split of females (50.8%) to males (49.2%). The largest age group is ages 60-69 and represents 14.7% of the population as determined by the 2019 American Community Survey.

Age Groups	Percentages
Ages 0 - 9	11.4%
Ages 10 - 19	11.5%
Ages 20 - 29	11.9%
Ages 30 - 39	12.5%
Ages 40 - 49	11.0%
Ages 50 - 59	12.8%
Ages 60 - 69	14.7%
Ages 70 - 79	9.2%
Ages 80+	5.0%

Data Source: 2019 American Community Survey, 5-year estimate

POPULATION BY RACE AND ETHNICITY

According to Vintage 2022 U.S. Census data, most of Jackson County residents (79.1%) identify as white non-Hispanic. The second largest group identifies as Hispanic/Latinx, making up 14.3% of the population. The third largest group identifies as two or more races, making up 3.8% of the population.

SOCIOECONOMIC INDICATORS

Table 1. Income Indicators for Jackson County Service Area

Indicator	Jackson County	Oregon
Median Income Data Source: 2019 American Community Survey, 5-year estimate	$53,571	$62,818
Percent of Renter Households with Severe Housing Cost Burden Data Source: 2019 American Community Survey, 5-year estimate	26.8% (8,682 renter households)	24.0% (145,586 renter households)

The median household income in Jackson County ($53,571) is lower than Oregon's median income of $62,818. Low-income households have an increased chance of experiencing severe housing cost burden, which is defined as households that spend 50% or more of their income on housing. In Oregon, 24% of renter households experience severe housing cost burden, compared to 26.8% in Jackson County.

Full demographic and socioeconomic information for the service area can be found in the Providence Medford Medical Center 2022 CHNA.

COMMUNITY HEALTH NEEDS ASSESSMENT PROCESS AND RESULTS

Summary of Community Health Needs Assessment Process and Results

Through a mixed-methods approach and using quantitative and qualitative data, the CHNA team, made up of representatives from Providence and Asante, collected information from the following sources: American Community Survey, Behavioral Risk Factor Surveillance System (BRFSS), U.S. Centers for Disease Control and Prevention (CDC), County Health Rankings & Roadmaps, ESRi Updated Demographics, Oregon Health Authority, Oregon Student Wellness Survey, and the U.S. Census (such as public health data regarding health behaviors, morbidity and mortality, and hospital-level data).

We conducted five listening sessions with 68 individuals who are from diverse communities, have lower incomes, and/or are medically underserved. We conducted 10 stakeholder interviews with 12 representatives from organizations that serve these populations, specifically seeking to gain a deeper understanding of community strengths and opportunities. In addition, we conducted a community health survey in English and Spanish that engaged 1,251 residents. Below is a short list of highlights from our quantitative and qualitative data collection:

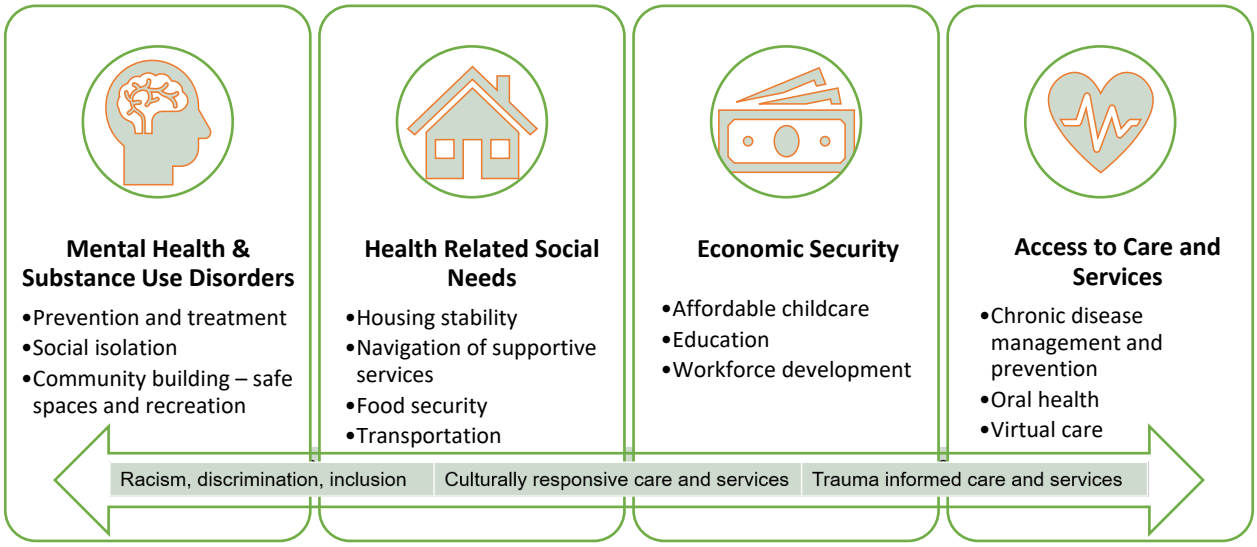
- Strong community partnerships are present among nonprofits, health care organizations, school districts, faith-based organizations, community and civic groups, and social support organizations, all working together to address community needs.
- Stakeholders identified housing as a foundational need and discussed the importance of Housing First, meaning people first need to be safely and stably housed before they can address their physical and behavioral health needs.
- Nearly 34% of community health survey respondents reported needing counseling or mental health services within the last year.
- Among 11th grade students in Jackson and Josephine counties, 44-48% reported signs of depression in 2020.

Although the CHNA is conducted in both Jackson and Josephine counties, the CHIP is created solely for Jackson County where Providence serves the community through inpatient and ambulatory services.

Significant Community Health Needs Prioritized

A wide spectrum of significant health needs was identified in the 2022 CHNA, some of which are most appropriately addressed by other community organizations. The following graphic summarizes PMMC's priority areas for its 2023-2025 community benefit efforts:

Oregon Region 2022 CHNA Priorities



Needs Beyond the Hospital's Service Program

No hospital facility can address all of the health needs present in its community. We are committed to continuing our Mission through community benefit grant-making and ongoing partnerships in our community.

While we strive to care for our communities each day, we recognize that we cannot address all needs effectively or independently. While not constituting a direct intervention, PMMC will collaborate with community partners to address the aforementioned health and social needs to coordinate care and referrals that may positively affect these unmet needs. We strongly believe that together we can better address the needs of our communities by leveraging our collective strengths.

COMMUNITY HEALTH IMPROVEMENT PLAN

Summary of Community Health Improvement Planning Process

The 2023-2025 PMMC CHIP was developed by the Providence Community Health Team with input from the Providence Medford SAAC. The SAAC is made up of Providence employees and community members. Below are the steps taken to complete the PMMC CHIP:

- The SAAC discussed and voted on four priorities that would be addressed in the PMMC CHIP.
- The community health team drafted strategies and measures to address priorities and presented them to the SAAC for input.
- SAAC input was incorporated into the final PMMC CHIP document.
- The final PMMC CHIP was approved by the PMMC SAAC and Providence system leadership team on April 24, 2023.

Since several strategies to address the prioritized needs will be one-year community grants, the 2023-2025 PMMC CHIP will be updated annually to include new strategies and measures to address prioritized needs.

Addressing the Needs of the Community: 2023- 2025 Key Community Benefit Initiatives and Evaluation Plan

COMMUNITY NEED ADDRESSED #1: MENTAL HEALTH AND SUBSTANCE USE DISORDERS

Population Served

Adults with low incomes who need access to mental health and/or substance use disorder services

Long-Term Goal(s)/ Vision

Provide community members living with mental health challenges and substance use disorders with resources and opportunities to strengthen resiliency and gain necessary skills to reach their personal goals.

Table 2. Strategies and Strategy Measures for Addressing Community Mental Health and Well-being

Strategy	Program/ Responsible Organization	Population Served	Strategy Measure	Baseline (2022)	2023-2025 Target(s)
1. Provide opportunities to rebuild self-confidence, purpose, and abilities through education, productive work, and meaningful relationships	Compass House – Clubhouse (2022 grant)	Adults with severe and persistent mental illness	Number of community members served per year	55	72 (2023)

2. Provide supports that stabilize and strengthen resiliency to empower youth and their families to engage and thrive independently	Maslow Project (2022 grant)	Youth experiencing houselessness	Number of youths served per year	0	50 (2023)
3. Peer Support Specialists identify patients who frequently visit the emergency department, and connect them with resources that address unmet needs while providing trusted support and advocacy	Better Outcomes Through Bridges ED-Outreach/ Providence Medford Medical Center (Ongoing)	Adults discharging from Providence Medford Medical Center ED with low incomes and in need of access to mental health/substance use disorder services	Emergency department utilization percent change	-15.90%	-20% (2023) -22% (2024) -25% (2025)
4. Mobile crisis response system to address mental health emergencies in place of law enforcement	United Way (2022 & 2023 grants)	Community members living with mental illness and/or substance use disorders	Number of community members served per year	0	175 (2023) 225 (2024)
5. Expanding school-based behavioral health services to elementary aged children	La Clinica (2023 grant)	Elementary aged children (at four different schools) experiencing behavioral health challenges	Number of children served; Number of behavioral health visits provided per year	211; 3,060	260; 3,800 (2024)
6. Provide mental health services to youth experiencing homelessness	Maslow Project (2023 grant)	Youth experiencing homelessness	Number of youths served per year	0	100 (2024)

Evidence Based Sources

Healthy People 2030 Evidence-Based Resources: https://health.gov/healthypeople/tools-action/browse-evidence-based-resources

County Health Rankings and Roadmaps Evidence-Based Strategies: https://www.countyhealthrankings.org/take-action-to-improve-health/what-works-for-health/strategies

AHA White Papers on SDOHs: https://www.aha.org/social-determinants-health/populationcommunity-health/community-partnerships

Resource Commitment

Community benefit grants, staff time

Key Community Partners

Compass House, Maslow Project, United Way, La Clinica

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

Long-Term Goal(s)/ Vision

Increase access to safe shelter and support for individuals experiencing homelessness or those at risk of eviction.

Table 3. Strategies and Strategy Measures for Addressing Housing Stability

Strategy	Program/ Responsible Organization	Population Served	Strategy Measure	Baseline (2022)	2023-2025 Target(s)
1. Provide temporary housing for patients in need of a safe place to recover post hospital stay	Rogue Retreat-Redwood Inn (Ongoing)	Patients experiencing houselessness	Number of patients served per year	10	20 (2023) 25 (2024) 25 (2025)
2. Provide emergency transitional housing	ACCESS (2022 grant)	Vulnerable individuals and families experiencing houselessness	Number of community members served per year	187	235 (2023)
3. Provide low-barrier shelter to patients discharged from PMMC who are experiencing houselessness	Rogue Retreat-Kelly Shelter (Ongoing)	Patients experiencing houselessness who have been discharged from PMMC	Number of community members served per year	30	50 (2023) 50 (2024) 50 (2025)
4. Access to resources addressing health related social needs	Providence/ACCESS - Community Resource Desk (Ongoing)	Vulnerable individuals and families with unmet social needs	Clients served	965	1,062 (2023) 1,168 (2024)

					1,284 (2025)
5. Provide resources and support to families with minor children to avoid eviction	ACCESS (2023 grant)	Community members experiencing housing instability	Number of community members who have avoided eviction	1,103	1,150 (2024)
6. Provide support and case management services to Latinx community members who are engaging in the resident-owned community model at Talent Mobile Estates	Coalicion Fortaleza (2023 grant)	Community members whose homes were destroyed during the 2020 Almeda fires	Number of community members engaged in the resident owned community development initiatives	200	435 (150 families; avg. family size 2.91) (2024)

Evidence Based Sources

Healthy People 2030 Evidence-Based Resources: https://health.gov/healthypeople/tools-action/browse-evidence-based-resources

County Health Rankings and Roadmaps Evidence-Based Strategies: https://www.countyhealthrankings.org/take-action-to-improve-health/what-works-for-health/strategies

AHA White Papers on SDOHs: https://www.aha.org/social-determinants-health/populationcommunity-health/community-partnerships

Resource Commitment

Community benefit grants, staff time, in-kind hospital space for physical Community Resource Desk

Key Community Partners

ACCESS, Rogue Retreat, City of Medford, Coalicion Fortaleza

COMMUNITY NEED ADDRESSED #3: ACCESS TO CARE AND SERVICES

Long-Term Goal(s)/ Vision

To improve access to health care, preventive services, and resource navigation for people with low incomes and those who are uninsured or under-insured.

Table 4. Strategies and Strategy Measures for Addressing Access to Care and Services

Strategy	Program/ Responsible Organization	Population Served	Strategy Measure	Baseline (2022)	2023-2025 Target(s)
1. Access to free emergency and restorative dental services	Medical Teams International dental van clinics (Ongoing)	Un/underinsured	Number of patients served; Numbers of community clinics	75; 10	70; 10 (2023-2025)
2. Safe and secure discharge from hospital	Patient Support Program (Ongoing)	Low income	Number of patients served	693	707 (2023) 721 (2024) 735 (2025)
3. Access to diabetes self-management education and support	Diabetes Self-Management Education Program (Ongoing)	Community members living with diabetes	Number of patients served	517	768 (2023) 768 (2024) 768 (2025)
4. Access to diabetes prevention education and support	Diabetes Prevention Program (Ongoing)	Community members living with pre-diabetes	Number of patients served	15	0 (2023) 15 (2024) 15 (2025)

Evidence Based Sources

Healthy People 2030 Evidence-Based Resources: https://health.gov/healthypeople/tools-action/browse-evidence-based-resources

County Health Rankings and Roadmaps Evidence-Based Strategies: https://www.countyhealthrankings.org/take-action-to-improve-health/what-works-for-health/strategies

AHA White Papers on SDOHs: https://www.aha.org/social-determinants-health/populationcommunity-health/community-partnerships

Resource Commitment

Community benefit grants, staff time

Key Community Partners

Medical Teams International, Project Access Now, St. Vincent de Paul

COMMUNITY NEED ADDRESSED #4: ECONOMIC SECURITY: AFFORDABLE CHILDCARE

Long-Term Goal(s)/ Vision

To improve access to affordable childcare for families with low incomes.

Table 5. Strategies and Strategy Measures for Addressing Affordable Childcare

Strategy	Program/ Responsible Organization	Population Served	Strategy Measure	Baseline (2022)	2023-2025 Target(s)
1. Provide therapeutic childcare paired with child and adult mental health care	Oasis Center of the Rogue Valley/Family Nurturing Center (2022 grant)	Children under the age of six living with a family member who is receiving low-barrier substance use disorder and health care services	Number of children and family members served per year	55	120 (2023)

Evidence Based Sources

Healthy People 2030 Evidence-Based Resources: https://health.gov/healthypeople/tools-action/browse-evidence-based-resources

County Health Rankings and Roadmaps Evidence-Based Strategies: https://www.countyhealthrankings.org/take-action-to-improve-health/what-works-for-health/strategies

AHA White Papers on SDOHs: https://www.aha.org/social-determinants-health/populationcommunity-health/community-partnerships

Resource Commitment

Community benefit grants, staff time

Key Community Partners

Oasis Center of the Rogue Valley, Family Nurturing Center

Other Community Benefit Programs

Table 5. Other Community Benefit Programs in Response to Community Needs

Initiative (Community Need Addressed)	Program Name	Description	Population Served (Low-Income, Vulnerable or Broader Community)
Health-related Social Needs	Connect Oregon	Uses technology platform, Unite Us, to enable health and social service providers to send and receive referrals leading to improved coordinated care and community well-being	Low-income
Access to Care and Services	Providence Medication Assistance Program (MAP)	MAP is a prescription assistance program that helps patients with low incomes who are un- or under-insured pay for medications.	Low-income/un- and under-insured individuals
Mental Health and Substance Use Disorders (SUD)	Providence Better Outcomes Through Bridges (BOB) - Caring Contacts	Caring Contacts peer support specialists connect patients to community resources and behavioral health programs while providing needed support services along the way.	Low-income/adults recently discharged from the emergency department in behavioral health crisis

2023- 2025 CHIP GOVERNANCE APPROVAL

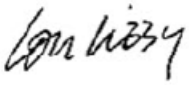
This Community Health Improvement Plan was adopted by the Service Area Advisory Council of the hospital on April 24, 2023. The final report was made widely available by May 15, 2023.

4/27/2023

Chris Pizzi
Chief Executive, Southern Oregon Service Area

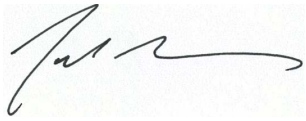
4/27/2023

William Olson
Chief Executive, Oregon Region



4/27/2023

Louis Libby
Chair, Oregon Community Ministry Board



4/27/2023

Joel Gilbertson
Chief Executive, Central Division

CHNA/CHIP Contact:

Joseph Ichter, DrPH
Senior Director, Community Health Investment
Joseph.ichter@providence.org

To request a copy free of charge, provide comments, or view electronic copies of current and previous Community Health Improvement Plans please email CHI@providence.org.