

2026-
2028

COMMUNITY HEALTH IMPROVEMENT PLAN



Providence Hood River Memorial Hospital

Hood River, Oregon

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



CONTENTS

Executive Summary.....	3
Providence Hood River Memorial Hospital 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.....	16

EXECUTIVE SUMMARY

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

PHRMH 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 PHRMH 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 Hood River Memorial 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, Providence Hood River Memorial Hospital 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

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 Hood River Memorial Hospital (PHRMH) is a critical-access hospital founded at its current campus in 1932 and located in Hood River, OR. The hospital has 25 licensed beds, a staff of more than 500, and professional relationships with more than 150 physicians/providers. Major programs and services offered to the community include the following: primary care, women’s health care including maternity care, cancer care including infusion services, surgical services, orthopedics care, heart care, weight management, behavioral health care, dialysis care, occupation health care, memory care and retirement or assisted living options.

Our Commitment to Community

PHRMH 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 Hood River Medical Hospital (PHRMH) conducted a 2025 Community Health Needs Assessment (CHNA) in partnership with Adventist Health Columbia Gorge, Hood River County Public Health, North Central Public Health District, and PacificSource Community Solutions. The CHNA service area is the entirety of Hood River and Wasco counties.

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, we collected information from the following sources: American Community Survey, Behavioral Risk Factor Surveillance System, Environmental Justice Index, Oregon Health Authority, National Center for Health Statistics, US Census Bureau, local public health data, and more. To actively engage the community, we conducted 34 listening sessions with people who have chronic conditions, are from diverse communities, have low-income, and are medically underserved. The 34 listening sessions included 321 community partners and community members. Community partners that participated in listening sessions have a deep understanding of the community's strengths and needs. In addition to listening sessions, the core group conducted a community survey during the spring of 2024. Approximately 1,100 people who most likely lived or worked in Hood River or Wasco counties completed the survey.

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 PHRMH CHNA](#).

Significant Community Health Needs Prioritized

PHRMH 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 need identified in the 2025 CHNA will not be addressed, and an explanation is provided below:

- Economic Security: PHRMH 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 Hood River Memorial Hospital (PHRMH) 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 Hood River and Wasco 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 PHRMH: Mental health and substance use disorders, health related social needs, economic security, and access to care and services. Prioritizing these needs allows PHRMH 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 Hood River and Wasco 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 Columbia Gorge 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>Collective Impact Health Specialist: Partner with Hat Creek Consulting to support the Hood River community by providing technical assistance (project strategy, design, and grant writing) to strengthen cross-sector collaboration, identify shared priorities, and secure coordinated funding to improve community health outcomes</p>	Community members experiencing food insecurity	<p>Number of projects supported through strategy and design</p> <p>Number of grant applications submitted</p> <p>Number of grants received addressing food security</p>	<p>2 projects supported through strategy and design</p> <p>1 grant applications submitted</p> <p>0 grants received addressing food security</p>	<p>4 projects supported through strategy and design</p> <p>4 grant applications submitted</p> <p>3 grants received addressing food security</p>
<p>Community Benefit Grant Making: Partner with community-based organizations (CBO) in Hood River County addressing food/nutrition insecurity</p>	Low-income Hood River County community members experiencing food/nutrition insecurity	Number of community benefit grants supporting food security	2 community benefit grants supporting food security	1-3 community benefit grants supporting food security (2026-2028)

Community and Research Informed Resources

- [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

PHRMH will commit staff time, 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 food security include FISH Food Bank, Columbia Gorge Food Bank, and Hood River Valley Adult Center.

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
<p>Collective Impact Health Specialist: Partner with Hat Creek Consulting to support the Hood River community by providing technical assistance (project strategy, design, and grant writing) to strengthen cross-sector collaboration, identify shared priorities, and secure coordinated funding to improve community health outcomes</p>	Community members experiencing housing instability	<p>Number of projects supported through strategy and design</p> <p>Number of grant applications submitted</p> <p>Number of grants received addressing housing instability</p>	<p>2 projects supported through strategy and design</p> <p>2 grant applications submitted</p> <p>0 grants received addressing housing instability</p>	<p>4 projects supported through strategy and design</p> <p>4 grant applications submitted</p> <p>3 grants received addressing housing instability</p>
<p>Community Benefit Grants: Partner with community-based organizations (CBO) addressing housing instability and homelessness in Hood River County, with a focus on eviction prevention, housing stabilization, and access to supportive</p>	Community members experiencing housing instability	Number of community benefit grants supporting housing initiatives	0 community benefit grants supporting housing initiatives	1-3 community benefit grants supporting housing initiatives (2026-2028)

services for populations disproportionately impacted by housing cost burden and economic insecurity				
---	--	--	--	--

Community and Research Informed Resources

- [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

PHRMH will commit staff time, 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 housing stability include Mid-County Community Action Council and Nch’i Wana Housing.

COMMUNITY NEED ADDRESSED #3: 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 3. 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

<p>Work2BeWell (W2BW) Program: 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</p> <p>Number of student-centered presentations</p>	<p>12 W2BW Clubs</p> <p>10 student-centered presentations</p>	<p>24 W2BW Clubs</p> <p>22 student-centered presentations</p>
<p>Better Outcomes Through Bridges (BOB) Emergency Department (ED) Outreach & Peer Support: Identifies behavior health patients with frequent ED visits in need of support after discharge and connects patients to community resources and behavior health programs while providing support services</p>	<p>Adults with frequent ED visits discharging from the ED with low-income and in need of access to mental health/substance use disorder services</p>	<p>Number of new, active episodes of care initiated</p>	<p>69 active episodes of care initiated</p>	<p>80 active episodes of care initiated</p>
<p>Community Benefit Grants: Partner with community-based organizations (CBO) addressing mental health and substance use disorders in Hood River 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</p>	<p>Underserved Hood River County community members in need of mental health/SUD support</p>	<p>Number of community benefit grants supporting CBOs</p>	<p>2 community benefit grants supporting CBOs</p>	<p>1-3 community benefit grants supporting CBOs (2026-2028)</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

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.

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
Diabetes Prevention Program: An evidence-based lifestyle change program supporting people with prediabetes or at high risk for type 2 diabetes in making sustainable	People living with pre-diabetes in Hood River County	Number of people enrolled in program	2 people enrolled in program	4 people enrolled in program

nutrition, physical activity, and behavior changes to prevent or delay the onset of type 2 diabetes and improve overall health				
Data for Change Program: Strengthens data capacity among community benefit grantees through tailored technical assistance and shared learning to improve outcomes, advance health equity, and communicate impact.	Providence community benefit grantees addressing priority needs raised in the most recent Community Health Needs Assessment	Number of grantees receiving technical assistance	3 grantees received technical assistance (2021-2025)	Provide technical assistance to at least one grantee
Patient Support Program (PSP): Partner with Project Access NOW to reduce discharge barriers and support safe and timely hospital discharges	Low-income patients discharging from PHRMH	Number of patients supported through PSP program	85 patients supported	Maintain baseline - 85 patients supported

Community and Research Informed Resources

- [Medicare Diabetes Prevention Program Expanded Model - Healthy People 2030 | odphp.health.gov](https://www.odphp.health.gov/medicare-diabetes-prevention-program-expanded-model-healthy-people-2030)

Resource Commitment

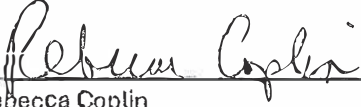
PHRMH will commit staff time, cash and in-kind donations to support these strategies.


Key Community Partners

PHRMH works with many community partners across Hood River County to help address needs for those who are underserved. An example of the partners we work with as part of our commitment to addressing access to care and services include Project Access NOW.

2026- 2028 CHIP Governance Approval

This Community Health Improvement Plan was adopted by the Columbia Gorge Service Area Advisory Council of the hospital on March 19, 2026. The final report was made widely available by May 15, 2026.

 4-3-2026
Rebecca Coplin Date
Chief Administrative Officer, Providence Hood River Memorial Hospital
Providence

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

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

CHNA/CHIP Contact:

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

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

