

2026-  
2028

# COMMUNITY HEALTH IMPROVEMENT PLAN



## Providence Medford Medical Center

Medford, 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 Medford 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
Other Community Benefit Programs .....	15
2026- 2028 CHIP Governance Approval.....	16

# EXECUTIVE SUMMARY

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

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. 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, 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 Medford 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, PMMC will focus on the following areas for its 2026-2028 Community Benefit efforts. The priorities from the CHNA have been refined to better address the identified need and opportunity.

### ACCESS TO CARE AND SERVICES: PRIMARY CARE AND PREVENTATIVE HEALTH

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

### MENTAL HEALTH/SUBSTANCE USE DISORDERS: PREVENTION AND TREATMENT

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

## 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.

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 Medford Medical Center (PMMC) is an acute-care hospital founded in 1911 and located in Medford, Oregon. The hospital has 120 licensed beds, a staff of more than 1000, and professional relationships with more than 530 local physicians. Major programs and services offered to the community include the following: Emergency services, stroke care, cardiac and vascular care, birth center, total joint replacement and spine health programs, robotic surgery, urology, urogynecology, gynecology, general surgery 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 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 Medford Medical Center (PMMC) conducted a 2025 Community Health Needs Assessment (CHNA) in partnership with Asante. The CHNA service area is the entirety of Jackson and Josephine 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, 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 PMMC CHNA](#).

## Significant Community Health Needs Prioritized

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

### ACCESS TO CARE AND SERVICES: PRIMARY CARE AND PREVENTATIVE HEALTH

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

### MENTAL HEALTH/SUBSTANCE USE DISORDERS: PREVENTION AND TREATMENT

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

### 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.

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: PMMC 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 Medford Medical Center (PMMC) was the basis for the 2026-2028 CHIP. The assessment, which was completed as part of the Providence and Asante collaborative, identified community needs, assets, resources, and strategies to improve health for residents of Jackson and Josephine counties in Oregon.

The service area advisory council evaluated the needs and supporting data identified in the 2025 CHNA and selected the following areas of focus for PMMC: Mental health and substance use disorders, health related social needs, economic security, and access to care and services. Prioritizing these needs allows PMMC 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 Jackson 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 Southern Oregon Service Area Advisory Council adopted the 2026-2028 CHIP, including the following strategies for addressing the priority community needs.

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

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

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

### Population Served

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

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

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

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

Identified need: ACCESS TO CARE AND SERVICES: PRIMARY CARE AND PREVENTATIVE HEALTH				
Strategy	Population Served	Strategy Measure(s)	2025 Baseline	2028 Target
<b>Medicaid Intake/Eligibility Specialist:</b> 0.5 FTE from Medford Aging and People with Disabilities providing Medicaid eligibility assessments, referrals, and care coordination for hospitalized patients to support timely access to long-term or in-home services and safe post-acute discharge planning	Patients with and eligible for Medicaid insurance	Number of patients served	225 patients served	400 patients served
<b>Diabetes Prevention Program:</b> Evidence based lifestyle program supporting people with pre-diabetes to prevent or delay type 2 diabetes	People living with pre-diabetes in Yamhill County	Number of people served	7 people served	9 people served
<b>Mobile Dental Clinic:</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	Under-insured or uninsured community members experiencing oral pain and in need of dental services	Number of people served in Jackson County	59 people served	Maintain baseline (59 people served)

<p><b>Data for Change Program:</b> Strengthens data capacity among community benefit grantees through tailored technical assistance and shared learning to improve outcomes, advance health equity, and communicate impact.</p>	<p>Providence community benefit grantees addressing priority needs raised in the most recent Community Health Needs Assessment</p>	<p>Number of grantees receiving technical assistance</p>	<p>9 grantees received technical assistance (2021-2025)</p>	<p>Provide technical assistance to at least one grantee</p>
<p><b>Patient Support Program (PSP):</b> Partner with Project Access NOW to reduce discharge barriers and support safe and timely hospital discharges</p>	<p>Low-income patients discharging from PMMC</p>	<p>Number of patients supported through PSP program</p>	<p>250 patients supported</p>	<p>Maintain baseline (250 patients supported)</p>
<p><b>Community Benefit Grants:</b> Partner with community-based organizations in Jackson County to improve access to care and services, with a focus on expanding equitable, culturally responsive, community driven prevention support and strengthening sustainable, locally led solutions.</p>	<p>Underserved Jackson County community members in need of medical care</p>	<p>Number of community benefit grants supporting CBOs</p>	<p>1 grant</p>	<p>1-3 grants (2026-2028)</p>

*Community and Research Informed Resources*

- [Recommendations of the Joint Task Force on Hospital Discharge Challenges](#)
- [Medicare Diabetes Prevention Program Expanded Model - Healthy People 2030 | odphp.health.gov](#)
- [Improving Access to Oral Health Care for Vulnerable and Underserved Populations | Healthy People 2030](#)

*Resource Commitment*

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

*Key Community Partners*

PMMC works with many community partners across Jackson County to help address needs for those who are underserved. Examples of the partners we work with as part of our commitment to addressing access to care and services include Medical Teams International and Medford Aging and People with Disabilities.

## COMMUNITY NEED ADDRESSED #2: MENTAL HEALTH AND SUBSTANCE USE DISORDERS: PREVENTION AND TREATMENT

### 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

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

**Table 2. Strategies and Measures for Addressing Mental Health and Substance Use Disorders: Prevention and Treatment**

Identified need: MENTAL HEALTH AND SUBSTANCE USE DISORDERS: PREVENTION AND TREATMENT				
Strategy	Population Served	Strategy Measure(s)	2025 Baseline	2028 Target
<b>Providence Assessment, Intake, and Referral (AIR) Program:</b> 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 region behavioral health services	8,263 referrals received	9,089 referrals received
<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	Oregon Youth (11-18) and Oregon Young Adults (18-22)	Number of middle and high school W2BW clubs  Number of student-centered presentations	12 W2BW Clubs  10 student-centered presentations	24 W2BW Clubs  22 student-centered presentations
<b>Better Outcomes Through Bridges (BOB) Emergency Department (ED) Outreach &amp; Peer Support:</b> Identifies behavior health patients with frequent ED visits in	Adults with frequent ED visits discharging from the ED with low-income and in need of access to mental	Number of new, active episodes of care initiated	93 active episodes of care initiated	105 active episodes of care initiated

need of support after discharge and connects patients to community resources and behavior health programs while providing support services	health/substance use disorder services			
<b>Community Benefit Grants:</b> Partner with community-based organizations (CBO) addressing mental health and substance use disorders in Jackson 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	Underserved Jackson County community members in need of mental health/SUD support	Number of community benefit grants supporting CBO between 2026-2028	N/A	1-3 community benefit grants supporting CBOs (2026-2028)

*Community and Research Informed Resources*

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

*Resource Commitment*

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

*Key Community Partners*

PMMC works with many community partners across Jackson 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 La Clinica and United Way of Jackson County.

## COMMUNITY NEED ADDRESSED #3: 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
<b>Kelly Shelter:</b> Partner with Rogue Retreat to provide low barrier, short-term shelter and case management for patients experiencing homelessness who are discharged from the emergency department or inpatient care	PMMC inpatient and emergency room patients	Number of shelter beds reserved for Providence patients	5 shelter beds reserved	Maintain baseline (5 shelter beds reserved)
<b>Community Resource Desk Program:</b> Partner with ACCESS supporting individuals and families to navigate housing resources	Individuals and families experiencing housing instability	Number of clients and household members  Percentage of resource connection rate	369 clients 789 household members  49% of clients connected to resources	455 clients 905 household members  65% of clients connected to resources
<b>Community Benefit Grant Making:</b> Partner with community-based- organizations (CBO) in Jackson County addressing housing instability	Low-income Jackson County community members experiencing housing instability	Number of community benefit grants supporting CBOs	N/A	1-3 grants supporting CBOs (2026-2028)

### Community and Research Informed Resources

- [Patient Navigators | County Health Rankings & Roadmaps](#)
- [Effects of Housing First approaches on health and well-being of adults who are homeless or at risk of homelessness: systematic review and meta-analysis of randomized controlled trials](#)

### Resource Commitment

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

### Key Community Partners

PMMC works with many community partners across Jackson 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 instability, include Rogue Retreat, Project Access NOW, and ACCESS.

## Other Community Benefit Programs

**Table 3. Other Community Benefit Programs in Response to Community Needs**

<b>Initiative (Community Need Addressed)</b>	<b>Program Name</b>	<b>Description</b>	<b>Population Served (Low Income, Vulnerable or Broader Community)</b>
1. Health Related Social Needs: Food Security	ACCESS Healthy Mobile Food Pantry	Providence partners with ACCESS to host a free food pantry on the PMMC campus 2–3 times per month	Providence Medical Group Pediatric Clinic families and community members experiencing food insecurity

## 2026- 2028 CHIP Governance Approval

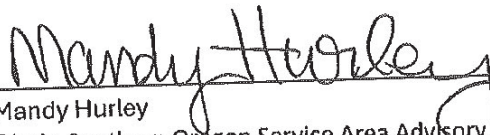
This Community Health Improvement Plan was adopted by the Southern Oregon Service Area Advisory Council of the hospital on April 27, 2026. The final report was made widely available by May 15, 2026.



April 27, 2026

Susan Sauder  
Chief Executive, Providence Medford Medical Center  
Providence

Date



April 27, 2026

Mandy Hurley  
Chair, Southern Oregon Service Area Advisory Council

Date



Jennifer Burrows  
Chief Executive, Oregon  
Providence

4/29/26

Date

**CHNA/CHIP Contact:**

Sonya Kauffman Smith  
Manager, Community Health – Oregon  
[Sonya.kauffmansmith@providence.org](mailto: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.