

2026-
2028

COMMUNITY HEALTH IMPROVEMENT PLAN



Providence Milwaukie Hospital

Milwaukie, Oregon

To provide feedback about this
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EXECUTIVE SUMMARY

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

PMH 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 PMH 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 Milwaukie 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, PMH 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.

HEALTH RELATED SOCIAL NEEDS: TRANSPORTATION

Transportation refers to the availability of reliable, affordable, and accessible transportation that enables people to reach health care, supportive services, and basic needs. Transportation barriers—such as long distances, limited public transit, mobility challenges, and costs- can prevent timely access to care, particularly for older adults, people with disabilities, rural residents, and individuals experiencing housing instability.

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.

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 Milwaukie Hospital (PMH) is a community hospital founded in 1968 and located in Milwaukie, OR. The hospital has 77 licensed beds, a staff of more than 800, and professional relationships with more than 160 physicians. Major programs and services offered to the community include the following: Primary and specialty care, general and specialty surgery, radiology, diagnostic imaging, geriatric psychology, sleep lab, residency program, teaching kitchen, pathology and 24/7 emergency medicine.

Our Commitment to Community

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

The CHNA is an opportunity for Providence hospitals to engage the community every three years with the goal of better understanding strengths and needs. Through a mixed-methods approach, using quantitative and qualitative data, the CHNA process relies on several sources of information: state and national public health data, qualitative data from key informant interviews and community listening sessions, hospital utilization data, and more. An oversight committee reviews all the data from the CHNA and identifies priority needs to address in the 2026-2028 Community Health Improvement Plan (CHIP).

More information on the CHNA process and findings can be found in the [2025 PMH CHNA](#).

Significant Community Health Needs Prioritized

PMH 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.

HEALTH RELATED SOCIAL NEEDS: TRANSPORTATION

Transportation refers to the availability of reliable, affordable, and accessible transportation that enables people to reach health care, supportive services, and basic needs. Transportation barriers—such as long distances, limited public transit, mobility challenges, and costs- can prevent timely access to care, particularly for older adults, people with disabilities, rural residents, and individuals experiencing housing instability.

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.

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: PMH 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 Milwaukie Hospital (PMH) was the basis for the 2026-2028 CHIP. The assessment, which was completed as part of the Healthy Columbia Willamette Collaborative, identified community needs, assets, resources, and strategies to improve health for residents of Clackamas, Multnomah, and Washington counties in Oregon and Clark County in Washington state.

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

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

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

COMMUNITY NEED ADDRESSED #1: 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 primary 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
<p>Health Systems Access to Care Fund: Providence participates in a collaborative funding model to strengthen health care safety net- capacity by providing grant funding to ten community supported- clinics, sustaining core operations and ensuring continued access</p>	Uninsured or under-insured people who face barriers to accessing healthcare	Yearly financial support	Provided funding to support ten safety net clinics	Continue to provide grant funding to ten safety net clinics
<p>Smile Care Everywhere Program: Partner with Pacific University to provide free and accessible dental hygiene and dental therapy services</p>	Under or uninsured, low-income and Spanish-speaking community members in need of dental care	Number of community members provided dental care	Dental Hygiene: 6 people N/A	Dental Hygiene: 12 people Dental Therapy: 10 people

<p>Mobile Vision Clinic: Partner with Pacific University College of Optometry to provide free vision screenings, examinations, education, and prescription eye wear (if needed)</p>	Under or uninsured, low-income and Spanish-speaking community members in need of vision care	Number of community members provided vision care	8 community members provided vision care	16 community members provided vision care
<p>Neighborhood Health Center Federally Qualified Health Center (FQHC) : Co-location of FQHC on PMH campus; supporting increased access to primary and preventive care for Medicaid, un-, and underinsured individuals</p>	Medicaid insured-, uninsured, and other underserved community members	Continued partnership with Neighborhood Health Center	Continued partnership	Continued partnership
<p>Mobile Dental Clinic: Partner with Medical Teams International to provide free emergency dental services via mobile dental clinics to help close gaps in access to care for underserved communities</p>	Under-insured or uninsured community members experiencing oral pain and in need of dental services	Number of people served in Clackamas County	101 people served	Maintain baseline (101 people served)
<p>Community Health Worker (CHW) Training: Provided by Providence Promotores program staff</p>	Spanish speaking community members interested in becoming a state certified CHW	Number CHWs trained Number of CHW's certified through the Oregon Health Authority (OHA)	20 CHWs trained TBD	60 CHWs trained (2027) 50 CHWs trained (2027)
<p>Spanish speaking- Community Health Workers (CHW) Internship: 400-hour paid internship in a Providence clinical setting, gaining hands-on- experience supporting entry into the healthcare workforce</p>	Certified CHW's who complete Providence CHW training	Number of CHWs completing internship	1 CHW completed internship	10 CHWs completed internship (2027)

<p>Recuperative Care Program (RCP): Partner with Central City Concern to provide dedicated access to medical respite, for a minimum of 30 days, in Multnomah, Clackamas, and Washington Counties</p>	<p>Unhoused patients discharging from hospital inpatient units who are too medically fragile to discharge to shelter or unsheltered</p>	<p>Number of patients placed at RCP</p>	<p>7 patients placed with RCP</p>	<p>30-35 patients placed with RCP</p>
<p>Diabetes Prevention Program: An evidence-based lifestyle change program supporting people with prediabetes or at high risk for type 2 diabetes in making sustainable nutrition, physical activity, and behavior changes to prevent or delay the onset of type 2 diabetes and improve overall health</p>	<p>People living with pre-diabetes in Clackamas County</p>	<p>Number of people enrolled in program</p>	<p>20 people enrolled in program</p>	<p>23 people enrolled in program</p>

Community and Research Informed Resources

- [Screening and Preventive Interventions for Oral Health in Adults - Healthy People 2030 | odphp.health.gov](https://odphp.health.gov)
- [Improving access to oral health care for vulnerable and underserving populations | Healthy People 2030](#)
- [The Financial Impact of a Partnership Between an Academic Medical Center and a Free Clinic - The American Journal of Medicine](#)
- [Community health workers | County Health Rankings & Roadmaps](#)
- [Career pathways programs | County Health Rankings & Roadmaps](#)
- [How a Medical Respite Care Program Offers a Pathway to Health and Housing for People Experiencing Homelessness - Center for Health Care Strategies](#)

Resource Commitment

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

Key Community Partners

PMH works with many community partners across Clackamas 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 Impact NW, Project Access NOW, Medical Teams International, and Pacific University.

COMMUNITY NEED ADDRESSED #2: HEALTH RELATED SOCIAL NEEDS: TRANSPORTATION

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 facing geographic, economic, mobility, or systemic barriers.

Long-Term Goal(s)/ Vision

Increase equitable access to reliable, affordable, and accessible transportation so community members can obtain timely health care, supportive services, and basic needs.

Table 2. Strategies and Measures for Addressing Health Related Social Needs: Transportation

Identified need: HEALTH RELATED SOCIAL NEEDS: TRANSPORTATION				
Strategy	Population Served	Strategy Measure(s)	2025 Baseline	2028 Target
Patient Support Program: Partner with Project Access NOW to facilitate safe and timely discharges while addressing health related- social needs	Low-income patients discharging from PMH experiencing transportation barriers	Number of patients receiving transportation resources	638 patients received transportation resources	675 patients received transportation resources
Community Resource Desk: Partner with Impact NW supporting individuals and families to navigate HRSN resources	Individuals and families with unmet social needs	Number of clients and household members provided transportation resources Percentage of transportation resource connection rate	81 clients 113 household members 74% of clients connected with resources	110 clients 200 household members 80% of clients connected with resources
Community Benefit Grants: Partner with community-based- organizations (CBO) addressing lack of access to transportation in Clackamas County,	Clackamas County community members with lack of access to affordable, reliable, and	Number of community benefit grants supporting community based organizations	N/A	1-3 community benefit grants

with a focus on reducing barriers to health care, social services, and basic needs for populations disproportionately impacted by geographic isolation, economic insecurity, and limited transportation options	accessible transportation			
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Community and Research Informed Resources

- [Patient Navigators | County Health Rankings & Roadmaps](#)

Resource Commitment

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

Key Community Partners

PMH works with many community partners across Clackamas County to help address needs for those who are underserved. Examples of the partners we work with as part of our commitment to addressing transportation barriers, include Impact NW, Ride Connection, and Project Access NOW.

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 increase 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
Acute Senior Psychiatry Care: Specialty psychiatric care provided to stabilize	Senior individuals experiencing severe mental	Number of unique patients served	310 patients served	326 patients served

patients for return to the community	health challenges needing acute psychiatry care			
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 region’s behavioral health services	8,263 referrals received	9,089 referrals received
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	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
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	Adults with frequent ED visits discharging from the ED with low-income and in need of access to mental health/substance use disorder services	Number of new, active episodes of care initiated	71 care episodes initiated	80 care episodes initiated
Community Benefit Grants: Partner with community-based organizations (CBO) addressing mental health and substance use disorders in Clackamas County, with a focus on	Underserved Clackamas County community members in need of mental health/SUD support	Number of community benefit grants supporting community-based organizations	1 community benefit grant supporting CBO	1-3 community benefit grants supporting CBOs

expanding equitable access to culturally responsive, community driven prevention, treatment, and recovery support while building sustainable, locally led behavioral health interventions				
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Community and Research Informed Resources

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

Resource Commitment

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

Key Community Partners

PMH works with many community partners across Clackamas 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 and substance use disorders include the Black Parent Initiative, WomenFirst Transition & Referral Center, and Kinship House.

Other Community Benefit Programs

Table 4. Other Community Benefit Programs in Response to Community Needs

Initiative (Community Need Addressed)	Program Name	Description	Population Served (Low Income, Vulnerable or Broader Community)
1. Housing and Access to Care	Clackamas County Medical Respite	Clackamas County is partnering with My Father’s Heart to open its first medical respite facility. Providence is supporting workflows, Medicaid payer engagement, and potential contracting for PMH discharges	Unhoused patients discharging from inpatient units who are medically unable to return to shelter or unsheltered settings

2026- 2028 CHIP Governance Approval


This Community Health Improvement Plan was adopted by the Clackamas County Service Area Advisory Council of the hospital on March 11, 2026. The final report was made widely available by May 15, 2026.



Brad Henry
Chief Executive, Providence Willamette Falls Medical Center
Providence

4/14/26


Date



Tim Cook
Chair, Clackamas County Service Area Advisory Council

4/22/2026

Date



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