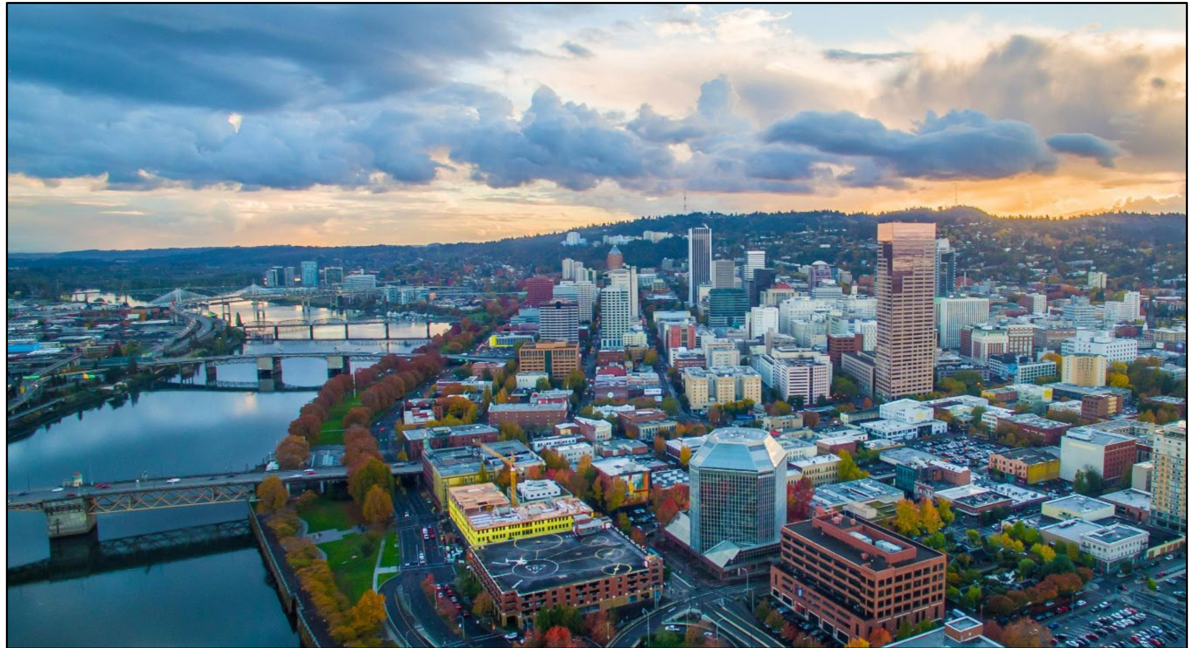
2026-2028

COMMUNITY HEALTH IMPROVEMENT PLAN



Providence Portland Medical Center

Portland, Oregon

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

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EXECUTIVE SUMMARY

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

PPMC 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 PPMC 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 Portland 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, PPMC 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

Health related social needs refer to essential, non-medical conditions that influence health and well-being, including access to safe and stable housing, nutritious and culturally appropriate food, reliable transportation, and basic utilities. When these needs are unaffordable and unmet, they create barriers to accessing care, managing health conditions, and maintaining overall quality of life.

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 Portland Medical Center (PPMC) is a tertiary care hospital founded in 1941 and located in Portland, Oregon. The hospital has 483 licensed beds, a staff of more than 3,000, and professional relationships with more than 1,200 local physicians. Major programs and services offered to the community include the following: primary and specialty care, a birth center with family suites, general and specialty surgery, radiology, diagnostic imaging, pathology and 24/7 emergency medicine. It is recognized for excellence in patient care and research related to cancer care, heart health, orthopedics, women's health, digestive health, rehabilitation services, and behavioral health.

Our Commitment to Community

PPMC 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 Portland Medical Center (PPMC) 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 PPMC CHNA.

Significant Community Health Needs Prioritized

PPMC 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

Health related social needs refer to essential, non-medical conditions that influence health and well-being, including access to safe and stable housing, nutritious and culturally appropriate food, reliable transportation, and basic utilities. When these needs are unaffordable and unmet, they create barriers to accessing care, managing health conditions, and maintaining overall quality of life.

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: PPMC 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 Portland Medical Center (PPMC) 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 PPMC: Mental health and substance use disorders, health related social needs, economic security, and access to care and services. Prioritizing these needs allows PPMC 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 Multnomah 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 Multnomah 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 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**
Smile Care Everywhere Program: Partnering with Pacific University to provide free and accessible dental hygiene and dental therapy services	Under or uninsured, low-income and Spanish-speaking community members in need of dental care	Number of community members provided dental care (Dental Hygiene and Dental Therapy)	Dental Hygiene: 78 community members Dental Therapy: 10 community members	Dental Hygiene: 80 community members Dental Therapy: 25 community members
Mobile Vision Clinic: Partner with Pacific University College of Optometry to provide free vison screenings, examinations, education, and prescription eye wear (if needed)	Under or uninsured, low-income and Spanish-speaking community members in need of vision care	Number of community members provided vision care	80 community members	Maintain baseline (80 community members)
Mobile Dental Clinics: Partner with Medical Teams International to	Under-insured or uninsured	Number of people served	383 people served	Maintain Baseline (383 people)

provide free emergency dental services via mobile dental clinics to help close gaps in access to care for underserved communities	community members experiencing oral pain and in need of dental services	in Multnomah County		
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	People living with pre-diabetes in Multnomah County	Number of people enrolled in program	46 people enrolled in program	51 people enrolled in program
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	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
Community Health Worker (CHW) Training: Provided by Providence Promotores staff to train community members to support	Spanish speaking community members interested in becoming a state	Number CHW's trained Number of CHW's certified through the	20 CHWs trained TBD	60 CHWs trained (2027) 50 CHWs trained (2027)

care navigation, health education, and resource connection	certified CHW	Oregon Health Authority (OHA)		
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	Unhoused patients discharging from hospital inpatient units who are too medically fragile to discharge to shelter or unsheltered	Number of patients placed at RCP	7 patients placed with RCP	30-35 patients placed with RCP
Patient Support Program: Partner with Project Access NOW to reduce discharge barriers and support safe, timely hospital discharges	Low-income patients discharged from PPMC	Number of patients receiving resources	2,596 patients receiving resources	2,600 patients receiving resources

Community and Research Informed Resources

- Patient navigators | County Health Rankings & Roadmaps
- Improving Access to Oral Health Care for Vulnerable and Underserved Populations | Healthy People 2030
- Screening and Preventive Interventions for Oral Health in Adults - Healthy People 2030 | odphp.health.gov
- Medicare Diabetes Prevention Program Expanded Model - Healthy People 2030 | odphp.health.gov

Resource Commitment

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

Key Community Partners

PPMC works with many community partners across Multnomah 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 Pacific University, Central City Concern, and Medical Teams International.

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**
Behavioral Health Intervention Team (BHIT): Specially trained behavioral health social workers who proactively identify, assess, intervene, and discharge plan for a vulnerable patient population	Individuals admitted to a PPMC inpatient medical unit who have behavioral health-related concerns or challenges	Number of unique patients served	894 unique patients served	961 unique patients served
BOB Folktime Program: Peer support specialists serve patients who present to the emergency department in psychiatric distress	Adults presenting to the emergency department in psychiatric distress in need of mental health/substance abuse services	Number of unique patients served Emergency department utilization % change	15 unique patients served TBD	110 unique patients served 25% decrease from 2025
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 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 presentations	24 W2BW Clubs 22 presentations
Community Benefit Grants: Partner with community-based organizations (CBO) addressing mental health and substance use disorders in Multnomah 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 Multnomah County community members in need of mental health/SUD support	Number of community benefit grants supporting CBOs	3 community benefit grants	1-3 community benefit grants

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

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

Key Community Partners

PPMC works with many community partners across Multnomah 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 North by Northeast Community Health Center, Maybelle Center, Rahab's Sisters.

COMMUNITY NEED ADDRESSED #3: HEALTH RELATED SOCIAL NEEDS

Population Served

In alignment with our mission, we prioritize underserved populations, including individuals and families with low incomes who are uninsured or underinsured. Our focus is on those experiencing unmet basic needs, such as food and nutrition insecurity, housing or utility instability, and limited access to reliable transportation.

Long-Term Goal(s)/ Vision

Advance health equity by addressing unmet social needs that create barriers to health, particularly for individuals and families experiencing economic, geographic, or systemic challenges.

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

Identified need: HEALTH RELATED SOCIAL NEEDS				
Strategy	**Population Served**	**Strategy Measure(s)**	**2025 Baseline**	**2028 Target**
Community Resource Desk Program: Partnering with Impact Northwest supporting individuals and families to navigate HRSN resources	Individuals and families with unmet social needs	Number of clients and household members Percentage of resource connection rate	3,558 clients 10,301 household members 85% of patients connected with resources	3,900 clients 11,700 household members 90% of patients connected with resources
Gateway Food Pantry: Partner with Nourish Oregon to provide three days' worth of healthy and culturally appropriate food to patients (and their household members) of two high need medical clinics	Patients and their household members who are experiencing food insecurity	Total individuals served	4,275 individuals served	Maintain baseline (4,275 individuals served)

Community Benefit Grant Making: Partner with community-based- organizations (CBO) in Multnomah County addressing health related social needs (food/nutrition, housing, utilities, transportation)	Low-income Multnomah County community members with a health-related social need	Number of community benefit grants supporting health related social needs	N/A	1-3 community grants (2026-2028)

Community and Research Informed Resources

- Patient Navigators | County Health Rankings & Roadmaps
- Perspectives From Patients Using a Food Pantry in a Family Medicine Residency Clinic: A Qualitative Study

Resource Commitment

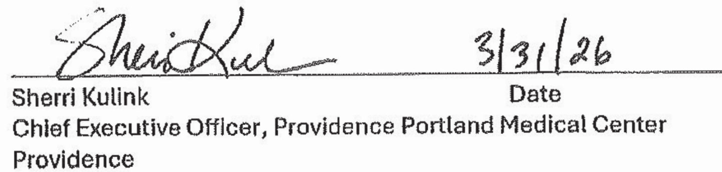
PPMC will commit staff time, supplies and equipment, cash and in-kind donations to support these strategies.

Key Community Partners

PPMC works with many community partners across Multnomah County to help address needs for those who are underserved. Examples of the partners we work with as part of our commitment to addressing health-related social needs include Impact Northwest, Nourish Oregon, and Project Access NOW.

2026- 2028 CHIP Governance Approval

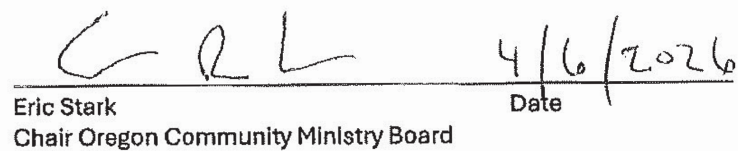
This Community Health Improvement Plan was adopted by the Multnomah County Service Area Advisory Council of the hospital on March 6, 2026. The final report was made widely available by May 15, 2026.



Sherri Kulink | Date

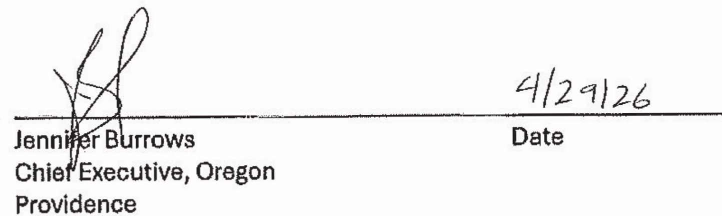
Chief Executive Officer, Providence Portland Medical Center

Providence



Eric Stark | Date

Chair Oregon Community Ministry Board



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.