COMMUNITY HEALTH IMPROVEMENT PLAN

2020 - 2022

Providence Medford Medical Center

Jackson County, Oregon

To provide feedback about this CHIP or obtain a printed copy free of charge, please email Dr. Joseph Ichter at Joseph.Ichter@providence.org

PROVIDENCE
Medford
Medical Center

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EXECUTIVE SUMMARY

Improving the health of our communities is fundamental and a commitment rooted deeply in our heritage and purpose. As expressions of God's healing love, witnessed through the ministry of Jesus, our Mission calls us to be steadfast in serving all with a special focus on our most poor and vulnerable neighbors. This core belief drives the programs we build, investments we make, and strategies we implement.

Knowing where to focus our resources starts with our community health needs assessment (CHNA), an opportunity in which we engage the community every three years to help us identify and prioritize the most pressing needs, assets and opportunities. In Southern Oregon, Providence Medford Medical Center (PMMC) is a member of Jefferson Regional Health Alliance (JRHA), a collaboration of regional community leaders learning and working together to improve the health care resources of Southern Oregonians. The collaborative includes AllCare Health, Asante, Addictions Recovery Center, Jackson County Health & Human Services – Public Health and Mental Health Divisions, Jackson Care Connect, La Clinica, Oregon Health Authority, Options for Southern Oregon, Oregon State University Extension Service, PrimaryHealth, Rogue Community Health and Providence Health & Services. Although the 2018 Community Health Assessment of Jackson and Josephine Counties was produced a year earlier than PMMC required, additional updated data was included as appropriate.

Based on geographic location relative to other hospitals in the area and patient demographics, Jackson County is PMMC's primary service area with Josephine County considered as a secondary service area. Our 168-bed hospital provides an array of services including primary care, surgical services, obstetrics and gynecology, diagnostic imaging, pediatrics, intensive care, 24/7 emergency care and one of the most comprehensive rehabilitation programs in the region. PMMC provided over $53M[1] in Community Benefit in 2019.

PMMC Community Health Improvement Plan Priorities

As a result of the findings of our 2019 Community Health Needs Assessment (CHNA) and through a prioritization process aligned with our Mission, resources, and hospital strategic plan, PMMC will focus on the following areas for its 2020-2022 Community Health Improvement Plan efforts:

PRIORITY 1: SOCIAL DETERMINANTS OF HEALTH AND WELL-BEING

Focus areas in housing and food security

PRIORITY 2: CHRONIC CONDITIONS

Focus on prevention of obesity and diabetes

PRIORITY 3: BEHAVIORAL HEALTH/WELL-BEING AND SUBSTANCE USE DISORDERS

Screening and treatment for mental health and substance use disorders

[1] Unpaid costs of Medicare are included in this Community Benefit reporting.

PRIORITY 4: ACCESS TO CARE

Focus on services navigation and coordination

Responding to the COVID-19 Pandemic

The 2020 Community Health Improvement Planning (CHIP) process was disrupted by the SARS-CoV-2 virus and COVID-19, which has impacted all of our communities. While we have focused on crisis response, it has required a significant re-direction of resources and reduced community engagement in the CHIP process.

This CHIP is currently designed to address the needs identified and prioritized through the 2019 CHNA, though COVID-19 will have substantial impacts on our community needs. These impacts are likely to exacerbate some of the needs identified, and cause others to rise in level of priority. While this is a dynamic situation, we recognize the greatest needs of our community will change in the coming months, and it is important that we adapt our efforts to respond accordingly. Additionally, the data projections included were crafted based on data collection and project forecasting done prior to the COVID-19 pandemic, so may be modified as we understand adjusted resources and priorities within our communities in the aftermath of the pandemic.

This CHIP will be updated by March 2021 to better document the impact of and our response to COVID-19 in our community. We are committed to supporting, strengthening, and serving our community in ways that align with our Mission, engage our expertise, and leverage our Community Benefit dollars in the most impactful ways.

MISSION, VISION, AND VALUES

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

INTRODUCTION

Who We Are

PMMC is a full-service, 168-bed, acute care, not-for-profit community hospital providing exceptional health care to southern Oregon and northern California. Services offered include emergency services, stroke care, cardiac and vascular care, birth center, total joint replacement and spine health programs, robotic surgery, pain management services and one of the most comprehensive rehabilitation programs in the region.

Our Commitment to Community

PMMC dedicates resources to improve the health and quality of life for the communities it serves, with special emphasis on the needs of the economically poor and vulnerable. During 2019, PMMC provided over $53 million in community benefit[2][3] in response to unmet needs and improve the health and well-being of those we serve in the Medford service area.

Community Benefit Governance and Management Structure

PMMC further demonstrates organizational commitment to the community benefit process through the allocation of staff time, financial resources, participation and collaboration with community partners. The PMMC administration is ultimately responsible for coordinating implementation of State and Federal 501r requirements as well as providing the opportunity for community leaders and internal hospital Executive Management Team members, physicians and other staff to work together in planning and implementing the Community Health Improvement Plan in conjunction with the Community Health Division.

As a primary source of Community Benefit advice and local leadership, PMMC's Service Area Advisory Council (SAAC) plays a pivotal role to support the Board of Trustees in overseeing community benefit issues. Acting in accordance with a Board-approved charter, the SAAC is charged with identifying policies and programs that address identified needs in the service area particularly for underserved populations, overseeing development and implementation of the Community Health Needs Assessment and Community Health Improvement Plan Reports, and overseeing and directing the Community Benefit activities. The SAAC delegates some work to the Community Benefit Committee, a majority of members who have knowledge and experience with the populations most likely to have disproportionate unmet

[2] A community benefit is an initiative, program or activity that provides treatment or promotes health and healing as a response to identified community needs and meets at least one of the following community benefit objectives: a. Improves access to health services; b. Enhances public health; c. Advances increased general knowledge; and/or d. Relieves government burden to improve health. Note: Community benefit includes both services to the economically poor and broader community.

[3] To be reported as a community benefit initiative or program, community need must be demonstrated. Community need can be demonstrated through the following: 1) community health needs assessment developed by the ministry or in partnership with other community organizations; 2) documentation that demonstrates community need and/or a request from a public agency or community group was the basis for initiating or continuing the activity or program; 3) or the involvement of unrelated, collaborative tax-exempt or government organizations as partners in the community benefit initiative or program.

health needs. The Community Benefit Committee generally meets monthly during the community benefit grant cycle, to provide input into where grant funding will be allocated.

Planning for the Uninsured and Underinsured

Our mission is to provide quality care to all our patients, regardless of ability to pay. We believe that no one should delay seeking needed medical care because they lack health insurance. That is why PMMC has a Financial Assistance Program (FAP) that provides free or discounted services to eligible patients. Services must be medically necessary as defined by the Providence Financial Assistance Policy. Patients receiving emergency or medically necessary care at Providence hospitals and clinics may receive the following discounts based upon the following eligibility:

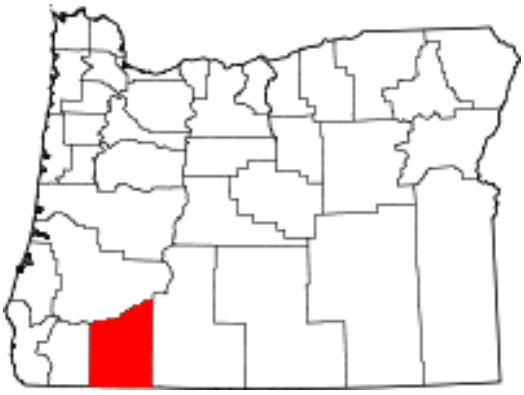
- 100% financial assistance is provided for households making up to 300% FPL
- 75% financial assistance for households between 301% and 400% FPL
- Financial assistance applies to self-pay balances and patient responsibility balances after insurance pays.

One way PMMC informs the public of FAP is by posting notices. Notices are posted in high volume inpatient and outpatient service areas. Notices are also posted at locations where a patient may pay their bill. Notices include contact information on how a patient can obtain more information on financial assistance as well as where to apply for assistance. These notices are posted in English and Spanish and any other languages that are representative of 5% or greater of patients in the hospital's service area. All patients who demonstrate lack of financial coverage by third party insurers are offered an opportunity to complete the Patient Financial Assistance Application and are offered information, assistance, and referral as appropriate to government sponsored programs for which they may be eligible. For information on our Financial Assistance Program click here.

OUR COMMUNITY

Description of Community Served

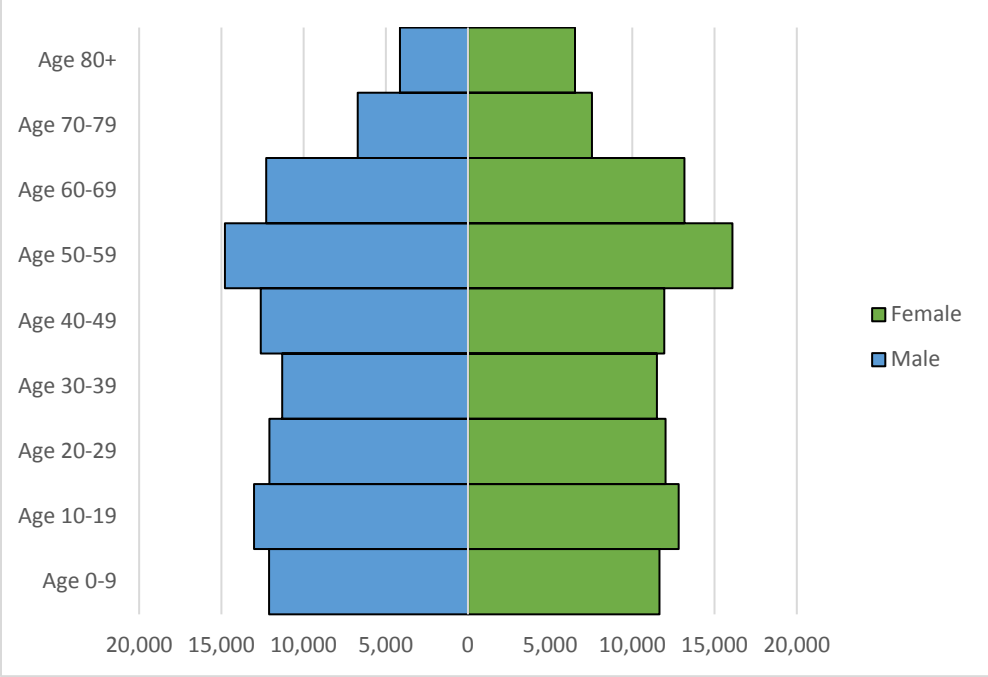
Based on geographic location relative to other hospitals in the area and patient demographics, Jackson County (in red) is PMMC's primary service area with Josephine County considered as a secondary service area.



Population and Demographics

As of 2019, Jackson County is home to approximately 223,000 residents. The ratio of males to females is 1:1 through the age of 55, when females begin making up a greater proportion of the total population. Due to life expectancy, females often outnumber males at older ages, but the trend starts slightly earlier in Southern Oregon than in other counties in Oregon.

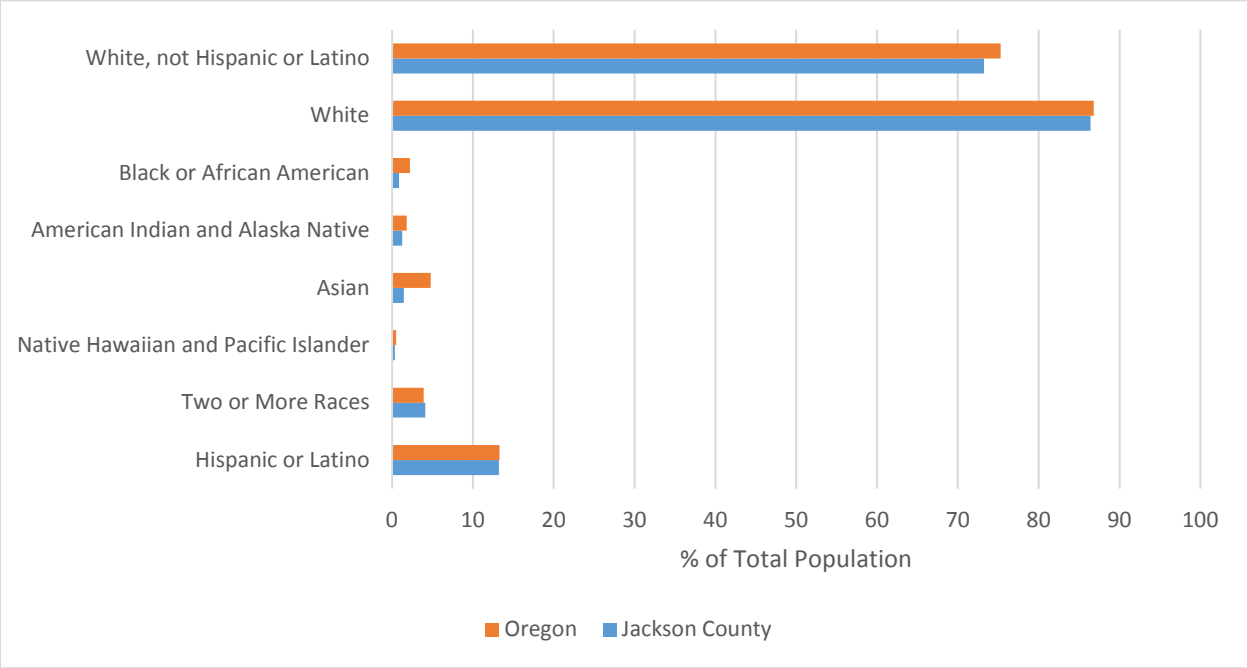
Figure 1: 2018 Jackson County by Age and Gender



Race and Ethnicity

According to July 2019 US Census data, the vast majority of residents (73.2 percent) identify as White non-Hispanic. The second largest population group in Jackson County is individuals who identify as Hispanic/Latino, making up 13 percent of the population. The Hispanic/Latino population is expected to make up 19 percent of the total population by 2021.

Figure 2: 2018 Race and Ethnicity Demographics of Jackson County and Oregon Residents by Percentage of Total Population



Income

In 2018, Jackson County's median household income was $50,851 and the per capita income was $28,728, which were both lower than those of the state of Oregon ($59,393 and $32,045, respectively). The current rental market has less than 2 percent vacancy.

Health and Well-being

In Jackson County in 2017, the combined 2014-2017 Oregon Behavioral Risk Factor Surveillance System (BRFSS) results found that 26.2 percent of adults have a depression diagnosis, higher than the national and Oregon average (25.6 percent). Twenty-six percent of people in Jackson County are Oregon Health Plan members in 2017 according to the Oregon health Authority, with the American Community Survey finding an additional 12 percent were uninsured during the same time period. 53 percent of CORE survey respondents report having fewer than two servings of fruit per day and almost 62 percent report having fewer than two servings of vegetables.

COMMUNITY NEEDS AND ASSETS ASSESSMENT PROCESS AND RESULTS

Summary of Community Needs Assessment Process and Results

Through a mixed-method approach using quantitative and qualitative data, the CHNA process utilized several sources of information to identify community needs. As part of the collaborative CHNA, public health data sources accessed for this report include the U.S. Census, Oregon Health Authority, and Jackson and Josephine County Public Health, among others. In addition to an online and paper community survey that engaged over 1,100 residents, approximately 170 individuals from multi-sector organizations, residents, and community stakeholders participated in community forums, focus groups and interviews to gather feedback on community strengths, challenges and priority health concerns. In 2019, Providence conducted a supplemental mailed Community Health Survey using an address-based random-sampling of residents in the Southern Oregon service area, yielding 143 responses. Across the data collection process, these populations included people with low incomes, as well as people with a variety of identities and experiences including older adults, young people, people who identify as LGBTQ+, Hispanic/Latinx people, people of color, recent immigrants, people experiencing homelessness, and rurally residing individuals. From this quantitative and qualitative data, key findings include:

- One in five (21%) respondents with low incomes reported experiencing food insecurity in the last 12 months, and one in four reported lacking stable housing or were worried about losing it soon.
- 53% of survey respondents reported having been diagnosed with at least one chronic physical condition, and 26% reported at least one chronic behavioral health condition, with a substantially higher impact on populations below 200% Federal Poverty Level (FPL).
- Behavioral health disparities exist by family income, with those at 200% or below FPL having substantially higher rates of depression (39 %) and anxiety (31%). Seniors reported particular concern with social isolation.

Identification and Selection of Significant Health Needs

The prioritized needs were chosen based on various community health data and identifiable gaps in available care and services. These health needs were those that had worsened over time, are worse than the state or national average, or have a disproportionate impact on those who are low-income, communities of color, or otherwise marginalized populations.

Community Health Needs Prioritized

The prioritized needs were chosen based on community health data and identifiable gaps in available care and services. In the course of our work, we determined that emphasis on these needs would have the greatest impact on the community's overall health with significant opportunities for collaboration. These interventions were prioritized based upon relative needs and opportunities, particularly those that serve identified high needs ZIP codes and neighborhoods including low-income and minority populations.

SOCIAL DETERMINANTS OF HEALTH AND WELL-BEING

- **Affordable housing** (or housing accessibility) is a major challenge for low and moderate income families in the area, particularly for those in recovery from substance use disorder. One in four low-income survey respondents reported lacking stable housing or were worried about losing it soon.
- A key barrier for many of Oregon's families continues to be **healthy food access**. One in five (21%) respondents with low incomes reported experiencing food insecurity in the last 12 months. Because nutrition is closely linked with oral health and chronic conditions, improving access to healthy food could lead to improved health outcomes in these other areas.
- Economic development and **living-wage jobs** are key opportunities to improve the health and well-being of our communities. This also speaks to the challenge in Oregon of the "benefits cliff," whereby public benefits phase out quickly as family income increases, although the increase may not be great enough for self-sufficiency.
- **Transportation** is a challenge for some populations, particularly for the elderly and those living in rural areas.

CHRONIC CONDITIONS

- Chronic disease accounts for two-thirds of emergency room encounters and continue to disproportionately impact communities of color.
- **Diabetes** continues to be one of the top reasons uninsured adults seek care in an Emergency Department, though the condition is likely better managed in a primary care setting. This suggests opportunities regarding prevention, education, and nutrition support. Diabetes is more common in Medicare recipients than in those who are privately insured.
- Over half (53.3%) of CORE survey respondents reported having been diagnosed with at least one chronic physical condition, and over a quarter (26.3%) report at least one chronic behavioral health condition.
- **Obesity** is a public health challenge, for both youth and adults. 26.1 percent of Jackson County's adult population is obese, slightly lower than Oregon's overall percentage of 28.6 percent according to BRFSS. However, the obesity rate is much higher (34.2%) in the secondary service, area Josephine County. The current generation of youth may be the first to have a shorter life expectancy than their parents due to complications from obesity and its associated conditions.

COMMUNITY MENTAL HEALTH/WELL-BEING AND SUBSTANCE USE DISORDERS

- **Access to mental health services** remain a barrier for many community members. There is a need to reduce stigma associated with mental health treatment and increase availability of providers and treatment services. This is particularly true amongst youth and adolescents, presenting opportunities to partner with school-based health centers. Barriers to accessing mental health services are more acute for non-English speakers.

- Behavioral health disparities exist by family income, with those at 200% or below FPL having substantially higher rates of depression (39%) and anxiety (31%). Seniors reported particular concern with social isolation.
- Access to **substance use treatment** continues to be a challenge for many. This includes alcohol and drug addiction services, both residential and outpatient treatment options. Substance use is prevalent among youth and adults in Jackson and Josephine Counties, which can be associated with trauma.
- As we continue to learn about adverse childhood experiences (ACES) and the impacts of trauma on health later in life (i.e. child abuse, neglect, domestic violence, sexual assault, etc.), increasing **community resilience** and preventing exposure to these events in the first place has become increasingly important.

ACCESS TO CARE

- Timely and consistent access to **primary care** remains a challenge, particularly for those on the Oregon Health Plan (Medicaid) and individuals that are uninsured.
- **Dental** conditions are among the top preventable reasons uninsured individuals access the Emergency Department, which is rarely the best point of care for these conditions. This presents an opportunity for prevention education and increasing access to preventive services.
- It is important that community members feel welcome, safe, and respected in health care settings. A crucial step in improving the health and well-being of communities of color is to increase access to **culturally-responsive care**.

Needs Beyond the Hospital's Service Program

No hospital facility can address all of the health needs present in its community. We are committed to continuing our Mission through Community Benefit grant-making and ongoing partnerships in our community. While we care for our community each day, we recognize that we cannot address all needs effectively or independently, and some of the areas identified in our CHNA may be out of scope for us.

However, we are confident these needs will also be addressed by other in the community. PMMC will continue to collaborate with local organizations that address community needs to coordinate care and referrals to address these unmet needs. We strongly believe that together we can better address the needs of our communities by leveraging our collective strengths.

The following community health need identified in the ministry CHNA will not be addressed at this time:

- **Transportation**: Due to resource constraints, and a relative lack of expertise in this area, PMMC will not directly address community transportation needs. Through the Community Resource Desk, PMMC connects community members to organizations such as Translink and Aging and Disability Resource Connection of Oregon (ADRC), to addressing transportation needs in Jackson County.

COMMUNITY HEALTH IMPROVEMENT PLAN

Summary of Community Health Improvement Planning Process

A CHIP planning committee of hospital leaders, Service Area Advisory Council members and community partners was formed to provide input in the PMMC CHIP process. Due to the 2020 COVID-19 pandemic, the original CHIP process was altered to accommodate a travel ban, social distance requirements, and unforeseen time commitments of key leaders. Below are the altered steps taken to compete the 2020-2022 PMMC CHIP:

- Providence Community Health Division (CHD) staff drafted four CHIP initiatives, including community needs and goals, to present to the CHIP planning committee for input
- In collaboration with community partner organizations, CHD staff drafted the PMMC CHIP to present to hospital leadership and the CHIP planning committee for input
- Input was gathered and incorporated into the final PMMC CHIP document
- Final PMMC CHIP document was approved by PMMC hospital and system level leadership

PMMC anticipates strategies may change and certain community health needs may become more pronounced, requiring changes to the initiatives identified below.

Addressing the Needs of the Community: 2020- 2022 Key Community Benefit Initiatives and Evaluation Plan

INITIATIVE #1: SOCIAL DETERMINANTS OF HEALTH RESULTING FROM POVERTY AND INEQUITY

Community Need Addressed

Housing opportunities for unsheltered community members

Goal (Anticipated Impact)

Increase access to safe shelter and supports for individuals who are experiencing homelessness

Scope (Target Population)

Unsheltered individuals living in Jackson County

Table 1. Outcome Measures for Addressing Homelessness

Outcome Measure	Baseline	FY20 Target	FY22 Target
Decrease number of unsheltered individuals living in Jackson County	263 unsheltered	5% decrease from baseline	10% decrease from baseline

Decrease homeless rates for K-12 students living in Jackson County	2,206 students experiencing homelessness (2017-2018)	5% decrease from baseline	10% decrease from baseline

Table 2. Strategies and Strategy Measures for Addressing Homelessness

Strategy(ies)	Strategy Measure	Baseline	FY20 Target	FY22 Target
Provide shelter or transitional housing to unsheltered homeless individuals and families	Number of persons housed in shelters or transitional housing	457	5% increase from baseline	10% increase from baseline
Provide case management, peer support and navigation to connect unsheltered individuals to permanent housing	Number of unsheltered individuals taking part in services that assist with securing permanent housing	251	5% increase from baseline	10% increase from baseline

Evidence Based Sources

- Supportive Housing Helps Vulnerable People Live and Thrive in the Community https://www.cbpp.org/research/housing/supportive-housing-helps-vulnerable-people-live-and-thrive-in-the-community
- Home Is Where Our Health Is https://www.rwjf.org/en/blog/2019/07/home-is-where-our-health-is.html
- Housing Is Health https://jamanetwork.com/journals/jama/fullarticle/2667710

Resource Commitment

$100,000 community benefit funds for 2020, staff time, other resources to be determined in 2020-2022 cycle

Key Community Partners

City of Medford, Rogue Retreat, Kelly Shelter, Jackson County Continuum of Care

INITIATIVE #2: CHRONIC HEALTH CONDITIONS

Community Need Addressed

Pre-diabetes/diabetes

Goal (Anticipated Impact)

Increase the number of community members receiving diabetes prevention services

Scope (Target Population)

Jackson County residents at risk of developing type 2 diabetes

Table 3. Outcome Measures for Addressing Pre-diabetes/Diabetes

Outcome Measure	Baseline	FY20 Target	FY22 Target
Increase number of Diabetes Prevention Program (DPP) cohorts offered in Medford	0	2	4
Increase percentage of Providence Medical Group (PMG) pediatric and family medicine clinics promoting healthy lifestyle behaviors to pediatric population	5%	25%	75%

Table 4. Strategies and Strategy Measures for Addressing Pre-diabetes/Diabetes

Strategy(ies)	Strategy Measure	Baseline	FY20 Target	FY22 Target
Offer community DPP information sessions to recruit participants	Number of community DPP information sessions offered	0	4	8
Increase DPP referrals by identifying community partners as a referral source	Number of community partners referring to DPP	0	2	3
Increase the number of PMG providers discussing healthy lifestyle behaviors with pediatric patients and family members	Number of PMG providers discussing healthy lifestyle behaviors (5.2.1.0 + 9 tool)	0	10	20

Evidence Based Sources

- "The **National Diabetes Prevention Program** is a partnership of public and private organizations working to prevent or delay type 2 diabetes. Partners make it easier for people at risk for type 2

diabetes to participate in evidence-based lifestyle change programs to reduce their risk of type 2 diabetes." **https://www.cdc.gov/diabetes/prevention/index.html**

- Evidence and Challenges for Translation and Population Impact of the Diabetes Prevention Program https://www.ncbi.nlm.nih.gov/pubmed/32080770
- Public Health Approaches to Type 2 Diabetes Prevention: the US National Diabetes Prevention Program and Beyond https://www.ncbi.nlm.nih.gov/pubmed/31385061
- Addressing Childhood Obesity: Opportunities for Prevention Pediatr Clin North Am. 2015 Oct; 62(5): 1241–1261.
- A Review of the Prevention and Medical Management of Childhood Obesity https://www.ncbi.nlm.nih.gov/pubmed/29157503
- Addressing Childhood Obesity: Opportunities for Prevention https://www.ncbi.nlm.nih.gov/pubmed/26318950
- Early childhood obesity prevention efforts through a life course health development perspective: A scoping review https://www.ncbi.nlm.nih.gov/pubmed/30592757

Resource Commitment

The Providence Diabetes Prevention Program is a subsidized service. The cost of each cohort is $17,700 in addition of 0.3 FTE. Providence will provide training for coaches to become certified DPP Lifestyle Coaches (LSC), and maintain skills with additional in-person training and monthly coaching calls. Additional staff time and other resources to be determined in 2020-2022 cycle.

Key Community Partners

Allcare CCO, Jackson County CCO, Oregon Wellness Network, Senior Centers, Retirement Homes, FQHC's in the area, CoMagine Health, Jackson County Health Department

INITIATIVE #3: COMMUNITY MENTAL HEALTH/WELL-BEING AND SUBSTANCE USE DISORDERS

Community Need Addressed

Mental health and/or substance use disorder services

Goal (Anticipated Impact)

Increase access to affordable and comprehensive mental health and substance use disorder treatment for Jackson County residents

Scope (Target Population)

Low-income community members living with mental health and/or substance use disorders

Table 5. Outcome Measures for Addressing Mental Health and Substance Use Disorders

Outcome Measure	Baseline	FY20 Target	FY22 Target
Percentage of persons presenting with mental	67%	70%	76%

health/substance use disorders being connected to behavioral health services receiving services			

Table 6. Strategies and Strategy Measures for Addressing Mental Health and Substance Use Disorders

In addition to Providence's Behavioral Health program, we will focus on supporting community-level mental health with likeminded partners.

Strategy(ies)	Strategy Measure	Baseline	FY20 Target	FY22 Target
Add behavioral health capacity at federally qualified health center La Clinica	Behaviorist FTE	3	6	12
	Number of neighborhood clinics with behavioral health services	3	4	5
Screen eligible patients for depression and provide follow-up at La Clinica	Number of patients screened for depression	60%	65%	75%
Screen eligible patients for substance use disorders at La Clinica	Number of patients screened for substance use disorders	63%	65%	75%
Provide access to individuals seeking treatment for substance use disorders at Addictions Recovery Center	Number of individuals receiving treatment for substance disorders through the Addiction Recovery Center Walk-in and Addiction Medicine clinics	2,300	1,680 *(reduced services due to COVID-19 pandemic)*	2,300

Evidence Based Sources

- Collaborative Care Teams Improve Mental Health Outcomes https://www.cfah.org/hbns/2012/collaborative-care-teams-improve-mental-health-outcomes.html
- Primary Care Behavioral Health Consultation Reduces Depression Levels Among Mood-Disordered Patients https://www.integration.samhsa.gov/Primary_Care_Behavioral_Health_Consultation_Reduces_Depression.pdf

Resource Commitment

$77,000 community benefit funds for 2020, staff time, other resources to be determined in 2020-2022 cycle.

Key Community Partners

La Clinica, Addiction Recovery Center

INITIATIVE #4: SOCIAL DETERMINANTS OF HEALTH RESULTING FROM POVERTY AND INEQUITY

Community Need Addressed

Child food insecurity

Goal (Anticipated Impact)

Decrease rate of children experiencing food insecurity in Jackson County

Scope (Target Population)

Low income, food insecure households with children under 18 years in Jackson County

Table 7. Outcome Measures for Addressing Child Food Insecurity

Outcome Measure	Baseline	FY20 Target	FY22 Target
Decrease child food insecurity in Jackson County	20.9% (2017)	At or below Oregon state level (2017: 18.9%)	At or below Oregon state level
Decrease percent of 6th graders in Jackson County who report ever feeling they did not have enough to eat	23.8% (2017-2018)	21.8%	20%

Table 8. Strategies and Strategy Measures for Addressing

Strategy(ies)	Strategy Measure	Baseline	FY20 Target	FY22 Target
Dedicate funding through Providence Health & Services community benefit grants	Dollars invested to address food insecurity	$0	$50,000	$50,000
Provide resources to food insecure households through the Providence Community Resource Desk	Number of households receiving resources through the Community Resource Desk	81	105	141

Evidence Based Sources

- "There is a broad base of literature illustrating links between food insecurity and poor child health and behavioral outcomes at every age. Children struggling with food insecurity may be at greater risk for stunted development, anemia and asthma, oral health problems and hospitalization. Overall, food insecurity is linked with poorer physical quality of life, which may prevent children from fully engaging in daily activities. At school, food-insecure children are at increased risk of falling behind their food-secure peers both academically and socially; food insecurity is linked to lower reading and mathematics test scores, and they may be more likely to exhibit behavioral problems, including hyperactivity, aggression and anxiety." - **Feeding America, 2019** https://www.feedingamerica.org/sites/default/files/2019-05/2017-map-the-meal-gap-child-food-insecurity_0.pdf
- Association of Food Insecurity with Children's Behavioral, Emotional, and Academic Outcomes: A Systematic Review https://www.ncbi.nlm.nih.gov/pubmed/28134627
- The Impact of Food Insecurity on Child Health https://www.ncbi.nlm.nih.gov/pubmed/32122567

Resource Commitment

Providence in-kind physical desk space, equipment, staff time, other resources to be determined in 2020-2022 cycle.

Key Community Partners

Jackson County WIC, Rogue Valley Farm to School, OSU Extension, ACCESS

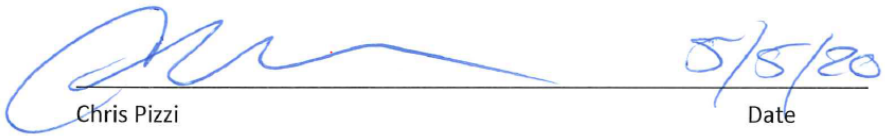
Other Community Benefit Programs

Table 9. Other Community Benefit Programs in Response to Community Needs

Initiative (Community Need Addressed)	Program Name	Description	Target Population (Low Income, Vulnerable or Broader Community)
1. Access to dental services	Medical Teams International Dental Van Clinics	Free emergency and restorative dental services	Un/underinsured
2. Social determinants of health	Community Resource Desk	Access to resources addressing social needs	Low income
3. Social determinants of health	Patient Support Program	Safe and secure discharge from hospital	Low income
4. Chronic conditions	Diabetes Education	Diabetes self-management education	Broader community living with diabetes
5. Social determinants of health	Coordinated Entry System (Continuum of Care)	Program used to ensure individuals experiencing homelessness with the most severe needs and highest vulnerability scores are prioritized for housing	Homeless
6. Chronic conditions, Mental health & well-being	The Family Connection: Nurturing Parenting Classes	Parenting education related to adverse childhood experiences (ACES), child resiliency and healthy lifestyle behaviors	Broader parenting community

2020-2022 CHIP GOVERNANCE APPROVAL

This Community Health Improvement Plan was adopted by the Service Area Advisory Council of the hospital on April 23, 2020. The final report was made widely available by May 15, 2020.

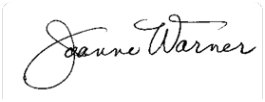


Chris Pizzi — Date: 5/5/20

Chief Executive, Providence Medford Medical Center

Lisa Vance — Date: 8 May 2020

Chief Executive, Oregon Region



Joanne Warner — Date: 8 May 2020

Chair, Oregon Community Ministry Boards

Joel Gilbertson — Date: 11 May 2020

Senior Vice President, Community Partnerships

Providence St. Joseph Health

CHNA/CHIP Contact:

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

APPENDICES

Appendix 1: Definition of Terms

Community Benefit: An initiative, program or activity that provides treatment or promotes health and healing as a response to identified community needs and meets at least one of the following community benefit objectives:

a. Improves access to health services;
b. Enhances public health;
c. Advances increased general knowledge; and/or
d. Relieves government burden to improve health.

Community benefit includes services to persons living in poverty, persons who are vulnerable, and the broader community.

To be reported as a community benefit initiative or program, community need must be demonstrated. Community need can be demonstrated through the following:

a. Community health needs assessment developed by the ministry or in partnership with other community organizations;
b. Documentation that demonstrates community need and/or a request from a public agency or community group was the basis for initiating or continuing the activity or program; or
c. The involvement of unrelated, collaborative tax-exempt or government organizations as partners in the community benefit initiative or program.

Health Equity: Healthy People 2020 defines *health equity* as the "attainment of the highest level of health for all people. Achieving health equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and health care disparities."

Social Determinants of Health: Powerful, complex relationships exist between health and biology, genetics, and individual behavior, and between health and health services, socioeconomic status, the physical environment, discrimination, racism, literacy levels, and legislative policies. These factors, which influence an individual's or population's health, are known as *determinants of health*. *Social determinants of health* are conditions in the environment in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.

Initiative: An initiative is an umbrella category under which a ministry organizes its key priority efforts. Each effort should be entered as a program in CBISA Online (Lyon Software). Please be sure to report on all your Key Community Benefit initiatives. If a ministry reports at the initiative level, the goal (anticipated impact), outcome measure, strategy and strategy measure are reported at the initiative level. Be sure to list all the programs that are under the initiative. Note: All Community Benefit initiatives must submit financial and programmatic data in CBISA Online.

Program: A program is defined as a program or service provided to benefit the community (in alignment with guidelines) and entered in CBISA Online (Lyon Software). Please be sure to report on all community benefit programs. Note: All community benefit programs, defined as "programs", are required to include financial and programmatic data into CBISA Online.

Goal (Anticipated Impact): The goal is the desired ultimate result for the initiative's or program's efforts. This result may take years to achieve and may require other interventions as well as this program. (E.g. increase immunization rates; reduce obesity prevalence.).

Scope (Target Population): Definition of group being addressed in this initiative: specific description of group or population included (or not included, if relevant) for whom outcomes will be measured and work is focused. Identify if this initiative is primarily for persons living in poverty or primarily for the broader community.

Outcome measure: An outcome measure is a quantitative statement of the goal and should answer the following question: "How will you know if you're making progress on goal?" It should be quantitative, objective, meaningful, and not yet a "target" level.