Providence Medford Medical Center, Fiscal Year Ended 12/31/2023

1. The year of publication for the current community health needs assessment

The year of publication for the most recent community health needs assessment was 2022.

2. State the top health needs identified in the hospital's most recent community health needs assessment. Include information on geographies, populations or demographic groups affected.

In Southern Oregon, Providence Medford Medical Center (PMMC) collaborated with Asante to produce a comprehensive assessment of our communities' most pressing needs, share our findings with the broader public and develop new relationships leading to a healthier community. Before engaging in a collaborative process, both health systems agreed to a set of "principles of collaboration." These included:

- Collaborate to identify key health needs and issues in Jackson and Josephine counties
- Focus on community engagement and collaborative participation
- Avoid community partner burnout with respect to qualitative data collection through a collective approach to listening sessions and key informant interviews
- Commit to cash and/or in-kind resources from both parties, with resources used to develop a CHNA that satisfies regulatory requirements

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.

Through a mixed-methods approach and using quantitative and qualitative data, the CHNA team collected information from the following sources: American Community Survey, Behavioral Risk Factor Surveillance System (BRFSS), Centers for Disease Control and Prevention (CDC), County Health Rankings & Roadmaps, ESRi Updated Demographics, Oregon Health Authority, Oregon Student Wellness Survey, and the U.S. Census (such as public health data regarding health behaviors, morbidity and mortality, and hospital-level data).

We conducted five listening sessions with 68 individuals from diverse communities, including those with lower incomes -and/or medically underserved. Stakeholder interviews were held with 12 representatives from 10 organizations that serve these populations, specifically seeking to gain a deeper understanding of community strengths and opportunities. In addition, we conducted a community health survey in English and Spanish that engaged 1,237 residents. Below are highlights from our quantitative and qualitative data collection:

- Strong community partnerships are present between nonprofits, health care organizations, school districts, faith-based organizations, community and civic groups, and social support organizations, all working together to address community needs.
- Stakeholders identified housing as a foundational need and discussed the importance of Housing First, meaning people first need to be safely and stably housed before they can address their physical and behavioral health needs.

- Nearly 34% of community health survey respondents reported needing counseling or mental health services within the last year.
- 44-48% of 11th grade students in Jackson and Josephine counties reported signs of depression in 2020.

While care was taken to select and gather data that would tell the story of both health systems' service areas, it is important to recognize the limitations and gaps in information that naturally occur.

Asante and PMMC identified a wide spectrum of significant health needs, some of which are most appropriately addressed by other community organizations. Considering PMMC's unique capabilities, community partnerships and potential areas of community impact, we are committed to addressing the following priorities as aligned with the collaborative priority areas:

Mental Health and Substance Use Disorder: Focus on prevention and treatment, social isolation, and community building related to safe spaces and recreation. This priority area refers to the growing challenges of accessing care due to workforce shortages, a lack of culturally responsive care and affordability.

Health Related Social Needs: Focus on housing stability, navigation of supportive services, food insecurity and transportation. This priority area refers to the unmet social needs that exacerbate poor health and quality-of-life outcomes.

Economic Security: Focus on affordable childcare, education, and workforce development. This priority area affects nearly every aspect of a person's life and refers to the challenge of affording basic living expenses and obtaining affordable education.

Access to Care and Services: Focus on chronic disease management and prevention, oral health, and virtual care. This priority area refers to the lack of timely access to care and services due to physical, geographic, and systemic limitations, among others.

Three consistent cross-cutting themes surfaced during the assessment process and analysis, affecting all four priority areas:

- Racism, discrimination, and inclusion
- Culturally responsive care and services
- Trauma-informed care and services

3. Identify the significant community benefit activities the hospital engaged in that addressed the health needs identified above.

In 2023, PMMC contributed $33.2 million in community benefit across all categories including financial assistance. Outside of charity care and unreimbursed Medicaid costs, our proactive community benefit, such as community health improvement services, subsidized health services, health professions education, and research totaled $2.1 million. Community Health Investment (CHI) allocated $559k in grants across the Medford service area.

The following 2-3 activities under each health need represent a snapshot of PMMC's community benefit. Due to several programs being offered regionally, the title indicates whether the program is hospital specific or Oregon region.

Mental Health and Substance Use Disorder

Select examples of community benefit activities

Cash and In-Kind Contributions: Community Health Grants - (Providence Medford Medical Center)

In the Medford service area, grants were given to four community partners to address the area of mental health and substance use disorder.

- La Clinica
    - Providence supported La Clinica with a $75,000 grant to help increase access to behavioral health services for children and youth in the school setting. Qualified and credentialed mental health professionals delivered services in school-based health centers including access to a child psychiatrist through telehealth. During the one-year grant period, 260 unique patients at four elementary schools received a total of 4,320 behavioral visits (an average of 17 visits per student).
- Oasis Center of the Rogue Valley
    - Providence awarded Oasis Center of the Rogue Valley with a $75,000 grant to support a program of therapeutic childcare paired with child and adult mental health care delivered within a low-barrier primary care medical clinic. The Oasis care model integrates social and medical services to support the complex needs of children and pregnant women and adults with substance use disorders. These low-income families face significant challenges including housing instability, food insecurity, transportation barriers, inter-generational trauma, and mental health issues. This program is provided at no cost to families. Out of 20 families served, 13 engaged in the full array of services available which includes but is not limited to one-on-one parenting support/home visitation, parent engagement in mental health services, parenting support/education, and children's mental health.
- Maslow Project
    - Providence supported Maslow Project with a $40,000 grant to provide intensive case management for youth and adolescent clients. Using a self-sufficiency tool to assess individual progress, the key domains of case management focusing on social-emotional well-being, physical health, mental health, and other social supports. Qualified Mental Health Associates (QMHAs) assist clients in reaching goals identified on their mental health treatment plan, and when necessary, provide a warm handoff to more enhanced treatment services. As a result of this funding, 290 high school aged youth received ongoing case management support from QMHAs and 70% increased their self-sufficiency scores.
- United Way of Jackson County
    - Providence provided a $200,000 grant to United Way of Jackson County for the Mobile Crisis Intervention Service (MCIS) Pilot. The purpose is to bring a team of mental health and emergency medical providers to community members experiencing a behavioral health crisis, meeting individuals where they are when they need assistance. MCIS responses will be available to any community member in behavioral health crisis regardless of health plan, ability to pay, or demographics with the intent to divert individuals in crisis from arrest or hospitalization. Over 200 people were served in 2023.

      Client Success Story
      Mobile Crisis Intervention Service (MCIS) was called by Medford Police Department (MPD) stating they were contacted by staff at a local independent living program. There was a client who was agitated, threatening and crying. MPD requested mobile team

assistance. The MCIS team had just completed another call and were nearby the location. They responded and arrived on scene prior to law enforcement. The team helped the client de-escalate and process recent losses. The MCIS Team coordinated with client's treatment providers and established a plan for client to be taken to the hospital for medical clearance in order to be admitted to the Beckett Center for respite support. The MCIS team transported client to the hospital where they met with client's treatment providers who stayed with client through emergency department screening. The MCIS team coordinated with Beckett Center and hospital to facilitate admission to Beckett Center.

Community Health Improvement Services (CHIS): Providence Assessment, Intake & Referral (Prov AIR) - $1.5 million (Oregon Regional Services)

Every year over 30,000 Oregonians enter an emergency department in behavioral health crisis. Prov AIR was implemented in 2017 to make acute inpatient psychiatric care more accessible and equitable for patients throughout Oregon. Since the program's advent, this 24-hour team of master's level clinicians have worked around the clock to process an average of 600+ referrals a month for patients in need of acute, subacute, and residential levels of care. Through these efforts, the team coordinated 300+ admissions a month for high-risk Oregonians in need of acute psychiatric care at one of Providences four inpatient units.

CHIS: Better Outcomes through Bridges (BOB) Program - $1.4 million (Oregon Regional Services excluding Providence Hood River Memorial Hospital)

The BOB program focuses on serving some of the community's most vulnerable and underserved people with the goal to empower individuals on their journey toward better well-being by engaging with compassion, dignity, and integrity. Peer support specialists work with patients discharged from the emergency department in behavioral health crisis and facilitate connection to community resources and behavioral health programs. Furthermore, emergency department staff and peer support specialists work collaboratively to identify behavioral health patients with frequent ED visits that may need additional support and services. In 2023, there was an 11.9% decrease in ED utilization after six months for patients pre-and post-BOB program.

Health Related Social Needs

This section also addresses question 4a.

Cash and In-Kind Contributions: Community Health Grants - (Providence Medford Medical Center)

In the Medford service area, grants were given to four community partners to address the area of housing instability and homelessness.

- Coalición Fortaleza
    - Providence provided a $75,000 grant to help restore Latinx and indigenous neighborhoods that were destroyed by wildfires and to create pathways to home ownership in the form of resident-owned communities. In partnership with CASA of Oregon, Coalición Fortaleza will restore the Talent Mobile Estates (TME) mobile home park and turn it into the first resident-owned communities in southern Oregon. Eighty

percent of previous TME households engaged in community development with 140 individuals ultimately being served.

Client Success Story

One success story from the TME community is of Raymundo and his family. Raymundo is indigenous from Oaxaca and his family lived at TME before the fire and they are currently living in an RV. He has been very involved in the community engagements and is an IDA Program saver. His wife gave birth during the fires and we have been able to see his daughter grow and grow every year. In July 2023 Raymundo was selected to receive one of the first two units (made of mass timber) and he has accepted! We are so excited that he and his family will transition to permanent housing this year.

- ACCESS
    - Providence awarded ACCESS a $44,000 grant for the Eviction Prevention for Families with Minor Children program. The goal of this program is to prevent families with minor children who are unstably housed from becoming homeless. Funding goes directly to families to provide rent payments. Over the grant period 12 families were provided with an average $4,000 in financial assistance including acute case management. Follow-up calls with these families confirmed that 10 families remained housed six months after intervention.

      Client Success Story

      One of our participants is a mother of four young children who recently fled a situation of domestic violence. Due to this separation and additional associate challenges, stabilizing housing for herself and children proved to be exceptionally challenging. The threat of eviction and her family becoming homeless further exacerbated her stress and worry—especially due to the unique needs of her one child with a disability. Through the Providence grant, her household was able to receive vital services to not only secure housing but to also garner a greater level of stability. Because of this support, the mother is now looking for a job and pursuing assistance in caring for her children.

Cash and In-Kind Contributions: Patient Support Program - $907k (Providence Medford Medical Center)

Serving low-income patients in all eight Providence Oregon hospitals, the Patient Support Program (PSP) is another example of leveraging a community partnership to address barriers to care and help patients safely transition home or participate in treatment without worrying about basic needs. This program has expanded to include pregnant moms, heart patients, and vulnerable seniors. In 2023, the top need was transportation followed by medication costs. PSP is solely operated by Project Access NOW and served 692 clients by issuing 1,222 vouchers for services.

Cash and In-Kind Contributions: Community Resource Desk - $125,000 (Providence Medford Medical Center)

In an active partnership with ACCESS, Providence continues to co-locate staff through the Community Resource Desk (CRD) program. The CRD helps individuals and families who need support connect with community resources. It is free, confidential, and open to anyone who approaches the desk (staffed by bilingual Spanish/English speakers). In 2023, the CRD served 859 individuals and achieved an 94% resource connection rate. The top requested resource was housing services.

Access to Care and Services

Select examples of community benefit activities

CHIS: Supplies for Inpatient Patient Discharge - $19K (Providence Medford Medical Center)

This program was developed in response to disadvantaged and vulnerable PMMC patients who lack the necessary clothing, non-covered or unaffordable prescriptions, or medical supplies to discharge from the hospital after an inpatient stay. The supplies provided ensure patients have basic necessities to help them safely transition from the hospital setting. This service is provided by the hospital to enhance access to and quality of health care services. This program supports underinsured and uninsured persons and goes beyond basic discharge planning.

In addition to the programs listed above, the following community benefit activities were also reported: Regional Medication Assistance Program, Telestroke, Diabetes Health Education, Athletic Trainer Program, the Medical Forensic Program, and Wound Care Clinic.

4. ***Identify any community benefit activity that addresses the social determinants of health. Separate activities into those that:***
    a. ***Address individual health-related social needs***
    b. ***Address systemic issues or root causes of health and health equity***

At Providence, we recognized that long-standing inequities and systemic injustices exist in the world. This has led to health disparities among communities that have been marginalized because of their race, ethnicity, gender, sexual orientation, age, ability, religion, or socioeconomic status. Our vision, Health for a Better World, is driven by a belief that health is a human right.

In 2023, Providence Community Health Investment issued 38 grants to community organizations across all five of our Oregon service areas, many of which address health-related social needs and systemic issues of health and health equity. Seven grants were awarded in the Medford service area, six of which are detailed in question 3. This funding directly supports underserved and marginalized populations including immigrants and refugees, communities of color, and youth. These grants are classified under the appropriate funding priorities by year, and in 2023, our largest funding priorities were access to care and services and mental health and substance use disorder services.

Select examples of health equity work

Supporting Federally Qualified Health Center to Improve Type 2 Diabetes Management

Providence awarded La Clinica $50,000 for a second year of their pilot program to improve type 2 diabetes outcomes through integrated diabetes management. The pilot's approach uses a composite diabetes measurement system, which provides a more helpful performance metric for diabetes management. The Robert Wood Johnson Foundation and the National Committee for Quality Assurance recommend using composite measures, rather than solely relying on Hemoglobin A1c measure, as the new gold standard for quality measurement in managing diabetes. The overall percentage of patients with diabetes meeting all five indicators (smoking cessation, blood pressure control, Metformin therapy, statin therapy, and glycemic (A1C) control) improved from a baseline of 19.3% to 25.8%. As a result of this funding, 2,378 unduplicated individuals were served.

Patient Testimonials

Patient Testimonial on the effectiveness of reminder calls from outreach workers: “Thank you so much for calling me every 3 months about my A1C’s. Your calls are the only thing keeping me on track with my diabetes management and I am grateful to you.”

Patient Testimonial regarding the impact of one-on-one case management and education from nurses: “I was very afraid to inject myself with insulin and wasn’t doing this. You showed me that I can do it, and now I am not afraid to do it on my own.”

Patient Testimonial underscoring the importance of Spanish-language group nutrition education classes: “I like learning about nutrition from Ana Maria – she is fun and she knows my culture. I meet other people like me and we motivate each other to eat healthy”