LEGACY HEALTH

Legacy Good Samaritan
Hospital and Medical Center

DBA

Legacy Good Samaritan Medical Center

Community Health Needs Assessment

and

Community Health Improvement Plan

FY 2018

INTRODUCTION

ABOUT LEGACY GOOD SAMARITAN MEDICAL CENTER

Originally founded in 1875 by the Episcopal Diocese of Oregon, Legacy Good Samaritan Medical Center is one of the oldest hospitals in the Pacific Northwest.

Today, "Good Sam" is a nationally acclaimed medical center and part of Legacy Health, a six-hospital system established in 1989 by the merger of two nonprofit systems in the four-county metropolitan Portland, Oregon area, and the addition of the more recent acquisition of Silverton Medical Center in Marion County to the south. The system's mission is:

> *"Our legacy is good health for our people, our patients, our communities, our world."*

Legacy Good Samaritan is distinguished by the range of specialty care it offers, including its highly rated Legacy Cancer Institute, the world-renowned Legacy Devers Eye Institute, the respected Legacy Weight and Diabetes Institute, its comprehensive cardiac care capabilities and its pioneering organ transplant services.

In addition, Legacy is part of a new collaborative providing psychiatric emergency services — Unity Center for Behavioral Health. Unity Center is a joint effort of Adventist Health, Kaiser Permanente, Oregon Health & Science University and Legacy Health. It is the first collaborative medical initiative of its kind in the Pacific Northwest.

ABOUT THE AREA WE SERVE

Legacy Good Samaritan Medical Center defines service area based on actual patient origin (zip codes) and geographic location. Good Samaritan is located in one of the original Portland neighborhoods — inner Northwest Portland, which borders downtown. The primary service area extends from the Columbia River in the north to below Highway 99E in the south, west to Walker Road and east to N.E./S.E. 161st. Good Samaritan draws patients from as far west as the Gales Creek region of Washington county.

The primary service area includes the "close-in" neighborhood communities of Nob Hill, Old Town/Chinatown, Pearl District, Goose Hollow, John's Landing, Lair Hill, West Sylvan, Garden Home, Multnomah Village, Forest Heights, West Slope and Cedar Mills. These communities include both the wealthiest neighborhoods in the metro area and the very poorest — sometimes within blocks of each other.

As a tertiary facility, Legacy Good Samaritan draws patients from throughout Multnomah County, spanning west into Washington and Columbia counties. ZIP codes for the primary

service area include: 97005-97008, 97018, 97051, 97053, 97054, 97056, 97064, 97201-97222, 97225, 97227, 97229, 97230-97233,97236, 97239 and 97266. ZIP codes for the Washington county region include: 97106, 97109, 97113, 97116, 97117, 97119, 97123-97125, 97133, and 97144. While ZIP codes west of Walker Road (Washington County) are considered as part of Legacy Good Samaritan's broader service area, the focus of this report is on the primary service area within Multnomah County.

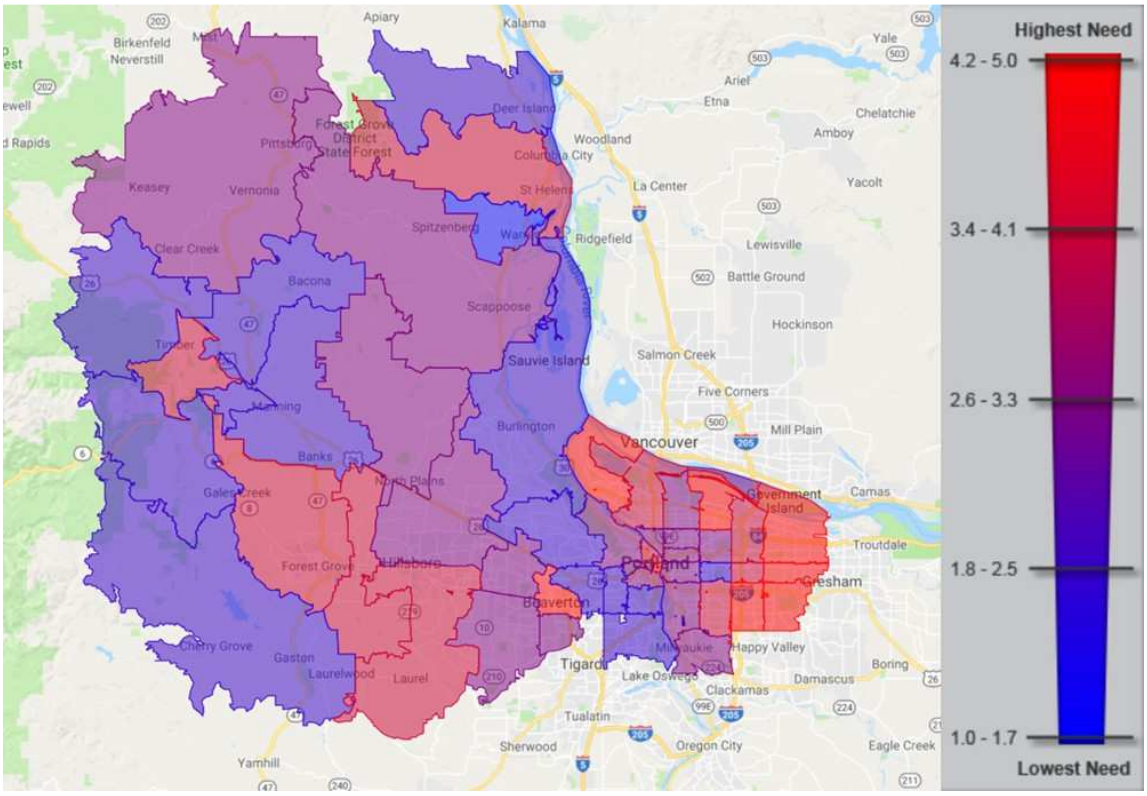
The Legacy Good Samaritan primary service area population includes approximately 1.4 million, with residents of Multnomah and Washington counties, with 1.6% percent growth from 2016 to 2017. The majority live in Multnomah County, which has the following demographics for race and ethnicity: 71 percent non-Hispanic white, 11.2 percent Hispanic, 5.0 percent African-American, 7.3 percent Asian and Pacific Islander, and 0.6 percent Native American. The foreign-born population represents 14.2 percent of total population in the area, an increase of nearly 20 percent since 2005.

While communities of color are less visible on the west side of the Willamette River in Legacy Good Samaritan's surrounding neighborhoods, this area is the site of a significant portion of the metro area's homeless population, where communities of color are disproportionately represented.

Multnomah County's median household income (MHI) averaged over the years 2008-2012 was $51,582, with 17.1 percent of the population living below poverty. In Multnomah County, the average non-Hispanic white median household income was $55,346 compared to Asian at $54,561, Hispanic/Latino at $36,572, American Indian/Alaska Native at $29,695 and Black/African-American at $27,347.

Statistics for families living below poverty level show non-Hispanic whites at 7.9 percent relative to Asians at 12.6 percent, multiracial families at 19.6 percent, Black/African-Americans at 32.6 percent, Hispanic/Latino at 30.7 percent and American Indian/Alaska Natives at 35.5 percent. The 2011 overall high school graduation rate in Multnomah County was 67.2 percent. Portland Public Schools, the area's largest school district, has reported a 15 percent difference between graduation rates for its non-Hispanic white student population and its African-American and Hispanic students.

The Dignity Health and Truven Health Community Needs Index (CNI) is accepted as the national standard in identifying communities with health disparities and comparing relative need. CNI for the four-county area shows (on a scale of 1/low need to 5/high need) two of the top nine areas of high need in close proximity to Legacy Good Samaritan: 97205-Goose Hollow and 97209-Old Town. Legacy Good Samaritan's focus is the highest CNI ZIP codes in its area, which include 97209-Old Town, 97205-Good Hollow, 97204-Downtown, 97201-Downtown and 97210-Nob Hill. [Source: http://cni.chw-interactive.org/] as shown below.



With the longstanding income disparities in the Legacy Good Samaritan service area, safety net services have expanded:

- Multnomah County Health Department operates federally qualified health centers (FQHCs) in downtown Portland.
- Central City Concern offers comprehensive health (FQHC), housing, mental health, meaningful employment and peer support for homeless individuals just one mile from the hospital.
- Legacy Good Samaritan contracts with Central City Concern to provide recuperative care services for discharged patients, striving to bring stability to people in need.
- Outside In is also an FQHC in downtown Portland and focuses on homeless youth and other marginalized members of the community, a large proportion of whom are LGBTQ.
- SW Community Health Center is a largely volunteer-staffed safety net clinic serving individuals without health insurance and below the 100 percent poverty level in S.W. Portland and Hillsboro to the west. Legacy Health Internal Medicine residents volunteer at the clinic, and the hospital president serves on its board.
- FQHCs are located in both central and west Washington County: Virginia Garcia Memorial Health Clinic (multiple sites) and Neighborhood Health Center.

ABOUT THIS REPORT

The purpose of this report

The Patient Protection and Affordable Care Act (ACA), IRS Section 501(r)(3), requires tax-exempt hospital facilities like ours to conduct a Community Health Needs Assessment (CHNA) at least once every three years. This report is approved by the Legacy Health Board of Directors and made available to the public in compliance with the IRS requirements.

The purpose of the CHNA is to:

- Determine the priority factors influencing the health of the community we serve
- Identify the needs and gaps affecting the health status of various populations within this community
- Identify how our organization's resources and expertise can help address these issues

This report summarizes the findings of a regional community health needs assessment completed July 31, 2016 (Appendix A). The next section explains how this regional CHNA came about.

A collaborative approach to assessing our community's needs

Prior to 2010, each of the metro area hospitals/health systems and public health departments in Clackamas, Multnomah, and Washington counties in Oregon, and Clark County in Washington, conducted community health needs assessments independently. This was a significant duplication of efforts and resources since the organizations were, for the most part, serving (and assessing) the same communities.

To reduce this duplication of effort and streamline the process of meeting the ACA's triennial CHNA requirements, these entities joined forces to establish the Healthy Columbia Willamette Collaborative (HCWC). This public-private partnership unites 15 hospitals, four counties, and two coordinated care organizations (CCOs, or managed Medicaid organizations) to produce a shared regional needs assessment. The HCWC produced its first regional CHNA in 2013, and the second — on which this report is based — in 2016.

This report draws on the regional CHNA findings specifically for Multnomah County, which includes a majority of the primary service area for Legacy Good Samaritan Medical Center.

How information was gathered

The HCWC identified community health needs through a comprehensive study of population, hospital, Medicaid, and community data. This included:

- Population data about health-related behaviors, morbidity (the rate of disease in a population) and mortality (the frequency of death in a certain population)

- Medicaid data from local CCOs about the most frequent conditions for which individuals on Medicaid sought care in our service area
- Hospital data for uninsured people who were seen in the emergency department with a condition that could have been managed in primary or ambulatory care
- An online survey about quality of life, issues affecting community health, and risky health behaviors
- Listening sessions with diverse communities in the region to identify community members' vision for a healthy community, needs in the community, and existing strengths
- An inventory of recent community engagement projects in the region that assess communities' health needs

More detailed information on these sources of information can be found beginning on page 8 of the Healthy Columbia Willamette Collaborative CHNA Reports (Appendix A).

WHAT WE LEARNED FROM OUR COMMUNITY HEALTH NEEDS ASSESSMENT

By the numbers: A data snapshot of the community we serve

Here are some of the notable findings about the community Legacy Good Samaritan serves — and its health status — revealed by the CHNA data compiled by the HCWC (and other sources, if applicable):

Population:

- Approximately 777,000 people lived in Multnomah County in 2014, having increased 11.3 percent from 2000 to 2010, according to U.S. Census data.
- Multnomah County's certified population estimate as of July 1, 2017, was 803,000, a 1.6 percent increase over the prior year. [Source: https://www.pdx/edu/prc/population-reports-estimates, 12/15/17]
- The City of Portland is home to 79 percent of the county's population
- Multnomah County is the most populous of Oregon's 36 counties [Source: https://statisticalatlas.com/county/Oregon/Multnomah-County/Population]

Race and ethnicity:

Although the racial and ethnic population of Multnomah County is predominantly white (non-Hispanic/Latino), the demographics of the county continue to diversify:

- The foreign-born population in Multnomah County accounted for 14.2 percent of the country's population in 2014, an increase of 19.3 percent since 2005.
- The Hispanic/Latino population increased 61.6 percent from 2000 to 2010 — a higher rate than any other racial/ethnic group, but the smallest increase of the four counties.
- Looking at ethnicity and race, in 2014 the Legacy Emanuel primary service area was 71.0 percent non-Hispanic white, 11.2 percent Hispanic, 6.7 percent Asian, 5.0 percent Black or African-American, 0.6 percent Native American/Alaska Native and 0.6 percent Native Hawaiian and other Pacific Islander.

Social determinants of health:

While our health is influenced by our biology, genetics, and individual behavior, external factors are also important, such as our income and economic stability, where we live, how much education we have, and our access to health care and the availability of providers. These factors are called "social determinants of health." In Multnomah County, the CHNA revealed:

- Multnomah County had the lowest median household income in the four-county region ($53,660).

- Approximately 19 percent of individuals were living in poverty in Multnomah County in 2014 (the highest rate in the region), including 24.4 percent of children 18 or younger.
- Over 20 percent of households received Supplemental Nutrition Assistance Program (SNAP) benefits in the past year, the greatest proportion of families among the four counties studied.
- People receiving Medicaid, whose incomes are below 139 percent of the Federal Poverty Level, make up 26 percent of the population in Multnomah County, the highest percentage in the region.
- Multnomah County residents have been affected by increased housing costs and growing rates of homelessness, which are highest in the four-county region.
- There is a higher percentage (42.4 percent) of substandard housing units compared to neighboring counties.
- 91percent of residents have at least a high school diploma and 41.6 percent have at least a four-year college degree.
- At 725:1, Multnomah County has the highest ratio of primary care providers (the ratio of population to the total number of PCPs) of the four counties.
- At 159:1, Multnomah County also has the highest ratio of mental health care providers of the four counties.

Health behaviors:

Population health data from state surveys show that certain risky health behaviors are prevalent in Multnomah County. Notably:

- Access to health care was identified as a priority health issue for adults, specifically lack of access to preventive services (e.g. flu shots or pneumonia vaccines), lack of dental care and lack of a usual source of health care.
- Binge drinking, cigarette smoking, and not eating enough healthy foods were identified as top risky behaviors among all age groups.
- For teenagers specifically, the CHNA identified lack of exercise, alcohol use and marijuana use as common behaviors.

Chronic health conditions among low-income residents:

By analyzing Medicaid claims data from local CCOs, the CHNA showed that:

- Among youth, asthma, attention deficit disorder and post-traumatic stress disorder (PTSD) were the most commonly diagnosed chronic conditions.
- Among adults on Medicaid in Oregon, depression, diabetes and hypertension were the most common diagnoses.

Emergency department admissions among uninsured residents

People without health insurance tend to rely on the hospital emergency department for care, including for conditions that could have been treated by a primary care provider.

By analyzing utilization data from local hospitals for this patient population, the HCWC learned:

- The most common conditions for which uninsured adults sought ED care were diabetes, hypertension (high blood pressure), skin infections and kidney/urinary infections.
- For youth, the top conditions were asthma and severe ear, nose and throat infections.

Morbidity and mortality

Epidemiologists from the four county health departments looked at over 100 health indicators, with several emerging as priority health issues affecting residents in Multnomah County. These included:

- Obesity: 54 percent of adults are overweight or obese, as are about a quarter of 8thand 11thgraders.
- Mental health: Nearly 25 percent of adults suffer from depression, and suicide is one of the top causes of death in the county.
- Substance use and abuse: Alcohol and drug use rank among the top causes of mortality.

What the community identifies as their health needs

Through an online survey, listening sessions, and an inventory of community engagement projects, the HCWC heard directly from community members about what they see as priority health issues or problems, and what contributes to these problems. The top five issues they identified were:

- Homelessness and the lack of safe, affordable housing
- Unemployment and lack of living-wage jobs
- Mental and behavioral health challenges
- Hunger and lack of healthy, affordable food
- Lack of access to physical, mental and/or oral health care

The priority health issues facing the community we serve

When all this data from the various assessment approaches was compiled, some specific health issues were identified in more than one assessment component (e.g., population, community engagement, emergency department or Medicaid data). These common themes emerge as the priority health issues facing the community we serve:

- Access to health care
- No usual source of health care among adults
- Asthma in low-income and uninsured children
- Depression in adults
- Diabetes and hypertension in adults

- Cancer (breast, colorectal and lung)
- Lack of dental visits for adults

WHAT LEGACY GOOD SAMARITAN IS DOING TO ADDRESS THESE ISSUES

Priorities: Where Legacy Good Samaritan focuses its community benefit resources

Each year, Legacy Good Samaritan invests a significant amount of goods, services and funds to benefit the health of the community we serve, particularly health services for the low income and uninsured.

Consistent with our mission of good health for our community, in FY 17 Legacy Health's community benefit totaled $383.1 million and unreimbursed costs were $360.3 million. Of this, Legacy Good Samaritan total community benefit was $54.4 million including unreimbursed costs of $48 million.

Our aim in making community benefits investments is fourfold:

- To influence the things we can, such as health behaviors and social determinants of health
- To prevent and/or treat specific health problems
- To support existing programs and initiatives in the community that are effective in addressing specific health needs
- To help build programs and services that achieve our shared vision for a healthy community

Based on the findings of the HCWC's 2016 regional community health needs assessment, and how we can best apply our resources and expertise to help address these needs, Legacy Good Samaritan is focusing its efforts on these priority issues:

- **Access to care**: Improving residents' ability to get the health care services they need, with an emphasis on primary and preventive care and management of chronic conditions such as asthma in children, and diabetes and hypertension in adults
- **Behavioral health**: Expanding the availability of and access to behavioral and mental health services for youth and adults to help address such conditions as depression, suicide and PTSD
- **Social determinants of health**: Addressing the need for policies, systems, services and environments that support healthy behaviors, which means advancing solutions for such issues as homelessness and affordable housing for the underserved, food scarcity and, once again, access to health care. Education, meaningful employment, and removing barriers to culturally competent services are key to improving the health of the community.

Details on the specific initiatives Legacy Good Samaritan is undertaking to address these priority issues can be found in our Community Health Improvement Plan (CHIP), which is provided in a separate document following this report.

Building on success: What we've done since the 2013 CHNA

In Legacy Good Samaritan's previous CHNA, we identified access to health care, chronic disease, mental health, substance use disorder, health literacy and education, and youth as our CHNA priorities. Since this last report, we have invested time, resources and funding in programs and services we believed would have an impact on these needs.

A $10 million Community Health Fund was established in 1998 by the Legacy Health Board. The funding is supported by operating revenue on an annual basis. Every partner organization receiving funding meets the needs identified in the CHNA.

Here are some highlights of what we've achieved:

Organization	Program supported	Outcomes	Alignment
Project Access NOW	Outreach, Enrollment & Access, Premium Assistance (Ongoing program support)	Donated care in 2017 provided for over 20,000 patients, assistance with enrolling 30,000 individuals of which 1,200 received premium & out-of-pocket support and 40,000 prescriptions were filled at no cost to patients	Access to care
Central City Concern	Housing is Healthcare	Once complete, project will provide for 379 individuals and families to have access to housing and other health & support services	Access to care
Transition Projects	Access to housing and services	Over 10,000 individuals served annually	Access to care
Rose Haven	Program support	In 2015, Rose Haven provided services to 2,935 women and children affected by domestic violence and homelessness (292% increase from 2009)	Access to care
Mental Health Association	Peer Support	In year one of support, 43 patients were provided services, 23 of those patients were provided 57 referrals to community resources (housing/shelter, alcohol and drug, food, clothing, financial assistance), with more than 167 contacts by the Peer Support Specialists	Mental health
Lifeworks NW	Campaign for Project Network	Opening of LEED-certified 36-bed Project Network residential drug and alcohol treatment facility in NE Portland to assist women disrupt a cycle of addiction and abuse, for mothers by limiting financial interruptions and future foster care placement of their at-risk children	Substance use disorder
Latino Network	School & Community-Based Programs	35 School locations, serving 631 students & families annually	Youth & Education
Wallace Medical Concern	Increasing Health Literacy via Community Collaborations	In 2014-2015 WMC served 7,818 people total with 18,514 visits (21% increase over previous year)	Health Literacy
Health Literacy Conference	Health Literacy	Over 500 individuals reached annually from over 120 community & health organizations	Health Literacy
North by Northeast Community Health Center	Blood pressure checks	Provides early awareness for cardiovascular health issues and connects individuals to health care services	Chronic disease

Various community partners	Food programs	From April 2014 to March 2017, Legacy Health's contributions through cash in-kind dollars and food drive's accounted for 308,923 total meals provided to our community	Chronic disease

Health care services for the low income and uninsured

While the Affordable Care Act has significantly lowered the uninsured rate in Oregon, longstanding income disparities in the Legacy Good Samaritan service area underscore the ongoing need for safety net services, which are detailed in the separate CHIP document following this report.

CONCLUSION

As you'll see in the Community Health Improvement Plan that follows this report, going forward we plan to sustain our efforts in addressing many of the priority issues to which we have devoted resources in the past because these needs still exist – as affirmed by the findings of our latest regional CHNA.

At Legacy Good Samaritan, our top priority has been – and continues to be – a focus on the issues which have the greatest impact on the health of our community.

If you have any questions or wish to obtain a copy of this needs assessment, please email us at CommunityBenefit@lhs.org.

APPENDIX A

Healthy Columbia Willamette Collaborative CHNA Report, 2016

Healthy Columbia Willamette Collaborative Community Needs Assessment Report can be found at:

http://www.qcorp.org/sites/qcorp/files/HCWC%202016%20Community%20Health%20Needs%20Assessment.pdf.

COMMUNITY HEALTH IMPROVEMENT PLAN

EXECUTIVE SUMMARY

This Community Health Improvement Plan is based on the 2016 Community Health Needs Assessment (CHNA) conducted by the Healthy Columbia Willamette Collaborative (HCWC). The HCWC is a public-private partnership which unites 15 hospitals, four counties and two coordinated care organizations (CCOs, or managed Medicaid organizations) to produce a shared regional needs assessment. The region supported by the HCWC include Clackamas, Multnomah and Washington counties in Oregon, and Clark County in Washington. The HCWC produced its first regional CHNA in 2013, and the second — on which this report is based — in 2016.

Tied to our mission of improving the health of the community, this improvement plan is intended to guide Legacy Good Samaritan's community-focused work, including investments and community health efforts based on prioritized health needs identified in the CHNA. This plan is focused on the Multnomah County area, as that is the primary service area for Legacy Good Samaritan. Each prioritized focus area is aligned with strategies and indicators for measuring outcomes.

The strategies and outcomes will be assessed annually and revised as needed to address community needs. Legacy Good Samaritan believes that multi-year sustainable partnerships with the community have strong potential to impact long-term health status. Therefore, the Legacy Good Samaritan CHIP includes both continued effective strategies as well as new strategies. This plan is not intended to be an exhaustive listing of all our efforts to address community needs, but rather an overview of prioritized focus areas and strategies tied to measurable tactics.

SUMMARY OF PRIORITIZED FOCUS AREAS

The 2016 HCWC Community Health Needs Assessment identified numerous health-related needs across the four-county region. Legacy Good Samaritan has grouped the needs of Multnomah County into three categories:

Access to Care

- Primary care access
- Culturally appropriate care
- Health coverage programs

Behavioral Health

- Behavioral health providers, services
- Awareness, education and availability of services

- Early intervention of care
- Navigation to services post-discharge
- Prevention of Adverse Childhood Experiences (ACES)

Social Determinants of Health

- Access to healthy food
- Improving health literacy
- Affordable housing
- Meaningful employment

These prioritized focus areas will be address through community partnerships and initiatives tied to the strategies outlined in the following plan.

INTRODUCTION

Our vision at Legacy Health is to be essential to the health of the region, and our mission is "Our legacy is good health for our people, our communities, our world." Legacy Health remains committed to our mission and fulfills its commitment to the community through its partnerships and community investments. Legacy formally participates in the development of a Community Health Needs Assessment (CHNA) as part of the Healthy Columbia Willamette Collaborative (HCWC).

The CHNA is conducted in accordance with the Patient Protection and Affordable Care Act (ACA), IRS Section 501(r)(3), which requires tax-exempt hospital facilities like ours to conduct a CHNA once every three years. The CHNA is approved by the Legacy Health Board of Directors and made available to the public in compliance with the IRS requirements.

ABOUT LEGACY HEALTH

Legacy Health is a local, nonprofit health system with six hospitals and dedicated children's care offered at Randall Children's Hospital at Legacy Emanuel. Legacy also includes more than 70 primary care, specialty and urgent care clinics, as well as almost 3,000 providers who are either employed, on the medical staff or part of Legacy Health Partners. We have lab, research and hospice services. Among our major partnerships are PacificSource Health Plans and the Unity Center for Behavioral Health.

Legacy Health employs more than 13,000 people across its two-state region and focuses its resources on caring for those in our communities, especially marginalized individuals in need. In fiscal year 2017 Legacy provided $383.2 million in community benefit across our five county-region (Multnomah, Clackamas, Washington, Marion and Clark counties) representing 20.7 percent of net patient revenue.

PURPOSE OF COMMUNITY HEALTH IMPROVEMENT PLAN

The Community Health Improvement Plan (CHIP) is based on the 2016 Community Health Needs Assessment (CHNA) conducted by the Healthy Columbia Willamette Collaborative (HCWC). The CHIP serves to:

- Prioritize factors influencing the health of the communities we serve
- Define the strategies employed to address the needs and gaps affecting the health status of various populations within this community
- Identify how our organization will apply resources and expertise to these strategies, and how we will measure the outcome of the strategies

The CHIP is designed to align Legacy Good Samaritan resources with community need. It is the roadmap Legacy Good Samaritan will follow for the next three years, adapting to changing needs and opportunities along the way. Many of the strategies are a continuation of current work and investments, as we are committed to long-term dedication of resources which can build sustainable solutions.

The HCWC report, completed in the summer of 2016, documents the community health needs of the four-county region and each county individually. Priority health issues were identified based upon data collected including:

- Population data about health-related behaviors, morbidity and mortality
- Medicaid data from local Coordinated Care Organizations (CCOs) about chronic conditions for adults and youth
- Hospital data for uninsured individuals seen in emergency departments for conditions which should have been managed in a more appropriate care setting (e.g. primary care)
- Quality of life data from an online survey of 3,167 respondents; questions addressed issues affecting community health and risky health behaviors
- Listening sessions with 29 community-based organizations including 364 total participants to assess community needs and existing strengths
- Inventory of community engagement projects to assess community health needs

The three priority areas Legacy Health identified as those we can impact most significantly are: access to care, behavioral health and the social determinants of health.

Access to Care

Access to health care and preventive services are critical to improving the health of the community. Community members indicated the lack of a usual source of primary care, especially among adults, which disrupts continuity of care. For those individuals who do not qualify for Medicaid, but who cannot afford basic health care, assistance with insurance premiums is needed. Additionally, individuals are more likely to seek care when it is delivered in a culturally responsive and sensitive manner.

Behavioral Health

Behavioral health care access, early interventions and navigation to needed services post-discharge from a health facility were identified as lacking in our region. The awareness and education to support acknowledgement and acceptance of behavioral health challenges among adults and youth were noted as needed in the community. These actions can help to eliminate discrimination and stigmas attached to behavioral health challenges. For youth, identifying and addressing adverse childhood experiences (ACES) can improve access and reduce risk factors (e.g. suicidal ideation, depression, gang involvement).

Social Determinants of Health

Basic needs, such as access to food, safe and affordable housing, pathways to living-wage jobs and youth education, when addressed, can change the course of an individual's life. Delivering health care and services in a culturally and linguistically appropriate manner, increase access and the ability for independence.

SUMMARY OF PRIORITIZED FOCUS AREAS, STRATEGIES AND KEY INDICATORS

ACCESS TO CARE

Priority Needs

Primary care access

- Legacy Health will continue to support community-based clinics and organizations serving providing primary care services (including care for chronic conditions) for low income and uninsured individuals
- Provide in-kind lab services for clinics providing primary care services

Culturally appropriate care

- Improve health outcomes and quality of care by supporting community organizations that meet social, cultural and linguistic needs of patients in our community as well as reduce racial and ethical health disparities.

Health coverage programs

- Support programs working to ensure all individuals have access to health coverage and assistance with premium pay for low income and uninsured residents

Action Plan

Action Plan	Indicators
Provide funding and/or other resources, e.g., in-kind laboratory services, board representation, program alignment and partnerships, IS support, to local FQHC and volunteer staff community-based clinics and culturally specific health service organizations	Number of services, hours and support provided to community-based organizations
Improve access to care through funded FQHC/safety net/community clinics that offer primary care services (and care for chronic conditions)	Number of low-income partner organizations patients with access to community-based primary care
Partner with Project Access NOW to increase insurance enrollment and access to care for low income and uninsured individuals who qualify for their Premium Assistance support and Outreach, Enrollment, and Access programs	Number of eligible under 200% of FPL individuals obtaining health care/Number of Project Access NOW premium assistance insured enrollees

Support Basic Rights Oregon, Q Center and other organizations in efforts to reduce disparities that stem from structural and legal factors, social discrimination and lack of culturally competent health care	Number of interactions from patient referrals to culturally competent services

Community Resources

Access to Care community resources:
Basic Rights Oregon
Central City Concern
Familias en Acción
Native American Rehabilitation Association
Outside In
Project Access NOW
Q Center
Southwest Community Health Center
The Wallace Medical Concern
TransActive Gender Center
Virginia Garcia Memorial Foundation

BEHAVIORAL HEALTH

Priority Needs

Behavioral health providers, services

- Awareness, education and availability of services
- Build capacity in community-based behavioral health organizations and collaborate with regional initiatives

Early intervention of care

- Early identification, diagnosis and treatment of behavioral health issues can help children reach their full potential.
- Provide funding to community organizations and programs that support provide behavioral health screenings that identify patients with possible behavioral health (or substance use) disorders and provide guidance for referral for specialized health treatment

Navigation to services post-discharge

- Legacy Health will partner with behavioral health organizations to provide navigation for post-discharge support services

Prevention of Adverse Childhood Experiences (ACES)

- Partner with organizations supporting individuals experiencing the trauma of disruptive life challenges to reduce the likelihood Adverse Childhood Experiences (ACEs) in children/youth and reduce the likelihood of poor health implications that children and adults face relating to their trauma experiences

Action Plan

Action Plan	Indicators
Legacy Health commits to supporting New Avenues for Youth as well as similar programs that are designed to recognize and address early signs of behavioral health issues, and refer more severe, chronic mental health issues to more extensive therapy	Number of youth reached by therapist and staff trained to recognize early signs of behavioral health issues, and those referred to more extensive therapy
Provide funding to community organizations and programs that provide behavioral health screenings that identify patients with possible behavioral health (or substance use)	Number of individuals referred and/or recognized with behavioral health issues

disorders and give guidance for referral for specialized health treatment	
Support accessibility and affordability to behavioral health treatment and coordination of services	Number of low-income uninsured with access to services. Number of County Health Ranking poor mental health days

Community Resources

Behavioral Health community resources:
Albertina Kerr
Bradley Angle
Basic Rights Oregon
Cascadia Behavioral Health
Central City Concern
De Paul Treatment Center
FolkTime
Lifeworks NW
Mental Health Association of Oregon
Native American Rehabilitation Association
NAMI Multnomah
NAMI Oregon
New Avenues for Youth
NorthStar
Rose Haven
Trillium Family Services

SOCIAL DETERMINANTS OF HEALTH

Priority Needs

Access to healthy food

- Partner with food programs to improve access to healthy meals

Improving health literacy

- Increase health literacy education in community
- Provide regional leadership in health literacy with the goal of improving health outcomes for people with limited health literacy. Continue to host an annual regional health literacy conference and program support to community-based, health system, public sector, and academic organizations

Affordable housing

- Support community-based recuperative care programs (housing and support services) post-discharge for homeless and other individuals in need of support services and housing insecurities

Meaningful employment

- Support youth employment opportunities designed to improve career development and access to living-wage jobs
- Offer college scholarships and paid summer work experience to [communities of color] for students entering health care careers
- Build capacity in youth development and education programs that increase graduation rates and access/opportunity for higher education achievement
- Support programs that reduce poverty-related barriers to educational success and build capacity for economic stability

Action Plan

Action Plan	Indicators
Legacy Health will continue to support food banks and programs that provide food to individuals struggling with food insecurities	Number of meals served by cash in-kind dollars and food drive donations
Community health literacy education via regional health literacy conference and program support to community-based, health system, public sector, and academic organizations working on projects focused on improved health literacy	Number of community organizations and individuals reached through regional health literacy conference

Partner with Central City Concern other health and community organizations in efforts to build affordable housing units for low income individuals and	Number of completed affordable housing units/projects
Provide workforce training and college scholarships through YES Program and other career-focused efforts to support ethnically diverse youth entering health careers	Number of students [of color] entering health care careers though YES Program, and number of high school internships, job shadows
Financial support to provide labor resources to education and community-based programs focused on healthy lifestyle, educational attainment and career readiness	School district graduation rates and youth reached through community and school based programs

Community Resources

Social Determinants of Health community resources:	
Basic Rights Oregon	New Avenues for Youth
Central City Concern	Oregon Association of Minority Entrepreneurs
Coalition of Communities of Color	Oregon Community Warehouse
Columbia Pacific Food Bank	Oregon Health Care Interpreters Association
Familias en Acción	Oregon Latino Health Coalition
Friendly House	Oregon Public Health Institute
Girls, Inc.	Outside In
Girls on the Run-Portland Metro	Partners for a Hunger Free Oregon
Latino Network	Partners in Diversity
Lift Urban Portland	Portland Workforce Alliance
Meals on Wheels People	Project Access NOW
MIKE Program	The Wallace Medical Concern
Native American Youth and Family Center	Transition Projects

LEGACY HEALTH COMMUNITY RESOURCES

Legacy Health recognizes the power of collaboration. Exchanging knowledge, skills and experiences with our community organizations helps us achieve more together than we would separately. Legacy Health has identified the following resources in our communities to partner with and better address the priority needs in our area.

Organizations	Priority need(s) addressed*
Adventist Health	Funding/collaborative partner
Albertina Kerr	AC, BH
All Hands Raised	SD
AWARE Food Bank	SD
Basic Rights Oregon	AC, BH, SD
Battleground Healthcare	AC
Birch Community Services	SD
Boys and Girls Club of SW Washington	BH
Bradley Angle	SD
Canby St. Vincent De Paul	SD
Cascadia Behavioral Health	BH
Central City Concern	AC, BH, SD
Children's Center	BH, SD
Children's Community Clinic	AC
Clark County Food Bank	SD
Coalition of Communities of Color	SD
Columbia Pacific Food Bank	SD
Columbia River Mental Health Foundation	BH
Community Action of Washington County	AC, SD
Compassion Connect	AC, SD
Council for the Homeless	SD
Daybreak Youth Services	BH
De Paul Treatment Center	BH
Ecumenical Ministries of Oregon	SD
Familias en Acción	AC, SD
Farmworkers Housing Development Corporation	SD
FolkTime, Inc.	BH
Free Clinic of SW Washington	AC, SD
Friendly House	AC
Girls on the Run-Portland Metro	SD
Girls, Inc	SD
"I Have a Dream" Oregon	SD
Kaiser Permanente	Funding/collaborative partner
Latino Network	AC, SD
Liberty House	AC, BH
Lifeworks NW	BH
Lift Urban Portland	SD
Meals on Wheels	SD
Mental Health Association of Oregon	BH
MIKE Program	SD

Momentum Alliance	SD
My Father's House	SD
NAMI Multnomah	BH
NAMI Oregon	BH
Native American Rehabilitation Association of the NW	AC
Native American Youth and Family Center	SD
New Avenues for Youth	AC, BH, SD
North by Northeast Community Health Center	AC
NorthStar	BH
Oregon Association of Minority Entrepreneurs	SD
Oregon Community Warehouse	AC
Oregon Health Care Interpreters Association	AC
Oregon Health & Science University	Funding/collaborative partner
Oregon Humanities	SD
Oregon Latino Health Coalition	SD
Oregon Public Health Institute	AC, SD
Outside In	AC, SD
Partners for a Hunger Free Oregon	SD
Partners In Diversity	SD
Project Access NOW	AC, SD
Q Center	AC
Rose Haven	BH, SD
Salem Health Foundation	AC
Salem/Keiser Coalition for Equality	SD
Salud Medical Center	AC
Sandy Community Action Center	SD
Share, Inc.	SD
Silverton Area Community Aid, Inc.	SD
Snowcap	SD
Southwest Community Health Center	AC
Southwest Washington Regional Health Alliance	SD
The Intertwine Alliance Foundation	BH
The Skanner Foundation	SD
The Wallace Medical Concern	AC
TransActive Gender Center	AC
Transition Projects	SD
Trillium Family Services	BH
Urban League of Portland	SD
Vietnamese Community of Clark County	SD
Virginia Garcia Memorial Foundation	AC
Washington State University Foundation	SD
West Linn Food Pantry	SD

*Key: Access to Care (AC), Behavioral Health (BH), Social Determinants of Health (SDOH)