

# Legacy Health

**LEGACY MOUNT HOOD MEDICAL CENTER**

**COMMUNITY HEALTH IMPROVEMENT PLAN**

**FY 2015**



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## I. INTRODUCTION

The mission of Legacy Health, the parent of Legacy Mount Hood Medical Center, is to ‘...improve the health of.....our community...’ With this, Legacy Mount Hood has had a long-standing commitment to meet community health needs for vulnerable populations beyond the health care environment.

The Legacy Mount Hood Medical Center Community Health Improvement Plan (CHIP) FY 15 meets the IRS 501©(3) requirement for implementation strategies addressing priority community health issues identified in the hospital’s Community Health Needs Assessment. Legacy Mount Hood adheres to the philosophy that multi-year sustainable partnerships with the community have greater impact on long-term improved health status. Thus, the Legacy Mount Hood CHIP includes both the continuation of current effective strategies as well as new strategies.

Community health needs assessments and community health improvement plans are approved by the Legacy Health Board of Directors and made available to the public in compliance with IRS requirements.

**Focus issues:** The Legacy Mount Hood Community Health Needs Assessment FY 15 priority focus issues, with a lens addressing racial and ethnic equity, are addressed in this CHIP and include:

- Access to health care
- Chronic disease
- Mental health
- Substance use disorder (formerly called Substance abuse)
- Health literacy
- Education and youth

**Target populations:** Aligned to the CHNA lens on communities experiencing disparities, the Legacy Mount Hood CHIP target populations are: Multnomah County primary service area African American, Latino and Native American low income populations and the high need Community Needs Index/top Legacy Mount Hood emergency department self-pay/Medicaid zip codes of 97233-Rockwood at 4.6; 97024-Fairview at 4.0; and 97030-Central Gresham, 97230-Parkrose and 97236-Powell Butte at 3.8 each.

## II. FOCUS ISSUE: ACCESS TO HEALTH CARE

**Goal:** Improve access to health care for vulnerable communities experiencing disparities.

- A. **Strategy 1:** Support community-based clinics and/organizations serving the low income and uninsured

**Tactic:** 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

**Indicators:**

- Number of low income partner organization patients with access to community-based primary care
- Number of uninsured self-pay visits to emergency room

**Community partners:** The Wallace Medical Concern, Project Access NOW, Familias en Accion, Multnomah County Health Department

B. **Strategy 2:** Offer services for the low income and uninsured

**Tactics:**

- Provide health services for the low income uninsured based on charity care financial policies, i.e., up to 400% of FPL
- Participate as a service provider and contribute financial and labor support to Project Access NOW which connects low income uninsured patients to providers at no charge
- Contribute financially to Project Access NOW community-based program funding federal exchange premium assistance for residents 139% to 200% of FPL
- Certify providers to be competent in language other than English to provide care in that language
- Provide free mammograms for the low income uninsured

**Indicators:**

- Number of eligible under 400% of FPL individuals obtaining health care
- Number of Project Access NOW premium assisted federal exchange insured enrollees
- Number of hospital and Legacy Medical Group providers certified to provide care in language other than English

**Community partners:** Project Access NOW; Clackamas, Multnomah and Washington County hospitals; Mount Hood Medical Center Foundation

C. **Strategy 3:** Enroll patients in Oregon Health Plan

**Tactic:** Employees trained as enrollment assisters assist patients in application process on-site

**Indicator:** Number of Oregon Health Plan enrollees

**Community partner:** Oregon Health Authority

D. **Strategy 4:** Partner with community-based organizations to conduct prevention and detection screenings

**Tactic:** Provide support to local community-based initiatives to raise awareness about breast health screening for women of color

**Indicator:** Number of people screened through partner organizations

**Community partners:** Susan G. Komen Foundation, Familias en Accion, other community-based organizations

### III. FOCUS ISSUE: CHRONIC DISEASE

**Goal:** Prevent and reduce chronic disease through increased access to culturally appropriate and/or low cost services.

A. **Strategy 1:** Partner with community-based programs that serve racial, ethnic, senior and underserved populations to provide chronic disease screenings

**Tactic:** Provide diabetes, glaucoma, eye disease, breast health and other screenings at no charge at public events targeting communities of color and seniors at high risk

**Indicator:** Number of underserved, senior and communities of color residents accessing screenings through partner organizations

**Community partners:** Familias en Accion, American Diabetes Association, Susan G. Komen Foundation, Oregon Lions Sight and Hearing Foundation, other community-based organizations, faith community

B. **Strategy 2:** Partner with racially and ethnically diverse organizations to provide chronic disease support services and education to raise awareness and support behavior changes

**Tactics:**

- Support organizations offering Stanford University's chronic disease self-management program for people with diabetes
- Support safety net clinics offering peer support groups and the Tormando chronic disease self-management program for Spanish-speaking patients
- Achieve hospital baby-friendly status
- Achieve 90% exclusive breast feeding rate upon discharge among all race and ethnic patients (*Healthy Columbia Willamette Collaborative initiative*)
- Participate in City of Gresham HEAL (Healthy Eating Active Living) Community Program
- Provide land at no charge for a community cooperative garden on hospital campus
- Hold annual drive for food program serving local community
- Partner with culturally specific organizations providing patient navigation

**Indicators:**

- Number of underserved and communities of color residents accessing partner community-based chronic disease education and support services
- Hospital exclusive breast feeding rate by race and ethnicity

**Community partners:** The Wallace Medical Concern and other safety net clinics; Partners for a Hunger Free Oregon, Familias en Accion and other community-based organizations; Healthy Columbia Willamette Collaborative: 15 hospitals; Clark, Clackamas, Multnomah and Washington public health departments; Health Share of Oregon and FamilyCare Coordinated Care Organizations

#### IV. FOCUS ISSUE: MENTAL HEALTH

**Goal:** Improve access to mental health and supportive services for the uninsured and low income.

A. **Strategy 1:** Build capacity in community-based mental health organizations and collaborate with regional initiatives

**Tactics:**

- Provide funding and labor resources to local community mental health programs
- Participate with mental health providers to develop improved mental health coordination of services

**Indicators:**

- Number of low income uninsured with access to services

- Number of County Health Ranking poor mental health days

**Community partners:** De Paul Treatment Center, Lifeworks NW, The Wallace Medical Concern, National Association for the Mentally Ill-Oregon, Cascadia, Mental Health America of Oregon, Folktime

- B. **Strategy 2:** Provide healthy green space for patients, family members, employees and the community

**Tactic:** Offer Healing Gardens in hospital

**Indicator:** Number of healing gardens

**Community partners:** community, Intertwine

## V. FOCUS ISSUE: SUBSTANCE USE DISORDER

**Goal:** Prevent and reduce substance use disorder through increased access to services for the uninsured and low income.

- A. **Strategy 1:** Reduce opioid misuse and abuse

**Tactic:** Participate in regional hospital and public health department opioid prescription program, including uniform opiate prescribing policies and practices (*Healthy Columbia Willamette Collaborative initiative*)

**Indicators:**

- Number of medication agreements
- Number of aligned prescribing guidelines across metro area

**Community partners:** Healthy Columbia Willamette Collaborative: 15 hospitals; Clark, Clackamas, Multnomah and Washington public health departments; Health Share of Oregon and Family Care Coordinated Care Organizations

- B. **Strategy 2:** Implement CCO aligned Screening, Brief Intervention and Referral to Treatment (SBIRT) screenings

**Tactic:** Conduct SBIRT screenings in emergency department and Legacy Medical Group

**Indicators:**

- Number of people screened
- Number of patients who received a substance use disorder brief intervention

- C. **Strategy 3:** Build capacity in community-based substance use disorder treatment and prevention programs

**Tactics:**

- Fund community-based culturally appropriate substance use disorder programs
- Fund community education and prevention to reduce driving under the influence on intoxicants

**Indicator:** Number of people served by partner organization programs

**Community partners:** Native American and Rehabilitation Association, Oregon Impact, Central City Concern, De Paul Treatment Centers

## VI. FOCUS ISSUE: HEALTH LITERACY

**Goal:** Improve health outcomes for people with limited health literacy.

A. **Strategy 1:** Fund community-based clinic projects focusing on improved health literacy

**Tactics:**

- Fund development of Learner Web program for patients with low health literacy to learn how to access and navigate electronic health portals with goal that other clinics will be able to use the learning program when developed
- Fund FQHCs and safety net clinics: train staff in health literacy tools and revision of documents into plain language

**Indicators:**

- Number of FQHC patients accessing EPIC electronic health portal
- Number of other health systems and FQHCs using Learner Web program

**Community partners:** Portland State University Linguistics Department; The Wallace Medical Concern, other safety net clinics, Multnomah County Health Department and other health systems serving low income and vulnerable populations using EPIC

B. **Strategy 2:** Increase health literacy education in community

**Tactics:**

- Host regional health literacy conference with national experts at reduced fee
- Present 'health literacy introduction' to community and health system audiences
- Provide cancer, chronic disease and other screenings and education at health fairs and community events for the public
- Offer disease/injury prevention and treatment education classes for the public

**Indicators:**

- Number of health literacy conference attendees
- Number of attendees at community events
- Number of education classes and attendees

**Community partners:** 70 different community-based, health system, public sector, academic organizations; school districts

## VII. FOCUS ISSUE: EDUCATION AND YOUTH

**Goal:** Increase education achievement rates and health care workforce rates for communities of color experiencing education disparities.

A. **Strategy 1:** Offer college scholarships and paid summer work experience to communities of color students entering health care careers

**Tactic:** Fund and offer Youth Employment in Summers (YES) program for African American, Native American and Latino students entering health care careers

**Indicator:** Number of students of color entering health care careers through YES

**Community partners:** Hispanic Metropolitan Chamber of Commerce, Mt. Hood Community College

B. **Strategy 2:** Build capacity in youth development and education programs

**Tactic:** Financially support and provide labor resources to education and community-based programs focused on health care careers

**Indicator:** High school graduation rate

**Community partners:** Center for Advanced Learning, David Douglas High School

C. **Strategy 3:** Train future health care professionals of color

**Tactic:** Provide high school internships and job shadows

**Indicator:** Number of high school internships and job shadows offered

**Community partners:** Center for Advanced Learning, David Douglas High School