LEGACY EMANUEL HOSPITAL AND HEALTH CENTER

DBA LEGACY EMANUEL MEDICAL CENTER

COMMUNITY NEEDS ASSESSMENT AND IMPLEMENTATION STRATEGIES PLAN

2011/2012

CONTENTS

INTRODUCTION

Legacy Emanuel Medical Center was founded in 1912 by two Lutheran congregations and is located within a high-density geographic area in inner city Portland, Oregon. Rich in character, both North and Northeast Portland are diverse urban areas that are distinct and unique to the city. The historically African American neighborhoods surrounding the hospital are changing due to the increase in housing prices, i.e., the community is now mixed and the African American community is more widely spread throughout the metropolitan area.

Legacy Emanuel is a member of Legacy Health, a five hospital system established in 1989 by the merger of two nonprofit systems in metropolitan Portland Oregon. Included within Legacy Emanuel is the Randall Children's Hospital—one of two Children's hospitals in Oregon and SW Washington. Legacy's mission is "Good health for our people, our patients, our communities, our world." Consistent with this mission, in fiscal year 2011 Legacy Emanuel provided $36.0 million in charity care; total unreimbursed costs of care for people in need amounted to $89.3 million. Legacy Emanuel provides the greatest amount of charity care of all hospitals in the metro area.

Legacy Emanuel is committed to multi-year partnerships with various community organizations that are located directly on the hospital's campus. In-kind support of space, telephones and other services (at no charge) enables them to focus on their missions and services to the community. In addition, the Ronald McDonald House was built on the Emanuel campus on land donated a decade ago.

In 2004, Legacy gave the African American Health Coalition a building valued at $1.6 million; the $80,000 annual rent from this building will provide financial sustainability to the African American Health Coalition for the future. The African American Coalition is a culturally specific organization dedicated to reducing health disparities between African Americans and non-Hispanic whites in our local community; they have been recognized as a national model for their innovative and effective programs.

A model developed by the University of Wisconsin provides a rubric for examining the many factors contributing to a community's health. The four groups of factors are social and economic, health behaviors, clinical care, and physical environment. Aligned with these factors, the Legacy Emanuel Community Needs Assessment 2011 addresses issues key to the health of a community beyond the health care delivery system. The purpose of this Community Needs Assessment is to determine the priority factors influencing the health of the community and to identify how Legacy's resources and expertise can be matched with external resources to optimally address those issues. The community is defined as the primary service area (five mile radius).

Quantitative secondary data for this analysis is focused on demographic characteristics, health factors, and health outcomes derived from a review of national and local research. Data is the most recently available—years range from 2007 to 2010. Data at the primary service area level is used when available, followed by county (Multnomah) and Oregon state in order of preference and availability. Race and ethnicity data is most commonly available only at the county and/or state level.

Qualitative research consists of interviews conducted by leadership with 65 elected officials (state, county and city) and public sector (public health, human services), faith, business and community members. Interviews occurred between August 2010 and January 2011. The exhibit lists interviewees, by title and organization and identifies those with expertise in public health and/or with the medically underserved, low-income and/or communities of color populations.

Exhibits and Appendices provide data detail, sources and needs.

COMMUNITY PROFILE

Service area

Legacy Emanuel is located in one of the oldest neighborhoods in Portland--inner north Portland across the river slightly north of downtown. The five mile primary service area extends from the Columbia River in the north to south of Highway 99E in the south and from Walker Road in the west to NE/SE 82nd in the east. The service area includes the close-in neighborhoods of Boise/Eliot, Kenton and Piedmont, St. Johns, Irvington, Alameda, and Lloyd District/ Sullivan's Gulch, Rose City and Laurelhurst. The Community Needs Assessment uses Multnomah County data as it covers the five mile service area when five mile data is not available. Zip codes for the five mile area include: 97201-97205, 97207-97209, 97210-97215, 97217-97219, 97221, 97225, 97227, 97229, 97232, 97239.

Population

In November 2010, the Portland State University (PSU) Population Research Center reported the Oregon metro area tri-county population at 1,644,535 residents; with Clark County, the four county area was 2,080,926.

The primary service area included 443,503 people in 2010; projected.5 percent annual growth between 2010 and 2015 is the lowest of Legacy Health hospital service areas. County rankings in the metro are shifting. In 1960, 59 percent of the population lived in Multnomah County; by 2008, it was only 33 percent.

Median age was 37.8 years in Oregon in 2009. Multnomah County was 36.9 years.

Racial and ethnic diversity

By ethnicity, in 2010 the Legacy Emanuel primary service area was 74.1 percent non-Hispanic white, 8.6 percent Hispanic, 6.6 percent African American 5.9 percent Asian, 3.4 percent bi-racial and .7 percent Native American. A recently published Coalition of Communities of Color Report showed that communities of color nearly doubled as a percent of population between 1990 and 2008 in Multnomah County.

The African American/Black population continues to be most concentrated in the historical neighborhoods of North/Northeast Portland, but increased housing prices have resulted in the community moving increasingly to East Multnomah County. Multnomah County continues to have triple the percentage population of African Americans as the other three counties and the majority remain in the Legacy Emanuel immediate neighborhoods.

The service area is drawing Hispanics moving into the service area at a higher rate than any other group (more than doubling in numbers in the past 15 years). Additionally, they have a higher birth rate than other communities of color. The Hispanic population accounts for about one-fifth of the births in Oregon and Washington, while they make up just one-tenth of the population. Between 1995 and 2004 babies born to Hispanic mothers increased 67 percent. It is projected that communities of color will make up the majority of the Oregon population by 2040, and that 25 percent of the population will be Hispanic.

The Portland Native American community is the ninth largest Indian urban population in the US. With a child poverty rate of 46% and 70% unemployment rate in 2009, the Native American community struggles across multiple indicators in contrast to the non-Hispanic white community.

The immigrant and refugee population is increasing significantly in the region. Nearly one-third of these populations arrived after 1995 and half have arrived since 1990. Recent immigrants and refugees are more likely to be culturally and linguistically isolated. A small but increasing African refugee population has settled primarily in North and NE Portland and is distinct from the African American/Black population. Available data suggests that in general, the African population is generally poorer than other communities.

Census numbers do not adequately represent the true and changing picture. More than 100 languages are spoken in the Portland public schools. Schools near Legacy Emanuel are 40 to 70 percent children of color, primarily African-American and increasingly Hispanic. With this, schools are experiencing 50 percent English-as-a-Second-Language and 50-80 percent reduced-cost or free lunch rates.

While the area's population is growing slowly, its composition is changing. Legacy Emanuel's service area is experiencing increases in demographics that have lower income levels, less education, lower health status, and lower health literacy.

HEALTH STATUS/HEALTH OUTCOMES

The health status of the area can be analyzed using both vital statistics and accepted indicators of health status.

Mortality

The Crude Death Rate and Age Adjusted Death Rate in Oregon were greater than the national average in 2007. County level age adjusted death rates showed Multnomah County to be much higher than the state rate. Premature death rates were aligned in a similar pattern.

The most common causes of mortality in Oregon is consistent with the national most common disease deaths—heart and cancer. In 2006 Multnomah County experienced the highest rate among the four metro counties both in cancer and heart deaths.

Infant mortality is an accepted indicator of a community's health status. In 2006 Multnomah County was higher than the state rate and the highest among the four metro counties—6.3/1000 compared to the state's 5.7. The non-Hispanic white rate was 4.9/1000 relative to the 7.3 communities of color rate. Native Americans were the highest at 9.8 followed by African Americans at 8.6.

Morbidity

A community's health morbidity statistics commonly include those diseases most related to high mortality (heart, cancer and low birth weight), chronic conditions such as cardiovascular disease, diabetes and asthma and self-reported health and mental health status (the latter have been statistically validated as predictors of community health status). Individuals with multiple chronic diseases often also experience other risk factors such as obesity and smoking, and use health care services to a greater degree.

The economic cost of racial and ethnic disparities is significant. The Urban Institute reports the estimated national cost of racial and ethnic disparities for African Americans and Hispanics in 2009

(calculated based on change in expenditure if the cohort's age specific prevalence rates were the same as non-Hispanic whites) was $23.9 billion.

Low birth weight

Low birth weight is correlated to adult morbidity, specifically hypertension, diabetes and heart disease. In 2007 Multnomah County's low birth weight was 6.1 percent. While African American and Hispanic women had prenatal care in the first trimester in similar percentages, African Americans had double the rate of low birth weight babies (and infant mortalities) as Hispanic women. Hispanic women's low birth weights and infant mortality rates were equal to non-Hispanic whites at the state level even though prenatal care percents were over 12 percentage points less. This information is consistent with national data.

Heart disease

Major risk factors for heart disease are smoking, lack of physical exercise, hypertension and overweight/obesity. In 2006, the cost of hospitalizations in Oregon for heart and stroke totaled more than $1.2 billion. As with heart disease mortality, communities of color experienced the greatest morbidity rates. In 2009, age adjusted coronary heart disease prevalence in Oregon was 4 percent for African Americans, 8 percent for Native Americans, 4 percent for Asian/Pacific Islanders and 2 percent for Hispanics compared to 4 percent for non-Hispanic whites. The prevalence of hypertension among Oregonians has been stable the last few years while the prevalence of high cholesterol increased.

Cancer

Oregon, US and Multnomah County cancer incidence per 100,000 in 2007 were within significant differences of each other—about 466. National Cancer Institute data not detailed here showed Hispanic and Asians with the lowest rates among races and ethnicities.

Diabetes

Diabetes is increasing at an alarming rate. The prevalence in Oregon is 35 percent higher than ten years ago. People with diabetes are more likely to also have heart disease and self-report their general health as fair or poor as compared to good or excellent. Diabetes prevalence was 7.3 percent in Multnomah County as compared to 6.9 percent in Oregon in 2008. The elderly are more likely to have diabetes (15 percent of Oregonians 65 years and older) as are low income persons. Diabetes is more prevalent in communities of color. Percents in Oregon in 2005 were: African Americans (13 percent), Native Americans (12 percent), Hispanics (10 percent) and Asians (7 percent) non-Hispanic whites (6 percent). According to studies, communities of color are also more likely to have diabetes-related complications at two to four times the rate of non-Hispanic whites. This is seen as due to poorer control of the disease and co-morbidities, i.e., high blood pressure and cholesterol, as well as poorer access to care.

HEALTH FACTORS

The previous section outlined the current health status of the area. In this section, we examine the factors that lead to that status. A community's health is the product of many different factors. A model developed by the University of Wisconsin provides a useful rubric for examining them. The four groups of factors are Social and Economic, Health Behaviors, Clinical Care, and Physical Environment. This section of this report is arranged according to these factors. The following chart shows the factors and the percentage impact they are thought to have on community health status:

Social and Economic	40%
Health Behaviors	30%
Clinical Care	20%
Physical Environment	10%
	100%

Social and economic factors

Social and economic determinants include education, health literacy, employment, income, housing and community involvement.

Education

Education is often cited as the key to upward social and economic mobility for individuals and, in turn, a community's health status. Research has concluded that if Americans without a college degree experienced the lower death rates and better health of college graduates, the improvements in health status and life expectancy would be more than $1 trillion annually.

The 2009 the high school graduation rate of individuals 25 and older in Multnomah County (89.0 percent) was equal to the state average; the college degree rate at 39.1 percent for people 25 years and older was 10 percentage points better than the state average. Again, disaggregation reflects distinct differences among ethnicities and races. Non-Hispanic whites have a 7 percent chance of not completing high school compared to 33 percent for communities of color. The difference lies not only in high school completion, but earlier—for those with less than any high school at all. For those getting to high school, the difference in completion is about two percent. But the difference of those achieving less than high school is 29.8 percent among communities of color compared to 6.7 percent for non-Hispanic whites. Multnomah County college completion rates are: 40.2 percent for non-Hispanic whites, 34.9 percent Asians, 18.1 percent for African Americans, 15.7 percent for Native Americans, and 14.5 percent for Hispanics. The large percent of communities of color having less than high school negatively impacts higher achievement percentages.

The combination of disparities in educational achievement among race and ethnic cohorts and the increasing diversity of the total population are resulting in the younger current generation not meeting prior generation rates of high school and college completion.

Gaps in achievement begin in early childhood. Children entering first grade without school readiness skills continue to be behind throughout school. Children of racial and ethnic diversity are more likely to enter school lacking these skills. With the increasing diversity in the service area, the overall graduation rate will continue to decline.

Health literacy

Health literacy is linked to functional literacy – reading, writing, arithmetic – but also includes a social dimension. It is the ability to obtain, process and understand health information in order to make appropriate health decisions and practice positive health behaviors. The National Patient Safety Foundation has said that no other single factor has as great an influence on health status, and studies have determined that health care utilization and expenditures are far greater in the presence of low health literacy.

Nearly half of the US adult population has low health literacy. Low health literacy is a quality and cost issue for patients and society. Patients with low health literacy are less likely to comply with treatment, are less likely to seek preventive care, and enter the health care system sicker. Patients with low health literacy are twice as likely to be hospitalized. Annual health care costs for people with low health literacy are four times higher. The economic burden of low health literacy has been variously estimated to be $106-238 billion annually. Higher illness rates mean lower productivity at

work, and poor parental health often results in low student school attendance – with a direct correlation to lower educational achievement. Evidence points to low health literacy as a significant cause of low patient compliance, which in turn is correlated with provider dissatisfaction. Patients out of compliance have a lower quality of care and lower quality of life.

We do not have local data on low health literacy, but nationally research has shown that specific populations are particularly at risk:

- Hispanic, African American, and Native American populations
- Recent immigrants
- People age 65 and older

The growth of communities of color in the area will present significant challenges to health care providers by increasing the prevalence of low health literacy. If the number of insured people is increased by health care reform, the bulk of the newly insured will be from those populations most at risk for low health literacy: minorities and the poor. Unlike many modifiable health behaviors, the onus for dealing with health literacy falls primarily on health care providers.

Employment/income

Educated workers attract higher wage businesses to the community. Higher wage jobs mean higher worker benefits and disposable incomes. Employment is correlated to levels of income, family and support systems and community safety. When these factors are jeopardized, health status is challenged.

Oregon has particularly suffered in the current recession, ranking second in national unemployment at times. In 2009 Oregon had an unemployment rate of 11.8 percent as compared to the US's 9.9 percent. Multnomah County was just barely under the state average at 11.5 percent.

Oregon's median household income in 2009 was $48,475. Multnomah County showed a higher median household income than the state. Race and ethnic cohorts varied greatly. Communities of color earn half the incomes of non-Hispanic whites in Multnomah County. Incomes were the highest for non-Hispanic whites and lowest for Native Americans—a $28,000 difference. African Americans were just $5,000 higher than Native Americans. In contrast, Asians were just $3,000 less than non-Hispanic whites.

Poverty is highly correlated to poor health. Persons with lower incomes are more likely to have chronic diseases, higher acuity illness, disability and premature death. Low income individuals are much more likely to self-report themselves (and their children) as being in poor or fair health compared to people with increased incomes.

Oregon all ages poverty revealed race and ethnic Hispanic and Native American at double and African American at nearly triple that of non-Hispanic whites. In Multnomah County in 2008, the rate of under 18 years poverty was 12.5% for non-Hispanic white children and 33.3% for children of color. Households headed by females are even more at risk for poverty. In Oregon in 2008, more than 50 percent of Hispanic families headed by females were at poverty level compared to one-third of non-Hispanic white families headed by females.

Poverty is increasing with the distinct shift in employment industries—moving from manufacturing and resources (lower-skilled employees with higher paying jobs) to service sector (lower wage jobs). Jobs paying less than $30,000 annually have accounted for 63 percent of all net job growth since 2000. Nearly sixty percent of families living below the federal poverty line have a household member who works and 14 percent have a full-time year-round worker.

Housing

Home ownership is considered a significant contributor to long-term stability and, in turn, positively correlated to education achievement and better health status and income. Among the four metro counties, Multnomah shows the lowest home ownership rate at 54.9 percent in 2009--nearly ten percentage points lower than the state. Race and ethnic differences are apparent. In 2008, home ownership in Multnomah County was 62 percent for non-Hispanic whites as compared to 45 percent for communities of color—nearly a 40 percent difference. In 2009 in Oregon, 70.9 percent of non-Hispanic whites owned homes as compared to 48.0 percent Hispanics, 44.5 percent African Americans, 54.6 percent Native Americans and 59.0 percent Asians/Pacific Islanders.

The national standard is that renters should not pay more than one-third of their income in rent. Oregon is ranked third in most unaffordable rental markets in the nation. In 2009 42.4 percent of renters in Multnomah County fell into this category. Multnomah County also ranked highest among the four metro counties in all poverty, children in poverty and unemployment.

Health behaviors

Individual behaviors account for the second greatest weighting among Health Factors. Risk factors such as obesity, tobacco use and substance abuse are each significant contributors to mortality and morbidity.

Obesity

Obesity is now considered among the top public health issues in the country. Reduced physical activity, convenience, and fast foods have doubled the rates in adults in the last two decades. In Oregon in 2009, nearly 60 percent of adults were overweight or obese and about 25 percent were obese. Multnomah County showed 20.5 percent of adults to be obese. Obesity has consequences beyond the condition itself. It is a leading risk factor for diabetes, hypertension, heart disease, stroke and other diseases.

The increasing prevalence of childhood overweight and obesity is of concern. It results in increased risk of chronic disease, asthma, respiratory problems, orthopedic conditions and being overweight or obese in adulthood. Centers for Disease Control research reports that the prevalence of childhood obesity tripled nationally between 1976 and 2008—from 5.5 percent to 16.9 percent. Adding in the percentage that was overweight, nearly 50 percent of children were overweight or obese nationally in 2008. While all age cohorts increased rates, teens increased the most. One measure of the effect of obesity on health and health care costs is the projection that one third of all children and 50 percent of children of color born in 2000 will acquire Type 2 diabetes.

Tobacco use

Smoking is considered one of the two most prominent individually based risk factors for disease and the most preventable cause of death and disease. Smoking is correlated to cardiovascular disease and cancers including lung, cervix and bladder. Adults with three or more chronic diseases are three times more likely to have smoked or be current smokers.

Oregon adult smoking prevalence decreased 19 percent and 11th grade smoking 20 percent over the past ten years due to state prevention efforts, higher cigarette taxes and bans on smoking in public places. The state's adult smoking rate in 2009 was 19 percent and Multnomah County was 20 percent. Still, these rates are unacceptably high.

Teen births

Teen birth is one of the most powerful predictors of poverty. Teen birth rates (ages 15-19 years) are decreasing--in Oregon by over a third between 1991 and 2006. In 2006, Multnomah County was the highest among the four metro counties and 15 births greater than the national target of 24/1000. Race and ethnicity data showed significant differences in 2007 in Oregon. Ranked in order from

lowest to highest—Asians: 15, non-Hispanic whites: 27, Blacks: 44, Native Americans 54 and Hispanics 93. Thus, there was a 75 birth per 1000 teen difference between Asians (lowest) and Hispanics (highest). State level trending data is not available, but the Guttmacher Institute reported nationally that teen pregnancies fell in all race and ethnicity cohorts between 1990 and 2005: non-Hispanic whites—50 percent decrease, Blacks 45 percent decrease and Hispanics 26 percent decrease.

Clinical health care

Health care services

The Legacy Emanuel Medical Center five mile primary service area includes four other tertiary hospitals including two trauma 1 centers—one of which is Legacy Emanuel. Providence Health and Services operates one hospital about five miles west of Legacy Emanuel and the other three miles southeast. The last tertiary and other trauma 1 center is OHSU which is also site of the only medical school in Oregon. Two full-service children's hospitals are within two of the hospitals' licenses—including Randall Children's Hospital at Legacy Emanuel. Kaiser Permanente formerly sited a hospital about a mile north of Legacy Emanuel; although no longer the location of a hospital, Kaiser maintains a strong clinic presence in the area.

The primary service area includes two Medically Underserved Areas (MUA): St. Johns community and SE Portland. With the long-standing income disparities in the Legacy Emanuel area, safety net services have expanded in the last decade. Multnomah County Health Department operates FQHCs in Northeast and Southeast Portland. Two blocks from Emanuel is the site of a NARA (Native American Rehabilitation Association) FQHC. Five years ago a nonprofit volunteer based safety net clinic opened one mile from the hospital; it is dedicated to providing primary care for uninsured low income residents, primarily African American, from the immediately surrounding zip codes. Providence Medical Group operates a clinic about a mile north of Emanuel bordering on the medically underserved area.

A local nonprofit, Project Access NOW, links uninsured low income individuals to providers and health system services providing services at no charge. All of the health systems in the metro area are very involved with this program and Legacy Health, in addition to providing clinical services, provides and cash donation and office space to the administrative offices of Project Access NOW inkind. Legacy Emanuel's internal medicine residency program operates a teaching clinic and a midwifery clinic serving the low income and often uninsured.

Services to those in need

Legacy Emanuel's charity care policy includes patients with incomes up to 400 percent of the Federal Poverty Level. Eighty percent of uninsured patients do not pay anything and 15 percent pay a small portion of their bill. In FY 11, Legacy Emanuel provided $36.0 million in charity care and $89.3 million in total unpaid costs of care for those in need.

Catholic Healthcare West and Thomson Reuters developed the Community Needs Index (CNI), a tool that produces a composite picture of needs using a variety of demographic and socio economic indicators. The five areas measured are Income, Culture (Race, Ethnicity, Language), Education, Insurance and Housing. The tool has been validated by comparing it with hospital admission rates. Admission rates for highly needy communities as measured by the CNI are more than 60% greater than communities with the lowest indices. The CNI is increasingly being used as the national standard in identifying communities with health disparities and comparing relative need.

Comparison of Legacy top self-pay zip codes by dollars and cases shows consistency with CNI mapping. Nine zip codes accounted for 28.4% of Legacy self-pay (generally free) care dollars in FY 10, or $48.8 million, and all score in the upper ranges of the CNI. The locations of two of the top four are directly north of Legacy Emanuel in St. Johns (97203 and 97217). The third is located in

the heart of Legacy Good Samaritan's neighborhood (97209) directly across the river from Legacy Emanuel. This type of mapping allows for highly selective targeting of initiatives to areas where they are needed most.

Access to care

Lack of access is correlated with increased rates and severity of chronic diseases, hospitalizations and mortality. Access is influenced by a number of factors: health insurance, proximity to services, transportation, income, culture, language, and provider acceptance of uninsured, Medicaid and Medicare patients.

The poor and communities of color have a disproportionate impact from lack of access to care. The Agency for Healthcare Research and Quality reports that Hispanics receive worse care across 60 percent of core quality measures. The Robert Wood Johnson Foundation reports that low income people on average receive worse care across 12 of 17 quality measures, including access to care, cancer screening and preventive health services.

Health insurance

Health insurance coverage is significantly correlated to health status. The uninsured are 2.8 times more likely than the insured to be hospitalized for diabetes, 2.4 times more likely for hypertension and 1.6 times for pneumonia. One study reported that case management of Oregon Health Plan patients showed a 43 percent reduction in emergency department visits.

Oregon has had a high uninsured rate as compared to the nation—in 2010 at 18.0 percent (600,000 people under 65 years). In 2009 Multnomah County experienced a 16.8 percent uninsured rate. Adults 18 to 64 years are more likely to be uninsured than children or seniors.

Nationally, 50 percent of the uninsured are people of color. Uninsured rates vary significantly by race and ethnicity. In Multnomah County, 14.4% of non-Hispanic whites were uninsured relative to 21.3 percent of communities of color in 2008. In Oregon during the same year, Native Americans and Hispanics experienced nearly triple the uninsured rates of non-Hispanic whites—29.3 percent and 28.2 percent as compared to 11.3 percent.

Provider and service availability

Oregon average of primary care provider availability is 40 providers less than the target of 175 per 100,000 people. The rates differ enormously among counties, consistent with hospital locations and population density. In 2007, Multnomah County's 211/100,000 was the highest of all state counties; the majority of the providers, particularly specialists, were located in Portland surrounding the tertiary hospitals. Legacy Emanuel as a tertiary facility located in a low income neighborhood has a greater proportion of specialists relative to primary care providers. Availability is a particular issue in low income areas, where physicians do not tend to locate.

Preventive screenings are an additional indicator of health care access. Sigmoidoscopy/ colonoscopy rates 50 years plus, cholesterol screenings and diabetic screenings 65 years plus were 67.7 percent, 73.9 percent and 84 percent in Oregon as compared to national target rates (90^{th} percentile) of 61.8 percent, 77.0 percent and 88 percent respectively. Thus, Oregon is over the target for sigmoidoscopy/ colonoscopy and under the others.

Receiving prenatal care in the first trimester is a health care access indicator and correlated to low birth weight and infant mortality. In 2006, Oregon's rate of women obtaining prenatal care in the first trimester was 79.2 percent and Multnomah County was 78.4 percent. Disparities in accessing prenatal care among race and ethnicity cohorts at the state level were described in the Morbidity sections, including how different races and ethnicities display greatly varying low birth weight and infant mortality numbers.

Childhood immunization rates are also an indicator of health care access. In 2009, 72 percent of children 19-35 months in the US had their immunizations as compared to 67 percent in Oregon. The national goal is 80 percent.

Physical environment

The physical environment plays a role in community health. Indicators that are tracked include quality (air, noise and water) and the built environment (access to healthy food, transportation, trails and sidewalks). Research over the last two decades clearly identifies the relationship between neighborhoods with higher income families and increased access to grocery stores and availability of physical access opportunities, e.g., sidewalks, trails. Some studies have even suggested that health status can be correlated with zip code, which the CNI method validates.

Access to healthy food makes healthy choices easier. The Urban and Environmental Policy Institute in 2002 reported that middle and upper income neighborhoods had twice as many supermarkets as low-income neighborhoods. The national target is that 70 percent of a community's census tract boundaries will be within one half mile of a healthy food retail store. Within Oregon in 2006, only 47 percent of the state's census tracts met this target. Multnomah County was 45 percent. Access to healthy food is a serious problem in many parts of our service area. As can be experienced driving through some neighborhoods surrounding Legacy Emanuel, the lack of large grocery stores is evident.

The number of liquor stores per 10,000 people is a reverse health status indicator. Multnomah County at .7 was higher than the state and highest among all metro area counties. Multnomah County has the greatest population density, highest poverty levels, and lowest health status.

STAKEHOLDER ASSESSMENT

Quantitative research provides a detailed look at data and trends in specific population cohorts. One-on-one interviews with key stakeholders provide context. Between August 2010 and January 2011 Legacy Emanuel and Legacy Health management interviewed 66 elected officials and public sector (public health, human services), and faith, business and community leaders, including representatives of culturally, racially and ethnically diverse communities. Interviewees were intentionally designated based on their direct involvement with organizations and/or issues in the service areas, i.e., they have played visible roles in meeting community needs.

A standard set of questions elicited responses encompassing community health, primary issues facing the community, health and public health issues, roles of health systems in addressing needs and whether issues for people of cultural, racial and ethnic diversity differed from other populations.

Stakeholders provided a rich interpretation of community health including types of care (e.g., physical, mental, dental), social determinants (education, income/jobs, health care, community engagement, environment and housing) to individual assets (e.g., stability, emotional spiritual, holistic, opportunity), individual assets (e.g., stability, emotional, spiritual) and community assets (e.g., interconnectedness, access, quality, interdependence). A thread of 'inclusion' ran through most of the interviews, a belief that all individuals must have access to a community's assets and that disparities and inequities must be challenged and addressed in order for a community to truly 'healthy.' As with our earlier examination of data concerning the factors that influence a community's health, the actual provision of health care services was seen by most respondents as less important than economic and social factors.

Following is a summary of what we learned from the stakeholders. Percentages are based on the number of mentions due to respondents providing more than one designation.

Community health characteristics

Asked about the definition of "community health" and what a healthy community looks like, stakeholders designated the three most important characteristics in a community's health from a list. Income/Jobs, Education and Health Care and Access were cited the most in this order. Adding those who cited Public Health to Health Care, the percent rose to place it first. These three characteristics were each more than twice the others. Housing, Social/Human Services and Community Involvement followed in rankings.

Community needs/issues

Assessment of community needs and issues reflects the gap between the previous question's ideal state and the current reality. The three most important characteristics of a healthy community were cited as the three greatest issues, but in a different order. Income/jobs remained number one. Health Care and Access switched with Education for second place. Disparities and equity issues are seen as barriers to the higher-level items like Income/Jobs and Access to Health Care as Diversity/Disparities/Equity/Culturally Appropriate moved to fourth place. There was a consistent theme about the lack of voice for communities of color and institutional racism resulting in disparities and inequities.

Health care/public health issues

Specifically questioned about Health Care/Public Health needs, Access for Low Income and Uninsured (coverage, cost, primary care shortage/access and affordability) was listed nearly a third of the time, followed by Mental Health and/or Addictions/Substance Abuse. Concern about issues related to cultural competency, disparities, equity and racism were cited nearly one out of ten times. Interviewees were vocal about health disparities for communities of color and some proposed that an equity lens be used in looking at all issues and needs. Concerns about the impact on the future generation of the significantly increasing numbers of chronic disease and obese children were shared, particularly for communities of color due to the adult mortality and morbidity disparities resulting. Chronic Disease, Obesity, Dental, Nutrition/Hunger, Prevention and Education, Seniors, Built Environment and Violence: Domestic and Child then followed in order. These concerns center on the role of government, specifically health policy.

Racial/ethnically diverse community issues

We asked specifically about health disparities for communities of color, given the findings of our data review that demonstrated significant and increasing concerns in this area. The majority of stakeholder input indicated that the health care and social needs of these populations were essentially the same, but that the intensity of the needs were exacerbated; i.e., communities of color have fewer resources and experience magnified barriers across all factors. Several respondents noted that these communities do not have sufficient voice in policy discussions and civic projects.

Hospitals' roles

Stakeholder recommendations for the role of hospitals in community health centered primarily on relationships, leadership and advocacy. Recommendations were for increased partnerships with community based organizations in terms of services, dollars, and labor; advocacy with legislators and elected officials; collaboration with other health systems; prevention and education; health care access for the uninsured and health care access related to affordability and costs. Stakeholders felt

that health systems would influence issues most effectively and efficiently by working in broader and deeper partnerships with fewer organizations.

CONCLUSION

Significant segments of the population in the Legacy Emanuel service area are less well-off across a range of measures – economics, education, health, and more. Communities of color bear a disproportionate burden. County level data shows consistent race and ethnic data disparities across indicators. The 2010 Communities of Color Report in Multnomah County stated that "suffering a legacy of racism and unequal treatment has imperiled our health and well-being."

The size of communities of color in the Legacy Emanuel area is growing. If economic, education, and social systems do not change course to reduce historic inequities, they will only become a greater factor in the community's health. One of the promises of health care reform is coverage for those who currently do not have health insurance. The newly insured will be disproportionately from communities of diversity, and thus as a whole this newly insured population will be significantly less educated, poorer, and have lower health status and greater health care needs.

If we are to address the health care-related needs of the Legacy Emanuel area, and turn first to the most serious need, that need is found in communities of color. Our mission and our desire to have the greatest impact possible leads us to consider our community benefit activities through this lens.

The range of possible activities is tremendous, so we prioritize using the following broad criteria:

1. Size: The number of people affected, and the geography impacted.
2. Seriousness: The impact on the area's health, on its economic strength, and on its institutions.
3. Change Potential: The potential for positive intervention, and the sustainability of positive impact.
4. Capacity: The extent to which Legacy Emanuel has the resources and expertise to have a significant impact.
5. Legacy and Legacy Emanuel's strategic plans: The alignment of the issue with one of the health system's areas of strategic focus and mission and the hospital's strategic focuses.

ACTION PLAN

Using these criteria and the lens of racial and ethnic equity, a Legacy Emanuel Medical Center Implementation Strategies Plan details needs and implementation strategies in order of priority. All needs expressed by stakeholders related to health, health care and public health are listed, including those not addressed as a focus priority due to lack of resources. Many needs beyond the five focus areas are addressed within hospital services and activities and these can be found in the Plan. Legacy Emanuel's resources and strengths are on health-related services and, thus, the five focus areas are health-related needs and actions. Community stakeholders clearly stressed recommending focused attention in contrast to a broader superficial approach in addressing issues.

Based on the criteria, Legacy Emanuel will focus on:

- **communities of color**
- **charity care**
- **access to health care**
- **health literacy**
- **youth and education**.

IMPLEMENTATION STRATEGIES PLAN

The Legacy Emanuel Implementation Strategies Plan follows Exhibits and Appendices.

Exhibit 1: Demographics

	Data Year/ Source	US	OREGON	WASH.	Clackamas	Clark	Multnomah	Washington
Total Population	2009/1 2010*/2	307,006,556	3,844,195*	6,664,195	381,775	436,391	730,140	532,620
Live Births	2007,09,07 /3,4,5	4,324,008	49,373	89,200	8.2%	6.8%	20.8%	15.9%
Gender								
Male	2009/1	49.3%	49.6%	49.9%	49.5%	49.8%	49.6%	50.1%
Female	2009/1	50.7%	50.4%	50.1%	50.5 %	50.2%	50.4%	49.9%
Age								
Median Year	2009/1	36.7	37.8	37.1	38.9	35.1	36.9	35.0
Under 5 years	2009/1	6.9%	6.4%	6.6%	5.6%	7.0%	6.8%	7.5%
5 to 19 years	2009/1	14.0%	19.3%	19.9%	20.0%	21.9%	18.2%	20.9%
20 to 44 years	2009/1	34.5%	34.0%	35.1%	32.6%	35.7%	37.7%	37.7%
45 to 64 years	2009/1	32.0%	27.3%	26.7%	29.8%	25.2%	26.9%	24.9%
65 years & older	2009/1	12.6%	13.0%	11.7%	12.0%	10.2%	10.4%	9.0%
Lang. Other Eng. Spoken at Home	2009/6	20.0%	14.6%	17.0%	11.9%	13.3%	18.6%	22.9%
Population Growth	**Year**	**4 Counties**	**OREGON**		**Clackamas**	**Clark**	**Multnomah**	**Washington**
	2010/6	2,080,926	3,844,195		381,775	436,391	730,140	532,620
	2015/6	2,187,871	3,941,265		391,415	476,850	759,817	559,789
Annual Increase	2010-15	1.0%	.5%		.5%	1.9%	.8%	1.0%
		Primary Service Area	**Emanuel/ Good Samaritan**	**Meridian Park**	**Mount Hood**	**Salmon Creek**		
	2010/7	948,044	443,503	226,068	116,486	161,987		
	2015/7	1,005,822	458,517	242,530	125,479	179,296		
Annual Increase	2010-15	1.2%	.5%	1.5%	1.5%	2.1%		

Exhibit 2: Demographics by Race and Ethnicity

		Data Year/ Source	Total	Non-Hispanic White	Hispanic	Black/African American	Native American	Asian	2 or more races
Total Population	OR	2008/1,2	3,790,060	79.9%	11.0%	1.7%	1.7%	3.4%	3.5%
	WA	2008/2	6,549,224	75.3%	9.8%	3.4%	1.4%	6.5%	4.0%
	Total GPA	2010/3	2,120,737	76.7%	10.7%	2.9%	0.7%	5.6%	3.0%
Primary Service Area (five miles)	Emanuel/Good Samaritan	2010/3	443,503	74.1%	8.6%	6.6%	0.7%	5.9%	3.4%
	Meridian Park	2010/3	226,068	81.9%	8.8%	1.0%	0.4%	5.0%	2.5%
	Mount Hood	2010/3	116,486	78.9%	11.9%	1.9%	0.7%	3.2%	3.0%
	Salmon Creek	2010/3	161,987	88.3%	5.8%	1.2%	0.6%	1.5%	2.4%
County	Clackamas	2009/4	386,143	84.6%	7.6%	1.1%	1.0%	3.8%	2.4%
	Multnomah	2009/4	726,855	73.6%	10.9%	6.0%	1.2%	6.1%	3.1%
	Washington	2009/4	537,318	71.2%	15.3%	2.1%	1.0%	8.7%	2.6%
	Clark	2009/4	432,002	83.3%	7.1%	2.2%	1.0%	4.0%	2.6%
	Four Cty Area	2009/4	2,082,318	77.0%	10.6%	3.3%	1.1%	5.9%	2.7%
Live Births	OR	2007/5	49,378	69.4%	20.5%	2.3%	1.7%	5.4%	N/a
	WA	2007/5	88,978	63.3%	18.9%	4.3%	2.0%	9.3%	N/a
Gender	OR M	2008/1,2	49.7%	49.1%	54.2%	53.0%	48.8%	46.3%	49.0%
	OR F	2008/1,2	50.3%	50.9%	45.8%	47.0%	51.2%	53.7%	51.0%
	WA M	2008/2	49.9%	N/A	N/A	N/A	N/A	N/A	N/A
	WA F	2008/2	50.1%	N/A	N/A	N/A	N/A	N/A	N/A
Age									
Under 5 years	OR	2008/1,2	6.4%	5.2%	13.3%	8.3%	6.0%	6.2%	13.3%
5 to 17 years	OR	2008/1,2	19.2%	14.9%	26.3%	21.7%	22.3%	15.9%	29.6%
18 to 44 years	OR	2008/1,2	33.6%	34.9%	45.4%	39.1%	38.9%	46.4%	35.7%
45 to 64 years	OR	2008/1,2	27.6%	29.9%	12.1%	23.4%	26.2%	23.1%	16.5%
65 years and older	OR	2008/1,2	13.2%	15.1%	2.9%	7.5%	6.7%	8.5%	4.9%
Total	OR	2008/1,2	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Exhibit 3: Mortality and Morbidity Rates

Age Adjusted: AA	Data Year/ Source	US	OREGON	WASH.	Clackamas	Clark	Multnomah	Washington
Mortality /100,000								
Total Death Rate Crude	2007/1	803.6	838.0	731.6	N/A	N/A	N/A	N//A
Death Rate AA	2006/1,4	760.2	770.5	722.5	766.5	745.1	833.0	684.7
Premature Death	2006/5	N/A	653.7	597.9	541.8	573.2	699.9	462.4
Heart Death Rate AA	2006/1,4	190.9	160.1	165.8	161.4	176.7	175.3	146.2
Cancer Death Rate AA	2006/1,4	178.4	181.3	174.2	187.8	176.0	188.3	150.8
Diabetes Death Rate AA	2006/4	N/A	28.2	24.4	27.3	23.2	29.7	24.7
Infant Mortality /1000	2007/2 WA 2009/6 OR	6.8	5.7	4.9	4.7	4.7	6.3	3.4
Morbidity								
Low Birth Weight	2007/1	8.2%	6.1%	6.3%	5.2%	6.6%	6.1%	6.0%
Cancer Incidence /100,000	2007/7	464.5	465.6	479.1	467.0	460.9	466.0	428.2
Heart Disease Ever Had	2008/3	3.8%	3.7%	3.3%	N/A	N/A	N/A	N/A
Diabetes	2008/1	8.0%	6.9%	7.0%	7.7%	8.4%	7.3%	6.4%
Asthma	2008/1,3	13.3%	14.9%	14.9%	14.9%	16.9%	14.3%	13.7%
Health Status:good or excellent	2008/5	N/A	85%%	87%	88%	87%	86%	88%
Poor Mental Health Days (days per year)	2008/5	N/A	3.3	3.3	2.8	3.2	3.7	2.9

Exhibit 4: Mortality and Morbidity Rates By Race and Ethnicity

	Data Year/ Source	Total	Non-Hispanic White	Hispanic	Non-Hispanic Black	Native American	Asian/ Pacific Islander
Mortality /100,000							
Total Rate Age Adjusted AA							
Oregon	2006/1	770.5	785.4	421.5	828.1	757.7	430.3
Clackamas	2006/1	766.5	783.2	426.6	683.3	824.7	376.5
Multnomah	2006/1	833.0	857.6	451.1	895.7	819.8	509.3
Washington	2006/1	684.7	711.2	312.7	1180.4	522.2	381.3
Washington	2006/1	722.5	735.4	467.2	903.6	904.6	462.7
Clark	2006/1	745.1	759.4	381.8	825.3	409.4	472.9
Heart Death Rate AA							
Oregon	2006/1	160.1	163.5	74.4	154.9	128.3	100.5
Clackamas	2006/1	161.4	166.8	N/A	N/A	N/A	64
Multnomah	2006/1	175.3	178.6	79.7	181.4	143.3	147.9
Washington	2006/1	146.2	152.1	24.8	N/A	343.4	78.3
Washington	2006/1	165.8	170.2	101.6	183.7	178.5	93.1
Clark	2006/1	176.7	179.2	91.1	179.7	N/A	114.7
Cancer Death Rate AA							
Oregon	2006/1	181.3	186.4	84.6	162.3	151.5	99.2
Clackamas	2006/1	187.8	192.1	68	N/A	266.7	107.2
Multnomah	2006/1	188.3	196.7	110.1	168.8	107.7	120.9
Washington	2006/1	150.8	158.5	59.1	269.8	N/A	72.8
Washington	2006/1	174.2	178.7	98.5	214.1	152.5	128.5
Clark	2006/1	176.0	178.9	61.5	86.9	N/A	159.7
Diabetes Death Rate AA							
Oregon	2006/1	28.2	27.2	36.5	62.4	80.3	29.5
Clackamas	2006/1	27.3	27.1	N/A	N/A	N/A	N/A
Multnomah	2006/1	29.7	27.8	24.5	62.6	N/A	26.8
Washington	2006/1	24.7	24.6	N/A	N/A	N/A	25.7
Washington	2006/1	24.4	23.7	26.2	57.6	40.2	21.5
Clark	2006/1	23.2	23.5	N/A	N/A	N/A	N/A

	Data Year/ Source	Total	Non-Hispanic White	Hispanic	Non-Hispanic Black	Native American	Asian/ Pacific Islander
Infant Mortality /1000							
Oregon	2006/2	5.6	5.5	5.4	9.4	N/A	N/A
Washington	2006/2	5.1	4.5	4.8	8.1	N/A	N/A
Morbidity							
Low Birth Weight							
Oregon	2007/2	6.1%	5.9%	5.9%	9.8%	N/A	N/A
Washington	2007/2	6.3%	6.0%	5.7%	9.8%	N/A	N/A
Cancer Incidence AA /100,000							
Oregon	2006/2	456.5	450.2	340.8	356.5	N/A	N/A
Washington	2006/2	482.1	479.4	340.7	488.5	N/A	N/A
Coronary Heart Disease Prevalence AA							
Oregon*	2005/3	3.7%	3.9-4.0%	2.0-4.0%	4.0-9.0%	8.0-13.0%	4.0-9.2%
Washington	2005/3	3.3%	N/A	N/A	N/A	N/A	N/A
**Ranges based on 95% confidence*							
Diabetes Prevalence AA							
Oregon	2005/5	6.9%	6%	10%	13%	12%	7%
Washington	2005/6	7%	6%	9%	14%	12%	9%
Asthma Ever Had							
Oregon	2006/2	14.9%	15.2%	7.3%	13.0%	N/A	N/A
Washington	2006/2	14.9%	14.5%	10.0%	14.7%	N/A	N/A
Adults Reporting Poor Mental Health							
Oregon	2007/7	32.9%	33.8%	N/A	N/A	N/A	N/A
Washington	2007/7	35.0%	35.3%	26.8%	30.5%	48.4%	30.8%

Exhibit 5: Social Economic and Environment Determinant Factors

	Data Year/ Source	Target 90th percentile	OREGON	WASH.	Clackamas	Clark	Multnomah	Washington
Socio Economic								
Education								
High School Grad. 4 years	2006/2	84% OR 89% WA	73%	73%	75%	77%	73%	78%
HS Grad. 25 yrs older	2009/1	N/A	89.1%	89.7%	91.6%	91.0%	89.0%	90.5%
College Degree 25 yrs older	2009/1	31%	29.2%	31.0%	32.7%	24.2%	39.1%	38.3%
Employment								
Unemployment	2009/1		11.8%	9.5%	11.1%	12.5%	11.5%	10.6%
Income								
Median Household Income	2009/1	N/A	$48,475	$56,548	$59,876	$56,074	$50,773	$60,963
All Poverty	2009/1	N/A	14.3%	12.3%	9.2%	11.8%	15.1%	10.2%
Children in Poverty (< 18)	2009/1	13%	19.2%	16.2%	13.5%	16.9%	19.6%	12.7%
Home Ownership	2009/1	N/A	63.1%	64.3%	70.4%	64.3%	54.9%	62.2%
Rent 35% of HH Income	2009/1	N/A	42.6%	40.3%	42.9%	40.4%	42.4%	38.4%
Single Female Parent HH	2008/1	7%	10.1%	10.1%	9.1%	10.8%	10.7%	9.8%
Crime								
Violent Crime Rate /100,000	2007/2	117	285	342	126	237	638	157
Physical Environment								
Quality Environment								
Air Pollution—Particulate Matter Days	2005/2	0	4	2	4	3	4	25
Built Environment								
Access to Healthy Food: Census boundary .5 mile healthy food retailer	2006/2	71%	47%	47%	67%	63%	45%	61%
Liquor Store Density	2006/2	N/A	.5	.5	.4	.3	.7	.4

Exhibit 6: Social Economic Determinant Factors by Race and Ethnicity

		Data Year/ Source	Total	Non-Hispanic White	Hispanic	Black/African American	Native American	Asian/ Pacific Islander	2 or more races
Education									
High School Grad 25 yrs older	***OR***	2008/2,3	88.6%	91.4%	54.7%	86.8%	84.1%	85.6%	87.9%
	WA	2008,07/ 3,1	89.6%	92.2%	57.7%	85.7%	80.7%	84.6%	90.2%
College Degree 25 yrs older	***OR***	2008/2	28.1%	29.2%	10.4%	20.1%	12.8%	45.7%	24.1%
	WA	2008/3 2007/1	30.7%	31.5% 2007	11.2% 2007	18.7% 2007	11.7% 2007	43.2% 2007	22.6% 2007
Employment									
Unemploy. (16 older)	***OR***	2009/3	11.8%*	11.4%	14.8%	18.1%	16.4%	6.7%	N/a
* Nov 2010: 10.5%	Clack.	2009/3	11.1%	11.3%	6.0%	-	-	-	N/a
	Mult.	2009/3	11.5%	10.2%	18.6%	17.7%	-	8.2%	N/a
	Wash.	2009/3	10.6%	10.8%	11.9%	-	-	4.7%	N/a
	WA	2009/3	9.5%	9.1%	10.8%	15.3%	17.1%	6.8%	N/a
	Clark	2009/3	12.5%	12.0%	16.3%	-	-	6.1%	N/a
Income									
Median HH Income	***OR***	2009/3	$48,457	$49,825	$35,861	$32,266	$34,072	$58,283	
	Clack.	2009/3	$59,876	$60,923	$43,136	-	-	$75,282	
	Mult.	2009/3	$50,733	$54,373	$36,356	$28,222	$23,173	$51,391	
	Wash.	2009/3	$60,963	$62,442	$40,386	$52,363	$49,133	$76,682	
	WA	2009/3	$56,548	$58,431	$42,532	$38,287	$42,393	$67,506	
	Clark	2009/3	$56,074	$56,763	$55,363	$30,985	$27,159	$70,805	
Home Ownership	***OR***	2009/4	65.9%	70.9%	48.0%	44.5%	54.6%	59.0%	51.9%
All Pov.<100% FPL	***OR***	2008/2,3	13.6%	11.2%	25.8%	29.4%	26.5%	12.8%	17.4%
	WA	2008/3	11.3%	9.1%	23.5%	22.9%	26.1%	9.2%	15.4%
Child Pov.<100% FPL	***OR***	2008/2,3	18.1%	12.9%	33.2%	37.7%	32.9%	11.9%	16.5%
	WA	2008/3	14.3%						
Female Head HH w Children Poverty	***OR***	2008/2		34.2%	54.3%	55.8%	44.2%	37.6%	47.0%

Exhibit 7: Clinical Care and Behavior Health Factors

	Data Year/ Source	Target 90th percentile	ORE.	WASH.	Clackamas	Clark	Multnomah	Washington
Clinical Care								
Access								
Uninsured 2010/2*	2009/1	N/A	18.0%*	12.5%	13.2%	12.8%	16.8%	14.8%
Uninsured Children 0-18 yrs	2009/3	10%	12%	6%	N/A	N/A	N/A	N/A
Primary Care Provider /100,000	2007/5	175	133	136	107	102	211	123
Prenatal Care First Trimester	2006/4,5	83.2%	79.2%	70.3%	82.8%	N/A	78.4%	85.6%
Diabetic Screening-65 yr	2006/6	88%	84%	85%	84%	85%	85%	82%
Cholesterol Screening	2009/6,7	77.0%	73.9%	72.9%	N/A	75.0%	N/A	N/A
Sygmoidoscopy or Colonoscopy-50 yr plus	2008/3 2006/8	61.8%	66.7%	66.2%	N/A	N/A	N/A	N/A
Pap Smears-18 yr plus	2006/8	N/A	81.7%	82.7%	81.1%	82.1%	81.4%	83.1%
Immunized: 19-35 months	2009/3	72%	67%	75%	N/A	N/a	N/A	N/A
Quality								
Preventable Hospital Stays	2006/5	40,37 OR,WA	49	50	42	61	46	45
Behaviors								
Tobacco Use Adult Smoking	2009/5 OR 2010/7 WA	14%	19%	14.8%	17%	14.4%	20%	14%
Teen Smoking WA: 10th grade OR: 11th grade	2009/10 OR 2008/7 WA	N/A	17%	14%	18%	16%	16%	14%
Diet Adult Obesity	2009/9	26.9%	23.6%	26.9%	24.2%	32.1%	20.5%	18.6%
Adult Overweight	2009/3	33.9%	34.6%	32.5%	N/A	N/A	N/A	N/A
Child 10-17 yrs	2007/3	31.6%	24.3%	29.5%	N/A	N/A	N/A	N/A
Alcohol Use								
Heavy Drinking (Women: 1 drink/day, Men: 2 drinks/day)	2007/11	N/A	6.3%	N/A	5.7%	N/A	7.1%	4.4%
Motor Vehicle Deaths /100,000	2006/5	8	14	12	11	10	9	8
High Risk Sex								
Chlamydia /100,000	2006/5	197	266	294	196	242	429	197
Teen Births 15-19 yrs /1000	2006/5	24	37	34	24	35	39	33

Exhibit 8: Clinical Care and Behavior Health Factors by Race and Ethnicity

		Data Year/ Source	Total	Non-Hispanic White	Hispanic	Black/African American	Native American	Asian/ Pacific Islander
Clinical Care								
Access								
Uninsured	***OR***	2008/1	18.0% under 65	11.3%	28.2%	12.1%	29.3%	10.2%
	WA	2007/2	12.5%	N/A	N/A	N/A	N/A	N/A
Prenatal Care First Trimester	***OR***	2006/3	79.2%	82.4%	70.1%	72.1%	N/A	N/A
	WA	2006/3	70.3%	74.0%	60.5%	63.7%	N/A	N/A
Behaviors								
Tobacco Adults Smoking	***OR***	2008/3	16.3%	15.7%	N/A	N/A	N/A	N/A
	WA	2008/3	15.7%	15.6%	12.2%	N/A	37.5%	N/A
Diet								
Adults Obese	***WA***	2007/4	25%	24%	***30%***	30%	36%	11%
Adults Overweight or Obese	***OR***	2009/3	58.2%	58.4%	***N/A***	N/A	N/A	N/A
	WA	2009/3	59.4%	60.0%	57.5%	74.3%	70.8%	37.4%
High Risk Sex								
Teen Birth Rate /1000	***OR***	2007/5	35.9	27	93	44	54	15
	WA	2007/5	34.8	24	99	42	84	22

Exhibit 1: Demographics
1: US Census Bureau American Community Survey 2009 and 2006-2008. www.census.gov/acs
2: Portland State University Population Research Center. www.pdx.edu/prc
3: Oregon Department of Human Services Center for Health Statistics. http://www.dhs.state.or.us/dhs/ph/chs/data/birth/lb.shtml
4: Washington State Department of Health. Health Statistics. http://www.doh.wa.gov/ehsphl/chs/chs-data/birth/Bir_Main.htm
5: Center for Disease Control User Guide to the 2007 Natality Public Use File. Cdc.gov/wonder/help/natality
6: Legacy Finance. PSU Population Research Center. www.pdx.edu.prc
7: Legacy Finance. Oregon Department of Administrative Services Office of Economic Analysis. Www.oregon.gov/DAS/OES/demographic

Exhibit 2: Demographics by Race and Ethnicity
1: Oregon Department of Human Services Office of Multicultural Health. www.oregon.gov/DHS/ph/omh
2: US Census Bureau American Community Survey 2008, 2009. cdc.gov/acs
3: Legacy Finance, Intelligmed Demographic Profile System.
4: Oregon Department of Human Services. Off0ice of Multicultural Health. www.oregon.gov/ph/mch Washington State OFM County Population Projections www.ofm.wa.gov/pop/gma/projections , Clark County 2010-2014 Consolidated Housing and Community Development Plan www.co.clark.wa.us/cdbg/documents. US Census Bureau Quick Facts quickfacts.census.gov/qfd/states/41000.html
5: Kaiser Family Foundation State Health Facts. www.kff.org

Exhibit 3: Mortality and Morbidity Rates
1: Center for Disease Control. National Center for Health Statistics. www.cdc.gov/nchs
2: Oregon Department of Human Services Center for Health Statistics Vital Statistics. http://www.dhs.state.or.us/dhs/ph/chs/data
3: Center for Disease Control Community Health Status Report. Behavioral Risk Factor Surveillance System 2009. www.cdc.gov/brfss
4: US Department of Health and Human Services. Office of Women's Health. Health Data. www.healthstatus2010.c0m
5: County Health Rankings. www.countyhealthrankings.org
6: Washington State Department of Health Center for Health Statistics. http://www.doh.wa.gov/ehsphl
7: National Cancer Institute State Cancer Profiles 2003-2007. state cancer profiles.cancer.gov/incidencerates

Exhibit 4: Mortality and Morbidity Rates By Race and Ethnicity
1: US Department of Health and Human Services. Office of Women's Health. Health Data. www.healthstatus2010.c0m
2: Kaiser Family Foundation State Facts. www.kff.org
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2: Oregon Department of Human Services Office of Multicultural Health. www.oregon.gov/DHS/ph/omh
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Appendix A
Community Health Characteristics: Most Important

Issue	Number	Percent
Income/Jobs	40	21.3%
Education	37	19.7%
Health Care and Access	33	17.6%
Housing	18	9.6%
Public Health	13	6.9%
Community Involvement	11	5.9%
Environment	9	4.8%
Social/Human Services	8	4.3%
Economic Development	5	2.7%
Public Safety	4	2.1%
Revenue/Public Services	2	1.1%
Equity	2	1.1%
Mental Health	2	1.1%
Food/Hunger	1	0.5%
Dental	1	0.5%
Early Childhood	1	0.5%
Leadership	1	0.5%
Total	188	100.0%

Appendix B
Community Health: Greatest Needs/Issues

Issue	Number	Percent
Income/Jobs	38	20.0%
Health Care and Access	31	16.3%
Education	25	13.2%
Diversity/Disparities/Equity/Culturally Approp. Services	20	10.5%
Housing	14	7.4%
Mental Health	11	5.8%
Public Health	6	3.2%
Health	6	3.2%
Economy Funding	5	2.6%
Dental	4	2.1%
Addiction/ Substance Abuse	3	1.6%
Poverty	3	1.6%
Environment	3	1.6%
Obesity	3	1.6%
Early Childhood	3	1.6%
Chronic Disease	2	1.1%
Public Safety	2	1.1%
Nutrition/Hunger	2	1.1%
Transportation	1	0.5%
Civic Involvement	1	0.5%
Economy	1	0.5%
Childhood Chronic Disease	1	0.5%
Childhood Obesity	1	0.5%
Adult Literacy	1	0.5%
Domestic Violence	1	0.5%
Seniors	1	0.5%
HIV/AIDS	1	0.5%
Total	190	100.0%

Appendix C
Health Care and Public Health: Greatest Issues

Issue	Number	Percent
Healthcare or Access Specified	20	9.7%
Coverage	14	6.8%
Cost	14	6.8%
Cultural Competency	8	3.9%
Primary Care Shortage/Access	7	3.4%
Care Coordination	4	1.9%
Medical Homes	2	1.0%
Disparities, Equity, Racism	11	5.3%
Workforce Diversity	6	2.9%
Mental Health	19	9.2%
Addiction/ Substance Abuse	16	7.7%
Chronic Diseases	14	6.8%
Obesity	11	5.3%
Dental	9	4.3%
Prevention and Education	7	3.4%
Nutrition/Hunger	6	2.9%
Public Health	6	2.9%
Violence: Domestic and Child	5	2.4%
Built Environment	5	2.4%
Prenatal Care	4	1.9%
Seniors	4	1.9%
Early Childhood	3	1.4%
Childhood Mental Health	2	1.0%
STDs	2	1.0%
Natural Environment	2	1.0%
Childhood Obesity and Physical Activity	1	0.5%
Tobacco	1	0.5%
Autism	1	0.5%
Disasters-Medical and Natural	1	0.5%
Transgender Care	1	0.5%
HIV/AIDS	1	0.5%
Total	207	100.0%

Appendix D
Hospitals' Roles

Issue	Number	Percent
Partner with Community Organizations:$, Services,Labor	22	24.7%
Advocate with Legislature, Elected Officials	9	10.1%
Collaboration with other Health Systems	9	10.1%
Prevention Education	8	9.0%
Health Access: Uncompensated Care	8	9.0%
Health Access: Affordability, Reduce Costs	5	5.6%
Public/Private Sector Partnerships	4	4.5%
Mental Health	4	4.5%
Employment Diversity	4	4.5%
Culturally Appropriate/Competent Care	4	4.5%
Education: Health Workforce	3	3.4%
Conveners regarding Issues	3	3.4%
Be Accessible	3	3.4%
Social Determinants	2	2.2%
Dental	1	1.1%
Total	89	100.0%

Appendix E
Needs/Issues Ranked by Priority
Ranking Based on Criteria: Size, Seriousness, Change Potential, Capacity, Strategic Focus

Need/Issue	Criteria	Rating 1 (low) 5 (high)	Total Score
Access: Coverage, Cost, Cultural Competency, Location, Availability, Primary Care Shortage, Medical Homes, Care Management	Size	5	
	Seriousness	5	
	Change Potential	4	
	Capacity	5	
	Strategic Focus	5	24
Disparities/Equity/Racism: Disease Rates, Services, Workforce Diversity	Size	4	
	Seriousness	5	
	Change Potential	5	
	Capacity	4	
	Strategic Focus	5	23
Health Literacy	Size	4	
	Seriousness	5	
	Change Potential	5	
	Capacity	4	
	Strategic Focus	5	23
Youth and Education	Size	4	
	Seriousness	5	
	Change Potential	4	
	Capacity	4	
	Strategic Focus	5	22
Chronic Disease and Obesity	Size	5	
	Seriousness	5	
	Change Potential	3	
	Capacity	4	
	Strategic Focus	4	21
Mental Health	Size	3	
	Seriousness	5	
	Change Potential	3	
	Capacity	3	
	Strategic Focus	5	19
Prevention and Education	Size	4	
	Seriousness	5	
	Change Potential	3	
	Capacity	3	
	Strategic Focus	4	19
Early Childhood	Size	3	
	Seriousness	5	
	Change Potential	3	
	Capacity	4	
	Strategic Focus	4	19
Childhood Obesity and Physical	Size	4	

Activity	Seriousness	5	
	Change Potential	3	
	Capacity	3	
	Strategic Focus	3	18
Prenatal Care	Size	2	
	Seriousness	5	
	Change Potential	4	
	Capacity	3	
	Strategic Focus	4	18
Public Health	Size	4	
	Seriousness	4	
	Change Potential	3	
	Capacity	2	
	Strategic Focus	2	15
Violence: Domestic and Child	Size	3	
	Seriousness	5	
	Change Potential	3	
	Capacity	2	
	Strategic Focus	2	15
Addictions/Substance Abuse	Size	4	
	Seriousness	4	
	Change Potential	2	
	Capacity	2	
	Strategic Focus	2	14
Seniors	Size	3	
	Seriousness	4	
	Change Potential	3	
	Capacity	3	
	Strategic Focus	1	14
Dental	Size	4	
	Seriousness	5	
	Change Potential	2	
	Capacity	1	
	Strategic Focus	1	13
Childhood Mental Health	Size	2	
	Seriousness	4	
	Change Potential	2	
	Capacity	2	
	Strategic Focus	2	12
Nutrition/Hunger	Size	3	
	Seriousness	4	
	Change Potential	2	
	Capacity	2	
	Strategic Focus	1	12
Tobacco	Size	2	
	Seriousness	4	
	Change Potential	3	

	Capacity	1	
	Strategic Focus	1	11
Built Environment	Size	3	
	Seriousness	4	
	Change Potential	2	
	Capacity	1	
	Strategic Focus	1	11
Natural Environment	Size	4	
	Seriousness	3	
	Change Potential	2	
	Capacity	1	
	Strategic Focus	1	11
STDs and HIV/AIDs	Size	3	
	Seriousness	4	
	Change Potential	2	
	Capacity	1	
	Strategic Focus	1	11
Disasters: Medical and Natural	Size	3	
	Seriousness	4	
	Change Potential	2	
	Capacity	1	
	Strategic Focus	1	11
Transgender Care	Size	1	
	Seriousness	3	
	Change Potential	2	
	Capacity	2	
	Strategic Focus	1	9
Autism	Size	1	
	Seriousness	2	
	Change Potential	1	
	Capacity	1	
	Strategic Focus	1	6

Appendix F
Community Needs Assessment
65 Interviewees

Name	Organization	Expertise
Venetta Abdellatif, Director, Integrated Services	Multnomah County Health Department	Expertise in public health, disparities, chronic diseases and FQHCs serving medically underserved
Thomas D. Aschenbrener, President/CEO	Northwest Health Foundation	
Michael Balter, Executive Director	Boys and Girls Aid Society	Expertise in serving low income
Carolyn Becic, Executive Director	Oregon Mentors	
Doreen Binder, Executive Director	Transition Projects	Expertise in serving low income
Ed Blackburn, Executive Director	Central City Concern	Expertise in FQHC and comprehensive services for homeless low income
Sharon Brabenac, Development Director	YWCA of Greater Portland	Expertise in domestic violence and serving low income
The Right Rev. David Brauer-Rieke, Bishop	Oregon Lutheran Synod ELCA	
Rachel Bristol, Executive Director	Oregon Food Bank	Expertise in serving low income
Sam Brooks, Former President	OAME	Expertise dedicated to communities of color equity
Margaret Carter, Deputy Director of Human Services	Oregon Department of Human Services	Expertise in working with low income and communities of color
Gale Castillo, Executive Director	Hispanic Metropolitan Chamber	Organization dedicated to Hispanic community equity
Robin Christian, Executive Director	Children First for Oregon	Expertise in disparities in socio-economics, education, etc. for children
Jeff Cogen, Chair	Multnomah County	
Carlos Crespo, DrPh, Director	Portland State University School of Community Health	Academic researcher in social determinants and communities of color disparities
Marie Dahlstrom, Executive Director	Familias en Accion	Expertise in serving Hispanics and chronic disease management
Andy Davidson, President/CEO	OAHHS	
Marty Davis, Publisher	Just Out	Expertise in LGBT population
Chris DeMars, Program Officer	NW Health Foundation	
Kevin Dowling, Program Manager	CARES NW	Expertise in child abuse
Erin Fair, Policy Director	Care Oregon	Expertise in serving low income
Pietro Ferrari, Executive Director	Hacienda	Expertise in serving Hispanic community
Jeana Frazzini, Executive Director	Basic Rights Oregon	Expertise in LGBT population needs
Joanne Fuller, Director, Human Services	Multnomah County	Expertise in urban county human services and all operations
Dr. Algi Gatewood, President	Portland Community College, Cascade Campus	Expertise in inner city education for communities of color
Jill Ginsberg, MD, Medical Director, Community Health	North by Northeast Community Health Center	Expertise in safety net clinic for low income, chronic disease management

Name	Organization	Expertise
Bruce Goldberg, MD, Director	Oregon Department of Human Services	Expertise as head of Oregon public health and in medically underserved
Guadalupe Guajardo, Senior Consultant	Nonprofit Association of Oregon	Expertise in culturally competent training and consultation
Mary Lou Hennrich, Executive Director	Oregon Public Health Institute	Expertise in public health
Mardica Hicks, Executive Director	Children's Community Clinic	Expertise in medically underserved children of color, chronic diseases
Tony Hopson, President/CEO	SEI	Expertise in reducing disparities for African American families
Rob Ingram, Coordinator, Office of Youth Violence	City of Portland	Expertise in working with young men in communities of color,
Alissa Keny-Guyer State Legislator	House of Representatives	
Pastor Mark Knutson, Reverend	Augustana Lutheran Church	Multi-cultural church--site for Hispanic community
Kali Ladd, Education Policy Advisor	Mayor's Office City of Portland	Expertise in educational equity for communities of color
David Leslie, Executive Director	Ecumenical Ministries of Oregon	Expertise in social justice for the disenfranchised
Holden Leung, Executive Director	Asian Health and Service Center	Expertise in health and human services for Asian community
Marc Levy, CEO/President	United Way of the Columbia Willamette	Expertise in services for low income
Adrienne Livingston, Executive Director	Black United Fund	Expertise in decreasing disparities for communities of color
Nichole Maher, Executive Director	Native American Youth and Family Center	Expertise in decreasing disparities for Native American community
Sandra McDonough, President/CEO	Portland Business Alliance	
Charles McGee II, President/CEO	Black Parent Initiative	Expertise in to decreasing disparities for Black families
Andrew McGough, Executive Director	Worksystems Inc.	Expertise in serving low income young adults
Corliss McKeever, President/CEO	African American Health Coalition	Expertise in reducing health disparities for African Americans
Jeff Milberger, Clinic Director	NARA	Expertise in FQHC for Native Americans, chronic diseases
Mary Monat, Executive Director	LifeWorks NW	Expertise in mental health for medically underserved, low income
Marcus Mundy, President/CEO	The Urban League of Portland	Expertise in to decreasing disparities for African Americans
Vicki Nakashima, Executive Director	Partners in Diversity	Expertise in increasing equity for communities of color
Linda Nilsen-Solares, Executive Director	Project Access NOW	Expertise in health care access for low income medically underserved
Preston Pulliams, District President	Portland Community College	Expertise in reducing education disparities
Carman Rubio, Executive Director	Latino Network	Expertise in reducing disparities for Hispanics
Dan Ryan, Executive Director	Portland Schools Foundation	Expertise in increasing equity for all students
Rector Stephen Schneider, Rector	Grace Memorial Episcopal Church	Expertise in social justice
Kim Scott, Executive Director	Trillium Family Services	Expertise in serving low income children and families

Name	Organization	Expertise
Chip Shields, Senator	Oregon State Senate	
Lillian Shirley, Director	Multnomah County Health Department	Expertise in public health and health disparities
Lynn Thompson, CEO	Big Brothers Big Sisters Columbia Northwest	Expertise in serving low income families
Tricia Tillman, Administrator	Oregon Multicultural Health and Services	Expertise in reducing health disparities for communities of color
Joshua Todd, Director	Multnomah County Commission on Children, Families and Community	Expertise in serving low income
Greg Van Pelt, Chief Executive Oregon	Providence Health and Services Oregon Region	
Maree Wacker, CEO	American Red Cross Oregon Trail Chapter	
Larry Wallack, DrPH, Dean	Portland State University College of Urban and Public Affairs	Expertise as academic researcher in social determinants and disparities
Joyce White, Executive Director	Grantmakers of OR and SW WA	Expertise in research regarding foundation funding disparities for communities of color
Wim Wievel, PhD, President	Portland State University	
David Wynde, Vice President	US Bank	Expertise in increasing educational achievement, reducing racial and ethnic disparities

Legacy Emanuel Medical Center Implementation Strategies Plan

Needs/Issues listed in order of ranking from Community Needs Assessment Secondary Data and Interviews Appendix E. *Italics designate racial and ethnic community focus.*

Action	Impact
NEED: Disparities, Equity, Institutional Racism, Workforce Diversity	
Partnership, financial contribution and board membership with Native American Youth & Family services. Host & sponsor Native American Professional networking event.	*Increases opportunities for Native Americans, including family stability, relationships and employment.*
Partnership and financial contribution to the Oregon Association of Minority Entrepreneurs.	*-Increases entrepreneurship and economic stability within diverse communities, small business owners and women owned businesses* *-Increased Legacy's use of minority women emerging and small business*
Financial contribution and partnership with Partners in Diversity, as well as host a "Say Hey" event annually.	*Help recruit, retain and support professionals of color in Oregon and SW Washington.*
Offer the YES (Youth Employment in Summers) program (paid summer employment ($4800) for African American students entering health care careers.	*Increases the diversity of the health care workforce — four students annually.*
Legacy employment requires management positions and above to include interviewees of color; waiver required for positions not fulfilling this requirement.	*Increases workforce diversity.*
Participation in Legacy Health Diversity Advisory Council that focuses on strengthening our workforce diversity, supporting our diverse community and provide culturally competent care.	*Increases workforce diversity, enhanced employee awareness of diversity, increased executive board representation within minority organizations and increased relationships with cultural specific organizations.*
Financial contribution and partnership with the Hispanic Chamber.	*Provides a vital forum for the Hispanic business & community to share ideas, concerns and successes to increase business opportunities, resources and networks.*
Partnership and ongoing relationship with African American Chamber of Commerce.	*Enhances economic base, better capitalized businesses and equitable participation within the economic mainstream.*
Provide free office space, phones and internet and financial contribution to African American Health Coalition. AAHC offers cooking exercise classes, an annual wellness village and conference and partners with health providers to use culturally appropriate practices.	*Reduces health disparities through health education, advocacy and research.*
NEED: Access to care—Charity Care, Coverage, Cost, Location, Availability, Primary Care Provider Access and Shortage, Medical Homes, Care Coordination and Cultural Competency.	
Health services for low income uninsured based on charity care financial policies, i.e., up to 400% of FPL.	Access to care for those in need.
Financial, service and labor support to Project Access NOW which connects low income uninsured patients to providers at no charge.	Increases quality and reduced morbidity and mortality for low-income uninsured through access to services at earlier stages.

Financial and labor support to Worship in Pink, a program of the Komen Foundation to raise awareness about breast health screening to vulnerable populations.	*Partnering with faith organizations to provide training and increase breast health screenings among women of color.*
Exercise and support groups open to all cancer patients.	Improves the health and quality of life for cancer patients.
Financial donation, board membership and host of The Urban League of Portland's health programming, including National Day of service "Let's Move" Day.	*-Improves health, education and employment for African American Community.* *-Increase awareness about health disparities through hosting three community viewings of the Unnatural causes video series.*
Partnership and financial contribution with the Native American Rehabilitation Association, including their FQHC.	*Improves access to education, physical and mental health services and substance abuse treatment in culturally appropriate environment.*
Offer Midwifery Clinic for low income women.	Improves birth outcomes, reducing birth mortality and morbidity.
Contract with Central City Concern to provide housing and comprehensive services, including primary care, for homeless patients discharged from hospital.	Reduces morbidity, improves access to medical services and housing, employment and mental health/substance abuse services for the homeless.
NEED: Health Literacy	
Host, with Legacy Health--Oregon and SW Washington Health Literacy Conference.	*Improves health outcomes and quality. Reduces racial and ethnic disparities.*
Partner with local children's safety net clinic serving primarily African American and Hispanic children to improve health literacy communication with parents and children.	*Improve health outcomes in children's safety net clinic.*
NEED: Youth and Education	
Financial support and partnership with the Portland Workforce Alliance.	Provides real life work experiences for students while enriching their academic experience, encouraging all students to graduate.
Partnership with three local high schools.	Increases familiarity with health care careers through clinical job shadows for students.
Offer the YES (Youth Employment in Summers) program (paid summer employment ($4800) for African American students entering health care careers.	*Increases the diversity of the health care workforce — four students annually.*
Financial support, board membership and partnership with Self Enhancement Inc.	*Culturally appropriate environment closes the achievement gap through family support services and academic programs.*
Financial support to All Hands Raise (previously known as Portland School Foundation).	Increases education achievement for all students.
Financial donation, board membership and partnership with the Native American Youth & Family Services.	*Improves family and youth education, employment, reduction of poverty and quality of life through culturally specific services.*
Hold annual Back to School Drive for local school children.	Increases access to school items for local low income children.
Financial support to REAP dedicated to education achievement for African American and other students of color.	Increase education achievement for students of color.
NEED: Chronic Disease and Obesity	
Participate in and sponsor Pacific NW Diabetes week.	-Increases awareness through education and resources to the community about diabetes prevention and services. -Encourages healthy eating by providing a healthy eating

	demonstration and talk at the Lloyd Center mall.
Ongoing partnership with the African American Health Coalition, providing free office space, phones and internet as well as financial donation.	*-Increases the health and wellness of African Americans through health education, advocacy and research* *-Provides "spice it up" healthy cooking classes for the community.* *-Holds health education, material and classes at annual wellness village fair.*
Weight loss incentives for employees (ongoing Weight Watchers Classes, reimbursement for cost of weight-loss, discounts for fitness club membership, etc.).	Reduced chronic disease rates for employees and families.
NEED: Mental Health	
Participation in local business leaders' organization working on improving police and mental health coordination in response to mental health calls to 911 and police.	Improve care and quality of services to people with mental health issues.
Financial support to local NAMI—National Association for the Mentally Ill.	Increased education and awareness about mental illness.
Through Caremark joint partnership, participation in local Brazelon Project with mental health providers to develop improved mental health coordination of services to mentally ill.	Improved coordination of care for the mentally ill.
NEED: Prevention and Education	
Trauma Nurses Talk Tough provides bike, skateboard, ski and snowboard helmets sold for $5. Helmets provided to low income children served by human service organizations at no cost.	Reduces traumatic injuries among children at all income levels. 9,800 helmets sold annually across the metro Portland area.
Offer Teen Cardiac Health Screenings at minimal cost.	Reduces mortality of undiagnosed heart conditions among teens, such as hypertrophic cardio-myopathy, the most common cause of sudden death in athletes.. Over 300 teens screened annually.
Offer child safety store and resource center program for the public.	-Reduces childhood preventable falls through hands-on practice and one-on-one injury prevention education. -Improves water and toy safety through information and education.
Offer free inspection and correct installation of child passenger safety seats throughout community.	When car seats are installed correctly they are 70% effective in reducing fatalities and hospitalization for children.
Provide land at no charge for a community cooperative garden on hospital campus.	-Increases urban access for community members to availability of fresh fruits and vegetables either through growing themselves or volunteering in turn for organic and fresh produce.
Provide injury prevention programs to school age youth.	Reduces car and other mobile injuries among youth. 36,000 students hear presentations annually.
Partner with courts and community programs to conduct burn injury prevention classes for teens at risk of lighting fires.	Reduces mortality and morbidity due to youth lighting fires.
Conduct burn injury programs for utility workers across the state.	Reduces mortality and morbidity due to electrical injuries.
Legacy Devers Eye Institute provides free glaucoma and eye disease screenings at public events.	Detects glaucoma at early stages, particularly for high risk populations.
Participate in numerous local community	Encourages healthy behaviors by providing information

health fairs.	about service and free classes and providing free health resources and screenings.
NEED: Early Childhood	
Offer child safety store and resource center program for the public. Hands-on practice, information and one-on-one injury prevention education. See Prevention and Education.	Reduces childhood preventable falls and increases water and toy safety.
Offer free inspection and correct installation of child passenger safety seats throughout community. See Prevention and Education.	When car seats are installed correctly they are 70% effective in reducing fatalities and hospitalization for children.
Provide shaken baby education and volunteer knitted purple hats to babies to raise awareness about newborn babies' susceptibility to brain injury.	Prevents brain injury among newborns and babies.
NEED: Childhood Obesity & Physical Activity	
Offer Randall Children's Hospital at Legacy Emanuel Healthy Kids' Fair—healthy activities, education and resources.	Increases awareness about healthy lifestyles, physical activity and safety for children.
Sponsor and partner with the Lloyd Center mall to create "Legacy Funland" - a health focused play area.	Improves physical activity through providing children a safe place to play.
Financial support to Juvenile Diabetes and Research Foundation.	Reduces juvenile diabetes and its impact.
NEED: Prenatal Care	
Midwifery Clinic partners with March of Dimes to offer "Centering Pregnancy" program—ten two hour small group sessions for at-risk pregnant women.	Increases healthy birth outcomes, i.e., reduced prematurity, improved patient knowledge and satisfaction, and reduced emergency visits.
Midwifery Clinic provides care for low income women. See Access to Care.	Improved birth outcomes for low income women.
NEED: Public Health	
Limited resources prevent addressing as priority need.	
NEED: Violence - Domestic and Child	
Host CARES NW which evaluates and cares for children suspected of child abuse. Collaborators: Providence Health and Services, Kaiser Permanente and Courts.	Reduces the trauma associated with child abuse.
Provide shaken baby education and volunteer knitted purple hats to babies to raise awareness about newborn babies' susceptibility to brain injury. See Early Childhood.	Reduces brain injury among newborns and babies.
NEED: Addiction/Substance Abuse	
Relationship & financial contribution with Native American Rehabilitation Association—culturally appropriate education and outpatient & inpatient substance abuse treatment for Native Americans.	*Reduces mortality and morbidity associated with addictions and substance abuse among Native Americans.*
Partnership and financial support to Oregon Impact which provides community education, prevention and awareness activities to stop individuals from driving under the influence of intoxicants.	Reduces mortality and morbidity resulting from vehicles and substance abuse.

NEED: Seniors	
Financial donation to Martin Luther King Loaves and Fishes site.	*Improves nutrition and social access for local seniors, primarily African American.*
Hospital volunteer services enables seniors to care for patients and families.	Increases sociability, mental agility and sense of worth for older adults and reduces probability of illness.
NEED: Dental	
Limited resources prevent addressing as a priority need.	
NEED: Childhood Mental Health	
Offer Inpatient Adolescent Psychiatry Services.	Improves access for adolescents in need of acute mental health services.
NEED: Nutrition/Hunger	
Host summer 2x weekly Farmers Markets at the hospital.	Increases access to local, healthy food for employees, patients and the community.
Hold annual hospital staff food drive for the NE Emergency Food program serving local low income community.	Improved nutrition and reduction in hunger through collection of over 4,000 pounds of food.
Provide land at no charge for a community cooperative garden on hospital campus.	Increases urban access for community to fresh fruits and vegetables either through growing themselves or volunteering in turn for organic and fresh produce.
NEED: Tobacco	
Hospital campus is tobacco-free.	Increases public awareness regarding risks of tobacco use and reduction in tobacco-related diseases from limited access.
NEED: Built Environment	
Provide car seat safety program which inspects and installs car seats correctly and disposes of car seats in environmentally friendly manner.	Recycles used/outdated car safety seats and dispose of the materials in an environmentally correct manner.
Provide land at no charge for a community cooperative garden on hospital campus. See Nutrition and Hunger.	Increases urban access for community to fresh fruits and vegetables either through growing themselves or volunteering in turn for organic and fresh produce.
Offer office space and phones to three nonprofit organizations on campus at no charge, i.e., African American Health Coalition, Lutheran Synod and NW Parish Nurse Ministries.	Enables nonprofits to focus their missions.
On-site “Green Team” reviews issues of sustainability on a monthly basis.	Improves awareness and increased opportunities for “green” initiatives on campus.
Food, equipment and supplies and sustainability practices implemented.	Reduces green-house emissions.
Offer conference rooms available to public sector and nonprofit organizations at no charge.	Reduces need for additional community event space and enables nonprofits to focus on missions.
Hold 2x weekly summer Farmers Market on-site.	Local, healthy food available to employees, patients and public.
Offer Hospital Healing Gardens at two locations within hospital.	Provides a healing green space for employees, patients, family members and community.
NEED: Natural Environment	
Limited resources prevent addressing as priority need.	
NEED: STDS and HIV/AIDS	
Limited resources prevent addressing as priority need.	
NEED: Disasters—Medical and Natural	
Participation in regional disaster preparedness.	Improved community’s ability to contend with natural disasters.

NEED: Transgender Care
Limited resources prevent addressing as priority need.
NEED: Autism
Limited resources prevent addressing as priority need.