LEGACY GOOD SAMARITAN HOSPITAL AND MEDICAL CENTER

DBA LEGACY GOOD SAMARITAN MEDICAL CENTER

COMMUNITY NEEDS ASSESSMENT AND IMPLEMENTATION STRATEGIES PLAN

2011/2012

CONTENTS

INTRODUCTION

Legacy Good Samaritan celebrated its 135th anniversary in 2011. Founded in 1875 by the Episcopal Diocese of Oregon, Good Samaritan is one of the oldest hospitals in the Pacific Northwest. It is located within an urban, high-density geographic area in inner city Portland. The service area extends across the river to the east and west to the border of the suburbs. The service area is a mix of older established, high income residents to low income residents 'hidden' in older apartments and single room occupancies, and the homeless on the streets and in shelters.

Legacy Good Samaritan is a member of Legacy Health, a five-hospital system established in 1989 by the merger of two nonprofit systems in metropolitan Portland, Oregon. Legacy's mission is "Good health for our people, our patients, our communities, our world." Consistent with this mission, in fiscal year 2011 Legacy Good Samaritan provided $15.7 million in charity care; total unreimbursed costs of care for people in need amounted to $39 million.

Legacy Good Samaritan is committed to multi-year partnerships with various community organizations that are located directly on the hospital 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.

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 Good Samaritan 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 are 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 state of Oregon, in order of preference and availability. Race and ethnicity data are most commonly available only at the county and/or state level.

Qualitative research consists of interviews conducted by leadership with 66 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 show data, sources and interviewees. The Legacy Good Samaritan Implementation Strategies Plan follows.

COMMUNITY PROFILE

Service Area

Legacy Good Samaritan is located in one of the original neighborhood establishing Portland--inner Northwest Portland bordering on 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 neighborhood communities of Nob Hill, Old Town/Chinatown, Pearl District, John's Landing, Lair Hill, West Sylvan, Garden Home, Multnomah Village, Forest Heights, West Slope, Cedar Mills and others. As mentioned earlier, some of these neighborhoods include both the wealthiest in the metro area and the very poorest—within blocks of each other. As a tertiary facility, Legacy Good Samaritan draws patients from the five mile primary service area and throughout Multnomah County and even from the other metro area counties. Thus, Multnomah County data is very appropriate to Legacy Good Samaritan's draw. 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 Good Samaritan 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 0.7 percent Native American. While communities of color are less visible on the inner west of the Willamette River in Legacy Good Samaritan's surrounding neighborhoods, this area is the site of a significant portion of the homeless and here communities of color are disproportionately represented, i.e., often over 25 percent of the population.

Hispanics are moving into the area at a higher rate than any other group (more than doubling in numbers in the past 15 years) and 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 Hispanics 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.

It is clear that overall, while the area's population is growing slowly, its composition is changing. Legacy Good Samaritan'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 was 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 are 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's was higher than the state rate and the highest among the four metro counties—6.3/1000 compared to the state's 5.7.

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, low birth weight in Oregon was 6.1 percent, with Multnomah County exactly the same. Hispanic women's low birth weights and infant mortality rates were equal to non-Hispanic whites at the state level even though prenatal care percentages were more than 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 4.0 percent for African Americans, 8.0 percent for Native Americans, 4.0 percent for Asian/Pacific Islanders and 2.0 percent for Hispanics compared to 4.0 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, U.S. 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. Percentages in Oregon in 2005 were: African Americans (13 percent), Native Americans (12 percent), Hispanics (10 percent), Asians (7 percent) and 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 amount to 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. The high school completion rate of non-Hispanic whites in Oregon is 91.4 percent, compared with 86.6 percent for African Americans, 85.6 percent for Asians, 84.1 percent for Native Americans, and 54.7 percent for Hispanics. College completion rates have a similar pattern: 29.2 percent for non-Hispanic whites, 20.1 percent for African Americans, 12.8 percent for Native Americans, and 10.4 percent for Hispanics. The outlier is the much higher college graduation rate for Asians, at 45.7 percent.

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 generations' 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 U.S. 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 more likely to 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 in jeopardy, health status is challenged.

Oregon has particularly suffered in the current recession, ranking second at times in national unemployment. In 2009, Oregon had an unemployment rate of 11.8 percent as compared to the U.S.'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. In Multnomah County, incomes were the highest for non-Hispanic whites and lowest for Native Americans—a $28,000 difference. African Americans' incomes 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's all age poverty revealed race and ethnic Hispanic and Native American at double, and African American at nearly triple, that of non-Hispanic whites. 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, is 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 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 the 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 overweight or obesity 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.
Over the past ten years, Oregon adult smoking prevalence decreased 19 percent, and 11th grade smoking 20 percent, 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's 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 in Oregon showed significant differences in 2007. 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 Good Samaritan five mile primary service area includes four other large tertiary hospitals, including two trauma 1 centers. Legacy Emanuel Medical Center is one of these tertiary trauma 1 centers and located just two miles east of Legacy Good Samaritan. Providence Health and Services operates one of the other tertiary centers three miles west of Legacy Good Samaritan and the other five miles east. The last tertiary and trauma 1 center is OHSU, which is also site of the only medical school in Oregon.

With the long-standing income disparities in the Legacy Good Samaritan area, safety net services have expanded. Multnomah County Health Department operates FQHCs in downtown Portland and inner Northeast. The nonprofit safety net clinics are among the oldest and most credible in Portland. Central City Concern offers comprehensive medical (FQHC), housing, detox sobering, alcohol and drug rehabilitation and employment services for the homeless just one mile from the hospital. Legacy Good Samaritan contracts with Central City Concern to provide recuperative care services for discharged patients in need of housing and other services. Wallace Medical Concern is over 25 years old and also operates a clinic in Old Town Portland; Legacy Good Samaritan provides inkind lab services, a financial donation, board representation and administrative office space on its campus at no charge. Outside In is also an FQHC focusing on the young adult homeless community, a large proportion of whom are LGBTQ.

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. Legacy Health, in addition to providing clinical services, provides cash donations and office space to the administrative offices of Project Access NOW, inkind, on the Legacy Good Samaritan campus. Legacy Good Samaritan's internal medicine residency program operates a teaching clinic on-site serving the low income and uninsured.

Services to those in need
Legacy Good Samaritan'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 Good Samaritan provided $15.7 million in charity care and $39.0 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 socioeconomic 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 percent 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 percent 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. One of the top four is located in the heart of Legacy Good Samaritan's neighborhood, bordering one block from the hospital itself.

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 Health Care 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 Oregon. In 2008, Native Americans and Hispanics experienced nearly triple the uninsured rates of non-Hispanic whites—29.3 percent and 28.2 percent, respectively, as compared to 11.3 percent.

Provider and service availability

Oregon's 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. 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 for 50 years plus, cholesterol screenings and diabetic screenings for 65 years

plus were 67.7 percent, 73.9 percent and 84 percent in Oregon as compared to national target rates (90th 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 U.S. 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. The lack of large grocery stores is evident when driving through some low income neighborhoods that Legacy Good Samaritan serves.

The number of liquor stores per 10,000 people is a reverse health status indicator. Multnomah County at 0.7 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 in Oregon. This is particularly evident in inner Old Town/Chinatown and downtown Portland, where there are many SRO (single room occupancy) apartments and homeless people.

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 Good Samaritan 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. 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. Percents 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 double 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 individuals (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 around the role of government, specifically health policy.

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Racial and 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 Good Samaritan 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.

Additionally, the size of communities of color in the Legacy Good Samaritan 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 Good Samaritan 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 Good Samaritan has the resources and expertise to have a significant impact.
5. Legacy and Legacy Good Samaritan'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 in response to the evident disparities for communities of color, a Legacy Good Samaritan Medical Center Implementation Strategies Plan details strategies in order of priority of need. 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 Good Samaritan'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 Good Samaritan will focus on:

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

IMPLEMENTATION STRATEGIES PLAN

Please see the Legacy Good Samaritan Implementation Strategies Plan following 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 drinks/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 Smokg	***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
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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
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2: US Census Bureau American Community Survey 2008, 2009. cdc.gov/acs
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US Census Bureau Quick Facts quickfacts.census.gov/qfd/states/41000.html
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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
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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
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www.healthstatus2010.c0m
2: Kaiser Family Foundation State Facts. www.kff.org
3: Oregon Department of Human Services. The Burden of Heart Disease and Stroke in Oregon. 2007. www.oregon.gov/DHS/ph/hdsp
4: US Department of Health and Human Services. Center for Disease Control National Center for Health Statistics. www.cdc.gov/nchs
5: Oregon Department of Human Services. The Burden of Diabetes in Oregon.
http://www.oregon.gov/DHS/ph/diabetes/pubs.shtml
6: Washington State Department of Public Health 2007. Obesity and Diabetes Advisory Committee Policy Recommendations December 2009. healthequity.wa.gov/committees/diabetes/docs
7: US Census Bureau Current Population Survey Annual Social and Economic Supplement 2009. www.bls.census.gov/cps

Exhibit 5: Social Economic and Environment Determinant Factors
1: US Census Bureau American Community Survey 2009 and 2006-2008. www.census.gov/acs
2: County Health Rankings. www.countyhealthrankings.org

Exhibit 6: Social Economic Determinant Factors by Race and Ethnicity
1: US Department of Education. National Center for Education Statistics. 2009.
www.nces.ed.gov/programs/digest/d09/tables
2: Oregon Department of Human Services Office of Multicultural Health. www.oregon.gov/DHS/ph/omh
3: US Census Bureau American Community Survey 2008, 2009. www.census.gov/acs

4: 2010 Oregon Benchmark Race and Ethnicity Report: A Report on the Progress of Oregon's Racial and Ethnic Diverse Population. November 2010. www.oregon.gov/DAS/OPB/obm_pub

Exhibit 7: Clinical Care and Behavior Health Factors
1: US Census Bureau American Community Survey 2009 and 2006-2008. www.census.gov/acs
2: Oregon Office of Health Policy and Research. Email October 2010.
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Appendix A
Community Health Characteristics: Most Important

Issue	Number	Percent
Income/Jobs	36	20.6%
Education	34	19.4%
Health Care and Access	33	18.9%
Housing	15	8.6%
Social/Human Services	12	6.9%
Public Health	11	6.3%
Community Involvement	10	5.7%
Environment	6	3.4%
Economic Development	5	2.9%
Public Safety	4	2.3%
Mental Health	2	1.1%
Revenue/Public Services	2	1.1%
Equity	2	1.1%
Food/Hunger	1	0.6%
Early Childhood	1	0.6%
Leadership	1	0.6%
Total	175	100.0%

Appendix B
Community Health: Greatest Needs/Issues

Issue	Number	Percent
Income/Jobs	35	19.3%
Health Care and Access	26	14.4%
Education	20	11.0%
Diversity//Disparities/Equity/Culturally Appropriate Services	20	11.0%
Housing	12	6.6%
Mental Health	10	5.5%
Health	8	4.4%
Dental	6	3.3%
Addiction/ Substance Abuse	5	2.8%
Public Health	5	2.8%
Economy Funding	5	2.8%
Public Safety	4	2.2%
Poverty	3	1.7%
Environment	3	1.7%
Obesity	3	1.7%
Early Childhood	3	1.7%
Chronic Disease	2	1.1%
Nutrition/Hunger	2	1.1%
Transportation	2	1.1%
Civic Involvement	1	0.6%
Economy	1	0.6%
Childhood Obesity	1	0.6%
Adult Literacy	1	0.6%
Domestic Violence	1	0.6%
Seniors	1	0.6%
HIV/AIDS	1	0.6%
Total	181	100.0%

Appendix C
Health Care and Public Health: Greatest Issues

Issue	Number	Percent
Health care or Access Specified	19	11.1%
Cost	14	8.2%
Coverage	13	7.6%
Cultural Competency	8	4.7%
Primary Care Shortage/Access	7	4.1%
Care Coordination/Management	4	2.3%
Medical Homes	2	1.2%
Mental Health	21	12.3%
Addiction/ Substance Abuse	16	9.4%
Disparities, Equity, Racism	10	5.8%
Workforce Diversity	6	3.5%
Chronic Diseases	14	8.2%
Obesity	10	5.8%
Dental	9	5.3%
Nutrition/Hunger	8	4.7%
Prevention and Education	6	3.5%
Seniors	6	3.5%
Built Environment	5	2.9%
Violence: Child and Domestic	5	2.9%
Prenatal Care	4	2.3%
Public Health	4	2.3%
Childhood Obesity and Physical Activity	3	1.8%
STDs	2	1.2%
Early Childhood	2	1.2%
Tobacco	1	0.6%
Natural Environment	1	0.6%
Autism	1	0.6%
Disasters-Medical and Natural	1	0.6%
Transgender Care	1	0.6%
HIV/Aids	1	0.6%
Total Needs Designated	171	100.0%

Appendix D
Hospitals' Roles

Issue	Number	Percent
Partner with Community Based Organizations: Dollars, Services and Labor	24	29.3%
Advocate with Legislature, Elected Officials	10	12.2%
Collaboration with other Health Systems	7	8.5%
Prevention Education	6	7.3%
Health Access: Uncompensated Care	6	7.3%
Health Access: Affordability, Reduce Costs	5	6.1%
Public/Private Sector Partnerships	4	4.9%
Employment Diversity	4	4.9%
Culturally Appropriate/Competent Care	4	4.9%
Conveners regarding Issues	3	3.7%
Education: Health Workforce	3	3.7%
Be Accessible	3	3.7%
Social Determinants	2	2.4%
Dental	1	1.2%
Total	82	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/Access, Medical Homes, Care Management	Size	5	
	Seriousness	5	
	Change Potential	4	
	Capacity	5	
	Strategic Focus	5	24
Health Literacy	Size	4	
	Seriousness	5	
	Change Potential	5	
	Capacity	4	
	Strategic Focus	5	23
Disparities/Equity/Racism: Disease Rates, Services, Workforce Diversity	Size	4	
	Seriousness	5	
	Change Potential	4	
	Capacity	4	
	Strategic Focus	5	22
Youth and Education	Size	4	
	Seriousness	5	
	Change Potential	4	
	Capacity	4	
	Strategic Focus	4	21
Chronic Disease and Obesity	Size	5	
	Seriousness	5	
	Change Potential	3	
	Capacity	3	
	Strategic Focus	4	20
Mental Health	Size	4	
	Seriousness	5	
	Change Potential	3	
	Capacity	3	
	Strategic Focus	5	20
Seniors	Size	5	
	Seriousness	3	
	Change Potential	4	
	Capacity	4	
	Strategic Focus	4	20
Prenatal Care	Size	2	
	Seriousness	5	
	Change Potential	4	
	Capacity	4	
	Strategic Focus	4	19
Prevention and Education	Size	4	
	Seriousness	5	

	Change Potential	3	
	Capacity	3	
	Strategic Focus	4	19
Addiction/Substance Abuse	Size	4	
	Seriousness	5	
	Change Potential	3	
	Capacity	3	
	Strategic Focus	2	17
Violence: Domestic and Child	Size	3	
	Seriousness	5	
	Change Potential	3	
	Capacity	2	
	Strategic Focus	2	15
Public Health	Size	4	
	Seriousness	4	
	Change Potential	3	
	Capacity	2	
	Strategic Focus	2	15
Childhood Obesity and Physical Activity	Size	3	
	Seriousness	4	
	Change Potential	3	
	Capacity	2	
	Strategic Focus	2	14
Early Childhood	Size	3	
	Seriousness	4	
	Change Potential	3	
	Capacity	2	
	Strategic Focus	2	14
Dental	Size	3	
	Seriousness	4	
	Change Potential	2	
	Capacity	2	
	Strategic Focus	2	13
Nutrition/Hunger	Size	4	
	Seriousness	4	
	Change Potential	2	
	Capacity	2	
	Strategic Focus	1	13
Tobacco	Size	4	
	Seriousness	4	
	Change Potential	3	
	Capacity	1	
	Strategic Focus	1	13
Built Environment	Size	4	
	Seriousness	4	
	Change Potential	2	
	Capacity	2	

	Strategic Focus	1	13
Natural Environment	Size	4	
	Seriousness	4	
	Change Potential	2	
	Capacity	2	
	Strategic Focus	1	13
STDs and HIV/AIDs	Size	3	
	Seriousness	4	
	Change Potential	2	
	Capacity	2	
	Strategic Focus	1	12
Disasters: Medical and Natural	Size	3	
	Seriousness	3	
	Change Potential	2	
	Capacity	1	
	Strategic Focus	1	10
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
66 Interviewees

Name	Organization	Expertise
Venetta Abdellatif, Director, Integrated Services	Multnomah County Health Department	Expertise in public health, disparities, chronic diseases, FQHCs
Vaune Albanese, Executive Director	Friendly House	Expertise in serving low income
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 comprehensive services and FQHC for homeless
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	Oregon Association for Minority Entrepreneurs	Expertise in 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 socio-economic, education disparities for children
Lisa Cline, Executive Director	Wallace Medical Concern	Safety net clinic for low income, medically underserved
Jeff Cogen, Chair	Multnomah County Commission	
Ken Cowdery, Executive Director	New Avenues for Youth	Expertise serving homeless youth
Carlos Crespo, DrPh, Director	Portland State University School of Community Health	Academic researcher in social determinants, communities of color
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 LGBTQ population
Delanie Delimont, Executive Director	NW Portland Ministries	Expertise in serving low income
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	Multnomah County	Expertise in urban county human

Name	Organization	Expertise
Services		services and all operations
Samira Godil, Executive Director	SW Community Health Center	Expertise in clinic for medically underserved Muslim community
Bruce Goldberg, MD, Director	Oregon Department of Human Services	Expertise Oregon public health and 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
Rob Ingram, Coordinator, Office of Youth Violence	City of Portland	Expertise in working with communities of color
Alissa Keny-Guyer	State Legislator	
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, Executive Director	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
Very Reverend Bill Lupfer, Dean	Trinity Episcopal Cathedral	
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
Kathy Oliver, Executive Director	Outside In	Expertise in FQHC, homeless youth
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	
Kim Scott, Executive Director	Trillium Family Services	Expertise in serving low income children and families

Name	Organization	Expertise
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 disparities, for students of color

Legacy Good Samaritan 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: Access to Care: Charity care, Coverage, Cost, Cultural Competency, Location, Availability, Primary Care Shortage/Access, Medical Homes, and Care Coordination	
Hospital/health care services to low income uninsured within 400% of FPL at reduced or no charge.	Increased access for low income uninsured.
Financial, service and labor support to Project Access NOW which links low income uninsured patients to providers at no charge. Provide office space on campus at no charge.	Increased quality and reduced morbidity and mortality for low-income uninsured through access to services at earlier stages.
Free flu shot clinics held at 11 sites for low-income and uninsured seniors and homeless adults. Spanish and Chinese translation available. 173 shots administered; other health promotion materials shared. Perform blood pressure checks.	Reduced risk of flu in the community; reduced risk of complications in vulnerable populations. Greater awareness of other community resources related to a free nutrition course, smoking cessation, vaccine tracking, hypertension and its risks.
Financial support and participation in Oregon Public Health ALERT Immunization Registry. Collaborators: all metro area health systems.	Increased immunization rates.
Donations to safety net clinics: -Financial and inkind lab services to Southwest Community Health Center. -Financial donation and lab services and administrative office inkind at no charge to Wallace Medical Concern.	Increased access and care for low income uninsured patients.
Financial and staff support to Worship in Pink, a program of the Susan G Komen for the Cure to raise awareness about breast health screenings with partnering faith organizations.	*Increased breast health screenings among women of color.*
Offer exercise, meditation, walking and support groups and classes open to all cancer patients.	Improved health and quality of life for cancer patients, tying in with the psychosocial needs as well as physical.
Legacy Devers Eye Institute provides free eye disease screenings at public events.	Detects glaucoma at early stages, particularly for high-risk populations.
RN volunteers at neighborhood events, offering free blood pressure checks and counseling, children through adults.	Increased access to screening that can help individuals identify their risk of hypertension.
NEED: Health Literacy	
Partnerships with organizations to increase health literacy in at-risk populations e.g. Friendly House, Northwest Portland Ministries and Central City Concern.	Improved health literacy in at-risk populations, i.e., low-income seniors, frail elderly, those with disabilities.
Host, with Legacy Health, the Oregon and SW Washington Health Literacy Conference.	Improved health outcomes and quality. Reduces race and ethnic disparities.
NEED: Disparities, Equity, Racism, Disease Rates, Services, Workforce Diversity,	
Use as lens in addressing all needs and developing actions.	*Reduced disparities for communities of color.*
Employment requires management positions and above to include interviewees of color; waiver required for positions not fulfilling this requirement.	*Increased workforce diversity.*
Provide work experiences for Portland Public Schools' Vocational Education program.	Increased work opportunities for youth in specialized program needing increased supervision.
Offer Youth Employment in Summers--paid summer employment ($4800) and college	*Exposes students of color to various aspects of health career. Increased diversity of the health care workforce.*

scholarships ($2500-$5000) for two students of color in a health-related course of study (annual).	
NEED: Youth and Education	
Offer Youth Employment in Summers (paid summer employment ($4800) and college scholarships ($2500-$5000) for two students of color in a health-related course of study (annual).	*Exposes students of color to various aspects of health career and supports educational achievement. Increased diversity of the health care workforce.*
Provide work experiences for Portland Public Schools' Vocational Education program.	Increased work opportunities for youth in specialized program needing increased supervision.
NEED: Chronic Disease and Obesity	
Weight loss program and incentive challenges offered to employees.	Reduced obesity and chronic diseases among employees—and their families.
Free and reduced cost Diabetes and Nutrition community education for public—at local businesses, community events, retirement homes and at the hospital.	Increased education for public about chronic diseases to reduce obesity and chronic diseases.
Host summer weekly Farm Stand at the hospital. (See Built Environment).	Increased local, healthy food available to employees, patients and public.
Pick-up spot for an organic farm share program, open to community.	Provides convenience for people to increase their consumption of fruits and vegetables, associated with decreased risk of chronic diseases.
Media interviews with registered dietitians regarding diabetes, exercise research and nutrition.	Increased public awareness of health-promoting behaviors.
Support Donate Life Northwest, dedicated to promoting organ donors.	Increased access to organ transplantation and quality of life for those with kidney disease.
Provide office space to Oregon Lions Sight and Hearing Foundation dedicated to screen, treat, save, and restore sight and hearing.	Reduced eye disease through screenings, transplantation of eye tissue.
NEED: Mental Health	
Financial donation, board representation and recuperative care contract for homeless patients with Central City Concern-comprehensive physical and mental health, housing, employment services.	Increased comprehensive services for homeless residents. Reduced emergency department and hospitalization for the homeless. Helps meet a huge community need for emergency and psychiatric services.
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.
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: Seniors	
Free and low-cost eye care provided at Devers Eye Institute.	Increased access to vision care, primarily seniors.
Hospital volunteer services program provides an avenue for seniors' many talents, keeping them engaged in broader community.	Increased sociability, mental agility and sense of worth for older adults.
NEED: Prenatal Care	
Scholarships for low-income women to attend childbirth classes.	Increased delivery safety and outcomes for mother and baby.
NEED: Prevention and Education	
Bike and skateboard helmets sold for $5 and ski helmets for $20 at public events held at the hospital. Availability publicized to partner schools.	Reduced traumatic injuries. 5,000 high-quality helmets, with expert fitting, sold annually across the metro Portland area.
Free mammograms for low income women.	Increased early stage-cancer detection.
Partnership with Making Memories--nurse	Increased self-breast exam reducing later stage breast

educators provided information about breast health and used models to coach women on a best-practices approach to breast self-exams.	cancer acuity.
NEED: Addiction/Substance Abuse	
Free meeting space for 12-step programs.	Increased local access for people in recovery.
NEED: Violence: Domestic and Child	
Sister hospital—Legacy Emanuel—is site of CARES NW, which evaluates and cares for children suspected of child abuse. Collaborators: Providence Health and Services, Kaiser Permanente and Courts.	Reduced trauma associated with child abuse.
NEED: Public Health	
Provide hygiene and toiletry items, supporting Transition Projects' homeless clients and very low income clients of Northwest Portland Ministries.	Improved hygiene lessens the risk of illness.
Nurses stock a closet with clothing to provide to homeless and very low income patients upon discharge who lack adequate clothing.	Proper clothing promotes health and healing.
NEED: Childhood Obesity and Physical Activity	
Limited resources prevent addressing as a priority activity.	
NEED: Early Childhood	
Limited resources prevent addressing as priority need.	
NEED: Dental	
Limited resources prevent addressing as a priority need.	
NEED: Nutrition/Hunger	
Offer weekly summer Farm Stand for employees, patients and public on-site.	Increased access to convenient local, fairly priced produce.
Financial donation and weekly volunteerism at Loaves & Fishes' Irving Street site.	Increased nutrition as well as socialization for otherwise isolated and low income seniors.
Annual food drive, led by nursing units, for local food pantries and school food-in-backpacks weekend program. Smaller drive at holidays.	Increased nutrition and reduced hunger for families and seniors. Gathers thousands of pounds of food for families and seniors.
Offer Food Rescue program in partnership with Trinity Episcopal Cathedral providing wholesome, excess food from hospital, twice weekly, to church that serves 300 hot lunches weekly, largely to homeless guests.	Increased nutrition and reduced hunger for homeless individuals.
NEED: Tobacco	
Campus is non-smoking, i.e., access to tobacco limited.	Reduced tobacco-associated disease.
NEED: Built Environment	
Weekly summer Farmer Stand on-site.	Increased local, healthy food available to employees, patients and public.
Hospital Healing Garden and labyrinth.	Reduced stress for patients, employees and public.
Food, equipment, supplies and sustainability practices implemented.	Reduced greenhouse emissions.
Conference rooms available to public sector, nonprofit organizations at no charge.	Addresses shortage of community meeting room space, enabling groups to gather to work on their mission.
Partner with Portland Parks and Recreation to provide public garden tours and guided walks.	Increased urban dweller exposure to nature; lifts mood through outdoor exercise in a group setting
NEED: Natural Environment	
Limited resources prevent addressing as priority need.	
NEED: STDs and HIV/AIDS	
Financial support to Cascade AIDS Project.	Increased access and support for those with HIV/AIDS and public awareness about HIV/AIDS
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.	