LEGACY MERIDIAN PARK HOSPITAL

DBA LEGACY MERIDIAN PARK MEDICAL CENTER

COMMUNITY NEEDS ASSESSMENT AND IMPLEMENTATION STRATEGIES PLAN

2011/2012

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INTRODUCTION

Opened in 1973, Legacy Meridian Park Medical Center is located in Tualatin, Oregon and straddles the Clackamas and Washington County border. It is a member of Legacy Health, a five hospital system established in 1989 by the merger of two systems. The hospital was built as a response to the significant population growth in the south metropolitan area. Legacy's mission is "Good health for our people, our patients, our communities,our world." Consistent with this mission, in fiscal year 2011 Legacy Meridian Park provided $6.7 million in charity care; total unreimbursed costs of care for people in need amounted to $15.6 million.

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 these factors. The four groups of factors are social and economic, health behaviors, clinical care, and physical environment. Aligned with these factors, the Legacy Meridian Park 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 (surrounding five miles) is used when available, followed by county and 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 54 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. An 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 include data, sources and interviewees.

COMMUNITY PROFILE

Service Area

As the south metro area's full-service hospital, the hospital five mile primary service area includes the fast-growing communities of Tualatin, Tigard, Wilsonville, Sherwood, West Linn and Lake Oswego. The five mile radius is predicated on the assumption that this includes approximately 80 percent of the hospital's discharges. Primary service area boundaries extend from Highway 219 on the west to SW Wilsonville Rd on the south to just east of Highway 43 on the east and just north of SW Hall Blvd on the north. Primary service area zip codes include: 97034, 97035, 97036, 97062, 97068, 97070, 97140, 97223 and 97224. With the establishment of a Legacy Clinic in Woodburn and Canby, these have been added to Legacy Meridian Park's target community strategies, but are

out of the five mile primary service area. Many of the residents commute to other cities for employment; there are few large employers located in the area except in Wilsonville.

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. Clackamas County experienced .5 percent growth and Washington 1.0 percent. The latter showed the greatest percent growth statewide.

The primary service area population in 2010 was 226,068. The two counties encompass residents far beyond the service area (Washington County's seat is 25 miles from Tualatin and Clackamas County extends over 40 miles to Mount Hood on the east). However, as primary service area data is not readily available cross indicators, Washington and Clackamas County information serve as the best available. Washington and Clackamas Counties populations were 532,620 and 381,775 in 2009 respectively.

Median age in Oregon in 2009 was 38 years. By metro area county, Washington County had the youngest median age at 35 years and Clackamas the oldest at nearly 39 years. Consistent with median age, 12 percent of the Clackamas County population was 65 years and older—the highest percent among counties--compared to 9.0 percent in Washington County—the lowest. In line with this also, the percent of population under five years ranged from 5.6 percent in Clackamas County to 7.5 percent in Washington County. Washington County has the largest percentage of Hispanics which may account for both the lower median age and larger percentage of children.

Racial and ethnic diversity

The 2010 Legacy Meridian Park primary service area was primarily non-Hispanic white at 81.9 percent, relative to 8.8 percent Hispanic, 1.0 percent African American, 5.0 percent Asian, .4 percent Native American and 2.5 percent bi-racial. In comparison, Washington County in 2009 was 71.2 percent non-Hispanic white, 15.3 percent Hispanic, 8.7 percent Asian (the latter is the largest percent among all counties in the state), 2.1 percent African American, 1.0 percent Native American and 2.6 percent bi-racial and Clackamas was 84.6 percent non-Hispanic white, 7.6 percent Hispanic, 3.8 percent Asian, 1.1 percent African American, less than 1 percent Native American and 2.4 percent bi-racial.

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 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 immigrant and refugee population is increasing significantly. Recent immigrants and refugees are more likely to be culturally and linguistically isolated. Speaking a language other than English at home has increased significantly, particularly in Washington County where over 22 percent of the population falls into this cohort—as compared to 11 percent in Clackamas County. Spanish is the most common language spoken with Vietnamese and Chinese also prevalent.

A small, but increasing African refugee population has settled in mid-Washington County and is distinct from the African American/Black population. Available data suggests that in general, the African population is poorer than other communities.

While still a small population relative to the entire metro area, specific geographic areas are experiencing significant growth in the Slavic population—the far southern metro area south of the Clackamas County border in Woodburn. Slavs are counted in the non-Hispanic white population, but they have distinct cultural identity. Their socioeconomic indicators are generally lower than the other non-Hispanic white population.

While the area's population is growing slowly, its composition is changing dramatically. Legacy Meridian Park's service area is experiencing significant 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 Clackamas to be slightly lower and Washington County to be much lower than the state rate. Premature death rates were aligned in similar patterns. Washington County experienced a rate 80 per 100,000 less than the targeted US 90th percentile at 541 and Clackamas was exactly at the target.

The most common causes of mortality in Oregon are consistent with the national most common disease deaths—heart and cancer. In 2006 Washington County experienced the lowest rate among the four metro counties both in cancer and heart deaths. Clackamas Count was above the state rates in both.

Infant mortality is an accepted indicator of a community's health status. Both Washington and Clackamas Counties were below the state's 2009 rate—3.4 and 4.7/1000 as compared to 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 Clackamas at 5.2 percent and Washington at 6.0 percent. 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 (disaggregated data by county is not available). 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 cancer incidence in 2007 showed a slightly greater rate than the US. Washington County was very low at 428.2 and Clackamas was 467.0. National Cancer Institute data not detailed here showed Hispanic and Asians with the lowest rates among races and ethnicities.

Diabetes
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 6.4 percent in Washington County and 7.7 percent in Clackamas 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) and Asians (7 percent) non-Hispanic whites (6 percent). Communities of color are more likely to have diabetes-related complications at two to four times the rate of non-Hispanic whites, due to poorer control of the disease and co-morbidities, i.e., high blood pressure and cholesterol and 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:

Factor	Impact
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 and college degree rates of individuals 25 and older in Washington County (90.5 percent and 38.3 percent) and Clackamas (91.6 percent and 32.7 percent) are better than the US and Oregon averages. 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 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 our 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. Washington and Clackamas Counties were both lower than the state average at 10.6 percent and 11.2 percent.

Oregon's median household income in 2009 was $48,475. Both Clackamas and Washington County had higher median household incomes than the state.

Race and ethnic cohorts varied greatly. In both Washington and Clackamas Counties, incomes were the highest for Asians and lowest for Hispanics—a nearly $20,000 difference. 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. 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 counties,

Clackamas County home ownership is the highest at 70.4 percent and compared to Washington County at 62.2 percent. 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 most unaffordable rental markets in the nation. In 2009 38.4 percent and 42.9 percent of renters in Washington County and Clackamas County fell into this category. Washington County was the only among the four counties where less than forty percent paid one-third of their income and it also ranked lowest among the counties in child 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. Washington County showed 18.6 percent of adults to be obese as compared to 24.2 percent in Clackamas County. 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 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 Clackamas and Washington posted rates at 17 percent and 14 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, Clackamas experienced the lowest at 24/1000 among the four counties and Washington was 33—just under the state

average. Race and ethnicity data showed significant differences in 2007. Ranked in order from lowest to highest—Asians: 15 Oregon, 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 Meridian Park primary service area is also served by a tertiary hospital located just north of the primary service northern boundary—Providence St. Vincent Medical Center. Community-based Providence Willamette Falls Hospital located in Clackamas County is beyond the primary service area, but serves some of the overlapping area. Located in far west Washington County is community-based Tuality Hospital—outside the service area, but in the same primary service area county. Kaiser Permanente has a strong presence with clinics and is constructing a hospital in mid-Washington County.

Southwest Clackamas County includes a Medically Underserved Areas (MUA)—beyond the primary service area. Clackamas County Health Department Clinics are FQHCs, but are located across the Willamette River in areas further from Legacy Meridian Park. Legacy Medical Group Clinic in Canby (Meridian Park area) is a designated Rural Health Centers. One volunteer staffed safety net clinic, Essential Health Clinic, (inkind lab services donated by Legacy) is located in Tigard and the Virginia Garcia Memorial Health Clinic is a community-based FQHC whose primary clinics are in mid and far west Washington County. A new volunteer staffed safety net clinic in Oregon City will open winter 2012. Tigard High School has a school-based health center; the furniture and some equipment were donated by Legacy.

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 at no charge.

Services to those in need

Legacy Meridian Park'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 Meridian Park provided $6.7 million in charity care and $15.6 million in total unpaid costs of care for those in need. This was 11 percent of operating expenses.

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 Clackamas County experienced a 13.2 percent uninsured rate and Washington County 14.8 percent. Increasing numbers of working people are uninsured. Employers offering health benefits decreased from 69 percent in Oregon in 2000 to 60 percent in 2005. In addition, even within employers offering coverage, there are increased restrictions related to eligibility. 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 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, Washington and Clackamas Counties had 123 and 107 as compared to Multnomah County's 211. 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 (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 Clackamas and Washington Counties were 82.9 percent and 85.6 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. Clackamas and Washington Counties were over 67 percent and 61 percent. Access to healthy food is a serious problem in many parts of our service area.

The number of liquor stores per 10,000 people is a reverse health status indicator. Washington and Clackamas were at 0.4 each—as compared to Multnomah County at .7. (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 Meridian Park and Legacy Health management interviewed 54 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. Education, income/jobs and health care were cited the most in this order. Adding those who cited public health/health care to health care, the percent rose to place it first. These three characteristics were each 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. Two of the three most important characteristics of a healthy community were cited as the three greatest issues, but in a different order. Income/Jobs moved to first place—mentioned over a fifth of the time. Health care access moved from first to second place (viewed in terms of access, health care becomes primarily an economic issue rather than an availability or quality issue). Diversity/disparities/equity/culturally appropriate moved to third place. Again, disparities and equity issues are seen as barriers to the higher-level items like income/jobs and access to health care. 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 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, domestic violence and built environment 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 elected

officials, increased collaboration with other health systems, and serving as conveners for discussions about health care issues. 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 Meridian Park 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, when available, shows consistent race and ethnic data disparities across indicators.

Additionally, the size of communities of color in the Legacy Meridian Park area is growing rapidly. 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 Meridian Park area, and turn first to the most serious need, that need is found in communities of color, particularly in the Latino community. 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 Meridian Park has the resources and expertise to have a significant impact.
5. Legacy's strategic plan and Legacy Meridian Park's plan: The alignment of the issue with one of the health system's areas of strategic focus and mission and the hospital's strategic plan.

ACTION PLAN

Using these criteria and the lens of racial and ethnic equity, a Legacy Meridian Park Medical Center Implementation Strategies Plan following 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 Meridian Park'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 Meridian Park will focus on:

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

IMPLEMENTATION STRATEGIES PLAN

The Legacy Meridian Park Implementation Strategies Plan follows the 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 Veh. Death /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

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
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.
3: Kaiser Family Foundation State Health Facts. www.statehealthfacts.org/profile
4: Oregon Department of Human Services Center for Health Statistics Vital Statistics. http://www.dhs.state.or.us/dhs/ph/chs/data
5: County Health Rankings. www.countyhealthrankings.org
6: Center for Disease Control Chronic Disease Index 2009. www.cdc.gov/chronicdisease/index
7: Washington State Department of Health Chronic Disease Profile 2008 and 2010. www.doh.wa.gov/cfh/diabetes
8: US Department of Health and Human Services Community Health Status Indicators. www.communityhealth.hhs.gov/measures
9: Center for Disease Control Community Health Status Report. Behavioral Risk Factor Surveillance System 2009. www.cdc.gov/brfss
10: Oregon Tobacco Prevention and Education Program. http://oregon.gov/DHS/ph/tobacco/countyfacts

11: Oregon Health Policy Board and Oregon Health Authority. Oregon Health Improvement Plan Committee. Draft Oregon Health Improvement Plan: 2011-2020. October 2010. www/oregon.gov/DHS/[h/hpcdp/hip/index

Exhibit 8: Clinical Care and Behavior Health Factors by Race and Ethnicity
1: Oregon Department of Human Services Office of Multicultural Health. www.oregon.gov/OHA/omhs
2: Washington State Department of Human Services. www.insurance.wa.gov
3: Kaiser Family Foundation State Health Facts. www.kff.org
4: Washington State Department of Health Obesity and Diabetes Advisory Committee: Policy Recommendations December 10, 2009. healthequity.wa.gov/committees/diabetes
5: The National Campaign to Prevent Teen and Unplanned Pregnancy. State Profile. http://www.thenationalcampaign.org/state-data/state-profile.aspx?state=oregon, washington

EXHIBIT 9: Sources

Center for Disease Control Chronic Disease Index 2009. www.cdc.gov/chronicdisease/index

Center for Disease Control Community Health Status Report. Behavioral Risk Factor Surveillance System 2009. www.cdc.gov/brfss

Center for Disease Control. Defining Childhood Overweight and Obesity. www.cdc.gov/obesity/childhood/defining

Center for Disease Control. National Center for Health Statistics. www.cdc.gov/nchs

Center for Disease Control User Guide to the 2007 Natality Public Use File. Cdc.gov/wonder/help/natality

Clark County 2010-2014 Consolidated Housing and Community Development Plan. *www.co.clark.wa.us/cdbg/documents*

Coalition of Communities of Color and Portland State University. *Communities of Color in Multnomah County: An Unsettling Profile.* 2010. www.coalitioncommunitiescolor.com

County Health Rankings: Mobilizing Action Toward Community Health: 2010 Oregon and 2010 Washington. www.countyhealthrankings.org

Guttmacher Institute. *US Trends Teenage Pregnancies, Births and Abortions: National and State Trends and Trends by Race and Ethnicity*. www.guttmacher.org

Kaiser Family Foundation State Health Facts. www.kff.org, www.statehealthfacts.org/profile

Legacy Health Finance. Intelligmed Demographic Profile System.

Multnomah County Commission on Children and Families. *Improving Outcomes for Children and Families of Multnomah County Six –Year Plan*. 2008.

The National Campaign to Prevent Teen and Unplanned Pregnancy. State Profile. www.thenationalcampaign.org/state-data/state-profile.aspx?state=oregon,washington

National Cancer Institute State Cancer Profiles 2003-2007. www.statecancerprofiles.cancer.gov/incidencerates

North Carolina Department of Health and Human Services. Office of Healthy Carolinians/Health Education and the State Center for Health Statistics. *Community Assessment Guidebook*. 2002. www.schs.state.nc.us.

Oregon Department of Human Services. *The Burden of Diabetes in Oregon.* www.oregon.gov/DHS/ph/diabetes/pubs

Oregon Department of Human Services. *The Burden of Heart Disease and Stroke in Oregon*. 2007. www.oregon.gov/DHS/ph/hdsp

Oregon Department of Human Services Center for Health Statistics Vital Statistics. http://www.dhs.state.or.us/dhs/ph/chs/data

Oregon Department of Human Services Office of Multicultural Health. www.oregon.gov/DHS/ph/omh

Oregon Health Policy Board and Oregon Health Authority. Oregon Health Improvement Plan Committee. *Draft Oregon Health Improvement Plan: 2011-2020*. October 2010. www.oregon.gov.DHS/ph/hpcdp/hip/index

Oregon Perinatal Data Book 2007. www.oregon.gov/dhs/ph/pnh/docs/databook_2007

Oregon Progress Board. *2009 Benchmarks*. www.benchmarks.oregon.gov

Oregon Progress Board. *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_pubs

Oregon Department of Human Services. Oregon Tobacco Prevention and Education Program. http://oregon.gov/DHS/ph/tobacco/countyfacts

Portland Plan. http://www.portlandonline.com/portlandplan

Portland State University Institute of Metropolitan Studies. *Population Dynamics of the Portland-Vancouver MSA.* May 2010. http://mkn.research.pdx.edu/2010/05/population-dynamics

Portland State University Population Research Center November 2010. www.pdx.edu/prc

Robert Wood Johnson Foundation. Commission to Build a Healthier America. www.commissiononhealth.org

Roth, Richard and Eileen Barsi. *The Community Need Index*. Health Progress. July-August 2005.

The National Campaign to Prevent Teen and Unplanned Pregnancy. State Profile. http://www.thenationalcampaign.org/state-data/state-profile.aspx?state=oregon

The Oregonian. *Oregon's Income Gap Widens*. December 1, 2010.

Trust for America's Health. *F for Fat Report*. http://healthyamericans.org/reports/obesity2009/release.php?stateid=OR

US Census Bureau American Community Survey 2009 and 2006-2008. cdc.gov/acs

US Census Bureau Current Population Survey Annual Social and Economic Supplement 2009. www.bls.census.gov/cps

US Census Bureau. quickfacts.census.gov/qfd/states/41000.html

US Department of Education. National Center for Education Statistics. 2009. www.nces.ed.gov/programs/digest/d09/tables

US Department of Health and Human Services. Community Health Status Indicators. communityhealth.hhs.gov/measures

US Department of Health and Human Services. Office of Women's Health. Health Data. www.healthstatus2010.c0m

Waidman, Timothy. *Estimating the Cost of Racial and Ethnic Health Disparities.* The Urban Institute. September 2009

Washington Health Foundation. *2010 Healthiest State Report Card*. www.whf.org/policy-priorities/2010

Washington State Behavioral Risk Factor Surveillance System 2008. www.doh.wa.gov/ehsphl/chs/chs-data/brfss/brfss

Washington State Department of Health. Chronic Disease Profile 2008. www.doh.wa.gov/data/chronic

Washington State Department of Health. *Communicable Disease Report 2009*. www.doh.wa.gov/notify/annlrpt/cdr2009

Washington State Department of Health. Health Statistics. http://www.doh.wa.gov/ehsphl

Washington State Department of Health News Release Sept. 4, 2008. *Immunization rates in Washington decrease slightly*. http://www.doh.wa.gov/Publicat/2008_news/08-147.htm

Washington State Department of Health Obesity and Diabetes Advisory Committee: *Policy Recommendations*. December 10, 2009. www.healthequity.wa.gov/committees/diabetes/docs

Washington State Department of Human Services. Uninsured. www.insurance.wa.gov

Washington State OFM County Population Projections. www. Ofm.wa.gov/pop/gma/projections.

World Health Organization Social Determinants of Health. http://www.who.int/social_determinants/en/

Legacy Meridian Park Medical Center
Appendix A
Community Health Characteristics: Most Important

Issue	Number	Percent
Health Care and Access	32	21.8%
Education	28	19.0%
Income/Jobs	27	18.4%
Housing	14	9.5%
Public Health	12	8.2%
Social/Human Services	10	6.8%
Community Involvement	9	6.1%
Public Safety	5	3.4%
Environment	3	2.0%
Economic Development	3	2.0%
Equity	2	1.4%
Nutrition/Hunger	1	0.7%
Early Childhood	1	0.7%
Total	147	100.0%

Appendix B
Community Health: Greatest Needs/Issues

Issue	Number	Percent
Income/Jobs	29	21.5%
Health Care and Access	19	14.1%
Diversity//Disparities/Equity/Culturally Appropriate Services	18	13.3%
Education	17	12.6%
Housing	11	8.1%
Mental Health	7	5.2%
Health	6	4.4%
Addiction/ Substance Abuse	4	3.0%
Dental	3	2.2%
Public Health	3	2.2%
Economy Funding	3	2.2%
Obesity	3	2.2%
Poverty	2	1.5%
Chronic Disease	2	1.5%
Transportation	2	1.5%
Nutrition/Hunger	1	0.7%
Civic Involvement	1	0.7%
Childhood Obesity	1	0.7%
Adult Literacy	1	0.7%
Domestic Violence	1	0.7%
HIV/AIDS	1	0.7%
Total	135	100.0%

Appendix C
Health Care and Public Health: Greatest Issues

Issue	Number	Percent
Health care and Access not specified	20	11.3%
Cost	17	9.6%
Coverage	10	5.6%
Primary Care Shortage/Access	7	4.0%
Cultural Competency	6	3.4%
Medical Homes	1	0.6%
Care Coordination	3	1.7%
Disparities, Equity, Racism	9	5.1%
Workforce Diversity	5	2.8%
Mental Health	19	10.7%
Addiction/ Substance Abuse	12	6.8%
Chronic Disease	11	6.2%
Obesity	11	6.2%
Dental	11	6.2%
Nutrition/Hunger	7	4.0%
Prevention and Education	5	2.8%
Domestic Violence: Adult and Child	5	2.8%
Built Environment	5	2.8%
Seniors	2	1.1%
Public Health	2	1.1%
Tobacco	1	0.6%
Prenatal Care	1	0.6%
Childhood Obesity and Physical Activity	1	0.6%
Natural Environment	1	0.6%
Early Childhood	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	140	100.0%

Appendix D
Hospitals' Roles

Issue	Number	Percent
Partner with Community Based Organizations: Dollars, Services and Labor	17	23.9%
Advocate with Legislature, Elected Officials	8	11.3%
Prevention Education	7	9.9%
Health Access: Uncompensated Care	6	8.5%
Public/Private Sector Partnerships	6	8.5%
Collaboration with other Health Systems	5	7.0%
Health Access: Affordability, Reduce Costs	4	5.6%
Education: Health Workforce	4	5.6%
Employment Diversity	4	5.6%
Culturally Appropriate/Competent Care	4	5.6%
Social Determinants	2	2.8%
Conveners regarding Issues	2	2.8%
Be Accessible	1	1.4%
Dental	1	1.4%
Total	71	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	4	
	Strategic Focus	5	23
Health Literacy	Size	4	
	Seriousness	5	
	Change Potential	5	
	Capacity	4	
	Strategic Focus	5	22
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	3	20
Chronic Disease and Obesity	Size	5	
	Seriousness	5	
	Change Potential	2	
	Capacity	2	
	Strategic Focus	4	18
Mental Health	Size	3	
	Seriousness	4	
	Change Potential	3	
	Capacity	3	
	Strategic Focus	3	16
Prevention and Education	Size	4	
	Seriousness	4	
	Change Potential	3	
	Capacity	2	
	Strategic Focus	3	16
Prenatal Care	Size	2	
	Seriousness	4	
	Change Potential	3	

	Capacity	2	
	Strategic Focus	3	14
Addiction/Substance Abuse	Size	3	
	Seriousness	4	
	Change Potential	3	
	Capacity	1	
	Strategic Focus	1	12
Early Childhood	Size	3	
	Seriousness	4	
	Change Potential	3	
	Capacity	1	
	Strategic Focus	1	12
Childhood Obesity and Physical Activity	Size	3	
	Seriousness	5	
	Change Potential	2	
	Capacity	1	
	Strategic Focus	1	12
Seniors	Size	3	
	Seriousness	3	
	Change Potential	3	
	Capacity	1	
	Strategic Focus	2	12
Public Health	Size	4	
	Seriousness	4	
	Change Potential	2	
	Capacity	1	
	Strategic Focus	1	12
Built Environment	Size	4	
	Seriousness	4	
	Change Potential	2	
	Capacity	1	
	Strategic Focus	1	12
Tobacco	Size	2	
	Seriousness	4	
	Change Potential	3	
	Capacity	2	
	Strategic Focus	1	12
Natural Environment	Size	4	
	Seriousness	4	
	Change Potential	2	
	Capacity	1	
	Strategic Focus	1	12
Dental	Size	3	

	Seriousness	4	
	Change Potential	1	
	Capacity	1	
	Strategic Focus	2	11
Violence: Domestic and Child	Size	3	
	Seriousness	5	
	Change Potential	3	
	Capacity	2	
	Strategic Focus	1	11
Nutrition/Hunger	Size	3	
	Seriousness	4	
	Change Potential	2	
	Capacity	1	
	Strategic Focus	1	11
HIV/AIDs	Size	2	
	Seriousness	4	
	Change Potential	2	
	Capacity	1	
	Strategic Focus	1	10
Disasters: Medical and Natural	Size	2	
	Seriousness	4	
	Change Potential	2	
	Capacity	1	
	Strategic Focus	1	10
Transgender Care	Size	1	
	Seriousness	3	
	Change Potential	1	
	Capacity	1	
	Strategic Focus	1	7
Autism	Size	1	
	Seriousness	2	
	Change Potential	1	
	Capacity	1	
	Strategic Focus	1	6

Appendix F
Community Needs Assessment
54 Interviewees

Name	Organization	Expertise
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	
Cindy Becker, Administrator	Clackamas County Health and Human Services	Expertise in public health and serving 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	Oregon Association for Minority Entrepreneurs	Expertise in dedicated to communities of color equity
Lisa Brown, Executive Director	Community Action Organization of WA County	Expertise in serving low income
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
Rodney Cook, Director	Clackamas Office of Children and Families	Expertise in serving low income
Carlos Crespo, DrPh, Director	Portland State University School of Community Health	Academic researcher in social determinants, communities of color disparities
Marie Dahlstrom, Executive Director	Familias en Accion	Expertise in serving Hispanic 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
Bruce Goldberg, MD, Director	Oregon Department of Human Services	Expertise as head of Oregon public health and medically underserved services
Guadalupe Guajardo, Senior Consultant	Nonprofit Association of Oregon	Expertise in culturally competent training and consultation
Mary Lou Hennrich,	Oregon Public Health Institute	Expertise in public health

Name	Organization	Expertise
Executive Director		
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
Sia Lindstrom, Sr. Deputy County Administrator	Washington County	Expertise in health and human services for the low income
Adrienne Livingston, Executive Director	Black United Fund	Expertise in decreasing disparities for communities of color
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
Linda Moholt, Executive Director	Tualatin Chamber of Commerce	
Mary Monat, Executive Director	LifeWorks NW	Expertise in mental health for medically underserved, low income
Vicki Nakashima, Executive Director	Partners in Diversity	Expertise in increasing equity for communities of color
Sue Neal, Board Chair	Essential Health Clinic	Expertise in safety net clinic for low income
Linda Nilsen-Solares, Executive Director	Project Access NOW	Expertise in health care access for low income medically underserved
Lou Ogden, Mayor	City of Tualatin	
Kathleen O'Leary, Public Health Division Manager	Washington County Health Department	Expertise in public health and serving low income
Carman Rubio, Executive Director	Latino Network	Expertise in reducing disparities for Hispanics
Rob Saxton, Superintendent	Tigard Tualatin School District	
Kim Scott, Executive Director	Trillium Family Services	Expertise in serving low income children and families
Bill Thomas, Director	Washington County Commission on Children and Families	Expertise in serving low income families
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
Karin Kelly Torregroza, Executive Director	Vision Action Network	Expertise in increasing equity for 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	Expertise as academic researcher in social determinants and

Name	Organization	Expertise
	Affairs	disparities
Catherine West, Executive Director	Tualatin Resource Center	Expertise in serving low income
Joyce White, Executive Director	Grantmakers of Oregon and SW Washington	Expertise in research re. foundation funding for communities of color
Wim Wievel, PhD, President	Portland State University	
David Wynde, Vice President	US Bank	Expertise in increasing educational achievement, reducing disparities

Legacy Meridian Park Implementation Strategies Plan

Need/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, Location, Availability, Providers, Medical Homes, Care Coordination and Cultural Competency.	
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. Collaborators: all metro area hospitals, physicians, United Way of Columbia Willamette. Low income uninsured patients linked to providers at no charge.	Increased quality and reduced morbidity/ mortality for low-income uninsured through access to services in earlier stages of acuity.
Financial and in-kind service (labs, ultrasounds, deliveries) support to Washington County Community Action Organization's Opening Doors.	Reduced number low birth weight babies for low-income, primarily Hispanic, women connected to prenatal care.
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 Essential Clinic in Tigard. -Financial donation to Volunteers in Medicine Oregon City Clinic.	Increased access and care for low income uninsured patients.
Financial and labor support to Worship in Pink, a program of the Komen Foundation to raise awareness about breast health screenings among women of color.	*Partnering with faith organizations to increase breast health screenings among women of color.*
Exercise and support groups open to all cancer patients.	Improved the health and quality of life for cancer patients.
Legacy Devers Eye Institute free glaucoma and eye disease screenings at public events.	Detects glaucoma at early stages, particularly for high risk populations.
Financial and inkind support to Tigard School Based Health Center (a large percent are students of color).	Improved health access for teens.
Hospital and clinic care managers provide resources and care coordination for patients and families.	Improved health care quality for patients and families.
Participate in Washington County Thrives.	Support /advocacy for underserved for jobs, quality education, housing, health and wellness.
NEED/ISSUE: Health Literacy	
Partnerships with organizations to increase health literacy in at-risk populations e.g. Community Action Organization of Washington County, Essential Health Clinic, Health Department, and Senior Centers.	Improved health literacy in at-risk populations, i.e., communities of color and seniors.
Host, as member of Legacy Health—first Oregon and SW Washington Health Literacy Conference.	Improved health outcomes and quality. Reduces race and ethnic disparities.
NEED: Disparities, Equity, Workforce Diversity, Cultural Competency, Institutional Racism	
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.
In Kind and board representation to Tigard Turns the Tide youth development organization focused on education achievement for at	Increased education achievement for at risk youth.

risk youth, including students of color.	
Youth Employment in Summers (paid summer employment and college scholarships ($2500-$5000) for Hispanic students entering health care careers. Students in program as long as in school.	Increased diversity of the health care workforce—3-6 students annually participate.
NEED: Youth and Education	
Youth Employment in Summers (paid summer employment and college scholarships ($2500-$5000) for Hispanic students entering health care careers. Students in program as long as in school.	Increased diversity of the health care workforce—3-6 students annually participate.
High school internships and job shadows for students entering health care careers.	Introduce students to health care workforce careers.
Teen Volunteer program providing hospital experiences for high school students.	Introduce students to health care workforce careers.
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 (Famers Market, health fairs), retirement homes.	Increased educated public about chronic diseases to reduce obesity and chronic diseases.
Host summer weekly Farmers Markets at the hospital. (See Built Environment.)	See Built Environment.
Financial sponsor of the Tualatin Farmers Market. (See Built Environment). Hospital dietitian shares healthy meal recipe cards with attendees.	Increases nutritional awareness.
Founding member of the Tualatin Fit City program which educates businesses on developing healthier workforces with resources, lunchtime speakers and on site health fairs.	Increased healthy workforce.
NEED: Mental Health	
Limited financial resources prevent addressing as a priority need	
NEED: Prevention and Education	
Bike, skateboard, ski and snowboard helmets sold for $5 at community events in Tualatin and Canby.	Reduced traumatic injuries. 5000 sold annually across the metro Portland area.
Car seat safety check clinics by Injury Prevention staff in Canby and Sherwood. At the Canby 2011 clinic 100% of car seats checked were improperly installed.	Reduced traumatic injuries.
Free mammograms to low income.	Increased early stage cancer detection.
NEED: Prenatal Care	
Scholarships for low income women to attend childbirth classes.	Increased delivery safety and outcomes for mother and baby.
Financial and inkind service (labs, ultrasounds, deliveries) support to Washington County Community Action Organization's Opening Doors. See Access to Care.	*Reduced number low birth weight babies for low-income, primarily Hispanic, women connected to prenatal care.*
NEED: Addiction/Substance Abuse	
Host Drug Take Back event. Collaborators: Tualatin and West Linn police departments and West Linn, Wilsonville and Tualatin Chambers of Commerce.	Reduced abuse of prescription drugs.
Participant in the annual Sherwood YMCA Health and Safety Day for Kids. Use a Mr. Yuk program to address dangers of poisons in the home including use of others' prescription drugs.	Reduced poisoning incidence among children and medication abuse.
Participant in Tigard Turns the Tide STUD (Stop Underage Drinking	Reduced use of alcohol by youth.

in Tigard). See Disparities, etc.	
NEED: Early Childhood	
Limited resources prevent addressing as a priority need.	
NEED: Childhood Obesity and Physical Activity	
Partner in the Tualatin Fit Kids initiative.	Supports and educates parents, teachers, and others in healthier food choices for children and exercise.
Sponsor and drop site for the biannual Walk and Bike to School Day.	Increased exercise in children
Partner in the annual Tualatin Try-athlon for Kids.	Increased exercise in children
Sponsor of the Wilsonville Kiwanis Kids Fun Run.	Increased exercise in children.
Need: Seniors	
Financial and in-kind host of the Walk the Square at Washington Square mall.	Increased mobility and exercise for adults, primarily seniors.
Participant in the Tualatin Senior Center Fit Friday program offering lectures on health and wellness.	Reduced morbidity in seniors.
Participant in the annual Senior Health and Wellness event at the Sherwood YMCA.	Increases health education and resources for seniors.
Hospital volunteer services provides seniors sociability and sense of worth.	Increased sociability, mental agility and sense of worth for older adults.
NEED: Public Health	
Host Drug Take Back event. Collaborators: Tualatin and West Linn police departments and West Linn, Wilsonville and Tualatin Chambers of Commerce. See Addictions.	Reduced abuse of prescription drugs.
NEED : Built Environment	
Weekly summer Farmers Market on-site.	Increases access to healthy food for employees, patients and public.
Offer hospital on-site Healing Garden with labyrinth.	Reduced stress for patients, employees and public.
Food, equipment and supplies and sustainability practices implemented.	Reduced green-house emissions.
Conference rooms available to public sector and nonprofit organizations at no charge.	Enables nonprofits to focus on missions.
NEED: Tobacco	
Hospital campus is tobacco-free.	Limited access correlates to reduced use of tobacco.
NEED: Natural Environment	
Limited resources prevent addressing as a priority need.	
NEED: Dental	
Financial support by the hospital Auxiliary for the Dental Van in Tigard and Tualatin.	Improved oral health and health status.
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 the trauma associated with child abuse.
NEED: Nutrition/Hunger	
Offer weekly summer Farmers Market on-site.	Increased access to healthy food for employees, patients and public.
Financial donation to Oregon Food Bank's capital campaign for new warehouse.	Increased food availability for families.
Annual employee food drive for local food pantry.	Reduced hunger and increased

	nutrition for families.
NEED: 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.
Participation in Tualatin Valley Fire and Rescue Emergency Preparedness Fair in West Linn	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.	