LEGACY SALMON CREEK HOSPITAL

DBA LEGACY SALMON CREEK MEDICAL CENTER

COMMUNITY NEEDS ASSESSMENT AND IMPLEMENTATION STRATEGIES PLAN

2011/2012

CONTENTS

INTRODUCTION

Legacy Health is a five hospital system established in 1989 by the merger of two nonprofit systems in metropolitan Portland Oregon. In the late 1990s, Legacy Health recognized that an ever-increasing number of Clark County and SW Washington residents were seeking medical care across the Columbia River in Portland, Oregon. The county's sole hospital was operating the busiest emergency room in either Washington or Oregon. The entire county had the lowest ratio of beds to population of any of the state's five largest counties.

Legacy Salmon Creek Medical Center opened in 2005 in north Clark County within the unincorporated Salmon Creek area just north of Vancouver. The facility is located at the confluence of two major interstates—I-5 and I-205 and ushered in a new era for Legacy Health in a new state, county and community. As the first hospital built in SW Washington in 29 years, Clark County residents had access to specialized services never before available in their community. Legacy Salmon Creek Hospital is a full-service community hospital.

Legacy's mission is "Good health for our people, our patients, our communities, our world." Consistent with this mission, in fiscal year 2011 Legacy Salmon Creek provided $10.4 million in charity care; total unreimbursed costs of care for people in need amounted to $29.3 million.

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. The "health factors" section of this report is arranged according to these factors, following an overview of the service area, population changes and available health care services.

Our purpose is to determine the elements within the health factors that have the greatest impact on our communities, and to cross-walk them with Legacy Salmon Creek strategic priorities, available expertise and available resources. The final product is a roadmap for how Legacy Salmon Creek will address the community's health needs beyond its obvious role of providing direct care. Conclusions and implementation strategies are presented. 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 (Clark) and Washington State in order of preference and availability. Because Legacy Salmon Creek is located in an unincorporated area, county data is most appropriate. Race and ethnicity data is most commonly available only at the county and/or state level.

Qualitative research consists of interviews conducted by Legacy Salmon Creek and Legacy Health leadership with 28 elected officials (county, city and state) 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 provide data detail, sources and needs. The Legacy Salmon Creek Implementation Strategies Plan follows.

COMMUNITY PROFILE

Service area

Legacy Salmon Creek Hospital lies in Clark County between the cities of Vancouver to the south and Battle Ground and Ridgefield to the north in an unincorporated area known as Salmon Creek and Hazel Dell. The primary service area is defined as the five mile radius, but due to the hospital's location in an unincorporated area and since there are only two hospitals in the county, the county is the commonly used primary service area composition. This definition extends from the Columbia River on the south, north to La Center, west to Vancouver Lake and east to Camas.

Primary service area incorporated cities include Vancouver, Battle Ground, Ridgefield and Camas. Vancouver and Camas are primarily industrial, commercial and residential communities while and Battle Ground and Ridgefield are primarily residential. Zip codes include: 98601, 98603, 98604, 98606-07, 98616, 98622, 98629, 98642, 98660-68, 98671, 98674-75, 98682-87.

Many boundaries converge at or near the hospital campus, i.e., Fairgrounds and Felida neighborhoods, Vancouver School and Battle Ground School Districts, and the 17th Legislative and 18th Legislative Districts. The farmland surrounding the hospital is rapidly urbanizing. Residential growth accounts for the majority of new development. The unincorporated areas and incorporated cities in north county are projecting significant commercial development as they are located along a prime transportation highway as well as close to river and air transportation.

Population

In November 2010, the Portland State University (PSU) Population Research Center reported the metro Portland area four-county population at 2,080,926 (three Oregon and one Washington counties). It is estimated that if the economic recovery continues to be slow, population growth will continue at a similar rate, leading to a four-county metro area population of 2.2 million in 2015.

During the 1990s, Clark County was the fastest growing county in Washington. Since 2000 the population grew 20 percent to 436,391 in 2010. Of the four metro area counties, Clark is expected to show the greatest growth between 2010 and 2015 at 1.9 percent annually. Vancouver grew the most of all cities in Washington during the last decade--13 percent. Nearly half of newcomers move to the area from California and many others relocate from Oregon. The five mile service area was 161,987 in 2010.

About 38 percent of the county population lives in Vancouver and 9 percent lives in the unincorporated north. There are seven cities in the county, the largest being Vancouver (the fourth largest city in Washington), followed in order by Camas, Battle Ground, Washougal, Ridgefield, La Center and Yacolt. Population density initially was focused on the southern half of the county and then migrated to the east into Camas and even Washougal. As Camas housing prices have risen, the most rapid growth has shifted to the northern cities of Ridgefield, Battle Ground, La Center and Yacolt.

The population is slightly younger than the state. While 23.5 percent of Washington's population is 18 years and younger, 26.5 percent is in the same cohort in Clark County. This is reflected in the median age in Clark County being 35 years as compared to Washington at 37 years.

Racial and ethnic diversity

The Clark County population is growing in diversity, although continuing to be 9 percent less diverse than the state (non-Hispanic whites in Clark County in 2010 stood at 81.8 percent as compared to 72.5 percent in Washington). Hispanics constitute the second-largest population by race/ethnicity. (Note: Hispanic and other diverse populations are acknowledged to be undercounted in the census, so the numbers are likely higher.) The Hispanic population in Clark County nearly doubled between 2000 and 2010 to reach 7.6 percent. Hispanics are moving into the area at a higher rate than any other group--of the county's additional residents under 18 since 2000, 51 percent were Hispanic. Additionally, the higher birth rate is having an impact--Hispanics account for about one-fifth of the births in Washington while it makes up just 11 percent of the population.

Asians follow Hispanics as the second largest community of color at 4.1 percent in Clark County--three percent lower than the state. Bi-racial persons follow at 4.0 percent and then African Americans at 2.0 percent and Native Americans at .9 percent.

While still a small population relative to the entire metro area, specific geographic areas are experiencing significant growth in the Slavic population. This is the case in Clark County. Slavs are counted in the non-Hispanic white population, but they have a distinct cultural identity and their socioeconomic status is generally lower than other non-Hispanic white populations. It is clear that overall the composition of the population is changing dramatically. We are seeing significant increases in demographics that have lower income levels, less education, lower health status and lower health literacy.

These issues will be detailed in the “health factors” section of this report. These changes have major implications for organizations such as Legacy Salmon Creek that want to improve the overall health status of their communities. Efforts directed at the diverse communities will likely make the largest difference. Further, health reform will likely bring coverage to these populations in disproportionate numbers, posing a challenge for health care delivery.

HEALTH STATUS/HEALTH OUTCOMES

The current health status of the Legacy Salmon Creek area can be assessed using both vital statistics and accepted indicators of health status.

Mortality

The Crude Death Rate and Age Adjusted Death Rate in Washington were lower than the U.S. averages. Clark County had death rates higher than Washington and the Premature Death Rate was aligned in a similar pattern. The most common causes of mortality in Washington are consistent with the rest of the nation: heart disease and cancer. Cardiovascular disease accounts for over 30 percent of annual deaths and is the single largest cause of death nationally. One exception here was 2006, when the cancer age adjusted mortality rate in Washington was ranked first over heart disease.

Disaggregated mortality data by race and ethnicity reveals concerning patterns. African Americans had the highest or second highest in age adjusted total, heart and diabetes mortality rates as well as infant death rates. Native Americans also experienced very high rates of total heart and diabetes

deaths; infant mortality figures are not available. The African American and Native American mortality rates were double or triple the rates of Hispanics and Asians, who experience the lowest rates overall.

Infant mortality is an accepted indicator of a community's health status. African American women experienced nearly double the infant mortality rates of non-Hispanic white and Hispanic women in 2006 and 2007.

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. State specific estimates are not available Washington, but for comparison purposes California was estimated at $6.0 billion and North Carolina at $390 million.

Low birth weight

Low birth weight is correlated to adult morbidity, specifically hypertension, diabetes and heart disease. In 2007, low birth weight in Washington state and Clark County were both about 6 percent. While African American and Hispanic women had prenatal care in the first trimester in similar percentages in the state, African Americans had nearly double the rate of low birth weight babies (and infant mortalities) as Hispanic women. Hispanic women's low birth weights and infant mortality rates were equal to non-Hispanic whites even though prenatal care percents were 14 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. As with heart disease mortality, communities of color experienced the greatest morbidity rates. In 2005, age adjusted coronary heart disease prevalence in Oregon (Washington data not available) was 4 percent for African Americans, 8 percent for Native Americans and 4 percent for Asian/Pacific Islanders compared to 4 percent for non-Hispanic whites.

Cancer

Cancer incidence in 2007 showed a slightly greater rate in Washington than the U.S. National Cancer Institute data, not detailed here, which showed Hispanic and Asians with the lowest rates among races and ethnicities.

Diabetes

Diabetes is increasing at an alarming rate. Washington reported a 54 percent prevalence increase between 1994 and 2006. 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. The elderly are more likely to have diabetes as are low-income persons.

Diabetes is more prevalent in communities of color. Percentages in Washington in 2005 were: African Americans (14 percent), Native Americans (12 percent), Hispanics (9 percent), Asians (9 percent) and non-Hispanic whites (6 percent). Even controlling for income, education, age and gender, African Americans and Native Americans showed significantly higher prevalence than non-Hispanic whites. 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 comorbidities (i.e., high blood pressure and cholesterol), as well as poorer access to care.

HEALTH FACTORS

The previous section outlines the current health status of the service 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 such items as 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 worth more than $1 trillion annually.

The 2009 high school graduation rates of individuals 25 and older in Clark County and Washington State were better than the U.S. average. The college degree rate was better than the US average for Washington but less in Clark County. The various communities within the total area vary greatly, e.g., the college graduate completion rate within the Salmon Creek neighborhood where the hospital is located is 50 percent greater than Hazel Dell, the neighborhood bordering Salmon Creek and which borders Vancouver.

Again, disaggregated data reveal distinct differences among races and ethnicities. The high school completion rate of non-Hispanic whites in Washington is 92.2 percent, compared with 85.7 percent for African Americans, 84.6 percent for Asians, 80.7 percent for Native Americans, and 57.7 percent for Hispanics. The combination of disparities in educational achievement within communities of color and the increasing diversity of the total population are resulting in an overall decrease in high school and college completion rates in the current population.

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 our region, 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 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 region 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. This situation was identified early on in our assessment process as something that should be a key part of our community benefit activities.

Employment/income

Educated workers attract higher-wage businesses to the community. In turn, 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. Clark County has suffered greatly in the current recession. While Washington’s 9.5 percent unemployment was not as high as Oregon's, Clark County was a full three percentage points greater than the Washington average.

Data by race and ethnicity reveal distinct disparities in unemployment statistics. In 2009, the unemployment rate for African Americans, Hispanics and Native Americans were nearly six, two and eight percentage points greater respectively than non-Hispanic whites in Washington. Clark County data is available only for Hispanic populations as compared to non-Hispanic whites and the difference was four percentage points. Asian/Pacific Islanders showed unemployment rates lower than state and county for both overall and compared to non-Hispanic whites.

Washington's median household income in 2009 was greater than Oregon: $56,548 vs. $48,475. Clark County was very close to the state and higher than Multnomah County, but lower than Washington and Clackamas Counties. Similar to education achievement, differences exist within neighborhoods or census tracts within the county. As an example, the Salmon Creek neighborhood's median household income was one-third greater than its directly bordering neighborhood of Hazel Dell.

Racial and ethnic cohorts varied greatly in Clark County. Incomes were highest for Asians and lowest for African Americans and Native Americans. 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 higher incomes.

Poverty is increasing generally with the distinct shift in industries from manufacturing and resources to service sector jobs. Jobs paying less than $30,000 annually have accounted for 63 percent of all net job growth since 2000. Nearly 60 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. The recent recession has left many people with no job at all.

An analysis of poverty rates in Clark County places the poverty rate for communities of color at more than twice that of white communities. Disaggregated by cohort, only the Asian population is equal to non-Hispanic whites.

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. Consistent with income and poverty differences, Multnomah County had the lowest home ownership at 54.9 percent in 2009 within the metro four counties. Clark County ownership ranked second behind Clackamas County and was the same as the Washington average.

Race and ethnic differences were apparent. Although Washington data is not available, based on other indicators, it is proposed that Washington data follows the same pattern as Oregon in which home ownership is: 70.9 percent for non-Hispanic whites, 48.0 percent for Hispanics, 44.5 percent for African Americans, 54.6 percent for Native Americans and 59.0 percent for Asians/Pacific Islanders.

The national standard is that renters should not pay more than one-third of their income in rent. Washington is ranked ninth as the most unaffordable rental markets in the nation (Oregon is ranked third). In 2009 over 40 percent of renters in Clark County allocated more than 35 percent of their income in rent. Households with severe housing cost burdens are more likely to have higher rates of food insecurity and lack health insurance.

This overview of social and economic factors, which in the University of Wisconsin analysis contributes 40 percent of the impact on community health status, shows a clear pattern. There is a distinct portion of our population that has lower educational attainment, lower health literacy, higher unemployment, lower income and less affordable housing. Moreover, that population is largely Hispanic, African American and Native American. Any efforts to improve social and economic factors would logically focus on these cohorts.

Health behaviors

Individual behaviors account for the second greatest impact among the 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 foods and fast foods have doubled the rates in adults in the last two decades. In Washington in 2009, nearly 60 percent of adults were overweight or obese and about 25 percent were obese — consistent with national statistics. The Washington State Department of Health reported in 2006 that the increase in obesity rates contributed to about 60 percent of the diabetes prevalence increase.

The increasing prevalence of children who are overweight and obese is of great concern, carrying increased risk of chronic disease, asthma, respiratory problems, orthopedic conditions and — importantly — of being overweight or obese in adulthood. The 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. 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 born in 2000 will acquire Type 2 diabetes, which is associated with obesity. The difference for children of color is staggering: an estimated 50 percent will acquire the disease.

Research indicates that obesity rates are higher for adults with lower incomes and lower education levels even after adjusting for gender, race and ethnicity, and age. In Washington, the 21 percent obesity rate of adults with household incomes of $50,000 or more was a third less than that of adults in households less than $20,000 in 2009.

Race and ethnicity also has an impact. In Washington in 2009, 24 percent of the adult non-Hispanic white population was obese, as was 30 percent of the Hispanic population, 30 percent of the African American population, and 36 percent of the Native American population. Only 11 percent of Asians were obese.

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 (the other being obesity). 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. The smoking rate in Washington stood at 15.7 percent in 2008. Rates have decreased over time with state prevention programs, higher cigarette taxes and bans on smoking in public places. Still, this rate is unacceptably high.

Teen births

Teen birth is one of the most powerful predictors of poverty. The teen birth rate (ages 15–19 years) decreased in Washington by more than a third between 1991 and 2006. The rate in Clark County was higher than Washington state and the second highest (behind Multnomah County) among the four counties. Race and ethnicity data also showed significant differences in 2007. Ranked in order from lowest to highest rates: Asians, non-Hispanic whites, African Americans, Native Americans and Hispanics (the lowest being nearly 1/5 the highest).
With Washington rates of 99 teen births per 1,000 in the Hispanic population, 42 in the African American population and 84 in the Native American population, these cohorts are at significantly increased risk of poverty, and, in turn, at significantly increased risk of poor health status.

Clinical health care

Health care services

The Legacy Salmon Creek primary service area includes one other hospital--Peace Health SW Washington Medical Center. Kaiser Permanente has multiple clinics in the county and contracts with Peace Health for services.

The service area includes a Medically Underserved Areas (MUA) in central Vancouver. There is also one non-public sector Federally Qualified Health Center (FQHC) operated by SeaMar and one long-standing volunteer-based safety net Free Clinic in Vancouver. The Clark County Health Department does not operate primary care services directly.

A local program, Project Access Clark County, links uninsured low income individuals to providers and health system services providing services at no charge. All of the health systems in the metro area are very involved with this program and Legacy Health, in addition to providing clinical services, provides and cash donation and office space to the administrative offices of Project Access NOW inkind on the Legacy Good Samaritan Medical Center campus.

Services to those in need

Legacy Salmon Creek's provision of care for those in need is aligned to Legacy Health's in providing charity care and unreimbursed care for those in need. Legacy’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 Salmon Creek provided $29.3 million in total unpaid costs of care for those in need.

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

Health insurance

Health insurance coverage is significantly correlated with 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.

Washington's 12.5 percent uninsured rate is lower than Oregon's by six percent. Clark County is consistent with the state. Increasing numbers of working people are uninsured. Employers offering health benefits are decreasing. In addition, even when employers offer 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. Washington data by race and ethnicity is not available, but it is highly likely that Washington follows a similar pattern to Oregon where 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 services availability

Washington has fewer primary care providers than the ideal target of 175 per 100,000 people. The rates differ enormously among counties, consistent with hospital locations and population density. Clark County's 102 in 2007 (with the opening of Legacy Salmon Creek in 2005, the number may have increased) is far below the target. 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 and colonoscopy rates in Washington were higher than the targeted national goals — about 66 percent for those over 50 years — as was cholesterol screening at just over 72 percent. Diabetic screenings for those 65 years and older was 85 percent in Clark County relative to a 88 percent national target.

Receiving prenatal care in the first trimester is a health care access indicator and is correlated with low birth weight and infant mortality. In 2006, Washington’s rate of women obtaining prenatal care in the first trimester was nine percentage points lower than Oregon’s — 70.3 percent compared to 79.2 percent. Disparities in accessing prenatal care among race and ethnicity cohorts were described in the Morbidity sections, including how different races and ethnicities display 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 75 percent in Washington. Washington’s percent has increased significantly over the last seven year, but remains below the national goal of 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.

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. Clark County was 63 percent in 2006. 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. Clark County at 0.3 was the lowest (positive) among the four metro counties.

STAKEHOLDER ASSESSMENT

Quantitative research provides a detailed look at data and trends in specific population cohorts, while one-on-one interviews with key stakeholders provide context. Between August 2010 and January 2011, Legacy Salmon Creek and Legacy Health leadership interviewed 28 elected officials and public sector, faith, business and community leaders, including representatives of communities of color. Interviewees were intentionally selected based on their direct involvement with organizations and/or issues in the service areas, i.e., they have played visible roles in addressing 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 of health (education, income/jobs, health care, community engagement, environment and housing), 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 the community's assets and that disparities and inequities must be challenged and addressed in order for a community to be defined as 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.

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 was cited most often, closely followed by health care access and income/jobs. These three characteristics were each twice the others. Social/human services, community Involvement, public health and housing then followed in the 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 same three most important characteristics of a healthy community were cited as the three greatest issues, but in a slightly different order. Income/jobs and health care

and access tied as most frequently mentioned followed by education tied with diversity/disparities/equity/culturally appropriate services. Health, poverty, mental health, addition/substance abuse, housing and civic involvement were then in order. Again, disparities and equity issues are seen as barriers to the higher-level items like income/jobs, education 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, over 40 percent of citings included access for low income and uninsured (cost, coverage, cultural competency, primary care shortage/access. quality and medical homes) followed by chronic diseases and obesity, mental health and addictions/substance abuse and disparities/equity/racism, dental, nutrition/hunger, prevention and education, built environment, prenatal care and violence-domestic and child. These concerns center on the role of government, specifically health policy. 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.

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; increased collaboration with other health systems; and increased advocacy with elected officials. Stakeholders felt that health systems would influence issues most effectively and efficiently by working in broader and deeper partnerships with fewer organizations.

CONCLUSION

This report paints a picture of an area in which significant segments of the population are less well-off across a range of measures — economics, education, health and more. Poverty, lack of education and poor health status do not respect race, but it is clear that communities of color bear a disproportionate burden. The 2010 report Communities of Color in Multnomah County, while it focuses only on Oregon's most populous county, notes that "suffering a legacy of racism and unequal treatment has imperiled our health and well-being."

What is more, the size of the communities of color in the Legacy Salmon Creek area is growing rapidly. If economic, education and social systems do not change course to reduce historic inequities, these inequities will only become a greater factor in the community's health. Meanwhile, one of the promises of health care reform is coverage for those who currently do not have health insurance. Those 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 our community, 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, therefore, we will prioritize using the following broad criteria:

1. Size: The number of people affected, and the geography impacted.
2. Seriousness: The impact on the region'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 Salmon Creek has the resources and expertise to have a significant impact.
5. Legacy Salmon Creek and Legacy Health strategic plans: The alignment of the issue with one of our areas of strategic focus, and with our mission.

With these criteria and through the lens of racial and ethnic equity, we will present our analysis of community needs and our response using the health factors model by which our analysis was organized earlier.

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 Salmon Creek 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 by Legacy Salmon Creek 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 Salmon Creek's resources and strengths are in 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 Salmon Creek will focus on:

- Communities of color
- Charity care
- Access to health care
- Health literacy
- Youth and education.

IMPLEMENTATION STRATEGIES PLAN

Please see the Legacy Salmon Creek Medical Center Implementation Strategies Plan.

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

Exhibit 7: Clinical Care and Behavior Health Factors

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

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

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

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

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

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

Exhibit 4: Mortality and Morbidity Rates By Race and Ethnicity
1: US Department of Health and Human Services. Office of Women's Health. Health Data. www.healthstatus2010.c0m
2: Kaiser Family Foundation State Facts. www.kff.org
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/

Appendix A
Community Health Characteristics: Most Important

Issue	Number	Percent
Education	18	23.7%
Health Care and Access	16	21.1%
Income/Jobs	15	19.7%
Social/Human Services	7	9.2%
Community Involvement	5	6.6%
Public Health	5	6.6%
Housing	4	5.3%
Public Safety	3	3.9%
Equity	2	2.6%
Libraries, Museums, Arts	1	1.3%
Total	76	100.0%

Appendix B
Community Health: Greatest Needs/Issues

Issue	Number	Percent
Income/Jobs	12	16.4%
Health Care and Access	12	16.4%
Education	11	15.1%
Diversity//Disparities/Equity/Culturally Appropriate Services	11	15.1%
Health	4	5.5%
Poverty	4	5.5%
Mental Health	3	4.1%
Addiction/ Substance Abuse	3	4.1%
Affordable Housing	3	4.1%
Civic Involvement	3	4.1%
Chronic Disease	2	2.7%
Public Safety	1	1.4%
Public Health	1	1.4%
Obesity	1	1.4%
Domestic Violence	1	1.4%
HIV/AIDS	1	1.4%
Total	73	100.0%

Appendix C
Health Care and Public Health: Greatest Issues

Issue	Number	Percent
Health Care or Access Specified	12	16.4%
Cost	5	6.8%
Coverage	5	6.8%
Cultural Competency	5	6.8%
Primary Care Shortage/Access	3	4.1%
Quality	1	1.4%
Medical Homes	1	1.4%
Disparities, Equity, Racism	6	8.2%
Chronic Diseases	5	6.8%
Obesity	5	6.8%
Mental Health	4	5.5%
Addiction/ Substance Abuse	5	6.8%
Dental	3	4.1%
Nutrition/Hunger	3	4.1%
Prevention and Education	2	2.7%
Built Environment	2	2.7%
Prenatal Care	2	2.7%
Violence: Child and Domestic	1	1.4%
Seniors	1	1.4%
Early Childhood	1	1.4%
HIV/AIDS	1	1.4%
Total	73	100.0%

Appendix D
Hospitals' Roles

Issue	Number	Percent
Partner with Community Based Organizations: Dollars, Services and Labor	9	23.1%
Collaboration with other Health Systems	5	12.8%
Advocate with Legislature, Elected Officials	4	10.3%
Health Access: Affordability, Reduce Costs	4	10.3%
Prevention Education	3	7.7%
Health Access: Uncompensated Care	3	7.7%
Culturally Appropriate/Competent Care	2	5.1%
Mental Health	2	5.1%
Conveners regarding Issues	2	5.1%
Education: Health Workforce	2	5.1%
Employment Diversity	1	2.6%
Be Accessible	1	2.6%
Social Determinants	1	2.6%
Total	39	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: Charity care, Coverage, Cost, Cultural Competency, Location, Availability, Quality, Primary Care Shortage and Access, Medical Homes, Care Coordination	Size	5	
	Seriousness	5	
	Change Potential	4	
	Capacity	5	
	Strategic Focus	5	
			24
Disparities/Equity/Racism: Disease Rates, Services, Workforce Diversity	Size	4	
	Seriousness	5	
	Change Potential	5	
	Capacity	4	
	Strategic Focus	5	23
Health Literacy	Size	4	
	Seriousness	5	
	Change Potential	5	
	Capacity	4	
	Strategic Focus	5	23
Youth and Education	Size	4	
	Seriousness	5	
	Change Potential	4	
	Capacity	4	
	Strategic Focus	5	22
Chronic Disease and Obesity	Size	5	
	Seriousness	5	
	Change Potential	3	
	Capacity	4	
	Strategic Focus	4	21
Prevention and Education	Size	4	
	Seriousness	4	
	Change Potential	4	
	Capacity	3	
	Strategic Focus	3	18
Mental Health	Size	3	
	Seriousness	5	
	Change Potential	3	
	Capacity	3	
	Strategic Focus	3	17
Prenatal Care	Size	2	
	Seriousness	5	
	Change Potential	3	

	Capacity	3	
	Strategic Focus	4	17
Public Health	Size	4	
	Seriousness	4	
	Change Potential	4	
	Capacity	2	
	Strategic Focus	2	16
Early Childhood	Size	3	
	Seriousness	4	
	Change Potential	3	
	Capacity	3	
	Strategic Focus	3	16
Addictions/Substance Abuse	Size	4	
	Seriousness	5	
	Change Potential	3	
	Capacity	2	
	Strategic Focus	2	16
Violence: Domestic and Child	Size	3	
	Seriousness	5	
	Change Potential	3	
	Capacity	2	
	Strategic Focus	2	15
Seniors	Size	3	
	Seriousness	4	
	Change Potential	3	
	Capacity	3	
	Strategic Focus	2	15
Dental	Size	4	
	Seriousness	4	
	Change Potential	2	
	Capacity	2	
	Strategic Focus	2	14
Nutrition/Hunger	Size	3	
	Seriousness	4	
	Change Potential	2	
	Capacity	2	
	Strategic Focus	1	12
Built Environment	Size	4	
	Seriousness	4	
	Change Potential	2	
	Capacity	1	
	Strategic Focus	1	12
Natural Environment	Size	4	

	Seriousness	3	
	Change Potential	2	
	Capacity	2	
	Strategic Focus	1	12
HIV/AIDs	Size	3	
	Seriousness	4	
	Change Potential	2	
	Capacity	2	
	Strategic Focus	1	12

Appendix F 28 Interviewees

Name	Organization	Expertise
Thomas D. Aschenbrener, President/CEO	Northwest Health Foundation	
Sharon Brabenac, Development Director	YWCA of Greater Portland	
Sam Brooks, Former President	Oregon Association of Minority Entrepreneurs	Expertise in dedicated to communities of color equity
Marie Dahlstrom, Director	Familias en Accion	Expertise in serving Hispanic and medically underserved
John Deeder, Superintendent	Evergreen School District	
Chris DeMars, Program Officer	NW Health Foundation	
Hal Dengerink, PhD, President	Washington State University Vancouver	
Kevin Dowling, Program Manager	CARES NW	Expertise in child abuse
Jeana Frazzini, Executive Director	Basic Rights Oregon (includes SW Washington)	Expertise in LGBTQ needs
Guadalupe Guajardo, Senior Consultant	Nonprofit Association of Oregon (includes SW Washington)	Expertise in culturally competent training
Bob Knight, President	Clark College	
Cara Larson, Family Educator	Children's Home Society	Expertise in serving low income families
Marc Levy, Executive Director	United Way of the Columbia Willamette	Expertise in services for low income community
Adrienne Livingston, Executive Director	Black United Fund	Expertise in disparities for communities of color
Charles McGee II, President/CEO	Black Parent Initiative	Expertise in to decreasing disparities for Black families
Richard Melching, President	Community Foundation	
Vicki Nakashima, Executive Director	Partners in Diversity	Expertise in equity for communities of color
Linda Nilsen-Solares, Executive Director	Project Access NOW	Expertise in health care for medically underserved
Nancy Parker, Executive Director	Columbia River Mental Health	Expertise in mental health clinic serving low income
Sharon Pesut, Executive Director	Community Choices	Expertise in social determinants and disparities
Kelly Sills, Director of Comm. Development	Clark County	
Lynn Thompson, CEO	Big Brothers Big Sisters Columbia Northwest	Expertise in serving low income youth
Greg Van Pelt, Chief Executive Oregon	Providence Health and Services Oregon Region	
Carrie Vanzant, Clinic Manager	SeaMar Health Center	Expertise in FQHC serving medically underserved
Steven Webb, EdD., Superintendent	Vancouver School District	
Barbe West, Executive Director	Free Clinic of SW Washington	Expertise in safety net clinic for medically underserved
Joyce White, Executive Director	Grantmakers of OR and SW WA	Expertise funding disparities to communities of color

John Wiesman, Director	Clark County Health Depart.	Expertise in public health

Legacy Salmon Creek Medical Center Implementation Strategies Plan

Needs listed ranked order based on Community Needs Assessment Appendix E--Secondary Data and Primary Interview Research. *Italics designate racial and ethnic community focus.*

Action	Impact
NEED: Access to care: Charity care, Coverage, Cost, Location, Availability, Primary Care Shortage and Access, Quality, Medical Homes, Care Coordination and Cultural Competency.	
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 and mortality for low-income uninsured through access to services at earlier stages.
Financial and in-kind service (labs, ultrasounds, deliveries) support to Free Clinic of Southwest Washington, as well as board representation. In-kind support (labs, ultrasounds, deliveries) to new free clinic in Battle Ground.	Improved access to care at earlier stages to uninsured.
Financial support for nurse navigator at the Clark County Department of Public Health to provide prenatal care for women who otherwise would not have such services.	Reduced number of low birth weight babies and increased health outcomes among low-income, at-risk women.
Financial and labor support to Worship in Pink, a program of the Komen Foundation to raise awareness about breast health screenings.	*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.
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.*
Financial and in-kind support and board representation on nonprofit organizations (Free Clinic of Southwest Washington, Children's Center, Children's Home Society, Community Choices, Columbia River Mental Health.) which have as a part of their missions to better serve under-represented and minority populations.	*Increased services for communities of color.*
Offer Youth Employment in Summers (paid summer employment ($4800) and college scholarships ($2500-$5000) for under-represented students entering health care careers.	*Increased the diversity of the health care workforce—1-2 students annually.*
Placement of health care workers of color in classroom settings (at partner high schools, Clark College and WSU Vancouver) and at public forums, (with community partners) to both show and encourage under-represented populations in health care roles.	*Increased awareness about health professions among students of color.*
NEED: Health Literacy	
Partnerships with organizations to increase health literacy in at-risk populations e.g. Community Choices, Clark County Department of Public Health, Free Clinic of Southwest Washington, and Columbia River Mental Health.	*Improved health literacy in at-risk populations, i.e., communities of color, low-income communities, people with mental health issues and seniors.*
Host, with Legacy Health--Oregon and SW Washington Health Literacy Conference.	Improved health outcomes and quality. Reduces race and ethnic disparities.

Legacy Medical Group-Fisher's Landing clinic to serve as pilot project for Health Literacy efforts.	Improved health literacy.
NEED: Youth and Education	
Provide job shadow experiences, classroom speakers, tours and other events for three partner high schools (Fort Vancouver, Battle Ground and Prairie).	Broaden student awareness of health care career opportunities. .
Financial support for the Washington State University Vancouver's At Home/At School program for homeless K-12 youth.	Increased educational achievement for homeless youth
Hold annual back-to-school supply drive to benefit children served by Children's Home Society.	School supplies to help more than 100 at-risk students.
Offer Youth Employment in Summers (paid summer employment and college scholarships ($2500) for under-represented students entering health care careers.	*Increased the diversity of the health care workforce—1-2 students annually.*
NEED: Chronic Disease and Obesity	
Weight loss incentives for employees (periodic weight loss challenges, ongoing Weight Watchers Classes, reimbursement for cost of weight-loss, discounts for fitness club membership, etc.).	Reduced obesity and chronic diseases among employees and their families.
Host weekly Salmon Creek Farmers Market at the hospital, and provide financial support for off-site Salmon Creek Farmers Market, as well as educational offerings at the market.	Improved access to healthy food choices for the public and for employees; increased awareness about fitness, weight loss, disease prevention.
Host annual Healthy Kids Fair, with a healthy-weight check and other educational offerings aimed at reducing obesity.	Anti-obesity information provided to more than 2,000 individuals each year.
Participation in the annual American Heart Association Heart/Stroke Walk.	Increased awareness about heart disease and the benefits of regular exercise.
NEED: Prevention and Education	
Bike, skateboard, ski and snowboard helmets sold for $5 (and fitted for safety) at community events at the hospital and in the community.	Reduced traumatic injuries. 5,000 sold annually across the metro Portland area.
Participation in Safe Kids Coalition, a network of health care, law enforcement and others seeking to improve awareness and prevention efforts throughout the county.	Increased awareness around safety issues and coordination of local prevention-related resources.
Free mammograms to low income women.	Increased early stage cancer detection.
NEED: Mental Health	
Financial support and board representation for Columbia River Mental Health, the largest local mental health nonprofit.	Increased care to un- and under-insured people with mental health issues.
Board representation to Community Services Northwest providing a free mental health clinic to uninsured people as well as programs for people with co-occurring (mental health and chemical dependency) disorders.	Increased care to un- and under-insured people with mental health issues.
Participation in Regional Health Alliance planning, addressing issues of mental health care and chemical dependency in a four-county SW Washington region.	Support for improvements in service delivery for people with mental health issues.
Financial and in-kind support and board representation for Children's Center and Children's Home Society which provide free and low-cost mental health services.	Provides care to un- and under-insured children facing mental health issues.

NEED: Prenatal Care	
Financial support for nurse navigator at the Clark County Department of Public Health to provide prenatal care for women who otherwise would not have such services.	*Reduced number of low birth weight babies and improved health outcomes among low-income, at-risk women (including women of color).*
NEED: Public Health	
Board representation and financial support for the Clark County Department of Public Health.	Improved awareness of and increased support for public health issues.
Participation in Regional Health Alliance planning, addressing public health issues in a four-county SW Washington region.	Expertise and support for ongoing improvements in service delivery for public health issues.
Financial support for nurse navigator at the Clark County Department of Public Health to provide prenatal care for women who otherwise would not have such services.	*Reduced low birth weight babies and increased health outcomes among low-income, at-risk women (including women of color).*
Host Drug Take Back event with Clark County Sheriff.	Reduced abuse of prescription drugs.
NEED: Early Childhood	
NEED: Addiction/Substance Abuse	
Board representation for Community Services Northwest, a nonprofit agency providing mental health and support services for people with co-occurring (mental health and substance abuse) disorders.	Services for people struggling with mental health and chemical dependency issues.
Host Drug Take Back event with Clark County Sheriff.	Reduced abuse of prescription drugs.
NEED: Violence: Domestic and Child	
Operate a Child Abuse Assessment Team at hospital, offering medical exams for cases of suspected child sexual and physical abuse and/or neglect.	A new service averaging 20 child exams per month in partnership with the county's Children's Justice Center to reduce the trauma associated with child abuse.
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.
Partnership with Assistance League, with provides clothing and other items for victims of sexual assault and domestic violence for patients in our Emergency Room.	New clothing provided to those whose personal clothing has been collected as evidence by law enforcement.
NEED: Seniors	
Monthly meeting participation in Elder Care Alliance, a committee of the local Area Agency on Aging.	Increased strategic planning and partnerships to address issues facing the senior population.
Participation in senior-focused health care fairs and forums, as well as specific screenings (free glaucoma screenings, for example) throughout the year.	Increased outreach, education and awareness about health issues.
Hospital volunteer services provides seniors the opportunity to provide services for patients and families.	Increased sociability and reduced probability of illness among seniors.
NEED: Dental	
Financial support and board representation for Free Clinic of Southwest Washington.	Increased access to dental care for uninsured low income.
Provide high-profile location for Free Clinic Dental Van at our annual Healthy Kids Fair at the hospital.	Improved oral care and increased public awareness about oral health.
NEED: Nutrition/Hunger	
Annual food drive for Children's Center.	Reduced hunger for low-income families.
Annual participation in and financial support for Clark County	Improved nutrition and food to low-

Food Bank Walk and Knock, the county's largest food drive.	income families.
Financial support for Salmon Creek Farmers Market, with a weekly presence on the hospital campus as well as a presence in the larger community.	Increased access to local, healthy, fresh food for employees, patients and the public.
NEED: Built Environment	
Partnership with University of Washington as a national model for energy efficiency and water resource allocation in hospitals.	Raised awareness (locally, regionally, nationally) about ways to improve energy efficiency and water resource allocation in hospital settings.
Installation of two electric vehicle (EV) charging stations on hospital campus, for employee and public use.	Reduced greenhouse emissions, provide access for EV users, and raised awareness about alternative energies.
On-site "Green Team" reviews issues of sustainability on a monthly basis.	Improved awareness and increased opportunities for "green" initiatives on campus.
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.
Weekly summer Farmers Market on-site.	Increased access to healthy food for employees, patients and public.
NEED: HIV/AIDS	
Limited resources prevent addressing as priority need.	