LEGACY HEALTH

Silverton Hospital

DBA

Legacy Silverton Medical Center

Community Health Needs Assessment

and

Community Health Improvement Plan

FY 2017

Mission

Our legacy is good health for our people, our patients, our communities, our world

Vision

To be essential to the health of the region

Values

Respect • Service • Quality • Excellence
Responsibility • Innovation • Leadership

LEGACY
HEALTH

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Introduction

About Legacy Silverton Medical Center

Legacy Silverton Medical Center (LSMC) is a nonprofit regional hospital located in Silverton, Oregon, in the heart of the Willamette Valley, about an hour south of Portland and 20 minutes east-northeast of Salem, the state capital. Founded in 1917, the 48-bed facility moved to its current location in 1938.

Silverton joined Legacy Health on June 1, 2016 and has been reported on Legacy's financial summary beginning in fiscal year 2017, making it the newest member of the six-hospital health system established in 1989 by the merger of two nonprofit systems in the four-county metropolitan Portland, Oregon, area. The system's mission is:

> *Our legacy is good health for our people, our patients, our communities, our world.*

A full-service community hospital, Legacy Silverton offers a comprehensive mix of services, many of which are not typically found in a hospital of this size. These services include a Level IV trauma center, a 24-hour emergency department, family birth center, diagnostic imaging, orthopedics/sports medicine, foot care clinic, nutrition services, and wound care and infusion services.

In addition, Legacy is part of a new collaborative providing psychiatric emergency services — Unity Center for Behavioral Health. Unity Center is a joint effort of Adventist Health, Kaiser Permanente, Oregon Health & Science University, and Legacy Health. It is the first collaborative medical initiative of its kind in the Pacific Northwest.

About the area we serve

Legacy Silverton Medical Center defines service area based on actual patient origin (zip codes) and geographic location. Legacy Silverton sits in the Willamette Valley, located in Marion County, Oregon's fifth most populous county. Marion County represents the majority of the Legacy Silverton primary service area and covers about 1,200 square miles with a certified population estimate of 339,200, according to 2017 population data — an increase of 1.6 percent over 2016.[1] The primary service area includes the cities/towns of Silverton, Woodburn, Mt. Angel, Scotts Mills, Gervais, Molalla and Salem. ZIP codes include 97071, 97381, 97305, 97301, 97303, 97362, 97038, 97302, 97317, 97306, 97026, and 97375.

Marion County made up about 8.2 percent of Oregon's population in 2014, and it was estimated that its population had increased by 2.6 percent since 2010, which is aligned with the population growth rate in the state.

By ethnicity and race, Marion County has a lower percent of White residents, and a higher percent of residents that identify as Hispanic, American Indian/Alaskan Native and Native Hawaiian/Pacific Islander than Oregon overall. The three main languages spoken in Marion County are English, Spanish, and Russian.

Notably, because Marion County is a region known for its agriculture, many of its communities see a seasonal influx of migrant farm workers, with the Latino population the majority population in two of the communities (Woodburn and Gervais)[2] and continuing to grow.

Young Latinos represent the fastest-growing segment of Legacy Silverton's primary service area population. According to the Portland State University population forecast study, the average Marion County mother has 2.37 children, while the average Marion County Hispanic mother has 3.51 children.[3] Further, according to the Oregon Department of Education, the majority of Marion County kindergarten classes have more than 50 percent of students identifying as Hispanic.

By age, Marion County has a younger population than Oregon as a whole, with a large percentage of residents under age 25 than the state. The youth population (under age 18) represents more than 26 percent of the population, and those age 55 and older represent almost 25 percent of the population, with both age groups continuing to grow. The median age in Marion County is 36.1 years, while the Oregon median age is 39.2 years.

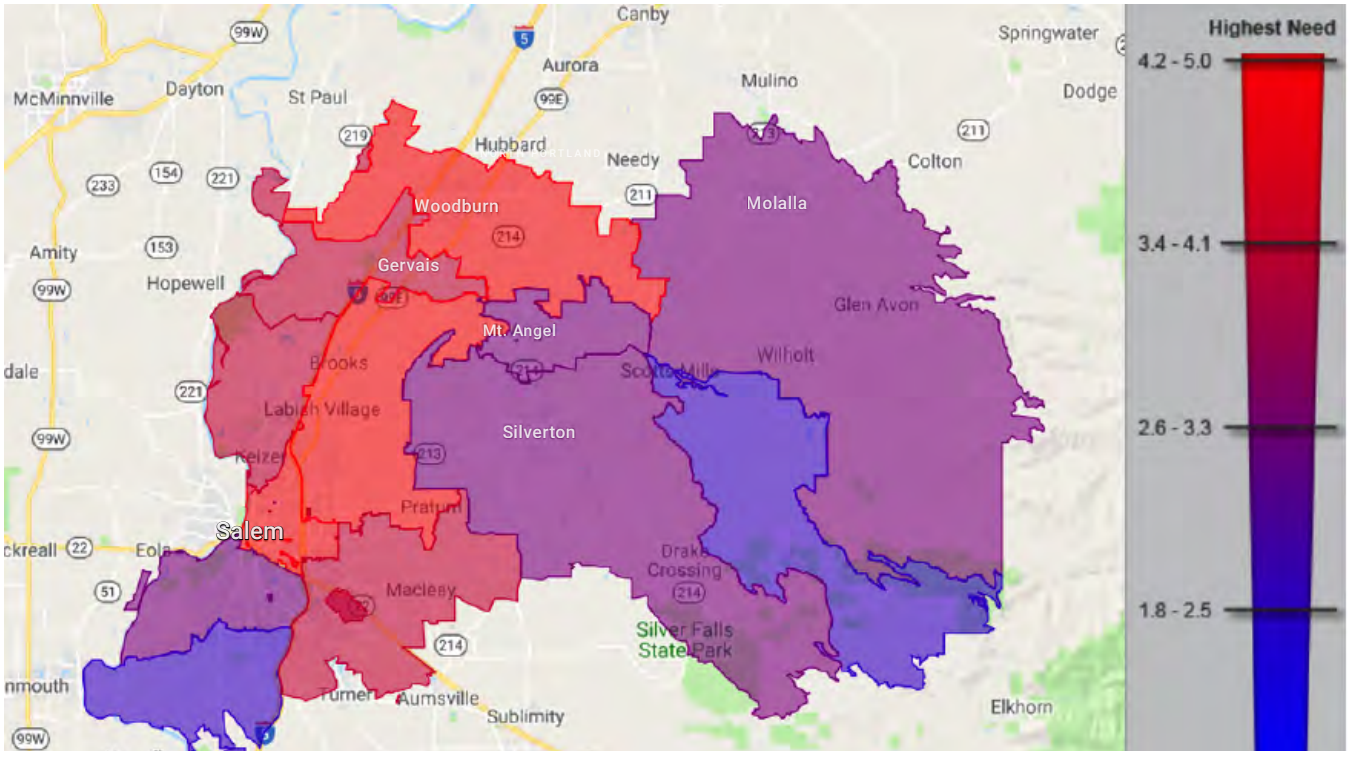
Socioeconomically, Marion County residents have a lower median household income than Oregon residents in general ($46,873 versus $50,251). Marion County also has a larger percent of its population (especially those under age 18) living below the federal poverty level when compared to the state. The percent of the population that is unemployed is about the same in Marion County as in Oregon overall.

Other noteworthy facts about the population Legacy Silverton serves:

- Marion County has a larger percentage of residents who are veterans than the state does.
- Marion County has a larger percentage of single-parent households than the state does, and many more are headed by women than men (13.2 percent versus 5.0 percent).
- Marion County has a higher percentage of residents who did not complete high school, and a lower percentage of residents with a college degree or higher, than Oregon overall.
- A smaller percentage of Marion County third graders are considered proficient readers than are Oregon third graders.

In addition, the most recent joint annual survey of the homeless community in Marion and Polk counties revealed:

- The majority of people surveyed were single adults without children (82 percent).
- 68 percent were male
- 84 percent were White
- Nearly one half said they had been homeless for one to three years.



The Dignity Health and Truven Health Community Needs Index (CNI) is accepted as the national standard in identifying communities with health disparities and comparing relative need. CNI for the Legacy Silverton primary service area shows (on a scale of 1/low need to 5/high need) several highest-need communities adjacent to Legacy Silverton.[4]

- The three most common reasons given for homelessness were "Could not afford rent" (28 percent), "Unemployed" (34 percent), and "Criminal history" (13 percent).
- The two primary factors respondents believed would improve their current situation were affordable housing and a job/income source.

With the increase in diversity, prevalence of migrant farm workers, and lower family incomes in the area, there is a continued need for safety net services. To this end, Legacy Silverton currently supports the well-established and comprehensive Yakima Valley Farm Workers Clinic at Salud Medical Center in Woodburn.

About this report

The purpose of this report

The Patient Protection and Affordable Care Act (ACA), IRS Section 501(r)(3), requires tax-exempt hospital facilities like ours to conduct a Community Health Needs Assessment (CHNA) at least once every three years. This report is approved by the Legacy Silverton Board of Directors and made available to the public in compliance with the IRS requirements.

The purpose of the CHNA is to:

- Determine the priority factors influencing the health of the community we serve
- Identify the needs and gaps affecting the health status of various populations within this community
- Identify how our organization's resources and expertise can help address these issues

This report summarizes the findings of a joint community health assessment and improvement plan conducted by the Marion and Polk county health departments. This report contains demographic, socioeconomic and health data reported in the Community Health Assessment for Marion County, Oregon 2015 (Appendix A). *(Data in county report has since been updated.)*

A collaborative approach to assessing our community's needs

In the summer of 2014, driven by shared data needs, the health departments of Marion and Polk counties began to discuss a joint community health assessment and improvement plan. The adjacent counties work with similar health care provider partners—many of which are required to conduct community health needs assessments every few years. These assessments represented a significant duplication of efforts and resources since the organizations were, for the most part, serving (and assessing) the same communities.

Driven by these shared data needs, Marion and Polk counties joined forces with their mutual partners and stakeholders and established the Marion Polk Community Health Assessment Steering Committee. Its vision was to "ensure the community health assessment represents the whole community by looking at the broad definition of health including the community system and the environment."

This report draws on the joint CHNA findings specifically for Marion County, which includes the primary service area for Legacy Silverton Medical Center.

How information was gathered

The Steering Committee identified community health needs through a comprehensive study of population, state, county, and community data, including:

- Surveying community partners working in social, health, community, educational and correctional health settings and the community at large
- An assessment of the Marion County public health system
- Compiling data from national and state surveillance systems such as the Centers for Disease Control and Prevention and Oregon Health Authority Behavioral Risk Factor Surveillance Survey, as well as state and local data from birth and death records
- Community forums in Woodburn, Salem, Stayton, Dallas and Independence

More detailed information on these sources of information can be found beginning on page 91 of the Marion County Community Health Assessment report (Appendix A).

What we learned from our community health needs assessment

By the numbers: A data snapshot of the community we serve

Here are some of the notable findings about the community Legacy Silverton serves—and its health status—revealed by the CHNA data compiled by the Marion Polk Community Health Assessment Steering Committee (and other sources, if applicable):

Population

- Marion County's certified population estimate as of July 1, 2017, was 339,200, a 1.6 percent increase over 2016.[1]
- Marion County is the fifth most populous of Oregon's 36 counties.
- The five largest cities in Marion County — Salem, Keizer, Woodburn, Silverton and Stayton — are home to 66.3 percent of the county's total population. The remaining nearly one-third live in one of the smaller 15 cities or on unincorporated land.

Race and ethnicity

Although the racial and ethnic population of Marion County is predominantly White, non-Hispanic/Latino, the county has a lower percentage of White residents than the state as a whole, and the demographics of the county continue to diversify:

- Because Marion County is an agricultural region, many of its communities experience a seasonal influx of migrant farm workers; the Latino population today is the majority population in two communities (Woodburn and Gervais)[2] and continues to grow.
- Young Latinos represent the fastest-growing segment of Legacy Silverton's primary service area population, with the majority of Marion County kindergarten classes having more than 50 percent of students identifying as Hispanic.
- Marion County has a larger percentage of residents who speak a language other than English at home than the state as a whole; Spanish and Russian are the main languages spoken in the county (after English).

Social determinants of health

While our health is influenced by our biology, genetics, and individual behavior, external factors are also important, such as our income/economic stability, where we live, how much education we have, and our access to healthcare/the availability of providers. These factors are called "social determinants of health." In Marion County, the CHNA revealed:

- Marion County residents have a lower median household income ($46,873) than Oregon residents in general ($50,251).
- Marion County has a larger percentage of its population (especially those under age 18) living below the federal poverty level when compared to the state.
- About one quarter of Marion County residents believe their access to healthy foods is fair to poor.
- Almost one quarter of Marion County residents believe their access to public transportation is poor (and nearly one-third of Marion County's population lives outside major population areas where they may experience higher difficulty accessing health care resources without a vehicle).
- A higher percentage of Marion County residents have public insurance or no insurance than in Oregon as a whole.
- Lack of affordable housing and living-wage jobs are contributing to increased homelessness in Marion County, which has the third-highest homeless population among the state's counties.[5]
- Marion County has a larger percentage of single parent households than Oregon as a whole; of these, more are headed by women (13.2 percent) than men (5.0 percent).
- Marion County has a higher percentage of residents who did not complete high school than the state as a whole, and a lower percentage of residents with a college degree or higher when compared to the state.
- A smaller percentage of Marion County third-graders are considered proficient readers than Oregon third-graders overall.
- A smaller percentage of individuals reported using urgent care and emergency care services as their usual health care source in 2015 versus 2011.

- A higher percentage of individuals reported access to all types of medical providers in 2015 than in 2011.
- The largest percentage of Marion County residents reported difficulty receiving eye and dental care.

Health behaviors:

Population health data from state surveys show that certain risky health behaviors are prevalent in Marion County. Notably:

- Almost 50 percent of Marion County adults 50 to 75 years of age are not up-to-date on their colon cancer screening.
- A larger percentage of Marion County residents (32.7 percent) are considered to be obese than Oregon residents overall (25.9 percent).
- Binge drinking among teens increases dramatically from 6th to 11th grade.
- A higher percent of Marion County driving deaths are related to alcohol than Oregon driving deaths overall.
- Syphilis incidence rates are increasing in Marion County (1.3 per 100,000 in 2009 to 7.3 per 100,000 in 2013).
- Childhood immunization rates are decreasing in Marion County (55.3 percent up-to-date two-year-olds in 2009 compared to 43.9 percent up-to-date two-year-olds in 2013).

Chronic health conditions:

Key findings from the community health assessment regarding chronic disease in Marion County include:

- Marion County has a higher percentage of adults with diabetes than Oregon overall.
- The age-adjusted hospitalization rate for diabetes in Marion County has been increasing since 2007, with men (16.6 per 10,000) and those who identify as Hispanic (10.3 per 10,000) hospitalized at higher rates than women (11.5 per 10,000) and those who identify as White, non-Hispanic (5.4 per 10,000).
- The percentage of Marion County adults who report having high cholesterol (over 30 percent) is more than double the Healthy People 2020 goal.
- Marion County's age-adjusted hospitalization rate due to heart failure has increased since 2008, with men (23.1 per 10,000) and those of Hispanic ethnicity (12.3 per 10,000) hospitalized at a higher rate than women (17.7 per 10,000) and those who identify as White, non-Hispanic (8.3 per 10,000).
- According to the Medicaid Behavioral Risk Factor Surveillance System in 2014, the Medicaid population of Marion County had a depression prevalence almost 10 percent higher than the state's.
- While 14.4 percent of Marion County community members reported having chronic pain, 44.5 percent of the Medicaid populations in Marion and Polk counties experienced chronic pain.

Emergency department admissions

People without health insurance tend to rely on the hospital emergency department for care, including for conditions that could have been treated by a primary care provider. Through this assessment, it was learned:

- While a higher percentage of the Marion County population is uninsured than the Oregon population, Marion County has a larger percentage of its population using public health insurance than in Oregon overall.
- Between 2011 and 2015, a larger percentage of Marion County residents reported going to the doctor's office and/or a free clinic when they needed health care, while a smaller percentage of Marion County residents reported going to urgent or emergency care.

Morbidity and mortality

Based on epidemiological data, these are some of the key health issues affecting residents of Marion County:

- The leading causes of death in Marion County are heart disease, lung cancer and stroke.
- Marion County men die of heart disease at a higher rate than women, and both Marion County men and women die at a higher rate from heart disease than Oregon men and women.
- While lung cancer mortality has decreased since 2009, lung cancer remains the leading cause of cancer death among men and women.
- While the overall trend in stroke mortality has been trending downward since 2009, Marion County residents who identify as Hispanic experience a

higher stroke mortality rate than Marion County residents who identify as White.

- Marion County residents die of colon cancer at a higher rate than Oregon residents. The overall trend in colon cancer mortality has increased from 2009 (about 12 per 100,000) to 2013 (about 16 per 100,000).
- Breast cancer rates in women have increased from about 16 per 100,000 in 2009 to 20 per 100,000 in 2013.
- The percent of women with gestational diabetes has been increasing steadily since 2008, with the highest incidence (nearly 25 percent) among women aged 40 to 44.
- Marion County has seen an increase in the age-adjusted mortality rates for falls among older adults.

What the community identifies as their health needs

When partners (providers of health and social services) and community members were asked what they saw as the top health concern in Marion County, they listed:

Partners:

- Mental health issues
- Access to affordable health care
- Substance use disorder

Community members:

- Obesity
- Access to affordable health care
- Substance use disorder

In the community survey, respondents were asked to report which diseases or health problems they currently have. These are the top five reported conditions, with the percent of community members who selected each one in parentheses:

- Arthritis (24.4)
- High blood pressure (23.7)
- Obesity (20.4)
- Depression (17.8)
- Chronic pain (14.4)

The priority health issues facing the community we serve

When all the data from the various assessment approaches is reviewed, some specific issues and common themes emerge as the priority health issues facing the community that Legacy Silverton serves:

- Access to health care, including eye and dental care
- Diabetes in adults and pregnant women
- Depression in adults
- Heart disease risk factors including high cholesterol, high blood pressure and obesity
- Cancer (lung, colorectal and breast)
- Substance use disorder

What Legacy Silverton is doing to address these issues

Priorities: Where Legacy Silverton focuses its community benefit resources

Each year, Legacy Silverton invests a significant amount of goods, services, and funds to benefit the health of the community we serve, particularly health services for the low income and uninsured.

Consistent with our mission of good health for our community, in FY16 Legacy Health's community benefit totaled $320.1 million, of this total, unreimbursed costs were $300.6 million. Legacy's financial reporting to include Legacy Silverton Medical Center began in fiscal year 2017 and is not reflected in the FY16 data. *(Community benefit totals for Legacy Silverton will be documented on future CHNA reporting.)*

Our aim in making community benefits investments is fourfold:

- To influence the things we can, such as health behaviors and social determinants of health
- To prevent and/or treat specific health problems
- To support existing programs and initiatives in the community that are effective in addressing specific health needs
- To help build programs and services that achieve our shared vision for a healthy community

Based on the findings of the Marion Polk Community Health Assessment Steering Committee report, and how we can best apply our resources and expertise to help address these needs, Legacy Silverton is focusing its efforts on these priority issues:

Access to care

Improving residents' ability to get the health care services they need, with an emphasis on primary/preventive care and management of chronic conditions such as obesity, diabetes and hypertension in adults.

Behavioral health

Expanding the availability of and access to behavioral and mental health services for youth and adults to help address such conditions as substance-use disorder, depression, suicide and PTSD.

Social determinants of health

Addressing the need for policies, systems, services and environments that support healthy behaviors, which means advancing solutions for such issues as homelessness and affordable housing for the underserved, food scarcity and access to health care. Education, meaningful employment, and removing barriers to culturally competent services are key to improving the health of the community.

Details on the specific initiatives Legacy Silverton is undertaking to address these priority issues can be found in our Community Health Improvement Plan (CHIP), which is provided following this report.

Building on success: Progress since last CHNA

An important piece of the CHNA process is revisiting the progress made on priority health topics set forth in the preceding CHNA. By reviewing the actions taken to address a priority health issue, and evaluating impact on the community, it aids in better targeting of resources and efforts for the following CHNA cycle. Legacy Silverton Medical Center was acquired by Legacy Health in fiscal year 2017 and at the time of this reporting, ongoing evaluation of prior and potential community resources to address priority health issues has continued and additional community impact data will be documented on future CHNA reports.

In addition to cash donations for community benefit programs, in 1998 the Legacy Health Board of Directors approved a $10 million-dollar fund from operating revenue to address major community health issues. Our focus from the beginning has been the significant health disparities within racial and ethnic communities and addressing the social determinants of health. Community Health Fund grants are aligned with a community health needs focus.

The following list *(see table below)* is not exhaustive of Legacy Health community benefit funded programs, but highlights what we have achieved in the most recent years based on the previous CHNA cycle.

Here are some highlights of what we've achieved

Organization	Program supported	Outcomes
Salud Medical Center	Outreach support	Support for outreach coordinator to assist community with access to health coverage, chronic disease management and other treatment and preventative services
Farmworkers Housing Development Corporation	Health and dental van	Provided funding and support for mobile health and dental van serving adults and children lacking insurance coverage and/or underinsured
Liberty House	Youth/child support services	In 2017, 1,161 children were served by Liberty House for assessment, counseling and/or non-face-to-face consults, an increase of 48 percent from 2015
Health Literacy Conference	Health literacy	Over 500 individuals reached annually from over 120 community and health organizations
Silverton Area Community Aid and other community partners	Food programs	From April 2014 to March 2017, Legacy Health's contributions through cash donations and food drives accounted for 308,923 total meals provided to our communities

Health care services for the low income and uninsured

While the Affordable Care Act has significantly lowered the uninsured rate in Oregon, longstanding income disparities in the Legacy Silverton service area underscore the ongoing need for safety-net services, which are detailed in the CHIP document following this report.

Conclusion

As you'll see in the Community Health Improvement Plan (CHIP) that follows this report, going forward we plan to sustain our efforts in addressing many of the priority issues to which we have devoted resources in the past because these needs still exist – as affirmed by the findings of our latest CHNA.

At Legacy Silverton Medical Center, our top priority has been — and continues to be — a focus on the issues which have the greatest impact on the health of our community.

If you have any questions or wish to obtain a copy of this needs assessment, please email us at **CommunityBenefit@lhs.org**.

Appendix A

Community Health Assessment, Marion County, Oregon, 2015

The Marion County Community Health Assessment can be found at: www.co.marion.or.us/HLT/communityassessments/Documents/2015CommunityHealthAssessmentwebsite.pdf

References

[1]*Portland State University: Populations Estimates and Report. (2017) https://www.pdx.edu/prc/population-reports-estimates*

[2]*Zip Atlas: Cities with the Highest Percentage of Hispanics in Oregon. (2017). http://www.zipatlas.com/us/or/city-comparison/percentage-hispanic-population.htm*

[3]*Portland State University: Population Forecasts for Marion County, its Cities and Unincorporated Area 2010–2030. (2008). https://pdxscholar.library.pdx.edu/populationreports/1/*

[4]*Dignity Health: Community Need Index. http://cni.chw-interactive.org/*

[5]*State of Oregon: Oregon Housing and Community Services. 2017 Point-in-Time Estimates of Homelessness in Oregon. (2017). http://www.oregon.gov/ohcs/ISD/RA/2017-Point-in-Time-Estimates-Homelessness-Oregon.pdf*

Executive summary

This Community Health Improvement Plan is based on the 2015 Community Health Assessment conducted by Marion and Polk counties. The Marion Polk CHA Steering Committee is comprised of four hospital organizations, three education systems, two public health organizations, two community organizations, two intergovernmental agencies, one CCO, one local government, and one public transportation agency to produce a shared needs assessment. Members include: Marion County, Polk County, Kaiser Permanente, Legacy Health, Salem Hospital, Santiam Hospital, Salem/Keizer School District, Western Oregon University, Chemeketa Community College, Early Childhood Learning Hub, Community Action Agency, City of Woodburn, Willamette Valley Community Health, Mid-Valley Behavioral Care Network, Northwest Senior & Disability Services, and Cherriots.

Tied to our mission of improving the health of the community, this improvement plan is intended to guide Legacy Silverton's community-focused work, including investments and community health efforts based on prioritized health needs identified in the CHNA. This plan is focused on the Marion County area, the primary service area for Legacy Silverton. Each prioritized focus area is aligned with strategies and indicators for measuring outcomes.

The strategies and outcomes will be assessed annually and revised as needed to address community needs. Legacy Silverton believes that multi-year sustainable partnerships with the community have strong potential to impact long-term health status. Therefore, the Legacy Silverton CHIP includes both continued effective strategies as well as new strategies. This plan is not intended to be an exhaustive listing of all our efforts to address community needs, but rather an overview of prioritized focus areas and strategies tied to measurable tactics.

Summary of prioritized focus areas

The 2015 Community Health Assessment identified numerous health-related needs across the Marion and Polk county region. Legacy Silverton has grouped the needs of Marion County into three categories:

Access to Care

- Primary care access
- Culturally appropriate care
- Health coverage programs

Behavioral Health

- Behavioral health providers, services
- Awareness, education and availability of services
- Early intervention of care
- Navigation to services post-discharge
- Prevention of Adverse Childhood Experiences (ACEs)

Social Determinants of Health

- Access to healthy food
- Improving health literacy
- Affordable housing
- Meaningful employment

These prioritized focus areas will be addressed through community partnerships and initiatives tied to the strategies outlined in the following plan.

Introduction

Our vision at Legacy Health is to be essential to the health of the region, as reflected in our mission: "Our legacy is good health for our people, our communities, our world." Legacy Health remains committed to our mission and fulfills its commitment to the community through its partnerships and community investments. Legacy participates in the development of the Community Health Assessment led by the Marion and Polk County health departments.

The CHNA is conducted in accordance with the Patient Protection and Affordable Care Act (ACA), IRS Section 501(r)(3), which requires tax-exempt hospital facilities like ours to conduct a CHNA once every three years. The CHNA is approved by the Legacy Silverton Board of Directors and made available to the public in compliance with the IRS requirements.

About Legacy Health

Legacy Health is a local, nonprofit health system with six hospitals and dedicated children's care offered at Randall Children's Hospital at Legacy Emanuel. Legacy also includes more than 70 primary care, specialty and urgent care clinics, as well as almost 3,000 providers who are either employed, on the medical staff or part of Legacy Health Partners. We have lab, research and hospice services. Among our major partnerships are PacificSource Health Plans and the Unity Center for Behavioral Health. Legacy Health employs more than 13,000 people across its two-state region and focuses its resources on caring for those in our communities, especially marginalized individuals in need.

Purpose of Community Health Improvement Plan

The Community Health Improvement Plan (CHIP) is based on the 2015 Marion County Health Assessment conducted by the Marion and Polk County collaborative. The CHIP serves to:

- Prioritize factors influencing the health of the communities we serve
- Define the strategies employed to address the needs and gaps affecting the health status of various populations within this community
- Identify how our organization will apply resources and expertise to these strategies, and how we will measure the outcome of the strategies

The CHIP is designed to align Legacy Silverton resources with community need. It is the roadmap Legacy Silverton will follow for the next three years, adapting to changing needs and opportunities along the way. Many of the strategies are a continuation of current work and investments, as we are committed to long-term dedication of resources which can build sustainable solutions.

The Marion County report, completed in 2015, documents the community health needs of Marion and Polk counties and each county individually. Priority health issues were identified based upon data collected including:

Mobilization for Action through Planning and Partnerships (MAPP)

- **Community themes and strength assessment** was conducted by surveying community partners working in social, health, community, educational and correctional health settings as well as the community-at-large
- **Local public health system assessment** was conducted for both Marion and Polk counties (2013)
- **Community health status assessment** was conducted by compiling data from national surveillance systems like the Behavioral Risk Factor Surveillance Survey and Oregon Healthy Teens as well as state and local data from birth and death certificates
- **Forces of change assessment** was conducted with organizations listed on p. 4 of the Marion County 2015 CHA report

Additional data collected includes:

- Marion County demographic, socioeconomic and health data
- Community meetings with members of both Marion and Polk counties on five occasions; meetings were held in Woodburn, Salem, Stayton, Dallas and Independence

The three priority areas Legacy Health identified as those we can impact most significantly are: access to care, behavioral health and the social determinants of health.

Access to Care

Access to health care and preventive services are critical to improving the health of the community. Community members indicated the lack of a usual source of primary care, especially among adults, which disrupts continuity of care. For those individuals who do not qualify for Medicaid, but who cannot afford basic health care, assistance with insurance premiums is needed. Additionally, individuals are more likely to seek care when it is delivered in a culturally responsive and sensitive manner.

Behavioral Health

Behavioral health care access, early interventions and navigation to needed services post-discharge from a health facility were identified as lacking in our region. The awareness and education to support acknowledgement and acceptance of behavioral health challenges among adults and youth were noted as needed in the community. These actions can help to eliminate discrimination and stigmas attached to behavioral health challenges. For youth, identifying and addressing adverse childhood experiences (ACEs) can improve access and reduce risk factors (e.g. suicidal ideation, depression, gang involvement).

Social Determinants of Health

Basic needs, such as access to food, safe and affordable housing, pathways to living-wage jobs and youth education, when addressed, can change the course of an individual's life. Delivering health care and services in a culturally and linguistically appropriate manner, increase access and the ability for independence.

Summary of prioritized focus areas, strategies and key indicators

Access to care

Priority needs

Primary care access

- Legacy Health will continue to support community-based clinics and organizations serving providing primary care services (including care for chronic conditions) for low-income and uninsured individuals
- Timeliness of prenatal care

Culturally appropriate care

- Improve health outcomes and quality of care by supporting community organizations that meet social, cultural and linguistic needs of patients in our community as well as reduce racial and ethical health disparities

Health coverage and health support programs

- Support programs working to ensure all individuals have access to health coverage and assistance with premium pay for low-income and uninsured residents
- Support accessing community-based programs that assist with specialty health needs

Community resources

Access to Care community resources

Basic Rights Oregon

Familias en Acción

Farmworkers Housing Development Corporation

Latino Network

Liberty House

Oregon Health Care Interpreters Association

Project Access Network

Salud Medical Center

Salem Free Clinics

Salem Health Foundation

Action plan	Indicators
Support Project Access Network and other like programs to connect low-income individuals and families to primary care, pay insurance premiums for those who qualify under the FPL, and connect low-income people with health support services	Number of enrolled individuals/families for health insurance coverage, amount of support provided for premium pay assistance, and number of referrals to health support services
Provide funding and/or other resources, e.g., in-kind laboratory services, board representation, program alignment and partnerships, IS support, to local FQHC and volunteer-staffed community-based clinics and culturally specific health service organizations	Number of services, hours and support provided to community-based organizations
Support for Salud Medical Center and other clinics that provide access to care services and/or primary care services, i.e., FQHC/safety net/ community clinics, and treat chronic health conditions	Number of low income partner organizations patients with access to community-based primary care
Support Basic Rights Oregon and other organizations in efforts to reduce disparities that stem from structural and legal factors, social discrimination and lack of culturally competent health care	Number of interactions from patient referrals to culturally competent services

Summary of prioritized focus areas, strategies and key indicators

Behavioral Health

Priority needs

Behavioral health providers, services

- Awareness, education and availability of services
- Build capacity in community-based behavioral health organizations and collaborate with regional initiatives

Early intervention of care

- Early identification, diagnosis and treatment of behavioral health issues can help children reach their full potential
- Provide funding to community organizations and programs that support provide behavioral health screenings that identify patients with possible behavioral health (or substance use) disorders and provide guidance for referral for specialized health treatment
- Identify programs to increase smoking cessation success and reduce the initiation of tobacco product use

Navigation to services post-discharge

- Legacy Health will partner with behavioral health organizations to provide navigation for post-discharge support services

Prevention of Adverse Childhood Experiences (ACEs)

- Partner with organizations supporting individuals experiencing the trauma of disruptive life challenges to reduce the likelihood Adverse Childhood Experiences (ACEs) in children/youth and reduce the likelihood of poor health implications that children and adults face relating to their trauma experiences

Community resources

Basic Rights Oregon

Liberty House

Mental Health Association of Oregon

NAMI Oregon

Action plan	Indicators
Liberty House funding to provide child-focused assessment services and medical consultations for those experiencing or have experienced abuse/neglect	Number of patients accessing assessment services and medical consultations provided by organization
Provide funding to community organizations and programs that provide behavioral health screenings that identify patients with possible behavioral health (or substance use) disorders and give guidance for referral for specialized health treatment	Number of individuals referred and/or recognized with behavioral health issues
Support accessibility and affordability to behavioral health treatment and coordination of services	Number of low-income uninsured with access to services. Number of County Health Rankings for poor mental health days

Summary of prioritized focus areas, strategies and key indicators

Social Determinants of Health

Priority needs

Access to healthy food

- Partner with food programs to improve access to healthy meals
- Obesity prevention

Improving health literacy

- Increase health literacy education in community
- Provide regional leadership in health literacy with the goal of improving health outcomes for people with limited health literacy. Continue to host an annual regional health literacy conference and program support to community-based, health system, public sector, and academic organizations

Affordable housing

- Support community-based recuperative care programs (housing and support services) for homeless and other individuals in need of support services and housing insecurities post-discharge

Meaningful employment

- Support youth employment opportunities designed to improve career development and access to living-wage jobs
- Offer college scholarships and paid summer work experience to [communities of color] for students entering health care careers
- Build capacity in youth development and education programs that increase graduation rates and access/opportunity for higher education achievement
- Support programs that reduce poverty-related barriers to educational success and build capacity for economic stability

Community Resources

AWARE Food Bank
Basic Rights Oregon
Familias en Acción
Farmworkers Housing Development Corporation
Latino Network
Oregon Association of Minority Entrepreneurs
Oregon Humanities
Oregon Latino Health Coalition
Partners for a Hunger Free Oregon
Salem/Keizer Coalition for Equality
Silverton Area Community Aid, Inc.

Action plan	Indicators
Legacy Health will continue to support food banks and programs that provide food to individuals struggling with food insecurities	Number of meals served by cash donations and food drive donations
Community health literacy education via regional health literacy conference and program support to community-based, health system, public sector, and academic organizations working on projects focused on improved health literacy	Number of community organizations and individuals reached through regional health literacy conference
Provide workforce training and college scholarships through YES Program and other career-focused efforts to support ethnically diverse youth entering health careers	Number of ethnically diverse students entering health care careers through YES Program, and number of high school internships, job shadows
Financial support to provide labor resources to education and community-based programs focused on healthy lifestyle, educational attainment and career readiness	School district graduation rates and youth reached through community and school based programs

Legacy Health Community Resources

Legacy Health recognizes the power of collaboration. Exchanging knowledge, skills and experiences with our community organizations helps us achieve more together than we would separately. Legacy Health has identified the following resources in our communities to partner with and better address the priority needs in our area.

Organizations	Priority need(s) addressed*
Adventist Health	Funding/collaborative partner
Albertina Kerr	AC, BH
All Hands Raised	SD
AWARE Food Bank	SD
Basic Rights Oregon	AC, BH, SD
Battleground Healthcare	AC
Birch Community Services	SD
Boys and Girls Club of SW Washington	BH
Bradley Angle	SD
Canby St. Vincent De Paul	SD
Cascadia Behavioral Health	BH
Central City Concern	AC, BH, SD
Children's Center	BH, SD
Children's Community Clinic	AC
Clark County Food Bank	SD
Coalition of Communities of Color	SD
Columbia Pacific Food Bank	SD
Columbia River Mental Health Foundation	BH
Community Action of Washington County	AC, SD
Compassion Connect	AC, SD
Council for the Homeless	SD
Daybreak Youth Services	BH
De Paul Treatment Center	BH
Ecumenical Ministries of Oregon	SD
Familias en Acción	AC, SD
Farmworkers Housing Development Corporation	SD
FolkTime, Inc.	BH
Free Clinic of SW Washington	AC, SD
Friendly House	AC
Girls on the Run-Portland Metro	SD
Girls, Inc.	SD
"I Have a Dream" Oregon	SD
Kaiser Permanente	Funding/collaborative partner
Latino Network	AC, SD
Liberty House	AC, BH

*Key: AC=Access to Care, BH=Behavioral Health, SD=Social Determinants of Health

(continued)

Organizations	Priority need(s) addressed*
Lifeworks NW	BH
Lift Urban Portland	SD
Meals on Wheels	SD
Mental Health Association of Oregon	BH
MIKE Program	SD
Momentum Alliance	SD
My Father's House	SD
NAMI Multnomah	BH
NAMI Oregon	BH
Native American Rehabilitation Association of the NW	AC
Native American Youth and Family Center	SD
New Avenues for Youth	AC, BH, SD
North by Northeast Community Health Center	AC
NorthStar	BH
Oregon Association of Minority Entrepreneurs	SD
Oregon Community Warehouse	AC
Oregon Health Care Interpreters Association	AC
Oregon Health & Science University	Funding/collaborative partner
Oregon Humanities	SD
Oregon Latino Health Coalition	SD
Oregon Public Health Institute	AC, SD
Outside In	AC, SD
Partners for a Hunger Free Oregon	SD
Partners In Diversity	SD
Project Access NOW	AC, SD
Q Center	AC
Rose Haven	BH, SD
Salem Health Foundation	AC
Salem/Keiser Coalition for Equality	SD
Salud Medical Center	AC
Sandy Community Action Center	SD
Share, Inc.	SD
Silverton Area Community Aid, Inc.	SD
Snowcap	SD
Southwest Community Health Center	AC
Southwest Washington Regional Health Alliance	SD
The Intertwine Alliance Foundation	BH
The Skanner Foundation	SD
The Wallace Medical Concern	AC

*Key: AC=Access to Care, BH=Behavioral Health, SD=Social Determinants of Health

(continued)

Organizations	Priority need(s) addressed*
TransActive Gender Center	AC
Transition Projects	SD
Trillium Family Services	BH
Urban League of Portland	SD
Vietnamese Community of Clark County	SD
Virginia Garcia Memorial Foundation	AC
Washington State University Foundation	SD
West Linn Food Pantry	SD

*Key: AC=Access to Care, BH=Behavioral Health, SD=Social Determinants of Health

Legacy Health

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