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
## TABLE OF CONTENTS

### Community Health Needs Assessment

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Introduction</td>
<td>4</td>
</tr>
<tr>
<td>Purpose of CHNA report</td>
<td>5</td>
</tr>
<tr>
<td>Community Profile</td>
<td>7</td>
</tr>
<tr>
<td>Summary Legacy prioritized focus areas</td>
<td>10</td>
</tr>
<tr>
<td>Building on success: 2013 CHNA report</td>
<td>10</td>
</tr>
<tr>
<td>Conclusion</td>
<td>12</td>
</tr>
<tr>
<td>Appendix A</td>
<td>12</td>
</tr>
<tr>
<td>References</td>
<td>12</td>
</tr>
</tbody>
</table>

### Community Health Improvement Plan

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Executive Summary</td>
<td>13</td>
</tr>
<tr>
<td>Introduction</td>
<td>14</td>
</tr>
<tr>
<td>Purpose of CHIP report</td>
<td>14</td>
</tr>
</tbody>
</table>

#### Summary of prioritized focus areas

<table>
<thead>
<tr>
<th>Focus Areas</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access to Care</td>
<td>16</td>
</tr>
<tr>
<td>Behavioral Health</td>
<td>17</td>
</tr>
<tr>
<td>Social Determinants of Health</td>
<td>18</td>
</tr>
<tr>
<td>Legacy Health Community Resources</td>
<td>20</td>
</tr>
</tbody>
</table>
Introduction

About Legacy Meridian Park Medical Center

Opened in 1973, Legacy Meridian Park Medical Center is located in Tualatin, Oregon, and spans the border of Clackamas and Washington counties. The full-service community hospital was built in response to the significant population growth in Portland’s south metropolitan (“South Metro”) area — growth that has continued and, in fact, last year exceeded that of the state.

Today, Legacy Meridian Park is a member of Legacy Health, a six-hospital system established in 1989 by the merger of two nonprofit systems in the four-county metropolitan Portland, Oregon, area, and the addition of the more recent acquisition of Silverton Medical Center in Marion County to the south. The system’s mission is:

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

Legacy Meridian Park is distinguished by its capabilities in orthopedics and total joint replacement, surgery and women’s health services and its identity as a neighbor and friend to the tight-knit community it serves.

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 Meridian Park Medical Center defines service area based on actual patient origin (ZIP codes) and geographic location. Meridian Park is located in Clackamas County, but in close proximity to Washington County — where a significant proportion of patients live. The primary service area includes the fast-growing suburban communities of Tualatin, Tigard, Wilsonville, Sherwood, West Linn, Canby and Lake Oswego, a radius that includes approximately 80 percent of the hospital’s discharges. Primary service area ZIP codes include 97002, 97004, 97013, 97015, 97023, 97027, 97034, 97035, 97036, 97042, 97045, 97062, 97068, 97070, 97086, 97089, 97140, 97223, 97224 and 97267.

The Legacy Meridian Park primary service area included approximately 530,000 people in this reporting period, with an estimated 4.7 percent growth projected by 2019. The majority of residents we serve live in Washington and Clackamas counties, which have an estimated combined population of 1,008,860.1 Our primary service area contains 24.6 percent of the four-county population (including Multnomah and Clark counties).

By ethnicity and race, the Legacy Meridian Park primary service area is 76.8 percent non-Hispanic white, 13.3 percent Hispanic, 1.2 percent African-American, 4.7 percent Asian and Pacific Islander, 2.9 percent multi-racial, .1 percent “other” race and .5 percent Native American.

The number of those who do not speak English at home has increased significantly, particularly in Washington County, where one fourth (23.3 percent) of the population falls into this cohort — as compared with 11.6 percent in Clackamas County. Spanish is the most common language spoken, with Vietnamese and Chinese also prevalent.

Some geographic areas are experiencing significant growth in the Slavic population — including the far southern metro area south of the Clackamas County border in Woodburn (located in Legacy Silverton Medical Center’s primary service area). These residents are counted in the non-Hispanic white population,
but they have a distinct cultural identity and their socioeconomic indicators are generally lower than the other non-Hispanic white population.

Clackamas County’s median household income (MHI) average over the years 2008–2012 was $63,951, with 9.7 percent of the families living below poverty. This compared to Washington County’s MHI average at $64,375 with 10.9 percent below poverty. Enormous disparities exist disaggregating by race and ethnicity, as evident in the table below.

To help address the health and income disparities in this region, some safety net clinic options exist:

- Southwest Clackamas County includes a Medically Underserved Area (MUA) beyond the primary service area. Clackamas County Health Department Clinics are federally qualified health centers (FQHCs) located throughout the county.
- Clackamas Volunteers in Medicine, a safety net clinic, in Oregon City opened in 2012 and is supported by Legacy Laboratory Services.
- The Legacy Medical Group–Canby clinic is a designated Rural Health Center.
- Southwest Community Health Center is a largely volunteer-staffed safety net clinic serving residents without health insurance and below the 100 percent poverty level in S.W. Portland and Hillsboro to the west. Legacy Health Internal Medicine residents volunteer at the clinic.
- FQHCs are located in both central and west Washington County: Virginia Garcia Memorial Health Clinic (multiple sites) and Neighborhood Health Center.

### 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 Health 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 regional community health needs assessment completed July 31, 2016 (Appendix A). The next section explains how this regional CHNA came about.

### A collaborative approach to assessing our community’s needs

Prior to 2010, each of the metro area hospitals/health systems and public health departments in Clackamas, Multnomah and Washington counties in Oregon, and Clark County in Washington, had conducted community health needs assessments independently. This was a significant duplication of efforts and

<table>
<thead>
<tr>
<th></th>
<th>Clackamas MHI</th>
<th>Clackamas percent below poverty</th>
<th>Washington MHI</th>
<th>Washington percent below poverty</th>
</tr>
</thead>
<tbody>
<tr>
<td>All</td>
<td>$63,951</td>
<td>9.7 percent</td>
<td>$64,375</td>
<td>7.9 percent</td>
</tr>
<tr>
<td>Non-Hispanic White</td>
<td>$64,821</td>
<td>8.4 percent</td>
<td>$66,708</td>
<td>5.4 percent</td>
</tr>
<tr>
<td>Hispanic/Latino</td>
<td>$47,844</td>
<td>22.0 percent</td>
<td>$42,588</td>
<td>23.9 percent</td>
</tr>
<tr>
<td>Asian</td>
<td>$76,404</td>
<td>6.3 percent</td>
<td>$79,486</td>
<td>7.3 percent</td>
</tr>
<tr>
<td>Black/African American</td>
<td>$47,545</td>
<td>26.9 percent</td>
<td>$59,463</td>
<td>14.7 percent</td>
</tr>
<tr>
<td>Native Hawaiian/Pacific Islander</td>
<td>$62,162</td>
<td>8.6 percent</td>
<td>$54,787</td>
<td>2.8 percent</td>
</tr>
<tr>
<td>Multi-racial</td>
<td>$52,720</td>
<td>16.9 percent</td>
<td>$64,275</td>
<td>10.6 percent</td>
</tr>
<tr>
<td>American Indian/Alaska Native</td>
<td>$34,258</td>
<td>27.0 percent</td>
<td>$45,706</td>
<td>26.8 percent</td>
</tr>
</tbody>
</table>
resources since the organizations were, for the most part, serving (and assessing) the same communities.

To reduce this duplication of effort and streamline the process of meeting the ACA's triennial CHNA requirements, these entities joined forces to establish the Healthy Columbia Willamette Collaborative (HCWC). This public-private partnership unites 15 hospitals, four counties and two coordinated care organizations (CCOs, or managed Medicaid organizations) to produce a shared regional needs assessment. The HCWC produced its first regional CHNA in 2013, and the second — on which this report is based — in 2016.

This report draws on the regional CHNA findings specifically for Clackamas and Washington County, which includes the primary service area for Legacy Meridian Park Medical Center.

**How information was gathered**

The HCWC identified community health needs through a comprehensive study of population, hospital, Medicaid, and community data. This included:

- Population data about health-related behaviors, morbidity (the rate of disease in a population) and mortality (the frequency of death in a certain population)
- Medicaid data from local CCOs about the most frequent conditions for which individuals on Medicaid sought care in our service area
- Hospital data for uninsured people who were seen in the emergency department with a condition that could have been managed in primary or ambulatory care
- An online survey about quality of life, issues affecting community health, and risky health behaviors
- Listening sessions with diverse communities in the region to identify community members’ vision for a healthy community, needs in the community, and existing strengths

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. Legacy Meridian Park’s community health focus is on the highest CNI-rated ZIP codes in its area, which include: 97223-Tigard, 97224-Tualatin and 97027-Gladstone.2
• An inventory of recent community engagement projects in the region that assess communities’ health needs

More detailed information on these sources of information can be found beginning on page 8 of the Healthy Columbia Willamette Collaborative CHNA Reports (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 Meridian Park serves — and its health status — revealed by the CHNA data compiled by the HCWC (and other sources, if applicable):

Population

• Clackamas County’s certified population estimate as of July 1, 2017, was 413,000, a 2.0 percent growth rate over the prior year (and exceeding the state’s growth rate of 1.6 percent for the same period).¹

• Washington County’s certified population estimate as of July 1, 2017, was 595,860, a 2.1 percent growth rate over the prior year (and exceeding the state’s growth rate of 1.6 percent for the same period).¹

• The Legacy Meridian Park primary service area, which spans the border of these two counties south of metropolitan Portland, included approximately 530,000 people in this reporting period, with an estimated 4.7 percent growth projected by 2019. [Intellimed]

Race and ethnicity

Although the racial and ethnic population of the primary area served by Legacy Meridian Park is predominantly white (non-Hispanic/Latino), the demographics of this area continue to diversify.

In Clackamas County:

• The foreign-born population in Clackamas County increased 19.3 percent from 2005 to 2014, while the Hispanic/Latino population increased 74 percent from 2000 to 2010.

• By ethnicity and race, in 2014 this area was 82.9 percent non-Hispanic white, 1.0 percent Black or African-American, 0.6 percent Native American/Alaska Native, 4.0 percent Asian, 0.3 percent Native Hawaiian and other Pacific Islander, and 8.4 percent Hispanic/Latino.

In Washington County:

• The foreign-born population in Washington County increased 11 percent from 2005-2014, while the Hispanic/Latino population increased 67.4 percent from 2000 to 2010

• By ethnicity and race, in 2014 this county was 67.7 percent non-Hispanic white, 1.8 percent Black or African American, 0.4 percent Native American/Alaska Native, 9.4 percent Asian, 0.3 percent Native Hawaiian and other Pacific Islander, and 16.3 percent Hispanic/Latino.

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 and economic stability, where we live, how much education we have, and our access to healthcare and the availability of providers. These factors are called “social determinants of health.” In Legacy Meridian Park’s service area, the CHNA revealed:

In Clackamas County:

• Clackamas County had the second-highest median household income in the four-county region ($65,316).

• Approximately 9.2 percent of individuals were living in poverty in Clackamas County in 2014 (the lowest proportion among the four-county region), including 11.9 percent of children 18 or younger.

• Over 13 percent of households received SNAP (food assistance) benefits in the past year.

• People receiving Medicaid, whose incomes are below 139 percent of the Federal Poverty Level, make up 17.6 percent of the population in the Clackamas County.

• Clackamas County residents have been affected by increased housing costs and high rates of homelessness, particularly among youth.

• There is a 37.1 percent rate of substandard housing units in Clackamas County.
• Nearly 93 percent of adults have at least a high school diploma (the highest rate in the region) and 33.2 percent have at least a four-year college degree.

• At 1,159:1, Clackamas County had the second-lowest ratio of population to primary care providers of the four counties.

• At 476:1, Clackamas County had the lowest ratio of population to mental health providers of the four counties.

In Washington County:

• Washington County had the highest median household income in the four-county region ($66,136).

• Approximately 12.8 percent of individuals were living in poverty in Washington County in 2014, including 17.5 percent of children 18 years or younger.

• Over 13 percent of households received SNAP (food assistance) benefits in the past year.

• People receiving Medicaid, whose incomes are below 139 percent of the Federal Poverty Level, make up 17.9 percent of the population in Washington County.

• Washington County residents have been affected by increased housing costs, although rates of homelessness are lower than other counties in the region.

• There is a 37.2 percent rate of substandard housing units in Washington County.

• Ninety percent of adult residents have at least a high school diploma and nearly 40 percent have at least a four-year college degree.

• At 1,110:1, Washington County had the third lowest ratio of population to primary care providers of the four counties.

• At 415:1, Washington County also had the third lowest ratio of population to mental health providers of the four counties.

Health behaviors

Population health data from state surveys show that certain risky health behaviors are prevalent in Clackamas and Washington counties. Notably:

In Clackamas County:

• Access to health care was identified as a priority health issue for adults, specifically lack of access to preventive services (such as flu shots or vaccines), lack of dental care, and not having a usual source of health care, such as a primary care provider.

• Binge drinking, cigarette smoking, lack of exercise, and not eating enough healthy foods were identified as top risky behaviors among all age groups.

• For teenagers specifically, the CHNA identified alcohol, marijuana, prescription drug, and vaping/e-cigarette use as common behaviors.

In Washington County:

• Access to health care and preventive services were identified as priority health issues for Washington County, including lack of health insurance for adults, lack of dental visits among teens, and lack of early prenatal care.

• Risky health behaviors such as binge drinking, lack of exercise among teens, and not eating enough healthy foods are prevalent in Washington County.

• For teenagers specifically, the assessment identified alcohol, marijuana, and vaping and e-cigarette use as common behaviors.

Chronic health conditions among low-income residents

By analyzing Medicaid claims data from local CCOs, the CHNA showed that:

In both Clackamas and Washington counties:

• Among youth, asthma, attention deficit disorder and post-traumatic stress disorder (PTSD) were the most commonly diagnosed chronic conditions.

• For adults on Medicaid in Oregon, depression, diabetes and hypertension were the most common diagnoses.

Emergency department admissions among uninsured residents

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. Utilization data from local hospitals were analyzed for Clackamas and Washington county residents who were uninsured or self-pay and were
admitted to the ED with these types of conditions. The HCWC learned:

In Clackamas County:

- The most common conditions for which uninsured adults sought ED care were diabetes, hypertension, kidney/urinary infections, and skin infections.
- For youth, the top conditions were asthma and severe ear, nose, and throat infections.

In Washington County:

- The most common conditions for which uninsured adults sought ED care were diabetes, hypertension, kidney/urinary infections, and severe ear, nose and throat infections.
- For youth within this population, the top diagnosed conditions were asthma, severe ear, nose, and throat infections, and dehydration.

**Morbidity and mortality**

Epidemiologists from the four county health departments looked at over 100 health indicators, with several emerging as priority health issues affecting residents in Clackamas and Washington counties. These included:

In Clackamas County:

- Obesity: 59.8 percent of adults are overweight or obese, as are nearly 48 percent of 8th and 11th graders.
- Cardiovascular disease: This condition is the top cause of death in the county.
- Mental health: Nearly 24 percent of adults suffer from depression, and suicide is one of the top causes of death in the county.
- Substance use/abuse: Alcohol and drug use rank among the top causes of mortality.
- Cancer (8 types)

In Washington County:

- Obesity — 57.6 percent of adults are overweight or obese, as are nearly 48 percent of 8th and 11th graders.
- Diabetes — This condition is among the top causes of death in the county.
- Substance use and abuse — Alcohol and drug use rank among the top causes of mortality.
- Mental health — Over 22 percent of adults suffer from depression (nearly one in four), and suicide is one of the top causes of death in the county.
- Cancer (five types)

**What the community identifies as their health needs**

Through an online survey, listening sessions, and an inventory of community engagement projects, the HCWC heard directly from community members about what they see as priority health issues or problems, and what contributes to these problems. The top five issues they identified in both Clackamas and Washington counties were:

- Homelessness and the lack of safe, affordable housing
- Unemployment and lack of living-wage jobs
- Mental and behavioral health challenges
- Hunger and lack of healthy, affordable food
- Lack of access to physical, mental and/or oral health care

**The priority health issues facing the community we serve**

When all this data from the various assessment approaches was compiled, some specific health issues were identified in more than one assessment component, e.g., population, community engagement, emergency department or Medicaid data. These common themes emerge as the priority health issues facing the community we serve:

- Access to health care
- No usual source of health care among adults
- Asthma in low-income and uninsured children
- Depression in adults
- Diabetes, high blood pressure and cardiovascular disease in adults
- Cancer (including breast, lung, prostate, pancreatic, colorectal, blood and ovarian)
- Lack of dental visits
What Legacy Meridian Park is doing to address these issues

Priorities: Where Legacy Meridian Park focuses its community benefit resources

Each year, Legacy Meridian Park 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 FY 17 Legacy Health’s community benefit totaled $383.1 million and unreimbursed costs were $360.3 million. Of this, Legacy Meridian Park’s total community benefit was $27.1 million including unreimbursed costs at $26.6 million.

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 HCWC’s 2016 regional community health needs assessment, and how we can best apply our resources and expertise to help address these needs, Legacy Meridian Park 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 and preventive care and management of chronic conditions such as asthma in children, and 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 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 Meridian Park is undertaking to address these priority issues can be found in our Community Health Improvement Plan (CHIP) following this report.

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 Meridian Park service area underscore the ongoing need for safety net services, which are delineated in the Community Health Improvement Plan that follows this report.

Building on success: What we’ve done since the 2013 CHNA

In Legacy Meridian Park’s previous CHNA, we identified access to health care, chronic disease, mental health, substance use disorder, health literacy and education and youth as our CHNA priorities. Since that report, we have invested time, resources and funding in programs and services we believed would have an impact on these needs.

A $10 million Community Health Fund was established in 1998 by the Legacy Health Board. The funding is supported by operating revenue on an annual basis. Every partner organization receiving funding meets the needs identified in the CHNA.

The table on page 11 has some highlights of what we’ve achieved:
### Some highlights of what we’ve achieved

<table>
<thead>
<tr>
<th>Organization</th>
<th>Program supported</th>
<th>Outcomes</th>
<th>Alignment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Project Access NOW</td>
<td>Outreach, enrollment and access, premium assistance</td>
<td>Donated care in 2017 provided for over 20,000 patients, assistance with enrolling 30,000 individuals of which 1,200 received premium and out-of-pocket support and 40,000 prescriptions were filled at no cost to patients</td>
<td>Access to care</td>
</tr>
<tr>
<td>Central City Concern</td>
<td>Housing is Healthcare</td>
<td>Once complete, project will provide for 379 individuals and families to have access to housing and other health and support services</td>
<td>Access to care</td>
</tr>
<tr>
<td>Transition Projects</td>
<td>Access to housing and services</td>
<td>Over 10,000 individuals served annually</td>
<td>Access to care</td>
</tr>
<tr>
<td>Rose Haven</td>
<td>Program support</td>
<td>In 2015, Rose Haven provided services to 2,935 women and children affected by domestic violence and homelessness (292 percent increase from 2009)</td>
<td>Access to care</td>
</tr>
<tr>
<td>Mental Health Association</td>
<td>Peer support</td>
<td>In year one of support, 43 patients were provided services, 23 of those patients were provided 57 referrals to community resources (housing/shelter, alcohol and drug, food, clothing, financial assistance), with more than 167 contacts by the Peer Support Specialists</td>
<td>Mental health</td>
</tr>
<tr>
<td>Lifeworks NW</td>
<td>Campaign for Project Network</td>
<td>Opening of LEED-certified 36-bed Project Network residential drug and alcohol treatment facility in N.E. Portland to assist women disrupt a cycle of addiction and abuse, for mothers by limiting financial interruptions and future foster care placement of their at-risk children</td>
<td>Substance use disorder</td>
</tr>
<tr>
<td>Latino Network</td>
<td>School and community-based programs</td>
<td>35 school locations, serving 631 students and families annually</td>
<td>Youth and education</td>
</tr>
<tr>
<td>Wallace Medical Concern</td>
<td>Increasing health literacy via community collaborations</td>
<td>In 2014–2015 WMC served 7,818 people total with 18,514 visits (21 percent increase over previous year)</td>
<td>Health literacy</td>
</tr>
<tr>
<td>Health Literacy Conference</td>
<td>Health literacy</td>
<td>Over 500 individuals reached annually from over 120 community and health organizations</td>
<td>Health literacy</td>
</tr>
<tr>
<td>North by Northeast Community Health Center</td>
<td>Blood pressure checks</td>
<td>Provides early awareness for cardiovascular health issues and connects individuals to health care services</td>
<td>Chronic disease</td>
</tr>
<tr>
<td>Various community partners</td>
<td>Food programs</td>
<td>From April 2014 to March 2017, Legacy Health’s contributions through cash in-kind dollars and food drives accounted for 308,923 total meals provided to our community</td>
<td>Chronic disease</td>
</tr>
</tbody>
</table>
Conclusion

As you’ll see in the Community Health Improvement Plan 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 regional CHNA.

At Legacy Meridian Park, our top priority has been — and continues to be — a focus on the issues that 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 report, please email us at: CommunityBenefit@lhs.org.

Appendix A

Healthy Columbia Willamette Collaborative CHNA Reports, 2016


References

2Dignity Health: Community Need Index. http://cni.chw-interactive.org/
Executive summary

This Community Health Improvement Plan is based on the 2016 Community Health Needs Assessment (CHNA) conducted by the Healthy Columbia Willamette Collaborative (HCWC). The HCWC is a public-private partnership which unites 15 hospitals, four counties and two coordinated care organizations (CCOs, or managed Medicaid organizations) to produce a shared regional needs assessment. The region supported by the HCWC include Clackamas, Multnomah and Washington counties in Oregon, and Clark County in Washington. The HCWC produced its first regional CHNA in 2013, and the second — on which this report is based — in 2016.

Tied to our mission of improving the health of the community, this improvement plan is intended to guide Legacy Meridian Park’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 Clackamas and Washington County area, as that is the primary service area for Legacy Meridian Park. 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 Meridian Park believes that multi-year sustainable partnerships with the community have strong potential to impact long-term health status. Therefore, the Legacy Meridian Park 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 2016 HCWC Community Health Needs Assessment identified numerous health-related needs across the four-county region. Legacy Meridian Park has grouped the needs of Clackamas and Washington 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, and our mission is “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 formally participates in the development of a Community Health Needs Assessment (CHNA) as part of the Healthy Columbia Willamette Collaborative (HCWC).

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 Health 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. In fiscal year 2017 Legacy provided $383.2 million in community benefit across our five county-region (Multnomah, Clackamas, Washington, Marion and Clark counties) representing 20.7 percent of net patient revenue.

Purpose of Community Health Improvement Plan

The Community Health Improvement Plan (CHIP) is based on the 2016 Community Health Needs Assessment (CHNA) conducted by the Healthy Columbia Willamette Collaborative (HCWC). 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 Meridian Park resources with community need. It is the roadmap Legacy Meridian Park 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 HCWC report, completed in the summer of 2016, documents the community health needs of the four-county region and each county individually. Priority health issues were identified based upon data collected including:

• Population data about health-related behaviors, morbidity and mortality

• Medicaid data from local Coordinated Care Organizations (CCOs) about chronic conditions for adults and youth

• Hospital data for uninsured individuals seen in emergency departments for conditions which should have been managed in a more appropriate care setting (e.g. primary care)

• Quality of life data from an online survey of 3,167 respondents; questions addressed issues affecting community health and risky health behaviors

• Listening sessions with 29 community-based organizations including 364 total participants to assess community needs and existing strengths
Inventory of community engagement projects to assess community health needs

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
- Provide in-kind lab services for clinics providing primary care services

**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 programs**
- Support programs working to ensure all individuals have access to health coverage and assistance with premium pay for low-income and uninsured residents

#### Community resources

**Access to Care community resources:**
- Basic Rights Oregon
- Community Action of Washington County
- Familias en Acción
- Founders Clinic
- Project Access NOW
- Q Center
- Southwest Community Health Center
- Virginia Garcia Memorial Foundation Behavioral Health

### Action plan and Indicators

<table>
<thead>
<tr>
<th>Action plan</th>
<th>Indicators</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provide funding and/or other resources, e.g., in-kind laboratory services,</td>
<td>Number of services, hours and support provided to community-based</td>
</tr>
<tr>
<td>board representation, program alignment and partnerships, IS support, to</td>
<td>organizations</td>
</tr>
<tr>
<td>local FQHC and volunteer-staffed community-based clinics and culturally</td>
<td></td>
</tr>
<tr>
<td>specific health service organizations</td>
<td></td>
</tr>
<tr>
<td>Improve access to care through funded FQHC/safety net/community clinics</td>
<td>Number of low-income partner organizations with access to community-based</td>
</tr>
<tr>
<td>that offer primary care services (and care for chronic conditions)</td>
<td>primary care</td>
</tr>
<tr>
<td>Partner with Project Access NOW to increase insurance enrollment and</td>
<td>Number of eligible under 200 percent of FPL individuals obtaining</td>
</tr>
<tr>
<td>access to care for low income and uninsured individuals who qualify for</td>
<td>health care/Number of Project Access NOW premium assistance</td>
</tr>
<tr>
<td>their Premium Assistance support and Outreach, Enrollment, and Access</td>
<td>insured enrollees</td>
</tr>
<tr>
<td>programs</td>
<td></td>
</tr>
<tr>
<td>Support Basic Rights Oregon, Q Center and other organizations in efforts</td>
<td>Number of interactions from patient referrals to culturally competent</td>
</tr>
<tr>
<td>to reduce disparities that stem from structural and legal factors, social</td>
<td>services</td>
</tr>
<tr>
<td>discrimination and lack of culturally competent health care</td>
<td></td>
</tr>
</tbody>
</table>
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

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
Behavioral Health community resources:
- Albertina Kerr
- Basic Rights Oregon
- Bradley Angle
- Cascadia Behavioral Health
- De Paul Treatment Center
- FolkTime
- Lifeworks NW
- Mental Health Association of Oregon
- NAMI Oregon
- Native American Rehabilitation Association
- NorthStar
- Rose Haven
- Trillium Family Services

<table>
<thead>
<tr>
<th>Action plan</th>
<th>Indicators</th>
</tr>
</thead>
<tbody>
<tr>
<td>Legacy Health commits to supporting New Avenues for Youth as well as similar programs that are designed to recognize and address early signs of behavioral health issues, and refer more severe, chronic mental health issues to more extensive therapy</td>
<td>Number of youth reached by therapist and staff trained to recognize early signs of behavioral health issues, and those referred to more extensive therapy</td>
</tr>
<tr>
<td>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</td>
<td>Number of individuals referred and/or recognized with behavioral health issues</td>
</tr>
<tr>
<td>Support accessibility and affordability to behavioral health treatment and coordination of services</td>
<td>Number of low-income uninsured with access to services. Number of County Health Rankings for poor mental health days</td>
</tr>
</tbody>
</table>
## 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

**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) post-discharge for homeless and other individuals in need of support services and housing insecurities

**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

- Basic Rights Oregon
- Canby St. Vincent De Paul
- Central City Concern
- Coalition of Communities of Color
- Community Action of Washington County
- Familias en Acción
- Girls on the Run-Portland Metro
- MIKE Program
- Oregon Association of Minority Entrepreneurs
- Oregon Community Warehouse
- Oregon Health Care Interpreters Association
- Oregon Latino Health Coalition
- Oregon Public Health Institute
- Partners in Diversity
- Project Access NOW
- Transition Projects
- Tualatin School House Pantry
- West Linn Food Pantry
<table>
<thead>
<tr>
<th>Action plan</th>
<th>Indicators</th>
</tr>
</thead>
<tbody>
<tr>
<td>Legacy Health will continue to support food banks and programs that</td>
<td>Number of meals served by cash donations and food drive donations</td>
</tr>
<tr>
<td>provide food to individuals struggling with food insecurities</td>
<td></td>
</tr>
<tr>
<td>Community health literacy education via regional health literacy</td>
<td>Number of community organizations and individuals reached through</td>
</tr>
<tr>
<td>conference and program support to community-based, health system, public</td>
<td>regional health literacy conference</td>
</tr>
<tr>
<td>sector, and academic organizations working on projects focused on</td>
<td></td>
</tr>
<tr>
<td>improved health literacy</td>
<td></td>
</tr>
<tr>
<td>Partner with Central City Concern and other health and community</td>
<td>Number of completed affordable housing units/ projects</td>
</tr>
<tr>
<td>organizations to address the challenges in affordable housing, homelessness</td>
<td></td>
</tr>
<tr>
<td>and health care</td>
<td></td>
</tr>
<tr>
<td>Provide workforce training and college scholarships through YES Program</td>
<td>Number of ethnically diverse students entering health care careers</td>
</tr>
<tr>
<td>and other career-focused efforts to support ethnically diverse</td>
<td>though YES Program, and number of high school internships, job shadows</td>
</tr>
<tr>
<td>youth entering health careers</td>
<td></td>
</tr>
<tr>
<td>Financial support to provide labor resources to education and</td>
<td>School district graduation rates and youth reached through community and</td>
</tr>
<tr>
<td>community-based programs focused on healthy lifestyle, educational</td>
<td>school based programs</td>
</tr>
<tr>
<td>attainment and career readiness</td>
<td></td>
</tr>
</tbody>
</table>
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.

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

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

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

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

(continued)
<table>
<thead>
<tr>
<th>Organizations</th>
<th>Priority need(s) addressed*</th>
</tr>
</thead>
<tbody>
<tr>
<td>TransActive Gender Center</td>
<td>AC</td>
</tr>
<tr>
<td>Transition Projects</td>
<td>SD</td>
</tr>
<tr>
<td>Trillium Family Services</td>
<td>BH</td>
</tr>
<tr>
<td>Urban League of Portland</td>
<td>SD</td>
</tr>
<tr>
<td>Vietnamese Community of Clark County</td>
<td>SD</td>
</tr>
<tr>
<td>Virginia Garcia Memorial Foundation</td>
<td>AC</td>
</tr>
<tr>
<td>Washington State University Foundation</td>
<td>SD</td>
</tr>
<tr>
<td>West Linn Food Pantry</td>
<td>SD</td>
</tr>
</tbody>
</table>

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