Legacy Health

LEGACY GOOD SAMARITAN HOSPITAL AND MEDICAL CENTER

DBA LEGACY GOOD SAMARITAN MEDICAL CENTER

COMMUNITY HEALTH IMPROVEMENT PLAN

FY 2015

LEGACY
HEALTH

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I. INTRODUCTION

The mission of Legacy Health, the parent of Legacy Good Samaritan Medical Center, is to '…improve the health of…..our community...' With this, Legacy Good Samaritan has had a long-standing commitment to meet community health needs for vulnerable populations beyond the health care environment.

The Legacy Good Samaritan Medical Center Community Health Improvement Plan (CHIP) FY 15 meets the IRS 501®(3) requirement for implementation strategies addressing priority community health issues identified in the hospital's Community Health Needs Assessment. Legacy Good Samaritan adheres to the philosophy that multi-year sustainable partnerships with the community have greater impact on long-term improved health status. Thus, the Legacy Good Samaritan CHIP includes both the continuation of current effective strategies as well as new strategies.

Community health needs assessments and community health improvement plans are approved by the Legacy Health Board of Directors and made available to the public in compliance with IRS requirements.

Focus issues: The Legacy Good Samaritan Community Health Needs Assessment FY 15 priority focus issues, with a lens addressing racial and ethnic equity, are addressed in this CHIP and include:

- Access to health care
- Chronic disease
- Mental health
- Substance use disorder (formerly called Substance abuse)
- Health literacy
- Education and youth

Target populations: Aligned to the CHNA lens on communities experiencing disparities, the Good Samaritan CHIP target populations are: Multnomah County primary service area African American, Latino and Native American low income populations and the high need Community Needs Index/top Legacy Good Samaritan emergency department self-pay/Medicaid zip codes of 97209-Old Town, 97205-Goose Hollow, 97201-Downtown, 97210-Nob Hill.

II. FOCUS ISSUE: ACCESS TO HEALTH CARE

Goal: Improve access to health care for vulnerable communities experiencing disparities.

A. ***Strategy 1:*** Support community-based clinics and/organizations serving the low income and uninsured

Tactics:

- 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 staff community-based clinics and culturally specific health service organizations
- Internal medicine residents volunteer in community based safety net clinic serving large Muslim population
- Offer office space on campus at no charge for safety net clinic offices and Project Access NOW which connects low income uninsured patients to in-kind providers

Indicators:
- Number of low income partner organization patients with access to community-based primary care
- Number of uninsured self-pay visits to emergency room

Community partners: Southwest Community Health Center, The Wallace Medical Concern, Central City Concern, Familias en Accion, Project Access NOW, Native American Rehabilitation Association (NARA), Multnomah County Health Department

B. ***Strategy 2:*** Offer services for the low income and uninsured

Tactics:
- Provide health services for the low income uninsured based on charity care financial policies, i.e., up to 400% of FPL
- Participate as a service provider and contribute financial and labor support to Project Access NOW which connects low income uninsured patients to providers at no charge
- Contribute financially to Project Access NOW community-based program funding federal exchange premium assistance for residents 139% to 200% of FPL
- Participate in Partnership Project supporting populations with HIV/AIDs
- Offer Legacy Medical Group Good Samaritan internal medicine resident clinic for low income, under and uninsured patients
- Certify providers to be competent in language other than English to provide care in that language

Indicator:
- Number of eligible under 400% of FPL individuals obtaining health care
- Number of Project Access NOW premium assisted federal exchange insured enrollees
- Number of hospital and Legacy Medical Group providers certified to provide care in language other than English

Community partners: Project Access NOW; 15 Clackamas, Multnomah and Washington County hospitals; Partnership Project

C. ***Strategy 3:*** Support community-based recuperative care programs (medical care, housing and supportive services) post-discharge for homeless patients

Tactic: Contract with community-based organization for homeless patients transitioning from acute hospital care

Indicator: Number of homeless patients transitioned from hospital to recuperative care services

Community partner: Central City Concern

D. ***Strategy 4:*** Enroll patients in Cover Oregon Health Plan

Tactic: Employees trained as enrollment assisters assist patients in application process on-site

Indicator: Number of Cover Oregon enrollees

Community partner: Oregon Health Authority

E. ***Strategy 5:*** Partner with community-based organizations to conduct prevention and detection screenings

Tactic: Provide support to local community-based initiatives to raise awareness about breast health screening for women of color

Indicator: Number of people screened through partner organizations

Community partners: Susan G. Komen Foundation, Familias en Accion, other community-based organizations

III. FOCUS ISSUE: CHRONIC DISEASE

Goal: Prevent and reduce chronic disease through increased access to culturally appropriate and/or low cost services.

A. ***Strategy 1:*** Partner with community-based programs that serve racial, ethnic and underserved populations to provide chronic disease screenings

Tactics:
- Provide diabetes, breast health and other screenings at no charge at public events targeting communities of color and seniors at high risk
- Provide office space and phones to Oregon Lions Sight and Hearing Foundation to provide glaucoma and eye disease screenings to vulnerable populations

Indicator: Number of underserved, senior and communities of color residents accessing screenings through partner organizations

Community partners: African American Health Coalition, Familias en Accion, American Diabetes Association, Susan G. Komen Foundation, Oregon Lions Sight and Hearing Foundation, other community-based organizations, churches

B. ***Strategy 2:*** Partner with racially and ethnically diverse organizations to provide chronic disease support services and education to raise awareness and support behavior changes

Tactics:
- Support organizations offering Stanford University's chronic disease self-management program for people with diabetes
- Support safety net clinics offering peer support groups and the Tormando chronic disease self-management program for Spanish-speaking patients
- Achieve hospital baby-friendly status
- Achieve 90% exclusive breast feeding rate upon discharge among all race and ethnic patients *(Healthy Columbia Willamette Collaborative initiative)*
- Sponsor Farmers Market weekly on hospital campus; SNAP cards accepted
- Hold annual drive for food program serving local community
- Partner with culturally specific organizations providing patient navigation
- Support organ donation organization to increase organ transplantations for at risk communities

Indicators:
- Number of underserved and communities of color residents accessing partner community-based chronic disease education and support services

- Hospital exclusive breast feeding rate by race and ethnicity

Community partners: The Wallace Medical Concern, SW Community Health Center and other safety net clinics; Partners for a Hunger Free Oregon, Familias en Accion and other community-based organizations; Healthy Columbia Willamette Collaborative: 15 hospitals; Clark, Clackamas, Multnomah and Washington public health departments; Health Share of Oregon and FamilyCare Coordinated Care Organizations, Donate Life Northwest

IV. FOCUS ISSUE: MENTAL HEALTH

Goal: Improve access to mental health and supportive services for the uninsured and low income.

A. ***Strategy 1:*** Build capacity in community-based mental health organizations and collaborate with regional initiatives

Tactics:
- Provide funding and labor resources to local community mental health programs
- Participate with mental health providers to develop improved mental health coordination of services
- Participate with local business leaders working to improve police and mental health coordination in response to mental health calls to 911 and Portland police

Indicators:
- Number of low income uninsured with access to services
- Number of County Health Ranking poor mental health days

Community partners: De Paul Treatment Center, Lifeworks NW, Central City Concern, National Association for the Mentally Ill-Oregon, Cascadia, Citizens Crime Commission, Folktime, Mental Health America of Oregon

B. ***Strategy 2:*** Provide healthy green space for patients, family members, employees and the community

Tactic: Offer Healing Gardens in hospital

Indicator: Number of healing gardens

Community partners: community, Intertwine

V. FOCUS ISSUE: SUBSTANCE USE DISORDER

Goal: Prevent and reduce substance use disorder through increased access to services for the uninsured and low income.

A. ***Strategy 1:*** Reduce opioid misuse and abuse

Tactic: Participate in regional hospital and public health department opioid prescription program, including uniform opiate prescribing policies and practices *(Healthy Columbia Willamette Collaborative initiative)*

Indicators:
- Number of medication agreements
- Number of aligned prescribing guidelines across metro area

Community partners: Healthy Columbia Willamette Collaborative: 15 hospitals; Clark, Clackamas, Multnomah and Washington public health departments; Health Share of Oregon and Family Care Coordinated Care Organizations

B. ***Strategy 2:*** Implement CCO aligned Screening, Brief Intervention and Referral to Treatment (SBIRT) screenings

Tactic: Conduct SBIRT screenings in emergency department and Legacy Medical Group

Indicators:
- Number of people screened
- Number of patients who received a substance use disorder brief intervention

C. ***Strategy 3:*** Build capacity in community-based substance use disorder treatment and prevention programs

Tactics:
- Fund community-based culturally appropriate substance use disorder programs
- Fund community education and prevention to reduce driving under the influence on intoxicants

Indicator: Number of people served by partner organization programs

Community partners: Native American and Rehabilitation Association, Oregon Impact, Central City Concern, De Paul Treatment Centers

VI. FOCUS ISSUE: HEALTH LITERACY

Goal: Improve health outcomes for people with limited health literacy.

A. ***Strategy 1:*** Fund community-based clinic projects focusing on improved health literacy

Tactics:
- Fund development of Learner Web program for patients with low health literacy to learn how to access and navigate electronic health portals with goal that other clinics will be able to use the learning program when developed
- Fund FQHC: train staff in health literacy tools and revision of documents into plain language
- Partnerships with organizations to increase health literacy in at-risk populations e.g. Friendly House, Northwest Portland Ministries and Central City Concern.

Indicators:
- Number of FQHC patients accessing electronic health portal
- Number of other health systems and FQHCs using Learner Web program

Community partners: Portland State University Linguistics Department; The Wallace Medical Concern and other safety net clinics, Multnomah County Health Department and other health systems serving low income and vulnerable populations using EPIC

B. ***Strategy 2:*** Increase health literacy education in community

Tactics:
- Host regional health literacy conference with national experts at reduced fee
- Present 'health literacy introduction' to community and health system audiences
- Provide cancer, chronic disease and other screenings and education at health fairs and community events for the public
- Offer disease/injury prevention and treatment education classes for the public

Indicators:
- Number of health literacy conference attendees
- Number of attendees at community events
- Number of education classes and attendees

Community partners: 70 different community-based, health system, public sector, academic organizations; school districts

VII. FOCUS ISSUE: EDUCATION AND YOUTH

Goal: Increase education achievement rates and health care workforce rates for communities of color experiencing education disparities

A. ***Strategy 1:*** Offer college scholarships and paid summer work experience to communities of color students entering health care careers

Tactic: Fund and offer Youth Employment in Summers (YES) program for African American, Native American and Latino students entering health care careers

Indicator: Number of students of color entering health care careers through YES

Community partners: REAP, Native American Youth and Family Services

B. ***Strategy 2:*** Build capacity in youth development and education programs

Tactic: Financially support and provide labor resources to education and community-based programs focused on health care careers

Indicator: High school graduation rate

Community partners: Portland Workforce Alliance, Portland Public Schools

C. ***Strategy 3:*** Train future health care professionals of color

Tactic: Provide high school internships and job shadows

Indicator: Number of high school internships and job shadows offered

***Community partners*:** High schools—Lincoln, Aloha, Beaverton, Southridge, Sunset, Westview