LEGACY HEALTH

Silverton Health

DBA

Legacy Silverton Medical Center

Community Health Improvement Plan

FY26–FY28

(April 1, 2025–March 31, 2028)

Mission

Our legacy is good health for our people, our patients, our communities and our world. Above all, we do the right thing.

Vision

To be essential to the health of the region.

Values

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

LEGACY
HEALTH

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Overview

Introduction

The vision at Legacy Health is to be essential to the health of the region. Legacy Health remains dedicated to its mission and fulfills its commitment to the community through partnerships and investments.

Legacy Silverton Medical Center (LSMC) participates in the development and implementation of the regional community health assessment (CHA) led by the Marion Polk Community Health Collaborative (MP-CHC).[1] The data and results of the MP-CHC CHA provide the foundation for the LSMC community health needs assessment (CHNA). Legacy Silverton Medical Center then develops a medical center-specific community health improvement plan (CHIP) to guide its actions on the community-identified priority issues selected in its CHNA.

All Legacy Health CHNAs and CHIPs are conducted in accordance with the Patient Protection and Affordable Care Act (ACA), IRS Section 501(r)(3),[2] which requires tax-exempt hospital facilities to conduct a CHNA and produce a corresponding CHIP once every three years. The Legacy Silverton Medical Center CHNA and CHIP are approved by the LSMC Board of Directors and made available to the public, in compliance with IRS requirements.

Purpose of this Community Health Improvement Plan

The FY26–FY28 LSMC CHIP is a plan of action to respond to the key community issues identified in the 2025 MP-CHC CHA[3] and prioritized in the FY26–FY28 LSMC CHNA.[4] Guided by Legacy Health's mission of improving the health of the community, the FY26–FY28 LSMC CHIP and its Implementation Strategy will direct Legacy Health's community health efforts and investments to address its prioritized areas (access to health care, economic stability, mental health and substance use) over the three-year period.

About Legacy Health

Legacy Health is a local, nonprofit health system that is driven by its mission to deliver good health for our people, our patients, our communities and our world. Legacy provides comprehensive primary, secondary and tertiary care services across the Portland and Vancouver metro area and mid-Willamette Valley. From rural areas to urban centers, Legacy plays a critical role in the lives of 2.5 million people.

Legacy Health Includes:

- Six medical centers
- Dedicated children's care at Randall Children's Hospital at Legacy Emanuel
- Unity Center for Behavioral Health (a collaboration with three other health care organizations)
- More than 80 primary care, urgent care and specialty clinics
- Over 14,000 employees, and more than 3,000 health care providers
- Partnership with PacificSource health plan
- Research and hospice

Legacy Silverton Medical Center

Legacy Silverton Medical Center is a full-service, community hospital that serves the heart of the Willamette Valley with levels of services not typically available in a community hospital: CT scanning, nuclear medicine, echocardiography, Level IV trauma care, and its own family birth center that is virtually connected to newborn specialists through Randall Children's Hospital at Legacy Emanuel. Legacy Silverton Medical Center delivers care with a personal touch and has been a proud and committed member of the local community for more than a century.

Service Area

Legacy Silverton Medical Center defines its service area by geographic location. The hospital is located in Silverton, a mid-sized city in Marion County. Marion County, which covers about 1,200 square miles, is the primary service area for LSMC. In 2024, approximately 348,044 people resided in the county, the fifth most populous in Oregon.[5] Marion County was ranked the 10th healthiest out of 36 counties in the state in 2023. Additional sociodemographic and health-related data for Marion County can be found in the 2025 MP-CHC CHA.[3]

CHIP Frameworks

Social Determinants of Health and Health Equity

The Legacy Silverton Medical Center FY26–FY28 CHIP is informed by both social determinants of health and health equity frameworks.

Social Determinants of Health

The state of Oregon defines social determinants of health as "…the social, economic, and environmental conditions in which people are born, grow, work, live, and age…"[6] These conditions have a profound effect on the quality and length of life, contribute to health inequities, and are influenced by the social determinants of equity, the systemic and structural factors that affect the distribution of social determinants of health in communities.[6,7]

Health Equity

"…Equity means justice. Health equity means that everyone has a fair and just opportunity to be as healthy as possible."[8] Reaching this state requires resolute efforts to:

- Remove barriers to health, such as poverty, discrimination, and their consequences, which include powerlessness and lack of access to health care, housing, and safe environments, among others;
- Address historical and contemporary injustices through policy, programmatic, and systems change; and
- Reduce and ultimately eliminate preventable health disparities.[7,9–12]

Health Disparities

According to the National Institute on Minority Health and Health Disparities, "health disparities are largely preventable health differences that adversely affect populations who experience greater challenges to optimal health and are closely linked with intergenerational social, economic, and/or environmental disadvantages…"[13] These differences "…may be observed in the risks, prevalence, or problems resulting from specific behaviors, as well as the incidence, prevalence, and mortality from conditions, diseases, and/or disorders. Health disparities also can be observed in health care access, quality, and utilization, and within the delivery of clinical care."[13]

There are numerous ways to decrease and ultimately eliminate preventable health disparities. These actions vary by system and target population. In health care, strategies that have led to reductions in disparities include expanding access to health insurance coverage; increasing the socioeconomic, racial, and ethnic diversity of health providers; teaching and practicing cultural humility; fostering positive behaviors used

to cope with trauma and toxic stress resulting from discrimination and inequities; integrating equity considerations into health system funding; and supporting community-oriented primary care.[14–19] Observed changes in health disparity indicators resulting from these or other interventions allow health systems, like Legacy, to assess progress toward achieving health equity.[9,12,17]

The figure below provides a visual representation of the integration of the social determinants of health and health equity frameworks, illustrating the influence of structural and social factors on health status and health equity.

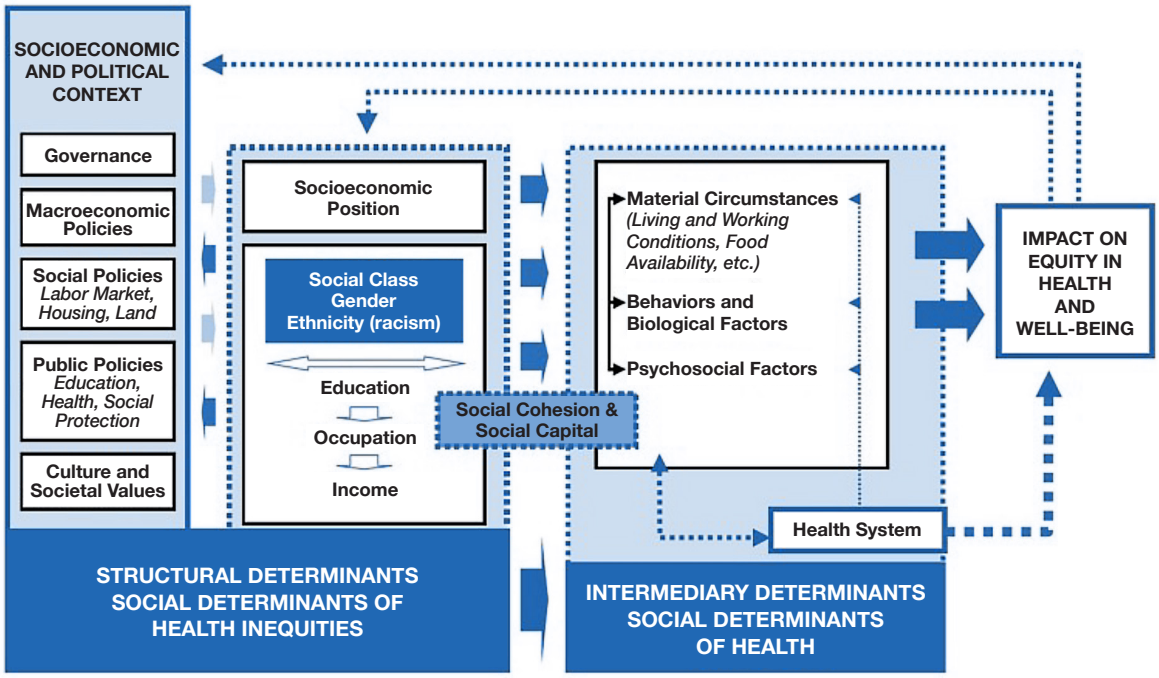

Figure 1: World Health Organization Framework for Social Determinants of Health[7,20]

Addressing social and structural determinants will lead to downstream changes in health-related outcomes and a decrease in health disparities observed in excluded, marginalized, and disenfranchised populations.[7,9,12,19] Significant disparities remain, however, despite ongoing, evidence-based, and collaborative efforts to diminish the influence of structural, social, environmental, and economic factors on the development and duration of these differences.[3]

To eliminate these persistent disparities, greater collective action must be taken by health care systems, public health departments, governmental and other service agencies, businesses, faith-based organizations, and other community partners to identify issues affecting the health of their communities; co-create, implement, and support policies, programs, and services focused on these issues and their root causes; evaluate changes resulting from these efforts; and, if warranted, modify practices.[11,12,17]

These activities embody the three actions critical to attaining health equity, as identified by the World Health Organization's Commission on the Social Determinants of Health: 1) measure and understand the problems and assess the impact of action, 2) improve daily living conditions, and 3) tackle the inequitable distribution of power, resources, and opportunities.[7] This interrelationship demonstrates that the elimination of health disparities is an essential step and marker of progress toward achieving equity in health and well-being.[7,9,12,18]

Through our CHNA and CHIP planning and implementation activities, Legacy Silverton Medical Center, in collaboration with our community, agency, and health system partners, is dedicated to addressing the social and structural determinants of health, reducing health disparities, and working toward the achievement of health equity for all members of our community.

Prioritization of Community-Identified Issues

Legacy Health was an active participant in the management, development and implementation of the 2025 MP-CHC CHA, which provides a comprehensive view of the current assets and needs of the communities served by LSMC. The 2025 MP-CHC CHA also identified six priority areas affecting the local community: access to health care, community safety, economic stability, education, housing stability, and mental health and substance use.[3]

The data and findings from the 2025 MP-CHC CHA[3] provided the basis for the FY26–FY28 LSMC CHNA.[4] In this CHNA, LSMC used an internal prioritization process to determine which of these six priority areas it could most effectively impact over the three-year period. The Legacy Health Community Benefit team and its Community Benefit Advisory Committee, which includes employees from across the Legacy system as well as external partners, participated in all prioritization activities.

The prioritization process applied techniques recommended by the National Association of County & City Health Officials[21] and the Catholic Health Association of the United States of America.[22] Participants first reviewed the 2025 MP-CHC CHA findings.[3] Next, they assessed each priority area in terms of the knowledge, skills, resources, conditions, and community partnerships available within LSMC to remedy the priority issue, and determined whether evidence-based solutions exist and are feasible to enact within the Legacy system or in collaboration with external partners.

After evaluating this information, participants ranked each area in terms of its potential as an actionable priority area. Combined ranking results were reviewed

and discussed. Consensus was reached on three areas for LSMC to prioritize in its community health-related improvement efforts during the FY26–FY28 CHIP period:

1. Access to Health Care
2. Economic Stability
3. Mental Health and Substance Use

Health Needs Identified but Not Prioritized

No single health care system or community health organization can ameliorate all the health and social issues present in the communities they serve. The three areas LSMC prioritized for action are those it has the capacity and capability to affect using evidence-based and feasible interventions during the FY26–FY28 CHIP period.

Other local health systems, public agencies, community-based organizations, and the PacificSource Community Solutions Marion-Polk Coordinated Care Organization may intervene on the remaining priority areas (community safety, education, housing stability). Legacy Silverton Medical Center will support collaborative efforts in these areas, when possible.

Summary of CHIP Planning Process

The Legacy Silverton Medical Center FY26–FY28 CHIP planning process included the following steps:

1. Engaged the Legacy Health Community Benefit planning team in the development of the Implementation Strategy.
   a. Reviewed the findings from the 2025 MP-CHC CHA.[3]
   b. Evaluated the extent of current knowledge, skills, resources, and conditions available within LSMC to address the three priority areas (access to health care, economic stability, mental health and substance use) selected in the FY26–FY28 LSMC CHNA.[4]
   c. Assessed the extent of partnerships LSMC currently has or could have with community-based organizations, other health systems, government agencies, and other entities to collectively intervene in the priority areas.
   d. Reviewed known evidence-based solutions or actions for the priority areas.
   e. Established goals for each of the three priority areas.
   f. Created SMARTIE (Specific, Measurable, Action-Oriented, Realistic/Relevant, Time Bound, Inclusive, and Equitable) objectives for each goal statement.
   g. Identified possible strategies to use to meet objectives.

2. Sought input on the CHIP Implementation Strategy from partners with subject-matter expertise or lived experience in the prioritized areas.

3. Modified and finalized the CHIP and its Implementation Strategy (goals, objectives, strategies) based upon feedback received from the above consultations and presentation to the LSMC Board of Directors.

CHIP Implementation Strategy

The Implementation Strategy tables (pp 11–12) display the current goals, objectives and strategies for each of the three priority areas of the FY26–FY28 LSMC CHIP. The components of this Implementation Strategy align with those used by partner health systems and agencies serving communities in Marion County and beyond, and are drawn from evidence-based sources.[23,24]

Populations Served

"Pursuing health equity means reducing and ultimately eliminating inequalities or disparities in health and its determinants that adversely affect excluded, marginalized, or disenfranchised groups of people." [8] The FY26–FY28 LSMC CHIP centers on priority populations: community members who have been historically or currently marginalized, disenfranchised or underserved. While several groups are named below, this list is not exhaustive. Many individuals live at the intersection of multiple identities and experiences that shape their access to health and well-being, often compounding barriers to care. We recognize that other communities facing inequities also exist and affirm their importance as part of our shared commitment to achieving health equity.

Priority populations for the FY26–FY28 LSMC CHIP include, but are not limited to, groups that are affected by:

Structural and Systemic Marginalization

- Racially, ethnically, and culturally diverse communities
- Immigrants and refugees
- Non-English speakers
- LGBTQ2IA+ communities
- People affected by incarceration

Economic and Resource Insecurity

- People with lower incomes
- Uninsured or underinsured individuals
- People experiencing housing insecurity or houselessness

Health and Support Needs

- Children (0–5 years)
- Older adults (65+ years)
- People with disabilities

Geographic Barriers

- Rural residents

CHIP Implementation Strategy Tables

Table 1. Access to Health Care

PRIORITY AREA **Access to Health Care**	
Goal	All persons have access to equitable, culturally and linguistically responsive, and affordable health-related services, programs, and resources.
Objectives	**Strategies**
Increase the number of members of priority populations who receive culturally and linguistically responsive health care and health-related services by the end of FY28.	1. Expand care delivery into under-resourced areas using options such as telehealth, co-location of services, mobile services, or repurposing or building new sites. 2. Increase the number of culturally and linguistically responsive interpreters in healthcare and health-related service settings. 3. Partner with local healthcare systems through the Health Systems Access to Care Fund to provide community health clinics with financial and technical assistance for their infrastructure and care delivery needs. 4. Support efforts to improve workforce utilization of and access to traditional health workers. 5. Support organizations in expanding the availability and accessibility of preventive care services to priority populations.

Table 2. Economic Stability

PRIORITY AREA **Economic Stability**	
Goal	All persons have access to the resources and opportunities they need to achieve long-term economic stability.
Objective	**Strategies**
Increase the number of members of priority populations who receive services that help them meet their economic stability needs (e.g., housing, food, transportation, employment, and education, etc.) by the end of FY28.	1. Increase partnerships and align community programs to increase access to local healthy foods and to implement methods to eliminate food insecurity. 2. Invest in community-based organizations that provide housing support services. 3. Support educational attainment opportunities for priority populations. 4. Support workforce development, job readiness, skills development, and training opportunities for priority populations. 5. Work with community partners to increase awareness of and linkage to existing transportation resources.

Table 3. Mental Health and Substance Use

PRIORITY AREA **Mental Health and Substance Use**	
Goal	Mental health and substance use prevention, treatment, and recovery services are accessible to all persons in a culturally and linguistically responsive, trauma-informed manner.
Objective	**Strategies**
Increase the number of members of priority populations who receive culturally and linguistically responsive and trauma informed mental health and substance use preventive, treatment, and recovery services by the end of FY28.	1. Collaborate with local agencies and organizations to reduce barriers to substance use treatment. 2. Connect people in recovery with traditional health workers. 3. Increase the number of people trained in mental health crisis mitigation and suicide prevention approaches, such as Mental Health First Aid, Sources of Strength, and Question, Persuade, Refer. 4. Increase opportunities for community-based social connections for priority populations. 5. Support community-based organizations providing access to mental health and substance use services.

Evaluation Plan

Legacy Silverton Medical Center will monitor and evaluate the implementation and outcomes of the strategies applied to meet our objectives. The reporting process includes the collection and documentation of process and outcome indicator data from both internal and external data sources. We anticipate the current objectives, strategies and indicators may change over time in response to fluctuations in system resources and community status.

Legacy Health Commitment

The goals, objectives and strategies outlined in the FY26–FY28 CHIP Implementation Strategy inform the community health efforts and investments LSMC will make in its prioritized areas during the three-year period. Legacy Health is committed to providing access to health care and health-related services, personnel time and technical assistance, and funding for Community Benefit initiatives, such as community health grants, to support the execution of this Implementation Strategy. Strategic partnerships and other collaborations will be developed and strengthened to enhance activities intended to impact these priority areas. Some examples of current or planned community alliances are described below:

Access to Health Care

Legacy Health is a founding member and ongoing contributor to the Health Systems Access to Care Fund (HSACF) (https://www.accesstocarefund.org), a collaboration of multiple health care organizations (Legacy Health, CareOregon, Kaiser Permanente NW, PeaceHealth, and Providence Health & Services) who provide financial and other assistance to local safety net health care providers in Oregon and SW Washington. Monies donated by these health systems are awarded by HSACF to community health clinics to strengthen their infrastructure and capacity to respond to changing patient needs resulting from inadequate access to health services in the region, Medicaid transformation, and ongoing healthcare reform.[25]

In alignment with the 2026–2030 MP-CHC CHIP,[26] LSMC is working with Collaborative partner organizations and other allies, including Salem Health, Santiam Hospital, PacificSource Community Solutions Marion-Polk Coordinated Care Organization, and the Willamette Health Council, to develop and implement shared strategies to enhance and expand access to health care and health-related services in the region.

Economic Stability

In Marion County, Oregon, Legacy Health has provided grant funding to community-based organizations, such as Catholic Community Services and Silverton Area Community Aid, to increase their capacity to distribute food to individuals and families affected by food insecurity, some of whom are Legacy patients. Funding for these organizations also has been used to support housing-related services, such as the provision of temporary shelter or the payment of utility bills.

Legacy Silverton Medical Center looks forward to collaborating with the PacificSource Community Solutions Marion-Polk Coordinated Care Organization as they develop transportation-related awareness campaigns and improve travel assistance throughout the region.

Mental Health and Substance Use

Legacy Health has provided grant funding to support community-based organizations (Catholic Community Services, Liberty House) that work on mental health and substance use issues in Marion County. Liberty House used their Legacy grant to support the expansion of services for children impacted by trauma at their new behavioral health clinic in North Marion County, a previously underserved area of the County. Catholic Community Services is using their funds to employ a community health worker to assist their shelter residents. This worker performs many tasks, including ensuring culturally responsive connections, providing for social needs, such as food and clothing, and linking residents to substance use disorder treatment and recovery services.

For questions or more information

If you have any questions, comments or wish to obtain a printed copy of this improvement plan, please email us at CommunityBenefit@LHS.org.

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