LEGACY HEALTH

Silverton Health

DBA

Legacy Silverton Medical Center

Community Health Needs Assessment

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 investments and partnerships.

Legacy Silverton Medical Center (LSMC) is an active participant 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 the results of the MP-CHC CHA provide the foundation for the LSMC community health needs assessment (CHNA). Legacy Silverton Medical Center then creates a medical center-specific community health improvement plan (CHIP) to direct its efforts 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 are publicly available in compliance with IRS regulations.

Purpose of this Community Health Needs Assessment

A CHNA is a collaborative, multilevel process that gathers diverse types of data from multiple sources to 1) describe the community in terms of demographic, social, health status, and environmental characteristics; 2) highlight factors influencing health and social outcomes; and 3) identify resources available to improve individual and community health and well-being. Assessment findings can be used to inform quality improvement efforts, establish benchmarks for health care and public health practice, and monitor health and social change over time, among other uses.[3]

Guided by Legacy Health's mission of improving the health of the community, the purpose of the FY26–FY28 LSMC CHNA is to:

- Highlight the impact of LSMC community improvement activities on community-identified priority areas during the past three years (FY23–FY25 CHNA/CHIP cycle),

- Describe the process and methods used to conduct the current LSMC CHNA,
- Introduce the community-identified areas LSMC will address in FY26–FY28 and the process used to select them, and
- Identify resources from Legacy Health and community partnerships that may be available to support efforts in these priority areas.

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's 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.[4] In 2023, Marion County was ranked the 10th healthiest out of 36 counties in the state. Additional sociodemographic and health-related data for Marion County can be found in the 2025 MP-CHC CHA *(see Appendix A)*.[5]

Legacy Silverton Medical Center's Community Health Impact (FY23–FY25): Addressing Priority Issues Through Collaboration

The FY23–FY25 LSMC CHNA[6] was informed by the collaborative Marion-Polk 2019 CHA[7] and its 2022 CHA Update.[8] The update engaged 1,181 individuals through a community survey and other methods of data collection. Results reaffirmed the eight strategic community issues identified in 2019 (access to health care, behavioral health support, economic stability, education, food environment/food insecurity, housing, substance use, and transportation).[8]

Using these findings, the Legacy Community Benefit team and Community Benefit Advisory Committee evaluated which of these strategic issues LSMC could most effectively improve during FY23–FY25 based on available expertise, resources, and partnerships. Four priority areas were selected in the FY23–FY25 LSMC CHNA:[6]

1. Access to Health Care
2. Behavioral Health Support
3. Food Environment/Food Security
4. Substance Use

A LSMC CHIP was then developed, outlining goals, objectives and strategies for action on each priority area for the FY23–FY25 period.[9] The following tables (see pp. 7–11) highlight some of the impact LSMC has had on these priority areas within Marion County over the past three years. These accomplishments were made possible by patient and staff-focused efforts within LSMC and through direct financial contributions to community-based organizations and partnerships. For example, during FY23–FY25, Legacy Community Health Grants, totaling $300,000, were awarded to Catholic Community Services, Liberty House, and Silverton Area Community Aid. These grants supported each organization's work across multiple objectives aligned with the FY23–FY25 LSMC CHIP. [9]

TABLE 1 Legacy Health Impact on Access to Health Care
PRIORITY AREA Access To Health Care
GOAL Community members have timely access to equitable, inclusive, culturally responsive, trauma informed, affordable, and high-quality services, programs and resources that improve their health.
IMPACT FY23–FY25: April 1, 2022, through March 31, 2025
Objective 1.1 By end of FY25 (March 31, 2025), increase access to health care services by 5% for community members who are low-income, underinsured or uninsured. Baseline data from FY22.
Legacy Health partners with CareOregon, Kaiser Permanente NW, PeaceHealth, and Providence Health & Services to finance and support the Health Systems Access to Care Fund (HSACF) (https://www.accesstocarefund.org). The monies donated by these health systems are awarded by HSACF to community supported health clinics in Oregon and SW Washington to strengthen their infrastructure and capacity to respond to changing patient needs resulting from Medicaid transformation, ongoing healthcare reform, and insufficient access to health services in the region. Legacy Health contributed $450,000 to the HSACF for FY23–FY25. In both 2022 and 2023, the HSACF awarded $50,000 grants to 10 organizations. These organizations provided health care services to 2,600 of the most marginalized people in the region each year, on average.
At the end of FY22, 29% of all patients with a primary care home associated with Legacy Silverton Medical Center (LSMC) were Medicaid members. This proportion rose to 34% by the end of FY25, an increase of 17%.
Among Medicaid members whose primary care home was associated with LSMC, 10% had received a preventive care visit by the end of FY22. By the end of FY25, 15% of this group had completed a preventive care visit.
Objective 1.2 By end of FY25 (March 31, 2025), increase diversity and cultural competency of the health care workforce by 5%. Baseline data from FY22.
A Legacy Community Health Grant awarded to Liberty House, an organization serving children living with trauma in Marion and Polk counties, enabled a bilingual/bicultural mental health therapist to complete her clinical training hours and obtain her license.
The number of traditional health workers, such as community health workers, health navigators, doulas, and peer mentors, employed at or contracted by LSMC increased during the CHIP period. In FY23, LSMC employed one community health worker and contracted with one doula. By the end of FY25, there were four employed community health workers and eight contracted doulas available. The average number of patient encounters per community health worker increased 83% from FY23 to FY25.
Between FY23 and FY25, the number of interpreter encounters within LSMC increased by 63% (from 27,388 to 44,684). In addition, by the end of FY25, 51 LSMC employees had been approved through the Legacy Bilingual Competency Program to use their non-English skills to provide language-concordant care.
Over the three-year CHIP period, LSMC employees completed more than 670 trainings on implicit bias and/or discrimination, inclusive work environments, cultural responsiveness, trauma-informed care, and related topics to enhance their care delivery, professional communications, and personal interactions.
By March 31, 2025, there was a 14.6% increase in the number of LSMC employees who self-identified as non-white or mixed race compared to the beginning of the CHIP period (196 vs. 171).

table continues

TABLE 1 **Legacy Health Impact on Access to Health Care *(continued)***
PRIORITY AREA **Access To Health Care**
GOAL Community members have timely access to equitable, inclusive, culturally responsive, trauma informed, affordable, and high-quality services, programs and resources that improve their health.
IMPACT FY23–FY25: April 1, 2022, through March 31, 2025
Objective 1.3 By end of FY25 (March 31, 2025), increase service coordination between community clinics, community-based organizations and health care systems to meet the health and social needs of community members by 5%. Baseline data from FY22.
Legacy Community Health Grant funding for 2024 and 2025 enabled the employment of a community health worker at Catholic Community Services, an organization addressing health and social needs in rural Marion County. In 2024, this worker, who also is a trained Oregon Health Plan (Medicaid) assister, engaged with individuals and families from three Catholic Community Services programs [St. Joseph Family Shelter Transitional Living Community (15 families (21 adults, 35 children)), Mission Benedict food and resource pantry (4 families), and Casa Adele Apartments for agricultural workers and their families (1 family)] and helped them with social connections and wraparound supports. These activities included navigating Oregon Health Plan (Medicaid) benefits; accessing physical, dental, mental health, and substance use services; acquiring food, clothing, diapers, transportation, and other tangible goods and services; employment assistance; procuring financial assistance for housing and utilities; finding emergency shelter and food boxes; and locating long-term, affordable and safe housing.
Between FY23 and FY25, Legacy Health connected 662 LSMC patients to Medication Assistance Programs where they received essential medications at low or no cost. The number of individuals receiving this assistance increased almost eight-fold during the three-year period.
Legacy Health began using the Unite Us community information exchange (CIE) platform with its child and adult patients during FY23. For LSMC, the number of patients referred to community-based organizations to meet their identified social needs doubled each year between FY23 and FY25. Patient referrals were for housing and utilities assistance, income support, benefits navigation, transportation, and individual and family support.

TABLE 2 Legacy Health Impact on Behavioral Health Support
PRIORITY AREA **Behavioral Health Support**
GOAL Improve awareness of and linkage to behavioral health services and care.
IMPACT FY23–FY25: April 1, 2022, through March 31, 2025
Objective 2.1 By end of FY25 (March 31, 2025), reduce systemic barriers to receiving behavioral health services by 5%. Baseline data from FY22.
During FY23 and FY24, a Legacy Community Health Grant assisted with the employment of two trauma-focused mental health practitioners at Liberty House, the Children's Advocacy Center serving Marion and Polk Counties. During this period, these therapists served approximately 162 clients.
Liberty House received a separate Community Health Grant (2024-2025) to support the expansion of services at their new behavioral health clinic in North Marion County. In 2024, 64 patients received care at this new location, 60% of whom lived in the surrounding community.
The provision of telehealth services improves access to health care and other health-related services for individuals with physical mobility issues or transportation challenges. In 2024, telehealth services were available for psychiatric care and consultation within the LSMC emergency department.
Between FY23 and FY25, approximately 74% of LSMC primary care patients aged 12 years and older who were Medicaid members were screened for depression each year. Of the 74% evaluated, 18%, 16%, and 14% received a positive screening result in FY23, FY24, and FY25, respectively. Among those with a positive depression screen, an average of 58% had a documented follow-up plan in their medical record over the three-year period.
Objective 2.2 By end of FY25 (March 31, 2025), increase service coordination between community clinics, community-based organizations and health care systems to meet the behavioral health-related health and social needs of community members by 5%. Baseline data from FY22.
In 2024 and 2025, Catholic Community Services, an organization assisting people with their health and social needs in rural Marion County, used their Legacy Community Health Grant funding to employ a community health worker who also is a trained Oregon Health Plan (Medicaid) assister. In 2024, this worker primarily supported 15 families (21 adults, 35 children) at the Catholic Community Services St. Joseph Family Shelter Transitional Living Community, a supervised housing project with on-site recovery support services, mentoring, and transportation assistance for parents at risk of losing their children due to substance use. The community health worker helped these families access physical, dental, mental health, and substance use services; navigate Oregon Health Plan (Medicaid) benefits; and acquire food, clothing, diapers, transportation, and other tangible goods and services, among other activities.
Between FY23–FY25, the number of LSMC patients referred through the Unite Us CIE platform to community-based organizations that could address their identified social needs doubled each year. Patient referrals were for items such as individual and family support and housing and utilities assistance.

TABLE 3 Legacy Health Impact on Food Environment/Food Insecurity
PRIORITY AREA Food Environment/Food Insecurity
GOAL Community members have access to affordable, culturally appropriate, healthy and dietary-specific foods, and experience improved food security.
IMPACT FY23–FY25: April 1, 2022, through March 31, 2025
Objective 3.1 Increase access to affordable, culturally appropriate, healthy and dietary-specific foods by 5% by the end of FY25 (March 31, 2025). Baseline data from FY22.
In FY24, Legacy Health provided a Community Health Grant to Silverton Area Community Aid, an organization in Silverton, Oregon that meets community members' social needs. Silverton Area Community Aid used most of this grant to expand their food delivery program to 262 homebound individuals or those with no transportation. Remaining funds were applied to food purchases to support the 16% increase in food pantry visits during the year.
Within Marion County 17,186 individuals were screened (72% of all patients) for food insecurity at LSMC inpatient units or clinics during FY25 compared to 11,016 (53% of all clinic patients) during FY22, a 56% increase in the proportion of patients screened. Approximately 7% of those screened each fiscal year (FY23–FY25) had an identified food need. Of these individuals, 21% each year, on average, received short-term food assistance (food bag) after screening. Among all patients at LSMC inpatient units or clinics in Marion County who were uninsured or Medicaid members, 58% (n = 4,135) were screened for food insecurity in FY25, a 57% increase from FY22 (n = 2,501, 37% of all clinic patients). For each fiscal year (FY23–FY25), 15–16% of those screened reported food needs. Of those individuals with identified food insecurity in FY24 and FY25, an average of 21.3% were provided with short-term food assistance after screening.
Objective 3.2 By end of FY25 (March 31, 2025), increase service coordination between community clinics, community-based organizations and health care systems to meet the food-related health and social needs of community members by 5%. Baseline data from FY22.
In FY23 and FY24, Silverton Area Community Aid, an organization in Silverton, Oregon that meets community members' social needs, used a Legacy Community Health Grant to support case management activities for more than 2,000 individuals. These activities included screening for social needs, food distribution, providing financial assistance, and arranging referrals for community members experiencing housing insecurity.
In 2024 and 2025, Catholic Community Services, an organization addressing health and social needs in rural Marion County, used funding from a Legacy Community Health Grant to support a community health worker. In 2024, this individual helped four families who accessed food through the Catholic Community Services Mission Benedict food pantry and resources center to enroll in the Oregon Health Plan (Medicaid).
The number of LSMC patients referred through the Unite Us CIE platform to community-based organizations for help with social needs doubled each year between FY23 and FY25. Patient referrals were for items such as income support and transportation.

TABLE 4 Legacy Health Impact on Impact on Substance Use
PRIORITY AREA Substance Use
GOAL Create and/or sustain equitable community and clinical efforts to prevent substance use disorder (SUD), improve access to and the quality of SUD treatment and achieve and maintain healthy recovery.
IMPACT FY23–FY25: April 1, 2022, through March 31, 2025
Objective 4.1 By end of FY25 (March 31, 2025), increase service coordination between community clinics, community-based organizations and health care systems to meet the substance use-related health and social needs of community members by 5%. Baseline data from FY22.
Using their Legacy Community Health 2024-2025 Grant award, Catholic Community Services, an organization supporting the health and social needs of people in rural Marion County, hired a community health worker, who also is a trained Oregon Health Plan (Medicaid) assister. In 2024, this individual primarily worked with 15 families (21 adults, 35 children) at the St. Joseph Family Shelter Transitional Living Community, a supervised housing community with on-site recovery services, mentoring, and transportation support for parents at risk of losing their children due to substance use. The community health worker helped these families access and engage in substance use treatment and recovery services, obtain employment assistance, and apply for Oregon Health Plan (Medicaid) benefits, among other activities.
In FY23, Legacy Health implemented the use of the Unite Us CIE platform for patients of all ages. The number of LSMC patients referred to community-based organizations for help with their social needs, such as individual and family support and housing and utilities assistance, doubled each year from FY23 through FY25.
Between FY23 and FY25, 61%, 63%, and 65% of LSMC primary care patients aged 12 years and older who were Medicaid members were screened for substance use. Of those tested, 3%, 4%, and 2.7% received a positive screening result in FY23, FY24, and FY25, respectively. Among those with a positive substance use screen, an average of 29% had a documented follow-up plan in their medical record over the three-year period.

Legacy Silverton Medical Center's Community Health Planning (FY26–FY28): Assessing Needs Through Collaboration

Marion-Polk Community Health Collaborative 2025 CHA

In January 2023, a collaboration of health systems, public health departments, the PacificSource Community Solutions Marion-Polk Coordinated Care Organization, and community agencies in Marion and Polk counties launched the Mobilizing for Action through Planning and Partnerships (MAPP) 2.0 process. MAPP 2.0 is an evidence-based framework created by the National Association of County & City Health Officials (NACCHO) that guides community health improvement through multiple assessments; the identification of key community issues; and the development, implementation and evaluation of strategies used to lessen the negative effects of these issues on community health.[10]

By April 2023, these partners had formed the Marion-Polk Community Health Collaborative (MP-CHC)[1] to coordinate local health efforts. Its Executive Committee directs strategy and resources, while the Steering Committee offers insights rooted in lived experience. Legacy Silverton Medical Center serves on both committees.[5]

In January 2024, the MP-CHC initiated the three MAPP 2.0 assessments, Community Status, Community Partner, and Community Context, which explored health status, beliefs, challenges, assets, and opportunities for action. These assessments included secondary analysis of existing population-based data sources, the collection of mixed-methods data with local organizational partners, and community engagement activities involving qualitative data collection. Surveys, focus groups, community input sessions, Forces of Change discussions, and PhotoVoice were used to gather information in multiple languages from 2,286 individuals in Marion and Polk counties.[5]

In October 2024, the MP-CHC reviewed the MAPP 2.0 assessment findings, first in small groups and then collectively. Six comprehensive priority areas were identified, noting "since CHIP priorities are broad, they can influence multiple health conditions and address the root causes responsible."[5 (p21)] In addition, all six areas influence the health and well-being of the local community; disproportionately affect low-income populations, communities of color, and other disenfranchised groups; and have known effective and feasible solutions.[5, 11, 12] The priority areas are:

1. Access to Healthcare
2. Community Safety
3. Economic Stability
4. Education
5. Housing Stability
6. Mental Health and Substance Use *(see Appendix A)*[5]

Legacy Silverton Medical Center FY26–FY28 CHNA

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.[5] Accordingly, the data and findings from the 2025 MP-CHC CHA Community Status, Community Partner, and Community Context assessments form the foundation of this FY26–FY28 LSMC CHNA.

Prioritization of Community-Identified Issues

While the 2025 MP-CHC CHA[5] identified six areas for action, LSMC used an internal prioritization process to determine which issues it could most effectively impact over the next three years. The Legacy Health Community Benefit team and its Community Benefit Advisory Committee, which includes staff from across the system as well as external partners, participated in the prioritization activities. The process applied techniques recommended by NACCHO[13] and the Catholic Health Association of the United States of America.[14]

Participants began by reviewing the 2025 MP-CHC CHA findings *(see Appendix A)*.[5] Next, they evaluated the knowledge, skills, resources, conditions, and community partnerships available to LSMC to address the six priority areas. They also assessed the availability of evidence-based solutions and their feasibility to implement within the Legacy system or in collaboration with external partners.

After consideration of this information, participants ranked each of the six areas in terms of its viability as an actionable priority area. Results were combined and the collective rankings discussed. At the end of this process, three areas were chosen as the focus of LSMC's community health-related improvement efforts for the FY26–FY28 CHNA/CHIP period:

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

Health Needs Identified but Not Prioritized

The remaining 2025 MP-CHC CHA[5] priority areas (community safety, education, housing stability) are critical needs to intervene upon, but fall outside LSMC's current capacity and capability for involvement. Other health systems, public agencies or community organizations may act on these areas. Legacy Silverton Medical Center will support these efforts, when possible.

Resources for Action

Legacy Health is committed to dedicating resources to impact the three priority areas identified in this CHNA. This includes providing personnel time and technical assistance, access to health care and health-related services, and funding for Community Benefit initiatives, such as strategic partnerships and community health grants. Additionally, Legacy will leverage strategic community partnerships and other collaborative efforts to guide action and enhance the likelihood of long-term success.

For questions or more information

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

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Appendix A

The 2025 Marion-Polk Community Health Collaborative Community Health Assessment[5] can be accessed at: https://www.marionpolkcommunityhealth.org.

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