LEGACY HEALTH

Legacy Emanuel Hospital & Health Center

DBA

# Legacy Emanuel Medical Center

## Community Health Improvement Plan

FY27–FY29

*(April 1, 2026–March 31, 2029)*

## 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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*Legacy Emanuel Medical Center*

# Community Health Improvement Plan

## Overview

### Introduction

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

Legacy actively participates in the development and implementation of the regional community health needs assessment (CHNA) led by the Healthy Columbia Willamette Collaborative (HCWC).[1] The data and results of the HCWC CHNA provide the foundation for the Legacy Emanuel Medical Center CHNA. Legacy Emanuel then produces a community health improvement plan (CHIP) to guide its efforts on the community-identified priority needs selected in its CHNA.

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

### What is a Community Health Improvement Plan?

The Legacy Emanuel FY27–FY29 CHIP is a plan of action to respond to the key community needs identified in the HCWC 2025 CHNA[3] and prioritized in the Legacy Emanuel FY27–FY29 CHNA.[4] Guided by Legacy's mission of improving the health of the community, the Legacy Emanuel FY27–FY29 CHIP and its Implementation Strategy *(goals, objectives, strategies)* will direct Legacy's community health efforts and investments to address its prioritized needs *(access to healthcare, behavioral health, education and workforce development, and food security)* over the three-year period.

## About Legacy Health

Legacy 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 healthcare organizations)*
- More than 80 primary care, urgent care and specialty clinics
- More than 14,000 employees and 3,000 healthcare providers
- Partnership with PacificSource health plan
- Research and hospice

## Legacy Emanuel Medical Center

Legacy Emanuel in North Portland is a local and regional leader in serious clinical illness and injury. It is one of only two Level 1 trauma centers in Oregon and home to the only burn center between Seattle, WA, and Sacramento, CA. As a 554-bed facility, Legacy Emanuel provides a full range of services, including round-the-clock expertise for critical health issues, experts in trauma, heart care, burns, significant wounds, stroke, brain surgery and more.

Randall Children's Hospital at Legacy Emanuel is a regional center for infants, children and teens located on the Legacy Emanuel campus, providing advanced pediatric services as a designated Level IV neonatal intensive care unit (NICU), a verified pediatric Level I trauma center, and a verified Level 1 children's surgery center.

Unity Center for Behavioral Health is a collaborative partnership between Legacy, Adventist Health, Kaiser Permanente and Oregon Health & Science University (OHSU). The center provides immediate psychiatric assessment, crisis stabilization and inpatient behavioral health services for individuals experiencing a mental health crisis. Unity operates under the governance of Legacy Emanuel.

## Service Area

Legacy Emanuel defines its service area by geographic location and where its patients live. Legacy Emanuel serves a predominantly urban community located in North and Northeast Portland, Oregon, with a primary service area that extends across Multnomah County. Clackamas and Washington Counties in Oregon, and Clark County in Washington, comprise Legacy Emanuel's secondary catchment areas. These counties are also served by 14 other licensed hospitals, including four Legacy medical centers, Kaiser Sunnyside Medical Center, Oregon Health & Science University Hospital, PeaceHealth Southwest Medical Center, Providence Portland Medical Center and other regional providers. Despite the availability of these healthcare facilities, gaps in access remain. Transportation challenges, language and cultural barriers, and lower levels of trust in healthcare providers and systems continue to limit access to timely and appropriate care, especially for members of priority populations.[3]

Multnomah County includes an estimated 793,829 residents and reflects significant demographic diversity.[5] Approximately 30% of residents identify as people of color, including about 6% Black or African American, 8% Asian, 9% multiracial and 13% Hispanic/Latino/a. Language diversity in the community is notable, where 76% of residents speak English only, while about 8% speak Spanish and 6% speak an Asian or Pacific Islander language at home. Recent demographic trends show increasing racial/ethnic diversity and a continued rise in households speaking languages other than English, which has implications for accessibility and health communication.[5,6]

Residents in the primary service county have a median household income of $90,263[5] with approximately 13% living below the federal poverty level.[7] An estimated 6% of community residents are uninsured,[8] and 36% are Medicaid recipients.[9,10] Approximately 39% of patient encounters at Legacy Emanuel are covered by Medicaid.[11]

Within Multnomah County, the primary service county, several neighborhoods, including Rockwood and Flavel, are designated as Medically Underserved Areas (MUAs) or contain Medically Underserved Populations (MUPs).[12] These federal designations indicate communities facing persistent challenges related to healthcare access, socioeconomic vulnerability and other factors associated with health inequities.[13]

## CHIP Frameworks

The Legacy Emanuel FY27–FY29 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…"*[14] 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 and health equity in communities.[14, 15]

### Health Equity

*"…Equity means justice. Health equity means that everyone has a fair and just opportunity to be as healthy as possible."*[16] 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 healthcare, housing and safe environments, among others;
- Address historical and contemporary injustices through policy, programming and systems change; and
- Reduce and ultimately eliminate preventable health disparities.[15, 17–20]

#### *Health Disparities*

According to the Centers for Medicare & Medicaid Services, *"health disparities are differences in the incidence, prevalence, mortality, burden of diseases, and other adverse health conditions or outcomes that exist among specific population groups…"*[21] Disparities also can be observed *"…in health care access, coverage, and quality of care, including differences in preventive, diagnostic, and treatment services."*[21]

These differences "*…can affect population groups based on race/ethnicity, gender, age, socioeconomic status, geography, sexual orientation, disability, or special health care needs. Health gaps occur among groups who have persistently experienced historical trauma, social disadvantage, or discrimination and who systematically experience worse health or greater health risks than more advantaged social groups."*[21]

There are numerous ways to mitigate preventable health disparities. These actions vary by system and target population. In healthcare, 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 and linguistic responsiveness; 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.[22–27] Observed changes in health disparity indicators resulting from these or other interventions allow health systems, like Legacy, to assess progress toward achieving health equity.[17,20,25]

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.

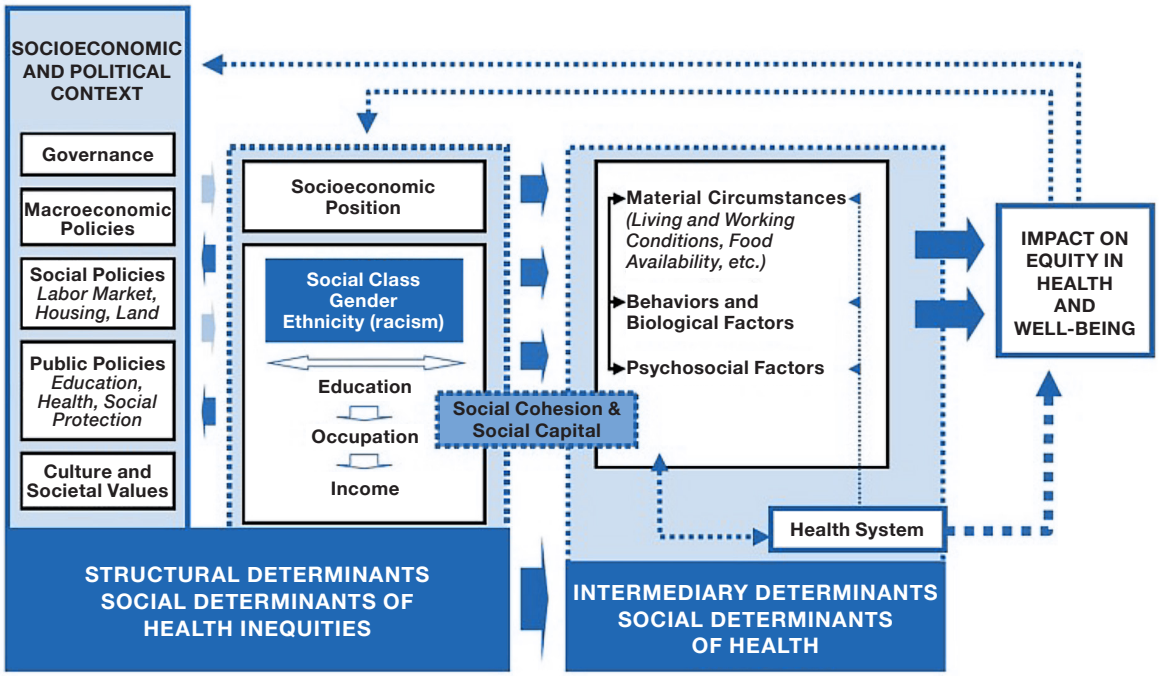


*Figure 1: World Health Organization Framework for Social Determinants of Health*[15,28]

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.[15,17,20,27] 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 healthcare 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; to cocreate, implement and support services, programs and policies focused on these issues and their root causes;

to evaluate changes resulting from these efforts; and then, if warranted, to modify practices and services.[19,20,25] 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.[15] 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.[15,17,20,26]

Through our CHNA and CHIP planning and implementation activities, Legacy Emanuel, 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 Needs

Legacy participated fully in the HCWC 2025 CHNA. The assessment provides a comprehensive view of the health and social needs affecting the communities served by Legacy Emanuel, confirming persistent community health issues while identifying emerging challenges across the region.[3] These and other findings from the HCWC 2025 CHNA served as the foundation for the Legacy Emanuel FY27–FY29 CHNA.[4]

### Prioritization Process

Legacy used a structured prioritization process to determine which of the community-identified needs reported in the HCWC 2025 CHNA[3] could be most effectively addressed during the FY27–FY29 CHIP implementation period. The Legacy Health Community Benefit team and its Community Benefit Advisory Committee participated in all prioritization activities.

The prioritization process implemented techniques recommended by the National Association of County & City Health Officials[29] and the Catholic Health Association of the United States of America.[30] Participants first reviewed the HCWC 2025 CHNA findings to understand the burden, scope and severity of each community-identified need and any associated health disparities affecting priority populations.[3] Next, they assessed each need in terms of the knowledge, skills, resources, conditions and community partnerships available within Legacy to remedy the priority need, and determined whether evidence-based solutions exist and are feasible to enact within the Legacy system or in collaboration with external partners.[31,32]

After evaluating this information, participants ranked each need in terms of its potential as an actionable priority area. Combined ranking results were reviewed and discussed. Consensus was reached on four priority needs for Legacy Emanuel to address through its community health-related improvement efforts during the FY27–FY29 CHNA/CHIP cycle:

1. Access to Healthcare
2. Behavioral Health
3. Education and Workforce Development
4. Food Security

### Health Needs Identified but Not Prioritized

The four needs Legacy Emanuel has prioritized for action are those it has the capacity and capability to affect using evidence-based and feasible interventions during the FY27–FY29 CHIP period. No single healthcare system or community health organization can resolve all the health and social issues present in the communities they serve.

When opportunities align with organizational capacity and priorities, Legacy Emanuel will support collaborative efforts among health systems, coordinated care organizations, public health agencies and community-based organizations to meet community needs not directly addressed in this CHIP.

## Summary of CHIP Planning Process

The Legacy Emanuel FY27–FY29 CHIP planning process included the following steps:

1. Engaged the Legacy Health Community Benefit team and its Advisory Committee in the development of the Implementation Strategy
   a. Reviewed the findings from the HCWC 2025 CHNA.[3]
   b. Evaluated the extent of current knowledge, skills, resources and conditions available within Legacy to address the four priority needs *(access to healthcare, behavioral health, education and workforce development, food security)* selected in the Legacy Emanuel FY27–FY29 CHNA.[4]
   c. Assessed the extent of partnerships Legacy currently has or could have with community-based organizations, other health systems, government agencies and other entities to collectively intervene on priority needs.
   d. Reviewed evidence-based solutions and interventions that address the identified priority needs.[31,32]
   e. Established goals for each of the four priority needs.

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 each objective.

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 Legacy Health Board of Directors.

## CHIP Implementation Strategy

The Implementation Strategy tables (pp 12–15) display the current goals, objectives and strategies for each of the four priority needs of the Legacy Emanuel FY27–FY29 CHIP. The components of this Implementation Strategy are drawn from evidence-based sources[31,32] and align with those used by partner health systems and agencies serving communities in Multnomah County, Oregon and beyond.

### Priority Populations

*"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."*[16] The Legacy Emanuel FY27–FY29 CHIP centers on priority populations: community members who have been historically or currently marginalized, disenfranchised or underserved. The primary focus of our CHIP-guided work will be on low-income, uninsured and underinsured members of these priority populations.

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 Legacy Emanuel FY27–FY29 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 experiencing or at-risk of housing instability or houselessness

• People experiencing or at-risk of food insecurity

### *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 Healthcare***

| PRIORITY NEED **Access to Healthcare** | |
|---|---|
| **Goal** | All persons can obtain necessary, timely, affordable, culturally and linguistically responsive, and trauma-informed health-related services, programs and resources that reflect the lived experiences of all persons. |
| **Objectives** | **Possible Strategies** |
| Increase access to health-related services, programs and resources for members of priority populations by the end of FY29 (March 31, 2029). | 1. Expand community-based navigation, referral and care coordination activities that connect individuals to health-related services, programs and resources.<br>2. Increase access to culturally and linguistically responsive health services and supports.<br>3. Reduce social, logistical and financial barriers that limit access to health-related services, programs and resources.<br>4. Support outreach, enrollment, renewal, navigation and coverage assistance programs that help eligible individuals obtain and maintain health coverage.<br>5. Support safety net organizations and programs that strengthen community-based care infrastructure and expand access to primary, specialty, preventive and supportive health services. |
| Increase the integration and sustainability of traditional health workers (THW) in clinical and community-based settings by the end of FY29 (March 31, 2029). | 1. Increase investments in traditional health worker training programs.<br>2. Integrate traditional health workers across the continuum of need *(healthcare, education, housing, food security, mental health, substance use, prenatal and postpartum care, etc.)*. |

## Current Strategic Investments Supporting CHIP Implementation for Access to Healthcare

### *Health Systems Access to Care Fund (HSACF)*

The Health Systems Access to Care Fund is a collaborative initiative led by major regional health systems. It provides funding to community supported clinics in Oregon and Southwest Washington to expand access to care, strengthen clinic capacity and respond to ongoing healthcare access needs.

**Population served:** Uninsured and underinsured populations with unmet access needs.

**FY27 baseline:** Financial support was provided through grants to ten safety-net clinics.

**FY29 target:** Maintain grant support for nine safety-net clinics.

### *Project Access NOW (PANOW) Payment Support Program*

In partnership with PANOW, this program helps uninsured and low-income community members access healthcare by covering insurance premiums and out-of-pocket costs through shared community investments.

**Population served:** Uninsured and underinsured populations with unmet access needs.

**FY27 baseline:** 2,677 community members served during FY24–FY26.

**FY29 target:** 2,750 community members served.

*Table 2: Behavioral Health*

| PRIORITY NEED **Behavioral Health** | |
|---|---|
| **Goal** | All persons have access to support systems that promote well-being and provide access to necessary, timely, affordable, culturally and linguistically responsive, and trauma-informed behavioral health-related prevention, treatment and recovery services, programs and resources that reflect the lived experiences of all persons. |
| **Objectives** | **Possible Strategies** |
| Increase access to behavioral health services, programs and resources for members of priority populations by the end of FY29 (March 31, 2029). | 1. Increase access to culturally responsive, trauma-informed and person-centered behavioral health services, programs and resources.<br>2. Reduce barriers that prevent individuals from receiving behavioral health services, such as cost, transportation, language and assessment requirements.<br>3. Strengthen community-based navigation, referral and care coordination activities that connect individuals to behavioral health services, programs and resources.<br>4. Support partnerships that integrate primary care and behavioral health services into supportive housing and other community-based settings. |

*table continues*

| PRIORITY NEED **Behavioral Health** | |
|---|---|
| **Objectives** | **Possible Strategies** |
| Increase community-based social connections that aim to reduce isolation and loneliness, strengthen supportive relationships and promote well-being for members of priority populations by the end of FY29 (March 31, 2029). | 1. Increase culturally responsive opportunities and programs that foster belonging, strengthen supportive relationships, and promote health and well-being.<br>2. Support peer-led approaches that strengthen social connections, supportive relationships and community well-being. |

***Table 3: Education and Workforce Development***

| PRIORITY NEED **Education and Workforce Development** | |
|---|---|
| **Goal** | All persons have access to a continuum of accessible learning, education, training, and credentialing opportunities and resources across the life course that mitigate structural barriers, support skill acquisition and advancement, and create pathways to economic mobility and stable, living wage employment. |
| **Objective** | **Possible Strategies** |
| Increase access to education, training and employment opportunities that enhance the competencies and career trajectories of members of priority populations by the end of FY29 (March 31, 2029). | 1. Expand pathways to employment through internships, apprenticeships, mentorship and work-based learning opportunities.<br>2. Support workforce development initiatives that create and sustain local pipelines for skilled healthcare and other workers into community-serving organizations, agencies and healthcare systems.<br>3. Increase education, training, skills development, job readiness and career advancement opportunities that support sustainable employment and professional success. |

## Current Strategic Investments Supporting CHIP Implementation for Education and Workforce Development

### *Internship Program*

In partnership with The Script *(formerly Emerging Leaders PDX)*, this program provides internships that create leadership and career development opportunities for individuals from underrepresented and diverse communities.

**Population served:** Underrepresented and ethnically diverse college students and recent graduates.

**FY27 baseline:** 10 student interns.

**FY29 target:** 13 student interns.

### *Corporate Work Study Program (CWS)*

In partnership with De La Salle North High School, this program provides internships that expose underserved students to healthcare careers, build real-world skills and support future success.

**Population served:** Underrepresented and ethnically diverse high school students.

**FY27 baseline:** No current baseline.

**FY29 target:** 10 high school students.

***Table 4: Food Security***

| PRIORITY NEED **Food Security** | |
|---|---|
| **Goal** | All persons have consistent access to affordable, safe and healthy food that meets their dietary needs and food preferences without social and structural barriers. |
| **Objective** | **Possible Strategies** |
| By the end of FY29 (March 31, 2029), increase the number of food insecure members of priority populations that have access to food that meets their dietary needs and food preferences without social and structural barriers. | 1. Increase investments in food banks, food pantries, meal programs and other food assistance initiatives that provide safe, nutritious, culturally responsive and medically appropriate food to people experiencing or at-risk of food insecurity.<br>2. Support medically tailored food and nutrition initiatives.<br>3. Strengthen food delivery programs that expand access to food for people who are homebound or face transportation barriers. |

## Evaluation Plan

Legacy Emanuel will monitor and evaluate the implementation and impact of the strategies applied to meet the objectives in our Implementation Strategy. 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 FY27–FY29 CHIP Implementation Strategy inform the community health efforts and investments Legacy Emanuel will make on its prioritized needs during the three-year period. Legacy is committed to providing access to healthcare 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.

## 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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## Appendix A: Legacy Health Board of Directors Approval

# Legacy Emanuel Medical Center

### *FY27–FY29 CHIP Board Approval and Adoption*

The Legacy Health Board of Directors reviewed and adopted the Legacy Emanuel Medical Center Community Health Improvement Plan (CHIP) on July 16, 2026.

The final plan was published on September 15, 2026, and made publicly available through the Legacy Health website.

**Legacy Health**

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