# **LEGACY HEALTH 2011 COMMUNITY NEEDS ASSESSMENT**

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# Legacy Health 2011 Community Needs Assessment

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# Legacy Health 2011 Community Needs Assessment

# Introduction

Legacy Health was established in 1989 by the merger of two systems composed of hospitals founded as early as 1875. Legacy Health includes Legacy Emanuel Medical Center and Legacy Good Samaritan Medical Center, located in inner city Portland; Legacy Mount Hood Medical Center, situated east of Portland; Legacy Meridian Park Medical Center, in the South Metro area; and Legacy Salmon Creek Medical Center, across the Columbia River in Southwest Washington. The Children's Hospital at Legacy Emanuel is on the campus of Legacy Emanuel Medical Center and serves Oregon and Southwest Washington.

Founded on a rich history derived largely from the Lutheran and Episcopal churches, Legacy has a mission of "good health for our people, our patients, our communities, our world." Consistent with this mission, in fiscal year 2011 Legacy provided \$77.7 million in charity care; total unreimbursed costs of care for people in need amounted to \$185.9 million.

A community's health is the product of many different factors. A model developed by the University of Wisconsin provides a useful rubric for examining these factors. The four groups are social and economic, health behaviors, clinical care and physical environment. The "health factors" section of this report is arranged according to these factors, following an overview of our service area, population changes and available health care services. The recommendations section also follows this format.

Our purpose is to determine the elements within the health factors that have the greatest impact on our communities, and to cross-walk them with Legacy's strategic priorities, available expertise and available resources.

The final product is a roadmap for how Legacy will address the community's health needs beyond its obvious role of providing direct care. Conclusions and recommended system wide activities are presented here, and will be complemented by tactics specific to each Legacy hospital service area (current IRS require-

ments call for hospital-specific plans). Those hospitalspecific plans will be developed over the coming months.

Quantitative secondary data for this analysis are focused on demographic characteristics, health factors and health outcomes derived from a review of national and local research. Our qualitative research consists of more than 100 interviews conducted by Legacy leadership with elected officials and leaders from the public sector, faith communities, business and community organizations from across the four-county Legacy Health service area.

# **Community profile**

## **Service area**

Legacy Health's primary and a significant portion of the secondary service area is the four-county metropolitan Portland area: Multnomah, Clackamas and Washington counties in Oregon, and Clark County in Washington.

## **Population**

In November 2010, the Portland State University (PSU) Population Research Center reported the Oregon metro area tri-county population at 1,644,535 residents; including Clark County, the four-county population is 2,080,926. The entire state experienced significantly slower growth this past year than previously forecast. Population growth in Oregon from 2009 to 2010 was 0.5 percent, the lowest since the early 1980s. Still, Multnomah, Clackamas and Washington counties accounted for 62 percent of the statewide growth, and Washington County showed the greatest percent growth statewide.

It is estimated that if the economic recovery continues to be slow, population growth will continue at a similar rate, leading to a four-county metro area population of 2.2 million in 2015.

The Portland metro area is home to 47 percent of the state's population, and accounted for 44.9 percent of births in Oregon in 2007. County rankings in the

metro are shifting. In 1960, 59 percent of the population lived in Multnomah County; by 2008, it was only 33 percent.

Median age varies only slightly by county, ranging from 35 to 39 years. Clackamas County has the highest population 65 years and older, at 12 percent, and Washington County the lowest at 9 percent.

## Racial and ethnic diversity

The Portland metro population in 2009 was primarily non-Hispanic white (76.7 percent). Other cohorts were Hispanic (10.7 percent), African American (2.9 percent), Asian (5.6 percent), Native American (0.7 percent) and bi-racial (3.0 percent). Communities of color in the Portland metro area grew by 40.7 percent between 2000 and 2008, more than seven times the overall population growth in the region.

Hispanics constitute the second-largest population by race/ethnicity in each service area. (Note: Hispanic and other diverse populations are acknowledged to be undercounted in the census, so the numbers are likely higher.) Hispanics are moving into the region at a higher rate than any other group (more than doubling in numbers in the past 15 years) and have a higher birth rate than other communities of color. The Hispanic population accounts for about one-fifth of the births in Oregon and Washington, while it makes up just one-tenth of the population. Between 1995 and 2004 babies born to Hispanic mothers increased 67 percent. It is projected that communities of color will make up the majority of the Oregon population by 2040 and that 25 percent of the population will be Hispanic.

The African American/black population continues to be concentrated in the historical neighborhoods of North/Northeast Portland, but rising housing prices have resulted in the community moving increasingly to east Multnomah County. Multnomah County continues to have triple the percentage population of African Americans as the other three counties. Washington and Multnomah Counties have the largest Asian population percentages.

The immigrant and refugee population is increasing significantly in the region. Nearly one-third of these populations arrived after 1995 and half have arrived since 1990. Recent immigrants and refugees are more likely to be culturally and linguistically isolated. Speaking a language other than English at home has

increased significantly, particularly in Washington County where one in five people falls into this cohort.

A small but increasing African refugee population has settled primarily in North, Northeast and Southwest Portland and mid-Washington County and is distinct from the African American/black population. Available data suggests that in general, the African population is poorer than other communities.

While still a small population relative to the entire metro area, specific geographic areas are experiencing significant growth in the Slavic population. This is the case in Clark and Multnomah Counties and the far southern metro. Slavs are counted in the non-Hispanic white population, but they have a distinct cultural identity. As with African immigrants, their socioeconomic status is generally lower than other non-Hispanic white populations.

It is clear that overall, while the region's population is growing slowly, its composition is changing dramatically. We are seeing significant increases in demographics that have lower income levels, less education, lower health status and lower health literacy. These issues will be detailed in the "health factors" section of this report.

These changes have major implications for organizations such as Legacy Health that want to improve the overall health status of their communities. Efforts directed at the diverse communities will likely make the largest difference. Further, health reform will likely bring coverage to these populations in disproportionate numbers, posing a challenge for health care delivery.

# Health status/ health outcomes

The current health status of our four-county region can be assessed using both vital statistics and accepted indicators of health status.

## **Mortality**

The Crude Death Rate and Age Adjusted Death Rate in Oregon were both greater than the national averages in 2007 and 2006 while the Washington rates were lower than the U.S. averages. Multnomah County and Clark County had death rates higher than their respective state averages, and Premature Death Rates were aligned in similar patterns.

The most common causes of mortality in Oregon and Washington are consistent with the rest of the nation: heart disease and cancer. Cardiovascular disease accounts for over 30 percent of annual deaths and is the single largest cause of death nationally. One exception here was 2006, when the cancer age adjusted mortality rate in both Oregon and Washington was ranked first over heart disease. Washington County experiences the lowest rate among the four counties in our service area both in cancer and heart deaths, and Multnomah County the highest.

Disaggregated mortality data by race and ethnicity reveals concerning patterns. African Americans had the highest or second highest in age adjusted total, heart and diabetes mortality rates as well as infant death rates. Native Americans also experienced very high rates of total heart and diabetes deaths; infant mortality figures are not available. The African American and Native American mortality rates were double or triple the rates of Hispanics and Asians, who experience the lowest rates overall.

Infant mortality is an accepted indicator of a community's health status. African American women experienced nearly double the infant mortality rates of non-Hispanic white and Hispanic women in 2006 and 2007.

## **Morbidity**

A community's health morbidity statistics commonly include those diseases most related to high mortality (heart, cancer and low birth weight), chronic conditions such as cardiovascular disease, diabetes and asthma, and self-reported health and mental health status (the latter have been statistically validated as predictors of community health status). Individuals with multiple chronic diseases often also experience other risk factors such as obesity and smoking, and use health care services to a greater degree.

The economic cost of racial and ethnic disparities is significant. The Urban Institute reports the estimated national cost of racial and ethnic disparities for African Americans and Hispanics in 2009 (calculated based on change in expenditure if the cohort's age specific prevalence rates were the same as non-Hispanic whites) was \$23.9 billion. State specific estimates are not available for Oregon and Washington, but for comparison purposes California was estimated at \$6.0 billion and North Carolina at \$390 million.

### Low birth weight

Low birth weight is correlated to adult morbidity, specifically hypertension, diabetes and heart disease. In 2007, low birth weights in Oregon and Washington were the same (6 percent) and the variation between counties was minimal. While African American and Hispanic women had prenatal care in the first trimester in similar percentages, African Americans had nearly double the rate of low birth weight babies (and infant mortalities) as Hispanic women. Hispanic women's low birth weights and infant mortality rates were equal to non-Hispanic whites even though prenatal care percents were over 12 percentage points less. This information is consistent with national data.

#### Heart disease

Major risk factors for heart disease are smoking, lack of physical exercise, hypertension and overweight/obesity. In 2006, the cost of hospitalizations in Oregon for heart and stroke totaled more than \$1.2 billion. As with heart disease mortality, communities of color experienced the greatest morbidity rates. In 2005, age adjusted coronary heart disease prevalence in Oregon was 4 percent for African Americans, 8 percent for Native Americans and 4 percent for Asian/Pacific Islanders compared to 4 percent for non-Hispanic whites. The prevalence of hypertension among Oregonians has been stable the last few years while the prevalence of high cholesterol increased.

#### Cancer

Cancer incidence in 2007 showed slightly greater rates in Oregon and Washington than the U.S. National Cancer Institute data, not detailed here, which showed Hispanic and Asians with the lowest rates among races and ethnicities.

#### **Diabetes**

Diabetes is increasing at an alarming rate. The prevalence in Oregon is 35 percent higher than 10 years ago, and Washington reported a 54 percent increase between 1994 and 2006. People with diabetes are more likely to also have heart disease and self-report their general health as fair or poor as compared to good or excellent. The elderly are more likely to have diabetes (15 percent of Oregonians 65 years and older) as are low-income persons.

Diabetes is more prevalent in communities of color. Percents in Oregon and Washington in 2005 were similar: African Americans (13 percent/14 percent), Native Americans (12 percent/12 percent), Hispanics (10 percent/9 percent), Asians (7 percent/9 percent) and non-Hispanic whites (6 percent/6 percent). Even controlling for income, education, age and gender, African Americans and Native Americans showed significantly higher prevalence than non-Hispanic whites. According to studies, communities of color are also more likely to have diabetes-related complications at two to four times the rate of non-Hispanic whites. This is seen as due to poorer control of the disease and comorbidities (i.e., high blood pressure and cholesterol), as well as poorer access to care.

# Health factors

The previous section outlines the current health status of our region. In this section, we examine the factors that lead to that status. A community's health is the product of many different factors. A model developed by the University of Wisconsin provides a useful rubric for examining them. The four groups of factors are social and economic, health behaviors, clinical care, and physical environment. This section of this report is arranged according to these factors. The following chart shows the factors and the percentage impact they are thought to have on community health status:

Social and economic	40%
Health behaviors	30%
Clinical care	20%
Physical environment	10%
	100%

## Social and economic factors

Social and economic determinants include such items as education, health literacy, employment, income, housing and community involvement.

#### **Education**

Education is often cited as the key to upward social and economic mobility for individuals and, in turn, a community's health status. Research has concluded that if Americans without a college degree experienced the lower death rates and better health of college graduates, the improvements in health status and life expectancy would be worth more than \$1 trillion annually.

The 2009 high school graduation and college degree rates of individuals 25 and older in Oregon and Washington were better than the U.S. averages. Again, however, disaggregated data reveal distinct differences among races and ethnicities. The high school completion rate of non-Hispanic whites in Oregon is 91.4 percent, compared with 86.6 percent for African Americans, 85.6 percent for Asians, 84.1 percent for Native Americans, and 54.7 percent for Hispanics. An analysis of Multnomah County suggests that high school dropout rates for children of color are nearly twice that of white children. College completion rates have a similar pattern: 29.2 percent for non-Hispanic whites, 20.1 percent for African Americans, 12.8 percent for Native Americans, and 10.4 percent for Hispanics. The outlier is the much higher college graduation rate for Asians at 45.7 percent.

The combination of disparities in educational achievement within communities of color and the increasing diversity of the total population is resulting in an overall decrease in high school and college completion rates in the current population.

Gaps in achievement begin in early childhood. Children entering first grade without school readiness skills continue to be behind throughout school. Children of racial and ethnic diversity are more likely to enter school lacking these skills. With the increasing diversity in our region, the overall graduation rate will continue to decline.

#### **Health literacy**

Health literacy is linked to functional literacy — reading, writing, arithmetic — but also includes a social dimension. It is the ability to obtain, process and understand health information in order to make appropriate health decisions and practice positive health behaviors. The National Patient Safety Foundation has said that no other single factor has as great an influence on health status, and studies have determined that health care utilization and expenditures are far greater in the presence of low health literacy.

Nearly half of the U.S. adult population has low health literacy. Low health literacy is a quality and cost issue for patients and society. Patients with low health literacy are less likely to comply with treatment, are less likely to seek preventive care, and enter the health care system sicker. Patients with low health literacy are twice as likely to be hospitalized. Annual health care costs for people with low health literacy are four times

higher. The economic burden of low health literacy has been variously estimated to be \$106–\$238 billion annually. Higher illness rates mean lower productivity at work, and poor parental health often results in low student school attendance — with a direct correlation to lower educational achievement.

Evidence points to low health literacy as a significant cause of low patient compliance, which in turn is correlated with provider dissatisfaction. Patients out of compliance have a lower quality of care and lower quality of life.

We do not have local data on low health literacy, but nationally research has shown that specific populations are particularly at risk:

- Hispanic, African American and Native American populations
- Recent immigrants
- People age 65 and older

The growth of communities of color in our region will present significant challenges to health care providers by increasing the prevalence of low health literacy. If the number of insured people is increased by health care reform, the bulk of the newly insured will be from those populations most at risk for low health literacy: minorities and the poor. Unlike many modifiable health behaviors, the onus for dealing with health literacy falls primarily on health care providers.

This situation was identified early on in our assessment process as something that should be a key part of our community benefit activities.

#### **Employment/income**

Educated workers attract higher-wage businesses to the community. In turn, higher wage jobs mean higher worker benefits and disposable incomes. Employment is correlated to levels of income, family and support systems and community safety. When these factors are jeopardized, health status is challenged.

Oregon has suffered greatly in the current recession, ranking second in national unemployment at times. In 2009 Oregon had an unemployment rate of 11.8 percent as compared to the U.S.'s 9.9 percent and Washington's 9.5 percent. Our three Oregon counties had rates slightly less than the state average, while Clark County was a full three percentage points greater than the Washington average.

Oregon's 2009 per capita personal income was 9 percent lower than the national average and Oregon ranked 32nd among states. Reasons behind this include Oregon's higher unemployment rate, higher rate of part-time jobs and shorter average workweek.

Data by race and ethnicity reveal distinct disparities in unemployment statistics. In 2009, the unemployment rate for African Americans, Hispanics and Native Americans were nearly seven, three and five percentage points greater respectively than non-Hispanic whites in Oregon. The trend was similar in Washington. Asian/Pacific Islanders showed unemployment rates lower than state and county averages in all categories.

Consistent with other statewide indicators, Washington's median household income in 2009 was greater than Oregon: \$56,548 vs. \$48,475. All three counties in the Oregon metro Portland area had higher median household incomes than the state as a whole.

Racial and ethnic cohorts varied greatly. Incomes were highest for Asians, and generally lowest for African Americans and Native Americans. Poverty is highly correlated to poor health. Persons with lower incomes are more likely to have chronic diseases, higher acuity illness, disability and premature death. Low-income individuals are much more likely to self-report themselves (and their children) as being in poor or fair health compared to people with higher incomes.

Households headed by females are even more at risk for poverty. In Oregon in 2008, more than 50 percent of Hispanic and African American families headed by females were at poverty level, compared to one-third of non-Hispanic white families headed by females.

Poverty is increasing generally with the distinct shift in industries from manufacturing and resources to service sector jobs. Jobs paying less than \$30,000 annually have accounted for 63 percent of all net job growth since 2000. Nearly 60 percent of families living below the federal poverty line have a household member who works and 14 percent have a full-time year-round worker. The recent recession has left many people with no job at all.

An analysis of poverty rates in Multnomah County places the poverty rate for communities of color at more than twice that of white communities.

#### Housing

Home ownership is considered a significant contributor to long-term stability and, in turn, positively correlated to education achievement and better health status and income. Consistent with income and poverty differences, Multnomah County had the lowest home ownership at 54.9 percent in 2009, compared with a high in Clackamas County at 70.4 percent. Race and ethnic differences were apparent, with homeownership at 70.9 percent for non-Hispanic whites, 48.0 percent for Hispanics, 44.5 percent for African Americans, 54.6 percent for Native Americans and 59.0 percent for Asians/Pacific Islanders.

The national standard is that renters should not pay more than one-third of their income in rent. Oregon is ranked third and Washington ninth as the most unaffordable rental markets in the nation. In 2009 over 40 percent of renters in three of the four counties allocated more than 35 percent of their income in rent. Households with severe housing cost burdens are more likely to have higher rates of food insecurity and lack health insurance.

This overview of social and economic factors, which in the University of Wisconsin analysis contributes 40 percent of the impact on community health status, shows a clear pattern. There is a distinct portion of our population that has lower educational attainment, lower health literacy, higher unemployment, lower income and less affordable housing. Moreover, that population is largely African American, Hispanic and Native American. Any efforts to improve social and economic factors would logically focus on these cohorts.

## **Health behaviors**

Individual behaviors account for the second greatest impact among the Health Factors. Risk factors such as obesity, tobacco use and substance abuse are each significant contributors to mortality and morbidity.

### Obesity

Obesity is now considered among the top public health issues in the country. Reduced physical activity, convenience foods and fast foods have doubled the rates in adults in the last two decades. In Oregon and Washington in 2009, nearly 60 percent of adults were overweight or obese and about 25 percent were obese — consistent with national statistics.

The increasing prevalence of children who are overweight and obese is of great concern, carrying increased risk of chronic disease, asthma, respiratory problems, orthopedic conditions and — importantly — of being overweight or obese in adulthood. The Centers for Disease Control reports that the prevalence of childhood obesity tripled nationally between 1976 and 2008, from 5.5 percent to 16.9 percent. Adding in the percentage who were overweight, nearly 50 percent of children were overweight or obese. While all age cohorts increased rates, teens increased the most.

One measure of the effect of obesity on health and health care costs is the projection that one-third of all children born in 2000 will acquire Type 2 diabetes, which is associated with obesity. The difference for children of color is staggering: an estimated 50 percent will acquire the disease. The Washington State Department of Health reported in 2006 that the increase in obesity rates contributed to about 60 percent of the diabetes prevalence increase.

Research indicates that obesity rates are higher for adults with lower incomes and lower education levels even after adjusting for gender, race and ethnicity, and age. In Washington, the 21 percent obesity rate of adults with household incomes of \$50,000 or more was a third less than that of adults in households less than \$20,000 in 2009.

Race and ethnicity also has an impact. Oregon data is not available, but in Washington in 2009, 24 percent of the adult non-Hispanic white population was obese, as was 30 percent of the Hispanic population, 30 percent of the African American population, and 36 percent of the Native American population. Only 11 percent of Asians were obese.

#### Tobacco use

Smoking is considered one of the two most prominent individually based risk factors for disease and the most preventable cause of death and disease (the other being obesity). Smoking is correlated to cardiovascular disease and cancers including lung, cervix and bladder. Adults with three or more chronic diseases are three times more likely to have smoked or be current smokers.

Smoking rates in Oregon and Washington stood at 16.3 percent and 15.7 percent respectively in 2008. Rates have decreased over time with state prevention programs, higher cigarette taxes and bans on smoking in public places. Still, these rates are unacceptably high.

#### **Teen births**

Teen birth is one of the most powerful predictors of poverty. Teen birth rates (ages 15–19 years) decreased in Oregon and Washington by more than a third between 1991 and 2006. There are differences in our counties, ranging from Multnomah County at 39 births per 1,000 to Clackamas at 24. Race and ethnicity data also showed significant differences in 2007. Ranked in order from lowest to highest rates: Asians, non-Hispanic whites, African Americans, Native Americans and Hispanics.

With rates of 93 teen births per 1,000 in the Hispanic population, 44 in the African American population and 54 in the Native American population, these cohorts are at significantly increased risk of poverty, and, in turn, at significantly increased risk of poor health status.

## Clinical health care

#### Health care services

There are 14 licensed hospitals in the four-county Legacy Health service area — 13 nonprofits and one public corporation (Oregon Health & Science University). Two full-service children's hospitals are within two of the hospitals' licenses. Legacy Health comprises five hospitals and one Children's Hospital with 1,578 licensed beds, 18 primary care clinics, 22 specialty clinics and 10,000 employees.

Four Legacy hospital primary service areas include Medically Underserved Areas (MUA): Legacy Emanuel (St. Johns community and Southeast Portland), Legacy Mount Hood (Rockwood), Legacy Meridian Park (Southwest Clackamas County) and Legacy Salmon Creek (Central Vancouver). Legacy Emanuel, Legacy Good Samaritan and Legacy Salmon Creek each include at least one non-public sector Federally Qualified Health Center (FQHC), and one has applied to be established in Legacy Mount Hood's service area. Multnomah County Health Department Clinics in the Emanuel, Good Samaritan and Mount Hood areas are FQHCs. Clackamas County Health Department Clinics are also FQHCs but are located in areas further from Legacy Meridian Park. All primary service areas include at least one volunteer-based safety net clinic.

Legacy Medical Group clinics in Sandy (Legacy Mount Hood service area) and Canby (Legacy Meridian Park area) are designated Rural Health Centers.

#### Services to those in need

Legacy Health is consistently a leader in providing charity care and unreimbursed care in the metro Portland area in terms of both dollars and percentage of expenses. Legacy's charity care policy includes patients with incomes up to 400 percent of the Federal Poverty Level. Eighty percent of uninsured patients do not pay anything, and 15 percent pay a small portion of their bill. The reduction in patients covered by the Oregon Health Plan resulted in Legacy's charity care increasing from \$8.8 million in FY 01 to \$77.7 million in FY 11; charity care alone accounts for 6.2 percent of operating expenses. Unpaid costs of public programs, i.e., Medicaid and Medicare, also continue to rise. In FY 11, total unreimbursed costs were 14.8 percent of operating expenses.

Catholic Healthcare West and Thomson Reuters developed the Community Needs Index (CNI), a tool that produces a composite picture of needs using a variety of demographic and socioeconomic indicators. The five areas measured are income, culture (race, ethnicity, language), education, insurance and housing. The tool has been validated by comparing it with hospital admission rates. Admission rates for highly needy communities as measured by the CNI are more than 60 percent greater than communities with the lowest indices. The CNI is increasingly being used as the national standard in identifying communities with health disparities and comparing relative need.

Comparison of Legacy top self-pay ZIP codes by dollars and cases shows consistency with CNI mapping. Nine ZIP codes accounted for 28.4 percent of Legacy self-pay (generally free) care dollars in FY 10, or \$48.8 million, and all score in the upper ranges of the CNI. The locations of three of the top four are not surprising: directly north of Legacy Emanuel in St. Johns (97203 and 97217) and next to Legacy Mount Hood (97030). The fourth is located in the heart of Legacy Good Samaritan's neighborhood, and in fact includes the Legacy Health System Office (97209).

This type of mapping allows for highly selective targeting of initiatives to areas where they are needed most.

#### Access to care

Lack of access is correlated with increased rates and severity of chronic diseases, hospitalizations and mortality. Access is influenced by a number of factors: health insurance, proximity to services, transportation, income, culture, language, and provider acceptance of uninsured, Medicaid and Medicare patients.

The poor and those of diverse race and ethnicity have a disproportionate impact from lack of access to care. The Agency for Healthcare Research and Quality reports that Hispanics receive worse care across 60 percent of core quality measures. The Robert Wood Johnson Foundation reports that low-income people on average receive worse care across 12 of 17 quality measures, including access to care, cancer screening and preventive health services.

#### Health insurance

Health insurance coverage is significantly correlated with health status. The uninsured are 2.8 times more likely than the insured to be hospitalized for diabetes, 2.4 times more likely for hypertension and 1.6 times for pneumonia. One study reported that case management of Oregon Health Plan patients produced a 43 percent reduction in emergency department visits, illustrating the value of insurance.

Oregon has had a higher uninsured rate than Washington, most recently 18.0 percent vs. 12.5 percent. Increasing numbers of working people are uninsured. Employers offering health benefits decreased from 69 percent in Oregon in 2000 to 60 percent in 2005. In addition, even when employers offer coverage, there are increased restrictions related to eligibility. Adults 18 to 64 years are more likely to be uninsured than children or seniors.

Nationally, 50 percent of the uninsured are people of color. Uninsured rates vary significantly by race and ethnicity in Oregon (Washington data are not available). In 2008, Native Americans and Hispanics experienced nearly triple the uninsured rates of non-Hispanic whites: 29.3 percent and 28.2 percent respectively as compared to 11.3 percent.

#### Provider and services availability

Oregon and Washington both have fewer primary care providers than the ideal target of 175 per 100,000 people. The rates differ enormously among counties, consistent with hospital locations and population

density. Availability is a particular issue in low income areas, where physicians do not tend to locate. (An exception is the 97209 ZIP code, which despite its high CNI number has a large population of physicians due to the presence of Legacy Good Samaritan Medical Center within the ZIP code.)

Preventive screenings are an additional indicator of health care access. Sigmoidoscopy and colonoscopy rates between Oregon and Washington were consistent — about 66 percent for those over 50 years — as was cholesterol screening at just over 72 percent. Diabetic screenings for those 65 years and older averaged about 85 percent across all counties probably due to seniors having access to health insurance through Medicare in 2006. Additional county level screening information is difficult to obtain.

Receiving prenatal care in the first trimester is a health care access indicator and is correlated with low birth weight and infant mortality. In 2006, Oregon's rate of women obtaining prenatal care in the first trimester was nine percentage points higher than Washington's — 79.2 percent compared to 70.3 percent. Data are not available across all counties. Disparities in accessing prenatal care among race and ethnicity cohorts were described in the Morbidity sections, including how different races and ethnicities display varying low birth weight and infant mortality numbers.

Childhood immunization rates are also an indicator of health care access. In 2009, 72 percent of children 19–35 months in the U.S. had their immunizations as compared to 75 percent in Washington and only 67 percent in Oregon. Washington's percent has increased significantly over the last seven years. Both Oregon and Washington remain below the national goal of 80 percent.

## **Physical environment**

The physical environment plays a role in community health. Indicators that are tracked include quality (air, noise and water) and the built environment (access to healthy food, transportation, trails and sidewalks). Research over the last two decades clearly identifies the relationship between neighborhoods with higher-income families and increased access to grocery stores and availability of physical access opportunities, e.g., sidewalks, trails. Some studies have even suggested that health status can be correlated with ZIP code, which the CNI method validates.

Access to healthy food makes healthy choices easier. The Urban and Environmental Policy Institute in 2002 reported that middle and upper income neighborhoods had twice as many supermarkets as low-income neighborhoods. The national target is that 70 percent of a community's census tract boundaries will be within one half mile of a healthy food retail store. Within Oregon and Washington in 2006, only 47 percent of the states' census tracts met this target. Clackamas, Clark and Washington counties were over 60 percent while Multnomah County was at 45 percent. Access to healthy food is a serious problem in many parts of our service area.

The number of liquor stores per 10,000 people is a reverse health status indicator. Multnomah County had 0.7 as compared to Washington and Clackamas at 0.4 each and Clark County at 0.3. In addition to having the highest incidence of liquor stores per 10,000 people, Multnomah County has the greatest population density, highest poverty levels and lowest health status.

# Stakeholder assessment

Quantitative research provides a detailed look at data and trends in specific population cohorts, while one-on-one interviews with key stakeholders provide context. Between August and December 2010, Legacy Health leadership interviewed 109 elected officials and public sector, faith, business and community leaders from across the metro area, including representatives of communities of color. Interviewees were intentionally selected based on their direct involvement with organizations and/or issues in the service areas, i.e., they have played visible roles in addressing community needs.

A standard set of questions elicited responses encompassing community health, primary issues facing the community, health and public health issues, roles of health systems in addressing needs and whether issues for people of cultural, racial and ethnic diversity differed from other populations.

Stakeholders provided a rich interpretation of community health, including types of care (e.g., physical, mental, dental), social determinants of health (education, income/jobs, health care, community engagement, environment and housing), individual assets

(e.g., stability, emotional, spiritual) and community assets (e.g., interconnectedness, access, quality, interdependence). A thread of "inclusion" ran through most of the interviews, a belief that all individuals must have access to the community's assets and that disparities and inequities must be challenged and addressed in order for a community to be defined as truly "healthy." As with our earlier examination of data concerning the factors that influence a community's health, the actual provision of health care services was seen by most respondents as less important than economic and social factors.

Following is a summary of what we learned from the stakeholders.

## **Community health characteristics**

Asked about the definition of "community health" and what a healthy community looks like, stakeholders designated the three most important characteristics in a community's health from a list. Nearly two-thirds cited income/jobs followed by education (just over half). Health care ranked third. These three characteristics were each nearly double the others. Housing, social/human services and community Involvement followed in the rankings.

## Community needs/issues

Assessment of community needs and issues reflects the gap between the previous question's ideal state and the current reality. The same three most important characteristics of a healthy community were cited as the three greatest issues, but in a slightly different order. Income/jobs remained in first place, mentioned by nearly two-thirds of the stakeholders. Health care access was in second place (viewed in terms of access, health care becomes primarily an economic issue rather than an availability or quality issue). Education and housing were next, followed by disparities/ equity/culturally appropriate/cultural competency. Again, disparities and equity issues are seen as barriers to the higher-level items like income/jobs and access to health care. There was a consistent theme about the lack of voice for communities of color and institutional racism resulting in disparities and inequities. Not surprisingly, mental health was mentioned by nearly one-fifth of the respondents. If addiction/ substance abuse are included in mental health, fully a quarter of respondents cited it as an issue.

## **Community services lacking**

A similar but more specific question regarding the gaps in community health asked stakeholders about services lacking to address and resolve community needs. In addition to the community characteristics addressed in the first two questions, this question elicited observations about actions, processes and infrastructure. Public and private service providers expressed concern about the lack of funding for current services resulting in an inability to meet community need. Changing demographics and the economic recession have increased need while budgets have been reduced. A lack of services connecting people to resources was seen as a significant barrier, as was a lack of collaboration among services.

Not surprisingly, health care access for the low income and uninsured (insurance coverage, primary care providers, safety net clinics) was mentioned by a third of the respondents. Nearly a quarter identified the lack of mental health and/or substance abuse services. Also seen as an issue is the lack of culturally appropriate services and providers who reflect the race and ethnicity of the client population. Lack of affordable housing concerns centered around the challenges of providing comprehensive services for the homeless — when individuals are in stable housing, providers are better able to serve their health and other needs.

## Health care/public health issues

Similar patterns emerged responding to a question about health/health care/public health needs. The overwhelming majority cited access for low income and uninsured (coverage and affordability), over a third cited mental health and/or addictions/substance abuse, followed by chronic diseases, prevention and education, and obesity. These concerns center around the role of government, specifically health policy. Interviewees were vocal about health disparities for communities of color and some proposed that an equity lens be used in looking at all issues and needs. Concerns about the impact on the future generation of the significantly increasing numbers of children experiencing chronic disease and obesity were shared, particularly for communities of color due to the adult mortality and morbidity disparities resulting.

# Racial/ethnically diverse community issues

We asked specifically about health disparities for communities of color, given the findings of our data review that demonstrated significant and increasing concerns in this area. The majority of stakeholder input indicated that the health care and social needs of these populations were essentially the same, but that the intensity of the needs were exacerbated; i.e., communities of color have fewer resources and experience magnified barriers across all factors. Several respondents noted that these communities do not have sufficient voice in policy discussions and civic projects.

## Hospitals' roles

Stakeholder recommendations for the role of hospitals in community health centered primarily on relationships, leadership and advocacy. Recommendations were for increased partnerships with community-based organizations in terms of services, dollars and labor; increased advocacy with elected officials; increased collaboration with other health systems; and increased role serving as conveners for discussions about health care issues. Stakeholders felt that health systems would influence issues most effectively and efficiently by working in broader and deeper partnerships with fewer organizations.

## Conclusion

This report paints a picture of a region in which significant segments of the population are less well off across a range of measures — economics, education, health and more. Poverty, lack of education and poor health status do not respect race, but it is clear that communities of color bear a disproportionate burden. The 2010 report *Communities of Color in Multnomah County*, while it focuses only on Oregon's most populous county, notes that "suffering a legacy of racism and unequal treatment has imperiled our health and well-being."

What is more, the size of the communities of color in our region is growing rapidly. If economic, education and social systems do not change course to reduce historic inequities, these inequities will only become a greater factor in the community's health. Meanwhile,

one of the promises of health care reform is coverage for those who currently do not have health insurance. Those newly insured will be disproportionately from communities of diversity, and thus as a whole this newly insured population will be significantly less educated, poorer and have lower health status and greater health care needs.

If we are to address the health care-related needs of our community, and turn first to the most serious need, that need is found in communities of color. Our mission and our desire to have the greatest impact possible leads us to consider our community benefit activities through this lens.

The range of possible activities is tremendous, therefore, we will prioritize using the following broad criteria:

- 1. **Size**: The number of people affected, and the geography impacted.
- 2. **Seriousness**: The impact on the region's health, on its economic strength, and on its institutions.
- 3. **Change potential**: The potential for positive intervention, and the sustainability of positive impact.
- 4. **Legacy's strategic plan**: The alignment of the issue with one of our areas of strategic focus, and with our mission.
- Capability: The extent to which Legacy has the resources and expertise to have a significant impact.

With these criteria and through the lens of racial and ethnic equity, we will present our analysis of community needs and our response using the health factors model by which our analysis was organized earlier. Within each factor, we will note the specific needs that we believe Legacy can address, describe our current activities to meet those needs, and propose new or expanded activities.

# **Action plan**

Legacy Health has a history of providing a multitude of services and assistance to meet community needs. Our charity and unreimbursed care alone sets us apart from the rest of the community, as we provide a higher percentage of our operating funds to this care than any other system in the region.

On the following pages, we show areas in which we believe Legacy is making a difference or can make a difference. We have arranged them according to the health factors model and considered the criteria spelled out earlier to prioritize our activities.

Our assessment has a few very clear conclusions that guide what we will continue to do and what new activities we will undertake with available resources. In short, we are focused on service to communities of color, on youth and their education, and on health literacy as a key to helping people take charge of their health. We of course will continue to be a significant provider of charity care and to help people without insurance gain access to care.

Please see the following pages for Action plan details.

# Action plan details

Need	Current actions	New initiatives/ opportunities
Social/economic factors		
Education	<ul> <li>Youth Employment in Summers (YES) — paid summer employment and college scholarships</li> <li>High school health care internships</li> <li>Clinical rotation sites for 20 health care programs</li> <li>College scholarships for low-income students</li> <li>Multnomah County Summer Youth Connects</li> <li>Community Health Fund (CHF) grant: Clark County At Home At School summer academic enrichment for homeless and at risk youth</li> <li>Contributions and board representation to youth development organizations focused on education achievement for students of color, e.g., NAYA, SEI</li> <li>In-kind and financial contributions to education efforts, e.g., partner schools, employees volunteering and school supply drives</li> </ul>	Focus on increasing diversity of workforce, partnering with outside organizations
Health literacy		<ul> <li>CLEAR Initiative: Building awareness and education. Inventory of departments' current practices.         Departments developing action plans.         Lead building community awareness.</li> <li>Partner with community-based organizations to increase health literacy in at-risk populations</li> <li>Oregon and SW Washington Health Literacy Conference</li> </ul>
Employment/ Income	Diversity Initiative, including Legacy recruitment, employment and construction and purchasing contracting	

Need	<b>Current actions</b>	New initiatives/ opportunities
Health behaviors		
Obesity	<ul> <li>CHF grant: Children's Community Clinic (safety net clinic) to care manage patients with chronic diseases and obesity</li> <li>Weight loss programs and challenges offered at sites</li> <li>Diabetes Education: Partnership with African American Health Coalition</li> <li>Farmers markets at hospital sites</li> </ul>	Expand partnerships with community-based organizations to develop and provide culturally appropriate services to patients of color
Clinical care		
Health care services to those in need	<ul> <li>Charity care (\$77.7 million) and unreimbursed costs of Medicaid and Medicare (\$106.7 million)</li> <li>Legacy Cancer Services:         <ul> <li>Worship in Pink: partnering with faith organizations to reach women of color</li> <li>Partnership with Familias en Accion: social and navigational support for Hispanic patients</li> <li>Screenings, exercise and support groups</li> </ul> </li> <li>Legacy Devers Eye Institute screenings, with attention to communities at high risk</li> <li>Partnership with safety net clinics</li> <li>Lab services provided free to four safety net clinics.</li> <li>Board service and donations to safety net clinics and mental health organizations, e.g., Wallace Medical Concern, Columbia River Mental Health</li> <li>Partnership Project serving AIDS/HIV patients</li> <li>Office space and phones on hospital campuses provided free to three nonprofit health-related organizations, including the African American Health Coalition</li> <li>Legacy Emanuel and Good Samaritan teaching clinics</li> <li>Legacy Emanuel midwifery clinic</li> </ul>	Collaborate with other organizations targeting high-need, high-utilization Community Needs Index ZIP codes. Measure and evaluate.      Expand services within low-income communities and communities of color

Need	Current actions	New initiatives/ opportunities
Health care access	<ul> <li>Project Access NOW: linking low-income uninsured to services provided at no charge</li> <li>Opening Doors Washington County and Clark County Navigator: linking low-income women to prenatal care</li> <li>Internal medicine residents volunteer weekly at safety net clinic with significant Muslim population</li> <li>Senior transportation support to medical appointments</li> <li>Recuperative care services includes medical home</li> <li>Financial support and participation in Oregon Public Health ALERT Immunization Registry</li> </ul>	<ul> <li>Expand Project Access portals to emergency department referrals</li> <li>Refer Medicaid patients to FQHCs         <ul> <li>increased federal reimbursement dollars provides them financial stability to also serve uninsured population</li> </ul> </li> <li>Support safety net clinics' efforts to obtain FQHC status</li> <li>Explore support for community health workers to serve high impact communities</li> </ul>
Physical environment		
	<ul> <li>Weekly farmers markets at each hospital site — open to public</li> <li>Healing gardens at each hospital site — open to public.</li> <li>Loaves and Fishes — weekly volunteering and financial donation</li> <li>Recycling (food, equipment, supplies) and sustainability practices</li> </ul>	

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