



LEGACY
HEALTH

Silverton Hospital

DBA

Legacy Silverton Medical Center

Community Health Improvement Plan

FY2023–FY2025

(April 1, 2022–March 31, 2025)

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*



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Legacy Silverton Medical Center

Community Health Improvement Plan

Executive Summary

The FY2023–FY2025 Legacy Silverton Medical Center Community Health Improvement Plan (CHIP) is the strategic implementation plan for the Legacy Silverton FY2023–FY2025 Community Health Needs Assessment (CHNA). This CHNA was based upon the 2019 Marion-Polk Community Health Assessment (CHA): 2022 Update conducted by Marion and Polk counties.

Legacy Silverton was an active participant in the Marion-Polk CHA Steering Committee that was comprised of members from the Marion and Polk County public health agencies, the regional coordinated care organization, hospital systems, academia, community-based organizations, as well as transportation and local governmental agencies. This committee provided direction for the MAPP (Mobilizing for Action through Planning and Partnerships) process and development of the 2019 Marion-Polk Community Health Assessment and its annual updates.

Tied to our mission of improving the health of the community, this community health improvement plan is intended to guide Legacy Silverton’s community-focused work, including investments and community efforts addressing the prioritized health issues identified in the CHNA. This plan is focused on the Marion County area, the primary service area for Legacy Silverton Medical Center. Each priority area has a set of targeted objectives and strategies, which will be continuously assessed and revised as needed to reflect changing community needs.

Legacy Silverton believes that multi-year sustainable partnerships with the community have strong potential to impact long-term health status. Therefore, the Legacy Silverton CHIP includes both continued effective strategies as well as new strategies. This plan is not intended to be an exhaustive listing of all our efforts to address community needs, but rather an overview of the work focused on our prioritized areas.

Introduction

Our vision at Legacy Health is to be essential to the health of the region. Legacy Health remains committed to our mission and fulfills its commitment to the community through its partnerships and community investments. Legacy participates in the development of the CHNA led by the Marion County and Polk County health departments and develops a hospital-specific CHIP.

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

About Legacy Health

Legacy Health is a nonprofit health system driven by its mission to deliver good health to our people, our patients, our communities and our world. Legacy offers a unique blend of health services across the Portland/Vancouver metro area and the mid-Willamette Valley. From wellness and urgent care to dedicated children's services and advanced medical centers — Legacy cares for patients of all ages when and where they need us. With an eye toward a healthier community, our partnerships tackle vital issues such as housing and mental health.

Legacy strives to help everyone live healthier and better lives, with the vision of being essential to the health of the region.

Legacy Health includes:

- Six hospitals, dedicated children's care at Randall Children's Hospital at Legacy Emanuel
- Unity Center for Behavioral Health, community-focused collaboration between Adventist Health, Kaiser Permanente, Legacy Health and OHSU
- More than 70 primary, specialty and urgent care clinics
- Nearly 3,000 doctors and providers
- Almost 14,000 employees
- Laboratory, research and hospice
- Partnership with PacificSource health plan

Legacy Silverton Medical Center

Legacy Silverton Medical Center (LSMC) is a nonprofit regional hospital located in Silverton, Oregon. Legacy Silverton sits in the heart of the Willamette Valley, located in Marion County. The medical center is located 14 miles northeast of Salem and 43 miles south of downtown Portland. Founded in 1917, the 48-bed facility has been at its current location since 1938. Silverton Hospital joined Legacy Health in 2016, making Legacy Silverton the newest member of the Legacy Health system of medical centers.

Legacy Silverton is a full-service community hospital that offers a comprehensive mix of services. These services include a Level IV trauma center, a 24-hour emergency department, family birth center, diagnostic imaging, orthopedics/sports medicine, nutrition services, and wound care and infusion services.

Legacy Silverton Medical Center defines its service areas by geographic location and where patients live. The primary service areas include the cities and towns of Silverton, Woodburn, Mt. Angel, Scotts Mills, Gervais, Molalla and Salem. Marion County, Oregon's fifth most populous county, represents the majority of Legacy Silverton's primary service area and covers about 1,200 square miles. According to U.S. Census data, Marion County had a population estimate of 349,204 in 2020 — an increase of 10.53% since 2010.¹

Purpose of this Plan

In 2022, the Legacy Silverton Medical Center completed its FY2023–FY2025 Community Health Needs Assessment (CHNA),² which is based on the findings of the 2019 Marion-Polk Community Health Assessment: 2022 Update.³ The Marion and Polk County Health Departments conducted their community health assessment in collaboration with local health, education, and transportation sectors, community-based organizations and local authorities guided by the Marion-Polk Community Health Assessment Steering Committee and Core Group.

This Legacy Silverton Community Health Improvement Plan (CHIP) responds to the strategic community issues identified in the 2019 Marion-Polk Community Health Assessment: 2022 Update and priorities established in the Legacy Silverton FY2023 CHNA.² Guided by Legacy Health's mission of improving the health of the community, the FY2023–FY2025 Legacy Silverton CHIP will direct Legacy Health's community health efforts and investments to address the prioritized community issues over the three-year period.

CHIP Frameworks

Health Equity and the Social Determinants of Health

The Legacy Silverton Medical Center FY2023–FY2025 CHIP is informed by both health equity and social determinants of health 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...” These conditions have a profound impact 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.⁴

Health Equity

Achieving health equity “...means that everyone has a fair and just opportunity to be as healthy as possible.”⁵ (p.2) Reaching this state requires persistent action to:

- Remove barriers to health, such as poverty, discrimination, and their consequences, which include powerlessness and lack of access to housing, safe environments, and health care, among others.
- Address historical and contemporary injustices through policy and systems change; and
- Reduce and ultimately eliminate preventable health disparities.^{5,6}

Health Disparities

Health disparities are “...preventable differences in the burden of disease, injury, violence, or opportunities to achieve optimal health that are experienced by populations that have been disadvantaged by their social or economic status, geographic location, and environment.”⁶

There are numerous ways to intervene upon factors leading to health disparities. These actions vary by system and by target population. In health care, some strategies that have led to reductions in disparities include increasing the socioeconomic, racial, and ethnic diversity of health providers; teaching and practicing cultural humility; supporting community-oriented primary care; and integrating equity considerations into health system funding.⁷ The observation of changes in measures of health disparities resulting from these or other interventions will allow us to assess our progress toward achieving health equity over time.^{5,6}

Significant health inequities and health disparities persist within our service community, despite ongoing, evidence-based, and collaborative efforts to address the structural and social determinants of these differences.^{3, 8} According to the Centers for Disease Control and Prevention, "... communities can prevent health disparities when community- and faith-based organizations, policymakers, employers, healthcare systems and providers, and public health agencies work together to develop policies, programs, and systems based on a health equity framework and community needs."⁶

Through our CHNA and CHIP planning and implementation activities, Legacy Health and the Silverton Medical Center, in collaboration with our community, agency, and health system partners, are committed to reducing health disparities and working toward the achievement of health equity for all members of our community.

The figure below provides a visual representation of the relationships between social and societal determinants and their impact on equity and health.

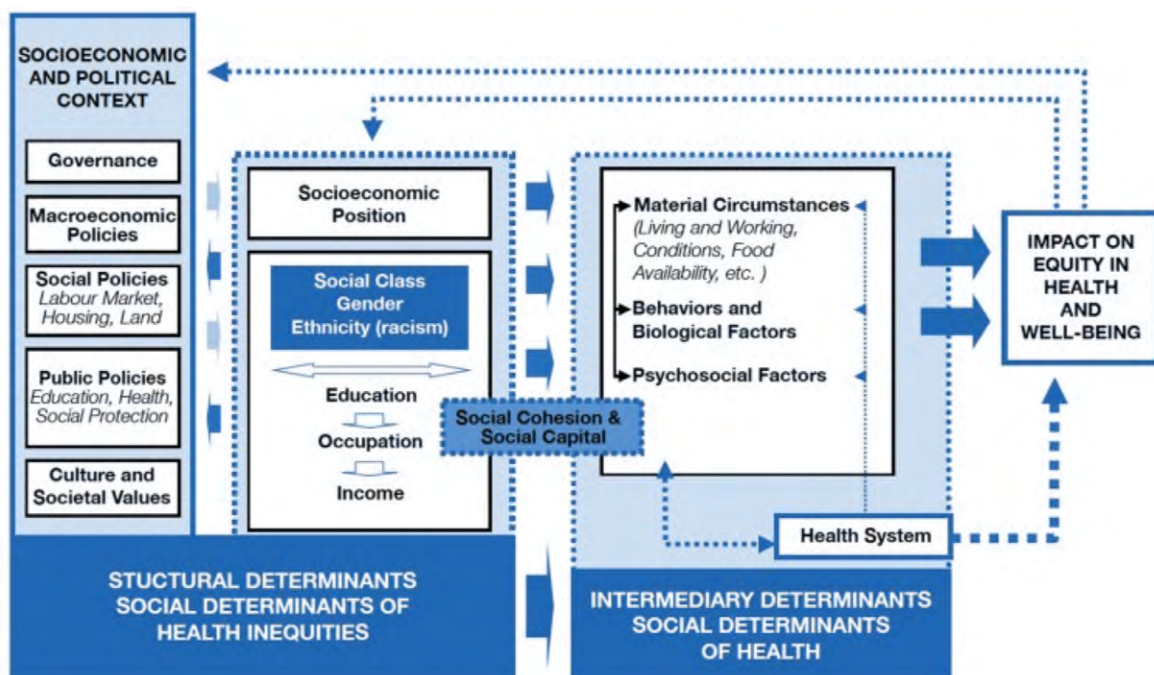


Figure 1: World Health Organization Framework for Social Determinants of Health⁹

Identification of CHIP Priority Areas

The Marion-Polk Community Health Assessments CHAs identified eight strategic issues affecting the local community. These issues all disproportionately affect low-income populations, communities of color, and other disenfranchised groups; severely impact the well-being of the local community; and have known feasible and effective solutions.^{3,8}

To determine which of the eight Marion-Polk CHA community-identified strategic issues would be the focus of the Legacy Silverton FY2023–FY2025 CHIP, the Legacy Health Community Benefit CHIP planning team (Community Benefit team and Community Benefit Advisory Committee members) considered the current knowledge, skills, and resources available within Legacy Health and the Silverton Medical Center to impact the eight issues and whether prevention-focused solutions to these issues are available. The four Legacy Silverton priority areas that will be addressed in our FY2023–FY2025 CHIP include:

- Access to Health Care
- Behavioral Health Supports
- Food Environment/Food Insecurity
- Substance Use

Health needs identified but not addressed

No singular health care facility or community health organization can remedy all the health and social issues present in our community. The four areas the Legacy Silverton Medical Center prioritized are those we have the capacity to impact during the FY2023–FY2025 CHIP period. The remaining four strategic issues in Marion and Polk counties (economic stability, education, housing, and transportation) ideally will be addressed by other local health systems and community-based organizations. Legacy Silverton is committed to engaging with our partner community organizations and health systems to address these remaining issues, when possible.

Summary of CHIP Planning Process

The Legacy Silverton FY2023-FY2025 CHIP planning process included the following steps:

1. Engaged the Legacy Health Community Benefit planning team in the development of goals for each of the four priority areas.
2. The Legacy Health Community Benefit team drafted a set of SMART (Specific, Measurable, Action-Oriented, Realistic/Relevant, and Time Bound) objectives and related strategies for each of the four goal statements.
3. Input was sought regarding these objective statements and associated strategies from our Community Benefit Advisory Committee, Silverton area community partners, other individuals with subject-matter expertise in the prioritized areas, and national experts in Community Benefit and CHIP development processes.
4. The CHIP implementation plan (goals, objectives, strategies) was modified based upon feedback received from the above consultations.

Implementation Plan — Goals, Objectives, Strategies

The following tables display the current goals, objectives, and strategy options for each of the four priority areas of the Legacy Silverton FY2023–FY2025 CHIP. These components of our improvement plan align with those used by partner organizations serving the communities in Marion and Polk counties and are drawn from evidence-based sources.^{10, 11}

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.
Objectives	Strategies
<p>Objective 1.1</p> <p>By end of FY25 (March 31, 2025), increase access to health care services by 5% for community members who are low-income, underinsured and/or uninsured.</p>	<p>1.1.1 Support community-based health clinics and federally qualified health centers (FQHCs) to provide preventive, primary, and/or specialty health care services, health coverage and continuity of care.</p> <p>1.1.2 Assess feasibility of opening Legacy-owned specialty care practices to patients from Federally Qualified Health Centers (FQHC) and community-based clinics.</p> <p>1.1.3 Provide patient-centered primary care home (PCPCH) at Legacy Health for contracted Oregon Health Plan members in coordination with PacificSource Community Solutions.</p> <p>1.1.4 Provide health professionals with health-related continuing education and programs.</p> <p>1.1.5 Provide health professional programming (through internships, externships, and residency) to students and physicians participating in health-related academic or technical training programs.</p> <p>1.1.6 Assess the feasibility of providing health services via telephone or videoconference (telehealth) for all patients, regardless of insurance or financial status.</p> <p>1.1.7 Continue to provide financial assistance and counseling to low-income individuals to enhance their access to health services through Legacy Health.</p> <p>1.1.8 Advocate for policy, systems, and environmental change (PSE) strategies that address access to health-related services</p>
<p>Objective 1.2</p> <p>By end of FY25 (March 31, 2025), increase diversity and cultural competency of the health care workforce by 5%. Baseline data from FY2022.</p>	<p>1.2.1 Support community-based and Legacy Health efforts to improve workforce utilization of traditional health workers (THW).</p> <p>1.2.2 Support and invest in community-based workforce readiness and training programs serving communities of color and groups that have been economically and/or socially marginalized.</p> <p>1.2.3 Provide scholarships and internships to high school graduates from communities that have been economically and/or socially marginalized to pursue post-secondary degrees in health care.</p>

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PRIORITY AREA Access to Health Care <i>continued</i>	
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.
Objectives	Strategies
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 FY2022.	1.3.1 Support community-based organizations, coalitions, and community health clinics to meet the health and social needs of community members. 1.3.2 Expand screening of community members for health-related social needs (e.g., food insecurity, housing instability, etc.) 1.3.3 Expand use of Connect Oregon/Unite Us platform throughout Legacy system to connect patients to community-based resources 1.3.4 Support community-based and Legacy Health efforts to increase the use of traditional health workers (THW) for the coordination of health and social services for community members. 1.3.5 Enroll eligible individuals in Legacy Health Medication Assistance Program and Care Support Resources Programs 1.3.6 Advocate for policy, systems, and environmental change (PSE) strategies that address access to health-related services

PRIORITY AREA Behavioral Health Supports	
Goal	Improve awareness of and linkage to behavioral health services and care
Objectives	Strategies
Objective 2.1 By end of FY25 (March 31, 2025), reduce systemic barriers to receiving behavioral health services by 5%. Baseline data from FY2022.	2.1.1 Assist community-based organizations in providing access to behavioral health services and treatment. 2.1.2 Support community-based organizations' efforts to destigmatize behavioral health issues. 2.1.3 Improve community member awareness of behavioral health services and care. 2.1.4 Expand trauma-informed care training opportunities. 2.1.5 Provide health education and workforce training to practitioners, administrators, and other employees to enhance the delivery of culturally and linguistically responsive behavioral health care services. 2.1.6 Assess the feasibility of providing behavioral health services via telephone or videoconference (telehealth) for all patients, regardless of insurance or financial status.

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PRIORITY AREA Behavioral Health Supports <i>continued</i>	
Goal	Improve awareness of and linkage to behavioral health services and care
Objectives	Strategies
<p>Objective 2.2</p> <p>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 FY2022.</p>	<p>2.2.1 Expand screening of community members for health-related social needs (e.g., food insecurity, housing instability, etc.).</p> <p>2.2.2 Expand use of Connect Oregon/Unite Us platform throughout Legacy system to connect patients to community-based behavioral health resources.</p> <p>2.2.3 Support community-based and Legacy Health efforts to increase the use of traditional health workers (THW) in the coordination of health and social services related to behavioral health.</p> <p>2.2.4 Assess the feasibility of providing behavioral health services via telephone or videoconference (telehealth) for all patients, regardless of insurance or financial status.</p> <p>2.2.5 Advocate for policy, systems, and environmental change (PSE) strategies that address behavioral health issues.</p>

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.
Objectives	Strategies
<p>Objective 3.1</p> <p>Support food banks, food pantries and meal programs to promote healthy eating and access to nutritious foods for children, adults, and families.</p>	<p>3.1.1 Support food banks, food pantries and meal programs to promote healthy eating and access to nutritious foods for children, adults, and families.</p> <p>3.1.2 Provide food vouchers to food insecure individuals</p>
<p>Objective 3.2</p> <p>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 FY2022.</p>	<p>3.2.1 Expand screening of community members for health-related social needs (e.g., food insecurity, housing instability, etc.)</p> <p>3.2.2 Expand use of Connect Oregon/Unite Us platform throughout Legacy system to connect patients to community-based food resources</p> <p>3.2.3 Support community-based and Legacy Health efforts to increase the use of traditional health workers (THW) in the coordination of health and social services related to food</p> <p>3.2.4 Join the Oregon Community Food Systems Network (https://ocfsn.org)</p> <p>3.2.5 Advocate for policy, systems, and environmental change (PSE) strategies that address issues related to the food environment and/or food insecurity</p>

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.
Objectives	Strategies
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 FY2022.	4.1.1 Collaborate with local agencies and organizations on improving substance use treatment access. 4.1.2 Support community-based and Legacy Health efforts to increase the use of traditional health workers (THW) in the coordination of health and social services related to substance use prevention, treatment, and recovery. 4.1.3 Expand screening of community members for health-related social needs (e.g., food insecurity, housing instability, etc.). 4.1.4 Expand use of Connect Oregon/Unite Us platform throughout Legacy system to connect patients to community and government behavioral health resources. 4.1.5 Assess the feasibility of providing behavioral health services via telephone or videoconference (telehealth) for all patients, regardless of insurance or financial status. 4.1.6 Advocate for policy, systems, and environmental change (PSE) strategies that address issues related to substance use prevention, treatment, and recovery.

Evaluation Plan

Legacy Silverton will monitor and evaluate the strategies identified to meet our objectives. The reporting process includes the collection and documentation of process and outcome indicator data from internal and external data sources. We anticipate the current strategies and indicators may change over time in relation to system resources and community status.

Legacy Health Commitment

The priority areas identified in this improvement plan will be addressed through the provision of personnel time and technical assistance, strategic community partnerships, operational funds, health service delivery, Community Benefit and Community Health grant awards.

For questions or more information

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

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