LEGACY HEALTH

Legacy Salmon Creek Hospital

DBA

Legacy Salmon Creek Medical Center

Community Health Needs Assessment

and

Community Health Improvement Plan

FY 2018

Mission

Our legacy is good health for our people, our patients, our communities, our world

Vision

To be essential to the health of the region

Values

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

LEGACY
HEALTH

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Introduction

About Legacy Salmon Creek Medical Center

Legacy Salmon Creek Medical Center is a full-service community hospital in Southwest Washington state (Clark County) within the unincorporated Salmon Creek area just north of Vancouver. The facility is located at the confluence of two major interstates—Interstate-5 and Interstate-205.

In the late 1990s, Legacy Health recognized that an ever-increasing number of Clark County and S.W. Washington residents were seeking medical care across the Columbia River in Portland, Oregon. At that time, Clark county's sole hospital was operating the busiest emergency room in either Southwest Washington or Oregon, and the entire county had the lowest ratio of beds to population of any of the state's five largest counties.

To address this demand, in 2005 Legacy Health ushered in a new era by opening a hospital in a new state, county, and community: Legacy Salmon Creek Medical Center. It is Southwest Washington's most modern hospital, with a range of innovations to improve the health and the life of the community it serves.

Today, Legacy Salmon Creek Medical Center is one of the six hospitals of Legacy Health, which was established in 1989 by the merger of two nonprofit systems in the four-county metropolitan Portland, Oregon area, and the more recent acquisition of Silverton Medical Center in Marion County. The system's mission is:

> *Our legacy is good health for our people, our patients, our communities, our world.*

Legacy Salmon Creek is distinguished by its comprehensive range of services for adults and children, including a family birth center, maternal-fetal medicine, a pediatric development and rehabilitation center, pediatrics, women's health, orthopedics and specialty care for cancer, heart disease, stroke, epilepsy and more.

About the area we serve

Legacy Salmon Creek Medical Center defines service area based on actual patient origin (ZIP codes) and geographic location. Salmon Creek lies in Clark County between the cities of Vancouver to the south and Battle Ground and Ridgefield to the north, in an unincorporated area known as Salmon Creek and near neighboring Hazel Dell. The primary service area extends from the Columbia River in the south, to La Center in the north, Vancouver Lake in the west and Camas in the east.

Incorporated cities in Legacy Salmon Creek's primary service area include Vancouver, Battle Ground, Ridgefield and Camas. Vancouver and Camas are primarily industrial, commercial and residential communities, while Battle Ground and Ridgefield are primarily residential. ZIP codes in our service area include 98601, 98603, 98604, 98606, 97607, 98616, 98622, 98629, 98642, 98660–68, 98671, 98674–75, 98682–87.

This community health needs assessment primarily uses Clark County and state data, unless otherwise noted.

The Legacy Salmon Creek primary service area included an estimated 453,819 people in 2017, having increased 30.9 percent from 2000 to 2015 — the largest population increase among the four counties studied, and it is one of the fastest-growing counties in the state (U.S. Census Bureau). According to Intellimed, an estimated 7.14 percent growth is projected for Clark County between 2017 and 2022.

Although the racial and ethnic population of Clark County is predominantly white (non-Hispanic/Latino), the demographics of Clark County continue to diversify. Notably, the foreign-born population in Clark County increased 16.4 percent from 2005 to 2014, with

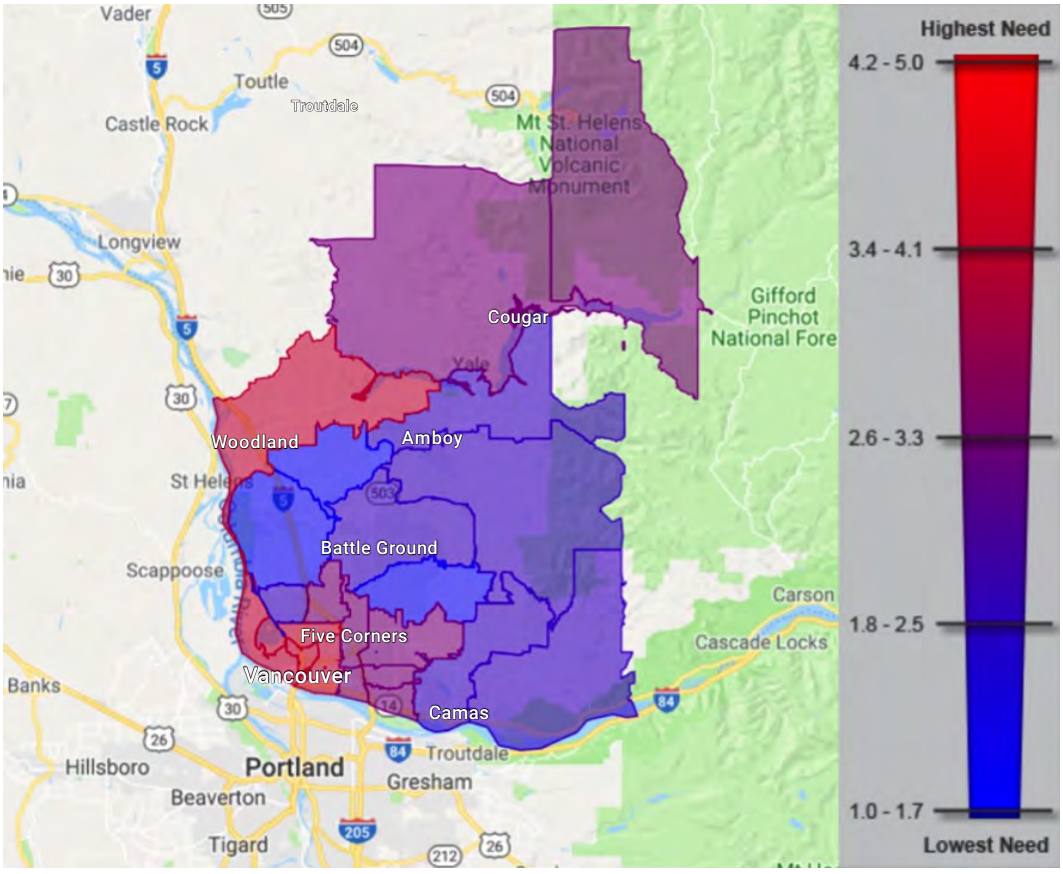
the Hispanic/Latino population increasing 98 percent from 2000 to 2010 — the highest rate of change of any ethnic population.

The ethnic and racial mix of Salmon Creek's service area in 2017 was 82.2 percent white, non-Hispanic/Latino, 2.2 percent Black or African-American, 0.96 percent Native American or Alaska Native, 5 percent Asian, 0.9 percent Native Hawaiian and other Pacific Islander, and 10.2 percent Hispanic/Latino. *(Legacy Health/ Intellimed data, 2017)*

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 County. "Slavs" are counted in the non-Hispanic white population, but they have a distinct cultural identity and their socioeconomic status is generally lower than other (non-Hispanic) white populations. Russian and other Slavic languages (Czech, Slovak and Ukrainian) are among the top five languages spoken at home in Clark County (0.8 percent).

Clark County's median household income (MHI) was $61,741 with 9.3 percent of the population living in poverty. This is compared to Oregon's Washington County's MHI at $66,136 with 8.7 percent living in poverty, Clackamas County at $65,316 with 6.8 percent living in poverty, and Multnomah County at $53,660 with 12.8 percent living in poverty. Relative to the state of Washington, Clark County's MHI is only slightly higher ($61,741 vs. $61,366). The county's rate of those living in poverty is lower than the state's as a whole (9.3 percent vs. 13.2 percent) as is the percentage of children under 18 living in poverty (11.2 percent vs. 17.5 percent).

As for safety net health services in Clark County, Legacy Salmon Creek's service area includes a Medically Underserved Area (MUA) in central Vancouver. There is one non-public sector federally qualified health center (FQHC) (Sea Mar Community Health Center) and one longstanding volunteer-based safety net Free Clinic of Southwest Washington in Vancouver. The Clark County Health Department does not operate primary care services directly. A local program, Project Access Clark County, links uninsured, low-income individuals to providers and health system services providing services at no charge. All the health systems in the metro area are very involved with this program.



The Dignity Health and Truven Health Community Needs Index (CNI) is accepted as the national standard in identifying communities with health disparities and comparing relative need. CNI is denoted on a scale of 1, low need, to 5, high need. Legacy Salmon Creek's community health focus is on the highest CNI ZIP codes in its service area, which include: 98660-West Vancouver, 98661-Downtown Vancouver, 98663-Rosemere East Vancouver, 98665-Hazel Dell and 98674-Woodland as shown at left.[1]

About this report

The purpose of this report

The Patient Protection and Affordable Care Act (ACA), IRS Section 501(r)(3), requires tax-exempt hospital facilities like ours to conduct a Community Health Needs Assessment (CHNA) at least once every three years. This report is approved by the Legacy Health Board of Directors and made available to the public in compliance with the IRS requirements.

The purpose of the CHNA is to:

- Determine the priority factors influencing the health of the community we serve
- Identify the needs and gaps affecting the health status of various populations within this community
- Identify how our organization's resources and expertise can help address these issues

This report summarizes the findings of a regional community health needs assessment completed July 31, 2016 (Appendix A). The next section explains how this regional CHNA came about.

A collaborative approach to assessing our community's needs

Prior to 2010, each of the metro area hospitals/health systems and public health departments in Clackamas, Multnomah and Washington counties in Oregon, and Clark County in Washington, had conducted community health needs assessments independently. This was a significant duplication of efforts and resources since the organizations were, for the most part, serving (and assessing) the same community.

To reduce this duplication of effort and streamline the process of meeting the ACA's triennial CHNA requirements, these entities joined forces to establish the Healthy Columbia Willamette Collaborative (HCWC). This public-private partnership brings together 15 hospitals, four counties and two coordinated care organizations (CCOs, or managed Medicaid organizations) to produce a shared regional needs assessment. The HCWC produced its first regional CHNA in 2013, and the second—on which this report is based—in 2016.

This report draws on the regional CHNA findings specifically for Clark County, which includes the primary service area for Legacy Salmon Creek Medical Center.

How information was gathered

The HCWC identified community health needs through a comprehensive study of population, hospital, Medicaid, and community data. This included:

- Population data about health-related behaviors, morbidity (the rate of disease in a population) and mortality (the frequency of death in a certain population)
- Medicaid data from local CCOs about the most frequent conditions for which individuals on Medicaid sought care in our service area
- Hospital data for uninsured people who were seen in the emergency department with a condition that could have been managed in primary or ambulatory care
- An online survey about quality of life, issues affecting community health, and risky health behaviors
- Listening sessions with diverse communities in the region to identify community members' vision for a healthy community, needs in the community, and existing strengths
- An inventory of recent community engagement projects in the region that assess communities' health needs

More detailed information on these sources of information can be found beginning on page 8 of the Healthy Columbia Willamette Collaborative CHNA Reports (Appendix A).

What we learned from our community health needs assessment

By the numbers: A data snapshot of the community we serve

Here are some of the notable findings about the community Legacy Salmon Creek serves — and its health status — revealed by the CHNA data compiled by the HCWC (and other sources, if applicable):

Population

- Approximately 451,000 people lived in Clark County in 2014, having increased 23.2 percent from 2000 to 2010 — the largest increase of the four-county region studied.
- The largest city in Clark County is Vancouver, with a population of about 162,000.
- Other parts of the county are more rural, with cities ranging from 1,000 to 21,000 people.

Race and ethnicity

Although the racial and ethnic population is predominantly white (non-Hispanic/Latino), the demographics of Clark County continue to diversify:

- The foreign-born population in Clark County increased 16.4 percent from 2005 to 2014, while the Hispanic/Latino population increased 98 percent from 2000 to 2010.

Social determinants of health

While our health is influenced by our biology, genetics and individual behavior, external factors are also important, such as our income/economic stability, where we live, how much education we have, and our access to healthcare/the availability of providers. These factors are called "social determinants of health." In Clark County, the CHNA revealed:

- Clark County had the second-lowest median household income in the four-county region ($61,741).
- Among the four counties studied, Clark County had the second-lowest percentage (8.5 percent) of individuals living in poverty in 2014, and the lowest percentage of children 18 or younger living in poverty (11.2 percent).
- Over 15 percent of households received SNAP benefits in the past year, the second-highest proportion of families in the four counties studied.
- People receiving Medicaid, make up 21percent of the population of Clark County with 27.7 percent of the population living at or below 200 percent of the federal poverty level.
- Clark County residents have been affected by increased housing costs, although rates of homelessness are lower than other counties in the region.
- The percentage of homeowners (28.2 percent) or renters (49.8 percent) who are paying 30 percent or more of their household income on housing is the lowest of the four counties studied.
- There is a lower percentage (36.3 percent) of substandard housing units compared to neighboring counties.
- Clark County had the highest percentage (23.2 percent) of the population living in a "food desert" — a low-income census tract with low access to supermarkets or large grocery stores.
- While nearly 92 percent of adults have at least a high school diploma, Clark County had the lowest rate (26.9 percent) of those with at least a four-year college degree among the four counties studied.
- At 1,510:1, Clark County has the highest (and therefore worst) ratio of population to primary care providers of the four counties.
- At 410:1, Clark County has the second-lowest (and therefore second-best) ratio of population to mental health care providers of the four counties.

Health behaviors

Population health data from state surveys and vital statistics show that certain risky health behaviors are prevalent in Clark County. Notably:

- Binge drinking, cigarette smoking among teens and pregnant women, not eating enough healthy foods, and lack of exercise are common in Clark County.
- Among teenagers specifically, the assessment identified cigarette smoking, and alcohol and marijuana use as prevalent behaviors.

- Access to health care and preventive services were identified as priority health issues for Clark County, specifically lack of dental visits for teens, lack of flu shots for adults, lack of pneumonia vaccines for adults 65 and older, and no usual source of health care among adults.

Chronic health conditions among low-income residents

Clark County Medicaid data was not available for this report.

Emergency department admissions among uninsured residents

People without health insurance tend to rely on the hospital emergency department for care, including for conditions that could have been treated by a primary care provider. By analyzing utilization data from local hospitals for this patient population, the HCWC learned:

- The most common conditions for adults in this population were hypertension, diabetes and kidney/urinary infections. For youth within this population, the top diagnosed conditions were severe ear, nose and throat infections, asthma and dehydration.

Morbidity and mortality

Epidemiologists from the four county health departments looked at over 100 health indicators, with several emerging as priority health issues affecting residents in Clark County. These included:

- Obesity — Over 70 percent of adults are classified as obese or overweight.
- Cardiovascular disease — This is the leading cause of death in the county.
- Cancer — Cancer is the second-leading cause of death in the county (with breast, prostate, lung and colorectal the most deadly types of cancer).
- Substance use/abuse — One-fifth of 10th graders use alcohol, with 11.6 percent reporting binge-drinking, while 19.1 percent of 10th graders have used marijuana and 20.9 percent report e-cigarette use. Deaths caused by alcohol and drug use and abuse are among the leading causes of death.
- Mental health — Depression is among the top-ranked health conditions in both adults and teens, and suicide is one of the leading causes of death.

What the community identifies as their health needs

Through an online survey, listening sessions, and an inventory of community engagement projects, the HCWC heard directly from community members about what they see as priority health issues or problems, and what contributes to these problems. The top five issues they identified were:

- Homelessness and lack of safe, affordable housing
- Unemployment and lack of living-wage jobs
- Mental health challenges, e.g., depression, lack of purpose or hope, anxiety, bipolar, PTSD, eating disorders
- Lack of access to physical, mental and/or oral health care
- Hunger and lack of healthy, affordable food

The priority health issues facing the community we serve

When all this data from the various assessment approaches was compiled, some specific health issues were identified in more than one assessment component (e.g., population, community engagement or emergency department data). These common themes emerge as the priority health issues facing the community we serve:

- Access to health care
- No usual source of health care among adults
- Asthma, particularly in children
- Hypertension and diabetes in adults
- Lack of dental visits for teens

What Legacy Salmon Creek is doing to address these issues

Priorities: Where Legacy Salmon Creek focuses its community benefit resources

Each year, Legacy Salmon Creek invests a significant amount of goods, services and funds to benefit the health of the community we serve, particularly health services for the low income and uninsured.

Consistent with our mission of good health for our community, in FY 17 Legacy Health's community benefit totaled $383.1 million and unreimbursed costs were $360.3 million. Of this, Legacy Salmon Creek's total community benefit was $53.2 million, including unreimbursed costs of $52.3 million.

Our aim in making community benefits investments is fourfold:

- To influence the things we can, such as health behaviors and social determinants of health
- To prevent and/or treat specific health problems
- To support existing programs and initiatives in the community that are effective in addressing specific health needs
- To help build programs and services that achieve our shared vision for a healthy community

Based on the findings of the HCWC's 2016 regional community health needs assessment, and how we can best apply our resources and expertise to help address these needs, Legacy Salmon Creek is focusing its efforts on these priority issues:

Access to care

Improving residents' ability to get the health care services they need, with an emphasis on primary/preventive care and management of chronic conditions such as asthma in children, and diabetes and hypertension in adults

Behavioral health

Expanding the availability of and access to behavioral and mental health services for youth and adults to help address such conditions as depression, suicide and PTSD

Social determinants of health

Addressing the need for policies, systems, services, and environments that support healthy behaviors, which means advancing solutions for such issues as homelessness and affordable housing for the underserved, food scarcity and, once again, access to health care. Education, meaningful employment, and removing barriers to culturally competent services are key to improving the health of the community.

Details on the specific initiatives Legacy Salmon Creek is undertaking to address these priority issues can be found in our Community Health Improvement Plan (CHIP), which is provided in a separate document following this report.

Building on success: What we've done since the 2013 CHNA

In Legacy Salmon Creek's previous CHNA, we identified access to health care, chronic disease, mental health, substance use disorder, health literacy, and education and youth as our CHNA priorities. Since this last report, we have invested time, resources, and funding in programs and services we believed would have an impact on these needs.

A $10 million Community Health Fund was established in 1998 by the Legacy Health Board. The funding is supported by operating revenue on an annual basis. Every partner organization receiving funding meets the needs identified in the CHNA.

The table on page 11 has some highlights of what we've achieved.

Health care services for the low-income and uninsured

While the Affordable Care Act has significantly lowered the uninsured rate in Washington State, longstanding income disparities in the Legacy Salmon Creek service area underscore the ongoing need for safety net services which are detailed in the separate CHIP document following this report.

Conclusion

As you'll see in the Community Health Improvement Plan that follows this report, going forward we plan to sustain our efforts in addressing many of the priority issues to which we have devoted resources in the past because these needs still exist – as affirmed by the findings of our latest regional CHNA.

At Legacy Salmon Creek, our top priority has been — and continues to be — a focus on the issues that have the greatest impact on the health of our community.

If you have any questions or wish to obtain a copy of this needs assessment, please email us at **CommunityBenefit@lhs.org**.

Appendix A

Healthy Columbia Willamette Collaborative CHNA Reports, 2016

Healthy Columbia Willamette Collaborative Community Needs Assessment Report can be found at: http://www.qcorp.org/sites/qcorp/files/HCWC%202016%20Community%20Health%20Needs%20Assessment.pdf.

References

[1]*Dignity Health: Community Need Index. http://cni.chw-interactive.org/*

Some highlights of what we've achieved

Organization	Program supported	Outcomes	Alignment
Free Clinic of SW Washington/Project Access Clark County	Premium Assistance Program (Ongoing program support)	Providers referred 873 patients from July 2014 to June 2015 and 855 patients from July 2015-June 2016 to Project Access Clark County for verification of program eligibility. Project Access staff coordinated on average 169 appointments per month during 2014–15, and 70 appointments per month during 2015–16	Access to care
Central City Concern	Housing is Healthcare	Once complete, project will provide for 379 individuals and families to have access to housing and other health and support services	Access to care
Transition Projects	Access to housing and services	Over 10,000 individuals served annually	Access to care
Mental Health Association	Peer support	In year one of support, 43 patients were provided services, 23 of those patients were provided 57 referrals to community resources (housing/shelter, alcohol and drug, food, clothing, financial assistance), with more than 167 contacts by the Peer Support Specialists	Mental health
Community Services Northwest	Housing and Outreach program support	In 2015, housing program supported over 200 individuals and families in living off the streets, together with outreach teams, connected with more than a dozen homeless camps in the Vancouver area to identify and assist those in need	Mental health/ Substance use disorder
Latino Network	School and community-based programs	35 school locations, serving 631 students and families annually	Youth and education
Wallace Medical Concern	Increasing health literacy via community collaborations	In 2014–2015 WMC served 7,818 people total with 18,514 visits (21 percent increase over previous year)	Health literacy
Health Literacy Conference	Health literacy	Over 500 individuals reached annually from over 120 community and health organizations	Health literacy
North by Northeast Community Health Center	Blood pressure checks	Provides early awareness for cardiovascular health issues and connects individuals to health care services	Chronic disease
Various community partners	Food programs	From April 2014 to March 2017, Legacy Health's contributions through cash in-kind dollars and food drives accounted for 308,923 total meals provided to our community	Chronic disease

Executive summary

This Community Health Improvement Plan is based on the 2016 Community Health Needs Assessment (CHNA) conducted by the Healthy Columbia Willamette Collaborative (HCWC). The HCWC is a public-private partnership which unites 15 hospitals, four counties and two coordinated care organizations (CCOs, or managed Medicaid organizations) to produce a shared regional needs assessment. The region supported by the HCWC include Clackamas, Multnomah and Washington counties in Oregon, and Clark County in Washington. The HCWC produced its first regional CHNA in 2013, and the second — on which this report is based — in 2016.

Tied to our mission of improving the health of the community, this improvement plan is intended to guide Legacy Salmon Creek's community-focused work, including investments and community health efforts based on prioritized health needs identified in the CHNA. This plan is focused on the Clark County area, as that is the primary service area for Legacy Salmon Creek. Each prioritized focus area is aligned with strategies and indicators for measuring outcomes.

The strategies and outcomes will be assessed annually and revised as needed to address community needs. Legacy Salmon Creek believes that multi-year sustainable partnerships with the community have strong potential to impact long-term health status. Therefore, the Legacy Salmon Creek 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 prioritized focus areas and strategies tied to measurable tactics.

Summary of prioritized focus areas

The 2016 HCWC Community Health Needs Assessment identified numerous health-related needs across the four-county region. Legacy Salmon Creek has grouped the needs of Clark County into three categories:

Access to Care

- Primary care access
- Culturally appropriate care
- Health coverage programs

Behavioral Health

- Behavioral health providers, services
- Awareness, education and availability of services
- Early intervention of care
- Navigation to services post-discharge
- Prevention of Adverse Childhood Experiences (ACEs)

Social Determinants of Health

- Access to healthy food
- Improving health literacy
- Affordable housing
- Meaningful employment

These prioritized focus areas will be address through community partnerships and initiatives tied to the strategies outlined in the following plan.

Introduction

Our vision at Legacy Health is to be essential to the health of the region, and our mission is "Our legacy is good health for our people, our communities, our world." Legacy Health remains committed to our mission and fulfills its commitment to the community through its partnerships and community investments. Legacy formally participates in the development of a Community Health Needs Assessment (CHNA) as part of the Healthy Columbia Willamette Collaborative (HCWC).

The CHNA is 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 once every three years. The CHNA is approved by the Legacy Health Board of Directors and made available to the public in compliance with the IRS requirements.

About Legacy Health

Legacy Health is a local, nonprofit health system with six hospitals and dedicated children's care offered at Randall Children's Hospital at Legacy Emanuel. Legacy also includes more than 70 primary care, specialty and urgent care clinics, as well as almost 3,000 providers who are either employed, on the medical staff or part of Legacy Health Partners. We have lab, research and hospice services. Among our major partnerships are PacificSource Health Plans and the Unity Center for Behavioral Health.

Legacy Health employs more than 13,000 people across its two-state region and focuses its resources on caring for those in our communities, especially marginalized individuals in need. In fiscal year 2017 Legacy provided $383.2 million in community benefit across our five county-region (Multnomah, Clackamas, Washington, Marion and Clark counties) representing 20.7 percent of net patient revenue.

Purpose of Community Health Improvement Plan

The Community Health Improvement Plan (CHIP) is based on the 2016 Community Health Needs Assessment (CHNA) conducted by the Healthy Columbia Willamette Collaborative (HCWC). The CHIP serves to:

- Prioritize factors influencing the health of the communities we serve
- Define the strategies employed to address the needs and gaps affecting the health status of various populations within this community
- Identify how our organization will apply resources and expertise to these strategies, and how we will measure the outcome of the strategies

The CHIP is designed to align Legacy Salmon Creek resources with community need. It is the roadmap Legacy Salmon Creek will follow for the next three years, adapting to changing needs and opportunities along the way. Many of the strategies are a continuation of current work and investments, as we are committed to long-term dedication of resources which can build sustainable solutions.

The HCWC report, completed in the summer of 2016, documents the community health needs of the four-county region and each county individually. Priority health issues were identified based upon data collected including:

- **Population data** about health-related behaviors, morbidity and mortality
- **Medicaid data** from local Coordinated Care Organizations (CCOs) about chronic conditions for adults and youth
- **Hospital data** for uninsured individuals seen in emergency departments for conditions which should have been managed in a more appropriate care setting (e.g. primary care)
- **Quality of life data** from an online survey of 3,167 respondents; questions addressed issues affecting community health and risky health behaviors
- **Listening sessions** with 29 community-based organizations including 364 total participants to assess community needs and existing strengths

- **Inventory** of community engagement projects to assess community health needs

The three priority areas Legacy Health identified as those we can impact most significantly are: access to care, behavioral health and the social determinants of health.

Access to Care

Access to health care and preventive services are critical to improving the health of the community. Community members indicated the lack of a usual source of primary care, especially among adults, which disrupts continuity of care. For those individuals who do not qualify for Medicaid, but who cannot afford basic health care, assistance with insurance premiums is needed. Additionally, individuals are more likely to seek care when it is delivered in a culturally responsive and sensitive manner.

Behavioral Health

Behavioral health care access, early interventions and navigation to needed services post-discharge from a health facility were identified as lacking in our region. The awareness and education to support acknowledgement and acceptance of behavioral health challenges among adults and youth were noted as needed in the community. These actions can help to eliminate discrimination and stigmas attached to behavioral health challenges. For youth, identifying and addressing adverse childhood experiences (ACEs) can improve access and reduce risk factors, e.g. suicidal ideation, depression, gang involvementS.

Social Determinants of Health

Basic needs, such as access to food, safe and affordable housing, pathways to living-wage jobs and youth education, when addressed, can change the course of an individual's life. Delivering health care and services in a culturally and linguistically appropriate manner, increase access and the ability for independence.

Summary of prioritized focus areas, strategies and key indicators

Access to Care

Priority needs

Primary care access

- Legacy Health will continue to support community-based clinics and organizations serving providing primary care services (including care for chronic conditions) for low income and uninsured individuals
- Provide in-kind lab services for clinics providing primary care services

Culturally appropriate care

- Improve health outcomes and quality of care by supporting community organizations that meet social, cultural and linguistic needs of patients in our community as well as reduce racial and ethical health disparities.

Health coverage programs

- Support programs working to ensure all individuals have access to health coverage and assistance with premium pay for low income and uninsured residents

Community Resources

Access to Care community resources

Battle Ground Health Care

Free Clinic of SW Washington

Project Access Clark County

Q Center

Action plan	Indicators
Provide funding and/or other resources, e.g., in-kind laboratory services, board representation, program alignment and partnerships, IS support, to local FQHC and volunteer-staffed community-based clinics and culturally specific health service organizations	Number of services, hours and support provided to community-based organizations
Improve access to care through funded FQHC/safety net/community clinics that offer primary care services (and care for chronic conditions)	Number of low-income partner organizations patients with access to community-based primary care
Partner with Project Access Clark County to increase insurance enrollment and access to care for low income and uninsured individuals who qualify for the Premium Assistance Program	Number of eligible under 250% of FPL individuals obtaining health care who live in Clark County/Number of Project Access premium assistance insured enrollees and financial screening appointments/Number of appointments scheduled monthly by Project Access coordinator
Support Basic Rights Oregon, Q Center and other organizations in efforts to reduce disparities that stem from structural and legal factors, social discrimination and lack of culturally competent health care	Number of interactions from patient referrals to culturally competent services

Summary of prioritized focus areas, strategies and key indicators

Behavioral Health

Priority needs

Behavioral health providers, services

- Awareness, education and availability of services
- Build capacity in community-based behavioral health organizations and collaborate with regional initiatives

Early intervention of care

- Early identification, diagnosis and treatment of behavioral health issues can help children reach their full potential.
- Provide funding to community organizations and programs that support provide behavioral health screenings that identify patients with possible behavioral health (or substance use) disorders and provide guidance for referral for specialized health treatment

Navigation to services post-discharge

- Legacy Health will partner with behavioral health organizations to provide navigation for post-discharge support services

Prevention of Adverse Childhood Experiences (ACEs)

- Partner with organizations supporting individuals experiencing the trauma of disruptive life challenges to reduce the likelihood Adverse Childhood Experiences (ACEs) in children/youth and reduce the likelihood of poor health implications that children and adults face relating to their trauma experiences

Community Resources

Behavioral Health community resources

Boys & Girls Club of SW Washington

Children's Center

Columbia River Mental Health Foundation

Daybreak Youth Services

Lifework NW

Trillium Family Services

Action plan	Indicators
Legacy Health commits to supporting the Boys & Girls Club of SW Washington as well as similar programs that are designed to recognize and address early signs of behavioral health issues, and refer more severe, chronic mental health issues to more extensive therapy	Number of youth reached by therapist and staff trained to recognize early signs of behavioral health issues, and those referred to more extensive therapy
Provide funding to community organizations and programs that provide behavioral health screenings that identify patients with possible behavioral health (or substance use) disorders and give guidance for referral for specialized health treatment	Number of individuals referred and/or recognized with behavioral health issues
Support accessibility and affordability to behavioral health treatment and coordination of services	Number of County Health Rankings for poor mental health days

Summary of prioritized focus areas, strategies and key indicators

Social Determinants of Health

Priority needs

Access to healthy food

- Partner with food programs to improve access to healthy meals

Improving health literacy

- Increase health literacy education in community
- Provide regional leadership in health literacy with the goal of improving health outcomes for people with limited health literacy. Continue to host an annual regional health literacy conference and program support to community-based, health system, public sector, and academic organizations

Affordable housing

- Support community-based recuperative care programs (housing and support services) post-discharge for homeless and other individuals in need of support services and housing insecurities

Meaningful employment

- Support youth employment opportunities designed to improve career development and access to living-wage jobs
- Offer college scholarships and paid summer work experience to [communities of color] for students entering health care careers
- Build capacity in youth development and education programs that increase graduation rates and access/opportunity for higher education achievement
- Support programs that reduce poverty-related barriers to educational success and build capacity for economic stability

Community resources

Social Determinants of Health community resources

Social Determinants of Health community resources

Clark County Food Bank

Council for the Homeless

Free Clinic of SW Washington

Girls on the Run-Portland Metro

Meals on Wheels People

Oregon Association of Minority Entrepreneurs

Oregon Community Warehouse

Share, Inc.

Southwest Washington Regional Health Alliance

Transition Projects

Washington State University Foundation

Vietnamese Community of Clark County

Action plan	Indicators
Legacy Health will continue to support food banks and programs that provide food to individuals struggling with food insecurities	Number of meals served by cash donations and food drive donations
Community health literacy education via regional health literacy conference and program support to community-based, health system, public sector, and academic organizations working on projects focused on improved health literacy	Number of community organizations and individuals reached through regional health literacy conference
Partner with Central City Concern and other health and community organizations to address the challenges in affordable housing, homelessness and health care	Number of completed affordable housing units/ projects
Provide workforce training and college scholarships through YES Program and other career-focused efforts to support ethnically diverse youth entering health careers	Number of ethnically diverse students entering health care careers though YES Program, and number of high school internships, job shadows
Financial support to provide labor resources to education and community-based programs focused on healthy lifestyle, educational attainment and career readiness	School district graduation rates and youth reached through community- and school-based programs

Legacy Health Community Resources

Legacy Health recognizes the power of collaboration. Exchanging knowledge, skills and experiences with our community organizations helps us achieve more together than we would separately. Legacy Health has identified the following resources in our communities to partner with and better address the priority needs in our area.

Organizations	Priority need(s) addressed*
Adventist Health	Funding/collaborative partner
Albertina Kerr	AC, BH
All Hands Raised	SD
AWARE Food Bank	SD
Basic Rights Oregon	AC, BH, SD
Battleground Healthcare	AC
Birch Community Services	SD
Boys and Girls Club of SW Washington	BH
Bradley Angle	SD
Canby St. Vincent De Paul	SD
Cascadia Behavioral Health	BH
Central City Concern	AC, BH, SD
Children's Center	BH, SD
Children's Community Clinic	AC
Clark County Food Bank	SD
Coalition of Communities of Color	SD
Columbia Pacific Food Bank	SD
Columbia River Mental Health Foundation	BH
Community Action of Washington County	AC, SD
Compassion Connect	AC, SD
Council for the Homeless	SD
Daybreak Youth Services	BH
De Paul Treatment Center	BH
Ecumenical Ministries of Oregon	SD
Familias en Acción	AC, SD
Farmworkers Housing Development Corporation	SD
FolkTime, Inc.	BH
Free Clinic of SW Washington	AC, SD
Friendly House	AC
Girls on the Run-Portland Metro	SD
Girls, Inc.	SD
"I Have a Dream" Oregon	SD
Kaiser Permanente	Funding/collaborative partner
Latino Network	AC, SD

*Key: AC=Access to Care, BH=Behavioral Health, SD=Social Determinants of Health

(continued)

Organizations	Priority need(s) addressed*
Liberty House	AC, BH
Lifeworks NW	BH
Lift Urban Portland	SD
Meals on Wheels	SD
Mental Health Association of Oregon	BH
MIKE Program	SD
Momentum Alliance	SD
My Father's House	SD
NAMI Multnomah	BH
NAMI Oregon	BH
Native American Rehabilitation Association of the NW	AC
Native American Youth and Family Center	SD
New Avenues for Youth	AC, BH, SD
North by Northeast Community Health Center	AC
NorthStar	BH
Oregon Association of Minority Entrepreneurs	SD
Oregon Community Warehouse	AC
Oregon Health Care Interpreters Association	AC
Oregon Health & Science University	Funding/collaborative partner
Oregon Humanities	SD
Oregon Latino Health Coalition	SD
Oregon Public Health Institute	AC, SD
Outside In	AC, SD
Partners for a Hunger Free Oregon	SD
Partners In Diversity	SD
Project Access NOW	AC, SD
Q Center	AC
Rose Haven	BH, SD
Salem Health Foundation	AC
Salem/Keiser Coalition for Equality	SD
Salud Medical Center	AC
Sandy Community Action Center	SD
Share, Inc.	SD
Silverton Area Community Aid, Inc.	SD
Snowcap	SD
Southwest Community Health Center	AC
Southwest Washington Regional Health Alliance	SD
The Intertwine Alliance Foundation	BH

*Key: AC=Access to Care, BH=Behavioral Health, SD=Social Determinants of Health

(continued)

Organizations	Priority need(s) addressed*
The Skanner Foundation	SD
The Wallace Medical Concern	AC
TransActive Gender Center	AC
Transition Projects	SD
Trillium Family Services	BH
Urban League of Portland	SD
Vietnamese Community of Clark County	SD
Virginia Garcia Memorial Foundation	AC
Washington State University Foundation	SD
West Linn Food Pantry	SD

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Legacy Health

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