Legacy Health

LEGACY SALMON CREEK HOSPITAL

DBA LEGACY SALMON CREEK MEDICAL CENTER

COMMUNITY HEALTH IMPROVEMENT PLAN

FY 2015

LEGACY
HEALTH

Contents

I. INTRODUCTION

The mission of Legacy Health, the parent of Legacy Salmon Creek Medical Center, is to '…improve the health of…..our community…' With this, Legacy Salmon Creek has had a long-standing commitment to meet community health needs for vulnerable populations beyond the health care environment.

The Legacy Salmon Creek Medical Center Community Health Improvement Plan (CHIP) FY 15 meets the IRS 501®(3) requirement for implementation strategies addressing priority community health issues identified in the hospital's Community Health Needs Assessment. Legacy Salmon Creek adheres to the philosophy that multi-year sustainable partnerships with the community have greater impact on long-term improved health status. Thus, the Legacy Salmon Creek CHIP includes both the continuation of current effective strategies as well as new strategies.

Community health needs assessments and community health improvement plans are approved by the Legacy Health Board of Directors and made available to the public in compliance with IRS requirements.

Focus issues: The Legacy Salmon Creek Community Health Needs Assessment FY 15 priority focus issues, with a lens addressing racial and ethnic equity, are addressed in this CHIP and include:

- Access to health care
- Chronic disease
- Mental health
- Substance use disorder (formerly called Substance abuse)
- Health literacy
- Education and youth

Target populations: Aligned to the CHNA lens on communities experiencing disparities, the Legacy Salmon Creek CHIP target populations are: Clark County primary service area African American, Latino and Native American low income populations and the high need Community Needs Index/top Legacy Salmon Creek emergency department self-pay/Medicaid zip codes of 98661-Downtown Vancouver, 98663-Rosemere East Vancouver and 98665-Hazel Dell.

II. FOCUS ISSUE: ACCESS TO HEALTH CARE

Goal: Improve access to health care for vulnerable communities experiencing disparities.

A. ***Strategy 1:*** Support community-based clinics and/organizations serving the low income and uninsured

Tactic: 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 staff community-based clinics and culturally specific health service organizations

Indicators:

- Number of low income partner organization patients with access to community-based primary care
- Number of uninsured self-pay visits to emergency room

Community partners: Free Clinic of Southwest Washington, Clark County Department of Public Health, Battle Ground Health Care

B. ***Strategy 2:*** Offer services for the low income and uninsured

Tactics:
- Provide health services for the low income uninsured based on charity care financial policies, i.e., up to 400% of FPL
- Participate as a service provider and contribute financial and labor support to Project Access Clark County which connects low income uninsured patients to providers at no charge
- Certify providers to be competent in language other than English to provide care in that language
- Financial support for nurse navigator at the Clark County Department of Public Health to provide prenatal care for women who otherwise would not have such services
- Provide free mammograms for low income uninsured

Indicator:
- Number of eligible under 400% of FPL individuals obtaining health care
- Number of hospital and Legacy Medical Group providers certified to provide care in language other than English

Community partners: Project Access Clark County; 15 Clackamas, Clark, Multnomah and Washington County hospitals; Clark County Department of Public Health, Salmon Creek Hospital Foundation

C. ***Strategy 3:*** Enroll patients in Washington Apple Health Plan

Tactic: Employees trained as enrollment assisters assist patients in application process on-site

Indicator: Number of Washington Apple Health Plan enrollees

Community partner: Washington Health Care Authority

D. ***Strategy 4:*** Partner with community-based organizations to conduct prevention and detection screenings

Tactic: Provide support to local community-based initiatives to raise awareness about breast health screening for women of color

Indicator: Number of people screened through partner organizations

Community partners: Susan G. Komen Foundation, other community-based organizations

III. FOCUS ISSUE: CHRONIC DISEASE

Goal: Prevent and reduce chronic disease through increased access to culturally appropriate and/or low cost services.

A. ***Strategy 1:*** Partner with community-based programs that serve racial, ethnic, senior and underserved populations to provide chronic disease screenings

Tactic: Provide diabetes, glaucoma, eye disease, breast health and other screenings at no charge at public events targeting communities of color and seniors at high risk

Indicator: Number of underserved and communities of color residents accessing screenings through partner organizations

Community partners: Free Clinic of Southwest Washington, Children's Center, Children's Home Society, Community Choices, Columbia River Mental Health, other community-based organizations, faith organizations

B. ***Strategy 2:*** Partner with racially and ethnically diverse organizations to provide chronic disease support services and education to raise awareness and support behavior changes

Tactics:

- Support organizations offering Stanford University's chronic disease self-management program for people with diabetes
- Support safety net clinics offering peer support groups and the Tormando chronic disease self-management program for Spanish-speaking patients
- Achieve hospital baby-friendly status
- Achieve 90% exclusive breast feeding rate upon discharge among all race and ethnic patients *(Healthy Columbia Willamette Collaborative initiative)*
- Sponsor Farmers Market weekly on hospital campus; SNAP cards accepted
- Hold annual drive for food program serving local community
- Partner with culturally specific organizations providing patient navigation

Indicators:

- Number of underserved and communities of color residents accessing partner community-based chronic disease education and support services
- Hospital exclusive breast feeding rate by race and ethnicity

Community partners: Free Clinic of Southwest Washington, Children's Center, Children's Home Society, and other community-based organizations; Healthy Columbia Willamette Collaborative: 15 hospitals; Clark, Clackamas, Multnomah and Washington public health departments; Health Share of Oregon and FamilyCare Coordinated Care Organizations

IV. FOCUS ISSUE: MENTAL HEALTH

Goal: Improve access to mental health and supportive services for the uninsured and low income.

A. ***Strategy 1:*** Build capacity in community-based mental health organizations and collaborate with regional initiatives

Tactics:

- Provide funding and labor resources to local community mental health programs
- Participate with mental health providers to develop improved mental health coordination of services

Indicators:

- Number of low income uninsured with access to services
- Number of County Health Ranking poor mental health days

Community partners: Columbia River Mental Health, Free Clinic of Southwest Washington, Community Services Northwest, Children's Center

B. ***Strategy 2:*** Provide healthy green space for patients, family members, employees and the community

Tactic: Offer Healing Gardens in hospital

Indicator: Number of healing gardens

Community partners: community, Intertwine

V. FOCUS ISSUE: SUBSTANCE USE DISORDER

Goal: Prevent and reduce substance use disorder through increased access to services for the uninsured and low income.

A. ***Strategy 1:*** Reduce opioid misuse and abuse

Tactic: Participate in regional hospital and public health department opioid prescription program, including uniform opiate prescribing policies and practices *(Healthy Columbia Willamette Collaborative initiative)*

Indicators:
- Number of medication agreements
- Number of aligned prescribing guidelines across metro area

Community partners: Healthy Columbia Willamette Collaborative: 15 hospitals; Clark, Clackamas, Multnomah and Washington public health departments; Health Share of Oregon and FamilyCare Coordinated Care Organizations

B. ***Strategy 2:*** Implement CCO aligned Screening, Brief Intervention and Referral to Treatment (SBIRT) screenings

Tactic: Conduct SBIRT screenings in emergency department and Legacy Medical Group

Indicators:
- Number of people screened
- Number of patients who received a substance use disorder brief intervention

C. ***Strategy 3:*** Build capacity in community-based substance use disorder treatment and prevention programs

Tactics:
- Fund community-based culturally appropriate substance use disorder programs
- Fund community education and prevention to reduce driving under the influence on intoxicants

Indicator: Number of people served by partner organization programs

Community partner: Community Services Northwest

VI. FOCUS ISSUE: HEALTH LITERACY

Goal: Improve health outcomes for people with limited health literacy.

A. ***Strategy 1:*** Fund community-based clinic projects focusing on improved health literacy

Tactics:
- Fund development of Learner Web program for patients with low health literacy to learn how to access and navigate EPIC electronic health portals with goal that other clinics will be able to use the learning program when developed
- Fund safety net clinics: train staff in health literacy tools and revision of documents into plain language

Indicators:
- Number of safety net clinic patients accessing electronic health portal
- Number of other health systems and FQHCs using Learner Web program

Community partners: Clark County Department of Public Health, Free Clinic of Southwest Washington, Columbia River Mental Health and other health systems and/or clinics serving low income and vulnerable populations using EPIC

B. ***Strategy 2:*** Increase health literacy education in community

Tactics:
- Host regional health literacy conference at reduced registration fees with national experts
- Present 'health literacy introduction' to community and health system audiences
- Provide cancer, chronic disease and other screenings and education at health fairs and community events for the public
- Offer disease/injury prevention and treatment education classes for the public

Indicators:
- Number of health literacy conference attendees
- Number of attendees at community events
- Number of education classes and attendees

Community partners: 70 different community-based, health system, public sector, academic organizations; school districts

VII. FOCUS ISSUE: EDUCATION AND YOUTH

Goal: Increase education achievement rates and health care workforce rates for communities of color experiencing education disparities.

A. ***Strategy 1:*** Offer college scholarships and paid summer work experience to communities of color students entering health care careers

Tactic: Fund and offer Youth Employment in Summers (YES) program for African American, Native American and Latino students entering health care careers

Indicator: Number of students of color entering health care careers through YES

Community partner: Fort Vancouver High School

B. ***Strategy 2:*** Build capacity in youth development and education programs

Tactic: Financially support and provide labor resources to education and community-based programs focused on health care careers

Indicator: High school graduation rate

Community partners: Clark County School Districts

C. ***Strategy 3:*** Train future health care professionals of color

Tactic: Provide high school internships and job shadows

Indicator: Number of high school internships and job shadows offered

Community partners**:** High schools—Fort Vancouver, Prairie, Battle Ground