Salem Health Hospitals and Clinics
Community Health Implementation Plan
2023

Salem Health partnered with Marion and Polk County Public Health Departments, Santiam Hospital, Legacy Silverton, PacificSource Community Solutions and multiple community based organization in the development of the most recent Community Health Implementation Plan (CHIP). The plan identifies goals and strategies to improve health in the three priority areas identified in the 2019 Community Health Needs Assessment, and renewed in the 2022 update: substance abuse, housing and behavioral health. The full CHIP may be viewed here.

Salem Health has selected some of these strategies for our community health impact work. Other strategies within the priority areas are addressed by various contributors to the plan and partners within our community. The Salem Health tactics to identify these strategies are reviewed and updated annually, although the collaborative document serves as the five year plan from 2021-2025.

Salem Health also identifies other emerging community needs and organizational strategies as additional areas of focus and identifies tactics and outcome metrics.

While the full Community Health Implementation Plan spans a five year time frame, IRS requirements call for community hospitals to conduct a community health needs assessment and community health implementation plan every three years. For Salem Health's CHIP, the data is tracked annually. Strategies and tactics are reviewed and evaluated at this same cadence, and aligned with any update to the Community Health Needs Assessment and targets adjusted, if necessary.

This plan was adopted by the SHHC Board of Trustees May 4, 2023

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CHNA Priority: Housing

Aim G – Strategy 1 – Health system to support implementation of MWVHA strategic plan

SUSTAIN AND OPERATE

- SHHC representation on MWVHA Board; financial support of MWVHA. See Strategy 4 for metrics

Aim G - Strategy 2 – Build relationships with the local health system and the COC collaborative committee through establishing a Health and Safety Subcommittee

SUSTAIN AND OPERATE

- SHHC representation on Health and Safety subcommittee
- Started process mapping various failure points in ED and Care Management discharges for individuals experiencing chronic homelessness. That work was taken over by the Health and Safety Committee and SHHC employees continue to participate

Aim G – Strategy 4 – Strengthen collaboration between HS and street medical outreach teams that provide assessments, vaccinations, TB testing, mental health assistance and referrals.

REGENERATE AND IMPROVE

Process Metric	Outcome Metric (Year 1)
Provide community partners with "Right Time, Right Care, Right Place" fliers to guide decision making and decrease unnecessary ED visits and ambulance/911 calls.	Decrease number of unnecessary ED visits and by 25% Baseline: TBA Target: 25% reduction
Develop after hours process with ARCHES for discharges from SHED	Number of ED discharges placed that meet established criteria Baseline: N/A Target: 90%
Implement test of change for Church at the Park (C@P)to be designated as emergency contact for current clients	Percentage of clients who give permission to list C@P as contact Baseline: NA Target: 50% Percentage of times C@P is contacted and successfully intervenes on behalf of client Baseline: NA Target: 75%
Explore concept of navigator/peer support in SHED for chronically homeless with other service providers	Create concept and funding stream

Aim H – Strategy 3 – Collaborate with Senior and Disabled Services to identify actions to increase screening for housing accessibility , safety, and insecurity

REGENERATE AND IMPROVE

Process metric	Outcome Metric (Year 1)
Work with Diabetes and Nutrition Services Develop process for patients with diabetes to be discharged to LTC with appropriate glucose monitor (LTC staff unable to test levels)	Process created and launched *(this tactic crosswalks with Diabetes and Obesity work)*

CHNA Priority: Behavioral Health

Aim D – Strategy 5 – Enable community-based orgs to destigmatize behavior health by providing culturally responsive information to share with communities served

SUSTAIN AND OPERATE

Community Partnership Grants (examples of what we have funded):

- Polk County

The Gate Grant – "Your Choices Matter" – middle and high school curriculum for prevention for youth, parents and families

- Marion County

Salem Pastoral Grant – free counseling services to the financially marginalized

Boys and Girls Club – healthy lifestyle choices, daily fitness, bike safety, social-emotional activities self-efficacy, motivation and confidents

- Marion and Polk Counties

Liberty House – trauma informed care and play therapy

Salem Keizer Coalition for Equality provide culturally appropriate social emotional education that supports mental and emotional health positive family relations and protective factors

Community Health Education Classes and outreach

- Mental Health First Aid
- Good Food, Good Mood
- Resiliency Library
- New Dad Boot Camp

Salem Health Trauma Nurses

- Education and outreach in high schools and middle schools around region.

REGENERATE AND IMPROVE

Bring Sources of Strength (an evidence based suicide prevention program) to three schools in our region)

CHNA Priority: Substance Use

Aim B – Strategy 5 – Collaborate with local advisory board or work groups on improving substance use treatment access for specific populations such as community member with co-occurring disorders

SUSTAIN AND OPERATE

SHHC representation on community drug courts (ED, Psych and Government Relations)

Aim C – Strategy 4 – Promote treatment and recovery across the lifespan including emphasis on trauma informed care, addiction and life skills after rehabilitation

SUSTAIN AND OPERATE

Funding of Narcan (opioid overdose reversal) for Polk County law enforcement

Community Health Education Support groups

- AA and Al-Anon

Smoking Cessation programs

Prevention and Intervention Education Community-wide

- Forum on impact of fentanyl at Salem Area Chamber of Commerce Forum (Mar 2023)

REGENERATE AND IMPROVE
➢ Data collection and stratification of fentanyl use/abuse/treatment in our region (ongoing) to build a library for real time data

Additional Salem Health Hospitals and Clinics Community Health Implementation Work

<table>
<tr><th colspan="2">FY2022-23 Work: Diabetes and Obesity Health Disparities</th></tr>
<tr><td colspan="2">Goal 1:
Joint Commission introduces a new Patient Safety Goal in January 2023</td></tr>
<tr><td colspan="2">• Identify an individual to lead activities to improve health care equity
• Assess the patient’s health-related social needs
• Analyze quality and safety data to identify disparities
• Develop an action plan to improve health care equity
• Take action when the organization does not meet the goals in its action plan
• Inform key stakeholders about progress to improve health care equity</td></tr>
<tr><td colspan="2">REGENERATE AND IMPROVE</td></tr>
<tr><td>Process Metric</td><td>Outcome Metric (Year 1)</td></tr>
<tr><td>Create a standard to meet new patient safety goal</td><td>All elements of Patient Safety Goal are met
Baseline: NA
Target: 100%</td></tr>
<tr><td colspan="2">SUSTAIN AND OPERATE</td></tr>
<tr><td colspan="2">Partner, Convene, Advocate by working with our community to bring attention to health disparities</td></tr>
<tr><td>Community outreach, health screenings and education for Latina/o/x populations affected by diabetes, pre-diabetes, high blood pressure and high cholesterol</td><td>Baseline: Monthly screenings
Monthly education series in Spanish

Target: 400 individuals reached before December 2023</td></tr>
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FY 2022-23 Organizational Strategies	
Goal 2: Increase employee pipeline from career technical programs with students <2 years out from potential employment	
Regenerate and Improve	
Process metric	**Outcome Metric (Year 1)**
Provide clinical rotations for basic nursing students at Willamette Career Academy	Baseline: NA Target: 50% of students who graduate from program and go to work, will work for Salem Health
Develop one additional partnership to increase employee pipeline for local students	Baseline: 1 partnership Target: 2 partnerships
Goal 3: Create opportunities with community partners to reduce length of inpatient stay	
REGENERATE AND IMPROVE	
Process Metric	**Outcome Metric (Year 1)**
See Aim H Strategy 3 under Housing	
One additional partnership with community based organization	Baseline: 1 partnership Target: 2 partnerships

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