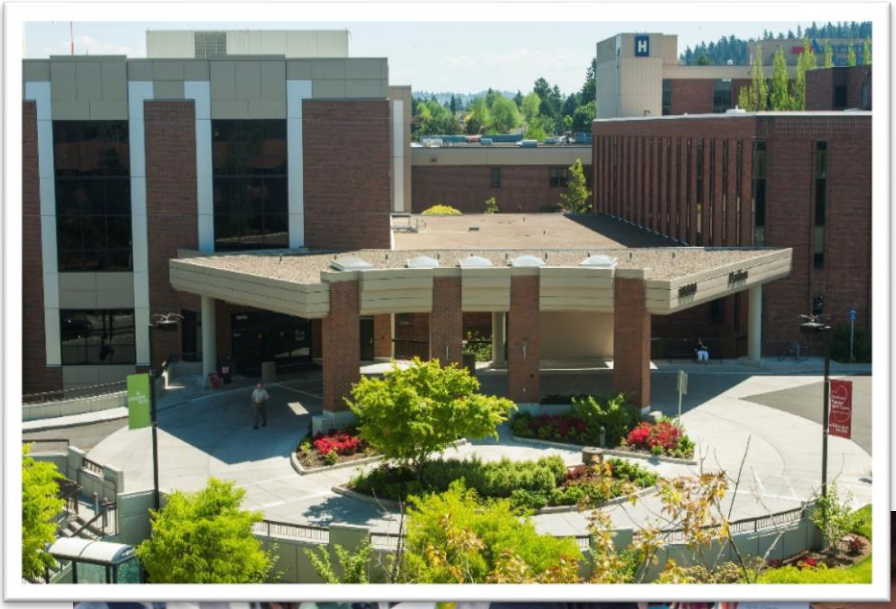
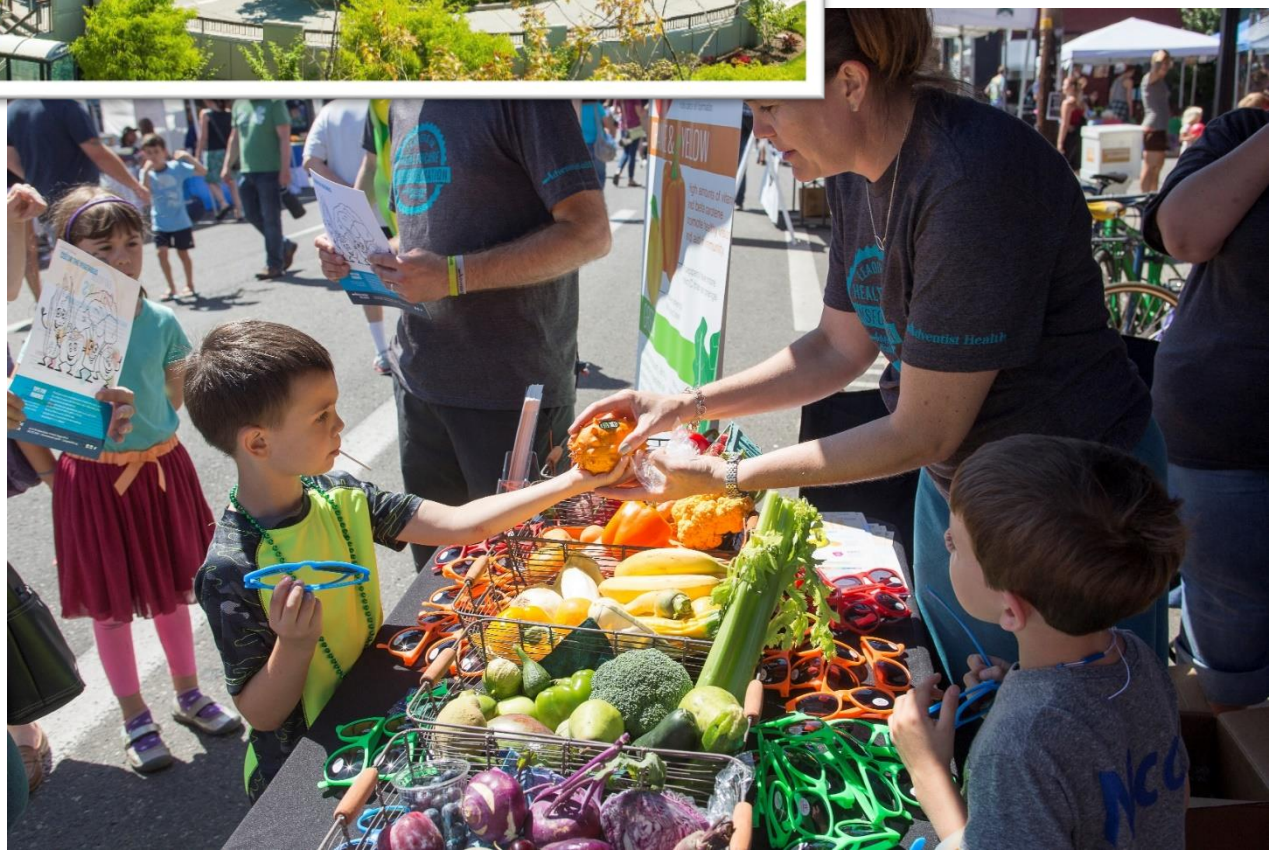
Adventist Medical Center - Portland

2017 Community Health Plan
(Implementation Strategy)
2016 Update/Annual Report





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Adventist Health Overview

Adventist Medical Center - Portland is an affiliate of Adventist Health, a faith-based, nonprofit, integrated health system headquartered in Roseville, California. We provide compassionate care in more than 75 communities throughout California, Hawaii, Oregon and Washington.

OUR MISSION:
Living God's love by inspiring health, wholeness and hope.

OUR VISION:
Adventist Health will be a recognized leader in mission focus, quality care and fiscal strength.

Adventist Health entities include:

- 20 hospitals with more than 2,700 beds
- More than 260 clinics (hospital-based, rural health and physician clinics)
- 15 home care agencies and seven hospice agencies
- Four joint-venture retirement centers
- Workforce of 32,900 includes more than 23,600 employees; 5,000 medical staff physicians; and 4,350 volunteers

We owe much of our heritage and organizational success to the Seventh-day Adventist Church, which has long been a promoter of prevention and whole person care. Inspired by our belief in the loving and healing power of Jesus Christ, we aim to bring physical, mental and spiritual health and healing to our neighbors of all faiths. Every individual, regardless of his/her personal beliefs, is welcome in our facilities. We are also eager to partner with members of other faiths to enhance the health of the communities we serve.

Our commitment to quality health care stems from our heritage, which dates back to 1866 when the first Seventh-day Adventist health care facility opened in Battle Creek, Michigan. There, dedicated pioneers promoted the "radical" concepts of proper nutrition, exercise and sanitation. Early on, the facility was devoted to prevention as well as healing. They called it a sanitarium, a place where patients—and their families—could learn to be well.

More than a century later, the health care system sponsored by the Seventh-day Adventist Church circles the globe with more than 170 hospitals and more than 500 clinics, nursing homes and dispensaries worldwide. And the same vision to treat the whole person—mind, body and spirit—continues to provide the foundation for our progressive approach to health care.

Letter from the CEO

Dear Friends and Colleagues,

For more than 120 years, Adventist Medical Center has been serving as a community resource for health. We have always been committed to providing more than just care for people who are sick—we strive to help people learn to live well and stay well.

You can have faith that the moment you connect with our team--from our volunteers to our providers to our educators—everyone in our organization is committed to seeing you and caring for you as a whole person. Our understanding of body, mind and spirit makes us unique and confirms our commitment to serving as the human expression of the healing ministry of Jesus Christ.

As Jesus ministered to people, He cared for their physical needs and then went on to address their emotional and spiritual health. Our mission calls us to do the same.

We are expanding our mission focus from “healthcare” and “healing” to “health”. Health calls us to think broadly about the people and the communities we serve. We continue to provide health care and healing, but are also challenging ourselves to think about how we can help each person we encounter to achieve optimal personal health. This means engaging with our communities to understand how we can support population health improvement, as well as creating an optimal work environment for our team members to support their personal health goals.

One of the things we’re most proud of is our exceptional team of medical providers. Our providers have the challenge and privilege to help make life-changing decisions each day through mission inspired, compassionate care. Adventist Health Medical Group providers partner with their patients to serve as a wellness resource and make a positive impact through the conversations they have. Our nursing staff maintains the highest certifications because they know every member of our community deserves the best care. And the rest of our team members do their very best work to support the people who are caring for the people.

We continue to look for opportunities to expand our mission. Last year we were able to provide significant support to a community partner who focuses on safe, healthy, affordable housing. We know that housing is health and providing a secure start for families is one of the best ways to impact the health of our community long term.

Thank you for partnering with us in our commitment to expand the impact of our mission and creating opportunity for us serve more people—inspiring health, wholeness and hope.

With gratitude,

David Russell, President & CEO

Hospital Identifying Information

Adventist Medical Center - Portland

Number of Beds: 302

Mailing Address: 10123 SE Market St., Portland, OR 97216

Contact Information: David Russell, President and CEO

(503) 251-6150

Existing healthcare facilities that can respond to the health needs of the community:

- Oregon Health Sciences University
- Legacy Health
- Kaiser Permanente
- Providence Health & Services
- Coalition of Community Health Clinics
- County Health Departments, etc.

Community Health Development Team

Edward Hoover, MA

Manager, LivingWell/Community Wellness

Peter Morgan, MBA

Community Benefits Specialist

Terry Johnsson, DMin

Executive Director of Mission Integration

Kristi Spurgeon-Johnson, MA

Director of Marketing and Communications

CHNA/CHP contact:
Peter Morgan III
Community Benefits Specialist
10123 SE Market St. Portland, OR 97216
Tel: 503/251-6346 Email: morganph@ah.org

To request a copy, provide comments or view electronic copies of current and previous community health needs assessments: https://www.adventisthealth.org/pages/about-us/community-health-needs-assessments.aspx or AdventistHealth.org/communitybenefit

Invitation to a Healthier Community

Fulfilling Adventist Health's Mission

Where and how we live is vital to our health. We recognize that health status is a product of multiple factors. To comprehensively address the needs of our community, we must take into account health behaviors and risks, the physical environment, the health system, and social determinant of health. Each component influences the next and through strategic and collective action improved health can be achieved.

The Community Health Plan marks the second phase in a collaborative effort to systematically investigate and identify our community's most pressing needs. After a thorough review of health status in our community through the Community Health Needs Assessment (CHNA), we identified areas that we could address through the use of our resources, expertise, and community partners. Through these actions and relationships, we aim to empower our community and fulfill our mission, "to share God's love by providing physical, mental and spiritual healing."

Identified Community Needs

The results of the CHNA guided the creation of this document and aided us in how we could best provide for our community and the most vulnerable among us. As a result, Adventist Medical Center - Portland has adopted the following priority areas for our community health investments for 2017-2019:

- **Chronic Disease**
- **Access to Care**
- **Behavioral Health/Addictions**
- **Social Determinants of Health**

Additionally, we engage in a process of continuous quality improvement, whereby we ask the following questions for each priority area:

- Are our interventions making a difference in improving health outcomes?
- Are we providing the appropriate resources in the appropriate locations?
- What changes or collaborations within our system need to be made?
- How are we using technology to track our health improvements and provide relevant feedback at the local level?
- Do we have the resources as a region to elevate the population's health status?

Building a healthy community requires multiple stakeholders working together with a common purpose. We invite you to explore how we intend to address health challenges in our community and partner to achieve change. More importantly though, we hope you imagine a healthier region and work with us to find solutions across a broad range of sectors to create communities we all want for ourselves and our families.

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Community Profile

How our community is defined

In conducting a community health needs assessment, a hospital has many decisions to make. One of the decisions a hospital needs to make is to determine what is the community that they serve as it applies to their needs assessment.

The Treasury Department and the IRS allow a hospital facility to take into account all of the relevant facts and circumstances in defining the community it serves. A hospital needs to make sure that it does nothing to exclude any at risk populations.

In keeping with the spirit of recent IRS regulations, AMC has determined from its hospital patient base, the zip codes where our patients live.

This data set was draw from 46,819 unduplicated patients from January 2015 to June 2016. In the following table, the top 22 zip codes are listed. This represents 77.96% of the 46,819 patients. The first column list the zip codes in order of total amount of patients from most to least. For each zip code, the number of Charity Care and Medicaid patients for that zip code is listed along with the total of both. For each category, a percent of the zip codes total patient counted is listed. For example, for zip code 97236, 6.65% of the 3,803 patients from that zip code had received Charity Care and 42.83% had Medicaid. Please note that the 46,819 patients are patients that were either inpatients or outpatients that use AMC hospital facilities for health care services. AMC patients that were patients exclusively of AMC Home Health Services, AMC Hospice or Adventist Health Medical Group are not counted in this group.

The above data indicates that our primary service area for Adventist Medical Center - Portland is comprised of the following areas within Multnomah and Clackamas Counties:

- Mid-Multnomah County (East/Southeast/Northeast Portland, Lents)
- East Multnomah County (Rockwood, Troutdale, Wood Village, Gresham)
- Eastern portions of Central Eastside and Southeast Portland
- Areas of Northern Clackamas County (including Gladstone, Happy Valley, Damascus, Sandy, Estacada, and Welches
- Secondary Service Area includes South-Eastern side of Vancouver, Washington (Clark County)

Demographics of the community

The demographics of our primary service community are fairly diverse, covering a wide area and somewhat global ethnic profile. The charts below highlight some of the more common groupings, but do not do justice to the many countries of origin. The top 10 admitting zip codes are highlighted in yellow. The following chart lists some of the languages spoken in our wonderful community.

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Race as a % of Population per Zip Code 2010-2014 American Community Survey 5-Year Estimates						
Zip Code	**White Alone**	**Black / African American Alone**	**American Indian/ Alaska Native Alone**	**Asian Alone**	**Native Hawaiian or other Pacific Islander**	**Hispanic/ Latino**
97009	88.3%	0.1%	0.1%	0.5%	0.0%	9.1%
97015	72.0%	1.5%	1.4%	9.0%	1.5%	10.0%
97022	89.6%	0.6%	1.4%	1.7%	0.0%	6.2%
97023	88.6%	0.4%	0.9%	0.7%	0.0%	7.8%
97024	73.1%	4.3%	1.5%	3.4%	0.0%	16.5%
97027	83.7%	1.4%	0.2%	2.9%	0.0%	9.4%
97030	69.8%	2.0%	0.6%	3.4%	1.2%	18.4%
97045	87.3%	0.6%	0.6%	1.4%	0.0%	7.6%
97055	90.4%	0.3%	0.3%	0.6%	0.1%	5.9%
97060	72.2%	2.3%	0.7%	6.8%	0.5%	14.5%
97067	91.2%	0.0%	0.0%	0.0%	0.1%	8.6%
97080	80.1%	1.0%	1.1%	2.6%	0.8%	11.5%
97086	68.5%	1.6%	0.2%	14.7%	0.3%	10.2%
97089	89.0%	0.3%	0.8%	3.6%	0.0%	4.4%
97202	82.3%	2.0%	0.2%	5.5%	0.1%	6.8%
97203	60.9%	9.3%	0.9%	4.0%	2.5%	16.7%
97206	74.4%	2.5%	0.8%	9.6%	0.4%	8.4%
97209	82.6%	3.6%	0.5%	4.8%	0.1%	5.4%
97211	63.8%	18.6%	0.8%	3.1%	0.1%	7.5%
97213	79.2%	4.6%	0.7%	6.5%	1.0%	4.0%
97214	84.7%	1.4%	0.7%	3.6%	0.1%	5.4%
97215	85.8%	1.0%	0.7%	4.6%	0.0%	4.7%
97216	60.6%	5.5%	0.9%	16.2%	0.6%	11.9%
97217	70.5%	10.5%	0.1%	5.3%	0.6%	8.9%
97218	52.0%	14.3%	0.6%	5.8%	0.5%	23.3%
97220	60.2%	7.4%	0.9%	11.4%	0.5%	14.5%
97222	83.1%	1.7%	0.5%	3.0%	0.3%	8.2%
97230	60.4%	9.6%	0.5%	9.0%	1.9%	14.1%
97233	57.3%	6.5%	0.8%	8.5%	1.6%	21.8%
97236	61.8%	6.5%	0.6%	11.2%	0.6%	16.7%
97266	56.0%	5.3%	0.6%	16.2%	0.0%	18.6%
97267	84.2%	1.7%	0.6%	1.7%	0.3%	7.8%
98682	75.9%	2.1%	0.7%	5.5%	0.8%	10.8%

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Zip Code	Total AMC-P Community	
Language data from 2000 American FactFinder QT-P16 (2010 N/A)	Zip Code Population	% of Total Zip Code Population
Population of Zip Code	540,059	100.0%
Speak only English	380,194	70.4%
Speak a language other than English	76,912	14.2%
Spanish or Spanish Creole	**28,878**	5.3%
French (incl. Patois, Cajun)	**1,584**	0.3%
French Creole	139	0.0%
Italian	511	0.1%
Portuguese or Portuguese Creole	112	0.0%
German	**2,971**	0.6%
Yiddish	5	0.0%
Other West Germanic languages	462	0.1%
Scandinavian languages	490	0.1%
Greek	324	0.1%
Russian	**7,588**	1.4%
Polish	214	0.0%
Serbo-Croatian	657	0.1%
Other Slavic languages	3,003	0.6%
Armenian	95	0.0%
Persian	348	0.1%
Gujarathi	197	0.0%
Hindi	288	0.1%
Urdu	143	0.0%
Other Indic languages	491	0.1%
Other Indo-European languages	3,413	0.6%
Chinese	**3,380**	0.6%
Japanese	**1,642**	0.3%
Korean	**1,742**	0.3%
Mon-Khmer, Cambodian	492	0.1%
Miao, Hmong	605	0.1%
Thai	222	0.0%
Laotian	**1,609**	0.3%
Vietnamese	**8,363**	1.5%
Other Asian languages	1,004	0.2%
Tagalog	**1,752**	0.3%
Other Pacific Island languages	1,072	0.2%
Navajo	42	0.0%
Other Native North American languages	125	0.0%
Hungarian	255	0.0%
Arabic	744	0.1%
Hebrew	50	0.0%
African languages	527	0.1%
Other and unspecified languages	373	0.1%

Priority Areas Identified

- Since our 2013-2013 CHNA it has been observed that the concentration of our patients, either receiving charity care and Medicaid, has increased by a substantial amount in a number of zip codes in our service area.
- Black/African Americans experienced the greatest number of disparities with the highest level of concern relative to other communities of color.
- Chronic diseases and conditions—such as heart disease, stroke, cancer, type 2 diabetes, obesity, and arthritis—are among the most common, costly, and preventable of all health problems.
- The suicide rate is increasing in Oregon
- Diabetes is becoming more common in the United States. Diabetes and obesity have more than doubled among Oregon adults since 1990.
- Obesity is the number two cause of preventable death in Oregon and nationally, second only to tobacco use. Obesity prevalence among Oregon adults has risen dramatically in the past two decades.
- During 2014, heart disease was the second leading cause of death in Oregon.

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- In 2014, COPD was the third leading cause of death in the U.S. and Oregon.
- 10.8% of adults and 7.8% of children in Oregon had asthma in 2011.
- Allergies are the 6th leading cause of chronic illness in the U.S.
- Up to one-third of cancer cases in the United States are related to excess weight or obesity, physical inactivity, and/or poor nutrition.
- Lung cancer is the leading cause of cancer mortality in both men and women in the United States.
- Breast cancer is the second leading cause of cancer death in women.
- While mental disorders are common in the United States, their burden of illness is particularly concentrated among those who experience disability due to serious mental illness (SMI).
- Alzheimer's disease is the sixth leading cause of death in the United States and is the fifth leading cause among people aged 65 years and over.
- In 2013, suicide was the second leading cause of death among persons aged 15-24 years, the second among persons aged 25-34 years, the fourth among persons aged 35-54 years, the eighth among persons aged 55-64 years, the seventeenth among persons 65 years and older, and the tenth leading cause of death across all ages.
- People with mental health disorders are more likely than people without mental health disorders to experience an alcohol or substance use disorder.
- The higher percentage of people who were current illicit drug users in 2014 than in prior years appears to reflect trends in marijuana use.
- Nonmedical pain reliever use continued to be the second most common type of illicit drug.
- In 2009-2010, Oregon was one of the top ten states for rates of drug-use in several categories.
- By 2013, the number of individuals receiving treatment had increased by more than 107% compared with 2004.
- From 2010–2014, there was an approximate 2.6-fold increase in the number of reported acute hepatitis C cases from 850 to 2,194 cases, respectively.
- Chlamydia is the most common reportable illness in Oregon. More than 13,000 cases occurred in 2012.
- Oregon's rate of early syphilis infections greatly increased during the last eight years. There were 0.7 cases per 100,000 people in 2007 and 10.5 cases per 100,000 people in 2014. This represents a 1500% increase. Increases continue during 2015.
- About 110,000 more Oregonians were poor in 2014 than in 2009 at the end of the Great Recession.
- Multnomah County child poverty prevalence is higher for all communities of color than nationally.
- Between 2014 and 2015, homelessness among individuals increased in 19 states. The largest increases were in New York (3,492 more people), California (2,391), Oregon (1,473), Washington (1,136), and Illinois (802).

Information gaps

Hospital data, while the data is current, is only a subset of the population. The HCWC hospital data was limited to Medicaid patients.

We would have liked to see a better response rate to our local community health expert survey. There will be an earlier start date to this effort in the next CHNA process. We also need to review best practices to improve participation in the survey.

A more robust section on children's health concerns is needed.

Community Health Needs Assessment Overview

Link to final CHNA report

AMC-P Community Health Needs Assessment: This Community Health Needs Assessment for Adventist Medical Center - Portland was approved by the Adventist Health Board of Trustees on October 18, 2016.

Methodology for CHNA

The information for this report was collected from multiple primary and secondary sources. First, our membership with the Healthy Columbia Willamette Collaborate gave us access to the group's in-debt analysis of the community health needs of Multnomah County. Secondly, a Community Health Expert survey was sent to public health experts within the hospital and through the community. The data also includes a review of publicly collected health and demographic statistics.

Prioritization of the Significant Needs (As identified by this report)

Category	Total Weighted Score
Diabetes	**4584**
Obesity	**4436**
Heart Disease	**4269**
Tobacco	**3900**
Housing/Homelessness	**3839**
Cancer	**3756**
Racial and Ethnic Health Disparities	**3756**
Mental Health- Depression	**3701**
Stroke	**3419**
Hunger	**3280**
Illicit Drug Use	**3210**
Suicide	**3177**
COPD	**3124**
Sexually Transmitted Disease	**2842**
Asthma	**2405**
Allergies	**2241**

The above ranking was determined by imputing data from the following information sources:

- East Multnomah County Service Provider Survey
- Healthy Columbia Willamette Collaborate Survey
- Leading Oregon causes of death 2014
- CHNA defined trends
- AMC Hospital Patient data
- As well as inputs from several community health experts
- All inputs were weighted by reliability of the data source and level of expertise

Collaborative Partners

While conducting our Community Health Needs Assessment, we solicited feedback and input from a broad range of stakeholders and health partners. One of the most significant partnerships was that of the Healthy Columbia Willamette Collaborative. The Collaborative includes 15 hospitals, 4 health departments and 2 Coordinated Care Organizations in the Clackamas, Multnomah and Washington counties of Oregon and in Clark County, Washington. This unique public-private partnership serves as a platform for collaboration around data collection, community input, analysis, and activities that leverage collective resources to improve the health and wellbeing of our communities.

Community Voices

The work conducted by the Healthy Columbia Willamette Collaborative and our own, more focused work included conducting many stakeholder interviews, listening sessions, and surveys. A specially chartered committee of Collaborative members and other community representatives made a strong effort to ensure that as many ethnic and cultural groups were included as possible.

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Identified Priority Needs from 2016 CHNA

Identified Need ONE – Chronic Disease

Goal

To reduce the current and future burden of Chronic Diseases (Cardiovascular Disease, Diabetes, Hypertension, Asthma, Cancer) in selected high risk communities within Mid-East Multnomah County and Northern Calaveras County.

Short-term Objectives

Objective 1: Reduce Breast Cancer Deaths. Expand National Breast Cancer Foundation (NBCF) grant funded mammography screenings to include 39 or more low-income, medically underserved women in 2017. (Triple the number from 2016)

1. Conduct provider and staff training about screening options and referral process
2. Refine & simplify referral process to facilitate ease of making referrals
3. Find/create culturally appropriate educational materials to encourage participation and personal breast health practices.

Objective 2: Reduce Colorectal Cancer Deaths. Establish new relationships and processes to increase age-appropriate colorectal cancer screenings (primarily colonoscopies) for lower income, medically underserved residents, and age-appropriate members of the general public in 2017.

1. Formalize new referral partnership with Mid-County Health Clinic (Multnomah County), and Clackamas County.
2. Refine & simplify referral process to facilitate ease of making referrals
3. Find/create culturally appropriate educational materials to encourage participation and personal colorectal health practices.
4. Conduct an awareness campaign in clinics, community (social media, LW podcasts) special Healthy Colon, Healthy You event at AMC

Objective 3: Reduce Lung Cancer Deaths. Continue to refine promotion and referral processes to increase Lung Cancer-related screenings (CT scan) for qualifying high risk smokers/former smokers in 2017.

1. Continue provider and staff training about CT/smoker screening project and referral process
2. Refine & simplify referral process to facilitate ease of making referrals
3. Find/create culturally appropriate educational materials to encourage participation and personal digestive health practices.

Objective 4: Save lives of Heart Attack Victims and prevent the disease. Train 400+ people in AHA "hands only" CPR and heart health practices, and report on the AHA tracking system. Involve participants in training friends and reporting.

1. Pull together training materials, equipment and process for reporting (step by step)
2. Train community members to help – churches, AH employees,
3. Build into AH/Compassion Network clinics, and selected AH events for 2017 and into 2018.

Objective 5: Provide healthier futures for babies and families via ongoing birthing classes and breastfeeding support at AMC/P and with other partners.

1. Work with Marketing and providers to promote existing classes/services more effectively.
2. Explore ways to strengthen connections with community-based breastfeeding and early child support resources for FBP families.
3. Develop a plan for incorporating desirable practices and possibly achieving "Baby-Friendly" status recognition.

Objective 6: Promote the adoption of healthier lifestyles to prevent/help reverse chronic disease through classes, support groups, media and other methods featuring lifestyle medicine approaches to health and healing. Some selected programs include:

1. Complete Health Improvement Program (3 – 18 session programs. Around 80 participants)
2. Pre-diabetes and Diabetes Education programs (monthly and quarterly classes. Over 100)
3. Sleeping Well Again (4-5 sessions/ year. Around 100 participants)
4. Weekly Smoke Free Support Group (Averaging 6-10 participants)
5. LivingWell Podcasts (Weekly)

Objective 7: Equip healthcare professionals with some of the latest information on plant-based nutrition and its application in the healing process through our Annual Northwest Health and Nutrition Conference, co-sponsored with NW Veg and other partners.

Intermediate/Long-Term Objectives

Objective 1: Continue early detection screening and education programming refining programs and promotions as needed

Objective 2: Lung Cancer prevention. Increase the percentage of homes in surrounding zip codes who have had their homes tested for radon.

1. Work with Oregon Radon Coalition to host a special community radon awareness education event at AMC in Winter, 2017 and sell discounted home test kits.
2. Work with Radon Coalition Plan on a radon project for smokers to run Fall, 2017 into Winter, 2018. This will include distributing home test kits to qualifying smokers who are working on quitting.

Evaluation Metrics

Objective	Baseline Measurement	Performance Target	Indicator	Data Source
#Mammograms		39	screens	records
#Colonoscopies/FIT		20% increase	screens	records
#Smoker CT Scans		45?	screens	records
# Radon Kits		100	Kits sold/used	records
# HO CPR trained		400+	Persons trained	records
# H&NC Attendees		275	Attendees	attendees

Community Partners

Partner Organization	Role in Addressing Priority Need
Mult County Health Dept, PACS, etc.	Referrals & follow-up
Schools, Churches, NW Veg	Volunteers, training, outlets
ACS, ALA, AHA, Radon Coalition	Materials, trackers, consultants, kits

Identified Need **TWO** – Access to Culturally Appropriate Health Care

Goal

A healthier community that has access to comprehensive, "whole-person" health care that is accessible and sensitive to their unique cultural and linguistic needs.

Short-term Objectives

Objective 1: Strengthen the continuum of health care and create additional healthcare access points with a focus on low-income adults, ages 19– 64, and those living below 200% of the FPL.

Interventions:

1. Expand Compassion Network to conduct 20 or more community-based clinics in 5-6 locations serving 800-1000 underserved residents in our primary service area between April 2017 and mid-2018.

2. Partner with other Housing is Health agencies to help fund the opening of Central City Concern's Eastside Health Center in their new 176-unit Housing Facility which is under development.
3. Help fund and provide other logistical support for the Impact Your Health PDX clinic in late August 2017.
4. Continue to promote awareness of the new Parkrose Urgent Care location that opened in 2016 and located in zip code 97230.
5. Refer appropriate patients to BUILD Community Health Workers – Target period is Spring, 2017 - Fall, 2017

Objective 2: Continue to assist the uninsured/underinsured by removing undesirable barriers to receiving appropriate health care, or being crushed by unmanageable health care bills.

Interventions:

1. As needed, provide financial assistance or "charity care" to patients without insurance or financial resources, including the necessary assistance to complete application forms.
2. Update, as needed, communication of the Adventist Health Financial Assistance Policy in the community, especially to at risk communities through financial counselors, posters, and other media.
3. Provide financial assistance to Project Access Now (PANOW), a program that connects low-income, uninsured people to donated care across the Portland metropolitan area.

Objective 3: To establish practices and processes to help provide more culturally responsive whole-person healthcare services to selected communities within our service area.

1. Charting modifications to more appropriately respond to concerns from LGBTQ community members.

Objective 4: Train/mentor interested local young people and more seasoned adults to be whole-person health care workers serving in the community. Partner with other organizations where possible.

1. Initiate project with Mt. Hood Community College to provide practicum opportunities for Medical Assistant's within our AHMG clinics in 2017.
2. AMC Spiritual Care Dept for Chaplaincy training, Spiritual Care volunteers, and local pastoral support/training programs

Intermediate/Long Term Objectives

Objective 1: A diverse AH/P/AHMG staff that are culturally responsive healthcare professionals and support staff at AMC/AHMG.

1. Ongoing training of existing and new providers/staff in areas of cultural sensitivity and respect.

Objective 2: Train/mentor interested local young people and more seasoned adults to be whole-person health care workers serving in the community. Partner with other organizations where possible

1. Continue relationship with Mt Hood Community College and possibly others.

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2. Explore partnership with David Douglas High School on Exploring Health Careers Project.
3. Recruit, and assist with training nurses to become Faith Community leaders in their Parishes. Faith Community Nursing/Health Ministries NW partnership.
4. Continue AMC Spiritual Care Dept's training programs, including CPE, Spiritual Care volunteers, and local pastoral support/training programs.

Objective 3: Regularly audit and adjust care environment and patient materials to be more culturally relevant and friendly including brochures, magazines, flyers, publications, and environment.

Evaluation Metrics

Objective	Baseline Measurement	Performance Target	Indicator	Data Source
Expanded Clinic Services	N/A New	1600+ served, 3+ new locations	Services, locations	AMEN, Comp Connect, CCC
BUILD Referrals	N/A New	8 referrals	Referrals	IRCO/OPHA
Charity Care, etc.	Variable	Variable	Unpaid bills	Financials
LGBTQ Process	N/A New	Charting in place	Operational	AHMG
Mt Hood CC Student Interns	N/A New	15?	Interns	MHCC,AHMG

Community Partners

Partner Organization	Role in Addressing Priority Need
Compassion Connect/Churches/Central CC	Admin, volunteers, facilities
BUILD Partners (IRCO, OPHA, Prov, Kaiser)	Provide CHW's to work with indiv/families
Project Access Now	Identify & assist uninsured with enrolling
Mt Hood Community College	Training local Medical Assistants

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Identified Need THREE – Behavioral Health

Goal

Our community residents will have increased mental/emotional wellbeing due to improved access to outpatient, whole-person behavioral health care, spiritual care, and community support services.

Short-term Objectives

Objective 1: Open UNITY Center for Behavioral Health (a partnership) in early 2017.

Objective 2: Open New Outpatient Emotional Wellness Clinic @ AMC/P campus by June, 2017

Objective 3: Open New, expanded capacity CCC Eastside Health Center and housing facility. Start Summer 2017, Open Winter 2018.

Objective 4: Serve 6,500 residents via First Friday, Soup & Salad, Grief Support and PrayerWorks/AMEN programs

Objective 5: Train and support individuals in hospital Chaplain/healthcare-based spiritual care practices

- Clinical Pastoral Education Students (12 participants trained)
- Spiritual Care Volunteers (15 volunteers trained)
- Area Pastors (50 churches, and 15 on-call chaplain/pastors)

Intermediate/Long Term Objectives

Objective 1: AH/P Emotional Wellness Clinic, LivingWell and Spiritual Care Dept. jointly offer community outreach programs on self-management of Depression and Anxiety, etc.

Objective 2: Explore building capacity by training community members and AH/P staff in Mental Health First Aid/Spiritual Care.

Evaluation Metrics

Objective	Baseline Measurement	Performance Target	Indicator	Data Source
UNITY Center	N/A	Open	Operating	UNITY
AHMG Emotional Wellness Center	N/A	Open	Operating	AHMG

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New Eastside Health Center	Small clinic	Open	Operating	CCC
AH/P Spiritual Care projects	5700	6500+	Participation #	AH/P Spirit Care

Community Partners

Partner Organization	Role in Addressing Priority Need
Central City Concern & UNITY Partners	Funding, Management
KPDQ Radio Station	Assist with promotion of programs

Identified Need **FOUR** – Social Determinants of Health

Goal

Financially and otherwise challenged community members are healthier because they have access to key factors that can contribute to more successful lives including housing, education, wholesome food, and a more culturally respectful community.

Short-term Objective

Objective 1: Contribute to the start-up funding of the Central City Concern's two comprehensive housing projects (331 units) for medically fragile and those in recovery, as well as workforce housing in East Portland. One facility to open in Winter 2018, the other in September 2018.

Objective 2: Partner with Meals on Wheels to deliver around 500 nutritious meals to needy Mid-county individuals in 2017.

Objective 3: To increase access to fresh produce by exploring partnerships with GROW Portland to help fund new community garden near AMC/P, and a local Public School in Powelhurst-Gilbert Neighborhood to expand food-backpack program to serve more "food insecure" children.

Objective 4: Community and relationship building with a health promotion twist at Festival of Nations event in September, National Nite Out events in local neighborhoods, and the Montavilla Street Fair.

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Intermediate Objectives

Objective 1: Continue funding and referral support for the Central Concern Eastside Housing Project's for remainder of agreement

Objective 2: Expand use of community, school & home gardens, food bank outlets, farmers' markets and engage convenience stores when possible.

- Intervention 1 – Build year-round community support for existing gardens, including home gardens – (incl. "low water" gardens, greenhouses, aquaculture, small herb gardens) Add sites as identified.
- Intervention 2 – PB Cooking and Nutrition Education using low cost whole grains, legumes, potatoes and colorful produce. Feature ethnic flavors
- Intervention 3 – Expand support for, and enhance School backpacks/food for kids – no junk food. Link with #2 above.

Long Term Objectives

Objective 1: Housing options for East County residents that are safe, healthy and available at variable rates, including adverse weather sites for homeless individuals.

Objective 2: Adequate year-round access and use of reasonably-priced fresh produce and staples, and less exposure to, and use of, poor quality food items. Vibrant farmers' markets. Expanded healthy options at convenience stores. Practicing "healthy chefs" in local restaurants offering healthier menu options

Evaluation Metrics

Objective	Baseline Measurement	Performance Target	Indicator	Data Source
New housing	Limited	New housing for 331	New rooms	CCC
New community garden		One new garden	New garden	GROW Portland
Meals on Wheels	Continue two routes	Continue two routes	Meals served	MOW
Community-building projects	3 local events	4-5 local events 400 interactions	# of events, # interactions	tally

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Community Partners

Partner Organization	Role in Addressing Priority Need
Legacy Health, Kaiser, OHSU, Providence, CareOregon	Funding Partners
Central City Concern	Managing housing facility
GROW, PACS, Zenger Farms, Portland Farmers Market, Schools, Churches, People to People, Division Midway Alliance, Neighborhood Associations, etc.	Outlets for education, growing food, & food distribution. Garden management. Special Events

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Identified Needs from CHNA, Not Addressed

Many of the identified community needs are quite extensive and not amenable to easy, quick-fix answers. While we are not able to address all of the identified needs to the degree that we would like, we are attempting to take action to address at least some portion within the four key areas. We are fortunate to have wonderful people and organizations within the community with whom we can partner to collectively extend our reach.

Three areas with relatively minimal involvement include:

Illicit Drugs: Due to limited internal resources, we are helping fund other groups like Central City Concern to help address this important need.

Poverty/Jobs: Adventist Medical Center - Portland addresses part of the growing poverty problem in our community with our access to healthcare initiatives. Limited annual programs like our Holiday Food basket and Warm Winter Clothing programs that are supported generously by employees and directed to those in need. The greater challenges in this area are being served by community groups better suited to address those needs. Adventist Medical Center - Portland does not have the resources or expertise to make a greater impact in this area.

Hunger: This area of concern is directly related to the issue of poverty which we are unable to solve. Nonetheless, Adventist Medical Center - Portland will continue to support the running of two routes on two days a week with Meals on Wheels, and sponsor an annual Celebration of Thanksgiving free community concert in the fall where donations to the Oregon Food Bank are collected at the door for admission. Thousands of pounds of non-perishable food have been collected.

By God's grace, and with His direction, we seek to learn better ways to minister to our neighbors and bring glory to His name. When possible, Adventist Medical Center - Portland will provide assistance to those community groups that are addressing other community needs as identified in our 2016 community health needs assessment.

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Making a difference: Evaluation of 2014-2016 CHP

Adventist Health wants to ensure that our efforts are making the necessary changes in the communities we serve. In 2013, we conducted a CHNA and the identified needs were: Chronic Disease, Access to Care, and Mental Illness

Through the subsequent years many things were accomplished. Below is a summary of a few of the activities:

Chronic Disease

- Held a Women's Health Fair with 245 attending form the community
- Held a Fair of the Heart with 250 attending
- Started the Community Health Improvement Program (CHIP) featuring lifestyle approaches to healing.
- Conducted Smoke Free Support Group with 400 attending
- Cancer Clinical Trial program
- Conducted numerous health education sessions
- Twice weekly Meals On Wheels deliveries
- Radon Screening home programs with nearly 150 kits distributed

Access to Care

- Assisted in the Enrollment 1,642 members of the community in Medicaid
- Donated to Project Access Now for members of the community needing assistance in paying for medical insurance
- Opened our new Parkrose Urgent Clinic located in high need community
- Provided rides for 148 at risk cancer patients
- Provided 321 nursing students hospital training opportunities

Mental Health

- Inpatient Subsidized Behavioral Health Unit (1,765 patients in 2015).
- Donated to the National Alliance for the Mentally Ill.

Strategic Partner List

Adventist Medical Center - Portland supports local partners to augment our own efforts, and to promote a healthier community. Partnership is not used as a legal term, but a description of the relationships of connectivity that are necessary to collectively improve the health of our region. One of our objectives is to partner with other nonprofit and faith-based organizations that share our values and priorities to improve the health status and quality of life of the community we serve. This is an intentional effort to avoid duplication and leverage the successful work already in existence in the community. Many important systemic efforts are underway in our region, and we have been in partnership with multiple not-for-profits to provide quality care to the underserved in our region. Some of those are listed below:

Selected Community Partners	
• Adventist Medical Evangelism Network	• Meals on Wheels
• American Lung Association	• Project Access Now
• American Heart Association	• Multnomah County Health Department
• American Cancer Society	• BUILD Project Partners
• Compassion Connect	• Area Churches
• Central City Concern & Partners	• National Breast Cancer Foundation
• UNITY Center	• NW Veg
• Healthy Columbia Willamette Collaborative	• Division Midway Alliance
• KPDQ Radio	• GROW Portland
• Portland Adventist Community Services	• AMR Ambulance

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Community Benefit Inventory

Adventist Medical Center - Portland knows working together is key to achieving the necessary health improvements to create the communities that allow each member to have safe and healthy places to live, learn, work, play, and pray. Below you will find an inventory of additional interventions taken from our Community Benefit Inventory for Social Accountability (CBISA) software and documented activities.

Year 2016 Inventory

Activities	Number of Programs	Individuals Served
Medical Care Services		
Charity Care	1	8,695
Medicaid	1	46,865
Community Health Improvement		
Meals on Wheels	1	7,000
Varied Health Education Topics		70,450
Health Professions Education		
Preceptored and Cohort Nursing Students	2	413
Medical Student Training and Coordination	1	108
Research		
Clinical Trail programs	1	37
Cash and In-Kind Contributions		
Cash Donations/Not for Profit	24	1,200
In-Kind Donations	12	5,240

Connecting Strategy and Community Health

As hospitals move toward population health management, community health interventions are a key element in achieving the overall goals of reducing the overall cost of health care, improving the health of the population, and improving access to affordable health services for the community both in outpatient and community settings. The key factor in improving quality and efficiency of the care hospitals provide is to include the larger community they serve as a part of their overall strategy.

Health systems must now step outside of the traditional roles of hospitals to begin to address the social, economic, and environmental conditions that contribute to poor health in the communities we serve. Bold leadership is required from our administrators, healthcare providers, and governing boards to meet the pressing health challenges we face as a nation. These challenges include a paradigm shift in how hospitals and health systems are positioning themselves and their strategies for success in a new payment environment. This will impact everyone in a community and will require shared responsibility among all stakeholders.

Population health is not just the overall health of a population but also includes the distribution of health. Overall health could be quite high if the majority of the population is relatively healthy—even though a minority of the population is much less healthy. Ideally such differences would be eliminated or at least substantially reduced.

Community health can serve as a strategic platform to improve the health outcomes of a defined group of people, concentrating on three correlated stages:

1) The distribution of specific health statuses and outcomes within a population;
2) Factors that cause the present outcomes distribution; and
3) Interventions that may modify the factors to improve health outcomes.

Improving population health requires effective initiatives to:

1) Increase the prevalence of evidence-based preventive health services and preventive health behaviors,
2) Improve care quality and patient safety and
3) Advance care coordination across the health care continuum.

Our mission as a health system is to share God's love by providing physical, mental and spiritual healing and we believe the best way to re-imagine our future business model with a major emphasis of community health is by working together with our community.

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Financial Assistance Policies

At Adventist Health, we are committed to keeping you healthy. Your ability to pay should never stop you from seeking needed care.

When you come to us for treatment, our patient financial services department will be happy to talk to you about payment options. Our financial assistance program offers:

If you are uninsured, you may be eligible to receive a discount for your services under our Uninsured Discount policy.

If you are uninsured, our financial counselors will help you find out if you qualify for a government program such as Medicaid (Medi-Cal in California). If one of these programs is right for you, they may be able to assist you with the application process.

If you do not qualify for a government program, we provide discounts to eligible low-income patients and underinsured patients. Please contact our patient financial services department if you cannot pay part of your bill. We will review your financial situation to determine if you are eligible for financial assistance.

More can information can be found by accessing our link, https://www.adventisthealth.org/nw/pages/patients-and-visitors/financial-services/financial-assistance.aspx .

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Community Benefit & Economic Value for Prior Year

Terms and definitions- as defined in the IRS 990 Schedule H Instructions

Our community benefit work is rooted deep within our mission, with a recent recommitment of deep community engagement within each of our ministries.

We have also incorporated our community benefit work to be an extension of our care continuum. Our strategic investments in our community are focused on a more planned, proactive approach to community health. The basic issue of good stewardship is making optimal use of limited charitable funds. Defaulting to charity care in our emergency rooms for the most vulnerable is not consistent with our mission. An upstream and more proactive and strategic allocation of resources enables us to help low-income populations avoid preventable pain and suffering; in turn allowing the reallocation of funds to serve an increasing number of people experiencing health disparities.

Valuation of Community Benefit
Year 2016

PORTLAND ADVENTIST MEDICAL CENTER
DBA ADVENTIST MEDICAL CENTER PORTLAND

Charity Care and Other Community Benefit	Net Community Benefit	% of Total Cost
Traditional charity care	3,300,008	1.33%
Medicaid and other means-tested government programs	6,672,923	2.68%
Community health improvement services	1,579,430	0.63%
Health professions education	1,092,584	0.44%
Subsidized health services	422,985	0.17%
Research	21,132	0.01%
Cash and in-kind contributions for community benefit	117,472	0.05%
Community building activities	34,443	0.01%
TOTAL COMMUNITY BENEFIT	**13,240,977**	**5.32%**

Medicare	Net Cost	% of Total Cost
Medicare shortfall	-	-
TOTAL COMMUNITY BENEFIT WITH MEDICARE	**13,240,977**	**5.32%**

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Appendices

Glossary of terms

Medical Care Services (Charity Care and Un-reimbursed Medi-Cal and Other Means Tested Government Programs)

Free or discounted health services provided to persons who meet the organization's criteria for financial assistance and are thereby deemed unable to pay for all or portion of the services. Charity Care does not include: a) bad debt or uncollectible charges that the hospital recorded as revenue but wrote-off due to failure to pay by patients, or the cost of providing care to such patients; b) the difference between the cost of care provided under Medicaid or other means-tested government programs, and the revenue derived there from; or c) contractual adjustments with any third-party payers. Clinical services are provided, despite a financial loss to the organization; measured after removing losses, and by cost associated with, Charity Care, Medicaid, and other means-tested government programs.

Community Health Improvement

Interventions carried out or supported and are subsidized by the health care organizations, for the express purpose of improving community health. Such services do not generate inpatient or outpatient bills, although there may be a nominal patient fee or sliding scale fee for these services. Community Health Improvement – These activities are carried out to improve community health, extend beyond patient care activities and are usually subsidized by the health care organization. Helps fund vital health improvement activities such as free and low cost health screenings, community health education, support groups, and other community health initiatives targeting identified community needs.

Subsidized Health Services – Clinical and social services that meet an identified community need and are provided despite a financial loss. These services are provided because they meet an identified community need and if were not available in the area they would fall to the responsibility of government or another not-for-profit organization.

Financial and In-Kind Contributions – Contributions that include donations and the cost of hours donated by staff to the community while on the organization's payroll, the indirect cost of space donated to tax-exempt companies (such as for meetings), and the financial value (generally measured at cost) of donated food, equipment, and supplies. Financial and in-kind contributions are given to community organizations committed to improving community health who are not affiliated with the health system.

Community Building Activities – Community-building activities include interventions the social determinants of health such as poverty, homelessness, and environmental problems.

Health Professions Education and Research

Educational programs that result in a degree, certificate, or training that is necessary to be licensed to practice as a health professional, as required by state law; or continuing education that is necessary to retain state license or certification by a board in the individual's health profession specialty. It does not include education

or training programs available exclusively to the organization's employees and medical staff, or scholarships provided to those individuals. Costs for medical residents and interns may be included.

Any study or investigation in which the goal is to generate generalized knowledge made available to the public, such as underlying biological mechanisms of health and disease; natural processes or principles affecting health or illness; evaluation of safety and efficacy of interventions for disease such as clinical trials and studies of therapeutic protocols; laboratory-based studies; epidemiology, health outcomes and effectiveness; behavioral or sociological studies related to health, delivery of care, or prevention; studies related to changes in the health care delivery system; and communication of findings and observations (including publication in a medical journal)

Community Health Needs Assessment and Community Health Plan Coordination Policy

Entity:

☒ **System-wide Corporate Policy**	**Corporate Policy**	**No. AD-04-006-S**
☒ **Standard Policy**	**Department:**	**Administrative Services**
☐ **Model Policy**	**Category/Section:**	**Planning**
	Manual:	**Policy/Procedure Manual**

POLICY SUMMARY/INTENT:

This policy is to clarify the general requirements, processes and procedures to be followed by each Adventist Health hospital. Adventist Health promotes effective, sustainable community benefit programming in support of our mission and tax-exempt status.

DEFINITIONS

1. Community Health Needs Assessment (CHNA)**:** A CHNA is a dynamic and ongoing process that is undertaken to identify the health strengths and needs of the respective community of each Adventist Health hospital. The CHNA will include a two document process, the first being a detailed document highlighting the health related data within each hospital community and the second document (Community Health Plan or CHP) containing the identified health priorities and action plans aimed at improving the identified needs and health status of that community.

   A CHNA relies on the collection and analysis of health data relevant to each hospital's community, the identification of priorities and resultant objectives and the development of measurable action steps that will enable the objectives to be measured and tracked over time.

2. Community Health Plan: The CHP is the second component of the CHNA and represents the response to the data collection process and identified priority areas. For each health need, the CHP must either: a) describe how the hospital plans to meet the identified health need, or b) identify the health need as one the hospital does not intend to specifically address and provide an explanation as to why the hospital does not intend to address that health need.

3. Community Benefit: A community benefit is a program, activity or other intervention that provides treatment or promotes health and healing as a response to identified community needs and meets at least one of these objectives:

   - Improve access to health care services
   - Enhance the health of the community
   - Advance medical or health care knowledge
   - Relieve or reduce the burden of government or other community efforts

   Community benefits include charity care and the unreimbursed costs of Medicaid and other means-tested government programs for the indigent, as well as health professions' education, research, community health improvement, subsidized health services and cash and in-kind contributions for community benefit.

AFFECTED DEPARTMENTS/SERVICES:
Adventist Health hospitals

POLICY: COMPLIANCE – KEY ELEMENTS
PURPOSE:
The provision of community benefit is central to Adventist Health's mission of service and compassion. Restoring and promoting the health and quality of life of those in the communities served, is a function of our mission "To share God's love by providing physical, mental and spiritual healing." The purpose of this policy is: a) to establish a system to capture and report the costs of services provided to the underprivileged and broader community; b) to clarify community benefit management roles; c) to standardize planning and reporting procedures; and d) to assure the effective coordination of community benefit planning and reporting in Adventist Health hospitals. As a charitable organization, Adventist Health will, at all times, meet the requirements to qualify for federal income tax exemption under Internal Revenue Code (IRC) §501(c)(3). The purpose of this document is to:

1. Set forth Adventist Health's policy on compliance with IRC §501(r) and the Patient Protection and Affordable Care Act with respect to CHNAs;
2. Set forth Adventist Health's policy on compliance with California (SB 697), Oregon (HB 3290), Washington (HB 2431) and Hawaii State legislation on community benefit;
3. Ensure the standardization and institutionalization of Adventist Health's community benefit practices with all Adventist Health hospitals; and
4. Describe the core principles that Adventist Health uses to ensure a strategic approach to community benefit program planning, implementation and evaluation.

A. General Requirements

1. Each licensed Adventist Health hospital will conduct a CHNA and adopt an implementation strategy to meet the community health needs identified through such assessment.

2. The Adventist Health *Community Health Planning & Reporting Guidelines* will be the standard for CHNAs and CHPs in all Adventist Health hospitals.

3. Accordingly, the CHNA and associated implementation strategy (also called the Community Health Plan) will initially be performed and completed in the calendar year ending December 31, 2013, with implementation to begin in 2014.

4. Thereafter, a CHNA and implementation strategy will be conducted and adopted within every succeeding three-year time period. Each successive three-year period will be known as the Assessment Period.

5. Adventist Health will comply with federal and state mandates in the reporting of community benefit costs and will provide a yearly report on system wide community benefit performance to board of directors. Adventist Health will issue and disseminate to diverse community stakeholders an annual web-based system wide report on its community benefit initiatives and performance.

6. The financial summary of the community benefit report will be approved by the hospital's chief financial officer.
7. The Adventist Health budget & reimbursement department will monitor community benefit data gathering and reporting for Adventist Health hospitals.

B. Documentation of Public Community Health Needs Assessment (CHNA)

1. Adventist Health will implement the use of the Lyon Software CBISA™ product as a tool to uniformly track community benefit costs to be used for consistent state and federal reporting.

2. A written public record of the CHNA process and its outcomes will be created and made available to key stakeholders in the community and to the general public. The written public report must include:

    a. A description of the hospital's community and how it was determined.

    b. The process and methods used to conduct the assessment.

    c. How the hospital took into account input from persons who represent the broad interests of the community served.

    d. All of the community health needs identified through the CHNA and their priorities, as well as a description of the process and criteria used in the prioritization.

    e. Existing health care facilities and other resources within the community available to meet the community health needs identified through the CHNA.

3. The CHNA and CHP will be submitted to the Adventist Health corporate office for approval by the board of directors. Each hospital will also review their CHNA and CHP with the local governing board. The Adventist Health government relations department will monitor hospital progress on the CHNA and CHP development and reporting. Helpful information (such as schedule deadlines) will be communicated to the hospitals' community benefit managers, with copies of such materials sent to hospital CFOs to ensure effective communication. In addition, specific communications will occur with individual hospitals as required.

4. The CHNA and CHP will be made available to the public and must be posted on each hospital's website so that it is readily accessible to the public. The CHNA must remain posted on the hospital's website until two subsequent CHNA documents have been posted. Adventist Health hospitals may also provide copies of the CHNA to community groups who may be interested in the findings (e.g., county or state health departments, community organizations, etc.).

5. For California hospitals, the CHPs will be compiled and submitted to OSHPD by the Adventist Health government relations department. Hospitals in other states will submit their plans as required by their state.

6. Financial assistance policies for each hospital must be available on each hospital's website and readily available to the public.

Corporate Initiated Policies: (For corporate office use)
References: **Replaces Policy: AD-04-002-S**
Author: **Administration**
Approved: **SMT 12-9-2013, AH Board 12-16-2013**
Review Date:
Revision Date:
Attachments:
Distribution: **AHEC, CFOs, PCEs, Hospital VPs, Corporate AVPs and Directors**

2017 Community Health Plan

This community health plan was adopted on April 20, 2017, by the Adventist Health System/West Board of Directors. The final report was made widely available on May 15, 2017.

CHNA/CHP contact:

Peter Morgan, MBA
Community Benefits Specialist
Phone: 503-251-6346
Fax: 503-251-6359
Email: morganph@ah.org
Adventist Medical Center-Portland
10123 SE Market Street
Portland, OR 97141

Request a copy, provide comments or view electronic copies of current and previous community health needs assessments: https://www.adventisthealth.org/pages/about-us/community-health-needs-assessments.aspx