2013 – 2015 Community Health Plan

(Implementation Strategy)

“And have our own people learn to apply themselves to honorable work to meet urgent needs, that they may not be unproductive.” - Titus 3:14
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Overview of Adventist Health

Portland Adventist Medical Center (dba Adventist Medical Center) is an affiliate of Adventist Health, a faith-based, not-for-profit, integrated health care delivery system headquartered in Roseville, California. We provide compassionate care in communities throughout California, Hawaii, Oregon and Washington.

Adventist Health entities include:

- 19 hospitals with more than 2,700 beds
- More than 220 clinics and outpatient centers
- 14 home care agencies and 7 hospice agencies
- Four joint-venture retirement centers
- Workforce of 28,600 includes more than 20,500 employees; 4,500 medical staff physicians; and 3,600 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 nearly 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.

**Our Mission:** To share God's love by providing physical, mental and spiritual healing.

**Our Vision:** Adventist Health will be a recognized leader in mission focus, quality care and fiscal strength.
Letter to the Community

Dear Community:

Portland Adventist Medical Center would like to thank you for your interest in the health of our community and for allowing our organization, as part of Adventist Health, to be a partner in an effort to improve the health of Portland. The enactment of the Affordable Care Act highlights the importance of understanding our community’s needs and providing opportunities to innovate our comprehensive prevention efforts. To help achieve this, Portland Adventist Medical Center is pleased to share our 2013 Community Health Plan.

We understand that this plan is an important step in improving the health of the communities that we serve. This plan was developed following completion of the Community Health Needs Assessment (CHNA) and in consultation with key community stakeholders. This plan will outline the area of focus identified in the CHNA as well as how Portland Adventist Medical Center will collaborate with community partners to improve systems of care.

We focus on providing patient-centered health care in a caring environment that extends well beyond hospital and clinic walls. Our emphasis on wellness and whole-person care ensures we meet the distinct medical needs of our communities. We invite you to join us by aligning with the strategies outlined in this report to address the priority health needs in our region. We are confident that through partnerships, collective approaches, and quality wellness strategies we will positively impact the health of Oregon.
Invitation to a Healthier Community

Where and how we live is vital to our health. As you read this document, think about health in our communities as the environment in which we live, work, and play. Economic opportunities, access to nutritious foods, green space, and the availability of social networks, are key determinants in shaping our health. Our hope is to focus beyond the pressing health care challenges to see the resources and assets that exist in our community and how we can align them for better health outcomes as a population.

The Community Health Plan marks the second phase in a collaborative effort to identify our community’s most pressing health needs. A Community Health Needs Assessment (CHNA) was conducted in 2013 to identify potential priority areas for community health. The CHNA was conducted not only in response to California’s community benefit legislation (SB 697), Oregon’s community benefit legislation (HB 3290) and The Affordable Care Act (H.R. 3590), but to truly fulfill the mission of the Adventist Health, “To share God’s love by providing physical, mental and spiritual healing.”

Community-based prevention, particularly interventions that look upstream to stop the root causes of disease, can reduce the burden of preventable illnesses. Economic opportunities, access to nutritious foods, green space, and the availability of social networks, are all key determinants in shaping our health. Our hope is to focus beyond the pressing health care challenges to see the resources and assets that exist in our community and how we can align them for better health outcomes as a population. Adventist Health uses The Community Guide, a free resource, to help communities choose programs and policies to improve health and prevent disease. This resource guides communities towards interventions that have proven to be effective, are appropriate for each unique community and evaluate the costs and return on investment for community health interventions.

Developing metrics for population-based interventions are imperative for continued success in elevating the health status of our community. To aid in comparability across regions, it is important to identify and be in alignment with statewide and national indicators.
When available, Healthy People 2020 was used as targets to align our local interventions. The Healthy People 2020 initiative provides science-based, 10-year national objectives for improving the health of all Americans.

The results of the CHNA guided the creation of a detailed plan to meet identified community needs, as well as community plans to address needs that our hospital may not be able to provide. In response to those identified needs Portland Adventist Medical Center has adopted the following priority areas for our community health investments for 2013-2015:

- Access to health care
- Chronic disease, with a focus on heart disease and stroke, respiratory disorders, cancer, diabetes and obesity
- Behavioral health, including mental health and tobacco usage

In addition, Portland Adventist Medical Center continues to provide leadership and expertise within our health system by asking the questions for each priority area:

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

Building a healthy environment requires multiple stakeholders working together with a common purpose. We invite you to explore our health challenges in our communities outlined in this assessment report. More importantly though, we hope you imagine a healthier region and collectively prioritize our health concerns and find solutions across a broad range of sectors to create communities we all want for ourselves and our children.
Identifying Information

Portland Adventist Medical Center
(dba Adventist Medical Center)
Number of Hospital Beds: 302
Tom Russell, President and CEO
Until December 2013
Bill Wing, Chair, Governing Board
10123 SE Market Street
Portland, OR 97216
503-251-6266
Community Health Plan Team Members

Marketing and Public Relations Department

Peter Morgan, MBA
Senior Financial Analyst
12 years Hospital Community Benefits experience
Chair- Oregon Association of Hospitals and Health Systems Community Benefit Technical Advisory Committee
Member Oregon Association of Hospitals and Health Systems Community Benefit Task Force
Member Healthy Columbia Willamette Collaborate
Contributor to CBISA Community
Mission, Vision and Values

Mission

The mission of Adventist Medical Center and those who serve here is to demonstrate the human expression of the healing ministry of Jesus Christ.

Vision

We will be the market leader in delivering innovative, accessible, cost-effective, high quality, whole-person care. We will be recognized for exceptional service consistently demonstrating our mission and values.

Values

In partnership with God, we will fulfill our mission and vision by treating others in harmony with our values:

<table>
<thead>
<tr>
<th>Value</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Integrity</td>
<td>Ensure our actions are consistent with our values</td>
</tr>
<tr>
<td>Quality</td>
<td>Provide care that is safe, reliable and patient-centered</td>
</tr>
<tr>
<td>Compassion</td>
<td>Reflect the love of Jesus through care, respect and empathy</td>
</tr>
<tr>
<td>Wholeness</td>
<td>Embrace a balanced life - integrating mind, body and spirit</td>
</tr>
<tr>
<td>Respect</td>
<td>Recognize the God-given dignity and individuality of each person</td>
</tr>
<tr>
<td>Family</td>
<td>Support each other in achieving our shared purpose</td>
</tr>
<tr>
<td>Stewardship</td>
<td>Serve our community through responsible resource management</td>
</tr>
</tbody>
</table>
We commit to:

- Delivering health care that nurtures body, mind and spirit through our personnel, programs and services;
- Encouraging healthful living practices consistent with optimal health and well being;
- Reflecting God’s love by serving our patients, guests and each other with compassion, dignity and respect;
- Focusing outreach and planning on improving the health of our local communities while providing emergency care for anyone with an immediate health care need;
- Offering services in the most medically and financially appropriate setting;
- Continually improving through technical excellence and a highly qualified professional staff;
- Creating an environment of care that inspires trust and confidence and promotes safety among our patients, families, employees, volunteers and physicians;
- Serving as a religious health care organization in a manner consistent with the philosophy of the Seventh-Day Adventist Church.
Community Profile

The primary service area for Portland Adventist Medical Center is comprised of the following areas of Multnomah and Clackamas Counties: Mid County, East County, the eastern most portions of Central Eastside and Southeast counties. Also included are the areas of Clackamas County that border East County and Southeast Multnomah County and the Sandy region. The majority of patients in our primary and secondary service areas speak English; however, more than 10% of community members speak Spanish in two zip codes within our service area. Seventy-six percent of patients that we serve are white; 10% are Latino or of Hispanic descent; and 6.4% are of Asian or Pacific Islander descent.

Within the counties we serve, 14.12% or 152,778 individuals live in households with income below the Federal Poverty Level (FPL). Poverty often creates barriers to wellness, including diminished access to health services, healthy food, and other necessities that contribute to poor health status. One indicator of need within our service is that 22% of Multnomah County residents receive social support benefits, including SNAP benefits (formerly known as food stamps).

The percentage of uninsured population by county is 12.05% in Clackamas County and 16.23% in Multnomah County. Within our service area, a particular area of need is zip code 97233 where 40% of patient count was both Charity Care or Medicaid patients and who also had the lowest income. The lack of health insurance is considered to be a key indicator regarding health status. The U.S. Department of Health and Human Services has designated Western Clackamas County as a health professional shortage area for the migrant and seasonal farm worker populations. The State of Oregon has granted Health Professional Shortage Area designation to the southern most parts of Clackamas County.
Figure 1. Shows Adventist Medical Center’s Primary and Secondary Community Services areas.

Primary Service Area (60% of Patients)
97236 97233 97226 97230 97030 97080
97206 97220 97216 97055 97060 97045
97086

Secondary Service Area (20% of Patients)
97222 97015 97267 97089 97009 97024
97202 97213 97023 97215 98682 97607
97027 97218 98671 97211 98683
Community Health Needs Assessment Overview

The Community Health Needs Assessment (CHNA) includes both the activity and product of identifying and prioritizing a community’s health needs, accomplished through the collection and analysis of data, including input from community stakeholders that is used to inform the development of a community health plan. The second component of the CHNA, the community health plan, includes strategies and plans to address prioritized needs, with the goal of contributing to improvements in the community’s health.

Portland Adventist Medical Center feels confident that we are working hard to listen to our community and collectively identify needs and assets in our region. Traditional, publicly available data were included in the assessment, along with qualitative data collected from a broad representation of the community.

Quantitative Data

- Morbidity and mortality data collected from the County Health Profiles and the Healthy Columbia Willamette Collaborative.
- Social Determinants of Health data collected from the U.S. Census Bureau, American Community Survey.
- Health Indicator Data Collected from a variety of publicly available databases.

To validate the data, and to ensure a broad representation of the community, qualitative data was collected from:

Qualitative Data

- Community agencies were surveyed, serving our primary service area, to assess their needs and to identify areas that Portland Adventist Medical Center can be a strategic partner.
- Community Health Expert surveys were distributed to local public health experts within our hospital and service area.
Identified Priority Needs

After conducting the CHNA, we asked the following questions:

1) What is really hurting our communities?
2) How can we make a difference?
3) What are the high impact interventions?
4) Who are our partners?
5) Who needs our help the most?

From this analysis, three primary focus areas were identified as needing immediate attention, moving forward:

Priority Area 1: Access to Care

Access to Care: Portland Adventist Medical Center (PAMC) is an acute care facility serving a moderate socio-economic population. As of 2011, the number of insured residents in Multnomah and Clackamas Counties, part of our primary service area, was 16.23% and 12.7% respectively. Multnomah County’s rate of uninsured is significantly higher than the state’s rate of 15.96% uninsured and the nation’s rate of 14.87% uninsured.

In 2011, 16.5% of Multnomah County residents’ income was below the federal poverty level. This is slightly higher than the 2011 state rate of 16.4%. In 2013, PAMC conducted an online health and quality of life survey to ensure that our service approach links with local community needs. Access to medical care and affordability of care were common themes among the survey respondents. Of those surveyed, affordability of health services was the second most critical need regarding impact on the overall quality of life within a key region in our service area. In the same survey, 66.7% of respondents identified low income and poverty as the primary community-wide issues impacting overall quality of life in East Multnomah County. This is meaningful because poverty, unemployment, and lack of educational achievement affect access to health care and limit a community’s ability to engage in healthy behaviors. Oregon’s overall child poverty rate is 21.6%. In Multnomah County, while one in eight white children live
in poverty, nearly one in three children of color live in poverty. Ensuring access to socio-economic support resources provides a foundation for community health.

The national benchmark for the primary care physician-to-patient ratio is 1,067:1. Oregon has a primary care physician-to-patient ratio of 1,134:1. Multnomah and Clackamas Counties’ physician-to-patient ratios are 819:1 and 1,193:1 respectively. The U.S. Department of Health and Human Services has designated Western Clackamas County as a health professional shortage area for the migrant and seasonal farm worker populations. The State of Oregon has granted Health Professional Shortage Area designation to the southern most parts of Clackamas County. The map and table below further detail county health insurance percentages for the uninsured and Medicaid recipients within our primary service area.
Goal: Improve local community access to comprehensive, quality primary and clinical health care services.

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

Interventions:

1. Expand the continuum of care through the opening and operation of our Parkrose location located in zip code 97230, which includes Urgent Care services.

2. Continue the partnership with the Healthy Columbia Willamette Collaborative and local free clinics to support the provision of health care services to uninsured and underinsured persons in our service area.
3. Improve communication and marketing of the availability of financial assistance to community health groups providing medical services to at risk members within our service area.

4. Train staff or enlist volunteers to partner with local clinics to provide coordinated care services, including support for enrollment and financial assistance applications, availability of medications, access to specialists, and linguistically and culturally appropriate health information (i.e. Health Leads Model).

5. Provide financial assistance or “charity care” to patients without insurance or financial resources, including the necessary assistance to complete application forms.

6. Provide prevention and early detection services, including medical screening examinations, regardless of individual’s ability to pay. These may include health screenings at hospital and community events, community flu clinics, and no-cost physician-led health lectures at community venues.

**Evaluation Indicators:**

*Short Term* – Increased number of adults and children who have health insurance.

*Long Term* – Decreased rates of adults and children in service area who go without care due to lack of access to appropriate care.
Priority Area 2: Chronic Disease

Chronic Disease: heart diseases and stroke, respiratory disorders, cancer, diabetes, and obesity: Chronic diseases are the leading causes of death and disability in the U.S. According to the Robert Wood Johnson County Health Rankings, Clackamas County is ranked #5 and Multnomah County is ranked #15 out of 36 counties in Oregon. These rankings help communities understand what influences morbidity and mortality rates. In 2011, the leading causes of death in Multnomah and Clackamas Counties were cancer, diseases of the heart, chronic lower respiratory diseases and cerebrovascular disease (stroke). Of note is that within Multnomah County, African Americans experienced the largest number of health disparities among racial/ethnic groups. According to a Multnomah County Health Department health disparities report, health indicators requiring intervention include Diabetes mortality for African Americans.

Community members within our service area identified chronic disease as a critical health issue: the need for chronic disease prevention and treatment was a common theme among the three unique surveys widely distributed by PAMC and the Healthy Columbia Willamette Collaborate to community members. Obesity, diabetes, cancer, heart disease and stroke, along with poor eating habits, stood out as concerns. Eighty percent of respondents listed overweight/obesity as the top health problem having the largest impact on the community as a whole. Sixty percent of those surveyed listed diabetes as the top health problem, and 33% and 20% listed heart disease and cancer respectively as the top community health problem.

In Clackamas County, 15% of adults smoke and 25% of adults are obese. Multnomah County adults share similar behaviors: 15% smoke and 24% of adults are obese. According to the Centers for Disease Control and Prevention, four modifiable health risk behaviors: lack of physical activity, poor nutrition, tobacco use, and excessive alcohol consumption, are responsible for much of the morbidity and mortality related to chronic disease.
**Respiratory disorders**: The burden of Asthma in Oregon is economic and personal, affecting the state with direct costs and indirect costs as well as reducing the quality of life for people with asthma and their families. One in four Oregonians with asthma is a smoker, which is a higher percentage than among people who do not have asthma (20%). A higher percent of extremely obese Oregonians report having asthma (20.4%) than healthy weight individuals (8.5%).

<table>
<thead>
<tr>
<th>Healthy Weight**</th>
<th>45 years and older</th>
<th>45-59 years</th>
<th>60-74 years</th>
<th>75 years and older</th>
</tr>
</thead>
<tbody>
<tr>
<td>County</td>
<td>Number</td>
<td>Percent</td>
<td>Number</td>
<td>Percent</td>
</tr>
<tr>
<td>Multnomah</td>
<td>89,562</td>
<td>37</td>
<td>56,872</td>
<td>38</td>
</tr>
<tr>
<td>Clackamas</td>
<td>49,422</td>
<td>35</td>
<td>28,422</td>
<td>34</td>
</tr>
<tr>
<td>Washington</td>
<td>52,849</td>
<td>34</td>
<td>32,007</td>
<td>33</td>
</tr>
<tr>
<td>Oregon in Total</td>
<td>466,517</td>
<td>33</td>
<td>259,198</td>
<td>33</td>
</tr>
</tbody>
</table>

* A healthy weight is a body mass index at or above 18.5 and less than 25.0 kg/m squared.

Data from BRFSS, by County, Oregon, 2004-2007, per Healthy Aging in Oregon Counties, 2009

<table>
<thead>
<tr>
<th>The U.S. Life Time Prevalence is 13.4% in 2011 according to the CDC.</th>
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</thead>
<tbody>
<tr>
<td>Adults with Current Asthma</td>
</tr>
<tr>
<td>Year</td>
</tr>
<tr>
<td>------</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>2010</td>
</tr>
<tr>
<td>2009</td>
</tr>
<tr>
<td>2007</td>
</tr>
<tr>
<td>2005</td>
</tr>
<tr>
<td>2003</td>
</tr>
</tbody>
</table>

Asthma: Adults who have been told they currently have asthma
Data source BRFSS

The U.S. Adult Asthma Current Prevalence is 8.8% in 2011 according to the CDC.
Goal: Reduce diseases of the heart and other chronic diseases by promoting improved health and healthy living through the provision of community education, specialty care, and community-based and collaborative prevention services.

Objective: Increase the use of evidence-based, innovative approaches to improve the effectiveness of PAMC’s chronic disease prevention and treatment model, and expand and include our community partners in the planning and implementation processes.

Heart disease and Stroke Interventions:

1. Reduce stroke-related death and disability through the use of evidence-based practices and comprehensive community engagement at PAMC’s Stroke Program.

2. Participate and provide the following community education/prevention programs:
a. The Annual American Heart Association Heart and Stroke Walk;
b. Utilize Heartistry to educate community members, patients and their family members about heart diseases, prevention and treatment;
c. Provide extensive cardiac rehab programs and monthly support groups for patients and family members;
d. Complete Health Improvement Program (CHIP) on campus and with faith-based partners; and
e. Continue to provide and innovate the Living Well Bistro restaurant.

**Respiratory Disorder Interventions:**

3. Provide the *Early Breathers* Support Group (COPD/Asthma), monthly no cost family support groups, weekly “Smoke-Free” support groups, and Radon Awareness Campaigns/screenings.

**Cancer Interventions:**

4. Engage in clinical trials/research studies to explore alternative and improved therapies for chronic disease.

5. Continue collaboration with the American Cancer Society and the East Portland Relay for Life.

6. Provide no-cost cancer support and nutrition classes groups to increase ongoing community education, support and coping skills for cancer patients and their support network.

7. Provide the Cancer Navigation-Accredited program, which addresses the unique needs of cancer patients in our service area.

8. Provide nutrition and lifestyle education programs to reduce cancer risk and improve immune system health.
**Diabetes and Obesity Interventions:**

9. Provide nutrition and lifestyle education programs to reduce diabetes risk and improve health.

10. Provide diabetes and Endocrine Center classes for diabetics and their families.

11. Provide the annual Living Well Diabetes Expo with no-cost annual education, prevention and screenings.

12. Provide no- and low-cost health screenings and education throughout the year for our community and employees.

13. Continue to support and align our efforts with the Healthy Columbia Willamette Collaborate.

It is important to address the population of adults and children without health insurance in the PAMC service area to further promote heart health; lack of insurance may significantly affect cardiovascular health.

**Evaluation Indicators:**

*Short Term* – Decreased rate of hospitalizations and/or readmission for cardiovascular disease, diabetes, stroke, cancer, and respiratory disorders.

*Long Term* – Increased locations in the PAMC Service Area for community-based chronic disease education and management programs.
Priority Area 3: Behavioral Health

Behavioral health, including mental health and tobacco usage: Mental health and behavioral disorders are common in the United States, and in a given year approximately one quarter of adults are diagnosable for one or more disorders. It is reported in the 2012 BRFSS and Trends Data that 20.1% of adults in the U.S. are limited in a number of activities because of physical, mental or emotional problems. 26.4% of Oregon adults reported limited activities due to behavioral health challenges in 2012 as compared to 23.8% in 2008. Depression, substance abuse and stress factors such as poverty and challenges with interpersonal relationships may play critical roles in a person’s mental health status.

Additionally, individuals living with serious mental illness face an increased risk of having chronic medical conditions; adults living with serious mental illness die on average 25 years earlier than other Americans. Suicide is a particular concern in the state of Oregon. A 2012 report on suicide trends and risk factors from the Oregon Health Authority found that the state’s overall suicide rate was 41% higher than the national suicide rate. Suicide is often committed out of anguish, the cause of which is attributed to behavioral and mental health disorders.

Tobacco usage: smoking prevalence is much higher among people with a mental illness. According to the National Alliance on Mental Illness, 36% of the 45.7 million adults who smoke have some form of mental illness (defined as diagnosable mental, behavioral, or emotional conditions). In comparison, 21% of adults without mental illness smoke. Oregon is one of only 13 states that does not require tobacco retailers to acquire licenses, ensuring less scrutiny for tobacco sales. According to the Oregonian (“Oregon is No. 1 at Selling Kids Tobacco”), 12.5% of Oregon 11th graders used tobacco in 2013. The U.S. Surgeon General recently reported that health risks associated with tobacco use are more numerous than previously believed, including lung, liver and colorectal cancers, diabetes, and rheumatoid arthritis. According to the same report, if current smoking trends continue without intervention, 5.6 million of American children and teens may go on to die prematurely during their adulthood due to smoking-related diseases.
The following tables further illustrate the need for behavioral health prevention and interventions, particularly mental health and emotional support and treatment services, and smoking education and prevention programs.

**Lack of Social or Emotional Support**

This indicator reports the percentage of adults aged 18 and older who self-report that they receive insufficient social and emotional support all of most of the time. This indicator is relevant because social and emotional support is critical for navigating the challenges of daily life as well as for good mental health. Social and emotional support is also linked to educational achievement and economic stability.

![Percent Population Without Adequate Social / Emotional Support](image)

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Report Area</td>
<td>845,159</td>
<td>133,848</td>
<td>15.84%</td>
</tr>
<tr>
<td>Clackamas County, OR</td>
<td>280,841</td>
<td>37,814</td>
<td>13.50%</td>
</tr>
<tr>
<td>Multnomah County, OR</td>
<td>564,318</td>
<td>95,934</td>
<td>17%</td>
</tr>
<tr>
<td>Oregon</td>
<td>2,898,286</td>
<td>483,726</td>
<td>16%</td>
</tr>
<tr>
<td>United States</td>
<td>229,932,154</td>
<td>48,120,985</td>
<td>20.93%</td>
</tr>
</tbody>
</table>

*Note: This indicator is compared with the state average. Data breakout by demographic groups are not available.*


<table>
<thead>
<tr>
<th>Report Area</th>
<th>Total Population Age 18+</th>
<th>Estimated Population Regularly Smoking Cigarettes</th>
<th>Percent Estimated Population Regularly Smoking Cigarettes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report Area</td>
<td>845,159</td>
<td>126,205</td>
<td>14.93%</td>
</tr>
<tr>
<td>Clackamas County, OR</td>
<td>280,841</td>
<td>43,250</td>
<td>15.40%</td>
</tr>
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<td>Multnomah County, OR</td>
<td>564,318</td>
<td>82,955</td>
<td>14.70%</td>
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<tr>
<td>Oregon</td>
<td>2,898,286</td>
<td>489,810</td>
<td>16.90%</td>
</tr>
<tr>
<td>United States</td>
<td>229,932,154</td>
<td>42,664,071</td>
<td>18.56%</td>
</tr>
</tbody>
</table>

**Goal:** Decrease hospital admittance rates related to behavioral health issues by improving wellness models for mental health and tobacco use.
**Objective:** Expand psychiatric care through the augmentation of behavioral health prevention and treatment services, and by increasing resources for evidenced-based models of care.

**Mental Health Interventions:**

1. Provide the largest private hospital mental health program in Oregon; continue collaboration with the CareMark Behavioral Health Services consortium.

2. Participate in the National Alliance on Mental Health (NAMI) annual education and awareness walk.

3. Establish Adventist Medical Group psychiatric clinics staffed by psychiatrists, psychiatric nurse practitioners and discharge planners.

4. Collaborate with partners to increase funding and sustainability through grant(s) that fund the implementation of evidence-based models of care between acute care, state hospitals and outpatient facilities.

5. Implement Mental Health Awareness week activities and education exhibits onsite at the hospital and within the community.

6. Provide Grief Recovery programs through Adventist Health Pastoral Care and Hospice Programs.

7. Provide no-cost community education interventions on various mental health topics and related issues: depression, anxiety, stress, sleep disorders, and lifestyle strategies.

8. Provide weekly Smoke Free support groups where tobacco users may support one another and gain the tools to become and remain smoke-free.

9. Provide onsite contact persons to screen patients to increase access to and insurance coverage for treatment and prevention services.
Evaluation Indicators

*Short Term* – Increased number of persons in our service area who have health coverage that includes mental health benefits.

*Long Term* – Increased screenings by primary care providers and increased community behavioral health resources.
Partner List

**Portland Adventist Medical Center** supports and enhances regional efforts in place to promote healthier communities. Partnership is not used as a legal term, but a description of the relationships of connectivity that is necessary to collectively improve the health of our region. One of the 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.

We believe that partnerships are effective tools in improving the health of our community. Together, we are able to leverage our resources and strengths and have a greater impact. We can build a greater sense of community and a shared commitment towards health improvement.

We would like to thank our partners for their service to our community:

- HealthShare of Oregon
- Program Salude
- Compassion Connect
- Portland Adventist Community Services
- American Cancer Society
- Complete Health Improvement Program
- National Alliance on Mental Illness (NAMI)
- CareMark Behavioral Health Services
- Oregon Food Bank
- New Hope Community Church
- Oregon Center for Nursing
- Walla Walla University School of Nursing
- Northwest Veg
- Wellsource
- Audiology Pacific
Many additional partnerships through our association with the Healthy Columbia Willamette Collaborate of which the following is just part of:

- African Partnership for Health
- Cancer Action Network
- State of Oregon
- American Diabetes Association of Oregon & SW Washington
- American Lung Association of the Mountain Pacific
- Basic Rights Oregon
- Catholic Charities of Oregon
- Catholic Community Services
- Children’s Community Clinic
- Children’s Health Alliance
- City of Portland’s Office of Equity Rights
Connecting Strategy and Community Health

Hospitals and health systems are facing continuous challenges during this historic shift in our health system. Given today’s state of health, where cost and heartache is soaring, now more than ever, we believe we can do something to change this. 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.

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.

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. 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.
Community Benefit Terms and Definitions

Medical Care Services (Charity Care and Unreimbursed Medicaid/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: 1) 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 such care to such patients; 2) the difference between the cost of care provided under Medicaid or other means-tested government programs and the revenue derived there from; or 3) contractual adjustments with any third-party payers.

Community Health Improvement
Activities that 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. Community-building activities improve the community’s health and safety by addressing the root causes of health problems, such as poverty, homelessness, and environmental hazards.

Health Professions Education
This category includes educational programs for physicians, interns, and residents, medical students, nurses and nursing students, pastoral care trainees and other health professionals when that education is necessary for a degree, certificate, or training that is required by state law, accrediting body or health profession society.

Subsidized Health Services
Clinical services are provided, despite a financial loss to the organization; measured after removing losses, and measured by cost, associated with bad debt, charity care, Medicaid, and other means-tested government programs. Subsidized health services are clinical programs that are provided despite a financial loss so significant that negative margins remain after removing the effects of financial assistance, bad debt, and Medicaid shortfalls. The service is provided because it meets an identified
community need and if no longer offered, it would either be unavailable in the area or fall to the responsibility of government or another not-for-profit organization to provide.

**Research**
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).

**Cash and In-Kind Contributions**
Financial or “in-kind” contributions to support community benefit activities provided by other entities. In-kind contributions include non-cash goods and services donated by the organization to another group that provides community benefit. Donations in this category must be restricted by the organization to a community benefit purpose.

**Financial Assistance Policy**
We’re committed to keeping you healthy. As a result, your ability to pay should never stop you from seeking needed care.

If you are uninsured or have a limited income, you may be eligible for a payment discount. You also may qualify for government programs such as Medicaid.

The most recent financial assistance policy can be found at the hospital’s website:

http://adventisthealthnw.com/for-patients-and-visitors/financial-assistance
Community Benefit Inventory

In addition to the priority areas listed previously the hospital offers many community health development interventions. As we shift into strategic initiatives to improve health within the communities we serve we will continue to support additional efforts identified as priorities to our communities. Below you will find a summary of our key interventions that may not have been included in the priority areas for the hospital.

Year 2013 – Inventory

<table>
<thead>
<tr>
<th>Activities</th>
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<tbody>
<tr>
<td><strong>Medical Care Services</strong></td>
</tr>
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Portland Adventist Medical Center have an extensive charity care policy, which enables the Medical Center to provide discounted care and charity assistance for financially qualified patients. Financial counselors are available to help patients determine eligibility for charity assistance and manage medical bills. This assistance is available for both emergency and non-emergency health care. Charity care does not include:

1) 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 such care to such patients; 2) the difference between the cost of care provided under Medicaid or other means-tested government programs and the revenue derived there from; or 3) contractual adjustments with any third-party payers.

| **Community Health Improvement** |

**AHA Heart and Stroke Walk**
AMC sponsored the AHA Heart and Stroke Walk. This included mobilizing over 147 walkers, setting up the health van for the event, giving away health information, etc. Over 1000 people attended this event.

Objectives: Educate the community on heart and stroke disease and help raise money to support funding of research activities

**Power Food for the Brain**
Diet was front and center when Neal Barnard, MD, presented information from his new book Power Foods for the Brain. Dr. Barnard shared secrets of the healing powers of food to preserve and enhance memory.
9 Ways to Prevent Diabetes
In a special presentation at AMC, Don Hall, Dr.PH, presented findings from his book 9 Ways to Prevent Diabetes. His presentation explained how simple steps may prevent or possibly reverse this common killer.

A Delicious Fair of the Heart
- Plant-based education - this is the wellness portion of the event
- 23 local vendors
- Cooking dems
- 300+ community members came out to learn about healthy eating choices
- Heart disease education-prevention/management, cholesterol and diabetes screening/counseling/referrals

Oregon Board of Medical Imaging
Staff member serves as a Radiation Therapist Member for this board. The position is appointed by the sitting state governor. This board drafts administrative rules, reviews disciplinary cases and determines any appropriate fines for licensees under the purview of this board. The board meets one day per quarter and has an extra planning meeting in July with a total of five meeting days per year. AMC supports this activity.

Vegfest 2013
- Educational booth, computer assessments on health age
- Education about plant-based nutrition and other life style factors for health/chronic disease prevention

Patient Enrollment Assistance
- Cost associated in enrollment assistance in government-funded health programs – 465 encounters, 336 served.

Health Share of Oregon
In June 2011, Governor John Kitzhaber and the Legislature passed a bi-partisan bill (House Bill 3650) that proposes a statewide system of Coordinated Care Organizations (CCOs). These organizations would manage all of the care for Oregon Health Plan members in their communities. The goal of the legislation is to create a new model of health care that will improve health. The vision is also aimed at beginning to lower the high cost of care by emphasizing prevention, reducing waste, improving efficiencies and eliminating avoidable differences in quality and outcomes. Health Share of Oregon, formerly known as the Tri-County Medicaid Collaborative, is set to providing treatment to Medicaid patients covered by the Oregon Health Plan. Health Share of Oregon includes Adventist Health, CareOregon, Central City Concern, Kaiser Permanente, Legacy Health, Oregon Health & Science University, Providence Health & Services and Tuality Healthcare under a single umbrella organization for OHP services. The establishment of Health Share
represents a watershed moment in Oregon health care reform efforts. Never before has such a diverse group of payers, providers and large delivery systems come together to address cost, quality, access and equity challenges in our health care system.

Health Professions Education

**Medical Students**
Coordination of rotations of medical students, with a 10% incremental time estimated for doctors and nurses. Twenty-six students.

**Advanced Life Support For Obstetric**
Partners included Providence and Peace Health NW. Two-day conference using lecture, classroom instruction, hands-on learning and testing. Designed to enhance cognitive and procedural skills of healthcare professionals to help them manage obstetrical emergencies – open to physicians, residents, CNMs, nurses and other healthcare professionals and maternity care providers.

**Preceptor Student Hours**
Preceptor Student Hours – No clinical instructor present. Student is assigned to an AMC staff member available to mentor and answer questions. Incremental time of employee with student present determined to be 15% of nurse’s time. 6,647 hours at 15% equals 1,012.05 hours plus 1/2 hour orientation per student (16.5).

**Cohort Student Hours**
Cohort Student Hours – Clinical instructor present, student assigned to AMC patient. AMC staff available to mentor and answer questions. Incremental time of student present determined to be 5% of nurse’s time. 29,580 hours at 5% equals 1,479.0 hours plus 1/2 hour orientation per student (75.6).

**Walla Walla School of Nursing**
- Hospital expenses to subsidize school of nursing. Data from Medicare Cost Report.

**Plant-Based Nutritional Conference**
- Professional education to better treat and prevent chronic diseases using nutrition
- Involved with both conference and booth
- CME coordination.

**All-City Palliative Care Conference**
- To provide palliative care education for healthcare professionals in the Portland area
- Joint venture with Portland VA, Providence, Adventist, Legacy and OHSU
- Coordinated by OHSU
### Subsidized Health Services

Subsidized health services are clinical services that Adventist Health provided despite a financial loss so significant that negative margins remain after removing the effects of financial assistance, Medicaid shortfalls and bad debt. The service is still provided because it meets an identified community need that is not offered elsewhere, and if Adventist Health withdrew services, the community’s capacity to provide the service would be below the community’s need, or provision of the service would become the responsibility of government or another not-for-profit organization.

Adventist Health provides the following services despite financial losses:
- Hospice
- Home Health
- Behavioral Health
- Cardio Rehab

### Research

Research which may be reported as community benefit includes clinical and community health research, as well as studies on health care delivery that are generalizable, shared with the public and funded by the government or a tax-exempt entity.

### Clinical Trials Program

This Cancer Clinical Trials program provides cancer patients with access to the Columbia River Oncology Program (CROP) Cancer Clinical Trials funded through the National Cancer Institute and other National research data bases. RN is the Clinical Trials RN funded by AMC who determines patient eligibility and manages the data needs for the trial. Cancer Services Manager attends CROP Administrative and Executive Committees as the AMC representative for the consortium.

### Cash and In-Kind Contributions

**Portland Adventist Community Services Board**

Attended PACS board meetings and board committee meetings as scheduled. PACS is a community Social Service organization providing emergency food, clothing, household goods and healthcare to residents without insurance in East Portland and East Multnomah County, Oregon.

**Donation of Medication**

Provide home infusion drugs, nursing visits, and supplies for IV therapy administration to patient who would qualify on discharge from AMC.
**American Red Cross Blood drives**
The total collected units for 2013 was 214, saving up to 642 lives.

**Celebration of Thanksgiving**
- A celebration concert featuring Selah
- 6,900 pounds of food collected for fighting hunger
- Only food collection and sorting time included due to marketing nature of the concert

**Meals on Wheels**
Our Spring Luncheons raise funds to feed needy seniors throughout the greater Portland-Vancouver metro area.

**Children’s Center Healing Garden Gala**
Children’s Center’s mission is to support and medically assess children who are suspected victims of abuse or neglect.

**Donation of Equipment**
Rehab equipment for patients that meet financial assistance requirements – training included.

**Community Benefit Operations**

**Assigned Staff**
Time spent in the community benefits process during the year for Community Benefits Committee members. (Excluding Wellness hours captured in other categories).

**CBISA Software Subscription Fee**
- Annual subscription fee
## Community Benefit Categories

<table>
<thead>
<tr>
<th>Community Benefit Categories</th>
<th>Net Community Benefit at Cost</th>
<th>Percent of Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unreimbursed costs of public programs at cost</td>
<td>$9,182,139</td>
<td>38.14%</td>
</tr>
<tr>
<td>Charity Care at cost</td>
<td>$6,638,694</td>
<td>27.58%</td>
</tr>
<tr>
<td>Subsidized Health Services</td>
<td>$6,646,514</td>
<td>27.61%</td>
</tr>
<tr>
<td>Cash and In-kind Contributions</td>
<td>$269,506</td>
<td>1.12%</td>
</tr>
<tr>
<td>Research</td>
<td>$46,945</td>
<td>0.20%</td>
</tr>
<tr>
<td>Health Professions Education</td>
<td>$439,544</td>
<td>1.83%</td>
</tr>
<tr>
<td>Community Health Improvement Services</td>
<td>$650,247</td>
<td>2.70%</td>
</tr>
<tr>
<td>Community Benefit Operations</td>
<td>$138,271</td>
<td>0.57%</td>
</tr>
<tr>
<td>Community Building Activities</td>
<td>$62,335</td>
<td>0.26%</td>
</tr>
<tr>
<td><strong>Total Community Benefit for 2013</strong></td>
<td><strong>$24,074,195</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>

### Uncompensated Care

- **Charges in millions:**
  - **Uncompensated Care**
    - **2005:**
    - **2006:**
    - **2007:**
    - **2008:**
    - **2009:**
    - **2010:**
    - **2011:**
    - **2012:**
    - **2013:**

- **Uncompensated Care Components:**
  - Charity Care
  - Bad Debt
Community Benefit & Economic Value

Portland Adventist Medical Center’s mission is “to share God’s love by providing physical, mental and spiritual healing.” We have been serving our communities health care needs since 1893. Our community benefit work is rooted deep within our mission and merely an extension of our mission and service. We have also incorporated our community benefit work to be an integral component of improving the “triple aim.” The “Triple Aim” concept broadly known and accepted within health care includes:

1) Improve the experience of care for our residents.
2) Improve the health of populations.
3) Reduce the per capita costs of health care.

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.
References

Centers for Disease Control and Prevention, National Center for Health Statistics, underlying Cause of Death, 2006-2010. As presented in http://www.chna.org

Quick Facts, U.S. Census Bureau, 2011.


U.S. Census Bureau, 2006-2010 American Community Survey 5-Year Estimates. As presented in http://www.chna.org

U.S. Census Bureau, 2008-2010 American Community Survey 3-Year Estimates.

Appendix A: Policy Community Health Needs Assessment and Community Health Plan Coordination
POLICY: COMMUNITY HEALTH NEEDS ASSESSMENT AND COMMUNITY HEALTH PLAN COORDINATION

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.