



ADVENTIST HEALTH PORTLAND

2022 COMMUNITY HEALTH
IMPLEMENTATION STRATEGY

APPROVED APRIL 27, 2023

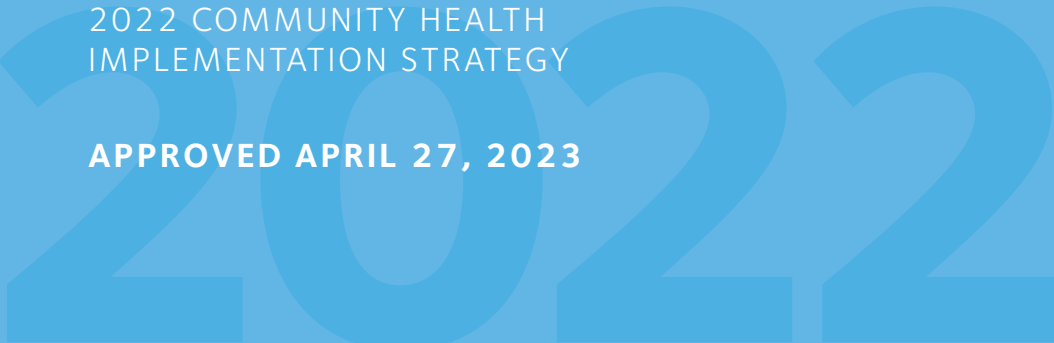


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Purpose & Summary

Non-profit health systems, community-based organizations, and public health agencies across the country all share a similar calling: to provide public service to help improve the lives of their community. To live out this calling and responsibility, Adventist Health Portland conducts a Community Health Needs Assessment (CHNA) every three years, with our most recent report completed in 2022. Now that our communities' voices, stories, and priority areas are reflected in the CHNA, our next step is to complete a Community Health Improvement Plan (CHIP), or as we refer to it in this report, a Community Health Implementation Strategy (CHIS).

The CHIS consists of a long-term community health improvement plan that strategically implements solutions and programs to address our health needs identified in the CHNA. Together with the Adventist Health Well-Being team, local public health officials, community-based organizations, medical providers, students, parents, and members of selected underserved, low-income, and minority populations, Adventist Health Portland intentionally developed a strategic plan to address the needs of our community.

In this CHIS, you will find strategies, tactics, and partnerships that address the following health needs identified in the 2022 Adventist Health Portland CHNA:

Access to Care

Food Security

Health Risk Behaviors

Housing

We hope this report is leveraged by all local partners and community members, empowering them to own the potential of healthy living for all. This report was reviewed and approved by our Adventist Health Portland well-being committee and Hospital Board, as well as the Adventist Health System Board on April 27, 2023. The entire report is published online and available in print form by contacting community.benefit@ah.org.



What if ...

It's not a prescription that changes your health?

Instead, it's a collaboration between you and your care providers?

And it's community-based organizations working together to support you?

Getting to know the Adventist Health Portland service area

East Portland, Adventist Health Portland's key service area, is a vibrant and diverse community with a total population of around 520,554 individuals from east Multnomah and Clackamas counties. In addition to many businesses and residences, East Portland is home to the Portland International Airport and the intersection of I-205 and I-84, the gateway to the Columbia River Gorge and Mt. Hood.

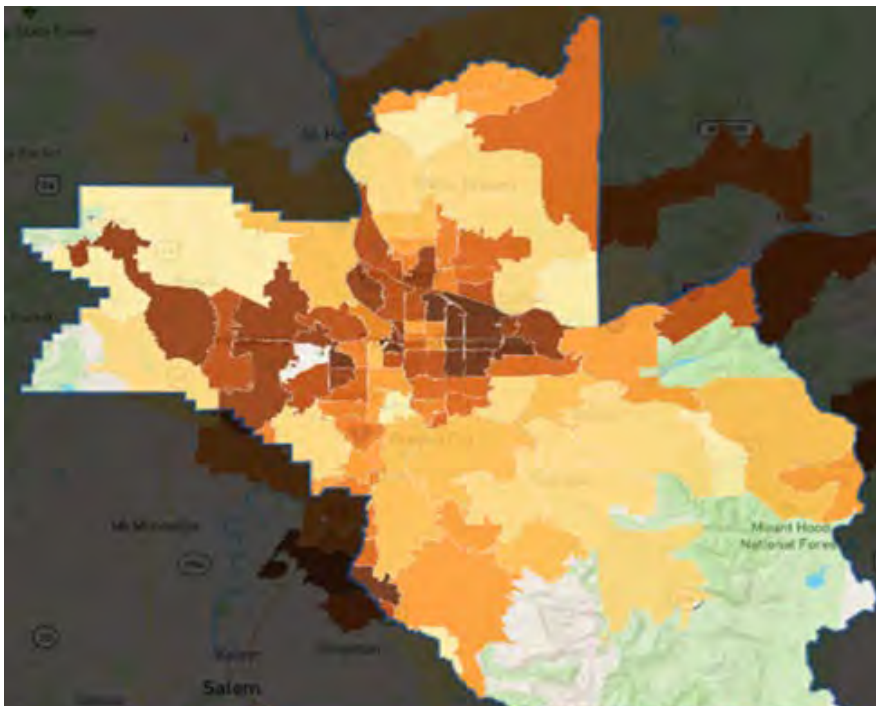
The median household income is \$98,912, compared with the statewide median of \$65,667. This higher median income is in part due to several affluent urban neighborhoods within our service area and not fully reflective of the

needs of the service area. Payor mix in Adventist Health Portland's service area is predominately Medicaid and Medicare. The largest segment of the population (28.6%) is made up of residents aged ages 35-54.

While the median household income for the service area overall indicates relative wealth, the David Douglas School District #40, which encompasses the medical center's main campus, provides a stark snapshot for this area. The combined student body of around 8,500 in grades Kindergarten through 12 includes 67.6% who identify as Hispanic, Native American, Asian, Black, Pacific Islander and multiple ethnicities. The district is very diverse

with over 70 spoken languages represented in the student population. And at the various schools, the percentage who qualify for free and reduced lunches ranges from 60.27% to 94.5%. Using the estimate that 5% of students who qualify for free and reduced lunches may be un-housed or living in unstable housing gives a range of 288-401 students.

For a more detailed look into community member comments, facts and numbers that are captured in the CHNA, please visit adventisthealth.org/about-us/community-benefit. The following pages provide a closer look into our community demographic as well as our approach to the CHIS.



What if our community worked together and made life all-around better? What if we offered various pathways to meet our diverse needs, so every member of our community experienced better health, prosperity and longevity?

Demographics

Quad-County Region

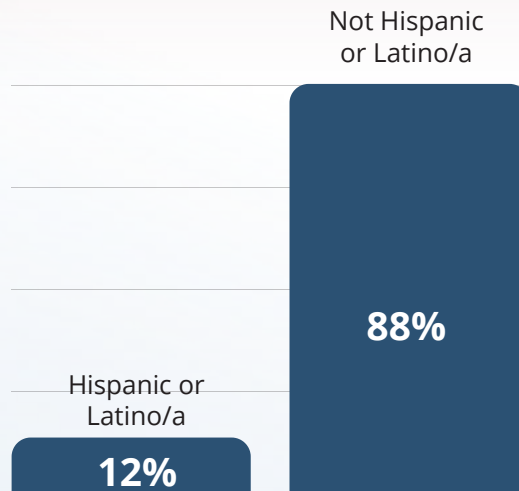
Total Population:
2,277,802

All data is a 2015-2019 combined estimate unless otherwise noted

Increase from 2009: 13%

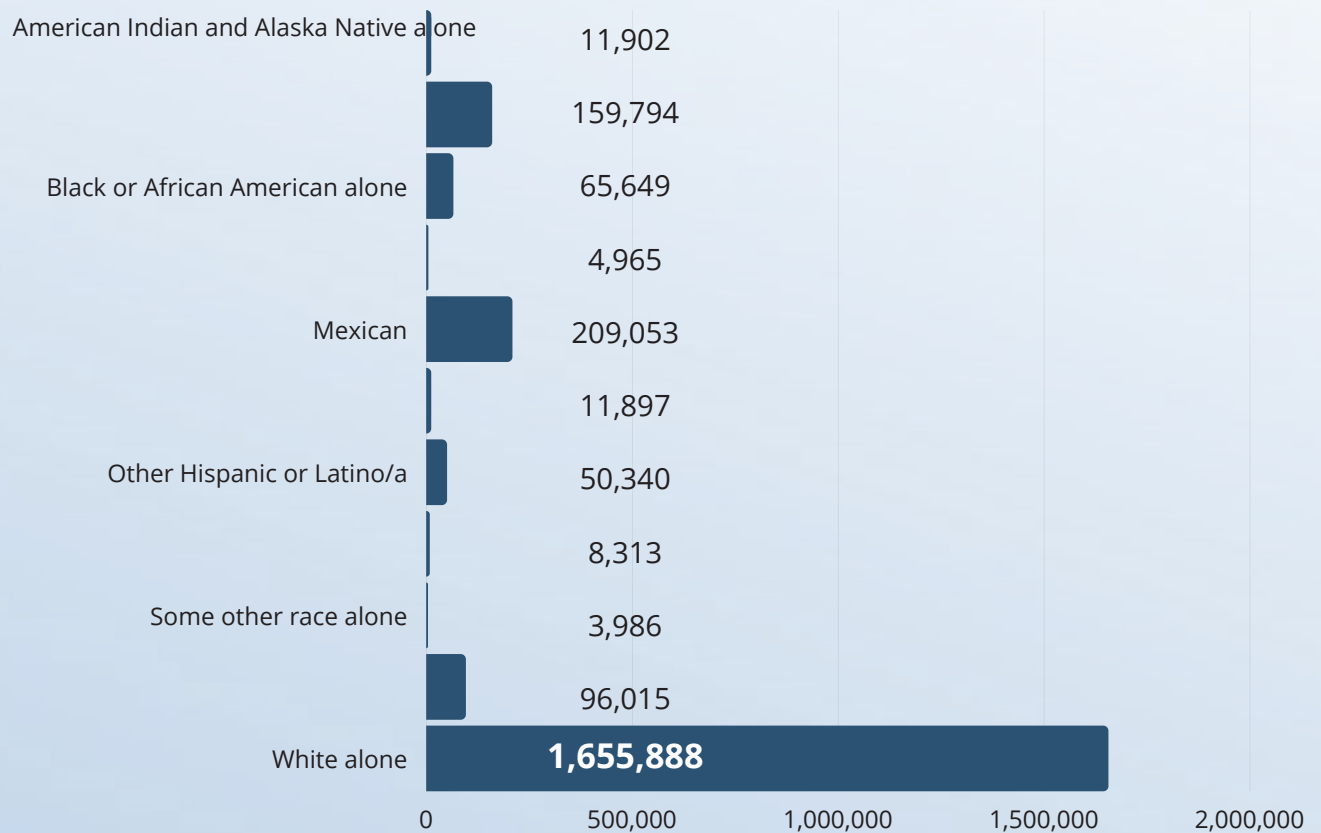
Not Hispanic or Latino/a: 88.0%

Hispanic or Latino/a (of any race): 12.0%



Race and Ethnicity

Count of individuals by racial group



About Us

Adventist Health Portland

Adventist Health Portland, an Oregon Health and Science University (OHSU) Health partner, is a faith-based, non-profit health care network consisting of a 302-bed medical center, 27 medical clinics, and home care and hospice services in the Portland metro area. Our full-service acute care medical center provides a complete range of inpatient, outpatient, emergency and diagnostic services to communities on Portland's east side. Our key services include cardiovascular care, emergency services, primary and urgent care, radiation oncology, surgery, imaging, rehabilitation, pregnancy care, and labor and delivery.

Our compassionate and talented team of over 1,900, includes associates, medical staff, physicians, allied health professionals and volunteers driven by one mission: living God's love by inspiring health, wholeness and hope. Together we are transforming the health care experience with an innovative, yet timeless, whole-person focus on physical, mental, spiritual and social healing. Annually, we have about 14,000 hospital admissions and surgeries, 500 deliveries, 40,000 emergency room visits and more than 500,000 outpatient visits.

Adventist Health Portland is also part of Adventist Health, a faith-based, non-profit integrated health system serving more than 75 communities on the West Coast and in Hawaii.

Adventist Health

Adventist Health is a faith-inspired, nonprofit integrated health system serving more than 80 communities on the West Coast and Hawaii. Founded on Adventist heritage and values, Adventist Health provides care in hospitals, clinics, home care agencies, hospice agencies and joint-venture retirement centers in both rural and urban communities. Our compassionate and talented team of 34,000 includes associates, medical staff physicians, allied health professionals and volunteers driven in pursuit of one mission: living God's love by inspiring health, wholeness and hope. Together, we are transforming the American healthcare experience with an innovative, yet timeless, whole-person focus on physical, mental, spiritual and social healing to support community well-being.

Adventist Health's Approach to CHNA & CHIS

Adventist Health prioritizes well-being in the communities we serve across our system. We use an intentional, community centered approach when creating our hospital CHNA's to understand the health needs of each community. After the completion of the community assessment process, we address health needs such as mental health, access to care, health risk behaviors, and others through the creation and execution of a Community Health Implementation Strategy (CHIS) for each of our hospitals and their communities.

The following pages highlight the key findings the Adventist Health Portland well-being steering committee and community partners identified as top priority health needs, or as we refer to them in this report, their 'High Priority Needs'. The High Priority Needs are addressed in this Community Health Implementation Strategy.

High Priority Needs

The following pages highlight the High Priority Needs that will be addressed in this Community Health Implementation Strategy.

Access to Care



Providing the best, top-quality health care services makes little impact on the health of a community if its citizens experience barriers to accessing the services they need. A language barrier can impact a person's health literacy, leaving them unable to fully understand how to make informed decisions about their care. A cultural barrier can impact the ability of a person to have their spiritual practices included in their care. A barrier posed by lack of trauma-informed care and supports can prevent a person from fully engaging in the healing process. Other barriers—including economic, education and transportation—can also negatively impact people's ability to access care.

We believe that all people should be afforded access to health care that aligns with their cultural, behavioral, and communication needs. Healthcare should be holistic, person-centered, and community centered. We recognize that social, economic, and cultural factors influence the ways in which people seek and receive care. As a health care system, we want to be aware of and reflective of these factors will improve well-being and health and increase access to care.

Some data called out in the CHNA and other regional publications show that access to care is challenged by the lack of culturally and linguistically responsive health care services and supports. This includes a lack of

translation of written materials, the availability of materials for persons who have visual or audio support needs, and inadequate interpretation services. Community members reported wanting to be cared for by health care providers who have shared experiences, cultures, and languages. They also shared that training alone in cultural competency is not enough. Oregon and Washington State data show that cultural and linguistic representation in the workforce does not reflect the region's residents. In 2020, Oregon's licensed health care workforce was less racially and ethnically diverse than the population being served.

Some ideas that we plan to explore, alongside our regional Healthy Columbia Willamette Collaborative (HCWC) partners, in the three years of our CHIS include the following:

- Support for additional trauma-informed physical and mental health services and supports, clinics, and/or community centers.
- Increased workforce development pipelines for health care workers that reflect and represent the region's diversity, including language, ability, culture, ethnicity, race, sexual orientation and gender identity.
- Expanded investments in traditional health workers to increase community representation in the workforce.
- Investment in building and repairing trust between the health care system and priority populations.
- Ongoing investment in efforts to address gaps in insurance eligibility for Hispanic/Latinx and multi-racial populations.
- Ensuring adequate resources for language accessibility in services and education and investing in health literacy efforts.

Food Security



Eating nutritious foods in amounts the body needs is vital to enjoying optimal health and well-being. Many in our service area experience barriers to accessing nutritious food. Barriers include poverty and lack of income to purchase healthier foods, living in a food “desert” where only convenience stores with highly processed and packaged foods are available, and lack of knowledge and/or capability to prepare whole foods.

Experiencing food insecurity means that a person may lack access at

times to enough food for an active, healthy life and has limited or uncertain availability of healthy foods. Food insecurity has become a larger problem in some neighborhoods throughout the four-county region from causes such as civil unrest as well as the COVID-19 pandemic which have resulted in job losses as well as store closures.

There is strong evidence that living far away from a grocery store is a health risk. Studies have found that wealthy urban communities have several supermarkets, with an abundance of fresh fruits and produce, whereas

predominantly low-income and minority communities do not; they must shop at convenience stores or smaller grocery stores that lack choices for healthy food options.

Our 2022 CHNA reports that in 2019, 2.5% of all residents, or 50,387 people, were low-income and experienced living far away from a grocery store. Socioeconomic barriers that come with living in poverty, such as lack of reliable transportation necessary to visit a grocery store, make obtaining food for this population more difficult.

Health Risk Behaviors



People are whole beings – mental, physical, spiritual, emotional, and social—and deserve access to holistic care that recognizes and integrates these interrelated dimensions.

We believe that all people should have access to whole-person care that may include practices that may go outside the boundaries of traditional medicine in order to promote an individual's health and well-being. For example, there are healing medicines or practices specific to communities of origin. There is also a recognized need for people to have access to the healing power of the natural world, such as spending time outdoors.

Among the stories of experience shared during the CHNA about barriers

to obtaining the services and support that was needed, 47% of the stories reported these were “not easy to access.” Two common gaps noted by community members identified a need for peer-to-peer support and the employment of more people who have lived experience with particular challenges such as substance use disorder, along with a need for ways to exchange information and educational resources among community members about addictions and services available to them.

Other mentions included the importance of holistic preventative care and various methods of self-care such as a need for a shared physical space in the community where people can meet together to

discuss health risk behaviors without stigma or shame, to learn more about traditional medicine approaches, and the importance of building awareness on how addictions affect individuals and the family systems of marginalized communities, such as LGBTQ2IA and BIPOC youth.

Data points from the CHNA highlight that drug overdose death was the second leading cause of accidental death in 2018-2020 at a regional (unweighted) rate of 13.3 per 100,000 people. Drug overdose significantly increased in the region, from 9.8 in 2014- 2016 to 13.3 per 100,000 in 2018-2020. This was in part due to the increase in Multnomah from 13.1 to 20.9 per 100,000 during the same period.

Housing



Safe and affordable housing can provide a stable place for families to live, learn, grow, and form social bonds. Housing is often the single most significant expense for a family. When too much of a paycheck is allotted to paying rent or mortgage, this housing cost burden can force people to choose between paying for other basic needs, such as utilities, food, transportation, or medical care. Without stable housing, it's hard to store and prepare nutritious food, hard to follow care plans for health management, and hard to think beyond the challenges of today to be able to make positive choices for future health and well-

being.

As reported in the 2022 collaborative CHNA, access to safe and affordable housing has decreased in the greater region, which is attributed to the cost of housing increasing faster than the median household income. This is especially true for lower income neighborhoods located throughout our East Portland service area. Overall, from 2015-2019, median household income in the greater region increased by 16.1%; however average rent increased by 18.9%. The Covid-19 pandemic years of 2020-2022 accelerated this disparity, as documented by rapidly escalating

housing sale values that have somewhat only recently leveled.

Multnomah County has significantly higher unhoused rates at 51.3 per 10,000 people compared with the overall region at 22.2 per 10,000 people. The statewide rate for Oregon is 35.0 per 10,000 people. Since 2016, the total unhoused population in Oregon has increased 2.0 percentage points, from 33.0 to 35.0 per 10,000 people. This represents a 9.1% increase in the number of people unhoused, from 13,328 people in 2016 to 14,655 people in 2020, respectively.



Action Plan for Addressing High Priority Needs

Committee members drew upon a broad spectrum of expertise and possible strategies to improve the health and well-being of vulnerable populations within the community.

The following pages reflect the goals, strategies, actions, and resources identified to address each selected High Priority Need.

ADDRESSING HIGH PRIORITY: Access to Care

GOAL	Increase access to care by identifying barriers that prevent patients from accessing the health and human support services they need and collaborating with community-based organizations (CBO) to meet needs and break down barriers.
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Priority Area:	Access to care	Sub-Category:	Barriers: Health Literacy	Defining Metric:	Limited English Proficiency
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Strategy:	Strengthen referral processes and address identified barriers that inhibit patients from accessing needed health and human support services.
Population Served:	All people who utilize Adventist Health hospital services.
Internal Partners:	Patient Care Executive, Clinic Manager & Patient Registration Manager, AH Board Members, Community Well-being Committee, Hospital Board, Chief Medical Officer
External Partners:	North by Northeast Community Health Center, Compassion Connect, Project Access Now

Actions: Program/Activity/Tactic/Policy	Organization	Lead
Facilitate development of a process that more smoothly integrates hospital intake and discharge workflows with patient information about their health needs and barriers and connects them with needed CBO resources. Facilitate availability of linguistic and culturally sensitive communications material to help connect patients with needed health and human support services. Identify and build active partnerships with CBOs providing health and human support services.	Adventist Health – Emergency Department	Michael Soto
	Adventist Health – Mission Integration	Terry Johnsson PhD
	North by Northeast Community Health Center	Suzy Jeffreys
	Compassion Connect- Free Clinics	Corina Ferguson
	Project Access Now	Dennis Lippert MD

YEAR ONE	YEAR TWO	YEAR THREE
<p>1.1 Facilitate evaluation of data such as appointment availability, sudden cancellations, or release of held appointments to identify and break down barriers that prevent people from accessing services and supports they need.</p> <p>1.2 Referral tracking: consider closed loop referral process with CBOs for tracking, evaluating process effectiveness.</p> <p>1.3 Review, facilitate availability of linguistic and culturally sensitive communications at patient point of contact about services provided by CBOs.</p> <p>1.4 Reaffirm current CBO partnerships, begin to identify ways to build relationships and actively engage with other potential partners.</p>	<p>1.1 Continue to facilitate the tracking, evaluation and strengthening of internal processes and workflows for connecting people with CBO services.</p> <p>1.2 Collaborate with the CBOs offering services/programs to track referrals and troubleshoot referral process where needed.</p> <p>1.3 Continue to facilitate the evaluation, adaptation and translation of communications materials as needed.</p> <p>1.4 Continue building rapport and engagement with ongoing and new CBO partners.</p>	<p>1.1 (& 1.2) Continue to actively facilitate evaluation, reporting out, and improvement of the referral process. Use lessons learned to improve patient experience of access to the services and supports they need.</p> <p>1.3 Continue to facilitate the evaluation, adaptation and translation of communications materials as needed.</p> <p>1.4 Continue working with internal and external groups to engage, evaluate, and realign efforts with various CBOs as needed.</p>

ADDRESSING HIGH PRIORITY: Food Security

GOAL	Increase access to nutritious foods by collaborating with community-based organizations (CBO) to increase awareness and linkage with nutritious food resources, land to grow personal crops, and culturally sensitive food.
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Priority Area:	Food Security	Sub-Category:	Food Access	Defining Metric:	Food Desert Census Tracts
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Strategy:	Be a resource that links people with nutritious food outlets, provides free access to whole foods/on-site community garden for growing personal crops, and promotes culturally sensitive foods.
Population Served:	Very low income (50% of median area income) and those living in food desert census tracts.
Internal Partners:	Patient Care Executive, Clinic Manager & Patient Registration Manager, AH Board Members, Community Well-being Committee, Adventist Health Community Board, Chief Medical Officer
External Partners:	Blanchet House, Outgrowing Hunger, Portland Adventist Community Services (PACS)

Actions: Program/Activity/Tactic/Policy	Organization	Lead
Be a resource for awareness and linkage to nutritious food sources, including providing a whole foods/onsite garden program and promoting CBO food partnerships. Facilitate increased access to culturally sensitive foods through active engagement with CBO food partnerships and enhanced communications about how to access locally available food sources. Increase active partnerships with food-related CBOs, including by volunteerism/board service (*Terry Johnsson serves on PACS board).	Adventist Health – Emergency Department	Michael Soto
	Adventist Health – Mission Integration	Terry Johnsson PhD
	Blanchet House	Scott Kerman
	Outgrowing Hunger	Adam Kohl
	Portland Adventist Community Services (PACS)*	Laura Pascoe

YEAR ONE	YEAR TWO	YEAR THREE
1.1 Review, facilitate updated parameters for individuals to use whole foods/on-site garden programs to fuller potential. 1.2 Facilitate the creation and accessibility of communications about local access to free food and/or culturally sensitive food. 1.3 Reaffirm current CBO partnerships, begin to identify ways to build relationships and actively engage with other potential CBO partners.	1.1 Continue to facilitate and expand/scale whole foods/onsite garden program. Consider sales of produce for sustainability. 1.2 Continue and expand/scale local access to free food, explore new partnership opportunities for free food and/or culturally sensitive food. 1.3 Continue building rapport and engagement with ongoing and new CBO food partners.	1.1 Continue to facilitate, evaluate and expand/scale/adapt whole foods/on-site garden program. Early ideas include outdoor community gathering place, farmer’s market style opportunity. 1.2 Continue to evaluate and expand/scale/realign CBO partnerships related to free food and/or culturally sensitive food. 1.3 Use lessons learned to work with internal and external groups to evaluate effectiveness and realign efforts as needed.

ADDRESSING HIGH PRIORITY: Health Risk Behaviors

GOAL	Provide low barrier access to treatment referrals and wrap-around supports for patients with substance use disorders (SUD) via collaboration with community-based organization (CBO) partners.				
Priority Area:	Health Risk Behaviors	Sub-Category:	Mental Health Risk Factors- Drugs & Alcohol	Defining Metric:	Substance Use Disorder (SUD)
Strategy:	Develop a mental health and SUD treatment framework that supports Emergency Department staff with best care practices for patients with substance use disorders or substance-induced medical emergencies and that facilitates low barrier referrals to engaged CBO partners.				
Population Served:	Adults with substance use disorders or substance-induced medical emergencies.				
Internal Partners:	Patient Care Executive, Clinic Manager & Patient Registration Manager, AH Board Members, Community Well-being Committee, Hospital Board, Nursing Staff, Chief Medical Officer.				
External Partners:	Fora Health, Oregon Change Clinic				

Actions: Program/Activity/Tactic/Policy	Organization	Lead
<p>Strengthen ongoing partnership with Fora Health, SUD/mental health treatment partner, to support priority, low barrier access to treatment for discharged Emergency Department patients.</p> <p>Facilitate the deployment of training programs in partnership with Fora Health to equip Emergency Department staff with best practices for caring for patients with SUD or substance-induced medical emergencies.</p> <p>Build trust among diverse ethnic groups for SUD/mental health services through connections with culturally sensitive referrals.</p> <p>Increase active partnerships with SUD-related CBOs, including by volunteerism/board service (*Terry Johnsson serves on Fora Health board).</p>	Adventist Health – Emergency Department	Michael Soto
	Adventist Health – Mission Integration	Terry Johnsson
	Fora Health*	Maree Wacker
	Oregon Change Clinic	Shannon Jones

YEAR ONE	YEAR TWO	YEAR THREE
<p>1.1 Reaffirm, strengthen current SUD-focused CBO partnerships, including new partner Oregon Change Clinic.</p> <p>1.2 Facilitate the planning and deployment of best practice SUD care training for Emergency Department staff with Fora Health.</p> <p>1.3 Explore strategies and channels for building trust with at least 1 population group for SUD/mental health services.</p>	<p>1.1 Continue to strengthen and expand/scale access for priority and low barrier SUD/mental health treatment with CBOs such as Oregon Change Clinic.</p> <p>1.2 Facilitate ongoing SUD care training and support for Emergency Department staff.</p> <p>1.3 Facilitate the implementation and evaluation of trust strategies identified in year 1; leverage existing trust capacity of SUD-focused CBO partners.</p>	<p>1.1 Evaluate, continue/expand/scale CBO partnerships for priority and low barrier SUD/mental health treatment.</p> <p>1.2 Facilitate ongoing SUD care training and support for Emergency Department staff.</p> <p>1.3 Use lessons learned to become a trusted resource for exceptional cultural sensitivity and diverse care providers among additional identified populations in our service area.</p>

ADDRESSING HIGH PRIORITY: Housing Access

GOAL	Increase access to safe and affordable housing/housing support services for un-housed patients of Adventist Health as well as community members with significant housing cost burden.
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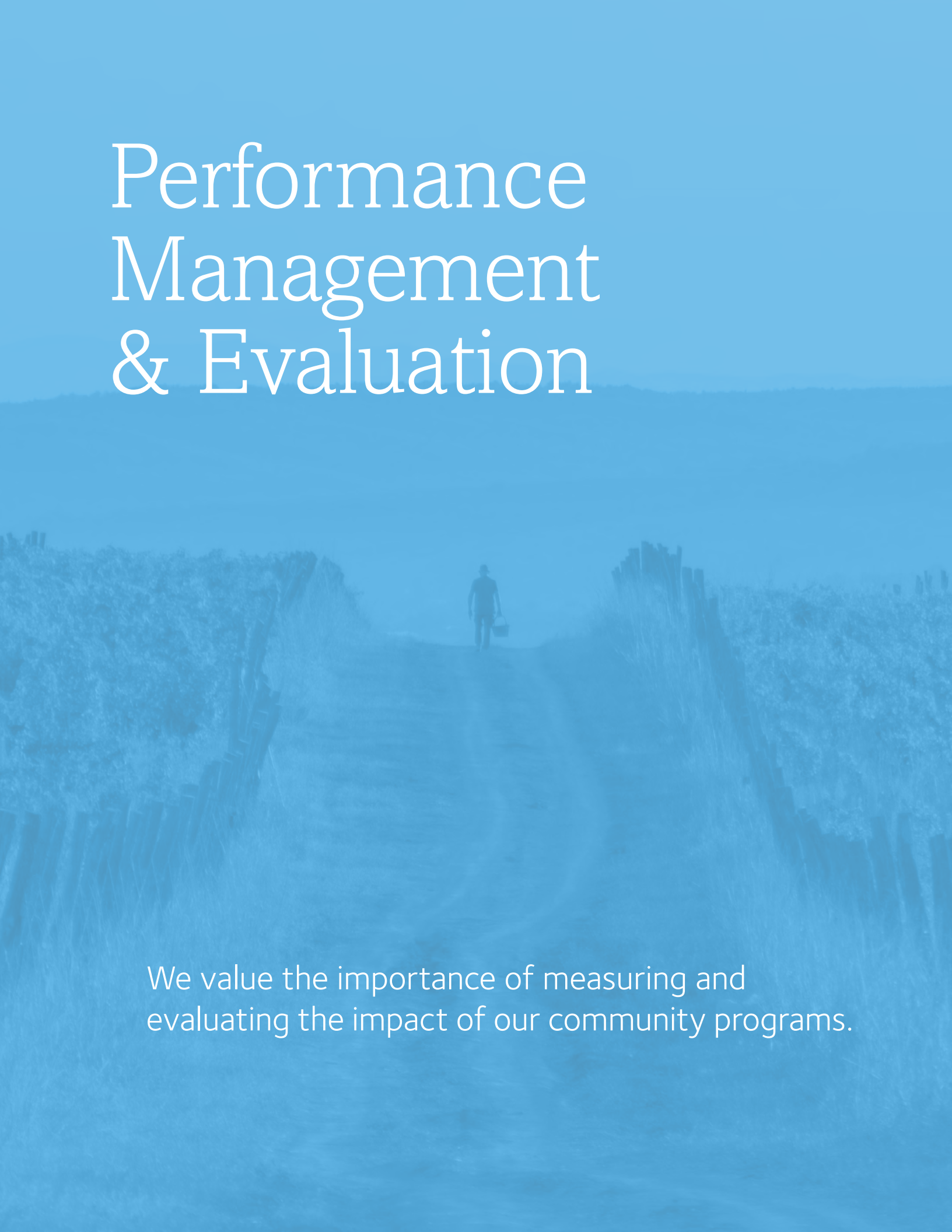
Priority Area:	Housing Access	Sub-Category:	Homelessness	Defining Metric:	Homeless Point in Time Estimates
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Strategy:	Leverage patient care intake and discharge contact points to increase awareness of and access to safe and affordable housing/housing support services provided by community-based organizations (CBO).
Population Served:	Individuals without stable lodging available to them when Adventist Health services have concluded.
Internal Partners:	Patient Care Executive, Clinic Manager & Patient Registration Manager, AH Board Members, Community Well-being Committee, Hospital Board, Nursing Staff, Chief Medical Officer.
External Partners:	Blanchet House, Transition Projects, Portland Rescue Mission

Actions: Program/Activity/Tactic/Policy	Organization	Lead
Identify and build active partnerships with CBOs providing housing/housing support services. Facilitate the development of ways to identify individuals without/at risk for losing stable housing and connect them with resources, such as our CBO partners with an Adventist Health Referral. Facilitate the development of an Emergency Department discharge workflow that connects patients with needed housing/housing support services. Work with local and state governments to help influence public policy addressing access to affordable, stable housing.	Adventist Health – Emergency Department	Michael Soto
	Adventist Health – Mission Integration	Terry Johnsson
	Blanchet House – Transitional, Housing	Scott Kerman
	Transition Projects – Shelter, Transitional, Employment	Ellen Velez
	Portland Rescue Mission – Shelter, Transitional, & Recovery	Eric Bauer

YEAR ONE	YEAR TWO	YEAR THREE
1.1 Reaffirm current housing-focused CBO partnerships, begin to identify ways to build relationships with other potential housing-focused CBO partners. 1.2 Facilitate the development of an internal workflow/process for identifying individuals burdened by housing costs and instability and making referrals to CBO partners. 1.3 Facilitate the development of an Emergency Department patient discharge workflow to connect patients more effectively with needed housing/housing support services.	1.1 Continue building rapport and active engagement with housing-focused CBOs. 1.2 (& 1.3) Continue to facilitate the development, adaptation and hardwiring of internal identification and referral workflows, processes. Consider “closed-loop” referral resources. 1.4 Use lessons learned to work with local and state governments to respond to changing environments, laws, and situations addressing housing stability in our service area.	1.1 Continue building housing-focused CBO relationships. Review what’s working well; realign partnerships as needed. 1.2 (& 1.3) Continue to review, facilitate the improvement of internal identification and referral processes. Explore expanding/scaling to ambulatory settings. 1.4 Continue policy-focused work with local and state governments. Review and realign efforts as needed.

Performance Management & Evaluation

A person is walking away from the viewer on a dirt path that leads into a field of tall, dry grass. The person is carrying a basket and is wearing a hat. The entire image is overlaid with a semi-transparent blue filter. The text 'Performance Management & Evaluation' is written in white, serif font in the upper left quadrant.

We value the importance of measuring and evaluating the impact of our community programs.

Performance Management & Evaluation

Adventist Health will support the High Priority Need action plans identified in this CHIS by monitoring progress on an ongoing basis and adjusting the approach as needed over the course of the next three years. There are several resources in place to aid in this. All CHIS programs and initiatives will include a completed logic model to identify intended activities, outputs, and short and long-term

outcomes. Establishing core metrics for each program or initiative will allow for the ongoing collection of performance management data. Actively tracking metric performance leads to the identification of strengths and challenges to the work, the local hospital, the Adventist Health Community Benefit team, and external partnerships. Together, we will work to share successes and create

performance improvement plans when necessary.

Along with that, where appropriate, evaluation activities designed to measure the overall strength and success of this work at the community level will be incorporated into performance management tracking.

CHIS Development

The development of the CHIS was directly built from the CHNA, whose goal focused on leveraging community stakeholders and data to address the most significant health needs of our community over the next three years. Adventist Health Portland community members were involved in the process of identifying and addressing health needs for a healthier community, completing the final report in fall of 2022.

Collaborating with community members again in early 2023, Adventist Health Community Well-

Being Directors facilitated a multi-step process to outline goals and strategies for the CHIS that foster change and positive impact in each of the High Priority Need areas. Each community relied on existing programs and services, and, where necessary, identified new opportunities to pursue collectively.

Once an approach received a consensus, the Community Well-Being Directors worked with Adventist Health leadership and expert consultants to set major annual milestones for each approach,

generating outputs and outcomes that allow for ongoing performance management of this work. For further information on how success will be tracked, refer to the Performance Management and Evaluation section, on this page.

Finally, the CHIS was presented to Adventist Health local Hospital Boards for review and feedback. In addition to this collaborative effort, we also welcome feedback at community.benefit@ah.org.



Significant Identified Health Needs

The Adventist Health Portland Community Well-Being team and Healthy Columbia Willamette Collaborative (HCWC) partners collectively reviewed all relevant significant health needs identified through the CHNA process. Working with the HCWC, findings were used to 1) inform a root cause of the health issues and trends, 2) inform the areas of inquiry for the CHNA community survey and community engagement sessions, and 3) inform prioritization and recommendations for Community Health Improvement Plan(s).

The initial health needs areas considered were:

- Housing and Homelessness
- Education
- Health Care
- Transportation
- Physical and Built Environment
- Public Safety
- Jobs/Economy
- Structural Racism
- Social/Culture/Inclusion
- Technology

NOTE: The Healthy Columbia Willamette Collaborative (HCWC) is a unique public-private partnership of 12 organizations in Clark County, Washington, and Clackamas, Multnomah and Washington counties in Oregon. HCWC is dedicated to advancing health equity in the quad-county region. It serves as a platform for collaboration around health improvement plans and activities that leverage collective resources to improve the health and well-being of local communities.



Community Health Financial Assistance for Medically Necessary Care Commitment

Adventist Health understands that community members may experience barriers in paying for the care they need. That is why we are committed to providing financial assistance to those who may need support in paying their medical expense(s).

Community members can find out if they qualify for financial aid in paying medical bills by completing a financial assistance application. Applications can be filled out at the time care is received or after the bill has been administered. To access the financial assistance policy for more information or contact a financial assistant counselor, please visit <https://www.adventisthealth.org/patient-resources/financial-services/financial-assistance/>.



Glossary of Terms

COMMUNITY ASSET

refers to community organizations, programs, policies, activities or tactics that improves the quality of community life.

DEFINING METRIC

this is the metric used to define the extent of the problem faced by the target population.

FUNDING

can be provided by (but not limited to) government agencies, public organizations, grants and philanthropic giving.

GOAL

there may be several overarching goals to address each prioritized health need. This is the overarching impact we want to achieve.

PARTNERS

describe any planned collaboration between the hospital and other facilities or organizations in addressing health needs.

POPULATION SERVED

who is included within the group to receive services of the program.

**PRIORITIZED HEALTH NEED/
PRIORITY AREA/SIGNIFICANT
HEALTH NEEDS**

a health need that was identified in a community health needs assessment and was then selected by committee as a high priority need to be addressed.

STAKEHOLDER- INTERNAL

colleagues and or board members who work for or with the hospital.

STAKEHOLDER- EXTERNAL

community members or organizations who regularly collaborate with the hospital.

STRATEGY

a specific action plan designed to achieve the expected outcome.

SUB-CATEGORY

if needed, a more granular focus within the identified priority area may be called out.

Approval Page

2023 CHIS Approval

In response to the 2022 Community Health Needs Assessment, this Community Health Implementation Strategy was adopted on April 27, 2023 by the Adventist Health System/ West Board of Directors.

The final report was made widely available on May 31, 2023.

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Thank you for reviewing our 2023 Community Health Implementation Strategy. We are proud to serve our local community and are committed to making it a healthier place for all.

Kyle King
Adventist Health Portland

