NOTICE OF MATERIAL CHANGE TRANSACTION
FILED BY ADVENTIST HEALTH SYSTEM/WEST
Supplemental Information Packet
February 13, 2023

Responses to Requests for Additional Information

10. Financial and staffing information. Please provide the following:

a. Preliminary financial reports (income, balance sheet, and cash flow statements), for the full fiscal year ("FY") 2022.

Please see reports attached as Exhibit A.

b. Current clinical staff FTE by service line

Please see spreadsheet attached as Exhibit B.

c. Desired/fully staffed clinical FTE by service line

Please see spreadsheet attached as Exhibit B.

d. Clinical FTE additions, losses, and net change, by service line, in FY2022

Please see spreadsheet attached as Exhibit B.

e. Clinical FTE expected additions, losses, and net change, by service line, during the first 6 months of FY2023 based on status of current MCMC recruitment efforts (i.e., absent the proposed transaction)

Please see spreadsheet attached as Exhibit B. [redacted] MCMC is confident that its business plans for affiliation with Adventist would expand services and drive additional volume to MCMC, requiring additional clinicians to serve the expanded patient population. MCMC is certain that its clinician recruitment efforts would be more successful under the proposed affiliation because recruited medical professionals would be practicing in a larger hospital system, backed by Adventist's excellent clinical staff and supported by Adventist's operating expertise and financial resources. These and other advantages of affiliation will make MCMC an even more attractive destination for clinical recruits.

11. Capital needs. The letter from Adventist's Office of Design and Construction provided as part of the Supplemental Information Packet dated January 18, 2023, includes a list of system upgrades and functionality challenges.

a. Are there plans (on the part of either Adventist or MCMC) to address these? If so, please describe. How would the proposed transaction impact MCMC's ability to address these concerns?

[redacted] The draft Affiliation Agreement contemplates that, after

closing, the parties will assess MCMC's capital needs, including those needs identified in the letter, and then rapidly develop, review, and approve a detailed capital plan to address those needs.

The proposed transaction will favorably affect MCMC's ability to address its capital needs because it will provide the health system with greater access to funding. MCMC believes that the Adventist capital investments will lead to dramatically faster, more extensive, and more beneficial improvements to MCMC's facilities and major movable equipment than MCMC could reasonably achieve as a free-standing community hospital over the ten-year horizon of Adventist's commitment. MCMC is optimistic that the updated facility will enhance the experience of patients and visitors, attract more patients to the facility, improve the quality and efficiency of care, and make MCMC an even more appealing and productive workplace for clinicians and other hospital staff.

b. The response to question 9(a) notes that Adventist has agreed to allocate up to $6 million of its $100 million capital investment for "Urgent Capital Needs" ($3 million annually in 2023 and 2024). To what extent will this investment be used to address the listed concerns?

As noted in the prior answer, decisions on future deployment of capital are dependent on a committee process that will be initiated after closing. Preliminarily, MCMC has provided Adventist with a list of priorities for immediate capital investment. [redacted] Investments in these areas will provide more patients with access to state-of-the-art care, eliminate the downtime and repair cost challenges necessarily associated with older equipment, and allow providers to diagnose and treat patients more effectively.

12. Recruitment and retention efforts. MCMC announced in December 2022 that 14 OHSU providers would be joining MCMC. The announcement also included some apparent successes in recruiting clinicians, including four (potentially eight) new primary care clinicians, three behavioral health providers, and additional physician hires in ENT, urology, and general surgery.

a. Do the 14 OHSU providers represent a net addition to clinical FTE? Or are these providers who were previously serving MCMC patients under the collaboration agreement with OHSU?

Thirteen of the 14 OHSU providers who were previously serving MCMC patients under the Collaboration Agreements have become full-time employed providers at MCMC. The change in the providers' employment status is tremendously beneficial to MCMC and its patient population. These providers are now fully invested in growing their practices and contributing to the medical staff at MCMC. Separately, MCMC recently announced the addition of three more specialists to its medical staff. The new general surgeon, urologist, and ENT physician were not affiliated previously with OHSU.

b. MCMC also announced it has "added a dedicated provider recruiter." Does MCMC have other plans under consideration to address recruitment and retention of clinicians? Absent the transaction, how successful does MCMC expect to be in addressing staffing shortages in next 6-12 months?

MCMC recognizes the need—and has considered and implemented numerous plans—to recruit and retain highly-qualified clinicians to its community. These efforts have paid off. Across most medical specialties, MCMC is either fully staffed or close to fully staffed.

Recruitment of primary care physicians has been more challenging, as it is for most rural hospitals. Until December 14, 2021, MCMC was not able to recruit and hire primary care physicians directly because OHSU had exclusive rights to primary care under the Collaboration Agreement. But MCMC is pleased to announce that in the last two weeks, it has added two new primary care physicians to its medical staff.

Absent affiliation with Adventist, MCMC expects that its ability to recruit new physicians and other providers would become more difficult. As just one example of the recruiting advantages that would be lost were the affiliation not to proceed, MCMC's partnership with Adventist's cardiology team through Northwest Regional Heart and Vascular ("NWRHV") has dramatically increased the health system's range of available services, number of cardiology patients, and complexity of procedures. The high-quality, community-based care available through NWRHV has made MCMC a more attractive future destination for cardiologists, cardiac advance practice providers ("APPs"), and other clinicians.

c. How does Adventist propose to address the recruitment and retention challenges facing MCMC? Please describe specific measures Adventist proposes to take within the first 6-12 months post-closing.

In order to recruit and retain high-quality, dedicated providers, a health system must create an attractive work environment. The facility improvements planned by the parties will give incoming and existing providers nicer, more modern places in which to serve their patients. Similarly, the planned equipment replacements and upgrades, as well as the anticipated EHR enhancements, will give clinicians more efficient and safer tools for performing their life-saving work. Providers will also benefit from, and be attracted and comforted by, the improved financial wherewithal and stability, the expanded training and continuing education curriculum, and enhanced provider wellness resources of an MCMC that is aligned with Adventist Health.

These general improvements notwithstanding, Adventist realizes that targeted and sustained effort will be required successfully to recruit and retain providers into MCMC's rural market. [redacted]

[redacted]

To aid in recruitment, Adventist has developed multiple models to accommodate the unique needs of each physician. The health system can support independent practitioners, offer employment, and structure professional services arrangements. Adventist is able to create strong relationships with providers by supporting the models in which they work best. These options will all be available to MCMC as part of the affiliation with Adventist.

13. Service reductions and closures. MCMC suspended medical oncology services at Celilo Cancer Center, effective February 28, 2023, due to staffing shortages. MCMC also reportedly closed its fitness center at the Water's Edge facility as part of cost-cutting efforts.

a. Please identify and describe any other patient service reductions, closures, or suspensions implemented in the last two years (2021 and 2022), including the types of services affected, reduction in clinical FTE, the main reason for the reduction in services and the impacts on patients and staff. Please include information on MCMC Specialty Clinics at Woods Court.

Other than medical oncology services, MCMC has not materially changed its patient service offerings in the past two years. MCMC is not planning for any additional service line reductions in 2023. MCMC is working aggressively to find an alternative arrangement for continuing to deliver care to Celilo Cancer Center's medical oncology patients.

When its lease expired, MCMC transitioned the services and staff formerly at the Woods Court building to a new facility at Nichols Landing. This transition was not a reduction in either services or staff. Rather, it was a consolidation that allowed MCMC to optimize use of one building instead of making partial use of two buildings. Separately, MCMC converted six underutilized, in-patient rehabilitation beds to acute care beds, better aligning its bed allocation with patient demand. MCMC has also made and is continually making changes to its internal processes in order improve its efficiency and ability to deliver high-quality care in a cost-effective manner.

b. Absent the transaction, what does MCMC plan to do to restore these services or prevent further service reductions? How successful does MCMC expect to be in restoring services or preventing further reductions in the next 6-12 months?

MCMC is fully engaged in attempting to minimize any disruption in care to Celilo Cancer Center's medical oncology patients. That effort will proceed apace independent of the closing date of the affiliation with Adventist. MCMC is not planning to reopen the fitness center, which does not provide a core service.

MCMC is actively recruiting physicians, APPs, support staff, and nurses. Further success in these efforts will enable MCMC to reduce the very heavy cost of engaging locum doctors and traveling nurses. Success in physician recruitment will also attract additional patients, generate additional revenues, and allow for more effective spreading of fixed costs.

MCMC is hopeful its current efforts will contribute to a stronger operating position, although success is by no means assured. Rural community hospitals face significant headwinds in the current environment. MCMC believes that the benefits of affiliation with Adventist include significantly more and better opportunities to attract new physicians and nurses, add services, grow revenue, and improve operating efficiencies to better serve the community.

c. How does Adventist propose to reverse service reductions/closures and prevent additional reductions? Please describe specific measures Adventist proposes to take within the first 6-12 months post-closing, including plans for how to restore the suspended medical oncology services at Celilo Cancer Center.

Adventist understands that, in the recent past, MCMC's ability to maintain its full array of medical services has been pressured by a lack of staffing coupled with a more difficult financial picture. Consummation of the proposed transaction will immediately help address the latter of these two issues, since it will give MCMC access to Adventist's robust financial resources and favorable access to capital. Even so, the parties will spend the first few months of their affiliation reviewing the financial performance and viability of MCMC's various divisions and services. They will then take targeted action to shore up the financial wherewithal and sustainability of those areas that have been struggling. It is important to reiterate here that the parties do not intend to cut or reduce services after the Closing. Instead, they plan to work together to come up with strategies and solutions for putting all existing services on a sound financial footing both now and in the future.

Addressing the staffing issues at MCMC will require Adventist to utilize all resources at its disposal. Successes in the battle against the Covid pandemic have provided needed relief to health care facilities and providers, and have offered hope that the worst may now be behind us. But many providers who decided to retire or seek alternative employment as a result of the pandemic will not be returning to health care. Moreover, the financial losses that many health systems, including MCMC, incurred to compensate locums providers, traveling nurses, and other temporary replacement staff members will take years to make up. So, the parties recognize that their efforts to recruit and retain the staff needed to run the Celilo Cancer Center and other key services will have to persist long after the 6- to 12-month period following closing.

[redacted] Where employing providers or retaining providers on a long-term basis is infeasible, the parties will seek to enter into temporary arrangements that, for example, have providers making in-person visits to the Celilo Cancer Center on a regular basis. Finally, the parties will work to enhance existing telemedicine offerings, which make it possible for MCMC patients to receive care and consultations from experienced specialists working in tertiary care centers in Portland and other remote locations.

d. The feasibility study report (p. 20) mentions plans for a 16-bed standalone inpatient behavioral health facility. Can you tell us more about the nature of these plans? How might they be affected by the proposed transaction?

The reference on page 20 of the feasibility study report to "the 16 bed standalone inpatient behavioral health facility" is to Columbia Gorge Crisis Resolution Center, which will consist of two facilities: one residential treatment facility ("RTF") consisting of 16 RTF beds, and one secure residential treatment facility ("SRTF"). The project is being developed with funding from Oregon House Bill 5202 (2022) and 5024 (2021), through the Oregon Health Authority ("OHA"). RTFs and SRTFs provide housing and treatment services to adults diagnosed with a qualifying mental illness and are staffed 24 hours per day. The Health Systems Division of OHA licenses RTFs and SRTFs pursuant to OAR Chapter 309 Division 35.

It is proposed that the RTF and SRTF be located on a 7.36-acre site owned by Wasco County adjacent to Kramer Field in The Dalles. Wasco County has received $4.5 million from HB 5202 and HB 5024 for the project. The RTF and SRTF will be built and managed by Columbia Care. Columbia Care has applied for an OHA grant of $11.5 million, which will result in a $16 million project. If the $11.5 million is received, the construction of the RTF could begin in May 2023, and construction of the SRTF could begin in early fall of 2023.

The RTF and SRTF will have a walk-in crisis center, where anyone experiencing a mental health or behavioral health crisis will be able to walk in and receive treatment without any barriers. The RTF and the SRTF will not provide acute care behavioral health services due to restrictions in Oregon's licensure rules. The purpose of the RTF and the SRTF is to stabilize individuals in mental health crisis and then to discharge them for continuing services at appropriate facilities.

MCMC is certain that the proposed affiliation with Adventist will improve MCMC's ability to serve the mental health needs of the community. In particular, the parties have discussed the possibility of increasing the number acute inpatient behavioral health beds at MCMC as part of any hospital renovation or replacement projects that they decide to undertake. The service rendered to patients in these beds would complement the services rendered to patients of the RTF and SRTF.

14. MCMC's CEO described various administrative measures undertaken to reduce expenses, including consolidating hospital divisions and sharing support staff across providers. Please provide additional information on these measures, including which divisions/providers were affected, what operations were consolidated, and the impacts on patients and staff.

MCMC realigned its staff to ensure that each provider has an assigned medical assistant ("MA"). MCMC also created a new MA training program to attract new MAs to the field and to the community. The first class of eight new MAs have met qualifications, graduated, and are now employed with MCMC. The next class of MAs are in training.

MCMC relocated a number of medical and administrative staff to better utilize existing space in the hospital and reduce outside lease expenses. MCMC believes that these streamlining efforts have improved access to care and clinical quality. MCMC has laid off a few staff members who chose not to take the positions offered to them, or whose positions were not comparable to positions open elsewhere in the health system. Prior answers address facilities and staff consolidation and repurposing of licensed beds.

15. Describe (i) MCMC and (ii) Adventist Health current policies relating to provision of the services listed below in Oregon. Your response should include whether MCMC/Adventist currently provides the service at any Oregon location, and if not, whether MCMC/Adventist provides referrals for the service. Please include a description of any policies governing providers' rights and obligations with respect to these services. Please also include copies of any relevant policy documents.

Both MCMC and Adventist are committed to providing a full range of high-quality health care services, including reproductive and end-of-life services. Neither organization has policies, procedures, or practices that curtail or otherwise attempt to influence the rights or obligations of their respective providers to do what they believe is in the best interests of their patients. Importantly, despite being a religious organization, Adventist imposes no religious-based restrictions on medical procedures and services.

a. Abortion (medication and surgical, including options counseling)

As indicated in its policy, Adventist's Oregon acute care hospitals do not provide abortions "on demand" or as a method of birth control. The reason is that hospitals are not generally considered cost-effective or efficient settings for performing these procedures.[1] Please see MCMC's relevant policy attached in Exhibit C, and Adventist's relevant policy attached as Exhibit D.

b. Fertility services (IVF, artificial insemination)

MCMC does not provide in-vitro fertilization ("IVF") or artificial insemination services. Its providers do, however, discuss fertility options with patients and, as appropriate, refer patient to specialty providers for needed services. At Adventist, the need for fertility services is governed by plan of care agreed to between a physician and a patient. Fertility services, including IVF and artificial insemination, are offered at some specialty clinics where permitted by available staff, equipment and other resources. Adventist refers patients to outside specialists for fertility services, when necessary and appropriate. Neither Adventist nor MCMC has a policy specifically addressing fertility services.

c. Birth control (including emergency contraception, intrauterine devices, and other forms of long-acting reversible contraception)

At both Adventist and MCMC, birth control is available subject to the plan of care agreed to between a physician and a patient. Neither Adventist nor MCMC has a

[1] *See* Jeff Diamant and Besheer Mohamed, "What the Data Says About Abortion in the U.S.", Pew Research Center (Jan. 11, 2023), accessed on Feb. 10, 2023, at: https://www.pewresearch.org/fact-tank/2023/01/11/what-the-data-says-about-abortion-in-the-u-s-2/ (noting that, in 2020, 96% of abortions were performed in abortion clinics and other clinics, while only 3% were performed in hospitals, and 1% were performed in physicians' offices).

policy specifically addressing birth control services. However, MCMC's protocol on "Pregnancy Testing Prior to Starting Contraception" is attached in Exhibit C.

d. Sterilization (tubal ligation, vasectomy, hysterectomy)

Both Adventist and MCMC provide sterilization services, including tubal ligations, vasectomies, and hysterectomies. These services are rendered only when clinically necessary and appropriate, and only with appropriate consent and in accordance with applicable laws and regulations. Neither Adventist nor MCMC has a policy specifically addressing sterilization services. However, MCMC's protocol on "Post-Vasectomy Sterility Testing" is attached in Exhibit C.

e. Family planning counseling

Neither Adventist nor MCMC has a dedicated program for offering family planning counseling. However, both organizations do offer comprehensive counseling services to their patients, and will refer patients to specialty providers for family planning counseling, as necessary and appropriate. Neither Adventist nor MCMC has a policy specifically addressing family planning counseling.

f. Gender-affirming services (including hormone therapy and gender-affirmation surgery)

Both Adventist and MCMC have policies and practices of offering culturally-appropriate, patient-centered care. Their staff are trained to address all patients using their preferred names and pronouns, and to make necessary accommodations to ensure that, for example, LBGTQIA2S+, BIPOC, and other patients have access to hospital rooms, restrooms, and other facilities that make them feel comfortable and respected. Both organizations also have strict non-discrimination policies to ensure that individuals are not excluded or treated inappropriately because of their gender identity or expression, transgender status, sex, or other gender- or sex-related characteristics. While neither Adventist nor MCMC perform gender-affirming surgeries or offer comprehensive hormone therapy regimens, they will refer patients who request these services to appropriate specialists. Please see MCMC's relevant policy attached in Exhibit C, and Adventist's relevant policy attached as Exhibit D.

g. End-of-life services (death with dignity)

Adventist and MCMC offer end-of-life care that attempts to minimize pain and suffering, and maximize dignity and comfort. Both organizations tailor their end-of-life care offerings to the needs and expressed desires of the patient, honoring do-not-resuscitate, do-not-intubate, and POLST orders, as applicable, and attending to the patient's physical, emotional, social, and spiritual needs. Both organizations also honor and respect the rights of patients to end their lives voluntarily pursuant to Oregon's Death with Dignity Law. In the event that a patient requests lethal medication under this law, Adventist or MCMC care teams, as applicable, will provide comprehensive counseling and support before transferring the patient to a facility or practitioner who assists with voluntary terminations of life. MCMC does not have a policy that specifically addresses the Death With Dignity law.

Adventist's policy titled, "Physician Aid-In-Dying: End of Life Option/Death With Dignity Act", is attached in Exhibit D.

EXHIBIT A

MCMC Financial Reports for FY 2022

Mid-Columbia Medical Center and Affiliates
Preliminary Consolidated Statements of Cash Flows

Years ended December 31,	2022	2021
Cash Flows from Operating Activities:		
Change in net assets	(11,921,873)	2,307,286
Adjustments to reconcile change in net assets to net cash from operating activities:		
Depreciation	4,778,887	4,715,585
Loss on sale of property and equipment	-	33,017
Amortization of debt issuance costs	7,916	7,916
Investment income	1,389,321	(1,340,299)
Amortization of goodwill	136,067	72,134
Restricted contributions and investment income	(926,481)	(649,590)
Changes in operating assets and liabilities:		
Patient accounts receivable - Net	(3,220,578)	(4,675,113)
Other receivables	1,094,320	(1,029,027)
Estimated third-party payor settlements - Net	179,270	(435,298)
Supplies inventory	306,438	(34,892)
Prepaid expenses	277,407	(259,796)
Other noncurrent assets - Net	285,059	145,088
Accounts payable	219,831	119,474
Medicare advance	(9,424,237)	(5,370,763)
Accrued compensation and related liabilites	330,199	187,360
Refundable advance	(3,618,703)	726,288
Accured paid time-off	(469,386)	15,661
Change in operating lease assets and liabilities - Net	632,790	-
Other noncurrent liabilties	(302,147)	(267,330)
Net cash from operating activies	(20,245,900)	(5,732,299)
Cash flows from investing activities:		
Net proceeds from (purchase of) assets limited as to use	4,777,175	(340,019)
Purchases of property and equipment	(1,750,805)	(2,355,556)
Net cash from investing activities	3,026,370	(2,695,575)
Cash flows from financing activities:		
Payments on long-term debt	(240,407)	(811,480)
Payments on capital lease obligations	(254,516)	(375,342)
Restricted contributions and investment income	926,481	649,590
Net cash from financing activities	431,558	(537,232)
Net change in cash and cash equivalents	(16,787,972)	(8,965,106)
Cash and cash equivalents at the beginning of the year	22,515,325	31,480,431
Cash and cash equivalents at the end of the year	5,727,353	22,515,325

MCMC
MID-COLUMBIA MEDICAL CENTER

Statement of Operations For 2022 Period 12 (December 2022)
Entity: MCMC Top Level
Department: ALL - ALL
Location: MCMC Top Level

	Current Month							Year-to-Date						
	Dec 2022 Actuals	Dec 2022 Budget	Variance $	Variance %	Dec 2021 Actuals	Variance $	Variance %	Dec 2022 YTD Actuals	Dec 2022 YTD Budget	Variance $	Variance %	Dec 2021 YTD Actuals	Variance $	Variance %
REVENUE														
Gross Patient Revenue														
PATIENT REVENUE-IP	5,996,838	4,844,555	1,152,283	23.8%	5,025,588	971,249	19.3%	61,805,303	57,107,022	4,698,281	8.2%	57,769,937	4,035,366	7.0%
PATIENT REVENUE-OP	13,909,413	19,063,283	- 5,153,870	- 27.0%	17,949,647	- 4,040,234	- 22.5%	198,251,682	225,033,821	- 26,782,138	- 11.9%	215,065,397	- 16,813,715	- 7.8%
PATIENT REVENUE-EMERGENCY	3,694,433	2,932,682	761,751	26.0%	2,813,218	881,215	31.3%	39,846,409	36,104,468	3,741,941	10.4%	35,312,913	4,533,495	12.8%
PATIENT REVENUE	**23,600,684**	**26,840,520**	**- 3,239,836**	**- 12.1%**	**25,788,453**	**- 2,187,769**	**- 8.5%**	**299,903,394**	**318,245,311**	**- 18,341,917**	**- 5.8%**	**308,148,248**	**- 8,244,853**	**- 2.7%**
Total Deductions	**15,774,385**	**15,661,555**	**- 112,830**	**- 0.7%**	**10,631,021**	**- 5,143,363**	**- 48.4%**	**176,025,179**	**186,726,035**	**10,700,857**	**5.7%**	**177,724,669**	**1,699,490**	**1.0%**
Deduction %	*66.8%*	*58.4%*			*41.2%*			*58.7%*	*58.7%*			*57.7%*		
Net Patient Revenue	**7,826,299**	**11,178,965**	**- 3,352,666**	**- 30.0%**	**15,157,432**	**- 7,331,132**	**- 48.4%**	**123,878,216**	**131,519,275**	**- 7,641,060**	**- 5.8%**	**130,423,579**	**- 6,545,363**	**- 5.0%**
Net Revenue %	*33.2%*	*41.6%*			*58.8%*			*41.3%*	*41.3%*			*42.3%*		
Total Other Revenue	**4,112,392**	**763,357**	**3,349,035**	**438.7%**	**2,324,084**	**1,788,308**	**76.9%**	**16,202,639**	**10,698,820**	**5,503,819**	**51.4%**	**15,767,213**	**435,426**	**2.8%**
TOTAL REVENUES	**11,938,691**	**11,942,322**	**- 3,630**	**- 0.0%**	**17,481,516**	**- 5,542,824**	**- 31.7%**	**140,080,854**	**142,218,095**	**- 2,137,241**	**- 1.5%**	**146,190,791**	**- 6,109,937**	**- 4.2%**
Operating Expenses														
SALARIES AND WAGES	5,720,464	5,653,960	- 66,504	- 1.2%	6,238,948	518,484	8.3%	66,901,890	68,714,204	1,812,314	2.6%	66,098,297	- 803,594	- 1.2%
PAYROLL TAXES AND EMPLOYEE BENEFITS	1,469,983	1,249,307	- 220,675	- 17.7%	1,725,705	255,723	14.8%	14,658,993	14,661,878	2,885	0.0%	14,096,871	- 562,122	- 4.0%
SUPPLIES	1,914,615	1,775,371	- 139,244	- 7.8%	2,155,755	241,139	11.2%	21,830,496	20,988,125	- 842,371	- 4.0%	21,593,188	- 237,307	- 1.1%
PROFESSIONAL FEES	697,439	645,449	- 51,990	- 8.1%	1,446,933	749,494	51.8%	8,960,014	8,249,893	- 710,121	- 8.6%	9,648,568	688,555	7.1%
PURCHASED SERVICES	2,238,841	1,097,948	- 1,140,893	- 103.9%	2,322,307	83,466	3.6%	19,696,208	12,474,921	- 7,221,287	- 57.9%	17,311,488	- 2,384,720	- 13.8%
INSURANCE EXPENSE	73,689	69,665	- 4,024	- 5.8%	183,931	110,242	59.9%	718,286	833,364	115,079	13.8%	1,077,847	359,562	33.4%
MARKETING	16,243	21,149	4,906	23.2%	11,284	- 4,959	- 43.9%	232,223	286,632	54,409	19.0%	201,544	- 30,679	- 15.2%
UTILITIES	158,855	106,113	- 52,743	- 49.7%	99,874	- 58,981	- 59.1%	1,293,046	1,267,477	- 25,569	- 2.0%	1,255,674	- 37,372	- 3.0%
RENT LEASES	842,877	346,507	- 496,370	- 143.2%	336,539	- 506,338	- 150.5%	4,703,225	4,274,730	- 428,495	- 10.0%	4,051,809	- 651,415	- 16.1%
REPAIRS AND MAINTENANCE	192,003	209,866	17,863	8.5%	187,686	- 4,317	- 2.3%	2,476,516	2,396,685	- 79,830	- 3.3%	2,164,620	- 311,895	- 14.4%
OTHER MISCELLANEOUS EXPENS	1,600,920	206,317	- 1,394,603	- 676.0%	316,246	- 1,284,674	- 406.2%	3,250,993	2,026,332	- 1,224,661	- 60.4%	2,216,780	- 1,034,213	- 46.7%
Total Operating Expenses	**14,925,928**	**11,381,653**	**- 3,544,275**	**- 31.1%**	**15,025,207**	**99,279**	**0.7%**	**144,721,888**	**136,174,241**	**- 8,547,646**	**- 6.3%**	**139,716,688**	**- 5,005,200**	**- 3.6%**
EBITDA	**-2,987,237**	**560,669**	**- 3,547,906**	**- 632.8%**	**2,456,308**	**- 5,443,545**	**- 221.6%**	**-4,641,033**	**6,043,854**	**- 10,684,887**	**- 176.8%**	**6,474,104**	**- 11,115,137**	**- 171.7%**
EBITDA %	*-25.0%*	*4.7%*			*14.1%*			*-3.3%*	*4.2%*			*4.4%*		
Depreciation & Interest														
DEPRECIATION AMORTIZATION	360,770	252,082	- 108,689	- 43.1%	385,357	24,587	6.4%	4,778,887	4,388,391	- 390,495	- 8.9%	4,715,579	- 63,307	- 1.3%
NON-OP INTEREST EXPENSE	30,162	32,458	2,297	7.1%	33,611	3,450	10.3%	363,687	391,291	27,604	7.1%	404,769	41,082	10.1%
Total Depreciation & Interest	**390,932**	**284,540**	**- 106,392**	**- 37.4%**	**418,968**	**28,036**	**6.7%**	**5,142,573**	**4,779,683**	**- 362,891**	**- 7.6%**	**5,120,348**	**- 22,225**	**- 0.4%**
Operating Margin	**- 3,378,168**	**276,129**	**- 3,654,298**	**- 1323.4%**	**2,037,340**	**- 5,415,509**	**- 265.8%**	**- 9,783,606**	**1,264,171**	**- 11,047,778**	**- 873.9%**	**1,353,756**	**- 11,137,362**	**- 822.7%**
Op Margin %	*-28.3%*	*2.3%*			*11.7%*			*-7.0%*	*0.9%*			*0.9%*		
NON OP-INVESTMENT INCOME	- 292,866	67,222	- 360,087	- 535.7%	359,390	- 652,256	- 181.5%	- 1,389,321	945,456	- 2,334,777	- 246.9%	1,405,163	- 2,794,484	- 198.9%
MCHF DISTRIBUTIONS	- 54,676	- 19,846	- 34,830	- 175.5%	- 29,301	- 25,375	- 86.6%	- 607,172	- 450,116	- 157,056	- 34.9%	- 437,289	- 169,883	- 38.8%
GAIN LOSS SALE OF PROPERTY PLANT EQUIPMENT	-	96,667	- 96,667	- 100.0%	-	-	-	-	1,160,000	- 1,160,000	- 100.0%	-	-	-
NON OP-INCOME TAX	577	- 1,678	2,255	134.4%	577	-	-	- 3,562	- 20,139	16,577	82.3%	- 13,374	9,812	73.4%
Total Margin	**- 3,725,133**	**418,493**	**- 4,143,627**	**- 990.1%**	**2,368,006**	**- 6,093,139**	**- 257.3%**	**- 11,783,661**	**2,899,373**	**- 14,683,034**	**- 506.4%**	**2,308,256**	**- 14,091,917**	**- 610.5%**

MCMC
MID-COLUMBIA MEDICAL CENTER

Balance Sheet
Entity: MCMC Top Level
Period: December 2022

	FY 2022M12_YTD (Dec 2022)	PRIOR Year (Dec 2021)
ASSETS		
Current Assets		
CASH	5,727,353	22,515,327
AR	34,728,597	27,878,664
AR ALLOWANCES	- 11,811,605	- 8,182,250
INVENTORY	1,585,823	1,892,261
PREPAID	1,347,384	1,624,790
AR OTHER	2,146,562	3,240,882
Total Current Assets	**33,724,114**	**48,969,674**
Board Designated		
BOARD DESIGNATED2	12,904,700	19,071,196
Total Board Designated	**12,904,700**	**19,071,196**
Property, Plant and Equipment		
MAJOR MOVEABLE EQUIPMENT	35,015,683	32,968,370
LAND AND LAND IMPROVEMENTS	1,243,592	1,239,938
FIXED BUILDING EQUIPMENT	9,304,597	9,278,335
CONSTRUCTION IN PROGRESS	1,251,820	1,822,419
BUILDINGS	26,141,705	25,885,178
ACCUMULATED DEPRECIATION	- 57,421,833	- 52,630,595
Total Property, Plant & Equipment	**15,535,564**	**18,563,646**
Other Assets		
NOTES RECEIVABLE	8,155	10,902
OTHER ASSETS2	40,929,018	3,444,404
INTANGIBLE ASSETS	1,034,262	1,178,244
Total Other Assets	**41,971,435**	**4,633,550**
ASSETS - ASSETS	**104,135,812**	**91,238,066**

	FY 2022M12_YTD (Dec 2022)	PRIOR YTD (Dec 2021)
LIABILITIES		
Current Liabilities		
ACCOUNTS PAYABLE	5,901,987	5,682,156
PR RELATED	7,199,165	7,338,353
PATIENT CREDIT BALANCES	157,467	213,476
OTHER ACCRUED LIABILITIES	916,454	13,903,385
MEDICARE AND WELFARE RESEF	1,646,424	1,467,154
MARGIN LOAN	-	-
CURRENT PORTION OF LT DEBT	394,328	478,006
INTERCOMPANY	0	- 0
Total Current Liabilities	**16,215,825**	**29,082,530**
Non-Current Liabilities		
LT DEBT-LEASE	38,689,404	450,445
LT DEBT-LOAN	8,095,920	8,346,406
OTHER NON-CURRENT LIABILITIE	897,966	1,200,113
Total Non-Current Liabilities	**47,683,289**	**9,996,964**
LIABILITIES	63,899,114	39,079,494
NET ASSETS		
NET ASSETS	40,236,699	52,158,572
Total Net Assets	**40,236,699**	**52,158,572**
Total Liabilities & Net Assets	**104,135,812**	**91,238,066**

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EXHIBIT B

Clinical Staffing Spreadsheet

This clinical staffing spreadsheet has been removed, pursuant to OAR 409-070-0070, because it contains trade secrets or other information protected from public disclosure by applicable privileges and confidentiality protections. In particular, the spreadsheet contains confidential information about MCMC's recruitment efforts, successes, and opportunities that constitute trade secrets under ORS 192.345(2) or that are covered by the attorney-client and attorney work product privileges.

EXHIBIT C

Copies of Relevant MCMC Policies

MCMC MID-COLUMBIA MEDICAL CENTER	**Mid-Columbia Medical Center** 1700 East 19th Street The Dalles, OR 97058	*Department:* Ethics *Source:* Patient Handbook

Title:

PATIENT RIGHTS and RESPONSIBILITIES

Approved by:	*Origination Date:*	*Reviewed:*	*Revised:*
Ethics Committee	6/85	1/09, 8/18	10/11, 2/14, 5/14, 6/14, 7/20

Philosophy:

Mid-Columbia Medical Center has a long-standing philosophy of providing quality care. The patient's right to treatment or service is respected and supported. Each patient and patient representative receives a copy of his or her rights. The individuality and human dignity of each patient is so important to us that the board of directors adopted the following resolution formalizing our commitment. On admission the packet of information, which includes patient rights, is reviewed by the admitting nurse with the patient and/or patient representative.

As a Patient you have a Right to:

1. Reasonable access to care treatment and services within the hospital's/clinic's capability.
2. Language interpreting & translation assistance, & communication aids & services at no cost to you.
3. Receive information with assistance for any vision, speech, hearing or cognitive impairments in a manner that meets your needs.
4. Have a family member, support person, or representative of your choice with you during your stay unless it infringes on other's rights, creates an unsafe situation, or is against medical or therapeutic advice.
5. To receive visitors, subject to your consent, whom you designate, including, but not limited to, a spouse, a domestic partner, support person(s), another family member, or a friend, and the right to withdraw or deny such consent at any time. Restrictions or limitations on visitations include when it infringes on other's rights, creates an unsafe situation or is against medical or therapeutic advice.
6. An assessment and interventions implemented to reduce falls based on your risk factors, developmental age and ability to move with or without assistive devices.
7. Participate or have your support person(s), or representative participate in the development and implementation of your care, treatment, and services.
8. Considerate and respectful care including consideration of your personal values, beliefs and preferences, psych-social, cultural and spiritual beliefs and personal dignity, as well as a right to pastoral and other spiritual services.
9. Not be discriminated against based on age, race, ethnicity, religion, culture, language, physical or mental disability, socioeconomic status, sex, sexual orientation, and gender identity or expression.
10. Formulate advance directives, (i.e. living will or power of attorney), or be provided with assistance to prepare the same. The hospital will follow advance directives and provide treatment and services within the hospital's capability and mission, and in compliance with laws and regulations, regardless of Advance directive status.
11. Access, request amendment to, and accounting of disclosures regarding your own health information as permitted under law.
12. Have a family member support person(s), or representative of your choice and your own physician notified promptly of your admission to the hospital.
13. Know the names of all physicians or other practitioners participating in your care and know which doctor is coordinating your care.
14. Obtain from your doctor, or a delegate of your doctor, complete information – in understandable language – concerning your care, outcomes or unanticipated outcomes of care, and your continuing health care requirements.
15. Read your medical record and expect that all records and communication pertaining to your care will be treated confidentially, unless you give permission to release information or reporting is required or permitted by law.
16. Be fully informed by your doctor – in understandable language – prior to your consent to any procedure or treatment, except in emergencies or where medically inadvisable, and have it documented to your patient record. (The information supplied rests in the professional judgment of your doctor, but usually includes a description of the procedure or treatment, the significant risks involved, benefits, side effects, reasonable medical alternatives, and the probable length of time you will be incapacitated.)

17. Make informed decisions, or delegate your support person(s) or representative (as allowed by law) to make informed decisions, concerning your health care including the right to refuse care, medical or surgical treatment and/or services forego or withdraw life-sustaining treatment or withhold resuscitative services, and to be informed of the medical consequences of your refusal.
18. Personal privacy in the discussion and performance of your health care.
19. Be informed of any human experimentation and research/education projects that affect patient care.
20. Be informed, before transfer to another health care facility, of the need for the transfer and the alternatives to transfer.
21. Designate a representative decision-maker. In the event you are incapable of understanding a proposed treatment or procedure or are unable to communicate your wishes regarding your care, your representative will make decisions on your behalf.
22. Withdraw the designation of a representative at any time.
23. A chaperone upon your request, or the request of a staff member.
24. Receive care in a safe setting and to be free from all forms of abuse or harassment including mental, physical, sexual, emotional, humiliation and verbal abuse, and neglect or exploitation and have access to protective services.
25. Appropriate assessment and management of pain.
26. Examine your bill and have it explained, regardless of the sources of payment.
27. A copy of the visitation rights, including the right to receive visitors designated by you.
28. Freely voice complaints and recommend changes without being subject to coercion, discrimination, reprisal or unreasonable interruption of care, treatment, or services.
29. Report concerns related to care, treatment, services and patient safety issues by asking to speak with the Nurse Manager/Supervisor or requesting to speak with a Risk Management by calling 541-296-7285 (ext. 7285 from a hospital phone).
30. File a formal grievance and receive a return notification within 7 days regarding the processing of the grievance. To obtain a copy of our grievance process handout, please contact Patient and Visitor Services at 541-296-7215.
31. Lodge a grievance with the following agencies:

Oregon Health Authority 800 NE Oregon Street, Suite 465 Portland, OR 97232 (971) 673-0540 Fax (971) 673-0556 http://www.oregon.gov/oha	BFCC-QIO Program 9090 Junction Drive, Suite 10 Annapolis Junction, MD 20701 **Toll Free Phone Numbers:** Helpline Calls: 1-877-588-1123 TTY Calls: 1-855-887-6668 **Fax Lines:** Appeals fax line: 1-855-694-2929 All other reviews fax line: 1-844-420-6672

32. Contact the Joint Commission's Office of Quality Monitoring to report any concerns or register complaints about a Joint Commission-accredited health care organization by either calling 1-800-994-6610 or E-mail: complaint@jointcommission.org

As a Patient you have the following Responsibilities:

1. A responsibility to actively participate in decisions regarding your health care.
2. A responsibility to be as accurate and complete as possible when asked for information about your medical history.
3. A responsibility to be honest and direct about everything that happens to you as a patient.
4. A responsibility to let your doctor or nurse know if you are concerned about a treatment, or if you feel you cannot or will not follow a specific treatment plan.
5. A responsibility to accept the outcome if your treatment plan is not followed.
6. A responsibility to notify your doctor or nurse at once if you notice, or think you notice, any perceived risks in your care or unexpected changes in your condition.
7. A responsibility to notify your doctor or nurse at once if you have any concern about your hospital care.
8. A responsibility to ask promptly for clarification if you do not understand what is asked of you, or why it is asked.
9. A responsibility to be considerate and respectful of other patients.
10. A responsibility to use hospital property and equipment only for their intended use.
11. A responsibility to follow the hospital's rules and regulations.
12. A responsibility to examine your bill and ask any questions you have regarding the charges or method of payment.

MID-COLUMBIA MEDICAL CENTER 1700 East 19th Street The Dalles, OR 97058	SCOPE: Organization Wide
SUBJECT/TITLE: ***Scope of Services for Mid-Columbia Medical Center***	
DEPARTMENT: Administration	OWNER: Executive Leadership Team

PURPOSE OF THE PLAN

The purpose of the Organizational Plan for Patient Care is to provide: 1) a framework by which the Executive Leadership Team, Directors/Managers, Medical Staff Leadership, hospital and department committees, teams and task forces, and staff as appropriate will plan, implement, direct, coordinate, evaluate and improve the health care services provided so that 2) they are responsive to the patient population served, our Mission, and identified patient care and community needs. The Plan is based on the assumption that the Hospital is a network of integrated and collaborative processes, and is supported by the strategic plan, the annual budget plan, community needs assessment, departmental plans and referenced policies. The plan serves as a basis to:

- Identify existing and new patient care services.
- Direct and integrate patient care services throughout the organization.
- Implement and coordinate services among departments.
- Demonstrate improvement in the services provided.
- Direct and support a comparable level of patient care throughout the hospital.

DESCRIPTION AND DEMOGRAPHICS

A. Mid-Columbia Medical Center (MCMC) is a 49-bed, not-for-profit, acute care facility that provides care to Wasco County and surrounding areas in the states of Oregon and Washington. MCMC has a tradition of and commitment to excellence based on the Planetree philosophy. MCMC strives to be a careful steward of the resources entrusted to it and is committed to addressing the needs and interests of the public, which it serves. The hospital's strong belief in the intrinsic dignity of each person commits it to be a just employer, to provide healthcare for the whole person, body, mind and spirit, and to collaborate with physicians and other healthcare providers to increase access to healthcare.

B. The Board of Trustees for MCMC has delegated operational decisions regarding patient care to the hospital CEO. The Board of Trustees retains responsibility for monitoring the performance of the CEO to ensure quality care is consistently provided to all patients. MCMC leaders participate with the Board and officers of the organization in developing policy decisions that affect patient care services.

C. MCMC is very active in the communities we serve. Leaders, physicians and staff are encouraged to participate in community programs and activities. Examples of facility involvement in the community, established in response to our community needs assessment are through a variety of community outreach and educational programs such as patient navigation and SOMOS (Serving Oregon and its Migrants by Offering Solutions).

D. MCMC is a full-service acute care facility, providing acute inpatient care, surgical care, labor and delivery, emergency services, and a variety of outpatient services.

LEADERSHIP RESPONSIBILITIES AND ORGANIZATION

Structure/Delegation

The activities of MCMC are governed by the Board of Trustees. The responsibility and accountability for these activities is delegated by the Board of Trustees to the CEO, who in turn delegates responsibility and accountability to Executive Leadership Team and/or designated Directors or Managers. The Executive Leadership Team works closely with the Medical Staff Leadership to provide direction, integration and coordination of the governance, management, clinical and support processes for MCMC.

Board of Trustee Meetings and Communication

- The Board of Trustees and Subcommittees meet at least every other month and per schedule, and are attended by the CEO and Executive Leadership for Mid-Columbia Medical Center or designee(s). Minutes are recorded and distributed to the CEO to disseminate and keep on file in the Administrative offices.
- Reports: The Quality Committee of the Board reviews the facility's Performance Improvement Plan and quarterly reports. Financial reports are reported to the Finance Committee of the Board. Strategic Planning activities are reported to the Board at large. Other business or operational information is presented directly to the Board.

DECISION-MAKING PROCESS AND PLANNING FOR SERVICES

A. All decision-making processes are based on our Mission, Vision, Core Values and Strategic Plan. The Executive Management Team solicits input from the department/service Directors and Managers and Medical Staff Leadership during the budgetary cycle and at various times during the year as changes in practice and technology occur. Department managers and physicians participate in the decision- making structures and processes through their administrative designee on the Executive Management Team.

B. Annually, the Plan for the Provision of Patient Care is reviewed and revised, as appropriate, by the Executive Management Team and leadership, taking into account: 1) our Mission, Vision, Core Values and Strategic Plan, as well as 2) quality standards of care and service, regulatory and accreditation standards, patient feedback and community needs. The Team uses data from sources including: ongoing patient satisfaction surveys, performance improvement findings, Medical Staff leadership recommendations, physician input and provider practices, employee input, market analysis, community needs assessment, staff recruitment/retention and new technologies to plan and redesign patient care services and the systems which support them. In addition, relevant community leaders and other community provider organizations are involved in the process. This may occur via Board feedback, surveys, joint meetings, task forces and/or open forums.

COMMUNICATION PROCESS

A. The Executive Management Team, department Directors/Managers and Medical Staff Leadership use a variety of mechanisms to communicate with each other and to the staff including publications, department meetings, electronic mail, walking rounds and general meetings.

B. Broad-based ongoing communication tools include:
Weekly Update to all employees, medical staff, and Leadership Team from CEO
Unit update.

C. Routine multi-disciplinary meetings include:

- Executive Management Team meetings.
- Full Management Team meetings, Division meetings, and Operations Council meetings
- Hospital and Medical Staff Leadership meetings
- Nursing/Quality Performance Improvement meetings (various)
- Medical Staff committee meetings (various)
- Hospital committee meetings (various)

D. Open forum communication sessions are held periodically and as needed by the Executive Management Team. These forums promote interactive discussion between leaders and staff on a variety of subjects. Medical Staff Leaders and department Directors/Managers hold regular staff meetings within their departments. Ad hoc meetings, communication sessions and conferences occur throughout the year as needed.

DEFINITION OF CLINICAL AND SUPPORT SERVICES

A. Clinical Services: are provided through an organized and systematic process designed to ensure the delivery of safe, effective, and timely care and treatment. Providing and delivering patient care requires specialized knowledge, judgment and skill derived from the principles of biological, physical, behavioral, psychosocial and medical sciences. As such, clinical services are planned, coordinated, provided, delegated and supervised by professional healthcare providers.

1. Patient Care is the provision of direct professional services to the patient and his or her family including: provision for patient rights, assessment, planning for care, intervention or treatment, reassessment of effectiveness, patient and family education and planning for care across the continuum.
2. Delivery of patient care is led by the physicians and/or advanced practice nurses in concert with a multi-disciplinary healthcare team, functioning collaboratively to achieve and improve patient and operational outcomes.
3. A Registered Nurse will assess each patient's need for nursing care in all settings in which nursing care is to be provided In accordance with the Oregon Nursing Practice Act. Nursing is defined as the provision of direct and indirect patient care measures that help people cope with the difficulties of daily living which are associated with their actual or potential health or illness problems or as it relates to their capacity for self-care. Additionally, nurses execute and administer diagnostic and therapeutic regimens prescribed by medical practitioners and supervise, delegate and evaluate patient care activities.

B. Support Services: are those services provided by those who may not have direct contact with patients, but who are integral to the support of care provided by clinical care staff. Support services departments and staff work collaboratively with patient care units and departments to assure that the overall physical plant and basic service needs of our patients, staff, physicians and guests are met.

INPATIENT ACUTE CARE

Acute Care at Mid-Columbia Center has 12 rooms, 19 beds; all of which are sufficient in size and equipment to treat most patients. Our private rooms which are 427, 429, 431, 433, 435, and 437 are more spacious than our double rooms. If a patient requires additional equipment at the bedside i.e. bariatric bed or lift the patient is put in a double room with no roommate if house census allows. Our pediatric patient population is placed in private rooms close to the unit station desk. If no private rooms are available close to the unit station desk the pediatric patient is then placed in a double room with the second bed placed out of service until the pediatric patient can be moved to a private room or the patient discharges. There is one fixed computer in each of our private rooms and two fixed computers in our double rooms for charting and electronic medication verification. There are six fixed computers in the main nursing station, as well as two portable computer workstations.

Acute Care

Patient Population	☑ Adult/Geriatric ☑ Pediatric ☑ Neonate ☐ Cardiac Telemetry ☐ Critical Care ☐ Emergency ☐Medical Surgical ☐NICU ☐Step-down ☐Women's	1) Essential (primary) hypertension 2) Acute Kidney Failure, unspecified 3) Hypo-osmolality and hyponatremia 4) Sepsis, unspecified organism 5) Weakness 6) Personal history of nicotine dependence 7) Urinary tract infection, site not specified. 8) Hyperlipidemia, unspecified 9) Type 2 diabetes mellitus without complications 10) Anemia, unspecified 11) Hypokalemia SB 469, 333-510-0110 (2c)

ICU

MCMC Critical Care has 6 beds; differing in size and equipment to treat all patients equally. ICU beds 1, 3, 4 are in an open bay, divided only by curtains, which makes them ideal for close monitoring. These beds are usually reserved for unstable patients who may require larger scale equipment, such as a ventilators or crash cart or floor lifts. ICU Rooms 5, 6 are small but private, set up with all equipment, (including wall mounted computers) needed for ICU patients needing less space requirements. ICU bed 2 is a small space but has ICU equipment necessary for an emergent admission. Beds 1-4 require the use of mobile computer workstations. There are five fixed computers in the ICU nursing station, as well as three mobile computer workstations.

TELE

The 11 Monitored (Tele) beds are made up of three private rooms and four double rooms. There is one fixed computer per patient bed for charting, with an additional two mobile computer workstations in the nursing station. Each fixed computer inside each patient room, and all mobile workstations, have electronic medication verification scanners. The telemetry nurse station has five fixed computers.

One additional Physician /pharmacist workstation in medication room with X-ray viewing capabilities.

Critical Care

Patient Population Patient Population *cont'd*	☑ Adult/Geriatric ☐ Pediatric ☐ Neonate ☑ Cardiac Telemetry ☑ Critical Care ☐ Emergency ☑ Medical Surgical ☐ NICU ☑ Step-down ☐Women's& Newborn	1) Essential (primary) hypertension 2) Acute kidney failure, unspecified 3) Hyperlipidemia, unspecified 4) Atherosclerotic heart disease of native coronary artery without angina pectoris 5) Chest pain, unspecified 6) Unspecified atrial fibrillation

		7) Sepsis, unspecified organism 8) Hypo-osmolality and hyponatremia 9) Hypokalemia 10) Nicotine dependence, cigarettes, uncomplicated SB 469, 333-510-0110 (2c

OB

The First Impressions Department of Mid-Columbia Medical Center shall provide care and services to all women and their families of childbearing years. The department also provides services to women with selected high-risk vaginal deliveries; pre-operative and post-surgical care for patients undergoing cesarean sections. The department provides services to women with pregnancy complications and antepartum testing such as non- stress testing, contraction stress testing and ultrasound. The services shall include inpatient as well as outpatients. These services include, but are not limited to, prenatal education, prenatal testing, intrapartum care, postpartum care, cesarean section and the care of normal, stable newborns, stabilization of the sick newborn and patients experiencing fetal demise or stillborn deliveries. Preterm mothers and their infants are transferred to a level III facility as appropriate. There shall be an initial and ongoing assessment of patients. The frequency and kinds of assessments shall be based on information collected from the initial assessment including psychosocial, physical, cultural, and spiritual assessments and diagnostic information.

Inpatients and outpatients receive care seven days a week twenty – four hours per day. Frequent Procedures, services and process include:

1. Prenatal education
2. Pre-admission, teaching and referral to community resources (e.g. WIC, prenatal Education).
3. Intra-partum Care
4. Pain Management
5. Epidural for pain relief during labor
6. Hydrotherapy for pain relief during labor
7. Cesarean Section
8. Normal newborn care
9. Stabilization of sick newborns
10. IV therapy of stable newborns
11. Post-partum care
12. Follow-up postpartum clinic and appropriate referrals

The staff consists of a Director who is an RN, registered nurses, a CNA, and a birth certificate clerk/unit clerk. Registered nurses have education and training in peri-natal nursing direct care. Staff is assigned to care for patients dependent upon their competency, skill, and orientation. The First Impressions Department follows the guidelines set forth by AWHONN, ACOG and the American Academy of Pediatrics.

EMERGENCY SERVICES

The patient population served by the Emergency Department consists of the newborn, pediatric, adolescent, adult and geriatric patient requiring or seeking emergent care for acute conditions.
The Emergency department offers a variety of medical services to unscheduled patients who need urgent medical attention, surgical procedures and/or acute care. The scope of services offered includes but are not limited to consultations, whereby a patient is carefully diagnosed by the on-call physician to ascertain the condition the patient presents with. Full and modified trauma response which may include General surgery, Anesthesia, lab, pharmacy, and other critical departments. The patient diagnosis may entail simple to complex procedures such as suture placement depending on location. It may also include laboratory tests for blood, stool, or urine. In some, cases the diagnosis may involve complex procedures using MRIs and CT-scans to observe the internal body structure of the patient. Diagnosis is then followed by treatment approaches based on the outcomes of the initial tests. The Emergency Department also maintain constant communication with the emergency medical service (EMS) providers, to offer medical advice concerning the patient being transported, in case they are in critical conditions. This open-line communication also comes in handy in case the emergency department has reached its capacity because they can advise the EMS to take patients to other centers, rather than wasting time coming and being turned away.

SURGERY

The Surgical Services Department of Mid-Columbia Medical Center provides care for the intraoperative and postoperative patient.

Patient Population includes the newborn, pediatric, adolescent, adult and geriatric patient requiring or seeking surgical intervention to maintain or restore an optimum level of wellness.

Procedures performed in the Surgical Services Department include general, plastic, ENT, ophthalmic, oral, thoracic, vascular, podiatric, urological, neurological, orthopedic, pain management, obstetrical and gynecological procedure. In the immediate postoperative phase, the patients are cared for by an RN and are the responsibility of an anesthesiologist/CRNA until the patient has been appropriately discharged from the Post Anesthesia Care Unit (PACU). Each patient undergoing a surgical procedure has in his/her attendance: 1 circulating registered nurse, 1 scrub tech and 1 anesthesiologist/CRNA. The position of scrub tech may be filled by a trained registered nurse or an operating room technician. If the complexity of the procedure or instrumentation, or the skill mix of the staff warrant, an additional circulator or scrub tech may be added to the case. If a procedure is scheduled for LOCAL anesthesia, an ACLS-certified registered nurse monitors the patient in lieu of the Anesthesiologist/CRNA. This registered nurse is not the circulating nurse. The Post Anesthesia Care Unit is staffed with 1 ACLS registered nurse for every 2 postop patients. If the acuity or number of patients warrants, an additional RN is added to the PACU staffing.

LABORATORY

The laboratory services all hospital in-patient units, on-site and off-site ambulatory clinics within the MCMC organization. Services provided are determined in conjunction with the CLIA laboratory director, administrative laboratory director, laboratory leadership, and the medical staff based on the need, volume, practicality, and expense. Point-of-Care testing (POCT) is provided in the hospital and the ambulatory clinic setting based on the Oregon Rural Health Clinic (RHC) guidelines and the needs of the practice.
The laboratory offers a full range of clinical laboratory services to meet the needs of the community. A test list can be found in the electronic medical record (EMR).

Laboratory Services Include:

- Clinical Chemistry
- Immunoassay Chemistry
- Special Chemistry

- Hematology
- Hemostasis (Coagulation)
- Urinalysis
- Microbiology (limited to Gram staining)
- Molecular Diagnostics
- Molecular Infectious Disease
- Serology
- Blood Gas
- Immunohematology (Blood Bank)
- Transfusion Medicine
- Point-of-Care Testing (POCT)
- Phlebotomy Services

The main campus laboratory operates 24-hours-a-day, 7-days-a-week to provide accurate, timely test results to support providers in the assessment of our patients. The extensive laboratory test menu reflects the commitment to meeting the clinical need of our patients.
The laboratory is supported by an independent laboratory information system (LIS) with EPIC AP (Pathology), EPIC Beaker (Laboratory), and Wellsky (Blood Bank). LIS systems are interfaced to the EPIC EMR for order entry and results reporting. The laboratory is staffed, according to workload requirements with approximately 20.5 FTE which excludes pathology staff and pathologists.

CARDIOPULOMONARY SERVICES

The Cardiopulmonary Services Department is responsible for the care of patients with deficiencies and abnormalities of the cardiopulmonary system. The scope of practice crosses all patient populations from neonatal to geriatric.

A. Performance and collection of diagnostic information
    1. Pulmonary function testing
    2. Electroencephalogram testing
    3. Electrocardiogram testing (inpatient, outpatient and emergent)
    4. Interventional diagnostics
    5. Cardio Stress tests
    6. Noninvasive and invasive diagnostic procedures
    7. Blood gas and other pertinent laboratory analysis
    8. E-patch monitoring
B. Patient assessment
    1. Physical examination
    2. Diagnostic data interpretation
C. Application of therapeutics to respiratory care
    1. Medical gas therapy
    2. Humidity therapy
    3. Aerosol therapy
    4. Artificial airway insertion, management, and care
    5. Airway clearance
    6. Invasive and non-invasive mechanical ventilation
D. Assessment of therapies
E. Disease management of acute and chronic diseases
F. Collaborative support of hemodynamics
G. Discharge planning and case management
H. Provision of emergency, acute, critical and post-acute care, including

1. Patient and environmental assessment
2. Therapeutic interventions
3. Patient land and air transport
4. Home oxygen evaluation and set ups

DIAGNOSTIC IMAGING

The Diagnostic Imaging Department provides quality inpatient, outpatient, and emergency diagnostic imaging services. Inpatient and emergency CT and X-Ray services are provided 24 hours a day, 7 days a week to meet the needs of acute and emergent patients. Outpatient diagnostic imaging services are provided during regular business hours on weekdays at the hospital Imaging Department as well as the orthopedic clinics located off-site at Water's Edge and Nichol's Landing. The Diagnostic Imaging Department offers diagnostic imaging examinations and procedures for acute and chronic medical conditions for pediatric, adolescent, adult, and geriatric patient age groups. A complete imaging exam list can be found in the electronic medical record (EMR) EPIC.

Diagnostic Imaging services include:

- Computed Tomography (CT)
- Magnetic Resonance Imaging (MRI)
- Nuclear Medicine (NM)
- Mammography (M)
- Bone Density (DEXA)
- Ultrasound (US)
- Radiology (XR)
- Positron Emission Tomography (PET CT)

*PET CT services are performed outside the hospital on the grounds by a contracting imaging service.

High Volume Imaging services include:

a. Screening Mammography (Routine Screening)
b. Diagnostic Mammography (Lump, Pain)
c. CT Head (CVA, TIA)
d. MRI Head (Headache, MS, Seizure)
e. CT Chest (Mass, Pulmonary Embolus)
f. CT Abdomen/Pelvis (Kidney Stone, Appendicitis)
g. Chest X-Ray (Chest Pain, Shortness of Breath)
h. Abdomen X-ray (Abdomen Pain)
i. US Carotid (Stenosis)
j. US Pelvic (Pelvic Pain)

AMBULATORY CLINICS

The Rural Health and other Ambulatory Clinics at MCMC provide outpatient medical services to all patients of appropriate age depending on the specialty of the clinic. The services that are provided by each clinic are listed on the website at www.mcmc.net.
The basic scope of services includes those diagnostic and therapeutic services and supplies that are commonly furnished in a medical practice or at the entry point into the health care delivery system. This is accomplished by the following direct services:

1. Prevention of illness and promotion of health through obtaining medical history, physical exams, assessing health status, treatment of various medical conditions, providing annual check-ups, well childcare and patient education.
2. Integration with health and wellness education and ancillary preventative and rehabilitation services.
3. Diagnosis of problems presented at the medical clinic by taking health histories, performing appropriate physical exams, lab tests, pap smears, pregnancy tests and other diagnostic testing and procedures.
4. Treatment of immediate problems and chronic illnesses with drug prescriptions, injections, and other procedures as medically necessary.
5. Acute care for minor injuries or illnesses.
6. Counseling regarding questions or concerns that patients may have about their physical and / or mental health.
7. Referral of patients to medical specialists, testing (imaging, etc.) public and private health and social services agencies.
8. Referral and follow-up treatment to patients who require hospitalization, emergency room care, assisted living, home health care, rehabilitative or therapeutic services including speech, physical, cognitive, nutritional, and occupational for all ages.

Basic Scope of Services include but are not limited to:

Acute Care
Geriatric Care
Preventative (Women's Health, Men's Health and Well Child Care)
Obstetrics
Family Planning
Chronic Disease Management and Education
Illness Prevention and Education
Immunization (Adult and Childhood)
Minor Procedures (circumcision, vasectomy, excisions and biopsies, minor wound repair)
Integrated Behavioral Health Services

CELILO

The following care is given to all patients seen through the Celilo Center Services of Mid-Columbia Medical Center. These standards guide the plan of care provided to patients receiving care/treatment.

1. Ongoing Assessment and Screenings
   - Name, dose, and frequency of medications including over the counter or herbal/dietary additives. Current pain or pain that has not been addressed by a physician or is not being controlled by the current treatment plan. Allergies or adverse reaction to medications. Significant changes in condition since the last visit. Complications that have occurred since the last visit.
2. Confidential Treatment
   - Patients will be provided with treatment areas that provide privacy and confidentiality of their health care treatment. Patient information will be provided to family members or friends only when authorized by the patient in writing and documented in the patients record. Patient information will be provided only to referral physicians unless authorized by the patient in writing and documented in the patients record.
3. Safety measures
   - Patients will be oriented to room and equipment. The exam tables will be always maintained at a low position when unattended. Side rails will be up if the patient is sedated by medication or post anesthesia until awake and alert. Patients with altered mental status will always have someone in attendance. The patients room environment will be kept free of physical hazards. Patients discharged after sedation or post anesthesia will be accompanied by a responsible adult.
4. Treatment Plan

- Each patient will be evaluated to determine their health care needs. Psychological, Social, Financial, Cultural and Spiritual concerns will be evaluated. Input from the patient and the patient's family is considered. The patients treatment choices or decisions will be respected.

5. Rehabilitation Needs
    - Rehabilitation Services help patients cope with activities of daily living affected by their medical condition and enable them to resume normal activities. Celilo Center Staff assess the need for these services and provide or refer them to the appropriate care provider.
6. Patient and Family Education
    - The patient is assessed for education needs throughout his/her care. Discharge information may be provided through verbal communication with the treating physician. Written discharged instructions will be provide to patients that have an invasive procedure and will include: Procedure performed. Physician performing the procedure. Post procedure expectations. Signs and symptoms of complications. Home pain management, when appropriate. Emergency contact information

DIETITIAN AND DIETARY SERVICES

Dietitian services are available for all inpatients to support patient nutritional needs through collaboration with providers and clinical oversight of dietary service functions. Outpatient dietitian and diabetic education services are also available to meet the needs of clinic patients and the community. Dietitian services and patient diet manuals/policies have oversight under the Pharmacy and Therapeutics Committee.

REHAB SERVICES

Rehab Services are currently provided inpatient six days per week.

A comprehensive Outpatient Rehab program also supports patients' post-discharge needs.

Speech Language Pathology

Speech Language Pathology practice includes the following areas: Fluency, Speech Production, Language, Cognition, Voice, Resonance, Feeding and Swallowing and Auditory Habilitation / Rehabilitation.

Occupational Therapy Services enable clients to participate in their everyday life occupations in the desired roles, contexts, and life situations that people find meaningful and purposeful. Clients may be persons, groups, or populations. The domain of occupational therapy consists ADLs (activities oriented toward taking care of one's own body and completed on a routine basis, e.g., bathing, feeding, dressing), IADLs (activities to support daily life within the home and community that often require complex interactions; e.g., household management, financial management, child care), Health management (activities related to developing, managing, and maintaining health and wellness routines, including self-management, with the goal of improving or maintaining health to support participation in other occupations; e.g., medication management, social and emotional health promotion and maintenance) and other related activities.

Physical Therapy practice is patient and client management through timely and appropriate screening, examination, evaluation, diagnosis, prognosis, and intervention, to optimize physical function, movement, performance, health, quality of life, and well-being across the lifespan, consistent with the WHO-ICF framework.

VISITING HEALTH SERVICES

VHS shall be provided to patients residing in Klickitat and Skamania Counties in Washington, Wasco County and parts of Sherman and Hood River Counties in Oregon, who's medical, rehabilitation, nursing, social, and related health needs can be met in a place of residence used as the patient's home. All services are ordered by the patient's physician, and treatment plans are developed in cooperation with the patient/caregiver and healthcare professionals involved in the care. VHS includes:

- Nursing
- Rehabilitative Services

- Medical Social Services
- Home Health Aid
- Home Infusion
- Patient Population

Major Clinical Functions include:

- Patient Care Process
- Patient/Family/Caregiver teaching
- Discharge Planning
- Patient safety / fall assessments
- Pain Management
- Restorative Nursing
- Rehabilitative Services
- Staff Education
- Inter-disciplinary cooperation in quality care
- Quality Assurance & Process Improvement

References:

Approval Process: Executive Leadership and Board of Directors.

Review/Revision Date	Title	Description of Change
1/25/23	COO, CNO	Revised Edits of Policy

MID-COLUMBIA MEDICAL CENTER 1700 East 19th Street The Dalles, OR 97058	SCOPE: Ambulatory Clinics
SUBJECT/TITLE: ***Description of Services***	
DEPARTMENTS: Columbia Crest Medical Clinic; MCMC Family Medicine; Water's Edge Medical Clinic; Columbia River Women's Center; other Ambulatory Clinics	OWNER: Ambulatory Policy Committee

Policy Statement:

The Rural Health and other Ambulatory Clinics at MCMC provide outpatient medical services to all patients of appropriate age depending on the specialty of the clinic. The services that are provided by each clinic are listed on the website at www.mcmc.net

The basic scope of services includes those diagnostic and therapeutic services and supplies that are commonly furnished in a medical practice or at the entry point into the health care delivery system. This is accomplished by the following direct services:

- Prevention of illness and promotion of health through obtaining medical history, physical exams, assessing health status, treatment of various medical conditions, providing annual check-ups, well childcare and patient education.
- Integration with health and wellness education and ancillary preventative and rehabilitation services.
- Diagnosis of problems presented at the medical clinic by taking health histories, performing appropriate physical exams, lab tests, pap smears, pregnancy tests and other diagnostic testing and procedures.
- Treatment of immediate problems and chronic illnesses with drug prescriptions, injections, and other procedures as medically necessary.
- Acute care for minor injuries or illnesses.
- Counseling regarding questions or concerns that patients may have about their physical and / or mental health.
- Referral of patients to medical specialists, testing (imaging, etc.) public and private health and social services agencies.
- Referral and follow-up treatment to patients who require hospitalization, emergency room care, assisted living, home health care, rehabilitative or therapeutic services including speech, physical, cognitive, nutritional, and occupational for all ages.

Specimens requiring testing not available at the RHC are referred to MCMC or other for further testing.

Basic Scope of Services include but are not limited to:

- Acute Care
- Geriatric Care
- Preventative (Women's Health, Men's Health and Well Child Care)
- Obstetrics
- Family Planning
- Chronic Disease Management and Education
- Illness Prevention and Education
- Immunization (Adult and Childhood)
- Minor Procedures (circumcision, vasectomy, excisions and biopsies, minor wound repair)
- Integrated Behavioral Health Services

Diagnostic laboratory procedures, including but not limited to:

- Urinalysis, by dipstick
- Hematocrit and/or Hemoglobin
- Blood sugar
- Examination of stool specimens for occult blood
- Pregnancy testing (urine)
- Primary culturing for transmittal to reference lab

Radiology and Diagnostic Imaging

If not performed in the RHC are referred to MCMC or other outside community resources

Other Off-Site Services are referred to MCMC or other outside community resources

Resources:

RHC 42 CFR §491.9 (b)(3)(i) & §42 CFR 491.9(c)(1) Direct Services

Review/Revision Date	Title	Description of Change
Created 4/2020	MCOC Policy & Procedure Committee	
Reviewed 2/2021, 2/2022, 1/2023	Ambulatory Policy Committee	

MID-COLUMBIA MEDICAL CENTER 1700 East 19th Street The Dalles, OR 97058	SCOPE: Ambulatory Clinics
SUBJECT/TITLE: ***Methotrexate for Ectopic Pregnancy***	
DEPARTMENT: Columbia River Women's Center	OWNER: Ambulatory Policy Committee

Purpose and/or Policy Statement:
To ensure safe handling, administration, follow up by physician and disposal of methotrexate in ectopic pregnancy patients at Columbia River Women's Center.

Definitions:
Ordering providers: OB/GYN Only
Administration staff: Competent Registered Nurse or Provider

Equipment:
Appropriate PPE; includes double chemo gloving, gown, and eye/face protection

Procedure:
1. Ordering
   a. Make sure the patient has a current height and weight--essential for calculating the appropriate medication dose.
   b. Orders for methotrexate for ectopic pregnancy MUST be entered by the provider in Epic, as order 0176468 "Staff to give methotrexate pres free 25mg/ml inj ($per 5mg)" Dose: 50mg/m². Route IM.
   c. Make sure that ectopic pregnancy (or pregnancy of unknown location) is on the problem list.
   d. Patients must have a type and screen, CBC, CMP, and HCG completed just prior to scheduled methotrexate injection to establish baseline levels (do not need to repeat labs if a second injection is needed).
   e. Nursing staff to route methotrexate order to MCMC Med Celilo pharmacy and contact Celilo pharmacy by phone to have them prepare the methotrexate. Provide patient name and MRN. The pharmacy will contact the office when the medication is ready for pick up.
   f. Pharmacist shall create an infusion plan within the CRWC encounter and transcribe the order for the purpose of generating a label. Pharmacy will prepare the dose in the sterile IV vertical flow hood at Celilo Cancer Center. The syringe will be labeled according to hospital policy; pharmacist to ensure the label includes NDC, lot number, manufacturer, and expiration date. Pharmacisit shall alert CRWC staff when medication syringe is ready to pick up. Pharmacy shall complete a pink department requisition sheet and provide a copy to CRWC staff.
   g. CRWC staff that picks up methotrexate pack will ensure 2 pair of chemo gloves are included and will also obtain a copy of pharmacy requisition form to give to CRWC office supervisor.
2. Administration
   a. Appropriate PPE will be used which includes double chemo gloving, gown, and eye/face protection during handling and disposal.
   b. Administer in the ventrogluteal site.
   c. Nursing staff will chart methotrexate injection in Immunizations/Injections.
   d. Methotrexate injectable is considered a hazardous material and must be disposed of as such. Refer to House Wide policy: Hazardous Drug Handling.
   e. If a methotrexate spill occurs, access the chemotherapy spill kit in the north Clean Supply closet #2.
   f. CRWC staff will dispose of the syringe and any vial wastage by delivering items back to Celilo pharmacy in the original packaging for disposal in the approved chemo sharps container.

3. Follow-up
   a. Discharge instructions (.CRWCECTOPIC) should be reviewed with patient b y either RN or provider
   b. Patient needs a quantitative beta hcg drawn on day 4 and day 7 following the methotrexate injection.
   c. If no additional doses of methotrexate are needed, the quantitative beta hcg should be done weekly until the level reaches zero.

References:

UpToDate topic: Ectopic Pregnancy: Methotrexate Therapy

ACOG Practice Bulletine No. 191 Tubal Ectopic Pregnancy (copy located here: R:\CRWC\Clinical Guidelines

Review/Revision Date	Title	Description of Change
Created 02/2013		
Reviewed 11/2018, 9/2019	MCOC Policy and Procedure Committee	
Reviewed 09/2020	Ambulatory Policy Committee	
Reviewed 7/2021	Ambulatory Policy Committee	Steps added to ordering
Revised 11/2022	Ambulatory Policy Committee	

MID-COLUMBIA MEDICAL CENTER 1700 East 19th Street The Dalles, OR 97058	SCOPE: Ambulatory Clinics
SUBJECT/TITLE: ***Protocol: Pregnancy testing prior to starting Contraception***	
DEPARTMENT: Columbia Crest Medical Clinic, MCMC Family Medicine, Water's Edge Medical Clinic, Columbia River Women's Center; other Ambulatory Clinics	OWNER: Ambulatory Policy Committee

Skill Level:
RN, LPN, MA (requires documented competency per CLIA regulations)

Purpose:
Allow staff to order urine pregnancy test prior to initiating contraception in the clinic (Depo Provera [see depo provera protocol for further guidance], intrauterine device [IUD] insertion, or Nexplanon) to facilitate efficient workflow and expedite patient care.

Subjective/Objective Findings:
1. Patient requesting contraception and scheduled for an appointment.
2. Patient intending to get Depo Provera, IUD insertion, or Nexplanon.
3. Last intercourse (unprotected or protected) is documented in the rooming note, along with current method of contraception.

Plan of Care
1. Have patient leave urine sample upon rooming.
2. Perform urine Hcg for pregnancy confirmation per laboratory policy or allow laboratory technician to perform.
3. If performed by RN/LPN/MA, order POC90000003 HCG URINE (Manual), POC document on paper lab log and in Enter/Edit results including provider name in result routing.
4. Verbally relay results to provider.

Medical Director/Provider Signature	**Date**

Review/Revision Date	Title	Description of Change
Created 7/2017		
Reviewed 7/2019	MCOC Policy Procedure and Protocol Committee	
Revised 6/2020	Ambulatory Policy Committee	Added department to include additional Ambulatory clinics
Reviewed 7/2021, 9/2022	Ambulatory Policy Committee	

MID-COLUMBIA MEDICAL CENTER 1700 East 19th Street The Dalles, OR 97058	SCOPE: Ambulatory Clinics
SUBJECT/TITLE: ***Protocol: Post Vasectomy Sterility Testing***	
DEPARTMENT: MCMC Gorge Urology, MCMC Family Medicine, Water's Edge Medical Clinic	OWNER: Ambulatory Policy Committee

Skill Level: RN, LPN, MA

Purpose:
To allow for timely post vasectomy testing for sterility for patients within one year of vasectomy and requesting sterility test.

Inclusion Criteria:
Current Gorge Urology patients who have undergone a vasectomy procedure.

Subjective/Objective Findings:
Patient requests post vasectomy sterility test
Medical record confirms patient is post vasectomy within last year
Repeat the test due to abnormal results showing moving sperm or high number of non-moving sperm

Plan of Care:
Order: Post Vasectomy Sperm Count Lab 101986

Medical Director/Provider Signature	**Date**

Review/Revision Date	Title	Description of Change
Created 4/2014		
Reviewed 9/2019	MCOC Policy Procedure and Protocol Committee	
Reviewed 2/2020	MCOC Policy Procedure and Protocol Committee	
Reviewed 2/2021	Ambulatory Policy Committee	
Revised 3/2022	Ambulatory Policy Committee	

MID-COLUMBIA MEDICAL CENTER
A Planetree Patient-Centered Hospital

MID-COLUMBIA MEDICAL CENTER 1700 East 19th Street The Dalles, OR 97058	SCOPE: Org Wide
SUBJECT/TITLE: ***Transgender Affirming Healthcare Policy***	
DEPARTMENT: Patient Care	OWNER: Director of Inpatient Nursing Services

Purpose and/or Policy Statement:

This policy provides guidance for staff regarding transgender, gender non-conforming, and gender nonbinary individuals visiting and accessing care at Mid-Columbia Medical Center (MCMC) to ensure all individuals experience encounters that are safe, professional, respectful and affirming.

Definitions:

1. Gender Expression: The way a person expresses gender through dress, grooming habits, mannerisms and other characteristics.
2. Gender Identity: An individual's inner sense of being male, female, or another gender. Gender identity is not necessarily the same as sex assigned or presumed at birth.
3. Gender Nonbinary/Genderqueer: A term used by people who identify their gender as being somewhere on the continuum between, or outside of, the binary gender system; genderqueer people may or may not also identify as transgender.
4. Transgender: An umbrella term used to describe people whose gender identity, one's inner sense of being male, female or something else, differs from their assigned or presumed sex at birth.

Expectations of care:

1. When a transgender patient presents for healthcare, they will be addressed and referred to on the basis of their self-identified gender, using their affirmed pronoun and name, regardless of patient's appearance, surgical or treatment history, legal name, or sex assigned at birth. If a patient's family member suggest that the patient is of a gender different from which the patient self-identifies, the patient's view should be honored.
2. Protocol for interaction with Transgender Patients
   a. Address patients by phone or in person without using terms that indicate gender. For example, instead of asking "how may I help you, sir? You can ask, "How may I help you?"
   b. Refer to patients using the first and last name provided to you. Once a patient has given the name they use, it is important for staff to use this name in all interactions.
   c. Avoid gender specific terms when talking with others about a patient until the patient has confirmed their pronouns
3. Patients should not be asked about transgender status, sex assigned at birth, or transition related procedures unless such information is directly relevant to the patient's care. If it is necessary to the patient's care for a healthcare provider to inquire about such information, the provider should explain to the patient:
   a. Why the requested information is relevant to the patient's care;
   b. That the information will be kept confidential but some disclosures of the information may be permitted or; and
   c. That the patient should consult the hospital's Notice of Privacy Practices for details concerning permitted disclosures of patient information.

4. Transgender and gender nonconforming patients have the right to refuse to be examined, observed, or treated by students or any other facility staff when the primary purpose is educational or informational rather than therapeutic without jeopardizing the patient's access to medical care
5. Recording Gender in the Electronic Health Record and Admitting/Registration Records
    a. Allowing departments throughout MCMC the ability to document patients' sex assigned at birth and current gender identity will give providers important information on which to base clinical decisions and improve the quality of care for patients. Recording gender identity and affirmed names/pronouns contributes to patient-centered care and will help patients feel more comfortable and welcome when interacting with front-line staff. To the maximum extent possible, any patient-facing content (wrist bands, labels, letters, etc) should reflect the patient's affirmed name and gender identity.
6. Room Assignments
    a. Transgender patient will be assigned to single occupancy if available. If single occupancy room is unavailable, transgender patients will be assigned to rooms based on their self-identified gender, regardless of whether this self-identified gender accords with their physical appearance, surgical or treatment history, genitalia, legal sex, sex assigned at birth, or name and sex as it appears in hospital records.
7. Access to Restrooms
    a. MCMC shall provide a safe and inclusive environment for all MCMC members, patients, and visitors by ensuring that individuals may use Gender Designated Facilities that best align with their gender identity and expression
8. Consent for medical and surgical services:
    a. It is acceptable for patients to sign an informed consent form for medical and surgical services using their affirmed name, which should be recorded in the patient's medical record. When using other consent forms, document in a progress note that the patient has signed the consent form using their affirmed name. The affirmed name, if documented in the record, is also acceptable to use during the 'pre procedural pause" mandated prior to any surgical procedure.

Procedure:

References:

Review/Revision Date	Title	Description of Change
9/23/22	Director of Inpatient Nursing	Development of policy

MID-COLUMBIA MEDICAL CENTER 1700 East 19th Street The Dalles, OR 97058	SCOPE: Organization-Wide
SUBJECT/TITLE: ***Do Not Resuscitate, Practitioner Orders for Life-Sustaining Treatment and End-Of-Life Decision Making***	
DEPARTMENT: Ethics Committee	OWNER: Case Management Director

PURPOSE:
This policy provides guidance regarding Do Not Resuscitate (DNR) orders, Practitioner Orders for Life-Sustaining Treatment (POLST) and End-of-Life decision making.

RESPONSIBILITIES:
Compliance with this policy is the responsibility of all MCMC providers and staff. Case Management is responsible to assist in the facilitation of these policy requirements.

POLICY:
MCMC complies with the federal Patient Self Determination Act and ORS 127.505 (et. seq.) and honors patients' end-of-life wishes. MCMC providers and staff are responsible for documenting and honoring patient preferences related to cardiopulmonary resuscitation and, when appropriate, POLST. Providers and staff are obligated to seek out and follow the best evidence of patients' preferences.
MCMC will not condition the provision of treatment on an individual having a POLST, Advance Directive or any instruction related to the administration, withholding or withdrawing of life-sustaining procedures or artificially administered nutrition and hydration.

At no time will MCMC communicate or suggest to any individual or person acting on behalf of the individual, that admission or treatment is conditioned on the individual's having a POLST, an Advance Directive or any instruction relating to the administration, withholding or withdrawing of life-sustaining procedures or artificially administered nutrition and hydration.

MCMC will not discriminate against an individual based on whether the individual has a POLST, Advance Directive or instruction relation to the administration, withholding or withdrawing of life-sustaining procedures or artificially administered nutrition and hydration.

However, these restrictions do not prohibit providing the written materials and information about advance directives as required by Oregon law or prohibit a licensed health care professional from engaging in a discussion with a patient about the written materials and information.

A patient with a disability or their representative has the right to designate up to three individuals to serve as a support person to the patient, one of whom may be present at all times during the patient's hospital stay.
MCMC will ensure that a designated support person is present for any discussion in which the patient with a disability is asked to consider electing hospice care or to sign an Advance Directive or other instrument allowing the withholding or withdrawing of life-sustaining procedures or artificially administered nutrition or hydration, unless the patient requests to have the discussion outside of the presence of a support person.

DEFINITIONS:

1. Advance Directive: Refer to Advance Directive policy for details.
2. Intellectual or developmental disability:
    a. "Developmental disability" means autism, cerebral palsy, epilepsy or other condition diagnosed by a qualified professional that:

i. Originates before an individual is 22 years of age and is expected to continue indefinitely;
ii. Results in a significant impairment in adaptive behavior as measured by a qualified professional;
iii. Is not attributed primarily to other conditions including, but not limited to, a mental or emotional disorder, sensory impairment, substance abuse, personality disorder, learning disability or attention deficit hyperactivity disorder; and
iv. Requires supports similar to those required by an individual with an intellectual disability.

b. "Intellectual disability" means an intelligence quotient of 70 or below as measured by a qualified professional and existing concurrently with significant impairment in adaptive behavior, that is manifested before the individual is 18 years of age.
i. An individual with intelligence quotients of 71 through 75 may be considered to have an intellectual disability if there is also significant impairment in adaptive behavior, as diagnosed and measured by a qualified professional.
ii. The impairment in adaptive behavior must be directly related to the intellectual disability.

3. Do not resuscitate order (DNR): Orders providers and staff to not attempt cardiopulmonary resuscitation when a patient is pulseless and not breathing.
4. Personal Representative and Health Care Representative: Refer to *Obtaining Consent for Hospital Services and Medical Procedures* policy for definition.
5. Patient with a disability: For the purpose of this policy and having a support person, a patient who needs assistance to effectively communicate with MCMC providers and staff, make health care decisions or engage in activities of daily living due to a disability, including but not limited to a physical, intellectual, behavioral or cognitive impairment, deafness, being hard of hearing or has another communication barrier, blindness, autism or dementia.
6. POLST: Practitioner orders for life-sustaining treatment: POLST is a set of medical orders documented on the "Portable Orders for Life-Sustaining Treatment" form which describe interventions patients with advanced illness or frailty want if unable to speak for themselves. A valid POLST form includes the patient's name, date completed and resuscitate or do not resuscitate orders, and is signed by a physician (MD or DO), nurse practitioner, physician assistant or naturopathic practitioner (ND). The signer does not need to have clinical privileges at MCMC. Any section that is not completed is assumed to indicate full treatment. While facilities need code status orders, POLST is NOT required for every skilled nursing facility discharge.
7. Support person: a family member, guardian, personal care assistant or other paid or unpaid attendant selected to physically or emotionally assist the patient with a disability or ensure effective communication with the patient with a disability.

KEY WORDS: POLST, AD, DNR, advance directive, withhold, withholding, withdraw, withdrawing, care, futile, futility.

POLICY REQUIREMENTS:

1. Documenting and honoring patient preferences
   A. Documenting **POLST and DNR orders**
      i. Ensure that a support person designated by a patient with a disability is present for any discussion in which the patient is asked to consider electing hospice care, agree to completing a POLST or to sign an Advance Directive or other instrument allowing the withholding or withdrawing of life-sustaining procedures or artificially administered nutrition or hydration, unless the patient requests to have the discussion outside of the presence of a support person.
      ii. Inform patients of their right to accept or refuse medical treatment;
      iii. Do not communicate or suggest that hospital admission, care or treatment are conditioned on the individual having a POLST, advance directive or any other instruction relating to the administration, withholding or withdrawing of life-sustaining procedures or artificially administered nutrition and hydration.
      iv. Ask patients if they have completed an Advance Directive and/or POLST.

v. Ask if there have been any changes to their preferences as currently recorded in these documents. Ensure requested changes are documented accordingly.
vi. Ensure a copy of any paper POLST form is scanned to Medical Records to be uploaded into the patient's medical record and submitted to the Oregon POLST Registry (unless the patient wishes to opt out). POLST forms completed in the ePOLST system are automatically loaded in the EPIC system without the need to send a copy to Medical Records.
vii. Patients may arrive with a POLST form from other care settings, or the practitioner may fill out the POLST form at MCMC.
viii. The POLST form will be completed by the attending practitioner after discussion with the patient or surrogate decision maker regarding patient preferences. The form has seven sections, any section not completed indicates full treatment, as it relates to that section. The attending practitioner signature is mandatory.
ix. If a POLST form is voided, this shall be indicated on the original form by writing "VOID" on the front and back of the form. The voided form will be sent to Medical Records to be filed in the patient's chart to prevent confusion between a new form and a voided form.
x. If the practitioner indicates Do Not Resuscitate (DNR) in Section A of the form, a corresponding order in the Mid-Columbia Medical Center patient medical record will be written to communicate this specific desire to the hospital staff following the practitioner's goals of care conversation with the patient and/or next of kin.

B. Withholding or withdrawing life-sustaining procedures for adult patient lacking decision making capacity.

1. A legally authorized health care representative may not make a decision to withhold or withdraw life sustaining procedures for a patient lacking decision making capacity unless:

a. The appointed legally authorized health care representative has been given authority in an advance directive (or letter of guardianship or a court order appointing a health care representative) to make decisions on withholding or withdrawing life-sustaining procedures; or

b. The patient meets one of the following clinical criteria in the opinion of the attending practitioner and that clinical criteria has been confirmed by a second practitioner who has examined the patient and who has clinical privileges or expertise with respect to the condition to be confirmed:
   i. A terminal condition (a health condition in which death is imminent irrespective of treatment, and where the application of life sustaining procedures or the artificial administration of nutrition and hydration serves only to postpone the moment of death)
   ii. Permanent unconsciousness (completely lacking an awareness of self and external environment, with no reasonable possibility of a return to a conscious state, and that condition has been medically confirmed by a neurological specialist who is an expert in the examination of unresponsive individuals)
   iii. A condition in which the administration of life sustaining procedures would not benefit the patient's medical condition and would cause permanent and severe pain
   iv. A progressive, debilitating illness that will be fatal and is in its advanced stages, and the patient is consistently and permanently unable to communicate by any means, swallow food or water safely, care for him

or herself and recognize familiar persons and there is not reasonable chance that the underlying condition will improve.

Then, a decision to withhold or withdraw life sustaining procedures by the health care team may be made by the patient's health care representative, which shall be the first of the following, in the following order, who can be located upon reasonable effort and who is willing to serve, and shall be considered for this purpose, as the legally authorized health care representative:

- A guardian authorized to make health care decisions
- Patient's spouse or registered domestic partner
- Adult designated by others on this list, if no one on the list objects
- Majority of adult children who can be located
- Parent
- Majority of adult siblings who can be located
- Other adult relative or friend

If none of the persons described above is available, then life sustaining procedures may be withheld or withdrawn upon the direction and under the supervision of the attending practitioner following review and a recommendation by the Chair/On Call Ethics Committee member or work group.

2. If the conditions above in B.1 do not apply, but the patient previously expressed preferences or instructions relating to the withholding or withdrawing of life sustaining procedures the Ethics Committee should be consulted for guidance.

C. Before life-sustaining procedures may be withhold or withdrawn, including an election for hospice treatment, under section B.1.b., the legally authorized health care representative must consult with concerned family and close friends and, if the patient has an Oregon Department of Human Services case manager, must provide notice to the patient's case manager. If the patient has an intellectual or developmental disability, their legally authorized health care representative must contact the Oregon Department of Human Services to determine if the patient has a case manager and provide notice of the plan of care. MCMC Case Managers may facilitate reporting by the legally authorized health care representative.

D. If the patient, even a patient lacking decision making capacity, manifests an objection to withholding or withdrawing life sustaining procedures, the patient's objection shall be honored.

E. If concerned parties disagree on which treatments should be provided an Ethics consult will be requested.

F. Do not place personal values ahead of the patient's or surrogate's preferences.

G. Any conflicts or disagreements among patients or surrogates and hospital staff should resolved through procedural fairness by convening stakeholder meetings, providing hospital policy documentation, and consulting Ethics.

2. Patients who had decision-making capacity when they expressed their preferences for, or to limit, life-sustaining interventions will have those wishes respected, even when refusal of care is likely to result in serious injury or death (see MCMC Patient Rights policy).

3. Patients with DNR orders or POLST forms will have those orders followed. Alternative orders for life-sustaining treatment may be written only if new information becomes available regarding updated patient wishes/legally authorized health care representative instructions and an updated document is completed.

RELEVANT REFERENCES:

- Oregon Revised Statutes (ORS) - 127.505 (et.seq); Advance Directives for Health Care; Declarations for Mental Health Treatment; Death with Dignity
- Practitioner Orders for Life-Sustaining Treatment www.oregonpolst.org.

RELATED DOCUMENTS/EXTERNAL LINKS:

- *Advance Directives* policy
- *Obtaining Consent for Hospital Services and Medical Procedures* policy

APPROVING PERSONS and COMMITTEE(S):

- Case Management Director
- Ethics Committee

Review/Revision Date	Title	Description of Change
August 2021	Ethics	Total revision combining DNR and POLST policies into one. Once approved separate DNR and POLST policies will be archived.
8/23/21	Ethics Committee	Approved

MID-COLUMBIA MEDICAL CENTER 1700 East 19th Street The Dalles, OR 97058	SCOPE: Patient Care
SUBJECT/TITLE: ***Comfort Care Measures for the Dying Patient***	
DEPARTMENT: Hospital Wide	OWNER: Director of Inpatient Services

Policy Statement:
Concern for the patient's comfort and dignity should guide all aspects of care during the final stages of life. Spiritual, social, and cultural variables will be taken into consideration when supporting patients and family members during end-of-life care and the grieving process.

Purpose:
To define the process to provide comfort measures only level of care to patients.

Definitions:

Comfort Care: Care that focuses on symptom control, pain relief, and quality of life, electing to forego disease-modifying therapy and often minimize time in the hospital. Encompasses hospice care in the hospital for patients who require palliative relief of symptoms and pain that can't be managed at home, as well as comfort measures only care in hospital for those unable to leave the hospital. Typically includes support to family members to help them understand the care plan and to address needs and concerns they have around their loves one's end-of-life.

Active dying/imminent death: Refers to a patient's last hours/days of life. These are patients who frequently will not be stable enough to transition to a setting outside of the hospital.

Do not resuscitate order (DNR): This orders the clinical staff to not attempt cardiopulmonary resuscitation when the patient is pulseless and not breathing. DNR orders are distinct from comfort care only and appropriate for both the dying patient and for chronically ill patients who are continuing to receive aggressive life sustaining care.

Do not intubate (DNI): This orders the clinical staff to not intubate the patient in the event of respiratory distress/arrest or cardiac arrest.

Healthcare representative/Medical Power of Attorney (POA): Refer to the Verification Healthcare Representative Policy and the Informed Consent Policy

Procedure:
1. Dying patients, or their healthcare representative (in patient's lacking capacity), have the right to participate in decisions about the course of their medical treatment, including decisions to stop disease-modifying therapy and to define the nature of support and symptom management desired in the final stages of life.
2. The interdisciplinary care team will identify, communicate, and manage the signs and symptoms of patients at the end-of-life to meet the physical, psychosocial, spiritual, social, and cultural needs the patients and their loved ones.
3. Clinical staff must make every effort to alleviate the pain and suffering of the dying patient. This may require either intermittent or continues administration of opioids, sometimes in conjunction with other sedating medications like benzodiazepines. The goal of this treatment is to relieve pain and suffering to the fullest extent possible.
4. Dying patients have the right to maximal possible comfort. The natural dying process involves a decreasing blood pressure and respirations, cardiac and electrocardiographic changes, and altered level of consciousness. Opioids and other medications necessary for patient comfort should not be withheld solely based on these indicators. Vital

sign, electrocardiographic monitoring, deep venous thrombosis prophylaxis, and other usual care routines may be omitted if they are unnecessary or create impediments for patient comfort. The focus should be on creating a peaceful environment that supports human contact. For example:

a. Reduce distractions such as loud noises
b. Keep lighting low, not harsh
c. Keep room free of clutter for safety
d. Facilitate relaxation with soft music, massage, etc.
e. Adapt scheduled activities to patient's routine.
f. Provide an area for family to gather other than the patient's room.

5. Consider consulting the Chaplain for expert assistance with dying patients or loved ones whose suffering or distress remain intractable despite maximal efforts at support. Examples of support include:
    a. Provide emotional support.
    b. Ensure appropriate homemade quilt i.e. Veteran vs regular quilt is provided to the patient
    c. Encourage the expression of feelings.
    d. Maintain dignity and privacy as much as possible.
    e. Encourage family to share in the patient's care when possible.
    f. Provide information about the grieving process and coping with the death of family of friends.
    g. Respecting cultural diversity and spiritual beliefs such as rituals and taboos and connecting with their spiritual leader
6. Practitioner:
    a. Confirm DNR/DNI status
    b. Use Epic order set MCMC Comfort Care
    c. For patients who are on Comfort Care or are transferring to another unit, the provider needs to ensure the patient is stable for transfer and that the current care needs can be met in the new setting.
    d. Assess patient comfort and interventions daily at minimum or more frequently if patient changing quickly.
    e. If the patient is discharged from the hospital on Hospice, ensure that the Physician Orders for Life Sustaining Treatment (POLST) or Advance Directive is completed prior to discharge. Once completed ensure a copy is on file and all caregivers have been provided the information.
7. Registered Nurse (RN):
    a. Titrate medications per practitioner orders as needed for patient comfort.
    b. Promote effective airway clearance by elevating the patient's head of bed and positioning on patient's side.
    c. Provide routine skin care and incontinence protection checking frequently for incontinence.
    d. Notify practitioner promptly if existing orders are insufficient in managing patient's comfort level or other barriers are identified to providing excellent end-of-life care.
    e. If receiving a comfort care patient from another unit, ensure medications, equipment is available on the unit before the patient arrives as these transitions can be a time of distress for patients and loved ones.
    f. Provide anticipatory guidance to loved one's about signs and symptoms of active dying i.e., congestion and breathing pattern changes.
    g. If appropriate, provide education to both the patient and loved one's regarding comfort measures including pain medication availability, stages of grief, and end-of-life care and decisions.
    h. Document in the patient's electronic health record (EHR) assessment, intervention, and re-assessment per the practitioner's orders.
8. Case Management
    a. Provide supportive counseling to patient and family members as appropriate.

b. Assess for community resources not limited to funeral, financial and support/bereavement service needs.
c. For Hospice Acute Care admitted patients, Case Management will collaborate with the Hospice Nurse to arrange the return of the Hospice patient to the home setting when appropriate. Case Management should keep the Hospice Nurse updated with changes in condition while the patient is admitted to the hospital when appropriate.

Relevant Documents:
Refer to the Verification Healthcare Representative Policy
Informed Consent Policy
Post-Mortem-Care-Patient Death
Do Not Resuscitate Guidelines
Autopsy Guidelines
Advance Directives: Patient Self Determination
Physician Order for Life Sustaining Treatment (POLST)

Approval Committees:
Best Practice Council

Review/Revision Date	Title	Description of Change
03/2021	Director of Inpatient Services	Combined two older policies into this updated policy

EXHIBIT D

Copies of Relevant Adventist Policies

Termination of Pregnancy, Induced

Disclaimer

Approvals

- Committee Approval: Patient Care Committee (PCC) approved on 2/1/2022
- Committee Approval: Clinical Committe of the Community Board approved on 3/23/2022
- Committee Approval: Perinatal Steering approved on 2/16/2022
- Committee Approval: Medical Executive Committee approved on 2/21/2022

Revision Insight

Document ID:	17491
Revision Number:	2
Owner:	Leslie Cassagneres, Program Manager, Contracts
Revision Official Date:	3 22/2022

Revision Note:
Corporate Systemwide Standard Policy.

STANDARD POLICY: TERMINATION OF PREGNANCY, INDUCED

Adventist Health Portland adopts the following systemwide Adventist Health Standard Policy.

POLICY SUMMARY/INTENT:

This policy describes Adventist Health's position on termination of pregnancy and applies to adults and minors.

While Adventist Health recognizes the rights of individuals related to contraception, hormonal therapies and termination of pregnancy, there are some basic principles that will be followed:

A respect for all human life.

A respect for the special trust-based relationship that exists between a patient and that patient's physician in making important healthcare decisions.

A respect for a person's right to have informed consent and to choose what is perceived to be best for that person—regardless of the personal beliefs of a provider.

A desire to treat others, as we would want to be treated.

Acknowledgement that Federal and/or state laws, including reporting requirements, will be followed.

DEFINITIONS:

A. **On Demand**: The intent of the term "on demand" is for no medical reason and/or medical pathology, no risk of harm, morbidity, and/or mortality to an unborn fetus or pregnant person be it immediate or a potential in the future.

B. **Facility:** In this policy, facility refers to an acute care hospital.

AFFECTED DEPARTMENTS/SERVICES:

All Clinical Departments

POLICY: COMPLIANCE – KEY ELEMENTS

A. Termination of Pregnancy:

1. All human life deserves respect and protection. Every reasonable effort must be made to nourish, support, and protect life in its entire spectrum.
2. When termination of pregnancy is requested by a patient, in order for justice to prevail for both the person who is pregnant and the fetus, the rights and interests of both parties must be considered.
3. Further consideration of the rights of the unborn fetus and the physical, mental and emotional health of the woman who is pregnant would emphasize the provision of sensitive care to the pregnant person and availability of counseling relative to the alternatives to termination of pregnancy.
4. Facility does not permit direct termination of pregnancy "on demand" by the patient or as a method of birth control. Any person seeking admission to the facility for a direct termination of pregnancy must be notified by the facility of this policy.
5. Adventist Health has adopted a practice of not admitting patients seeking direct termination of pregnancy as described above. However, medically indicated termination of pregnancy may be considered in the course of treatment of a patient who is pregnant at Adventist Health only when:
    a. The attending physician believes in good faith that the life or health of the patient or unborn fetus is in imminent danger or continuing the pregnancy would threaten the patient's and/or unborn fetus survival or potentially causes harm, morbidity, or mortality.[1]
    b. If other situations arise that are consistent with the principles stated in the preamble, the chairman of the Facility's Governing Board shall appoint a subcommittee of the board who, in consultation with the Facility's Ethics Committee, will evaluate and decide on a case-by-case basis the request for a medically indicated termination of pregnancy in the course of treatment of the patient who is pregnant.
6. Any fetus delivered alive shall be provided the same level of care and life support efforts by the medical staff and facility personnel as would be provided any other similar live born fetus.
7. No member of the Facility's medical staff is required to participate in any termination of pregnancy.
8. No staff member of the Facility is required to participate in any termination of pregnancy. [2]
9. All of the above statements apply to all Adventist Health hospitals. For all clinical sites (acute care, emergency care and ambulatory settings), Adventist Health does not direct physicians/providers on contraception, Plan B, hormonal therapies for any purpose, or birth control.

10. **In California**, signage stating “Abortion Not Provided” will be posted in a prominent location in the facility. [3]

ATTACHMENTS: (REFERENCED BY THIS DOCUMENT)	
OTHER DOCUMENTS: (WHICH REFERENCE THIS DOCUMENT)	
FEDERAL REGULATIONS:	
ACCREDITATION:	
CALIFORNIA:	**Not applicable**
HAWAII:	**Not applicable**
OREGON:	**2017 ORS 435.496**
WASHINGTON:	**Not applicable**
REFERENCES:	**(1) CA Health and Safety Code 123430 (d)** **(2) CA Health and Safety Code 123420 (a)** **(3) CA Health and Safety Code 123420 (c)**
ADVENTIST HEALTH SYSTEM/WEST POLICY OWNER:	**General Counsel**
ENTITY POLICY OWNER:	**Program Manager, Contracts**
APPROVED BY:	
ADVENTIST HEALTH SYSTEM/WEST:	**(01/13/2022) System Cabinet**
ADVENTIST HEALTH SYSTEM/WEST INDIVIDUAL:	**(12/01/2021 03:40PM PST) Meredith S Jobe, General Counsel**
ENTITY:	**(02/01/2022) Patient Care Committee (PCC), (02/16/2022) Perinatal Steering, (02/21/2022) Medical Executive Committee, (02/21/2022) Clinical Committe of the Community Board**
ENTITY INDIVIDUAL:	
REVIEW DATE:	
REVISION DATE:	**08/07/2019, 04/08/2020, 01/13/2022**
NEXT REVIEW DATE:	**03/21/2025**
APPROVAL PATHWAY:	**Clinical**

Adventist Health Portland

Legal Sex, Birth Sex, and Gender Identity Policy

Disclaimer

Approvals

- Committee Approval: Clinical Committe of the Community Board approved on 9/20/2021
- Committee Approval: Medical Executive Committee approved on 9/20/2021
- Committee Approval: Patient Care Committee (PCC) approved on 9/7/2021

Revision Insight

Document ID:	18266
Revision Number:	0
Owner:	Leslie Cassagneres, Program Manager, Contracts
Revision Official Date:	9 20/2021

Revision Note:
New Corporate Systemwide Standard Policy

MODEL POLICY: LEGAL SEX, BIRTH SEX, AND GENDER IDENTITY POLICY

Adventist Health Portland adopts the following systemwide Adventist Health Model Policy.

POLICY SUMMARY/INTENT:

Adventist Health's mission and values aim at providing an environment for patients that is free from discrimination and will not exclude or treat people differently because of their gender identity or expression, transgender status, sex, and self-identified gender, such as using the person's preferred pronouns and name.

Every patient has individual and specific health needs. Knowing a patient's birth sex, legal sex and gender identity will help Adventist Health deliver the appropriate care, treatment, and services.

DEFINITIONS:

1. **Legal Sex:** Represents a patient's current sex which may not necessarily align with their birth sex. Legal sex may result from gender reassignment/transition, and/or the patient legally changed their sex.

   Note: Legal sex does not reflect sexual orientation.

   Legal sex is the sex as defined by legal documents, such as birth certificate, passport, driver's license or healthcare card.

2. **Birth Sex:** Sex assigned at birth and recorded at birth, usually based on simple visual inspection of the genitals of newborn baby. Also known biological sex.

3. **Gender identity:** Gender identity is a person's internal sense of being a man, woman, both, or neither. This is a description of whether a person thinks of themselves as male or female, both, or neither. This may or may not be the sex assigned at birth.

AFFECTED DEPARTMENTS/SERVICES:

1. All hospital departments and services, including inpatient, outpatient, and ambulatory clinics (hospital-based clinics and rural health clinics).

POLICY: COMPLIANCE – KEY ELEMENTS

A. Registration:

   1. The registration process for both inpatient and outpatient is the initial intake of information regarding the person; such a name, date of birth, etc. The registration areas will have copies of the Birth Sex, Legal Sex, and Gender Identity trifolds and laminated forms. Individuals will have access to these documents to review and understand why birth sex. legal sex, and gender identity information would be necessary. Refer to the attachments.

      a. Birth Sex and Legal Sex:

         i. During this process their birth sex and legal sex will be asked.

         ii. If the person states their birth sex and legal sex are the same, registration will enter the information.

         iii. If the person states their legal sex is different than their birth sex, the person will be required to provide documentation; such as driver's license, passport, health card. Once documentation is obtained, it will be scanned into the medical record and the legal sex field will reflect the legal sex.

      b. Gender identity is voluntary.

      c. Preferred name:

         i. Registration will ask if the person has a preferred name. If they do, it will be documented.

   2. The information obtained during the registration process will reflect in the medical record.

   3. If during the person's encounters and/or admissions, they provide updated information, registration department will make the necessary changes.

   4. During the person's encounters and/or admissions, if the clinical team has updated information and/or the information in the medical record is not correct, they will advise Registration. Registration will make the necessary changes.

B. Patient Identification Bands:

   1. The patient identification bands, also known as wrist bands will not include sex.

C. Room Assignments:

1. As described in the Non-Discrimination Policy and the Conditions of Registration – upon a patient's request, an attempt will be made to make the room assignment based on the patient's gender identity.

D. Documentation and Medical Record:

1. If the patient provided information about their legal sex and/or gender identity, an alert will be present the first time a clinician opens the patient's medical record.
2. The banner bar will have information about the patient's birth sex, legal sex, and gender identity, and preferred name.
3. Use terms such as "patient" and their preferred pronouns.
4. Patient's gender/sex not necessary unless clinically pertinent/significant.
5. Care plan as deemed necessary.
6. Documents such as logs (example Central Log) and forms, legal sex will be used unless both birth and legal sex is necessary. Corresponding policies and procedures for those documents may need to address legal sex.
    a. Terms such as patient, parent, spouse, significant other will be used.
7. Should the patient request their medical record be released to another provider, hospital, etc. refer them to Health Information Management (HIM) Department.
8. Once a patient is discharged and they request changes to their medical record, refer them to HIM.

E. Birth Sex necessary for care, services, and treatment:

1. There are care, services, and treatments based on birth sex for preventive care (such as mammograms, pap tests, etc.), lab normal range values, diagnostic imaging, and other.
2. Preventative care needs to be discussed with the patient to ensure it is properly planned and scheduled.

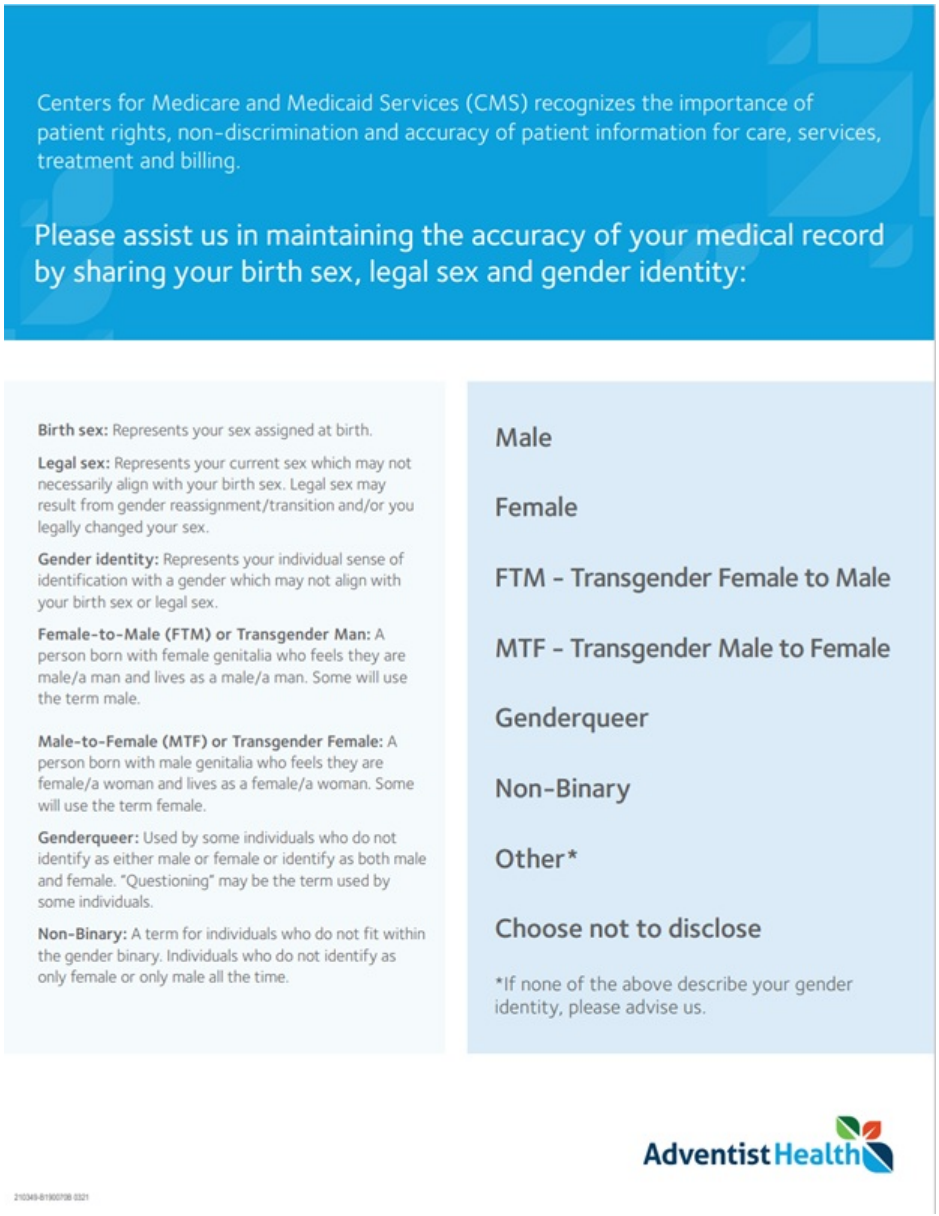
F. Reporting requirements:

1. Each state has specific reporting requirements; such as birth sex, gender identity, etc.
    a. These are reported as required by [site to enter the department].

G. Education:

1. Education regarding this policy will be provided to staff upon hire and periodically thereafter.
    a. Providers will be provided the information regarding this policy.

Attachment A: Birth Sex, Legal Sex, and Gender Identity Form



Centers for Medicare and Medicaid Services (CMS) recognizes the importance of patient rights, non-discrimination and accuracy of patient information for care, services, treatment and billing.

Please assist us in maintaining the accuracy of your medical record by sharing your birth sex, legal sex and gender identity:

Birth sex: Represents your sex assigned at birth.

Legal sex: Represents your current sex which may not necessarily align with your birth sex. Legal sex may result from gender reassignment/transition and/or you legally changed your sex.

Gender identity: Represents your individual sense of identification with a gender which may not align with your birth sex or legal sex.

Female-to-Male (FTM) or Transgender Man: A person born with female genitalia who feels they are male/a man and lives as a male/a man. Some will use the term male.

Male-to-Female (MTF) or Transgender Female: A person born with male genitalia who feels they are female/a woman and lives as a female/a woman. Some will use the term female.

Genderqueer: Used by some individuals who do not identify as either male or female or identify as both male and female. "Questioning" may be the term used by some individuals.

Non-Binary: A term for individuals who do not fit within the gender binary. Individuals who do not identify as only female or only male all the time.

Male

Female

FTM - Transgender Female to Male

MTF - Transgender Male to Female

Genderqueer

Non-Binary

Other*

Choose not to disclose

*If none of the above describe your gender identity, please advise us.

AdventistHealth

Attachment B: SAMPLE Birth Sex, Legal Sex, and Gender Identity Trifold

Non-Discrimination Policy – Patients

As a recipient of Federal financial assistance, [Insert site specific information] will provide an environment for patients that is free from discrimination and will not exclude or treat people differently because of their ability to pay, age, color, creed, culture, disability, gender identity or expression, language, marital status, national origin, religion, sex, pregnancy, sexual orientation, socioeconomic status, transgender status, type of insurance, or veteran's status, when delivering care, treatment, services and benefits for inpatients and outpatients, including assignments or transfers within the facility and referrals to or from the facility directly or through contractual or other arrangements.

This statement is in accordance with the provisions of Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, and Regulations of the U.S. Department of Health and Human Services issued pursuant to these statutes at Title 45 Code of Federal Regulations Parts 80, 84, and 91.

In case of questions, please contact:

Entity name: [Insert site specific info]
Contact person: [Insert site specific info]
Telephone number: [Insert site specific info]
TDD number: [Insert site specific info]

916-406-0000
ONE Adventist Health Way
Roseville, CA 95661
AdventistHealth.org

Birth sex, legal sex and gender identity and our registration process

AdventistHealth
Together inspired.

We recently improved our registration process to include birth sex, legal sex and gender identity.

We have done so to ensure the care, treatments, and services meet the individual needs of our patients.

Enclosed are a few frequently asked questions about why we are interested in knowing and how the information will be used. If you have additional questions, please speak with registration or your healthcare provider.

What is legal sex?

Legal sex is the sex as defined by legal documents, such as birth certificate, passport, driver's license or healthcare card.

What is birth sex?

Sex assigned at birth and recorded at birth, usually based on simple visual inspection of the genitals of a newborn baby. Also known as birth sex.

What is gender identity?

Gender identity is a person's internal sense of being a man, woman, both, or neither. This is a description of whether a person thinks of themselves as male or female, both, or neither. This may or may not be the sex assigned at birth.

Why is this information necessary?

Every patient has individual and specific health needs.

Knowing our patients' birth sex, legal sex and gender identity will help us deliver the appropriate care, treatment and services.

We wish to assure that we address and refer to our patients on the basis of their self-identified gender, using their preferred pronouns and name.

Do we have accurate information about you?

- You can check with the Registrar.
- You can speak to your healthcare provider, for example primary care physician.
- Our goal is to ensure the information we have in your medical (health) record is accurate.

We ensure the care, treatments, and services meet the individual needs of our patients

Who will see the information?

Information regarding your gender identity is part of your medical record. This information is confidential and protected by law.

Your healthcare provider and other clinical staff will have access to this information. Access to this information, will help deliver appropriate care, treatment, and services to you.

You do have the option to not disclose this information.

Your healthcare provider may ask you questions about your gender identity. You can choose to answer the questions or not at that point. Further discussions on these questions are between you and your healthcare provider.

ATTACHMENTS:
(REFERENCED BY THIS DOCUMENT)

OTHER DOCUMENTS:
(WHICH REFERENCE THIS DOCUMENT)

FEDERAL REGULATIONS:

ACCREDITATION:

CALIFORNIA: **Not applicable**

HAWAII: **Not applicable**

OREGON:	**Oregon Chapter 333 -5050033**
WASHINGTON:	**Not applicable**
REFERENCES:	**Affordable Care Act 1557, CMS: Patient Rights 482,13, CMS Meaningful Use 3, The Joint Commission RI 01.01.01**
ADVENTIST HEALTH SYSTEM/WEST POLICY OWNER:	**Director, Accreditation, Regulatory, and Licensing**
ENTITY POLICY OWNER:	**Policy & Contract Coordinator**
APPROVED BY:	
ADVENTIST HEALTH SYSTEM/WEST:	**(08/16/2021) Care Cabinet (CC)**
ADVENTIST HEALTH SYSTEM/WEST INDIVIDUAL:	
ENTITY:	**(09/07/2021) Patient Care Committee (PCC), (09/20/2021) Medical Executive Committee, (09/20/2021) Clinical Committe of the Community Board**
ENTITY INDIVIDUAL:	
REVIEW DATE:	
REVISION DATE:	**08/16/2021**
NEXT REVIEW DATE:	**09/19/2024**
APPROVAL PATHWAY:	**Clinical**

Physician Aid-In-Dying: End of Life Option/Death with Dignity Act(s)

Disclaimer

Approvals

- Committee Approval: Ethics Committee approved on 8/12/2020
- Committee Approval: Perinatal Steering approved on 8/19/2020
- Committee Approval: Surgery Steering approved on 8/12/2020
- Committee Approval: Patient Care Committee (PCC) approved on 6/2/2020
- Committee Approval: Medicine Steering approved on 10/14/2020
- Committee Approval: Medical Executive Committee approved on 10/19/2020
- Committee Approval: Clinical Committe of the Community Board approved on 10/19/2020
- Committee Approval: Emergency Department approved on 9/25/2020

Revision Insight

Document ID:	16513
Revision Number:	1
Owner:	Leslie Cassagneres, Program Manager, Contracts
Revision Official Date:	10/19/2020

Revision Note:
Updates to Corporate Systemwide Standard Policy. Also referenced as AD-14-091-S.

☒ Systemwide Standard Policy
☐ Systemwide Model Policy

Standard Policy No. 16513/Corp
Approval Pathway: Clinical
Department: Joint Patient Care Policies

STANDARD POLICY: PHYSICIAN AID-IN-DYING: END OF LIFE OPTION/DEATH WITH DIGNITY ACT(S)

Adventist Health Portland adopts the following systemwide Adventist Health Standard Policy.

POLICY SUMMARY/INTENT:

Adventist Health is a faith-based, nonprofit integrated health system whose mission is to "share God's love" by compassionately attending to the physical, mental, and spiritual needs at every stage of life, including the end of life. Adventist Health has clinical operations and facilities in states that have passed laws (referenced below) allowing for physician-assisted end of life options ("Death with Dignity Laws"). These Death with Dignity Laws allow terminal patients to choose to end their life, as long as certain requirements are met.

While Adventist Health recognizes the rights of terminally ill patients and physicians who may choose to participate in their respective state's Death with Dignity Laws, it chooses not to participate in these procedures. Adventist Health bases its policy on the following principles:

A respect for all human life.

A respect for the special trust-based relationship that exists between a patient and that patient's physician in making important healthcare decisions.

A respect for another person's right to have informed consent and to choose what is perceived to be best for that person—regardless of the personal beliefs of a provider.

A desire to treat others, as we would want to be treated.

An acknowledgement that Death with Dignity Laws do not require any person or entity to participate against the will of that person or entity.

Acknowledgment that Federal and/or state laws, including reporting requirements, will be followed.

AFFECTED DEPARTMENTS/SERVICES:

1. All inpatient clinical areas where care is delivered to terminally ill patients

POLICY: COMPLIANCE - KEY ELEMENTS:

Based on the principles above, Adventist Health adopts the following policy for all Adventist Health affiliates and their facilities:

A. The primary goal of care for patients who are terminally ill is to alleviate that patient's pain and suffering as effectively as possible and to affirm that patient's life. This requires thoughtful consideration of the physical, emotional, social, and spiritual needs of patients.

B. If a terminally ill patient requests assistance under a Death with Dignity Law, every reasonable measure that might help to alleviate the underlying causes for the request shall be explored. All conversations concerning end of life decisions need to be well documented in the patient's medical record. Patients should also be given written (or other) educational materials that inform them of the law(s) and options available.

C. If a terminally ill patient admitted to Adventist Health continues to request assistance under the End of Life Option or Death with Dignity Act(s), a referral will be facilitated, as applicable.

ATTACHMENTS:
(REFERENCED BY THIS DOCUMENT)
OTHER DOCUMENTS:
(WHICH REFERENCE THIS DOCUMENT)
FEDERAL REGULATIONS:
ACCREDITATION:

CALIFORNIA:	**Not applicable**
HAWAII:	**Not applicable**
OREGON:	**ORS Chapter 127: Death with Dignity Act**
WASHINGTON:	**Not applicable**

REFERENCES:

ADVENTIST HEALTH SYSTEM/WEST POLICY OWNER:	**System Chief Quality Officer**
ENTITY POLICY OWNER:	**Policy & Contract Coordinator**

APPROVED BY:

ADVENTIST HEALTH SYSTEM/WEST:	**(02/18/2020) Clinical Cabinet (CC), (03/10/2020) System Bioethics Committee**
ADVENTIST HEALTH SYSTEM/WEST INDIVIDUAL:	
ENTITY:	**(06/02/2020) Patient Care Committee (PCC), (08/04/2020) Ethics Committee, (08/06/2020) Surgery Steering, (08/19/2020) Perinatal Steering, (09/17/2020) Emergency Department, (10/14/2020) Medicine Steering, (10/19/2020) Medical Executive Committee, (10/19/2020) Clinical Committe of the Community Board**

ENTITY INDIVIDUAL:	
REVIEW DATE:	**05/16/2019**
REVISION DATE:	**05/24/2016, 04/08/2020**
NEXT REVIEW DATE:	**10/19/2023**
APPROVAL PATHWAY:	**Clinical**