2022 Portland Adventist Medical Center CBR-1 Supplemental Narrative

1. Portland Adventist Medical Center made widely available to the public their Community Health Needs Assessment on 12/31/22.

2. The community outreach efforts as represented on the 2022 CBR-1 for Portland Adventist Medical Center were largely based on our 2020-2022 CHNA which was published on December 31, 2019.

Top Health needs identified:

- Chronic Disease
- Access To Care
- Behavioral Health
- Social Determinants: Food Access/Safety

Activities that addressed Chronic Disease:

Target Population(s): • General Community, Slavic, BIPOC, Healthcare Professionals (Conference, CME, MD rotations, etc).

Goal: ADVENTIST HEALTH WILL WORK COLLABORATIVELY TO REDUCE THE INCIDENCE AND IMPACT OF CHRONIC DISEASES LIKE HEART DISEASE, CANCER, AND DIABETES THROUGH CULTURALLY SENSITIVE SCREENINGS, EDUCATION AND TREATMENT, INCLUDING THE USE OF LIFESTYLE MEDICINE APPROACHES

Strategy: Community Health Screenings and interactive Education activities around certain health conditions (CVD, CA, Covid-19, Diabetes, Obesity) with attention to the benefits/"How to" of moving towards a more whole food, plant-based diet, and other healthy lifestyle practices (e.g. sleep, exercise, stress management).

Actions: In 2022 we were still coming out of the COVID-19 pandemic and managing staff shortages and event policy restrictions. We did begin to make some small headway with our community partners in 2022. That included having several staff as participants in the OHSU vaccine equity committee, vaccination events, creating more health information print materials and videos for the general population and having a health and safety station theme at the limited events (Sunday Parks, Montavilla Fair, Portland Pickles games etc,) with COVID tests, sunscreen, heart health resources, and more.

Collaboration Partners: (place a "*" by the lead organization if other than Adventist Health) • NWVeg*, Faith Communities, Impact Your Health Portland*, Compassion Connect*, Hillsboro Medical Center Mammography Van, American Heart Association, American Cancer Society, Neighborhood associations, Goodskin Dermatology, etc.

Activities that addressed Access to Care:

Target Population(s): • Un-insured, underinsured, gap groups, communities of color/immigrants, transportation challenged.

Goal: TO WORK WITH OTHERS TO IMPROVE THE ACCESS TO QUALITY, CULTURALLY APPROPRIATE HEALTHCARE SERVICES IN OUR SERVICE AREA, AND TO WORK PROACTIVELY TO INCREASE THE NUMBERS OF THOSE ENTERING HEALTH CARE CAREERS.

Strategy: Strategy 1: Provide greater access to culturally responsive medical/dental services for low-income, underserved and immigrant individuals and families through direct services and selected partnerships Strategy 2: Provide educational opportunities to improve access to health professionals in the future.

Actions:

Compassion Connect and Impact Your Health: After two years of reductions due to the pandemic we were able to begin some community events again and touch 350 people at several events. Providing health, dental and vision screening and referrals for specialty care if needed.

• Project Access Now program support continued in 2022. Our funding support provided direct patient care for an estimated 1,701 individuals and additional assistance with enrolling in health plans.

• Slavic Navigator Outreach: The program was active during 2022. Much of their work was directed towards heart health and COVID prevention education and answering community questions. Included media articles/posts, radio interviews and phone-based work with patients, providers, civic leaders, etc. A total of 11,556 lives were touched in 2021.

• Patient Transport: For a while, patient services were significantly reduced due to COVID-19, but we did provide transportation services for patients who had no other practical way to receive care. Many of these patients had multiple treatment sessions. Over 5,000 miles of roundtrip transportation services were provided.

• Student Healthcare Leaders: There were two sessions in 2022: Summer & Fall. Number of graduating high school students in the summer included 24 students served. Number of graduating high school students in the fall included 24 students served for a total of 48 students.

• Student Externships & Internships: Opportunities within our hospital increased. A total of 160 RN students and 39 externships were able to complete their academic requirements and provide much needed support within departments across our hospital & community.

Collaboration Partners: (a "*" designates the lead organization)• Impact Your Health Portland group*, Compassion Connect*, Project Access Now*, Portland

Adventist Community Services*. Area high schools, local/out-of-state universities & colleges (OHSU, WWU, etc).

Activities that addressed Behavioral Health:

Target Population(s): • General population, housing challenged, mentally ill, General community, churched/unchurched, smokers, those who are grieving.

Goal: TO SUPPORT THE DEVELOPMENT OF A ROBUST AND SUSTAINABLE BEHAVIORAL HEALTH CARE SYSTEM FOR THE GREATER PORTLAND AREA AND CREATE SOCIAL SUPPORT RESOURCES THAT NURTURE OVERALL WELLBEING – ESPECIALLY FOR THOSE GOING THROUGH TOUGH TIMES.

Strategy: Strategy 1: Improve access to stable emergency and other more formal behavioral health/addiction recovery services through direct services and funded partnerships. Strategy 2: Provide a variety of Addiction, Grief, Social and Spiritual Support & Education Services.

Actions Portland Rescue Mission: A total of 500 pairs of socks were collected for donations to the Portland Rescue Mission. • Support Groups: A total of 40 people were served through the Cancer Support Group Series. Additionally, the "Grieving through the Holidays" session was attended by over 40 people. • New Online programs in Grief and Resiliency were provided in 2022 and offered to our community. Several dozen people attended each. We also created support videos for the website and distribution to the community.

Collaboration Partners: a "*" designates the lead organization if other than Adventist Health) • UNITY Center* (A partnership between AH, OHSU, Kaiser and Legacy), St Vincent DePaul (FORA Health)*, Partner churches, volunteers, specialty speakers

Activities that addressed Food Insecurity, a social determinant of health:

Target Population(s): Immigrant & low-income families, "house bound" seniors.

Goal: TO IMPROVE ACCESS TO QUALITY NUTRITION FOR FOOD INSECURE GROUPS AND BUILD CAPACITY FOR GREATER COMMUNITY NUTRITION SELF SUPPORT.

Strategy: Support Community and School Gardens for low-cost fresh produce, outdoor exercise, community-building, and increased self-sufficiency especially for BIPOC/Refugee community

Actions Results 2022: • Market Street Garden continued in 2022. The Garden provided 27 refugee families with a total of 42,000 sf of growing space. Hailing from Bhutan, Nepal, Burma, Congo, Burundi, Rwanda, Mexico, and Russia, gardeners emphasized the production of hard-to-find, culturally specific produce items such as mustard greens, black nightshade, African eggplant,

amaranth greens, and unique herbs from around the world. • Through our free Celebration of Thanksgiving event we collected 850 pounds of food for Portland Adventist Community Services (PACS). • Other community garden collaborations are in the works and are expected to deploy in 2023.

Collaboration Partners: (a "*" designates the lead organization if other than Adventist Health) Outgrowing Hunger*, PACS. Oregon Food Bank. Other side projects: Meals on Wheels – Cherry Blossom Center

Going Forward:

Our most current CHNA is our 2022 version which covers 2023-2025 which was published on December 2022. The top health needs identified in the 2022 CHNA focused largely on social determinants of health.

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

Top health needs identified in the 2022 CHNA:

- Access to Care
- Food Security
- Health Risk Behaviors
- Housing

Access to Care:

Target Population(s): All the community represented defined as our service area.

Goal: Increase access to care by identifying barriers that prevent patients from accessing the health and human support services they need and collaborating with community-based organizations (CBO) to meet needs and break down barriers.

Strategy: Strengthen referral processes and address identified barriers that inhibit patients from accessing needed health and human support services

Actions: Facilitate development of a process that more smoothly integrates hospital intake and discharge workflows with patient information about their health needs and barriers and connects them with needed CBO resources. Facilitate availability of linguistic and culturally sensitive communications material to help connect patients with needed health and human support

services. Identify and build active partnerships with CBOs providing health and human support services.

Collaboration Partners: North by Northeast Community Health Center, Compassion Connect, Project Access Now

Food security:

Target Population(s): Very low income (50% of median area income) and those living in food desert census tracts.

Goal: Increase access to nutritious foods by collaborating with community-based organizations (CBO) to increase awareness and linkage with nutritious food resources, land to grow personal crops, and culturally sensitive food.

Strategy: Be a resource that links people with nutritious food outlets, provides free access to whole foods/on-site community garden for growing personal crops, and promotes culturally sensitive food.

Actions: Be a resource for awareness and linkage to nutritious food sources, including providing a whole foods/onsite garden program and promoting CBO food partnerships. Facilitate increased access to culturally sensitive foods through active engagement with CBO food partnerships and enhanced communications about how to access locally available food sources. Increase active partnerships with food-related CBOs, including by volunteerism/board service.

Collaboration Partners: Blanchet House, Transition Projects, Portland Rescue Mission.

Health Risk Behaviors:

Target Population(s): Adults with substance use disorders or substance-induced medical emergencies.

Goal: Provide low barrier access to treatment referrals and wrap-around supports for patients with substance use disorders (SUD) via collaboration with community-based organization (CBO) partners.

Strategy: Develop a mental health and SUD treatment framework that supports Emergency Department staff with best care practices for patients with substance use disorders or substance-induced medical emergencies and that facilitates low barrier referrals to engaged CBO partners.

Actions: Strengthen ongoing partnership with Fora Health, SUD/mental health treatment partner, to support priority, low barrier access to treatment for discharged Emergency Department patients. Facilitate the deployment of training programs in partnership with Fora Health to equip Emergency Department staff with best practices for caring for patients with SUD or substance-induced medical emergencies. Build trust among diverse ethnic

groups for SUD/mental health services through connections with culturally sensitive referrals. Increase active partnerships with SUD-related CBOs, including by volunteerism/board service.

Collaboration Partners: Fora Health, Oregon Change Clinic

Housing Access:

Target Population(s): Individuals without stable lodging available to them when Adventist Health services have concluded.

Goal: Increase access to safe and affordable housing/housing support services for un-housed patients of Adventist Health as well as community members with significant housing cost burden.

Strategy: Leverage patient care intake and discharge contact points to increase awareness of and access to safe and affordable housing/housing support services provided by community-based organizations (CBO).

Actions: Identify and build active partnerships with CBOs providing housing/housing support services. Facilitate the development of ways to identify individuals without/at risk for losing stable housing and connect them with resources, such as our CBO partners with an Adventist Health Referral. Facilitate the development of an Emergency Department discharge workflow that connects patients with needed housing/housing support services. Work with local and state governments to help influence public policy addressing access to affordable, stable housing.

Collaboration Partners: Blanchet House, Transition Projects, Portland Rescue Mission